IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WHITMAN-WALKER CLINIC, INC., *et al.*, *Plaintiffs,* v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, *Defendants.*	Case No. 1:20-cv-01630 (JEB)

PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION OR, IN THE ALTERNATIVE, A STAY PENDING JUDICIAL REVIEW PURSUANT TO 5 U.S.C. § 705

Plaintiffs Whitman-Walker Clinic, Inc. d/b/a Whitman-Walker Health; The TransLatin@ Coalition; Los Angeles LGBT Center; Bradbury-Sullivan LGBT Community Center; American Association of Physicians for Human Rights d/b/a GLMA: Health Professionals Advancing LGBTQ Equality; AGLP: The Association of LGBTQ Psychiatrists; Dr. Sarah Henn; Dr. Randy Pumphrey; Dr. Robert Bolan; and Dr. Ward Carpenter (collectively, "plaintiffs") bring this motion for preliminary relief pursuant to Federal Rule of Civil Procedure 65 and Local Rule 65.1 or for an order pursuant to 5 U.S.C. § 705, postponing the effective date, enforcement, and implementation of the final agency action entitled, 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 and 45 C.F.R. pts. 86, 92, 147, 155, & 156) (the "Revised Rule"), promulgated by the U.S. Department of Health and Human Services ("HHS"); Alex M. Azar II, in his official capacity as Secretary of HHS; Roger Severino, in his official capacity as Director, Office of Civil Rights, HHS; and Seema Verma, in her official capacity as Administrator for the Centers of Medicare and Medicaid Service, HHS.

The accompanying Memorandum of Points and Authorities demonstrates plaintiffs are entitled to relief because: the Revised Rule violates the Administrative Procedure Act, the Equal Protection Guarantee and Due Process Clause of the Fifth Amendment, and the Free Speech and Establishment Clauses of the First Amendment to the United States Constitution; the Revised Rule will cause irreparable harm; and the equities and public interest weigh in plaintiffs' favor.

This motion is accompanied by a Memorandum of Points and Authorities; the declarations and exhibits in support of Naseema Shafi, CEO of Whitman-Walker Health; Dr. Sarah Henn, Chief Health Officer of Whitman-Walker Health; Dr. Randy Pumphrey, Senior Director of Behavioral Health at Whitman-Walker Health; Bamby Salcedo, President and CEO of the TransLatin@ Coalition; Arianna Inurritegui-Lint, Executive Director of Arianna's Center; Darrel Cummings, Chief of Staff of the Los Angeles LGBT Center; Dr. Robert Bolan, Chief Medical Officer and Director of Clinical Research for the Los Angeles LGBT Center; Dr. Ward Carpenter, Co-Director of Health Services for the Los Angeles LGBT Center; Adrian Shanker, Founder and Executive Director of the Bradbury-Sullivan LGBT Community Center; Hector Vargas, Executive Director of GLMA; Roy Harker, Executive Director of AGLP; Dr. Deborah Fabian, Member of GLMA; Dr. Randi Ettner; Elena Rose Vera, Executive Director of the Trans Lifeline; and Carrie Davis, Chief Community Officer of The Trevor Project; and a proposed Order.

Pursuant to Local Rule 65.1(d), plaintiffs respectfully request an expedited hearing on the motion. The Revised Rule is scheduled to go into effect on August 18, 2020. In the absence of injunctive relief or a stay of the effective date, plaintiffs, their members, and the patients and individuals whom they serve, as well as similarly-situated LGBTQ patients, health care providers, and LGBTQ organizations nationwide, will suffer direct, immediate, and irreparable harm,

particularly in light of the national emergency caused by the global coronavirus (COVID-19) pandemic.

Pursuant to Local Rule 7(m), counsel for plaintiffs consulted with counsel for defendants in advance of filing this motion. Plaintiffs sought defendants' consent for a stay of the effective date of the Revised Rule pending judicial review in lieu of filing this motion. Defendants informed plaintiffs they are considering plaintiffs' request, but defendants were not able to provide a response before plaintiffs determined it was necessary to move forward with the motion in light of the effective date.

Dated: July 9, 2020

Respectfully submitted,

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** Motion for pro hac vice granted.*

*** Application for admission to U.S. District Court for the District of Columbia forthcoming.*

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PLAINTIFFS' MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF THEIR MOTION FOR A PRELIMINARY INJUNCTION OR, IN THE ALTERNATIVE, A STAY PENDING JUDICIAL REVIEW PURSUANT TO 5 U.S.C. § 705

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Plaintiffs respectfully submit this memorandum of points and authorities in support of their motion for a preliminary injunction enjoining implementation of the rule promulgated by the U.S. Department of Health and Human Services ("HHS") entitled, 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 and 45 C.F.R. pts. 86, 92, 147, 155, & 156) (the "Revised Rule"), or, in the alternative, staying the Revised Rule pending judicial review pursuant to 5 U.S.C. § 705.

Plaintiffs are two private health care facilities that provide services to LGBTQ people (Whitman-Walker Clinic, Inc. d/b/a Whitman-Walker Health and Los Angeles LGBT Center); two LGBTQ-service organizations that provide a wide range of services to the LGBTQ community (the TransLatin@ Coalition and Bradbury-Sullivan LGBT Community Center); two national associations of health professionals (American Association of Physicians for Human Rights d/b/a GLMA: Health Professionals Advancing LGBTQ Equality and AGLP: The Association of LGBTQ+ Psychiatrists); and three individual physicians and one behavioral health provider who work for the private health care provider plaintiffs (Dr. Sarah Henn, Dr. Randy Pumphrey, Dr. Robert Bolan, and Dr. Ward Carpenter) (collectively, "plaintiffs").

INTRODUCTION

The Patient Protection and Affordable Care Act ("ACA") has a clear statutory command: HHS "shall *not* promulgate any regulation that," among other things, "creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care" or "impedes timely access to health care services." 42 U.S.C. § 18114 (emphasis added). But that is precisely what HHS has done. In willful disregard of this command and in defiance of the Supreme Court's decision in *Bostock v. Clayton County, Georgia*, 590 U.S. ___, 2020 WL 3146686 (June 15, 2020), HHS has published a regulation that invites discrimination against LGBTQ people, people with limited English proficiency ("LEP"), and others; burdens affirming health care providers; endangers public health; and harms the health and well-being of LGBTQ people, individuals with LEP, and countless others. And HHS has done so in the midst of a global pandemic.

As of the time of this filing, more than 130,000 Americans have died as a result of what may be the worst public health crisis in America in over a century.[1] An nearly 3 million Americans have tested positive for COVID-19.[2] An effective response to this pandemic turns on the unprecedented testing of patients and tracing the contacts of any person who tests positive.[3] For this to occur, people need to trust their health care providers. The Revised Rule will create the opposite effect. It will cause people to delay health care because of fear of discrimination and undermine our nation's ability to respond to the COVID-19 pandemic.

The Revised Rule is a paradigmatic example of arbitrary and capricious agency action. It purports to implement Section 1557 of the ACA, which specifically and explicitly prohibits discrimination in the provision of health care services on the basis of a person's sex, race, color, national origin, age, and disability. But instead of effectuating the statute's purpose, the Revised Rule undermines it. HHS also failed entirely to consider the harms to LGBTQ people and people with LEP, among others, that will result from the Revised Rule, including denial of access to health care and information. This failure permeated the entire rulemaking process, rendering the entire rule arbitrary and capricious. The Revised Rule also conflicts with existing laws that prohibit discrimination in health care and protect access to care and information. Put simply, the Revised Rule is infected in its entirety by a failure to consider the harms to the health and well-being of LGBTQ people and those with LEP, as well as to public health. Each of its provisions erects a barrier to access to health care for millions of Americans.

Plaintiffs, their members, and their patients will suffer immediate and irreparable harm if the Revised Rule is allowed to go into effect on August 18, 2020, only 60 days after publication. The Court should enjoin the Revised Rule or stay its effective date.

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[1] Centers for Disease Control and Prevention, *Coronavirus Disease 2019 (COVID-19): Cases in the U.S.*, https://perma.cc/A8VV-MFB6 (last visited July 9, 2020).

[2] *Id.*

[3] *See A National Plan to Enable Comprehensive COVID-19 Case Finding and Contact Tracing in the US* (Apr. 10, 2020), at 3 ("COVID-19 Plan"), https://perma.cc/GY86-WXNL.

FACTUAL BACKGROUND

A. Discrimination Against LGBTQ People Prior to the Affordable Care Act

HHS has documented that before the ACA was enacted in 2010, Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010), transgender people experienced many forms of discrimination in accessing health care services, insurance coverage, and facilities. HHS reported that for "transgender individuals, a major barrier to receiving care is a concern over being refused medical treatment based on bias against them." *See* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376, 31,460 (May 18, 2016) (formerly 45 C.F.R. pt. 92) (the "2016 Final Rule"). For example, "[i]n a 2010 report, 26.7% of transgender respondents reported that they were refused needed health care. A 2011 survey revealed that 25% of transgender individuals reported being subject to harassment in medical settings." *Id.*

Some entities providing insurance or health care discriminated against transgender patients by refusing to cover medically necessary treatments for gender dysphoria—a serious medical condition codified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) and International Classification of Diseases (ICD-11)—based on the misguided assumption that such treatments were cosmetic and experimental. *Id.* at 31,429. Those discriminatory exclusions prevented transgender people from obtaining medically necessary treatment for gender dysphoria in accordance with accepted standards of care. *Id.* at 31,460.

Today, medical consensus recognizes that such exclusions have no basis in medical science.[4] As HHS recognized in 2016, the overwhelming consensus among medical experts and every major medical organization is that treatments for gender dysphoria, including surgical procedures, are effective, safe, and medically necessary when clinically indicated to alleviate gender dysphoria. *See* 81 Fed. Reg. at 31,429.

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[4] *See* Decision No. 2576, National Coverage Determination 140.3: Transsexual Surgery at 18 (Docket No. A-13-87) (U.S. Dep't of Health & Human Servs. Appeals Bd. App. Div. 2014), https://perma.cc/3BGA-F9DH; *see also* Ettner ¶¶ 48–51.

B. Sections 1554 and 1557 of the ACA

In enacting the ACA, Congress recognized the importance of providing patients with prompt and nondiscriminatory access to medical care and information about all treatment options. These principles are codified in Sections 1554 and 1557 of the ACA.

Section 1554 prohibits HHS from promulgating regulations that conflict with the primary purpose of the Act—increasing access to timely, effective, and ethical health care. Specifically, it forbids the Secretary of HHS from promulgating any regulation that "creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care," "impedes timely access to healthcare services," or "interferes with communications regarding a full range of treatment options between the patient and the provider," among other things. 42 U.S.C. § 18114.

Section 1557 prohibits discrimination based on sex, which includes discrimination based on gender identity, transgender status, sexual orientation, and failure to conform to sex stereotypes. It also prohibits discrimination on the basis of race, color, national origin, age, and disability. Section 1557 provides, in relevant part:

> Except as otherwise provided for in this title [I] (or an amendment made by this title), an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 794 of Title 29 [Section 504 of the Rehabilitation Act of 1973], 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 this title [I] (or amendments).

42 U.S.C. § 18116(a).

Because Section 1557 applies to "any health program or activity," it covers nearly every health care provider in the country. Section 1557 authorizes HHS to "promulgate regulations to implement this section," limited, of course, by the restrictions in Section 1554. *Id.* § 18116(c).

C. The 2016 Final Rule

On May 18, 2016, HHS published the 2016 Final Rule implementing Section 1557, which specifically defined the statute's prohibition on discrimination "on the basis of . . . sex," to include

"discrimination on the basis of . . . sex stereotyping, and gender identity." 81 Fed. Reg. at 31,467 (formerly 45 C.F.R. § 92.4). The 2016 Final Rule defined "gender identity" as "an individual's internal sense of gender, which may be male, female, neither, or a combination of male and female, and which may be different from an individual's sex assigned at birth." *Id.* at 31,467. The 2016 Final Rule defined "sex stereotypes" as stereotypical notions of masculinity or femininity, including expectations of how individuals represent or communicate their gender to others, such as behavior, clothing, hairstyles, activities, voice, mannerisms, or body characteristics. *Id.* at 31,468. The 2016 Final Rule explained that its express references to gender identity and sex stereotyping were necessary to mitigate ongoing discrimination against transgender patients:

> [D]espite the ACA improving access to health services and health insurance, many . . . transgender individuals continue to experience discrimination in the health care context, which can lead to denials of adequate health care and increases in existing health disparities in underserved communities. *This continued discrimination demonstrates the need for further clarification regarding the prohibition of discrimination on the basis of sex*.

Id. at 31,460 (emphasis added).

HHS intentionally included gender identity and sex stereotyping within the definition of "on the basis of sex" to expand and protect the improvements in coverage and access to health services transgender people had continued to experience since Section 1557's enactment. *Id.*; *see also id.* at 31,455. HHS also supported the increased protections from an economic perspective as insurers would compensate health care providers for an expanded menu of services, resulting in significant savings to the federal government. *Id.* at 31,461. Finally, HHS took into account the intangible benefits of providing "equal access to health care for all." *Id.*

The 2016 Final Rule specifically required covered entities to treat individuals consistent with their gender identity and prohibited covered entities from having or implementing "a categorical coverage exclusion or limitation for all health care services related to gender transition" because such an exclusion is "discriminatory on its face." *Id.* at 31,456; 31,471 (formerly 45 C.F.R. § 92.206); 31,472 (formerly 45 C.F.R. § 92.207(b)(4)).

The 2016 Final Rule applied to "every health program or activity, any part of which receives Federal financial assistance provided or made available by the Department; every health program or activity administered by the Department; and every health program or activity administered by a Title I entity." *Id.* at 31,466 (formerly 45 C.F.R. § 92.2(a)). HHS estimated that the rule would "likely cover almost all licensed physicians because they accept Federal financial assistance." *Id.* at 31,445.

The 2016 Final Rule also included provisions to ensure that the approximately 25 million Americans with LEP have access to the health care they need.[5] It required health care providers and other covered entities to post nondiscrimination notices, include "taglines"—short statements that inform individuals of their right to language assistance and how to seek such assistance—in the top 15 languages spoken throughout the state, and adopt grievance procedures. *Id.* at 31,469 (formerly 45 C.F.R. §§ 92.7, 92.8). The 2016 Final Rule also included standards for language assistance services for persons with LEP. *Id.* at 31,470-71 (formerly 45 C.F.R. § 92.201).

Consistent with the plain language of Section 1557, the 2016 Final Rule adopted a unitary legal standard for addressing discrimination in health care and enforcing Section 1557. *Id.* at 31,472 (formerly 45 C.F.R. § 92.301). HHS explained that all enforcement mechanisms available under the statutes listed in Section 1557 are available for purposes of Section 1557 enforcement, regardless of an individual's protected characteristic or characteristics. *Id.* at 31,439-40. The preamble reinforced this plain meaning understanding of Section 1557's unitary standard. *See id.* at 31,439-40.

The 2016 Final Rule also ensured its application would not unduly impinge on religious freedoms and liberties. HHS did not include Title IX's blanket religious exemption because Section 1557 "contains no religious exemption," and HHS determined religious exemptions in the

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[5] U.S. Census Bureau, *Language Spoken at Home*, American Community Survey 2018 1-Year Estimates Subject Tables, tbl. S1601 (2018), https://perma.cc/Z452-RSWR; U.S. Census Bureau, *Characteristics of People by Language Spoken at Home*, American Community Survey 2018 1-Year Estimates Subject Tables, tbl. S1603, https://perma.cc/R59J-HG4K.

educational context of Title IX were not directly transferable to the health care context. *Id*. at 31,380. Instead, HHS determined a "more nuanced approach in the health care context" was warranted because "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." *Id*. The 2016 Final Rule thus provided: "Insofar as the application of any requirement under this part would violate applicable Federal statutory protections for religious freedom and conscience, such application shall not be required." *Id*. at 31,466 (formerly 45 C.F.R. § 92.2(b)(2)).

The 2016 Final Rule has resulted in a decrease in discriminatory policies and practices. It also helped persuade Medicaid administrators, insurance companies, and employee health plan sponsors to eliminate outdated exclusions that discriminated on the basis of sex and to cover procedures supported by evidence of medical necessity.[6] For example, a recent study of 37 states in the federal marketplace showed that in 2020, 97% of plans did not contain blanket exclusions of transition-related care.[7]

D. The Proposed Revisions to the 2016 Final Rule

As part of the Trump Administration's concerted and aggressive effort to undermine protections for LGBTQ people,[8] on June 14, 2019, HHS issued a Notice of Proposed Rulemaking, proposing to "make substantial revisions" to the 2016 Final Rule. *See* Notice of Proposed Rulemaking, Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27,846, 27,848 (June 14, 2019) ("Proposed Rule"). Those revisions included: repealing the definition of "on the basis of sex" and the specific prohibition on discrimination on the basis of

[6] *See* Sharita Gruberg and Frank J. Bewkes, *The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial*, Center for American Progress (Mar. 7, 2018), https://perma.cc/CTP2-UMEJ.

[7] Out2Enroll, *Summary of Findings: 2020 Marketplace Plan Compliance with Section 1557*, https://perma.cc/WU25-C9BN.

[8] *See, e.g.*, Erica L. Green, Katie Benner & Robert Pear, '*Transgender' Could Be Defined Out of Existence Under Trump Administration*, N.Y. Times (Oct. 21, 2018), https://perma.cc/YQR6-YN2F; Notification of Nonenforcement of Health and Human Services Grants Regulation, 84 Fed. Reg. 63,809 (Nov. 19, 2019).

gender identity and sex stereotyping; eliminating the notice and critical language access requirements; narrowing the scope of entities covered under Section 1557; eliminating the unitary legal standard and mechanisms for enforcing violations of Section 1557; incorporating sweeping religious exemptions; eliminating gender identity and sexual orientation protections in unrelated regulations; and eliminating protections related to discrimination on the basis of association. *Id.* at 27,848-49.

HHS received nearly 200,000 comments during the public comment period. 85 Fed. Reg. at 37,164. Those comments identified and expressed concerns about many of HHS's proposed revisions, emphasizing that the proposed changes, individually or combined, will cause immediate and irreparable harm to LGBTQ people. For example, they noted that repealing the definition of "on the basis of sex" and the specific prohibition on discrimination on the basis of gender identity and sex stereotyping will invite covered health care providers and insurers to discriminate against transgender people and cause confusion about patients' rights. *Id.* at 37,164-65. Commenters also observed that eliminating notice requirements and critical language access provisions will result in decreased access to health care for patients with LEP. *Id.* at 37,204. In addition, narrowing the scope of entities covered under Section 1557 will cause drastic reductions in protections and insurance coverage for LGBTQ people. *Id.* at 37,170-74.

E. The Revised Rule

Despite the significant concerns raised during the comment period, HHS published the Revised Rule on June 19, 2020, with only "minor and primarily technical corrections." *Id.* at 37,161. HHS claimed it was promulgating the Revised Rule to "better comply with the mandates of Congress," further "substantive compliance," reduce confusion, and "clarify the scope of Section 1557." *Id.* at 37,161. HHS further asserted it was reverting "to longstanding statutory interpretations that conform to the plain meaning of the underlying civil rights statutes and the United States Government's official position concerning those statutes." *Id.*

In publishing the Revised Rule, HHS did not take into account that, just four days earlier, on June 15, 2020, the Supreme Court held that discrimination based on transgender status or sexual

orientation "necessarily entails discrimination based on sex." *Bostock*, 2020 WL 3146686, at *11.[9] Rather, HHS proceeded with its elimination of the definition of "on the basis of sex" and the 2016 Final Rule's specific prohibitions on discrimination on the basis of gender identity and sex stereotyping, despite having acknowledged that "a holding by the U.S. Supreme Court on the meaning of 'on the basis of sex' under Title VII will likely have ramifications for the definition of 'on the basis of sex' under Title IX." 85 Fed. Reg. at 37,168.

Relying essentially on one district court opinion—*Franciscan Alliance, Inc.* v. *Burwell*, 227 F. Supp. 3d 660 (N.D. Tex. 2016)—which the preamble cites more than 40 times, HHS claimed "the ordinary public meaning of the term 'sex' in Title IX is unambiguous" and refers to a "biological binary meaning of sex." 85 Fed. Reg. at 37,178-80. HHS also declared that discrimination on the basis of sex under Title IX does not encompass discrimination based on gender identity or sex stereotyping. *Id.* at 37,183-86. According to HHS, it means "discrimination on the basis of the fact that an individual is biologically male or female." *Id.* at 37,178.

HHS also adhered to its other proposed revisions, repealing the notice and access to language provisions; excluding from Section 1557's scope certain health programs and activities and health insurance plans; incorporating sweeping religious exemptions; repealing the unitary legal standard; and repealing gender identity and sexual orientation protections in unrelated regulations and provisions relating to nondiscrimination based on association. *Id.* at 37,161-62.

F. Harms to Plaintiffs, Their Members, Their Patients, and Health Care Providers and Patients Nationwide

The Revised Rule's elimination of the specific prohibitions on discrimination on the basis of gender identity and sex stereotyping means plaintiffs' members and LGBTQ patients will face a greater risk of discrimination in health care. Patients may even be outright denied care on the

[9] Although the 2016 Final Rule framed discrimination against transgender people in terms of "gender identity" and *Bostock* framed it in terms of "transgender status," the result is the same: discrimination against transgender people is sex discrimination. *See*, *e.g.*, *Bostock*, 2020 WL 3146686, at *19 n.6 (Alito, J., dissenting) ("[T]here is no apparent difference between discrimination because of transgender status and discrimination because of gender identity.").

basis of their gender identity, transgender status, or sexual orientation. Many LGBTQ patients (including patients of Whitman-Walker Health and the LA LGBT Center) report being discriminated against on the basis of their sexual orientation, gender identity, or transgender status when seeking health care. Shafi ¶¶ 9, 17; Henn ¶ 9; Pumphrey ¶ 10; Cummings ¶ 22; Bolan ¶¶ 8-9, 12, 23; Carpenter ¶¶ 4, 8, 22; *see also* Vargas ¶¶ 10, 20-22; Harker ¶¶ 8-9; Shanker ¶¶ 17, 19. The problem is particularly acute for transgender patients who seek treatment for gender dysphoria or gender-affirming care, although transgender patients are discriminated against and misgendered even when they seek basic care. Shafi ¶ 17(c)-(e); Henn ¶ 9(a), (c), (g)-(j), (n), (o); Pumphrey ¶ 10(a); Cummings ¶¶ 22(a)-(c), 22(g), 22(h); Bolan ¶¶ 8-9, 12, 23; Carpenter ¶¶ 8, 22; *see also* Vargas ¶ 20(a)-(b); Harker ¶ 9; Shanker ¶¶ 8, 17, 19; Salcedo ¶¶ 11, 14, 20, 22, 31; Lint ¶¶ 16, 24, 28-31, 42-43.

In addition, patients will face and fear increased discrimination, which for many patients will cause them to delay or avoid obtaining needed medical care. Shafi ¶¶ 21, 22; Henn ¶¶ 7, 11, 19; Pumphrey ¶¶ 7, 12, 13; Cummings ¶¶ 5, 8, 16-19, 22(k), 22(m); Bolan ¶¶ 11-12, 15, 19-20; Carpenter ¶¶ 8(c), 9, 11, 16, 18-19; *see also* Salcedo ¶¶ 24, 25, 31, 33; Lint ¶ 48; Vargas ¶ 20(c); Harker ¶ 8; Shanker ¶¶ 22-23; Fabian ¶ 20. And if they do seek care, they will be discouraged from fully disclosing personal information that health care providers need for proper diagnosis and treatment. Cummings ¶¶ 22(g), (l)-(m), 24, 29; Carpenter ¶¶ 9, 11, 12 14; *see also* Harker ¶ 19; Shanker ¶¶ 22-23. Patients' delays or failures to obtain treatment will increase the direct cost of treating physical medical conditions and create risks to patient safety that can lead to poor patient outcomes. The Revised Rule thus will increase costs to patients, insurers, providers, and the overall health care system. Shafi ¶¶ 19-23; Cummings ¶¶ 14, 18, 20, 26, 33; *see also* Shanker ¶ 25; Salcedo ¶ 36.

The Revised Rule's elimination of the explicit prohibitions on categorical coverage exclusions for gender-affirming care, combined with its narrow interpretation of what constitutes a covered entity, will result in a reduction in coverage and access to medically necessary health care for transgender and gender nonconforming patients. Shanker ¶ 28; Shafi ¶¶ 24-29; Cummings

¶ 30; Salcedo ¶ 39; Lint ¶¶ 48, 57-58. As a result, the private health care provider plaintiffs will face increased costs because many private and public plans will refuse to cover medically necessary procedures based on the Revised Rule's elimination of protections against gender identity discrimination. Shafi ¶ 35; *see also* Salcedo ¶ 44. Plaintiffs, in turn, will be forced to cover the costs of these medically necessary procedures or turn away LGBTQ patients who need these services but cannot afford to pay for them out of pocket. Likewise, patients may forgo necessary care due to the high cost of these procedures.

The Revised Rule also will immediately scale back the notice and language access requirements from the 2016 Final Rule. The elimination of these notices will harm LGBTQ patients with LEP, in particular, because it will be more difficult for them to be aware of their rights, which language services and aids are available, how to access such services, and how to handle discrimination and complaints. Salcedo ¶¶ 40-41; Lint ¶ 53; Shafi ¶ 32; Cummings ¶¶13, 33. The health care system was already difficult to navigate for individuals with LEP, and the Revised Rule exacerbates these difficulties, undermining access to health care, health insurance, and legal redress. Salcedo ¶ 41; Lint ¶ 55; Shafi ¶ 32; Cummings ¶¶ 13, 27.

LEGAL STANDARD

A preliminary injunction is a stopgap measure to "preserve the relative positions of the parties" pending judicial review on the merits. *Univ. of Texas v. Camenisch*, 451 U.S. 390, 395 (1981). The Administrative Procedure Act ("APA") separately authorizes the Court to "postpone the effective date of an agency action" pending judicial review to "preserve status" and "prevent irreparable injury." 5 U.S.C. § 705. Section 705 "plainly and simply authorizes courts to stay agency rules pending judicial review." *District of Columbia v. U.S. Dep't of Agric.*, No. 20 Civ. 119, 2020 WL 1236657, at *34 (D.D.C. Mar. 13, 2020) (cleaned up).

A party seeking a preliminary injunction must "make a 'clear showing that four factors, taken together, warrant relief: likely success on the merits, likely irreparable harm in the absence of preliminary relief, a balance of the equities in its favor, and accord with the public interest.'"

Pursuing Am.'s Greatness v. FEC, 831 F.3d 500, 505 (D.C. Cir. 2016) (quoting *Winter v. Natural Resources Def. Council*, 555 U.S. 7, 20 (2008)).

Although plaintiffs seeking a preliminary injunction "have the burden of demonstrating likelihood of success on the merits, they are not required to prove their case in full at the preliminary injunction stage, but only such portions that enable them to obtain the injunctive relief that they seek." *Jacinto-Castanon de Nolasco v. U.S. Imm. & Customs Enforcement*, 319 F. Supp. 3d 491, 499 (D.D.C. 2018). Similarly, where "multiple causes of action are alleged, plaintiff need only show likelihood of success on one claim to justify injunctive relief." *Kirwa v. U.S. Dep't of Defense*, 285 F. Supp. 3d 21, 35 (D.D.C. 2017) (cleaned up). Courts in this district routinely grant motions for preliminary injunctions upon a finding that plaintiffs are likely to prevail on at least one claim entitling them to injunctive relief. *See, e.g.*, *Jubilant Draxlmage Inc. v. U.S. Int'l Trade Comm'n*, 396 F. Supp. 3d 113, 123 (D.D.C. 2019); *FBME Bank Ltd. v. Lew*, 125 F. Supp. 3d 109, 118 (D.D.C. 2015).

ARGUMENT

I. PLAINTIFFS ARE LIKELY TO SUCCEED ON THE MERITS.

A. The Revised Rule Violates the APA.

1. The Revised Rule is Arbitrary and Capricious.

The APA requires courts to "hold unlawful and set aside agency actions" that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). An agency rule is arbitrary and capricious if the agency has "entirely failed to consider an important aspect of the problem," or "offered an explanation for its decision that runs counter to the evidence before the agency." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). An agency "is required to 'examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made.'" *Stewart v. Azar*, 366 F. Supp. 3d 125, 135 (D.D.C. 2019) (Boasberg, J.) (quoting *State Farm*, 463 U.S. at 43). Where an agency departs from a prior policy, it must "display awareness that it is changing position," show that "there are good reasons" for the

reversal, and demonstrate that its new policy is "permissible under the statute." *F.C.C. v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009). The agency must also "be cognizant that longstanding policies may have 'engendered serious reliance interests that must be taken into account.'" *Dep't of Homeland Sec. v. Regents of the Univ. of California*, 140 S. Ct. 1891, 1913 (2020) (quoting *Encino Motorcars LLC v. Navarro*, 136 S. Ct. 2117, 2126 (2016)). It is "arbitrary and capricious to ignore such matters." *Id.*

The Revised Rule fails on all accounts. HHS failed to supply a reasoned explanation for its policy change from the 2016 Final Rule, it adopted a regulation not supported by and contrary to the evidence in the administrative record, and it failed to address important issues raised during the notice-and-comment process – in particular, the substantial harms LGBTQ people will suffer as a result of the Revised Rule.

a. HHS Failed to Supply a Reasoned Explanation for its Policy Change from the 2016 Final Rule to the Revised Rule.

The Revised Rule represents a significant change in policy from the 2016 Final Rule, eliminating many of the 2016 Final Rule's protections from discrimination in health care for LGBTQ people. The record before HHS does not support its proffered justifications for the Revised Rule – "to better comply with the mandates of Congress," reduce confusion, further substantive compliance, and revert to "longstanding statutory interpretations." *See* 85 Fed. Reg. at 37,161. The Revised Rule conflicts with Section 1557's prohibitions on discrimination in health care and the *Bostock* decision. It conflicts with Section 1554's prohibition on rules that create unreasonable barriers and impede access to health care services. The Revised Rule creates confusion; it does not reduce it. And there is no evidence that the Revised Rule furthers substantive compliance. The problems with the Revised Rule are particularly apparent with respect to the elimination of the definition of "on the basis of sex," the elimination of the prohibition on categorical insurance coverage exclusions, the elimination of notice and language access requirements, and the narrowing of entities covered under Section 1557.

(1) *Bostock* Forecloses HHS's Elimination of the Definition of "On the Basis of Sex."

On June 15, 2020, in *Bostock*, the Supreme Court categorically held that discrimination based on transgender status or sexual orientation "necessarily entails discrimination based on sex." *Bostock*, 2020 WL 3146686, at *11. The Court declared: "it is impossible to discriminate against a person for being homosexual or transgender without discriminating against that individual on the basis of sex." *Id.* at *7. Nevertheless, undeterred from its goal to foster discrimination against LGBTQ people, four days later on June 19, 2020, HHS published the Revised Rule repealing the 2016 Final Rule's definition of discrimination "on the basis of sex" and its specific prohibitions on discrimination on the basis of gender identity and sexual orientation. It did so even though the Revised Rule acknowledged that "a holding by the U.S. Supreme Court on the meaning of 'on the basis of sex' under Title VII will likely have ramifications for the definition of 'on the basis of sex' under Title IX." 85 Fed. Reg. at 37,168.

Moreover, HHS not only eliminated the definition of discrimination "on the basis of sex," but also declared affirmatively that discrimination on the basis of sex *does not* include discrimination on the basis of gender identity or sexual orientation. *See, e.g.*, *id.* at 37,183 ("The Department disagrees with commenters who contend that Section 1557 or Title IX encompass gender identity discrimination within their prohibition on sex discrimination."); *id.* at 37,180 ("Unlike other bases of discrimination, the categories of gender identity and sexual orientation . . . are not set forth" in the statutes incorporated into Section 1557). HHS staked its position entirely on: (1) the *Franciscan Alliance* decision where HHS refused to defend the 2016 Final Rule's provisions or to appeal the district court's ruling; and (2) the government's litigation position in *Bostock* "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.

Bostock conclusively rejects HHS's position that Section 1557 *does not* encompass discrimination against LGBTQ people and forecloses its repeal of the definition of discrimination "on the basis of sex." *Bostock* also forecloses HHS's elimination of gender identity and sexual orientation protections in unrelated regulations. *See* 85 Fed. Reg. at 37,219.

In light of the Supreme Court's ruling in *Bostock*, HHS could have postponed publication of the Revised Rule, as commenters urged, *see* 85 Fed. Reg. at 37,168, or rescinded it altogether. *See, e.g.*, *Williams Natural Gas Co. v. FERC*, 872 F.2d 438, 450 (D.C. Cir. 1989); *State Farm*, 463 U.S. at 42. It did neither.

Even apart from *Bostock*, HHS acted arbitrarily and capriciously in eliminating the definition of discrimination "on the basis of sex." HHS claimed in so doing it was reverting to "longstanding statutory interpretations" of the civil rights statutes underlying Section 1557 that conform with the government's "official position concerning those statutes." 85 Fed. Reg. at 37,161. But in 2012, OCR specifically stated, "Section 1557's sex discrimination prohibition extends to claims of discrimination based on gender identity or failure to conform to stereotypical notions of masculinity or femininity," and took the position that Section 1557 prohibited discrimination on the basis of sexual orientation.[10] In addition, in 2015, OCR entered into a voluntary agreement with The Brooklyn Hospital Center resolving allegations of gender identity discrimination under Section 1557. *See* 85 Fed. Reg. at 37,191. Consistent with OCR's position, the 2016 Final Rule defined discrimination "on the basis of sex" to include discrimination against LGBTQ people. *See* 81 Fed. Reg. at 31,467 (formerly 45 C.F.R. § 92.4).

HHS also ignored the considered views of other agencies and dozens of federal district and appellate courts, which held that discrimination on the basis of transgender status is a form of sex discrimination. *See* Letter from Sasha Buchert, Senior Attorney, Lambda Legal, et al., to the Hon. Alex M. Azar, II, Sec'y, U.S. Dep't Health & Hum. Servs. (Aug. 13, 2019), at 9-11, https://perma.cc/FV38-3ZLC (documenting cases).

HHS did not provide a reasonable explanation for its change in position. Rather, HHS simply "disavow[ed] the views" in the 2012 letter and the voluntary resolution agreement, stating it had "concluded that the 2012 OCR letter reflected an incorrect understanding of Title IX, as

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[10] Letter from Leon Rodriguez, Director, U.S. Dep't of Health & Human Servs., Office for Civil Rights, to Maya Rupert, Federal Policy Director, National Center for Lesbian Rights (Jul. 12, 2012), https://perma.cc/RB8V-ACZU.

incorporated into Section 1557." 85 Fed. Reg. at 37,191. HHS provided no further explanation, as required under *Fox Television Stations* when there is a policy reversal. *See* 556 U.S. at 515. The Revised Rule is arbitrary and capricious and should be set aside.

(2) HHS's Elimination of the Prohibition on Categorical Coverage Exclusions is Unreasonable and Not Supported by the Evidence.

HHS attempts to justify its elimination of the 2016 Final Rule's prohibition on categorical coverage exclusions related to gender-affirming care by claiming the prohibition "inappropriately interfered with the ethical and medical judgment of health professionals." 85 Fed. Reg. at 37,187. HHS stated it "does not believe that the nondiscrimination requirements in Title IX, incorporated by reference into Section 1557, foreclose medical study or debate on these issues." *Id.*

HHS's reasoning is illogical. Nothing in the 2016 Final Rule foreclosed medical study or debate on gender-affirming care. It simply prohibited insurance companies from *categorically* excluding or limiting coverage for *all* health services related to gender-affirming care. *See* 81 Fed. Reg. at 31,429. As such, the 2016 Final Rule enabled doctors, rather than insurance companies, to use their medical expertise to make individualized treatment decisions. If the Revised Rule goes into effect, many doctors who deem gender-affirming care to be medically necessary will be forced to either forgo compensation from insurers or deny patients care. Thus, it is the Revised Rule, not the 2016 Final Rule, that "inappropriately interfere[s] with the ethical and medical judgment of health professionals." 85 Fed. Reg. at 37,187.

HHS's decision to allow insurers to once again categorically exclude or limit coverage for gender-affirming care is based on a supposed "lack of scientific and medical consensus" regarding "the value of various 'gender-affirming' treatments for gender dysphoria." *Id.* This statement runs counter to the national medical consensus, and the evidence on which HHS relies does not support its conclusions.

First, virtually every major medical and mental health organization in the United States, including the American Medical Association, the Endocrine Society, the American Psychological Association, and the American Psychiatric Association, among others, has endorsed the protocols

for gender-affirming treatment set forth in the *Standards of Care for the Health of Transsexual, Transgender and Gender-nonconforming People*, published by the World Professional Association for Transgender Health (WPATH). Ettner ¶ 31.

Second, HHS cites an August 30, 2016 decision in which the Centers for Medicare and Medicaid Services ("CMS") "declined to issue a National Coverage Determination (NCD) on sex-reassignment surgery for Medicare beneficiaries with gender dysphoria." 85 Fed. Reg. at 37,187 & n.157 (citing CMS, *Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N)* (Aug. 30, 2016), https://perma.cc/9S73-4WQB). But declining to issue a NCD only means coverage determinations are made on a case-by-case basis, not that such treatment is or may be categorically excluded. CMS specifically explained that in declining to issue a national policy, the result "*is not national non-coverage*" under the Medicare program. Rather, coverage determinations would continue to be made on a case-by-case basis. CMS, *Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N)* (Aug. 30, 2016), at 2, https://perma.cc/9S73-4WQB (emphasis added). In addition, contrary to HHS's suggestion, CMS confirmed the value of gender-affirming treatments for gender dysphoria, specifically encouraging "robust clinical studies that will fill the evidence gaps and help inform which patients are most likely to achieve improved health outcomes with gender reassignment surgery, which types of surgery are most appropriate, and what types of physician criteria and care setting(s) are needed to ensure that patients achieve improved health outcomes." *Id.*

Third, HHS cites a 2018 Department of Defense report regarding whether to allow transgender people to serve in the military. 85 Fed. Reg. at 37,187 n.159 (citing Department of Defense, *Report and Recommendations on Military Service by Transgender Persons* (Feb. 22, 2018), https://perma.cc/7369-K2VC ("DOD Report")). HHS quotes the report's finding that there is "considerable scientific uncertainty and overall lack of high quality scientific evidence demonstrating the extent to which transition-related treatments . . . remedy the multifaceted mental health problems associated with gender dysphoria." *Id.* at 37,187 (quoting DOD Report at 5). Relying on this report is patently unreasonable. DOD commissioned the report at the request of

President Trump, who was seeking to reverse the Obama Administration policy allowing transgender people to serve openly in the military. *See* DOD Report, Cover Letter at 1. And the report's recommendations were expressly "based on each Panel member's independent *military judgment*." DOD Report at 4 (emphasis added). The report was not based on medical or scientific evidence or judgment.

Finally, HHS refers to other research that "has found that children who socially transition in childhood faced dramatically increased likelihood of persistence of gender dysphoria into adolescence and adulthood." 85 Fed. Reg. at 37,187 & n.160. HHS mischaracterizes the research. What the study concluded is that the intensity of early gender dysphoria appears to be an important predictor of persistence of gender dysphoria into adolescence and adulthood.[11] HHS's implication that "coming out" about one's gender identity in childhood somehow makes things worse later in life is both incorrect and misleading.

In addition, HHS fails to consider the reliance of transgender patients, insurance companies, and organizations like plaintiffs on the protections in the 2016 Final Rule. Indeed, some of the plaintiffs have relied on the 2016 Final Rule's prohibition on categorical coverage exclusions related to gender-affirming care to advocate for their transgender patients and clients. Shafi ¶ 25-26; Shanker ¶¶ 8-9, 11; *see also* Gruberg & Bewkes, *supra*. Because HHS was "not writing on a blank slate, it *was* required to assess whether there were reliance interests, determine whether they were significant, and weigh any such interests against competing policy concerns." *Dep't of Homeland Sec.*, 140 S. Ct. at 1915.

HHS's decision to allow covered insurance providers to exclude categorically or limit gender-affirming care is contrary to the evidence in the administrative record and unreasonable.

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[11] Thomas D. Steensma, et al., *Factors Associated with Desistance and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study*, 52(6) J. of the Am. Acad. of Child & Adolescent Psychiatry 582-90, 582 (2013).

(3) HHS Provided No Reasoned Explanation for the Elimination of the Notice and Language Access Requirements.

HHS's only proffered justification for repealing the notice and language access requirements in the 2016 Final Rule was that they were "unnecessary" because the statutes underlying Section 1557 contained notice provisions, and compressing them "into a single standard under the 2016 Rule has led to an unjustifiable burden and understandable confusion." 85 Fed. Reg. at 37,204. But HHS did not explain how individuals will know about their rights under Section 1557 without these notices, when not all the underlying statutes apply to every health care provider. And it pointed to no evidence of "understandable confusion" attributable to them.

Indeed, it is the elimination of these notice and language access provisions that is likely to create confusion. Without the notice, tagline, and LEP requirements, individuals will not know about their health care rights under Section 1557, and patients with LEP in particular may fail to understand or assert their rights because of language barriers. Patients with LEP, in turn, may fail to receive adequate care because of difficulties in understanding their providers or other staff, undermining the purpose and intent of the nondiscrimination provisions of Section 1557.

This terse explanation, which says "almost nothing," is wholly inadequate to justify a policy reversal. *Encino Motorcars*, 136 S. Ct. at 2127; *see also New York* v. *Dep't of Health & Human Servs.*, 414 F. Supp. 3d 475, 549 (S.D.N.Y. 2019).

(4) HHS's Narrowing of the Entities Covered Under Section 1557 is an Arbitrary Policy Reversal.

HHS's attempt to narrow the scope of entities covered under Section 1557 is also an arbitrary reversal in policy from the 2016 Final Rule. Although HHS acknowledged it was reversing course from the 2016 Final Rule, its explanation falls short of the required standard of a *reasoned* explanation for the change. *See Fox Television Stations*, 556 U.S. at 515.

HHS first attempts to limit Section 1557's nondiscrimination protections only to health programs or activities of HHS administered under Title I of the ACA, not to other health programs and activities that HHS administers. *See* 85 Fed. Reg. at 37,244 (to be codified at 45 C.F.R. § 92.3(a)(2)). Such a limitation, however, is inconsistent with the plain language of Section 1557,

which states Section 1557 applies to "any program or activity that is administered by an Executive Agency *or* an entity established under this title." 42 U.S.C. § 18116(a) (emphasis added).

HHS's only explanation for its policy change was it no longer agreed with the 2016 Final Rule's decision to add "health" as a limiting modifier to "program or activity" because Congress had not included such a modifier in the statutory text. *See* 85 Fed. Reg. at 37,170. Instead, HHS decided, "Congress had already placed a limitation in the text of Section 1557 by applying the statute to any program or activity administered by an Executive Agency 'under this title' (meaning Title I of the ACA)." *Id*. But HHS's new interpretation reads the word "or" out of the statute.

The consequence of HHS's unreasonable interpretation is that numerous HHS health programs and activities, including health programs and activities of CMS, the Centers for Disease Control and Prevention, Indian Health Service, the National Institutes of Health, and the Substance Abuse and Mental Health Services Administration, are no longer covered under Section 1557. This result is illogical and inconsistent with Section 1557.

HHS's declaration that health insurers are not a "program or activity" under Section 1557 and not subject to Section 1557's nondiscrimination prohibitions because they are not "principally engaged in the business of providing healthcare," 85 Fed. Reg. at 37,244-45 (to be codified at 45 C.F.R. § 92.3(c)), is likewise unreasonable. To support its new interpretation, HHS contends that providing "health insurance" is different than providing "healthcare" and points to the definitions of "healthcare" and "health insurance" in unrelated statutes to support its distinction. *See id.* at 37,172-73. But Section 1557 plainly covers "health programs and activities," not just direct health care. And health insurance clearly is a health-related program or activity. It is what enables the vast majority of Americans to access health care.

HHS's reliance on unrelated statutes for its new interpretation is also unavailing. For example, HHS points to 42 U.S.C. § 300gg-91. *See id.* at 37,172. But 42 U.S.C. § 300gg-91, which defines terms for federal laws regulating health insurance, specifically defines "health insurance coverage" to include benefits consisting of medical care and acknowledges health insurance is one way of providing health care. HHS's appeal to language in the Civil Rights

Restoration Act ("CRRA") also misses the mark. *See* 85 Fed. Reg. at 37,171-73. The CRRA's general language amended four civil rights statutes in 1988 to make clear that if any part of a program or activity receives federal financial assistance, the entire program must comply with applicable civil rights laws. *See* Pub. L. No. 100-259, 102 Stat. 28 (Mar. 22, 1988). Congress enacted Section 1557 more than two decades later to prohibit discrimination in all "health programs and activities," any part of which is receiving federal financial assistance, based on the characteristics listed in Title IX and three other statutes. The CRRA did not address whether health insurance is a "health program or activity." Congress did not incorporate the definitions contained in the CRRA into Section 1557. And Section 1557 is more expansive than the statutes the CRRA amended. HHS's reliance on the CRRA to exclude health insurance providers from Section 1557 is unreasonable and contrary to Section 1557, which covers all health programs and activities.

(5) HHS Failed to Provide a Reasoned Explanation for Incorporating Sweeping Religious Exemptions.

The 2016 Final Rule declined to import Title IX's blanket religious exemption into Section 1557, explaining that it would be inappropriate in the health care setting because the Title IX exemption is framed for educational institutions, which are very different from health care settings, and those differences "warrant different approaches." 81 Fed. Reg. at 31,380. The Revised Rule reversed this policy by incorporating not only Title IX's blanket religious exemption, but also sweeping religious exemptions from a number of different statutes. *See* 85 Fed. Reg. at 37,245 (to be codified at 45 C.F.R. § 92.6(b)).

In so doing, HHS did not analyze why Title IX's blanket exemption, framed for educational institutions, suddenly was appropriate for the health care setting. *See id.* at 37,205-09. Nor did HHS address its prior factual finding 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 also failed to address the concern that the Revised Rule decreases protections for patients while increasing exemptions for providers, even though at least one commenter pointed out that

between 2008 and January 2018, HHS received fewer than 50 complaints regarding violations of religious or conscience statutes while receiving 30,000 complaints of civil rights discrimination in 2017 alone. *See* 85 Fed. Reg. at 37,206.

HHS's primary justification for its policy reversal was its claim that avoiding burdens on conscience "will protect both providers' medical judgment and their consciences, thus helping to ensure that patients receive the high quality and conscientious care that they deserve." 85 Fed. Reg. at 37,206. But HHS provided no basis for its assertion that the religious conscience provisions will help "ensure that patients receive the high quality and conscientious care that they deserve." And it ignored HHS's prior factual finding that a blanket religious exemption could result in denial or delay of health care in favor of an unsupported, contradictory finding without acknowledging or explaining the inconsistency in positions. This unexplained inconsistency renders these provisions arbitrary and capricious. *See New York*, 414 F. Supp. 3d at 550-51.

HHS also ignored that the incorporation of these exemptions runs counter to medical ethics, standards of care, and other statutes, like the Emergency Medical Treatment and Labor Act ("EMTALA"). HHS failed to explain why the Revised Rule "does not conflict with EMTALA, which . . . does not contain an exception for conscience or other objections." *Id.* at 555.

b. HHS Failed to Consider Important Aspects of the Problem.

A rule is arbitrary and capricious, where, as here, the agency "'entirely failed to consider an important aspect of the problem.'" *Stewart*, 366 F. Supp. 3d at 135 (quoting *State Farm*, 463 U.S. at 43). An agency "must respond to significant points raised during the public comment period." *Allied Local & Reg'l Mfrs. Caucus v. EPA*, 215 F.3d 61, 80 (D.C. Cir. 2000). Defendants did not meet this standard.

HHS failed entirely to consider the harm the Revised Rule will cause to LGBTQ people, including those with LEP. Despite receiving nearly 200,000 comments, HHS published the Revised Rule with only "minor and primarily technical corrections." 85 Fed. Reg. at 37,161. It ignored the multitude of concerns that major medical organizations, patient advocacy organizations, and individuals raised that the Revised Rule would invite discrimination against

LGBTQ people and undercut access to health care. HHS's failure to consider these harms, which permeated the entire rulemaking process, renders the Revised Rule arbitrary and capricious.

(1) HHS's Dismissal of the Harm to LGBTQ People from the Revised Rule Does Not Withstand Scrutiny.

HHS brushed aside concerns that the Revised Rule would invite discrimination against LGBTQ people, and transgender individuals in particular, with the simple assertion: "The Department does not believe that this final rule will lead to significant burdens on entities due to changes to the gender identity language from the 2016 Rule, nor that the commenters have identified sufficient data to show that these negative consequences will occur or the extent to which they will occur." *Id*. at 37,225. Despite extensive evidence in the administrative record showing LGBTQ people already face particularly acute barriers to care and health disparities, HHS claimed it knew "of no data showing" that the Revised Rule would "disproportionately burden individuals on the basis of sexual orientation and/or gender identity." *Id.* at 37,182. HHS also specifically admitted it did not take into account the costs or harms to transgender patients, claiming it lacked "the data necessary to estimate the number of individuals who currently benefit from covered entities' policies governing discrimination on the basis of gender identity who would no longer receive those benefits after publication of this rule." *Id.* at 37,225. HHS further claimed it lacked data "to estimate what greater public health costs, cost-shifting, and expenses may result from entities changing their nondiscrimination policies and procedures after promulgation" of the Revised Rule. *Id*.

HHS is not entitled simply to disregard costs that are uncertain or difficult to quantify. As this Circuit has held, the "mere fact" that the effect of a rule "is *uncertain* is no justification for *disregarding* the effect entirely." *Pub. Citizen v. Fed. Motor Carrier Safety Admin.*, 374 F.3d 1209, 1219 (D.C. Cir. 2004).

HHS also contends the Revised Rule will not increase levels of discrimination because many states and localities already prohibit gender identity and sexual orientation discrimination, and the Revised Rule does not "prohibit[] entities from maintaining gender identity

nondiscrimination policies and procedures voluntarily." 85 Fed. Reg. at 37,225. But the effectiveness of a nondiscrimination statute and implementing regulation cannot be measured by reference to the entities that *voluntarily do not discriminate*. And, even if some states and localities offer the same level of protection as the 2016 Final Rule, *others do not*. HHS acknowledges receiving comments noting that many LGBTQ people live in states that do not prohibit insurers from discriminating based on LGBTQ status. *See id*. at 37,182. Furthermore, at least thirty (30) states do not have laws prohibiting health insurers from discriminating on the basis of gender identity.[12] The Revised Rule will have a significant effect on access to health care for LGBTQ people across the country. Shafi ¶¶ 13-23, 27-29; Cummings ¶¶ 16, 18, 20, 22, 29, 30, 32-33; Shanker ¶¶ 9-18, 20-24; Vargas ¶¶ 20, 23; Harker ¶¶ 15-20; Salcedo ¶ 21, 26; Lint ¶¶ 37-48.

Finally, HHS reasons that if the Revised Rule does lead to increased discrimination, any such discrimination will result in a "net cost savings," including as a result of the fact 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." 85 Fed. Reg. at 37,225. Such one-sided analysis is the height of arbitrary and capricious reasoning. Deeming discrimination a "net cost savings" not only fails to consider the significant costs of care not covered by insurance, but it also callously disregards the significant harm to those who suffer the effects of discrimination.

(2) HHS Failed Entirely to Consider How Elimination of Notice and Language Access Requirements Will Decrease Access to Health Care Information and Increase Costs.

HHS also failed to consider how repealing the notice, tagline, and language access requirements will decrease access to health care information and increase health care costs. HHS considered only the cost savings to covered entities from revoking those requirements.

For example, many commenters raised concerns that removal of these protections "may result in decreased access to, and utilization of, healthcare by people with disabilities, people with

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[12] Movement Advancement Project, *Equality Maps – Healthcare Laws and Policies – Private Insurance* (last updated June 24, 2020), https://perma.cc/TJP4-KDNJ.

LEP, older adults, people who are LGBT, and other vulnerable populations." 85 Fed. Reg. at 37,204. HHS's only response was that the 2016 Final Rule's notice provisions were "unnecessary" because the statutes underlying Section 1557 contained notice provisions and it was "unaware of data suggesting that those regulations have been or are inadequate to their purpose of making individuals aware of their civil rights." *Id.* HHS fails entirely to explain how LGBTQ people and others will be notified of their *health care rights* under Section 1557, as opposed to rights under the underlying statutes which may not apply to every health care entity. HHS also does not explain how individuals with LEP will know about their rights to language assistance.

The Revised Rule also attempted to justify repealing these requirements on the ground that they might save money. *See* 85 Fed. Reg. at 37,224. But it failed to account for the increased costs that will flow from repealing these protections. If people with LEP are not able to access health care due to language barriers, they may not seek the care they need until their health problems worsen, or they may not seek care at all. When and if they do seek the care they need, people with LEP may not be able to communicate with English-speaking physicians and pharmacists. They also may not understand how to fill out paperwork for healthcare providers or applications for health insurers.

Delays in seeking health care increase health care costs, inefficiency, and inadequacy in the provision of health care. Shafi ¶¶ 32-33; Henn ¶ 20; Pumphrey ¶ 7; Cummings ¶¶ 18, 33; Bolan ¶¶ 11, 13-16, 18, 20-21; Carpenter ¶¶ 8-9; Shanker ¶¶ 10, 14; Harker ¶ 19; Salcedo ¶ 44; Lint ¶ 55. These costs are passed on to taxpayers and patients through increased deductibles, copays, and premiums. Yet, the Revised Rule fails to account for any of these financial costs or the intangible costs to patients' well-being that flow from these increased barriers to health care.

2. The Revised Rule is Not in Accordance with Law.

The Revised Rule is "not in accordance with law," 5 U.S.C. § 706(2)(A), because it conflicts with Section 1554 of the ACA, Section 1557, and the *Bostock* decision.

a. Section 1554

Section 1554 of the ACA explicitly prohibits the Secretary of HHS from promulgating any regulation that "creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care," "impedes timely access to health care services," or "interferes with communications regarding a full range of treatment options between the patient and the provider." 42 U.S.C. § 18114. But that is precisely what the Revised Rule does.

By inviting health care insurers and providers to discriminate against LGBTQ people seeking health care, the Revised Rule discourages LGTBQ people from seeking health care in the first instance and from fully disclosing personal information that health care providers need for proper diagnosis and treatment. Shafi ¶ 21; Henn ¶ 16; Pumphrey ¶ 12; Cummings ¶¶ 24, 28; Bolan ¶¶ 13-15, 17, 19; Carpenter ¶¶ 11, 15; Shanker ¶¶ 22-23; Vargas ¶¶ 21-22; Harker ¶¶ 8, 19; Salcedo ¶¶ 32-33; Lint ¶ 48. The repeal of the notice and language access provisions also creates unreasonable barriers to obtaining health care information. Shafi ¶ 32; Cummings ¶¶ 13, 27, 33; Salcedo ¶¶ 40-41; Lint ¶ 55; Vargas ¶ 23. The Revised Rule violates Section 1554.

b. Section 1557

The Revised Rule is not in accordance with Section 1557 in multiple ways. First, the Revised Rule conflicts with the statutory language of Section 1557 by limiting the entities covered under Section 1557 to health programs or activities of HHS that are administered under Title I of the ACA, not to other health programs and activities that HHS administers. *See* 85 Fed. Reg. at 37,244 (to be codified at 45 C.F.R. § 92.3(a)(2)). This limitation contradicts the plain language of Section 1557, which states it applies to "any program or activity that is administered by an Executive Agency." 42 U.S.C. § 18116(a). Section 1557, by its terms, is not limited to health programs and activities administered under Title I of the ACA. The Revised Rule's exclusion of health insurance from the scope of Section 1557 also is not in accordance with Section 1557, which covers health programs and activities, not just direct health care. *See* 42 U.S.C. § 18116(a). Health insurance clearly is a health-related program or activity.

Second, the Revised Rule conflicts with the statutory language and purpose of Section 1557

by failing to make the enforcement mechanisms provided by Title VI, Title IX, the Age Discrimination Act, and the Rehabilitation Act available in the case of discrimination against a person based on any characteristic protected by these statutes. Section 1557 provides: "The enforcement mechanisms provided for and available under such title VI, title IX, section 794, *or* such Age Discrimination Act shall apply for purposes of violations of [Section 1557]." 42 U.S.C. § 18116(a) (emphasis added). Section 1557's context, structure, and text make evident that Congress did not intend to import multiple, piecemeal legal standards and burdens of proof derived from different statutory contexts into the doctrinal patchwork HHS proposes. Rather, "looking at Section 1557 and the Affordable Care Act as a whole, it appears that Congress intended to create a new, health specific, anti-discrimination cause of action that is subject to a *singular* standard, regardless of a plaintiff's protected class status." *Rumble v. Fairview Health Servs.*, No. 14 Civ. 2037, 2015 WL 1197415, at *10 (D. Minn. Mar. 16, 2015) (emphasis added).

Congress's use of the disjunctive "or" indicates that the enforcement mechanisms applicable under any of the incorporated statutes are available to every claim of discrimination under Section 1557, regardless of the particular type of discrimination. "In its elementary sense, the word 'or,' as used in a statute, is a disjunctive particle indicating that the various members of the sentence are to be taken separately." 73 Am. Jur. 2d Statutes § 147. And "a statute written in the disjunctive is generally construed as setting out separate and distinct alternatives." *In re Espy*, 80 F.3d 501, 505 (D.C. Cir. 1996) (cleaned up). The creation of a single legal standard for Section 1557 claims is also evident from Congress's desire to avoid absurd results. It is important to "recognize[] the absurd inconsistency that could result if the Court interpreted Section 1557 as Defendants [in this case] do." *Rumble*, 2015 WL 1197415, at *12. And "if different standards were applied based on the protected class status of the Section 1557 plaintiff, then courts would have no guidance about what standard to apply for a Section 1557 plaintiff bringing an intersectional discrimination claim." *Id.* Applying standard rules of construction, all enforcement mechanisms available under each of the statutes incorporated into Section 1557 are available to every claim of discrimination under Section 1557. The Revised Rule's elimination of a unitary

legal standard and enforcement mechanism is contrary to the text and structure of Section 1557.

Finally, the Revised Rule conflicts with the text of Section 1557 by importing sweeping exemptions based on religious or moral beliefs from the identified statutes in Section 1557 and other statutes. *See* 85 Fed. Reg. at 37,245 (to be codified at 45 C.F.R. § 92.6(b)). Section 1557 expressly incorporates the enforcement mechanisms from four civil rights statutes, but does not incorporate the religious exemptions from Title IX or any other statute. *See* 42 U.S.C. § 18116(a). Importing broad religious exemptions from other statutes conflicts with the plain language of Section 1557 and Congress's rejection of such exemptions. *See* 155 Cong. Rec. S13193-01 (2009).

c. Bostock

The Revised Rule also is not in accordance with law because it conflicts with the Supreme Court's ruling in *Bostock* that discrimination on the basis of a person's transgender status or sexual orientation is discrimination on the basis of sex. *See Bostock*, 2020 WL 3146686, at *7, 11. *Bostock* forecloses the Revised Rule's attempt to deny the full protection of Section 1557 to LGBTQ individuals and patients in health care settings, as well as its elimination of protections based on sexual orientation and gender identity in unrelated regulations promulgated under different statutes. *See* 85 Fed. Reg. at 37,218-22, 37,243.

B. Plaintiffs are Likely to Succeed on Their Equal Protection Claim.

By inviting health care discrimination against LGBTQ people and carving them out from regulatory nondiscrimination protections under Section 1557, the Revised Rule discriminates on the basis of sex, transgender status, and sexual orientation. Such discrimination is subject to heightened scrutiny. Yet, the Revised Rule fails any level of review because it is not rationally related to any legitimate governmental interest, let alone adequately tailored to further an exceedingly persuasive or compelling one.

Discrimination based on sexual orientation or transgender status is discrimination based on sex. *See Bostock*, 2020 WL 3146686, at *7, 11; *Whitaker ex rel. Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ*., 858 F.3d 1034, 1048 (7th Cir. 2017); *Latta v. Otter*, 771 F.3d 456, 479-80 (9th Cir. 2014) (Berzon, J., concurring); *Glenn v. Brumby*, 663 F.3d 1312, 1316 (11th Cir.

2011). Sex discrimination is subject to heightened scrutiny. *See United States v. Virginia*, 518 U.S. 515, 531 (1996). Discrimination based on sexual orientation or transgender status is also subject to heightened scrutiny on its own. *See*, *e.g.*, *SmithKline Beecham Corp. v. Abbott Labs.*, 740 F.3d 471 (9th Cir. 2014) (sexual orientation); *Windsor v. United States*, 699 F.3d 169, 185 (2d Cir. 2012) (same), *aff'd on other grounds*, 570 U.S. 744 (2013); *Karnoski v. Trump*, 926 F.3d 1180, 1201 (9th Cir. 2019) (transgender status); *F.V. v. Barron*, 286 F. Supp. 3d 1131, 1145 (D. Idaho 2018) (same); *Evancho v. Pine-Richland Sch. Dist.*, 237 F. Supp. 3d 267, 288 (W.D. Pa. 2017) (same).

To pass heightened scrutiny, the government bears the burden of demonstrating an "exceedingly persuasive justification" for the sex-based classification that "serves important governmental objectives" and that the discriminatory means employed are substantially related to the achievement of those objectives." *Virginia*, 518 U.S. at 531 (cleaned up).

The Revised Rule is not even rationally related to any of HHS's asserted goals – "to better comply with the mandates of Congress," reduce confusion, further substantive compliance, and revert to "longstanding statutory interpretations." *See* 85 Fed. Reg. at 37,161. The record does not support these justifications and inviting discrimination against LGBTQ people in health care does not advance any of these goals, particularly in light of *Bostock*'s confirmation that discrimination on the basis of gender identity or sexual orientation are forms of prohibited sex discrimination. To the contrary, the purpose and effect of the Revised Rule is to invite discrimination in health care against plaintiffs' members and their patients, and LGBTQ people nationwide, based on their gender identity, transgender status, sexual orientation, gender nonconformity, and exercise of their fundamental rights.

In addition, the exclusion of LGBTQ people from the nondiscrimination protections under Section 1557 is motivated by the Trump administration's and HHS officials' clear animus against LGBTQ people. Defendant Severino in particular has a history of anti-LGBTQ sentiments, advocacy, and comments. In 2016, before he became Director of OCR, defendant Severino decried the 2016 Final Rule because it ran counter to some people's "moral, and religious beliefs about

biology" and because, in his opinion, the 2016 Final Rule "create[d] special privileges, new protected classes, or new rights to particular procedures."[13] The Revised Rule eliminates every one of the protections for LGBTQ people he decried. Defendant Severino also denounced the Department of Justice's enforcement of Title IX's sex discrimination protections under the Obama administration as applied to transgender people as "using government power to coerce everyone, including children, into pledging allegiance to a radical new gender ideology."[14]

More broadly, the Revised Rule is just one of the latest in a long list of actions the current administration has taken to deprive LGBTQ people of the equal protection of the laws. Among these actions are: the removal of all mention of LGBTQ people from governmental websites;[15] the withdrawal of guidance protecting transgender students from discrimination in schools;[16] the institution of a ban prohibiting transgender people from serving openly, in a manner consistent with their gender identity, in the armed services;[17] the revocation of Department of Justice guidance noting that discrimination based on transgender status is prohibited under Title VII (again, contrary to *Bostock*);[18] the opposition to the reasoned position of the Equal Employment Opportunity Commission that Title VII prohibits discrimination based on sexual orientation or transgender status;[19] the refusal to enforce regulations prohibiting discrimination based on sexual

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[13] Ryan Anderson & Roger Severino, *Proposed Obamacare Gender Identity Mandate Threatens Freedom of Conscience and the Independence of Physicians*, The Heritage Foundation (Jan. 8, 2016), https://perma.cc/5XKG-S79Z.

[14] Roger Severino, *DOJ's Lawsuit Against North Carolina Is Abuse of Power*, The Daily Signal (May 9, 2016), https://perma.cc/3FFM-KFMB.

[15] *See* Mary Emily O'Hara, *Trump Administration Removes LGBTQ Content From Federal Websites*, NBC News (Jan. 24, 2017), https://perma.cc/LU5P-V6ZG.

[16] *See* Ariane de Vogue, et al., *Trump administration withdraws federal protections for transgender students*, CNN (Feb. 23, 2017), https://perma.cc/K6UD-DQAD.

[17] *See* Abby Phillip, et al., *Trump announces that he will ban transgender people from serving in the military*, Wash. Post (July 26, 2017), https://perma.cc/E7J2-E7ZF.

[18] *See* Charlie Savage, *In Shift, Justice Dept. Says Law Doesn't Bar Transgender Discrimination*, N.Y. Times (Oct. 5, 2017), https://perma.cc/WV2R-6MG4.

[19] *See* Joseph Goldstein, *Discrimination Based on Sex Is Debated in Case of Gay Sky Diver*, N.Y. Times (Sept. 26, 2017), https://perma.cc/K83R-R33F.

orientation and gender identity;[20] and the invitation to health care providers to refuse to provide care to LGBTQ people based on their personal religious and moral beliefs.[21]

C. Plaintiffs are Likely to Succeed on Their Due Process Claim.

The Fifth Amendment's Due Process Clause protects individuals' substantive rights to be free to make certain decisions central to privacy, bodily autonomy, bodily integrity, self-definition, intimacy, and personhood without unjustified governmental intrusion. *See Obergefell v. Hodges*, 135 S. Ct. 2584, 2593 (2015) (due process protects a person's right to "define and express their identity"); *Lawrence v. Texas*, 539 U.S. 558, 562 (2003) ("Liberty presumes an autonomy of self that includes freedom of thought, belief, expression, and certain intimate conduct."). Those decisions include the right to live openly and express oneself consistent with one's sexual orientation or gender identity. *See Arroyo Gonzalez v. Rossello Nevares*, 305 F. Supp. 3d 327, 333 (D.P.R. 2018).

By encouraging health care providers and insurers to interfere with and unduly burden patients' access to medically necessary health care, the Revised Rule violates the rights of plaintiffs, their members, and their patients to privacy, liberty, dignity, and autonomy guaranteed by the Fifth Amendment. There is no legitimate interest that supports such an infringement on patients' fundamental rights, let alone an interest that can survive the strict scrutiny required to justify infringement of these rights. The Revised Rule must be set aside. *See* 5 U.S.C. § 706(2)(B).

D. Plaintiffs are Likely to Succeed on Their Free Speech Claim.

The Revised Rule impermissibly chills LGBTQ patients who seek medical care from being open about their gender identity, transgender status, or sexual orientation and from expressing themselves in a manner consistent with each's gender identity or sexual orientation. *See Hartley v. Wilfert*, 918 F. Supp. 2d 45, 53 (D.D.C. 2013); *see also Henkle v. Gregory*, 150 F. Supp. 2d 1067, 1075-77 (D. Nev. 2001) (sexual orientation); *Doe ex rel. Doe v. Yunits*, No. 001060A, 2000

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[20] Notification of Nonenforcement of Health and Human Services Grants Regulation, 84 Fed. Reg. 63,809 (Nov. 19, 2019).

[21] Protecting Statutory Conscience Rights in Health Care, 84 Fed. Reg. 23,170 (May 21, 2019).

WL 33162199, at *3 (Mass. Super. Oct. 11, 2000) (gender identity), *aff'd sub nom.*, *Doe v. Brockton Sch. Comm.*, 2000 WL 33342399 (Mass. App. Ct. Nov. 30, 2000).

In discouraging LGBTQ individuals from engaging in this speech, the Revised Rule burdens speech based on its content and viewpoint because it attaches different consequences to the same speech depending on the identity of the speaker. *See Police Dep't of Chicago v. Mosley*, 408 U.S. 92, 96 (1972). For example, the Revised Rule facilitates discrimination when a transgender woman discloses her female identity, wears typically female attire, or checks the box marked "female" at her endocrinologist's office, in contrast to a cisgender[22] woman who discloses her female identity, wears the same attire, or checks the same box. Courts long have held that government policies that penalize gay or transgender people for disclosing their gender identity or sexual orientation (where heterosexual or cisgender individuals would not be penalized for the same disclosures) are content- or viewpoint-based restrictions that must satisfy a searching level of scrutiny. *See, e.g.*, *Log Cabin Republicans v. United States*, 716 F. Supp. 2d 884, 926 (C.D. Cal. 2010), *vacated as moot*, 658 F.3d 1162 (9th Cir. 2011); *Weaver v. Nebo Sch. Dist.*, 29 F. Supp. 2d 1279, 1286 (D. Utah 1998).

The government may not burden speech "because of disapproval of the ideas expressed." *R.A.V. v. City of St. Paul, Minn.*, 505 U.S. 377, 382 (1992) (citations omitted). Content-based regulation is subject to "the most exacting scrutiny," *Texas v. Johnson*, 491 U.S. 397, 412 (1989) (citation omitted), and "[v]iewpoint discrimination is . . . an egregious form of content discrimination." *Rosenberger v. Rector & Visitors of Univ. of Va.*, 515 U.S. 819, 829 (1995). These restrictions are subject to "strict scrutiny" and will survive review only if they promote a "compelling interest" and employ the "least restrictive means to further the articulated interest." *Am. Library Ass'n v. Reno*, 33 F.3d 78, 84 (D.C. Cir. 1994). The Revised Rule fails to satisfy that rigorous standard. There is no compelling governmental interest in facilitating discrimination or

[22] "Cisgender" refers to "a person whose gender identity corresponds with the sex the person had or was identified as having at birth." Cisgender, Merriam-Webster, https://perma.cc/T4GA-EQM9.

the denial of care to LGBTQ patients in the health care setting.

E. Plaintiffs are Likely to Succeed on Their Establishment Clause Claim.

The First Amendment's Establishment Clause prohibits the government from providing religious accommodations or exemptions that detrimentally affect third parties without regard to their interests. *See Cutter v. Wilkerson*, 544 U.S. 709, 720 (2005); *Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 709-10 (1985). Such religious exemptions impermissibly prefer the religion of those who are benefited over the beliefs and interests of those who are not. *See, e.g.*, *Texas Monthly, Inc. v. Bullock*, 489 U.S. 1, 15 (1989) (plurality opinion); *McCreary Cnty. v. ACLU of Ky.*, 545 U.S. 844, 860 (2005); *Santa Fe Indep. Sch. Dist. v. Doe*, 530 U.S. 290, 302 (2000).

The Revised Rule violates these principles because it imposes costs, burdens, and harms on plaintiffs, their members, and patients to facilitate the religious beliefs of objecting providers, without exception. The Revised Rule incorporates Title IX's blanket religious exemption and the "definitions, exemptions, affirmative rights, or protections" from unrelated statutes. 85 Fed. Reg. at 37,245 (to be codified at 45 C.F.R. § 92.6(b)). These exemptions allow health care institutions and providers to deny care or treatment to LGBTQ people based on religious, conscience, or moral grounds, significantly burdening LGBTQ people's access to health care. These exemptions also impair plaintiffs' ability to refer patients to other providers because they may discriminate against, provide inadequate care to, or refuse to treat their LGBTQ patients, causing significant harm to such patients. Shafi ¶ 20, 39; Henn ¶¶ 14, 27; Pumphrey ¶ 16; Cummings ¶¶ 25-27; Bolan ¶¶ 8, 17, 22-23; Carpenter ¶¶ 8, 15; Harker ¶ 20; Vargas ¶¶ 16, 20, 25.

And HHS shifts these substantial burdens onto plaintiffs, their members, and their patients without exception. There is no exception under the Revised Rule "for special circumstances," *Caldor*, 472 U.S. at 709, such as if an LGBTQ patient seeks care in a rural area with only one hospital for miles, Shafi ¶ 4; Cummings ¶ 5; Shanker ¶¶16-17, 22, 28, or if "a high percentage" of a health care provider's work force denies care. *Caldor*, 472 U.S. at 709. Nor is there an exception when honoring the dictates of objectors would cause a health care provider substantial economic burdens. *See id.* at 709-10. This "unyielding weighting in favor of [objectors] over all other

interests" is exactly what the Establishment Clause forbids. *Id.* at 710.

II. THE REVISED RULE WILL IRREPARABLY HARM PLAINTIFFS, THEIR MEMBERS, AND THEIR PATIENTS.

The Revised Rule will cause significant irreparable harm to plaintiffs, their members, and their patients in a multitude of ways. First, the very issuance of the Revised Rule has caused and, unless enjoined, will continue to cause LGBTQ people to experience significant distress, mental anguish, and hopelessness. Second, the Revised Rule invites discrimination against LGBTQ patients by health care providers and insurers. It also reduces patients' ability to know their rights and diminishes their access to care. Third, by inviting discrimination against LGBTQ people, including those with LEP, the Revised Rule will substantially burden plaintiffs, frustrate their missions, impose additional costs, and inhibit many of the plaintiffs' programmatic activities. Finally, the Revised Rule will cause irreparable harm by eliminating employment protections for some of plaintiffs' members and by infringing on constitutional rights.

Although "[p]laintiffs need only show a *threat* of irreparable harm, not that irreparable harm already ha[s] occurred," for preliminary relief, here irreparable harm already has occurred and will continue unless the Revised Rule is enjoined. *New York v. U.S. Dep't of Homeland Sec.*, 408 F. Supp. 3d 334, 350 (S.D.N.Y. 2019) (cleaned up); s*ee also League of Women Voters v. Newby*, 838 F.3d 1, 8-9 (D.C. Cir. 2016).

A. The Revised Rule Will Irreparably Harm LGBTQ People by Causing Significant Distress, Mental Anguish, and Stigma.

The Revised Rule is an official governmental act that sends LGBTQ people, particularly transgender people, the message that: they are not worthy of protection; their identities need not be recognized; and their health care needs may be disregarded. Ettner ¶ 56; Carpenter ¶ 20; Cummings ¶ 18; Davis ¶¶ 8-9. This governmental message already has and will continue to result in significant distress, hopelessness, hypervigilance, depression, generalized anxiety disorder, and trauma for LGBTQ people, and, more specifically, for transgender people. Ettner ¶ 56; Carpenter ¶ 16; Cummings ¶¶ 9, 12, 14; Davis ¶ 6. Indeed, after the Revised Rule was announced, crisis hotlines dedicated to LGBTQ youth and transgender people, such as The Trevor Project and Trans

Lifeline, experienced an increase in the number of calls and saw a significant number of callers reaching out in distress specifically due to the Revised Rule. Davis ¶ 10; Vera ¶¶ 6-8.

The Revised Rule also imposes upon LGBTQ people a stigma that will further erode their health. Research documents that structural forms of stigma (namely, policies sanctioning discrimination) harm the health of transgender people, and that structural stigma is associated with *all-cause mortality* (i.e. deaths from any cause). Ettner ¶ 62. In other words, stigma—a chronic source of psychological stress—disrupts physiological pathways, increasing disease vulnerability, and leading to premature death. *Id.*

Stigmatization and loss of dignity alone are sufficient to constitute irreparable harm. *See, e.g.*, *Whitaker*, 858 F.3d at 1044-46; *Caspar v. Snyder*, 77 F. Supp. 3d 616 (E.D. Mich. 2015); *Elzie v. Aspin*, 841 F. Supp. 439, 443 (D.D.C. 1993). Here, the Revised Rule causes not only stigma and loss of dignity, but also significantly and negatively affects the health and well-being of LGBTQ people.

B. The Revised Rule Invites Discrimination Against and Reduces Access to Care for LGBTQ People and Individuals with LEP, Irreparably Harming Plaintiffs' Members and Patients.

The Revised Rule sends a clear message to covered entities that they may discriminate against LGBTQ people with impunity. HHS acknowledged the 2016 Final Rule "likely induced many covered entities to conform their policies and operations to reflect gender identity as a protected category under Title IX." 85 Fed. Reg. at 37,225. And it also acknowledged that in connection with the 2016 Final Rule, it anticipated that 60% of the increase in its long-term caseload of discrimination claims would be attributable to claims based on gender identity or sex stereotyping. *Id.* at 37,235. In promulgating the Revised Rule, however, HHS stated that providers are free to revert to their former policies and notes that they will achieve cost savings because they "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; *see also id.* at 37,236. Through the Revised Rule, HHS is communicating that it believes Section 1557 does not prohibit discrimination against LGBTQ people and that such

discrimination is desirable. *See id.* at 37,184-91, 37,222. For example, HHS goes out of its way to tell medical providers that they are free to use incorrect pronouns when referring to transgender patients—that is, pronouns inconsistent with a patient's gender identity. *See id.* at 37,191.

OCR has opened the door to discrimination against transgender individuals in particular by eliminating the provisions in the 2016 Final Rule prohibiting covered insurers from adopting "categorical coverage exclusion[s] or limitation[s] for all health services related to gender transition" and from denying, limiting, or restricting "specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual." 81 Fed. Reg. at 31,472 (formerly 45 C.F.R. § 92.207(b)(3)-(5)). Under the Revised Rule, HHS specifically noted that insurers now have the option "of providing such coverage or not." 85 Fed. Reg. at 37,181; *see also id.* at 37,187-88. This change creates an immediate threat to plaintiffs' members and patients who live in the thirty (30) states that do not have laws prohibiting health insurers from discriminating on the basis of gender identity.[23]

In the event entities elect to revert to their prior practices, plaintiffs' members, patients, and clients will encounter new obstacles to obtaining medical care and an increased risk that health care providers or insurers will discriminate against them on the basis of their LGBTQ status. It is no secret that LGBTQ people already face disproportionate rates of discrimination in health care. *See*, *e.g.*, Ettner ¶ 64; Salcedo ¶ 31, Exs. A & B; Lint ¶ 43, Ex. A; Harker ¶¶ 8-10; Shanker ¶ 19, Ex. A. Yet, the Revised Rule sends the clear and unmistakable message that such discrimination is tolerated and according to defendants, acceptable. *See, e.g.*, Salcedo ¶¶ 27, 32; Lint ¶ 40; Fabian ¶ 19; Shafi ¶¶ 13-14, 16, 20; Henn ¶¶ 8, 10; Pumphrey ¶ 11; Cummings ¶¶ 17, 32; Bolan ¶¶ 8, 10, 14, 23-24; Carpenter ¶¶ 7-8; Vargas ¶¶ 14, 19 ; Harker ¶ 18; Shanker ¶ 22; Ettner ¶ 56.

The likelihood of an increase in this discrimination that the Revised Rule invites is not speculative. It is firmly rooted in research and the experiences of plaintiffs' members and patients who already have been subjected to egregious discrimination in health care settings. For example,

[23] Movement Advancement Project, Equality Maps – Healthcare Laws and Policies – Private Insurance (last updated June 24, 2020), https://perma.cc/TJP4-KDNJ.

health care providers have told Bamby Salcedo, CEO of the TransLatin@ Coalition, that they "did not treat people like her." Salcedo ¶ 14. Arianna Lint, a member of the TransLatin@ Coalition, was misgendered and threatened by a health care provider with the specter of summoning police officers. Lint ¶ 31. Dr. Deborah Fabian, an experienced orthopedic surgeon and member of GLMA, has been denied job opportunities because of her transgender status, intentionally misgendered by colleagues, and told that she is "disgusting" and "God thinks you're disgusting." Fabian ¶ 16. Plaintiffs' declarations identify additional examples of LGBTQ patients, clients, and members who have experienced similar discriminatory conduct. Shafi ¶ 17; Henn ¶ 9; Pumphrey ¶ 10; Cummings ¶ 22 ; Carpenter ¶ 8; Bolan ¶¶ 8-9, 12, 23; Shanker ¶¶ 8, 17(c)-(d); Vargas ¶¶ 20-21. Research further documents the alarming pervasiveness of discrimination against transgender and gender nonconforming people in health care. *See*, *e.g.*, Ettner ¶ 64; Salcedo ¶ 31; Lint ¶ 43; Harker ¶ 9; Shanker ¶ 19. According to a 2018 study, eight percent of LGBTQ respondents were refused health care because of their sexual orientation, and twenty-nine percent of transgender respondents were denied care because of their gender identity.[24]

These discriminatory experiences make it less likely that LGBTQ people will access the health care that they need because fear of discrimination. Shafi ¶ 22; Henn ¶¶ 11, 19; Pumphrey ¶ 7, 13-14; Cummings ¶¶ 8, 16-17; Carpenter ¶¶ 8-9, 22; Bolan ¶¶ 11-12; Shanker ¶ 19; Salcedo 31-33, 36; Lint ¶ 48. It is well documented that patients who fear discrimination tend to delay seeking care or avoid care altogether. Nearly one-quarter of transgender people report delaying or avoiding medical care when sick or injured, at least partially because they fear discrimination or disrespect by health care providers.[25] Patients with LEP will also suffer diminished access to care as a result of the Revised Rule, which eliminates language access protections necessary for them to meaningfully access the care they need and to ensure proper treatment and diagnoses. Shafi ¶ 32; Henn ¶ 25; Pumphrey ¶ 7; Bolan ¶¶ 19-21; Salcedo ¶¶ 40-41; Lint ¶ 55.

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[24] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People From Accessing Health Care*, Ctr. for Am. Progress (Jan. 18, 2018), https://perma.cc/ZG7E-7WK8.

[25] *See* Mirza & Rooney, *supra*.

By creating conditions under which LGBTQ patients, including those with LEP, are more likely to avoid or delay seeking care, the Revised Rule has caused and will continue to have dire consequences. Their health conditions will worsen and become more acute and difficult to treat. Shafi ¶¶ 21-22; Henn ¶¶ 20-21; Pumphrey ¶ 12; Cummings ¶¶ 16, 18, 22(m); Carpenter ¶¶ 11-15, 19; Bolan ¶¶ 19-21; Shanker ¶¶ 14-15; Salcedo ¶ 34; Lint ¶¶ 47-48, 51, 55. The delay or denial of health care, particularly in emergency situations, is likely to cause plaintiffs' patients wholly avoidable pain and injury. And it will have deadly consequences, as already occurred with a board member of the TransLatin@ Coalition, Lorena Borjas, who delayed going to a hospital for fear of discrimination and died as a result of COVID-19. Salcedo ¶ 25. These all are irreparable harms. *See Harris v. Bd. of Supervisors*, 366 F.3d 754, 765 (9th Cir. 2004).

The Revised Rule also reduces access to care by narrowing the entities covered under Section 1557. For example, the Indian Health Service will no longer be a covered entity. As such, patients like those at the Gallup Indian Medical Center in New Mexico will no longer have protections from discrimination in health care because state protections do not apply to federal facilities. Fabian ¶ 21. Additionally, the Revised Rule deems that health insurance is not a "health program or activity," which will directly affect the ability of plaintiffs' patients and members to access care. Shafi ¶ 28; Henn ¶ 22.

Numerous courts have recognized that loss of access to care causes irreparable harm that warrants immediate relief. *See, e.g.*, *Planned Parenthood S. Atl. v. Baker*, 941 F.3d 687, 707 (4th Cir. 2019); *Planned Parenthood of Kans. & Mo. v. Andersen*, 882 F.3d 1205 (10th Cir. 2018); *Minney v. U.S. Office of Personnel Mgmt.*, 130 F. Supp. 3d 225, 235 (D.D.C. 2015); *Risteen v. Youth For Understanding*, Inc., 245 F. Supp. 2d 1, 16 (D.D.C. 2002).

C. The Revised Rule Will Irreparably Harm Plaintiffs by Impeding Their Programmatic Activities and Mission and Imposing Additional Costs.

An organization is irreparably "harmed if the actions taken by the defendant have perceptibly impaired the organization's programs." *League of Women Voters*, 838 F.3d at 8 (cleaned up). "[T]he organization's tasks must be impeded," *Ctr. for Responsible Sci. v. Gottlieb*,

346 F. Supp. 3d 29, 37 (D.D.C. 2018), *aff'd sub nom. Ctr. for Responsible Sci. v. Hahn*, No. 18-5364, 2020 WL 1919656 (D.C. Cir. Apr. 10, 2020), and the organization must "show that the defendant's actions directly conflict with the organization's mission," *League of Women Voters*, 838 F.3d at 8. "Obstacles that unquestionably make it more difficult for an organization to accomplish its primary mission provide injury for purposes of irreparable harm." *Open Communities All. v. Carson*, 286 F. Supp. 3d 148, 177 (D.D.C. 2017) (cleaned up). The Revised Rule impairs plaintiffs' programmatic activities in a multitude of ways.

Plaintiffs like Whitman-Walker Health and Los Angeles LGBT Center, which are committed to treating every patient without regard to their sex, sexual orientation, gender identity, or transgender status, will see an increased demand for their services. LGBTQ patients, including those with LEP, will turn to these providers because of their fear of discrimination from other providers that the Revised Rule invites and fosters. Shafi ¶ 34; Henn ¶ 29; Pumphrey ¶ 9; Cummings ¶¶ 9, 14, 20, 25-26, 28; Carpenter ¶¶ 16, 21; Bolan ¶¶ 18, 22-23. This increased demand will, in turn, require additional expenditures and the diversion of already limited resources. Shafi ¶ 36; Henn ¶ 29; Pumphrey ¶ 15; Cummings ¶ 8; Bolan ¶ 22. The Revised Rule also impedes plaintiffs' ability to provide crucial health care referrals because plaintiffs will have to (1) develop additional mechanisms to vet the health care providers to whom they refer patients, and (2) help their patients obtain timely and needed health care from affirming providers who are increasingly overburdened and have long waitlists. Shafi ¶ 38; Henn ¶¶ 14, 27; Pumphrey ¶ 16; Cummings ¶¶ 9, 25-26; Carpenter ¶¶ 21-22; Bolan ¶¶ 22-23; Vargas ¶¶ 11, 25; Harker ¶¶ 20-22.

Additionally, the Revised Rule directly impedes plaintiffs' ability to care for and treat LGBTQ patients, including those with LEP. It erodes trust between health care providers and their patients, even though such trust is necessary for appropriate treatment. Shafi ¶ 19; Henn ¶ 15-16; Pumphrey ¶ 13; Cummings ¶ 16; Carpenter ¶¶ 8-9, 11-19; Bolan ¶¶ 13, 16-18, 20. The Revised Rule also will cause patients to hide their LGBTQ status from providers, even though such information can be critical to their health care and the lack of disclosure can result in a patient's health issues left unaddressed, precipitating the development of more acute conditions. Shafi ¶ 21;

Henn ¶ 15-18; Pumphrey ¶ 12; Cummings ¶ 18, 22(m); Carpenter ¶¶ 14-15; Bolan ¶¶ 13-17; Vargas ¶ 22; Harker ¶ 19. This situation, in turn, will make it more difficult and costlier for the private health care provider plaintiffs to treat their LGBTQ patients, including those with LEP. Henn ¶ 18; Pumphrey ¶ 12; Carpenter ¶¶ 9, 18-19; Bolan ¶¶ 18-19, 22; *see also* Harker ¶¶ 20-21.

The Revised Rule also impedes the ability of plaintiffs to advocate on behalf of LGBTQ patients when they encounter discrimination. For example, plaintiffs have previously relied on the 2016 Final Rule's provisions and clear guidance to advocate for their patients and clients when they encounter discriminatory health care providers and insurance coverage exclusions. Shafi ¶¶ 25-26; Shanker ¶¶ 8-9, 11. Plaintiffs no longer will be able to rely on these provisions in advocating for patients when they encounter discrimination. Vargas ¶¶ 26-27; Harker ¶¶ 20-21.

To counteract the Revised Rule's harmful effects and the confusion it engenders, plaintiffs also will be required to spend and divert already limited resources to help LGBTQ patients navigate the discriminatory barriers to care that they will encounter and the Revised Rule fosters. Shafi ¶ 37; Cummings ¶¶ 25-26; Shanker ¶¶ 24-28; Vargas ¶¶ 16, 24-25, 27; Salcedo ¶ 42; Lint ¶ 66. LGBTQ-affirming providers already are overwhelmed in trying to combat the COVID-19 pandemic. Shafi ¶ 36; Henn ¶ 29; Pumphrey ¶ 15; Cummings ¶ 9; Bolan ¶¶ 15, 21; Carpenter ¶ 20; *see also* Fabian ¶ 24. To meet the increased demand for their health care services and reimagine the process of health care referrals, plaintiffs will be required to divert resources from their efforts to stem the COVID-19 pandemic. They also will have to divert resources from their other critical programmatic work, like the provision of emergency housing, ESL classes, and case management. Salcedo ¶¶ 44, 46-49; Lint ¶¶ 62, 64; Shanker ¶¶ 13, 18, 29. This Court has recognized that the expenditure of resources for these services is another form of irreparable harm. *See District of Columbia*, 2020 WL 1236657, at *28.

Plaintiffs will also have to engage in increased education efforts for their patients, members, and clients, as well as outside health care providers and insurance companies. Shafi ¶ 37; Vargas ¶ 24; Harker ¶¶ 21-22; Shanker ¶¶ 8-9, 11. Educational efforts will have to be reimagined to combat the confusion the Revised Rule has caused about whether Section 1557's

prohibition on sex discrimination encompasses discrimination based on sexual orientation, gender identity, transgender status, and sex stereotypes. *Id.* Such expenditure of resources for "additional education of and outreach" "beyond those normally expended" constitutes irreparable harm. *District of Columbia*, 2020 WL 1236657, at *28.

Additionally, the Revised Rule frustrates plaintiffs' ability to promote nondiscrimination in health care through the adoption and implementation of the hospital-accreditation nondiscrimination standards and guidelines. Vargas ¶ 16.

The Revised Rule will also negatively affect the finances of the private health care provider plaintiffs. For example, the elimination of the prohibition on categorical exclusions for gender-affirming care in insurance plans will result in private health care providers like Whitman-Walker Health picking up the tab. Shafi ¶ 35. It will also increase operational costs for LGBTQ-affirming health care providers. Shafi ¶ 34; Cummings ¶ 18.

All the organizational plaintiffs share a mission to improve the health and well-being of LGBTQ people, free from discrimination. Shafi ¶ 3; Cummings ¶ 3; Shanker ¶ 3; Harker ¶¶ 4-7; Vargas ¶¶ 4-5; Salcedo ¶ 5; *see also* Lint ¶ 6. The Revised Rule, which invites and fosters discrimination against LGBTQ people in health care, not only frustrates plaintiffs' ability to fulfill their missions, but it also impedes their programmatic activities in service of their missions.

D. The Revised Rule Invites Small Employers to Discriminate Against LGBTQ Employees, Including Members of GLMA and AGLP.

Title VII, which prohibits employers from discriminating against individuals because of transgender status or sexual orientation, applies only to entities with more than fifteen employees. *See* 42 U.S.C. §§ 2000e(b) & 2000e-2(a)(1); *Bostock*, 2020 WL 3146686, at *11. Under the Revised Rule, employers that do not meet Title VII's fifteen-employee threshold will be free to discriminate against LGBTQ employees with respect to the provision of health care and benefits. GLMA and AGLP are national organizations that represent the interests of hundreds of thousands of LGBTQ health professionals across the country and whose members include hundreds of health care professionals. Vargas ¶ 5; Harker ¶¶ 4-5, 17. At least some members of these organizations

who are employed by entities with fewer than fifteen employees will be irreparably harmed if the Revised Rule is allowed to go into effect. Vargas ¶¶ 16-21, 26; Harker ¶¶ 11-22. Courts have recognized that denying LGBTQ employees access to the full benefits of employment enjoyed by their heterosexual and/or cisgender counterparts constitutes irreparable harm. *See, e.g.*, *Collins v. Brewer*, 727 F. Supp. 2d 797, 813 (D. Ariz. 2020); *Elzie*, 841 F. Supp. at 443.

E. Violations of Constitutional Rights Alone Amount to Irreparable Harm.

Because the Revised Rule unconstitutionally denies LGBTQ people equal protection under Section 1557 and infringes upon other constitutional rights, allowing the Revised Rule to go into effect will constitute irreparable harm *per se*. *See Mills v. District. of Columbia*, 571 F.3d 1304, 1312 (D.C. Cir. 2009); *see also Kimberly-Clark Corp. v. District of Columbia*, 286 F. Supp. 3d 128, 147 (D.D.C. 2017) (Boasberg, J.).

III. THE BALANCE OF EQUITIES FAVORS PLAINTIFFS, AND AN INJUNCTION OR STAY IS IN THE PUBLIC INTEREST.

The final two factors in determining whether to issue preliminary relief are whether the balance of equities tips in the moving party's favor and whether an injunction or stay is in the public interest. *See Winter*, 555 U.S. at 20. These factors "merge when the Government is the opposing party." *FBME Bank*, 125 F. Supp. 3d at 127 (cleaned up).

The Revised Rule unequivocally harms the public interest. Conversely, granting the requested preliminary relief serves the public interest in multiple ways. First, the irreparable harms that the Revised Rule will cause to plaintiffs also apply to a substantial number of nonparties. Thousands of LGBTQ individuals, organizations who support and serve those individuals, as well as health care providers across this country, will suffer increases in discrimination, detrimental health outcomes, impediments to health care, and increases in costs and burdens.

Second, the current COVID-19 pandemic also must be considered. Any barrier to the provision of health care services during this pandemic seriously endangers the public health, and the Revised Rule creates numerous barriers to care. Increasing testing capacity and contact tracing are key elements to combating the COVID-19 pandemic. *See* COVID-19 Plan, *supra*, at 3.

LGBTQ people are disproportionately vulnerable to COVID-19. Henn ¶ 12. Yet, the Revised Rule will discourage LGBTQ people, including those with LEP, from seeking care, including getting tested and treated for COVID-19. Shafi ¶ 22; Henn ¶ 13; Pumphrey ¶ 14; Cummings ¶ 8; Carpenter ¶ 20; Bolan ¶¶ 16, 21; *cf.* Fabian ¶¶ 23, 25. Without testing and treatment, the virus will spread through the community at large, which, in turn, will jeopardize the public health, result in unnecessary and preventable deaths, and put additional strains on hospitals already overwhelmed with COVID-19 patients. Shafi ¶ 22; Carpenter ¶ 20. With the private health care provider plaintiffs already overwhelmed by the COVID-19 pandemic, the shifting of resources to respond to the Revised Rule's effects will make it even harder for them to help stem this pandemic. Shafi ¶ 36; Cummings ¶¶ 8-9; *cf.* Fabian ¶ 24.

This public health concern alone outweighs any interest defendants might claim in having the Revised Rule take effect on August 18, 2020. The health and safety of the public are paradigmatic considerations in the "public interest" factor of the preliminary injunction test. *See, e.g.*, *California v. Azar*, 911 F.3d 558, 582 (9th Cir. 2018); *Roederer v. Treister*, 2 F. Supp. 3d 1153, 1163 (D. Or. 2014).

Third, enjoining the Revised Rule will prevent confusion that the Revised Rule creates, particularly in light of the *Bostock* decision. *Bostock*'s holding that discrimination on the basis of transgender status and sexual orientation is discrimination on the basis of sex directly conflicts with the Revised Rule's message that such discrimination is permissible and not a form of sex discrimination. And although *Bostock* controls, the general public cannot be expected to know how to resolve conflicting messages from different branches of government. LGBTQ patients will not know whether they are protected against discrimination when they go to the doctor, and health insurers and providers will be unsure of their legal obligations with regard to sex discrimination. Courts frequently consider the extent to which granting an injunction will remedy the public's confusion. *See, e.g.*, *League of Women Voters*, 838 F.3d at 12-13.

Finally, the public interest is served by ensuring the government abides by the APA and plaintiffs' constitutional rights are not violated. There is "a substantial public interest 'in having

governmental agencies abide by the federal laws that govern their existence and operations.'" *Id.* (citation omitted).

On the other side of the scale, allowing the Revised Rule to take effect runs directly counter to the public interest. Executive action typically is taken in the public interest. *See Schenck v. Pro-Choice Network of W.N.Y.*, 519 U.S. 357, 393 (1997) (Scalia, J., concurring in part and dissenting in part). Unfortunately, that is not the case here. The Revised Rule makes it more difficult to access and provide necessary health care during an unprecedented pandemic without any reasoned explanation.

There is no reason why the Revised Rule must take effect on August 18, 2020, as opposed to after a resolution on the merits of plaintiffs' claims. Because plaintiffs are likely to succeed on the merits, HHS's only harm "is that it will be required to keep in place the existing regulation . . . while judicial review of its new regulation runs its course." *District of Columbia*, 2020 WL 1236657, at *31. A preliminary injunction or stay of the effective date is warranted.

IV. THE COURT SHOULD ENTER A NATIONWIDE INJUNCTION AGAINST THE REVISED RULE IN ITS ENTIRETY.

Because the Revised Rule is so infected, there is no point in enjoining it on a piecemeal basis. Every provision erects a barrier to access to care for millions of Americans, particularly those who are LGBTQ or with LEP. The entirety of the Revised Rule runs counter to the statutory commands of Section 1554. Likewise, the Supreme Court's decision in *Bostock* has eviscerated completely the lynchpin of the Revised Rule – the rationale for eliminating the definition of discrimination "on the basis of sex" and its related provisions. HHS's refusal to reconsider the Revised Rule in light of *Bostock* is indicative of the lack of reasoned decision-making that permeates the entire Revised Rule. The Revised Rule's deficiencies "are numerous, fundamental, and far-reaching." *New York*, 414 F. Supp. 3d at 577. "[T]he rulemaking exercise here was sufficiently shot through with glaring legal defects as to not justify a search for survivors." *Id.*

In addition, a nationwide injunction enjoining the Revised Rule or, in the alternative, a stay of its effective date pursuant to 5 U.S.C. § 705 is the only appropriate remedy where, as here, an

agency action is likely unlawful and has nationwide applicability. *See Nat'l Mining Ass'n v. U.S. Army Corps*, 145 F.3d 1399, 1408-10 (D.C. Cir. 1998).

First, the Revised Rule violates the APA and the Constitution in the numerous ways. Because these are facial violations and the Revised Rule applies nationwide, it is not enough for a court to prevent the application of the facially invalid rule to a particular plaintiff. "Setting aside the rule just for the plaintiffs in this case would . . . be illogical given the fact that the APA violations found here would apply with equal force for any other plaintiff to whom the rule could apply." *City & Cnty. of San Francisco v. Azar*, 411 F. Supp. 3d 1001, 1025 (N.D. Cal. 2019). The scope of the injunction, therefore, must be nationwide to redress fully the violation. *See District of Columbia*, 2020 WL 1236657, at *34.

Second, plaintiffs, their members, and their patients are located throughout the United States, and plaintiffs provide health care services beyond the cities and states where they are based. Shafi ¶ 4; Cummings ¶¶ 4-5; Vargas ¶ 5; Harker ¶ 17; Salcedo ¶ 6; *see also*, *e.g.*, Lint ¶ 8; Fabian ¶¶ 17, 21. The irreparable harms that they will suffer will be felt nationwide.

This Circuit and others routinely grant nationwide injunctions in this context. *See, e.g.*, *Nat'l Mining Ass'n*, 145 F.3d at 1408-10; *Harmon* v. *Thornburgh*, 878 F.2d 484, 495 & n.21 (D.C. Cir.1989); *Planned Parenthood Fed'n of Am., Inc., v. Heckler,* 712 F.2d 650, 651 (D.C. Cir. 1983); *Doe* v. *Rumsfeld*, 341 F. Supp. 2d 1, 18-19 (D.D.C. 2004); *Doe #1 v. Trump*, 957 F.3d 1050, 1069-1070 (9th Cir. 2020); *Regents of the Univ. of Cal. v. DHS*, 908 F. 3d 476, 511-12 (9th Cir. 2018).

Not only is a nationwide injunction the appropriate remedy here, it is the only adequate remedy. Without nationwide relief at the preliminary stage, complete relief would not be available upon final adjudication because the Revised Rule's harms will have been realized. *See District of Columbia*, 2020 WL 1236657, at *34-35. Indeed, some harms already have occurred. The Court can prevent additional nationwide harms by preliminarily enjoining implementation of the Revised Rule or staying its effective date until judicial review has concluded.

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Respectfully submitted,

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WHITMAN-WALKER CLINIC, INC., *et al.*,

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

Case No. 1:20-cv-01630 (JEB)

INDEX OF DECLARATIONS IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION OR, IN THE ALTERNATIVE, A STAY PENDING JUDICIAL REVIEW PURSUANT TO 5 U.S.C. § 705

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2. Dr. Sarah Henn, Chief Health Officer of Whitman-Walker Health.

3. Dr. Randy Pumphrey, Senior Director of Behavioral Health at Whitman-Walker Health.

4. Bamby Salcedo, President and CEO of the TransLatin@ Coalition.

5. Arianna Inurritegui-Lint, Executive Director of Arianna's Center.

6. Darrel Cummings, Chief of Staff of the Los Angeles LGBT Center.

7. Dr. Robert Bolan, Chief Medical Officer and Director of Clinical Research for the Los Angeles LGBT Center.

8. Dr. Ward Carpenter, Co-Director of Health Services for the Los Angeles LGBT Center.

9. Adrian Shanker, Founder and Executive Director of the Bradbury-Sullivan LGBT Community Center.

10. Hector Vargas, Executive Director of American Association of Physicians for Human Rights d/b/a GLMA: Health Professionals Advancing LGBTQ Equality.

11. Roy Harker, Executive Director of AGLP: The Association of LGBTQ+ Psychiatrists.

12. Dr. Deborah Fabian, Member of GLMA: Health Professionals Advancing LGBTQ Equality.

13. Dr. Randi Ettner.

14. Elena Rose Vera, Executive Director of the Trans Lifeline.

15. Carrie Davis, Chief Community Officer of The Trevor Project.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WHITMAN-WALKER CLINIC, INC., *et al.*, *Plaintiffs,* v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, *Defendants*.	Case No. 1:20-cv-1630

DECLARATION OF NASEEMA SHAFI, CEO, WHITMAN-WALKER HEALTH

I, Naseema Shafi, declare as follows:

1. I am the Chief Executive Officer of Whitman-Walker Clinic, Inc., d/b/a Whitman-Walker Health ("Whitman-Walker"). I received a J.D. degree from the University of Maryland School of Law in 2005. I have served at Whitman-Walker for more than thirteen years, first as a Compliance Analyst and Director of Compliance; then as Chief Operating Officer, and subsequently as Deputy Executive Director. I assumed the CEO position in January 2019.

2. I am submitting this Declaration in support of Plaintiffs' motion for a preliminary injunction to prevent the revised regulation under Section 1557, published by the U.S. Department of Health and Human Services ("HHS") on June 19, 2020 (the "Revised Rule"), from taking effect.

3. The mission of Whitman-Walker is to offer affirming community-based health and wellness services to all with a special expertise in lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ) and HIV care. We empower all persons to live healthy, love openly, and achieve equality and inclusion.

4. Whitman-Walker was founded in 1973, and legally incorporated in 1978 to respond

to the health care needs of the LGBTQ community. In the early 1980s, we were one of the first nonprofit health clinics in the nation to respond to the HIV/AIDS epidemic. We became a Federally Qualified Health Center Look-Alike in 2007 and received full FQHC status in 2013. Our team provides a range of services, including primary medical care; HIV and lesbian, gay and bisexual (LGB) specialty care; medical, behavioral and care coordination services specific for transgender and gender expansive people;; behavioral-health services; dental services; legal services; insurance-navigation services; community health services that include HIV and STI testing; prevention counseling; women's health services; and youth and family support. These services are provided not only to people that live in Washington, DC, but also to people from neighboring states like Maryland and Virginia, and from across the region, including people from Pennsylvania, West Virginia and Delaware. Without nondiscrimination protections in health care, such as those contained in the 2016 Final Rule, many of these patients are unable to find nondiscriminatory, welcoming and competent care in their own communities.

5. In 2019, Whitman-Walker provided health care services to more than 20,760 individuals.

6. Whitman-Walker's patient population is incredibly diverse and reflects Whitman-Walker's 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. We are nationally known as experts in HIV and Hepatitis C specialty care and in gender-affirming care for transgender and gender expansive persons.

7. In 2019, more than 10% of the health care patients and clients we serve identified as transgender or gender expansive. Almost 45% of health care patients—60% of those who provided information on their sexual orientation—identified as lesbian, gay, bisexual, or otherwise

non-heterosexual. More than 9% of patients we served had limited English proficiency.

8. Whitman-Walker also employs a dynamic and diverse workforce that reflects the diversity of the populations we serve. At the present, we employ over 315 medical and behavioral-health providers and support staff, medical-adherence and insurance-navigation professionals, community health-workers, lawyers and paralegals, researchers, administrators, and professionals working in finance, development, human resources, and external affairs. We have employees of many races, ethnicities, genders, sexual orientations, religious and spiritual traditions, and life experiences. What unites us all is our shared commitment to creating and sustaining a welcoming, inclusive health care home for everyone who seeks our care.

9. Over the years, Whitman-Walker health care providers, lawyers and paralegals have encountered many instances of discrimination against our patients and legal clients by health care providers and staff outside of Whitman-Walker, based on sex assigned at birth, gender identity, transgender status, sexual orientation, HIV status, or actual or perceived ethnicity or immigration status. Our health care providers, lawyers, and other staff also have many years of experience advocating for patients with health insurance plans that discriminate against gender-affirming care, same-sex couples, and patients living with HIV or Hepatitis C who need specialized care. As such, Whitman-Walker was extensively involved in the proceedings that resulted in the rule published by HHS in May 2016 (“2016 Final Rule”), the Request for Information in 2013, and the Notice of Proposed Rulemaking in 2019.

10. Whitman-Walker receives various forms of federal funding from HHS and from institutions affiliated with or funded by HHS, including but not limited to funds under the Public Health Services Act (“PHSA”), direct grants, funding under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, 42 U.S.C. § 300ff et seq. (“Ryan White funding”), funds under

the 340B Drug Discount Program, research grants from the Centers for Disease Control and Prevention and the National Institutes of Health, and Medicaid and Medicare reimbursements. Whitman-Walker also receives funds from the Health Resources and Service Administration ("HRSA") and is a Federally Qualified Heath Center. In 2019, Whitman-Walker's federally funded research contracts and grants totaled more than $7 million.

11. As an entity principally engaged in the business of providing health care that receives federal funding from HHS, Whitman-Walker is a "health program or activity" subject to the Revised Rule.

12. By eliminating the regulatory protections and clear guidance provided in the 2016 Final Rule, the Revised Rule presents a grave threat to the health and wellbeing of the patient population that we serve, most specifically LGBTQ patients and patients with LEP. The Revised Rule also frustrates our ability to provide referrals to our patients and imposes increased costs on Whitman-Walker.

Harms to Whitman-Walker's LGBTQ Patients

13. The Revised Rule eliminates the definition of "on the basis of sex" and the specific prohibition of discrimination on the basis of gender identity, transgender status, and sex stereotyping. The Revised Rule also eliminates specific provisions related to discrimination against transgender individuals, as well as the provision relating to the discrimination on the basis of association. The elimination of these provisions will result in direct harms to the LGBTQ patients that Whitman-Walker serves.

14. The LGBTQ patients and clients Whitman-Walker serves, especially Whitman-Walker's transgender and gender-expansive patients, already face particularly acute barriers to care and health disparities that will be compounded by the Revised Rule. It is quite likely that the

Revised Rule will result in a substantial increase in discrimination against LGBTQ individuals by health care providers and institutions outside of Whitman-Walker, as well as by health insurance companies.

15. Dr. Henn's and Dr. Pumphrey's declarations describe a number of incidents of discrimination that our patients have encountered in other health care facilities and offices that our patients have reported to our medical and behavioral health providers. In addition, the lawyers, legal assistants and volunteer attorneys in our Legal Services Department have learned of many similar incidents from their clients.

16. Since the mid-1980s, Whitman-Walker has had an in-house Legal Services Department. Our attorneys and legal assistants provide information, counseling, and representation to Whitman-Walker's patients, and to others in the community who are LGBTQ or living with HIV, on a wide range of civil legal matters that relate directly or indirectly to health and wellness – including access to health care and discrimination based on HIV, sexual orientation, or gender identity. They also oversee legal clinics, staffed largely by volunteer attorneys, which assist transgender and gender-nonconforming individuals to change their legal names and to correct their birth certificates, driver's licenses, passports, Social Security records, and other identity documents to reflect their new names and actual gender identities.

17. Over the years, Whitman-Walker Legal Services staff and volunteer attorneys have encountered many instances of discrimination by health care providers and their staff based on the sexual orientation or gender identity of patients. Recent examples include:

a. As recounted in Dr. Henn's Declaration, Whitman-Walker transgender patients seeking gender affirming surgery have been rejected at local hospitals, even for procedures that are often performed on non-transgender patients (such as breast

surgery), and even though the patients had health insurance or were otherwise able to pay for the procedures.

b. In one instance, a health care worker at a dialysis clinic confronted a Whitman-Walker patient with end-stage renal disease and objected to being involved in the patient's care because of hostility to his sexual orientation.

c. In another case, a transgender woman who was about to have surgery at a Washington, DC hospital for an inner ear condition (unrelated in any way to her transgender-related health care) was confronted and harassed by hospital staff objecting to her gender identity. She was repeatedly and intentionally referred to as "he" and as "a man" by staff in the radiology department when she went for a pre-surgical scan; by desk staff at the surgery center; and by the nurse preparing her for surgery. Several nurses talked about her with each other and laughed. One staff person refused to talk with the patient when she addressed them. Even the anesthesiologist who she was expected to entrust with her life in one of her most vulnerable moments before surgery, mocked her and intentionally referred to her as a man. Health care providers are supposed to provide comfort to patients when they seek health care. Instead, the staff increased her fear just before her surgery because they showed complete disrespect and lack of care for the patient's health and wellbeing.

d. Another transgender woman went to the office of an ophthalmologist at the same medical center for an eye exam. She arrived on time, filled out the initial paperwork, and then waited for about 45 minutes without being called for her appointment. The patient went to the desk to inquire, and was treated rudely by

the staff. The staff then arbitrarily called a security guard to eject her from the office. As the patient spoke to the security guard, one of the clinic staff came to her and said, loudly and offensively, "Sir, your kind needs to go away. We're not serving your kind." She complained to the Office of the Chief Medical Officer and was eventually seen by the ophthalmologist on another day, after considerable effort by her and Whitman-Walker staff.

e. A transgender woman was seen by a medical provider at Whitman-Walker, who examined her and determined she might have broken her ankle. She was sent to the Emergency Room at a Washington, DC hospital. She identified herself to the ER check-in staff as a woman and presented a driver's license that contained a female gender marker. She then waited for a number of hours (she remembers five or six) without being examined. When she inquired about the delay, she was treated rudely and misgendered by ER staff. She was finally called from the waiting area, but was taken to the men's dressing room, rather than the area for women patients, to undress and put on a gown for a scan. During the four or more hours before she received the scan, examination and treatment, she suffered very significant physical pain.

18. By eliminating the explicit protections against discrimination based on gender identity, transgender status, and failure to conform with sex stereotypes, the Revised Rule invites an increase in discriminatory experiences for LGBTQ patients seeking health care services, such as those documented above. This result in harm to the patients and community that Whitman-Walker serves.

19. The discriminatory experiences LGBTQ patients have with other health care

providers erode patients' trust in health care providers overall and thus also challenges the ability of Whitman-Walker to treat its patients effectively and provide appropriate services and referrals.

20. The Revised Rule also empowers religiously-motivated discriminatory behavior by health care providers that is corrosive to fundamental professional standards, threatens patients' welfare, and places a significant strain on our ability to fulfill our critical mission. For example, the Revised Rule undermines our ability to provide referrals and our patients' ability to access health care. A significant amount of medical care in the United States is provided by religiously affiliated hospitals. This is illustrated by the fact that more than one in every six hospital beds in the country are in religiously-affiliated hospitals.[1] To the extent that the Revised Rule leads these institutions (or even a fraction of the medical professionals and staff at these institutions) to rely on the Rule's broad religious exemptions and refuse to provide care to LGBTQ patients, many patients will be left without other treatment options and there will be fewer specialists to whom we can refer our patients and feel confident that we are not exposing our patients to religiously-motivated discriminatory behavior.

21. The discrimination invited by the Revised Rule will also encourage LGBTQ patients to remain closeted to the extent possible when seeking medical care outside Whitman-Walker. When patients remain closeted to a health care provider, however, they are exposed to 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 PrEP, which is extremely effective at preventing HIV transmission. Patients who fail fully to disclose their gender identity and sex

[1] Julia Kaye, et al., Am. Civil Liberties Union, *Health Care Denied: Patients and Physicians Speak Out About Catholic Hospitals and the Threat to Women's Health and Lives* (Mar. 2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.

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).

22. Furthermore, at a time of public health crisis such as the present COVID-19 pandemic, the delay of necessary health care for fear of discrimination will make it harder for health care providers to help stem the pandemic, thereby potentially exposing more people to COVID-19, to which LGBTQ people are already more vulnerable.

23. The Revised Rule further notes that covered entities are not discriminating on the basis of sex if they refuse to use a transgender patient's pronouns consistent with their gender identity; refuse them access to sex-specific facilities that are consistent with their gender identity and instead forces them into facilities/shared rooms based on the sex they were incorrectly assigned at birth; and identifies them by the sex they were incorrectly assigned at birth such as on patient identification bracelets and any signage outside the patient's room. These discriminatory actions, which as documented above, have been experienced by Whitman-Walker's patients at other health care facilities, are inconsistent with the 2016 Final Rule and Section 1557 of the Affordable Care Act. They are also detrimental to transgender patients' health and wellbeing, and can lead to significant distress.

24. Whitman-Walker medical and behavioral health providers, care navigators and attorneys assist hundreds of transgender patients every year to navigate private health plans, Medicaid, and Medicare to obtain the gender-affirming services that they need—including a wide range of surgical procedures and hormone therapy. Many private and public plans continue to resist coverage of medically necessary procedures—if not through blanket exclusions of "sex change" or "sex transition" procedures, then through denials of coverage of specific procedures.

25. The 2016 Final Rule, which prohibits "categorical coverage exclusion[s] or limitation[s] for all health services related to gender transition" and denials, limitations, or restrictions "for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual," 81 Fed. Reg. at 31,472 (formerly codified as 45 C.F.R. § 92.207(b)), has been very valuable in persuading Medicaid administrators, insurance company personnel, and employee health plan sponsors to eliminate outdated exclusions and to agree to cover procedures when supported by evidence of medical necessity.

26. These provisions and others that specify insurance practices and plan features that constitute forms of unlawful discrimination provide useful guidance, not only for consumers and others advocating on their behalf – including health care providers like Whitman-Walker who assist patients in determining coverage of health care being provided or contemplated – but also for health insurance companies and plan administrators. For example, one of our Legal Services attorneys used the 2016 Rule to persuade a client's union health plan to eliminate a discriminatory exclusion and cover his mastectomy and chest reconstruction. The attorney also relied on the 2016 Rule to successfully overturn a Blue Cross company's denial of coverage of a transgender client's breast augmentation and genital surgery.

27. Based on Whitman-Walker's experience, the Revised Rule, which eliminates the aforementioned provisions, invites health plans to discriminate through the exclusion of gender-affirming procedures, which in turn threatens transgender patients who suffer from crippling gender dysphoria, and through the reinstitution of insurance practices regarding the "tiering" of certain drugs (e.g., to determine co-pays or cost-sharing ratios) that are of great concern to patients living with HIV or other medical conditions or disabilities that require expensive treatments.

28. In addition, the Revised Rule perplexingly exempts many forms of health insurance from Section 1557, subjecting LGBTQ patients who rely on those forms of insurance to discrimination based on sex assigned at birth, gender identity, transgender status, sexual orientation, race, national origin, age, or disability. For example, under the Revised Rule, "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." 85 Fed. Reg. at 37244–45 (to be codified as 45 C.F.R. § 92.3(c)). The Revised Rule also excludes HHS health-related programs and activities from Section 1557, unless the programs were established under Title I of the ACA. This limitation would affect numerous health-related programs and activities, including those of the Centers for Medicare and Medicaid Services. The narrowing of covered entities under Section 1557 will result in discrimination against LGBTQ patients, who already face disproportionate barriers to accessing appropriate care, and eliminate LGBTQ patient's remedies to address such discrimination.

29. In sum, the Revised Rule will exacerbate the acute health disparities LGBTQ people already face and send the message that discrimination on the basis of gender identity, transgender status, sexual orientation, and failure to conform with sex stereotypes is permissible under federal law, which will increase the number of Whitman-Walker's LGBTQ patients who will be denied care outside Whitman-Walker.

Harms to Whitman-Walker's LEP Patients

30. As noted above, Whitman-Walker serves hundreds of LEP patients in any given year. Language access protections for LEP patients are essential to ensuring that LEP patients receive adequate care, understand their rights, and are able to communicate fully and effectively with their health care providers. Whitman-Walker has found the clear guidance provided by the

2016 Final Rule to be helpful in improving the health and wellbeing of our LEP patients as they obtain care at Whitman-Walker and elsewhere.

31. The Revised Rule, however, eliminates the requirement that covered entities take reasonable steps to provide meaningful access to "each individual with LEP eligible to be served or likely to be encountered" and replaces it with a general reference to "LEP individuals." See, e.g., 85 Fed. Reg. at 37,245. Focusing on LEP individuals in general as opposed to each individual will result in some individuals not receiving the services they need for meaningful access, and thereby result in more acute health problems and outcomes for patients and raises concerns about patient safety.

32. The weakening of protections for LEP individuals will harm Whitman-Walker's LEP patients who get care elsewhere or are referred to providers outside our organization for specialty care, as they will no longer benefit from the notices, taglines, and additional language access provisions that are critical to ensure meaningful access to care. The Revised Rule will thus diminish or eliminate meaningful access to health care for Whitman-Walker's LEP patients, who will not be aware of their rights or the programs or services available to them when they go to other health care facilities.

33. Whitman-Walker will face increased burdens due to fewer clients being aware of their language access rights and the likelihood that more people will turn to Whitman-Walker for help in their language, rather than other covered health care providers. Whitman-Walker will also be burdened with increased costs because its patients will come to us sicker as a result of inadequate care elsewhere.

Additional Harms to Whitman-Walker

34. Escalating health care discrimination and fear of such discrimination, resulting

from the Revised Rule, is likely to result in increased demand for Whitman-Walker's health care services, which will present considerable operational and financial challenges. Many of Whitman-Walker's health care services lose money due to low third-party reimbursement rates and indirect cost reimbursement rates in contracts and grants which are substantially less than Whitman-Walker's cost of service. Increased demand for Whitman-Walker's health care services, driven by increased discrimination and fear of discrimination outside of Whitman-Walker, would exacerbate that pressure. We likely will be called upon to see more patients, and that patient care does not financially cover itself. As a result, Whitman-Walker may not be able to meet the increased demand and sustain the additional financial burdens resulting from an increased load of patients who either fear discrimination elsewhere or who were discriminated against or denied services at other institutions.

35. In addition, Whitman-Walker has large numbers of patients who require gender-affirming care, including hormone therapy and affirming, supportive mental health services. To the extent that the Revised Rule results in insurance plans and insurance companies reducing their coverage of such therapies, Whitman-Walker itself – as well as our patients – will be directly harmed by reduced reimbursements. In order to sustain the care that these patients need, we will be forced to turn to other measures, such as increasing charges to the patients themselves, and increasing our reliance on fundraising and grant revenue (which already is stretched thin).

36. The operational and financial pressures we will likely experience due to increased demand for our services as discrimination, and fear of discrimination, mount in the LGBTQ and LEP communities, will come at a time when Whitman-Walker already is struggling with the challenges posed by the COVID-19 pandemic. Since March of this year, many of our services have temporarily closed, and other health care services are being provided entirely through telemedicine

rather than in-person. Telemedicine services are being reimbursed at rates substantially lower than in-person services. The resulting very significant decline in revenues, and the very great operational challenges posed by suspending many services and re-tooling others, are posing challenges unique in Whitman-Walker's history. It will be particularly difficult to respond to increased demand at this already-difficult time.

37. At the same time, given Whitman-Walker's mission to provide health care to marginalized communities, including the LGBTQ community and people living with HIV, Whitman-Walker needs to increase its education programs and community outreach to help those affected by the Revised Rule find the health care services that they need and assist them with their trauma resulting from the Revised Rule. Whitman-Walker needs to continue informing the community about its commitment to serving all patients in a nondiscriminatory and welcoming manner and notifying its patients that the Revised Rule will not change Whitman-Walker's commitment to providing exceptional health care services to all members of the community. Whitman-Walker will continue fighting for its patients' rights, including, for example, advocating on behalf of transgender patients who seek treatment for gender dysphoria, but who are rejected because of their sex assigned at birth and gender identity. As a result of the Revised Rule, Whitman-Walker will also need to devote more resources to working with outside providers and organizations to remind them of the importance of providing health care to all patients on non-discriminatory terms.

38. The Revised Rule also adversely impacts Whitman-Walker by necessitating a diversion and reallocation of resources in order to provide referrals to patients that it does not have the resources to treat either because Whitman-Walker has reached its capacity for new patients (especially in the behavioral-health departments) or because the patient requires treatment in a

specialty that Whitman-Walker does not offer. These types of referrals are routine at Whitman-Walker where its focus is on primary care and HIV-specialty care. The Revised Rule will make it significantly more difficult and resource-intensive for us to locate, monitor, and provide appropriate referrals. With an increase in referral requests as a result of the Revised Rule, Whitman-Walker will need to allocate additional staff time to pre-screen service referrals to ensure that staff are sending patients to LGBTQ-affirming, LEP-welcoming providers and not to providers who themselves or whose staff would cause additional harm to Whitman-Walker patients.

39. The impact on Whitman-Walker and its patients of a broad, legally unsupported expansion of health care providers' refusal rights is also particularly worrisome. Religiously affiliated hospitals and health care systems occupy a large and growing percentage of health care markets, and providing a broad exemption from Section 1557's nondiscrimination provisions will affect Whitman-Walker's ability to make referrals and result in increased expenditures. It will also cause unnecessary confusion.

* * * * *

40. Health care systems should be safe places for everyone to seek care; where people's identities are affirmed, regardless of race, religion, sexual orientation, gender identity, disability, national origin, or other characteristics. It is Whitman-Walker's mission to offer affirming community-based health and wellness services to all, with a special expertise in LGBTQ and HIV care, and to empower all persons to live healthy, love openly, and achieve equality and inclusion. The Revised Rule frustrates our ability to live up to our mission by fostering discrimination against Whitman-Walker's LGBTQ patients, LEP patients, and others. The Revised Rule endangers the health, safety, and wellbeing of our patients; inhibits our ability to

provide them with the health care that they need, including the provision of referrals; increases the costs we must incur in order to provide our patients with adequate health care, as well as by the likelihood that more people will turn to Whitman-Walker to fill gaps in care and assistance caused by the Revised Rule; and imposes new compliance costs.

[*Signature on next page*.]

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

Dated this 1st day of July, 2020.

Naseema Shafi

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WHITMAN-WALKER CLINIC, INC., *et al.*, *Plaintiffs,* v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, *Defendants*.	Case No. 1:20-cv-1630

DECLARATION OF DR. SARAH HENN, MD, MPH
CHIEF HEALTH OFFICER, WHITMAN-WALKER HEALTH

I, Sarah Henn, declare as follows:

1. I am the Chief Health Officer of Whitman-Walker Clinic, Inc., d/b/a Whitman-Walker Health ("Whitman-Walker").

2. I received my medical degree from the University of Virginia; interned at Emory University; was a resident in Internal Medicine at the University of Virginia; and completed an Infectious Disease Fellowship at the University of Maryland. I earned a Masters of Public Health degree at The Johns Hopkins Bloomberg School of Public Health. I maintain active board certifications in Infectious Disease and Internal Medicine. A copy of my curriculum vitae is attached as **Exhibit A**.

3. I have been a physician at Whitman-Walker since 2007, and became Chief Health Officer in May 2018. I oversee all health care related services at Whitman-Walker, as well as maintain a panel of patients for whom I provide direct care. In addition, I am the primary investigator for multiple HIV and Hepatitis C treatment and prevention trials, and am the Leader

of our Clinical Research Site for the AIDS Clinical Trials Group funded by the National Institutes of Health.

4. I am submitting this Declaration in support of Plaintiffs' motion for a preliminary injunction to prevent the revised regulation under Section 1557, published by the U.S. Department of Health and Human Services ("HHS") on June 19, 2020 (the "Revised Rule"), from taking effect.

5. Whitman-Walker provides a range of services, including medical and community health care, transgender care and services, behavioral-health services, dental-health services, legal services, insurance-navigation services, and youth and family support. Whitman-Walker provides primary medical care, HIV and Hepatitis C specialty care, and gender-affirming care to transgender and gender non-binary persons within the diverse community of the greater Washington, DC metropolitan area. In calendar year 2019, our medical, dental, behavioral-health and community-health professionals provided health services to 20,760 patients—including medical care to 11,817 individuals, dental care to 2,014 patients, and walk-in sexually-transmitted-infection testing and treatment to 1,762 persons. In 2019, 3,587 of our patients were individuals living with HIV; 2,148 identified as transgender; and 9,295 identified as gay, lesbian, bisexual or otherwise non-heterosexual.

6. Whitman-Walker's patient population, including patients to whom I provide direct care and whose care I oversee, includes many persons who have experienced refusals of health care or who have been subjected to disapproval, disrespect, or hostility from medical providers and staff in hospitals, medical clinics, doctor's offices, or Emergency Medical Services personnel because of their actual or perceived sexual orientation, gender identity, transgender status, gender presentation, ethnicity or race, religious affiliation, poverty, substance use history, or for other reasons.

7. My patients and those whose care I oversee tell us that they are apprehensive or fearful of encountering stigma and discrimination in health care settings because of their past experiences. Many of our patients have delayed medical visits or postponed recommended screenings or treatment because of such fears. Frequently, persons living with HIV, diagnosed with sexually transmitted infections, struggling with substance use disorders, or whose gender identity is different from the sex that they were assigned at birth, face heightened stigma and discrimination and are particularly apprehensive in medical encounters. Our patients' concerns have been magnified by their belief that the federal government is permitting, if not encouraging, discrimination by health care personnel and health care institutions under the Revised Rule.

8. There is every reason to believe that the Revised Rule's elimination of protections from discrimination based on gender identity, sexual orientation, transgender status, failure to conform with sex stereotypes, along with its expansion of religious exemptions and weakening of safeguards for services to patients with Limited English Proficiency (LEP), will result in more discrimination against lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ) patients, and inadequate services to LEP patients, at other clinics, doctors' offices, hospitals, pharmacies, and other health care facilities outside Whitman-Walker.

9. I and other Whitman-Walker health care providers, including referral coordinators, behavioral-health providers, and other staff, have learned of many instances of discrimination, from our patients and from communications with outside providers and staff. Examples include the following:

a. Whitman-Walker was recently contacted by a transgender woman suffering from tonsillitis. She wanted treatment but knew of no hospital or facility other than Whitman-Walker where she could go. The caller reported that

in her suburban area, she and other transgender individuals she knows are routinely disrespected and poorly treated when they seek medical care, and asked for advice on where transgender patients can receive good care.

b. A gay man reported that he consulted a cardiologist for a heart issue. The cardiologist reviewed his medications and saw that one was Truvada—an antiretroviral medication that is used for "Pre-Exposure Prophylaxis" or "PrEP"—taken by persons who are not HIV-infected to avoid contracting HIV during sex. The cardiologist was startled and disapproving, and began lecturing the patient about what the cardiologist considered his inappropriate sex life.

c. A transgender man, together with his girlfriend, consulted a fertility clinic about their pregnancy options. Clinic staff told them that they would not help people like them.

d. A transgender patient of Whitman-Walker attempted to fill a prescription at a non-Whitman-Walker pharmacy for a hormone prescribed to assist in their gender transition, and was refused by the pharmacist.

e. Our patients seeking to fill prescriptions for Truvada for PrEP have also been refused by some pharmacies.

f. A gay man who is a long-term HIV survivor went to a local hospital emergency room after an accident that occurred during sex. He was treated with contempt by ER staff and was lectured about his sex life.

g. A transgender individual went to a local hospital emergency room suffering from acute abdominal pain. The individual was subjected to intrusive,

hostile questioning by ER personnel, loudly and in public, about their anatomy and gender identity.

h. One of our physicians, while in residency at a hospital in a major Midwestern city, heard other residents refuse to refer to transgender patients by pronouns conforming to their gender identity, citing their religious beliefs. They continued to refuse even when informed that they were violating hospital policy.

i. A transgender woman was scheduled to receive an ultrasound for cancer. The first radiological technician she encountered refused to perform the ultrasound. When she protested, a second technician performed the procedure, but mocked her openly.

j. Transgender patients have reported to us that they have been in medical or mental-health crisis and called for an ambulance, and that the Emergency Medical Service personnel who have arrived on the scene have intentionally used pronouns inconsistent with their gender identity, even when the patients have asked them to stop and told them that their language was increasing their distress.

k. A gay man who was engaged in sex, while under the influence of drugs, experienced a physical episode and was fearful he was having a heart attack. He called an ambulance, but the Emergency Medical Service personnel who arrived belittled him and his situation and refused to take him to an emergency room.

l. Local hospitals and surgeons have refused to perform gender-transition-related surgeries on Whitman-Walker transgender patients, even when they routinely perform the procedures in question on non-transgender patients, including in situations where the patient's insurance would cover the procedure or when the patient was able to pay for the procedure. This has happened with orchiectomies, breast augmentations, and breast reductions - procedures which are all routinely performed for treatment of cancer or for other reasons not related to gender identity.

m. A number of primary care physicians in our area have refused to prescribe hormone therapy for transgender patients seeking to transition from the sex they were assigned at birth to their actual gender identity. Many of these doctors have stated that they are not "comfortable" with such hormone therapy.

n. Our providers have seen situations in which a teenager who is transgender or gender-expansive has presented at a local hospital with symptoms for which hospitalization was indicated, but their hospitalization was delayed and even denied because hospital personnel took them less seriously than they took other young people with similar presentations who were not transgender.

o. Our transgender patients frequently report instances of being treated with disrespect and hostility by staff in doctors' offices, hospitals, and clinics. Frequently, staff at these facilities will refuse to address patients by their chosen names and gender pronouns, if these are not the same as the patients'

legal names and sex assigned at birth, or if patients appear to be transgender. The persistent use of names and pronouns other than what the patients have requested appears intentional and intended to communicate strong disapproval of the patients. I and my staff who frequently consult with transgender patients hear of such experiences from as many as four out of every five transgender patients. To state the obvious, there is no medically indicated reason to refuse to call patients by their names and pronouns, consistent with their gender identities.

10. These and many other experiences reveal that many medical providers and other staff continue to harbor explicit or implicit biases against LGBTQ people. Many providers and staff who harbor such feelings or beliefs nonetheless have provided care to LGBTQ patients, and kept their personal beliefs in check, because of anti-discrimination laws and regulations, such as the 2016 Final Rule; non-discrimination policies at many hospitals, clinics, and other health care facilities; and professional norms. The Revised Rule counteracts such non-discrimination policies and norms by signaling that discrimination based on sexual orientation, gender identity, and transgender status is permissible under federal law, and by extending religious exemptions to health care settings where they are inappropriate and dangerous. The result will likely be a significant increase in discriminatory incidents, denials of care, and the attendant harms to patients' health and well-being.

11. Discriminatory incidents are not only insulting and demoralizing for patients, but can jeopardize the patient's health, when a screening or treatment is denied or postponed, or the patient is discouraged from seeking medical care out of fear of repeated discrimination. Many if not most of my and Whitman-Walker's transgender patients express strong distrust of the health care system

generally, and a demonstrative reluctance to seek care outside Whitman-Walker unless they are in a crisis or in physical or mental stress. This is because they want to avoid discrimination or belittlement. Such incentives to avoid regular check-ups and other medical care can result in disease processes that are more advanced at diagnosis, less responsive to treatment, or even no longer curable in the case of some cancers.

12. In addition, LGBTQ people are more vulnerable to COVID-19. For example, LGBTQ people are less likely compared to the general population to have health insurance to begin with and are more likely to be smokers with the resultant comorbidities such as asthma, COPD, and CVD which increase the risk for complications from COVID-19. LGBTQ people are also more likely to work in jobs in that have been highly affected by the COVID-19 pandemic, often with more exposure and/or higher economic sensitivity to the COVID-19 crisis.[1]

13. As health care has had to go virtual due to the COVID-19 pandemic, hard coding within electronic health records and other limitations in functionality have made it very challenging for people with LEP to access care. In many cases for walk-in COVID-19 testing, registration and screening is being accomplished via the telephone. Many LGBTQ people and people with LEP have a challenging time with this need for electronic resources.

14. The Revised Rule frustrates my ability and the ability of my colleagues to successfully refer patients for specialty care from outside providers because we cannot assure our patients that those providers will provide care free from discrimination.

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[1] Human Rights Campaign Found., *The Lives and Livelihoods of Many in the LGBTQ Community are at Risk Amidst COVID-19 Crisis* (Mar. 2020), https://assets2.hrc.org/files/assets/resources/COVID19-IssueBrief-032020-FINAL.pdf?_ga=2.249711620.386339034.1593392090-1365884386.1591027992.

15. The Revised Rule also erodes trust between patients and their health care providers, endangers the provider-patient relationship, and is likely to harm many patients' health.

16. Good medical care is based on trust as well as frank, and full communication between the patient and their provider. In many, if not most encounters, providers need patients to fully disclose all aspects of their health history, sexual history, substance-use history, lifestyle, and gender identity in order to provide appropriate care for the patients' mental and physical health. Incomplete communication, or miscommunication, can have dangerous 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; and a patient who fails to fully 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 Revised Rule completely overlooks the importance of this information to medical providers, and instead focuses myopically on the limited instances in which sex assigned at birth may be relevant to care. Patients need to be encouraged to fully disclose all information relevant to their health care and potential treatment, which can only be achieved when patients are assured that the information they provide will be treated confidentially and with respect, and will not be used against them to deny treatment.

17. In order for Whitman-Walker's heath care providers to provide proper medical care and services to the LGBTQ community, our health care providers rely on frank and complete communication with their patients and the individuals who seek their services, and want the same happen when our patients need care elsewhere. Without full disclosure, we are not able to treat adequately our patients.

18. Patients remaining closeted to health care providers also results in increased costs to the health care system. When a patient is closeted and medical providers do not order medically necessary tests or screenings as a result, Whitman-Walker and its patients, as well as the health care system as a whole, suffer downstream effects, such as the exacerbation of a patient's distress and more acute conditions, and increased costs. In addition, I and other Whitman-Walker health care providers will bear an increased risk of malpractice when patients do not feel comfortable revealing important information about their sexual orientation, gender identity, and health history.

19. The Revised Rule also discourages LGBTQ patients from seeking preventative screenings and necessary medical treatment for fear of being subjected to discrimination.

20. The delay of preventative screenings and necessary health care can result in more acute health problems and outcomes for patients and raises concerns about patient safety. For example, research has identified pervasive health disparities for LGBTQ people with respect to cancer, HIV, obesity, mental health, tobacco use, and more. The delay of preventative screenings and necessary health care thus endangers the health and wellbeing of Whitman-Walker's LGBTQ patients and exposes them to lasting harms.

21. The delay of preventative screenings and necessary health care at other health care facilities fostered by the Revised Rule will cause LGBTQ patients to come to Whitman-Walker with more acute conditions and/or diseases that are more advanced at diagnosis, less responsive to treatment, or no longer treatable. This will in turn strain Whitman-Walker's resources, increase costs for providers, make it harder for our health care providers to treat the patients, and increase costs to the health care system in general.

22. Discrimination by health insurance providers against transgender individuals is yet another barrier to care that my patients and the patients whose care I oversee frequently experience.

Our providers, care navigators, and Legal Services attorneys continuously advocate for patients whose insurance – including Medicaid plans, Medicare, and private insurance plans – denies coverage of surgical procedures hormone therapies that are medically indicated and vital to patient health and well-being. The 2016 Final Rule has been an important tool in advocating for our patients. By declaring that discrimination in insurance based on gender identity or transgender status is not prohibited in federal law, and by limiting the types of insurance plans that are subject to federal nondiscrimination requirements, the Revised Rule will increase barriers to life-saving, medically-necessary care for transgender patients by allowing health insurers to revert back to policies excluding coverage for gender-affirming care. If patients with such coverage exclusions are to access the care they require, they will incur debilitating out of pocket costs to pay for their medical treatment. For many if not most of our transgender patients, lack of insurance coverage of gender-affirming surgeries and other treatments will mean that they are simply unavailable.

23. Ensuring that our health services are fully accessible to persons with limited English proficiency, and that our health care providers and other staff are able to communicate fully with all of our patients, is critical to Whitman-Walker's mission. Whitman-Walker has a number of patients whose primary language is Spanish or some other language, and who lack English proficiency. In 2019, approximately 9% of our patients had limited proficiency in English and needed interpreter services. Over the past several years, we have devoted considerable time and attention to developing and implementing a language access plan and training all staff in the details of that plan.

24. I and the providers I supervise have patients who, in hospital and medical-clinic settings, were refused Spanish-language interpreters, even when such interpreters were available

in the facility, because the provider or other staff thought that the patient ought to know English, or because of bias against immigrants.

25. Patients in these situations have had difficulty understanding their diagnosis and/or treatment plan, greatly increasing risk of a negative result and harm. Notices to LEP patients explaining their rights and what programs and services are available to them are crucial to promoting positive patient health outcomes. The Revised Rule's elimination of the requirement of such notices will result in harm to Whitman-Walker LEP patients by diminishing their meaningful access to health care, outside of what Whitman-Walker can provide. In addition, the Revised Rule will cause more patients to seek out care at Whitman-Walker due to a lack of appropriate language services available elsewhere.

26. Whitman-Walker's mission and fundamental principles of medical ethics that I adhere to in overseeing and providing care to patients dictate that all patients are deserving of the best and most respectful care available to them. All health care professionals are taught that their personal beliefs about a patient's actions, identity or beliefs cannot compromise the care that they provide to that patient in any way. Whitman-Walker and I, in my role as Chief Health Officer for Whitman-Walker, communicate that message to all health care staff from the beginning of the recruitment process to the first day of employment, and reinforce the message regularly.

27. The possibility that providers outside Whitman-Walker could invoke the overly broad religious exemptions in the Revised Rule to opt out of any aspect of care would fundamentally disrupt our care model and operations, as it would make it harder to refer patients to specialists and strain Whitman-Walker's already limited resources. Such discrimination would also violate basic tenets of medical ethics. Broad-based denials of care cannot be accommodated without lasting damage to the patient morale, health center, and our reputation in the community.

28. The Revised Rule removes or substantially weakens safeguards against health care discrimination against LGBTQ individuals, and the weakening of safeguards for LEP patients will make health care for significant numbers of Latinx people less accessible and less effective. In other words, the Revised Rule will make it harder for us to care for our patients who will face discrimination or have diminished access to care elsewhere as a result of the Revised Rule.

29. Although Whitman-Walker prides itself on being a refuge for LGBTQ individuals, LEP persons, and others who have experienced discrimination or culturally inadequate care elsewhere, it would be quite difficult for us to accommodate the substantial increase in demand for our services caused by the Revised Rule. Many if not most of our services are under-compensated due to private and public insurance reimbursement rates, and grant funds that do not fully account for the actual cost of service. Moreover, the COVID-19 pandemic has posed extraordinary financial and operational challenges. Many of our health services have been temporarily suspended since March of this year, or shifted entirely to telemedicine, with substantially lower reimbursement rates. The logistical challenges remain daunting, even without a significant increase in new patients.

[*Signature on next page.*]

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

Dated this 30 day of June, 2020.

Sarah Henn, MD, MPH

EXHIBIT A

Curriculum Vitae of Sarah Henn, MD, MPH

Sarah L. Henn, MD, MPH

1525 14th Street NW • Washington, DC 20005 • Phone: 202.745.6174 • E-Mail: shenn@whitman-walker.org

Education and Post-Doctoral Training

Bachelor of Arts 1988 - 1992
Hamilton College, Clinton, New York, Major International and Comparative Political Studies, Minor German

Doctor of Medicine 1993 - 1997
University of Virginia School of Medicine, Charlottesville, Virginia

Internship 1997 - 1998
Internal Medicine, Emory University Medical Center, Atlanta, Georgia

Residency 1998 - 2000
Internal Medicine, University of Virginia Medical Center, Charlottesville, Virginia

Master of Public Health 2001 - 2003
The Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland, Concentration in International Health

Fellowship 2004 - 2006
Infectious Diseases, University of Maryland Medical Center and the Institute for Human Virology, Baltimore, Maryland

Certifications, Licensures, & Appointments:

Board Certifications:

- American Board of Internal Medicine, Internal Medicine, 2000, recertified 2010
- American Board of Internal Medicine, Infectious Diseases, 2006, recertified 2016

Medical Licensure:

- District of Columbia, 2007 – present

Academic Appointments:

- George Washington University, Clinical Assistant Professor, 2008 - present

Professional Experience

Chief Health Officer May 2018 – present

Whitman-Walker Health, Washington DC

Responsibilities: Medical lead of a Federally Qualified Health Center serving over 12,000 clients with over 300 employees and an annual budget of over 100 million dollars. Key member of the executive team responsible for strategic planning and the overall management of the organization. Reports directly to the CEO/Executive Director.

Key Achievements:

- Established in conjunction with seven regional FQHC leaders the Coordinated Care Network, an incorporated independent entity, in the District of Columbia to centralize coordinated primary care, increase quality, reduce cost, and increase influence with payers and stakeholders positioning WWH effectively for value based payment transformation which negotiates directly with Medicaid MCO payers around service delivery for the care of over 100,000 individuals in the District of Columbia
- Expanded clinical services to include adolescents with a specialty focus on HIV Prevention, Sexual Health, and Gender Affirming Care
- Clinical Research Site (CRS) Leader of AIDS Clinical Trials Group (ACTG) site as part of Johns Hopkins' Clinical Trails Unit (CTU)

- Serves of the Executive Committee of the DC Center for AIDS Research (CFAR) and is a member of the DC CFAR housed at the George Washington University Milken School of Public Health

Senior Director of Health Care Operations and Medical Services January 2015 – April 2018

Whitman-Walker Health, Washington DC

Responsibilities: Leads medical operations of a Federally Qualified Health Center serving over 18,000 clients with near 300 employees and an annual budget of over 100 million dollars. Serves on the senior leadership team providing strategic direction for the health center. Oversees the integrated delivery of primary medical, specialty HIV, HIV prevention, gender affirming, dental, occupational therapy, aesthetics, laboratory, and pharmacy services. Negotiates and oversees contracts with outside vendors.

Key Achievements:

- Achieved Patient Center Medical Home highest level 3 accreditation for demonstrating strong performance and significant improvement in performance measures across the triple aim of better patient experience, better health, and lower per capita cost.
- Led the design and implementation of an improved patient scheduling system increasing same day and next day scheduled appointments to 30% of all patient visits and decreasing new patient wait times to under one week
- Improved laboratory patient experience while simultaneously negotiating improved rates with LabCorp achieving cost savings of up to 50% on frequently order tests and $10,000 per month in credit to WWH's account for labs performed for clients who are <200% federal poverty level
- Oversee pharmacy contract and performance in a pharmacy that dispenses up to 1000 prescriptions daily with a net profit of close to a million dollars monthly in close conjunction with the Deputy Executive Director
- Awarded over 1 million dollars in new research grants in 2017 from the National Institute of Drug Abuse and the Patient Centered Outcomes Research Institute
- Significantly improved health center policies, trainings, and practices related to LGBT health helping to result in WWH being recognized as a "Leader in LGBT Healthcare Equity" with a score of 100/100
- Achieved increased service integration and productivity by leading weekly interdepartmental medical operations meetings and working closely with providers to create buy-in and improve morale
- Transitioned medical operations of the Elizabeth Taylor Medical Center serving more than 10,000 patients to a new facility at 1525 14th St NW in May 2015
- Expanded medical services at the Max Robinson Center, in Southeast DC, more than tripling the number of care providers ensuring that the full suite of patient services are consistently available

Interim Sr. Director of Evidence Based Medicine 2015

Whitman-Walker Health, Washington DC

Responsibilities: Oversaw the clinical research department and the execution of large-scale research studies and collaborations. Acted as leader of clinical research site (CRS) for AIDS Clinical Trials Group (ACTG) and primary investigator for the Study to Help the AIDS Research Effort (SHARE), which is one of the four clinical sites for the Multicenter AIDS Cohort Study (MACS).

Key Accomplishments:

- Reorganized the structure of the department to allow for increased staff development opportunities and quality monitoring of research programs
- Maintained industry research funding of over 2 million annually while more than doubling ACTG study participation

Medical Director 2009 – 2014

The Elizabeth Taylor Center, Whitman-Walker Health, Washington DC

Responsibilities: Performed overall planning, organizing, scheduling, directing, and evaluation of clinical medical providers ensuring excellent patient care experience. Worked closely with the Chief Medical Officer and the Senior Director of Quality Improvement in the delivery of the highest quality of care and the development of quality improvement projects.

Key Accomplishments:

- Implemented ongoing provider education to improve quality indicators.
- Supervised 15 providers, including other physicians, physician volunteers, physician-assistants, and nurse practitioners

Staff Physician 2007 - 2009

Whitman-Walker Health, Washington DC

- Provided primary care at clinical sites in Northwest and Southeast Washington, DC and Northern Virginia
- Specialized in complex HIV care and Hepatitis C treatment
- Initiated Hepatitis C treatment program

Clinical Instructor, Division of Infectious Diseases 2006 - 2007

University of Maryland Medical Center, Baltimore, Maryland

- Maintained active outpatient infectious disease clinics at both the University of Maryland and the Veterans Administration Hospital in Baltimore, MD
- Attended on the inpatient HIV hospital services overseeing Infectious Disease fellows, Medical residents, and students
- Developed a research protocol to reduce maternal to child transmission of Hepatitis B in HIV co-infected mothers

Technical Advisor for PEPFAR 2004 - 2007

Institute for Human Virology, Baltimore, Maryland

- Launched and evaluated points of service for HIV/AIDS care in Nigeria
- Provided technical assistance and expertise to Nigerian physicians and medical staff in order to initiate HIV treatment for patients

Clinical Associate Staff Physician 2002 - 2003

The Cleveland Clinic Foundation, Cleveland, Ohio

- Trained internal medicine residents, interns, and medical students
- Attended on the inpatient medicine wards, primary care clinic, and pre-operative clinic performing medical consultations on national and international referrals.

- Supervised patient care team

Associate Physician **2000 - 2002**

Shenandoah Internal Medicine, Augusta Medical Center, Virginia

- Practiced private practice Internal Medicine in rural Virginia
- Attended to patients in both the outpatient and inpatient setting
- Cared for patients in the Intensive Care Unit, Cardiac Step Down Unit, and performed cardiac stress testing

Publications

Peer-reviewed journal articles

1. Lathouwers E, Wong EY, Brown K, Baugh B, Ghys A, Jezorwski J, Mohsine EG, Van Landuyt E, Opsomer M, De Meyer S. Week 48 Resistance Analyses of the Once-Daily, Single-Tablet Regimen Darunavir/Cobicistat/Emtricitabine/Tenofovir Alafenamide (D/C/F/TAF) in Adults Living with HIV-1 from the Phase III Randomized AMBER and EMERALD Trials. AIDS Res Hum Retroviruses. 2019 Oct 21;. doi: 10.1089/AID.2019.0111. [Epub ahead of print]

2. Eron JJ, Orkin C, Cunningham D, Pulido F, Post FA, De Wit S, Lathouwers E, Hufkens V, Jezorwski J, Petrovic R, Brown K, Van Landuyt E, Opsomer M. Week 96 efficacy and safety results of the phase 3, randomized EMERALD trial to evaluate switching from boosted-protease inhibitors plus emtricitabine/tenofovir disoproxil fumarate regimens to the once daily, single-tablet regimen of darunavir/cobicistat/emtricitabine/tenofovir alafenamide (D/C/F/TAF) in treatment-experienced, virologically-suppressed adults living with HIV-1. Antiviral Res. 2019 Oct;170:104543.

3. Naggie S, Fierer DS, Hughes MD, Kim AY, Luetkemeyer A, Vu V, Roa J, Rwema S, Brainard DM, McHutchison JG, Peters MG, Kiser JJ, Marks KM, Chung RT. Ledipasvir/Sofosbuvir for 8 Weeks to Treat Acute Hepatitis C Virus Infections in Men With Human Immunodeficiency Virus Infections: Sofosbuvir-Containing Regimens Without Interferon for Treatment of Acute HCV in HIV-1 Infected Individuals. Clin Infect Dis. 2019 Mar 28;. doi: 10.1093/cid/ciy913. [Epub ahead of print]

4. Orkin C, Molina JM, Negredo E, Arribas JR, Gathe J, Eron JJ, Van Landuyt E, Lathouwers E, Hufkens V, Petrovic R, Vanveggel S, Opsomer M; EMERALD study group. Efficacy and safety of switching from boosted protease inhibitors plus emtricitabine and tenofovir disoproxil fumarate regimens to single-tablet darunavir, cobicistat, emtricitabine, and tenofovir alafenamide at 48 weeks in adults with virologically suppressed HIV-1 (EMERALD): a phase 3, randomised, non-inferiority trial. Lancet HIV. 2018 Jan;5(1):e23-e34.

5. Cahn P, Kaplan R, Sax PE, Squires K, Molina JM, Avihingsanon A, Ratanasuwan W, Rojas E, Rassool M, Bloch M, Vandekerckhove L, Ruane P, Yazdanpanah Y, Katlama C, Xu X, Rodgers A, East L, Wenning L, Rawlins S, Homony B, Sklar P, Nguyen BY, Leavitt R, Teppler H; ONCEMRK Study Group. Raltegravir 1200 mg once daily versus raltegravir 400 mg twice daily, with tenofovir disoproxil fumarate and emtricitabine, for previously untreated HIV-1 infection: a randomised, double-blind, parallel-group, phase 3, non-inferiority trial. Lancet HIV. 2017 Nov;4(11):e486-e494.

6. Wyles D, Ruane PJ, Sulkowski MS, Dieterich D, Luetkemeyer A, Morgan TR, Sherman KE, Dretler R, Fishbein D, Gathe JC, Henn S, Hinestrosa F, Huynh C, McDonald C, Mills A, Overton ET, Ramgopal M, Rashbaum B, Ray G, Scarsella A, Yozviak J,

McPhee F, Liu Z, Hughes E, Yin PD, Noviello S, Ackerman P for the ALLY-2 Investigators, Daclatasvir plus Sofosbuvir for HCV in Patients Coinfected with HIV-1. N Engl J Med. 2015 Aug 20;373(8):714-25.

7. Alcaide ML, Feaster DJ, Duan R, Cohen S, Diaz C, Castro JG, Golden MR, Henn S, Colfax GN, Metsch LR, The incidence of Trichomonas vaginalis infection in women attending nine sexually transmitted diseases clinics in the USA. Sex Transm Infect. 2015 Jun 12 pii: sextrans-2015-052010.

8. Metsch LR, Feaster DJ, Gooden L, Schackman BR, Matheson T, Das M, Golden MR, Huffaker S, Haynes LF, Tross S, Malotte CK, Douaihy A, Korthuis PT, Duffus WA, Henn S, Bolan R, Philip SS, Castro JG, Castellon PC, McLaughlin G, Mandler RN, Branson B, Colfax GN., Effect of risk-reduction counseling with rapid HIV testing on risk of acquiring sexually transmitted infections: the AWARE randomized clinical trial. JAMA. 2013 Oct 23;310(16):1701-10.

9. Silver D, Karnik G, Osinusi A, Silk R, Stabinski L, Doonquah L, Henn S, Teferi G, Masur H, Kottilil S, Fishbein D., Effect of HIV on liver fibrosis among HCV-infected African Americans. Clinical Infectious Disease. 2013 May;56(9):1280-3.

10. Henn SL, Forrest GN, Febrile Neutropenia Associated with Painful Lesions of the Palms and Digits. Clinical Infectious Disease. 2006;43(6):747, 791-2.

11. Henn S, Bass N, Shields G, Crow TJ, DeLisi LE, Affective illness and schizophrenia in families with multiple schizophrenic members: independent illnesses or variant gene(s)? Eur Neuropsychopharmacol. 1995;5 Suppl:31-6.

Abstracts

1. Alt Olsen H, Sarkodie E, Coleman M, Davies M, Henn, S, Fast Forward to Viral Suppression: A Nurse-driven Model for Facilitating Same Day Start of ARVs Following Reactive HIV+ Result or First-time Engagement in HIV Care. 2019, Association of Nurses in AIDS Care, Portland. Abstract #B-11.

2. Coleman M, Sarkodie E. Eggleston A, Kelley E, Henn S, Measuring Retention in Real World PrEP Programs; What is the best way to evaluate engagement with PrEP? 14th International Conference on HIV Treatment, Prevention, and Adherence, Miami. Abstract # 3381.

3. Alt Olson H, Sarkodie E, Coleman M, Davies M, Henn S, Fast Forward to Viral Suppression: Immediate Initiation of ARVs Following Reactive HIV+ Test Results or Engagement in HIV Care for the First Time at a Community Health Center in Washington, DC. 2019. 14th International Conference on HIV Treatment, Prevention, and Adherence, Miami. Abstract #5035.

4. Alt Olson H, Sarkodie E, Colemen M, Davies M, Henn S, Immediate Initiation of ARVs Following Reactive HIV+ Test Result or Engagement in HIV Care for the First Time at a FQHC in Washington. 2019. 6th Annual SYNChronicity Conference.

5. Walsh B, Coleman M, Dietrich M, Du Mond J, Jue J, Sadler M, Saperstein S, Wickham C, Henn S, Improvements in Engagement, Retention, and Viral Load Suppression in a Mobile Outreach Retention and Engagement (MORE) Project at a Community Health Center in Washington DC. 2017. 9th IAS Conference on HIV Science. Abstact #A-854-0225-05081.

6. Dieterich M, Coleman M, Du Mond J, Jue J, Sadler M, Saperstein S, Wickham C, Walsh B, Henn S, HIV+ Participants in the Mobile Outreach and Retention (MORE) Program in Washington, DC with Co-Morbid Mental Health and/or Substance

Abuse Diagnoses are Significantly Less Likely to Achieve Viral Suppression Despite Comprehensive Support. 2017 12th International Conference on HIV Treatment and Prevention Adherence, Miami. Oral Abstract #277.

7. Osinusi A, Wang C, Zhang X, Shivabesan G, Shivakumar B, Silk R, Doonquah L, Henn S, Teferi G, Masur H, Kottillil S, Fishbein D, Augmentation of Interferon signaling pathway by Nitazoxanide: A therapeutic strategy for HIV/HCV Coinfected Relapsers to Peg-interferon and Ribavirin therapy. 2012 19th Conference on Retroviruses and Opportunistic Infections, Seattle.

8. Silver D, Karnik G, Osinus A, Silk R, Stabinski L, Doonquah L,Henn S, Tefari G, Masur H, Kotillil S, Fishbein D, Liver Fibrosis in African Americans, Comparing HCV Mono-Infection with HIV-HCV Co-Infection. 2011 American Association for the Study of Liver Disease Conference, San Francisco.

9. Henn SL, Weekes E, Forrest GN, Methicillin Resistant Staphylococcus Aureus Bacteremia Treated with Linezolid: A Retrospective Review of Outcomes. 2006 46th Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC), San Francisco. Abstract #876.

Awards:

Outstanding Employee of the Year 2016, Whitman-Walker Health, selected by employees and the Employee Advisory Group

George McCracken Infectious Disease Fellow 2006, Interscience Conference on Antimicrobial Agents and Chemotherapy, San Francisco

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WHITMAN-WALKER CLINIC, INC., *et al.*, *Plaintiffs,* v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, *Defendants*.	Case No. 1:20-cv-1630

DECLARATION OF RANDY PUMPHREY, D.MIN., LPC, BCC
SENIOR DIRECTOR OF BEHAVIORAL HEALTH, WHITMAN-WALKER HEALTH

I, Randy Pumphrey, declare:

1. I am the Senior Director of Behavioral Health at Whitman-Walker Clinic, Inc., d/b/a Whitman-Walker Health ("Whitman-Walker").

2. After earning a B.S. in American Studies, I received Masters of Divinity and Doctor of Ministry degrees from Wesley Theological Seminary. I initially worked as a Board Certified Chaplain at St. Elizabeth's Hospital (which became the Commission on Mental Health Services for the District of Columbia and the Psychiatric Institute of Washington), and subsequently received my Professional Counselor Licensure in 1997.

3. I have worked in mental-health and substance-use-disorder treatment since 1984, initially as an intern at Washington Hospital Center, then with St. Elizabeth's Hospital. In 1998 I became the Clinical Director of the Lambda Center, a joint partnership between the Psychiatric Institute of Washington and Whitman-Walker Clinic. I joined Whitman-Walker's staff in 2007 as the Manager of Mental Health Services, and became Senior Director of Behavioral Health in 2015.

In addition to managing Whitman-Walker's behavioral-health services, I maintain a panel of patients for whom I provide direct care. A copy of my curriculum vitae is attached as **Exhibit A**.

4. I am submitting this Declaration in support of Plaintiffs' motion for a preliminary injunction to prevent the revised regulation under Section 1557, published by the U.S. Department of Health and Human Services ("HHS") on June 19, 2020 (the "Revised Rule"), from taking effect.

5. As the Senior Director of Behavioral Health, I oversee Whitman-Walker's robust portfolio of mental-health services, and substance-use-disorder-treatment services. Our mental-health services include individual and group psychotherapy, psychiatry, and peer counseling. For individuals struggling with substance misuse, we offer individual and group counseling and support, and Medically-Assisted Treatment (MAT). In 2019, we provided mental-health or substance-use-disorder-treatment services to 2,912 patients. Our psychiatrists, psychologists, licensed psychotherapists, and trained peer counselors have a special mission to the lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ) community, and also to individuals living with HIV and their families and caregivers.

6. Many if not most of the individuals in our very diverse behavioral-health-patient population face considerable stigma and discrimination—as people living with HIV, as sexual or gender minority people, as people of color—and many of them struggle with internalized stigma and with acute or lower-level but persistent trauma. Many of them have experienced difficulty in finding therapists or other mental-health or substance-use-disorder professionals who are understanding and welcoming of their sexual orientation, gender identity, or struggles with HIV. We frequently receive phone calls and other inquiries from people seeking non-discriminatory, welcoming assistance with their substance use, depression, anxiety, or other challenges. Many of

these individuals have suffered from traumatizing encounters with hostile or disapproving health care professionals.

7. The Revised Rule's elimination of protections from discrimination based on gender identity, sexual orientation, transgender status, failure to conform with sex stereotypes, or LEP status, along with its expansion of religious exemptions, will result in more discrimination against LGBTQ patients, LEP patients, and patients living with HIV at other clinics, doctors' offices, hospitals, pharmacies, and other health care facilities outside Whitman-Walker. This increase in discrimination will harm the patients I serve and the patients whose care I supervise by directly harming their mental and behavioral health, discouraging access to mental and behavioral health care, and harming the patient-provider relationship, resulting in poor outcomes.

8. Experiencing discrimination in health care settings can have pronounced negative impacts on patients' mental and behavioral health. For example, a 2019 report by the Williams Institute at UCLA found that experiencing discrimination in health care settings is a unique risk factor for heightened suicidality among transgender individuals, a population already at heightened risk compared with the general population.[1] Conversely, nondiscrimination protections prohibiting discrimination in health care based on gender identity or transgender status have been associated with a decrease in suicidality among transgender and other gender minority individuals.[2] This is consistent with what I have observed over my years of experience in mental and behavioral health.

[1] *See* Jody L. Herman et al., The Williams Institute, *Suicide Thoughts and Attempts Among Transgender Adults* (2019), https://williamsinstitute.law.ucla.edu/publications/suicidality-transgender-adults/.

[2] *See* Alex McDowell et al., *Association of Nondiscrimination Policies with Mental Health Among Gender Minority Individuals*, JAMA Psych. (May 6, 2020), https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2765490.

9. The Revised Rule, by signaling that discrimination based on sexual orientation, gender identity, and transgender status is now permitted in health care settings, will on its own invoke increased fear and trauma among LGBTQ patients. Our clinic is likely to see an increased demand for mental-health services and behavioral-health services as a result. Patients will likely come to our care more distressed than they would otherwise due to the increased discrimination invited by the Revised Rule.

10. I and the providers and other behavioral-health staff that I supervise at Whitman-Walker have learned from patients about many incidents of discrimination or mistreatment based on a patient's actual or perceived sexual orientation, gender identity, or transgender status in other behavioral-health settings. For instance:

a. A transgender teenager was hospitalized after a suicide attempt. Hospital staff refused to address the teenager by the young person's preferred pronouns and gender throughout the teenager's hospital stay. This was experienced by the teenager as disapproval and contempt for the young person's gender identity. This discrimination exacerbated the teenager's acutely fragile state when the teenager was so desperately in need of health care providers' support and health care services that were free of judgment.

b. A facility that specializes in inpatient mental health and substance-use-disorder treatment, and which has explicit non-discrimination policies, nonetheless has significant trouble from nurses on weekend shifts (when the facility uses pool nurses rather than regular employees), who express strong disapproval of LGBTQ patients based on their religious beliefs or cultural upbringing. Despite the facility's non-discrimination policies, LGBTQ

patients encounter hostility, expressions of disapproval, and lack of responsiveness to their needs or requests from these nurses. For patients hospitalized for mental or substance-use disorders, these experiences can activate their disorders.

c. As I previously noted, behavioral health staff that I supervise often receive calls or other communications from LGBTQ persons expressing desperation about finding a therapist or substance use professional who will not discriminate against them because of their sexual orientation or gender identity.

d. Our behavioral-health providers who regularly interview our transgender patients to assess their stage of gender transition and readiness for gender-affirming surgical procedures, or who provide psychotherapy for these patients, report that the large majority of the patients they meet with—as many as four out of every five—report incidents of mistreatment or discrimination by health care providers and staff at hospitals, other clinics, doctor's offices, and other facilities.

e. A patient who was employed by a church consulted his health care provider. One of the nurses called his church and told them he was gay and living with HIV. As a result, he was fired and lost his pension, forcing him to live on a severely limited income.

11. These incidents reveal that many health care providers and other staff harbor explicit or implicit biases against LGBTQ people. Because of legal requirements, health care facility non-discrimination policies, and professional norms, many of them have kept their personal beliefs and feelings in check. By signaling that discrimination based on sexual

orientation, gender identity, and transgender status is permissible under federal law, the Revised Rule is very likely to result in many more incidents of discrimination and greater harm to LGBTQ individuals struggling with mental health or substance use issues, including the patients whom I treat and whose treatment I supervise.

12. Behavioral-health treatment assumes, and requires, trust between the patient and provider, and full and frank disclosure by the patient of all potentially relevant information about their life, including their sexual orientation, sexual and affectional experiences, and gender identity. I, and the providers that I supervise at Whitman-Walker, frequently work with patients who have concealed some or all aspects of their sexual and affectional orientation or history, or gender identity, from non-Whitman-Walker therapists or other behavioral health providers, often to the patients' harm. The Revised Rule will very likely discourage LGBTQ people and others needing treatment from fully disclosing relevant information to their therapists or counselors, or to those helping them with substance-use issues, which will likely increase their distress and undercut the effectiveness of their treatment.

13. For persons with traditionally stigmatized sexual orientation—such as gay, lesbian, or bisexual people—or who are transgender or gender expansive, competent mental-health services, or services for treatment of substance-use disorders, require an accepting—indeed, an affirming—attitude towards their sexual orientation or gender identity by their provider. Discriminatory behavior, statements, or attitudes expressed by a provider are a tremendous barrier to effective care. It is critical that a patient feel empowered and supported in fully disclosing their sexuality and gender identity to their counselor, therapist, psychologist, or psychiatrist. Without a trusting patient-provider relationship and full disclosure of all possibly relevant feelings and facts by the patient, effective treatment is unlikely to be possible. This is critical for good medical care

as well. The kind of discrimination permitted by the Revised Rule will erode patient-provider trust among the patients our clinic serves, making it more difficult for patients at Whitman-Walker to achieve successful outcomes in their care.

14. The COVID pandemic has greatly increased the fear and apprehension in our community. Many LGBTQ people, including many of our patients, who have lived through the HIV/AIDS era are feeling re-traumatized by a new pandemic. During the first three months of the pandemic and related shutdown, we have seen a significant numbers of our substance use clients relapse. Many people's fear of encountering discrimination in health care settings has been heightened. Our substance use patients who are struggling and are LGBTQ have expressed reluctance to use city-operated treatment facilities because they fear hostility and discrimination from other patients and staff at those facilities. The issuance of the Revised Rule, with its message that LGBTQ discrimination is permitted, and its extensive, approving discussion of anti-transgender sentiments among health care providers, could not have come at a worse time.

15. In addition, our staff have experienced major operational challenges in responding to COVID-19 – including shifting behavioral-health services to telemedicine and temporary suspension of some services. This is a particularly difficult time to respond to increased demand for our services stemming from increased fear of discrimination encouraged by the Revised Rule.

16. I and Whitman-Walker provide referral services for patients who need specialist care that we do not provide—including inpatient behavioral health care as well as specialist medical care. We also receive many outside requests for recommendations for LGBT-welcoming, non-discriminatory therapists and substance-use professionals in the community. The Revised Rule will make it significantly more difficult for us locate and monitor appropriate referrals, and patients will suffer as a result. Even more concerning, our behavioral-health patients who may

need hospitalization for a mental-health or substance-use crisis, or may need specialist medical care, will be in greater danger of encountering discrimination at inpatient behavioral health facilities or when they seek medical care outside Whitman-Walker—which may make their care at Whitman-Walker more difficult and perhaps less successful.

17. All Whitman-Walker employees, and all volunteers who serve as peer counselors or otherwise are involved in any way with our behavioral-health services, are asked to commit to our mission, which is to be welcoming to and understanding of every patient, regardless of sexual orientation, gender identity, race or ethnicity, income or educational background, or life experience. We welcome staff and volunteers from a wide range of religious, spiritual, cultural, and philosophical perspectives, but patient needs must always be paramount. The overly broad religious exemptions in the Revised Rule threaten to substantially harm patients who are already vulnerable to stigma and discrimination. The message that health care providers' religious preferences or beliefs take priority over patient needs also violates fundamental professional ethical standards that apply to all licensed therapists, psychologists, psychiatrists, and substance-use-disorder-treatment professionals, including myself.

18. The Revised Rule removes or substantially weakens protections for LGBTQ individuals vulnerable to discrimination in health care settings. The inevitable increase in discrimination against LGBTQ individuals in health care settings that will follow from the Revised Rule will make it harder for us to care for our patients at the Whitman-Walker Clinic.

[*Signature on next page.*]

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

Dated this 30 day of June, 2020.

Randy Pumphrey, D.MIN., LPC, BCC

EXHIBIT A

Curriculum Vitae of Randy Pumphrey, D.Min., LPC, BCC

Randy W. Pumphrey D.Min, LPC, BCC
2016 Perry Street NE
Washington, D.C. 20018
(Whitman Walker Health Office) 202-939-7679
Whitman-Walker email: rpumphrey@whitman-walker.org
Private Practice (cell) 202-369-4252
(e-mail) rpumphreylpc@verizon.net

PROFESSIONAL EXPERIENCE

Senior Director of Behavior Health at Whitman Walker Health (January 2015 to present)

- Works with the Chief Health Officer, Executive Director of the Health Center and the Chief Program Officer to strategically develop behavioral health programs, including recruitment and operational alignment with other health care services.
- Provides vision, leadership and strategic development to the behavioral health staff ensuring integration of services across the health center.
- Acts as member of Leadership Team, demonstrating leadership principles that encourage active feedback and an engaged workforce
- Develops and oversees programs for provision of behavioral health care, providing specific goals for implementation to other Behavioral Health staff.
- Monitors behavioral care outcome information, including: census data, Peer Review data, third-party related data and other metrics provided by Quality Improvement and Informatics to ensure appropriate response and program development.
- Monitors productivity, third-party revenue, and trends in health care delivery to ensure Behavioral Health programs are responsive to current payment methodologies and ready for future changes in health care reform.
- Collaborates with Administrative staff on various tasks including: grant funding, marketing and communication materials, development and fundraising, and community relations.
- Builds successful professional relationships with local community groups, business leaders, health care facilities and other organizations, acting as liaison and spokesperson for behavioral matters.
- Oversees the operations of all behavioral programs to ensure adherence to Whitman-Walker policies and compliance with local and Federal law.
- Ensures that behavioral health programs are being delivered by appropriately licensed and credentialed providers.
- Provides direct behavioral health care to clients
- Works with the Chief Medical Officer and Senior Director of Health Care Operations to strategically develop behavioral health programs, including recruitment and operational alignment with other health care services.
- Provides vision, leadership and strategic development to the behavioral health staff ensuring integration of services across the health center.
- Acts as member of Leadership Team, demonstrating leadership principles that encourage active feedback and an engaged workforce
- Develops and oversees programs for provision of behavioral health care, providing specific goals for implementation to other Behavioral Health staff.
- Monitors behavioral care outcome information, including: census data, Peer Review data, third-party related data and other metrics provided by Quality Improvement and Informatics to ensure appropriate response and program development.
- Monitors productivity, third-party revenue, and trends in health care delivery to ensure Behavioral Health programs are responsive to current payment methodologies and ready for future changes in health care reform.
- Collaborates with Administrative staff on various tasks including: grant funding, marketing and communication materials, development and fundraising, and community relations.

- Builds successful professional relationships with local community groups, business leaders, health care facilities and other organizations, acting as liaison and spokesperson for behavioral matters.
- Oversees the operations of all behavioral programs to ensure adherence to Whitman-Walker policies and compliance with local and Federal law.
- Ensures that behavioral health programs are being delivered by appropriately licensed and credentialed providers.
- Provides direct behavioral health care to clients

Behavioral Health Manager for Mental Health at Whitman Walker Health (August 2007 to December 2014.)

- Hire and Manage all Mental Health clinicians
- Provide individual administrative and clinical supervision to eight staff therapists and Master Level clinical interns
- Conduct individual and group psychotherapy (group topics include – Sexual Compulsion in Gay Men, Long Term Survivors of HIV, Stress Management with HIV)
- Manage department budgets
- Manage grant budgets
- Conduct community workshops on a variety of Mental Health issues and topics
- Operate as Deputy Behavioral Health Director in absence of Behavioral Health Director
- Provide administrative direction and supervision to the Mental Health Department

Private Practice – Psychotherapy and Spiritual Directions (October 2007 to present)

- Individual and couple's therapy with focus on co-occurring disorders, relationship issues – including love addiction and love avoidance, sexual compulsion, anxiety, depression, loss and grief, HIV, trauma and issues related to sexual orientation acceptance.
- Spiritual Direction – work in tandem with other therapists to deal with psycho-spiritual conflicts with their clients. Deal directly with client struggling to find meaning and acceptance through a variety of spiritual practice.

Director of The Lambda Center: Behavioral Healthcare for the LGBTQ community.

A partnership between The Psychiatric Institute of Washington and Whitman-Walker Clinic (September 1998 to July 2005 and The Psychiatric Institute of Washington from July 2005 to August 2007.)

- Hire and supervise all clinical staff
- Direct an interdisciplinary treatment team working with lesbian, gay, bisexual and transgender adult clients.
- Manage the operation of an Inpatient detoxification and mental health stabilization program, a Partial Hospitalization program, and an Intensive Outpatient program.
- Supervise Master's level interns in Counseling Psychology and Community Counseling as well as Master level counseling staff for LPC licensure.
- Conduct individual, group psychotherapy, a full spectrum of co-occurring recovery groups, process oriented topic groups as well as skills groups dealing with life management skills, cognitive impairments, emotional regulation, living with HIV/AIDS, spirituality, grief and loss, relational issues, family dynamics, sexual identity integration and gender identity integration.
- Orient all new hospital staff on issues of cultural competency.
- Successfully led Lambda Center through three Joint Commission Surveys, DCRA annual surveys, CMS surveys, APRA certification surveys and Tricare surveys.
- Education and community relations through seminars, national conferences, grand rounds and workshops that teach mental health and addiction treatment professionals about therapeutic interventions with the gay, lesbian, bi-sexual and transgender communities.

Chaplain

The Psychiatric Institute of Washington, Washington, D.C., (July 1986 –March 2005).

- Served as consultant with hospital administration to create an integrated spiritual program for a free standing Psychiatric hospital.
- Conduct weekly worship as well as special holiday celebrations for the Children's unit, the Adolescent unit and the Adult units.
- Facilitate weekly spiritual resource groups, process groups, dual diagnosis step groups, and conduct individual pastoral counseling.
- Consult with treatment staff regarding the religious and spiritual issues of clients within a variety of specialized programs including — intensive care, dual diagnosis, Gay and Lesbian, the Center for Post Traumatic Syndrome and Child / Adolescence.
- Assess the spiritual needs of clients upon referral.
- Designed assessment tool used by the hospital.
- Grand Round presentations "Mind, Body, Spirit -- The Healing Formula," "The Emerging Spirit - The Integration of Spirituality in Mental Health Care," "Spirituality in the Treatment of Gay and Lesbian persons."

Administrative Chaplain for the Acute Psychiatric Hospital

Commission on Mental Health Services, Saint Elizabeths Campus, D.C., (July 1987 - August J998).

- Coordinate and manage pastoral staff providing spiritual care for the Acute Psychiatric Hospital.
- Conduct individual and group pastoral counseling and spiritual direction to clients suffering with a full range of psychiatric disorders and dual diagnosis.
- Educate and counsel persons living with HIV infection/AIDS, addiction recovery and sexual identity integration.
- Teach interns and residents therapeutic and sensitivity issues with lesbian/gay/bisexual/transgender persons.
- Facilitate and lead workshops for hospitals and churches dealing with "Spirituality and Recovery," "Living with AIDS," "Meditation," "Visitation and Referral," and "Sensitivity to the Mentally III."
- Create group therapy forum for staff who had survived recent loss to work through issues of grief and loss.
- Conceptualized and implemented new pastoral care procedures to increase our direct patient care and maximize pastoral effectiveness.
- Monitor clinical record keeping.
- Clinical experience in Acute Care, Dual Diagnosis, Geriatric, Forensic, Long Term Chronic Care and Out-patient Day Programs. Clinical Supervision of pastoral interns and residents.
- Train, delegate, and schedule pastoral staff; residents, and interns.
- Perform weekly worship, preach, and distribute the Sacraments.

Pastoral Assistant

First United Methodist Church, Bradbury Heights, Washington D.C., (Oct. 1984-May 1985).

- Designed and implemented an educational program for youth.
- Participated on all church committees.
- Created and preached a special Advent worship series and taught the Lenten Bible study.

Youth Minister

Korean United Methodist Church of Washington D.C., (Oct. 1981 -Jan. 1983).

- Designed a Christian education program for trans-generational children.
- Conducted a weekly English worship service.
- Created and counseled a United Methodist youth group.
- Trained Korean parents as Sunday school teachers.

EDUCATION

Doctorate of Ministry; Wesley Theological Seminary, September 1991 to May 1997.
Thesis: "A Spiritual Recovery Program Informed by Process Theology."

Clinical Training: Clinical Pastoral Education

- The Commission on Mental Health, Washington, D.C.
  2 Basic units, 2 Advanced units, and 9 Supervisory units, June 1985 – August 1988.
- The Washington Hospital Center, Washington, D.C.
  1 Basic unit, September 1984 - May 1985.

Masters of Divinity; Wesley Theological Seminary, Sept. 1981 to May 1985.
Focus on Pastoral Care and Counseling.
Chair of the Arts Committee and Co-creator of the Liberation Resource Committee.

Bachelor of Science; Towson University, Towson Maryland, September 1979 to May 1981.
Major: American Studies with a concentration in American literature and Human development,
Honors: Cum Laude.
Outdoors adventure club, Orientation department team leader.

Associates of Arts Degree
Anne Arundel Community College, Maryland, Sept. 1977 to May 1979.
Major: American Studies
Honors: Magna Cum Laude

Additional continued education in a variety of mental health issues including – CBT, Ethics, Post Induction Therapy, Inner Child integration and Shame and Pain Reduction, Sexual Compulsion, Love Addiction, and Trauma

CREDENTIALS and PROFESSIONAL ASSOCIATIONS

- Licensed Professional Counselor in the District of Columbia. PRC1134 Exp.12/31/1998.
- Board Certified by the Association of Professional Chaplains, May 1990 (Retired Status)
- Ordained Elder in the United Methodist Church, June 1989.
- DC Behavioral Health Association Board, Secretary second term

LANGUAGES

Proficient at intermediate level signed English

REFERENCES:

UPON REQUEST

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WHITMAN-WALKER CLINIC, INC., *et al.*, *Plaintiffs,* v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, *Defendants*.	Case No. 1:20-cv-1630

DECLARATION OF BAMBY SALCEDO,
PRESIDENT AND CEO, THE TRANSLATIN@ COALITION

I, Bamby Salcedo, declare as follows:

1. I am a 50-year-old transgender woman, an immigrant, and a person living with HIV.

2. I was born and raised in Guadalajara, Mexico, where I lived until age 16. Seeking refuge from the discrimination I faced as an LGBTQ person, I immigrated to the United States in 1986, initially settling in central California and later moving to Los Angeles, where I have lived for the last 30 years. English is my second language.

3. I am a founding member and the President and CEO of the TransLatin@ Coalition ("the Coalition"), a 501(c)(3) national membership organization that was founded in 2009 in Los Angeles, California, by transgender and gender nonconforming Latinx immigrant community leaders.

4. I am submitting this Declaration in support of Plaintiffs' Motion for a Preliminary Injunction to prevent the revised regulation under Section 1557 of the Affordable Care Act ("ACA"), published by the U.S. Department of Health and Human Services ("HHS") on June 19, 2020 (the "Revised Rule"), from taking effect. The Revised Rule eliminates explicit regulatory

protections for LGBT people in health care that were included in the previous rule implementing Section 1557, which was promulgated in May 2016 ("2016 Final Rule").

5. The TransLatin@ Coalition was formed to organize and advocate for solutions to the unique challenges and specific needs of transgender, gender nonconforming, and intersex Latinx immigrants residing in the United States. The Coalition seeks to address these challenges in three key ways: one, by building a national network of affiliated transgender-led organizations and groups that provide direct services to transgender and gender nonconforming Latinx people; two, by amplifying educational and other resources that promote the empowerment of transgender and gender nonconforming Latinx individuals and leaders; and three, by working in partnership with local and national organizations across the country to create change that addresses the needs of and issues faced by transgender and gender nonconforming Latinx people through community-led campaigns, policy change, and leadership development. The Coalition's specific mission is "to advocate for the specific needs of the Trans Latin@ community that resides in the U.S.A. and to plan strategies that improve our quality of life."

6. The TransLatin@ Coalition's structure has three components. First, and foremost, the TransLatin@ Coalition is composed of thousands of transgender and gender nonconforming Latinx individual members across the United States, including in states and territories without any state-level protections from discrimination on the basis of sexual orientation, gender identity, or transgender status. These members include transgender Latinx individuals like me; Arianna Lint, a transgender woman and immigrant from Peru, based in Florida; and Elia Chino, a transgender woman and immigrant from Mexico, based in Texas. Second, the Coalition is made up of a network of affiliated organizations and groups across the country including in Tucson, Arizona; South Florida; Atlanta, Georgia; Chicago, Illinois; New York City; Houston, Texas; and

Washington, D.C. Leaders of these affiliated organizations—like Ms. Chino, the Executive Director of the Fundación Latinoamericana de Acción Social (FLAS) in Houston, Texas, and Ms. Lint, the Executive Director of Arianna's Center in South Florida and Puerto Rico—form part of the Coalition's leadership. The Coalition's affiliated organizations, and the individual Coalition members who are part of those organizations, serve thousands of transgender and gender nonconforming individuals across the United States. Lastly, in addition to the work of its network of affiliated organizations, the Coalition provides direct services to transgender, gender nonconforming, and intersex Latinx people through its Center for Violence Prevention and Transgender Wellness ("Transgender Wellness Center") in Los Angeles, California.

7. Among the services the Coalition and its affiliates provide are: community drop-in spaces; daily food distribution; re-entry services to people recently released from incarceration and immigration detention including rental assistance, transportation and food vouchers; English as a Second Language ("ESL") classes; immigration-focused legal services; leadership and workforce development education and training programs; emergency and transitional housing; case management; and, most notably, referrals to health care providers and organizations that provide competent and affirming health care services to our members and patrons, including gender affirming care.

8. The TransLatin@ Coalition and its membership are also involved in legislative advocacy in various states and Puerto Rico in order to ensure that government officials hear transgender and gender nonconforming Latinx voices on issues that affect the community's health and safety.

My Personal Experiences with Discrimination in Health Care

9. As an openly transgender woman living with HIV, I have experienced persistent discrimination from both health care providers and insurers during my life.

10. When I first moved to California as an adolescent, I lived with my father and his wife. However, because they did not accept my LGBTQ identity, I was forced to move and go live with extended family members outside of Sacramento, where I worked in a tortilla factory as a minor. While there, I experienced wage exploitation and was unable to be my authentic self. As such, without familial support or much proficiency in English, I moved to Los Angeles on my own as a teenager.

11. After moving to Los Angeles, I started my gender transition at age nineteen. At that time, there was virtually no one providing LGBTQ-welcoming, let alone gender affirming, health care in the way we know it today. I had to find community and support from other transgender women who, because of pervasive discrimination in housing and employment, were homeless and doing street-based sex work to survive like me. Indeed, I received most of my health care, both gender affirming and otherwise, through informal means, namely, from these other transgender women living on the street.

12. A year after starting my gender transition, I learned I was HIV-positive. This was a very traumatic and terrifying experience for me as many of my friends were dying from AIDS. At the time, there were no known effective treatments for HIV. I recall vividly how many of my friends were dying of AIDS as a result of lack of access to care or because AZT was not working.

13. As a young 20-year-old, transgender Latina immigrant from Mexico with no familial support, I was terrified. I remember telling myself, "I don't want to die." And so, even though I

was undocumented at the time and feared the consequences that may stem from my seeking health care, I went to a health clinic to ask for help.

14. At the clinic, however, I was told that they "did not know how to treat HIV," and that in any event, "they didn't treat people like me." I did not know how to advocate for myself at that time, so this was a devastating blow to my self-esteem, mental health, and wellbeing.

15. Because of the pain from my HIV diagnosis and the discrimination I faced from health care providers, as well as in employment and housing, I resorted to self-medication and abused drugs, attempting to stop the pain and the feelings of hurt and rejection I had.

16. The only care that was available for poor, undocumented people then, was through the community-based HIV support groups that were prevalent at the height of the HIV/AIDS epidemic, though these rarely served transgender women like myself. Ironically, the first time that I received consistent health care from any source was when I was incarcerated in 1993 for drug possession. This was around the time that HIV retroviral drugs were developed, and for the first time, I began receiving consistent HIV treatment while incarcerated.

17. After my incarceration, I again had to obtain my health care, both gender affirming and otherwise, through informal means, such as from other transgender women living on the street. I did not know how health insurance worked or whether it might even be available to me.

18. I saw many of my transgender friends experience complications from using street-based hormones, and I worried about the risks I was facing as well. Each time I tried to pursue hormone replacement therapy or other treatments for gender dysphoria through formal channels, however, it was denied to me because I was transgender.

19. Having had these experiences so often over the course of my life has created a persistent apprehension of and mistrust towards health care providers, whom I fear might deny me needed health care because I am transgender and because of my HIV status.

20. I have heard similar stories of discrimination in health care from many members of the Coalition, who share the same fear and apprehension. For example, one Coalition member, who is an undocumented transgender Latinx woman, was turned away from the emergency room when her breast implant burst and became infected. She was in excruciating pain at the time, yet the hospital refused to help her.

21. Even before the Revised Rule, I have long feared discrimination in health care services when I travel at least twice a month to states with no state protections from discrimination based on sexual orientation, gender identity, or transgender status. When I am in Texas, Florida, Georgia, or Arizona for my work, I expend precious time and energy worrying what might happen if I have a medical emergency and whether I would be turned away because I am transgender, as I had been in the past.

22. Even in California, I carry this concern as so many hospitals across this state are religiously affiliated and have discriminated against many of The Coalition's members, with hospital staff alleging that "their faith" means they cannot serve transgender and gender nonconforming people.

23. Knowing that the 2016 Final Rule explicitly states that such discrimination is unlawful does provide me with a level of comfort, even if it does not provide complete assurance that my fears will not be realized. The Revised Rule's elimination of the clear regulatory protections in the 2016 Final Rule eliminates whatever amount of comfort I might have had, and

heightens my fears, as it communicates to health care providers that such discrimination is acceptable.

24. This fear of discrimination in health care settings is even more troubling in the context of the COVID-19 pandemic. I have heard from Coalition members that even if they are experiencing severe symptoms, they will delay seeking care because they are worried they will be turned away, or experience other discrimination because they are transgender. These fears have been heightened by the Revised Rule. And delays in seeking care can be even more deadly for Latinx people, who are more likely to be affected by and die from COVID-19 than non-Latinx people.[1]

25. At the Coalition, we have already faced tremendous loss caused by the COVID-19 pandemic and fears of discrimination in health care. In March of this year, we lost a beloved TransLatin@ Coalition member and former board member based in New York for these exact reasons: Lorena Borjas. I spoke to Lorena a few days before she passed, and recall how she told me how she did not want to go to the hospital because of her experiences of discrimination from health care providers, even though she was experiencing symptoms consistent with COVID-19. By the time Lorena finally went to the hospital, she was in such a poor state of health that little could be done. If Lorena had not feared mistreatment at the hospital and been admitted sooner, there is a strong likelihood she would still be alive today.

26. For these reasons, I am even more afraid when I travel for work to states like Arizona, Texas, Georgia, or Florida, none of which has state level antidiscrimination protections for LGBTQ people in health care. I fear that, as a result of the Revised Rule, people like me will

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[1] Maria Godoi & Daniel Wood, *What Do Coronavirus Racial Disparities Look Like State By State?*, NPR (May 30, 2020), https://www.npr.org/sections/health-shots/2020/05/30/865413079/what-do-coronavirus-racial-disparities-look-like-state-by-state.

experience even more discrimination from health care providers and insurers because of our sex, gender identity, transgender status, national origin, disability, LEP status, or some combination of these characteristics.

27. Without clear federal protections like those being eliminated by the Revised Rule, we will have no recourse to address the discrimination we face. The Revised Rule deprives us of the clear nondiscrimination guidance the 2016 Final Rule provides to health care providers and insurers, and actually fosters discrimination against LGBTQ and LEP people.

The Revised Rule's Negative Effects on Transgender Latinx People

28. Not only do I worry about the personal harm I will experience because of the Revised Rule, I also worry about the significant harm to the transgender and gender nonconforming Latinx people who form part of the Coalition and whom the Coalition and its affiliated organizations serve. Many are immigrants to the United States, live in communities in which English is not the primary language spoken and who therefore speak, read, or write English less than very well, and many are living with HIV/AIDS. The Coalition's members and the individuals whom the Coalition and its affiliates serve already have experienced or fear discrimination from health care providers and insurers based on their sex, gender identity, transgender status, sexual orientation, national origin, LEP, disability or some combination of these characteristics. The Revised Rule now invites health care providers to discriminate against them because of their sex, gender identity, transgender status, sexual orientation, national origin, disability, and/or LEP status.

29. I also worry about the Coalition's ability to carry out its activities on behalf of its members and the individuals whom the Coalition and its affiliates serve, as well as the diversion of our already limited financial resources in order to respond to that harm.

30. The findings of the national "2015 U.S. Transgender Survey: Report on the Experiences of Latino/a Respondents," which the TransLatin@ Coalition co-published with the National Center for Transgender Equality, and the TransLatin@ Coalition's 2016 survey and report on health care experiences and outcomes for transgender and gender nonconforming Latinx people living in the California entitled "The State of Trans Health: Trans Latin@s and Their Healthcare Needs," help explain why the Revised Rule will cause even more harm to the Coalition's national membership and the individuals whom the Coalition and its affiliates serve throughout the United States. A copy of the "2015 U.S. Transgender Survey: Report on the Experiences of Latino/a Respondents" is attached as **Exhibit A**. A copy of the "The State of Trans Health" report is attached as **Exhibit B**.

31. According to the 2015 U.S. Transgender Survey, nearly one-third (32%) of transgender Latinx respondents who saw a health care provider in the past year reported having at least one negative experience related to being transgender. These experiences included being refused treatment, being verbally harassed, being physically or sexually assaulted, or having to teach the provider about transgender people in order to get appropriate care. As a result, more than a quarter (26%) of transgender Latinx respondents did not see a doctor when they needed to because of fear of being mistreated because of their transgender status. This is consistent with the findings of the Coalition's 2016 study "The State of Trans Health," where nearly one third of transgender and gender nonconforming Latinx people surveyed felt that their healthcare needs were not being met because they "fear mistreatment for being trans," and because of "a dislike of trans patients by clinics." The "State of Trans Health" also found that forty-two percent (42%) of those surveyed strongly agreed that a lack of "trans sensitive healthcare providers," was a barrier to meeting their healthcare needs.

32. As the findings of the 2015 U.S. Transgender Survey and "The State of Trans Health" demonstrate, the Revised Rule's invitation to health care providers and insurers to discriminate against The Coalition's membership and the individuals whom the Coalition and its affiliates serve based on sex, gender identity, transgender status, sexual orientation, national origin, disability, and/or LEP status will worsen the health and wellbeing of transgender and gender nonconforming people.

33. Transgender and gender nonconforming people will likely delay necessary health care and preventative screenings due to fear of discrimination, and will face reduced access to care as result. In addition, they will face barriers to coverage of gender affirming care because of the Revised Rule's guidance that insurers may exclude such care from coverage.

34. As the Coalition's members and the individuals whom the Coalition and its affiliates serve avoid necessary, routine, and preventative health care for fear of discrimination, they will face an increase in preventable health problems and consequences, including death, which will severely impede their ability to work, maintain housing, and afford other material necessities.

35. Under the Revised Rule, the Coalition's members and the individuals whom the Coalition and its affiliates serve will be required to pay considerable out of pocket medical expenses because insurers refuse to provide life-saving and medically necessary care, even though they do not have the financial recourse to do so.

36. Because of the desire to avoid discrimination encouraged by the Revised Rule, the Coalition's members and the individuals whom the Coalition and its affiliates serve will likely seek informal medical care from unlicensed providers they consider affirming. Not only may these unlicensed providers not be able to help, but they may also cause more harm. Further, transgender and gender nonconforming people who are harmed or unable to be helped by these informal

providers are likely to again avoid seeking licensed medical care for fear of discrimination, which will leave their underlying conditions and new health issues unaddressed. It is easy to see how this cycle could be serious and potentially life threatening.

37. Because many of the Coalition's members and the individuals whom the Coalition and its affiliates serve are immigrants and people who speak, read, or write English less than very well, they face increased harm from the Revised Rule's elimination of a single legal standard. 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. Discrimination based on sexual orientation, gender identity, transgender status, national origin, disability and LEP status is often intertwined, as threads braided into one rope, and is difficult to separate.

38. The Revised Rule also includes two specific changes that will disproportionately harm the Coalition, its members, and the individuals whom the Coalition and its affiliate serve: the removal of discrimination protections in the Center for Medicaid and Medicare regulations and the removal of language access protections.

39. Without protection from discrimination on the basis of sexual orientation and gender identity in public health insurance programs, transgender and gender nonconforming Latinx people will suffer disproportionately. The Coalition's "State of Trans Health" study found that 49.5% of transgender respondents receive health insurance coverage through Medicare, Medicaid, or Medi-Cal, California's state Medicaid program. Nationwide, as reflected in the 2015 U.S. Trans Survey, 18% of transgender Latinx respondents obtain their insurance through Medicaid or Medicare.

40. Additionally, our members and the thousands of people whom the Coalition and its affiliates serve also will be harmed by the Revised Rule's removal of language access protections.

Coalition members have expressed that seeing notices in health care settings in their first language and receiving communications from insurers they can read and understand increases the likelihood they will continue to seek preventative and necessary medical care when needed.

41. Without these accessible notices of rights, translation services, and information about how to file complaints, many Coalition members and those whom the Coalition and its affiliates serve will avoid seeking care until they feel they are sufficiently proficient in speaking and reading English, which will worsen their underlying and untreated medical conditions.

The Revised Rule's Harms to The TransLatin@ Coalition

42. As a direct result of the Revised Rule, the Coalition and its network of affiliated organizations will see a significant increase in requests for referrals to health care providers who will continue to provide affirming and welcoming health care services. The Coalition and its affiliates will need to divert resources to vet additional health care providers, as the already-known affirming providers will not to meet the demand for their services.

43. This increase in referral requests also will create a substantial backlog in available providers and appointments, resulting in critical delays in treatment for potentially serious health conditions.

44. The delay in seeking treatment, in turn, will result in serious financial difficulties for many individuals because they will have to pay for the expensive treatment required to address worsened health conditions and because of their inability to work while ill. As a result, the TransLatin@ Coalition and its network of affiliated organizations will be forced to divert significant financial resources to emergency support services including daily food distribution, rental assistance, and transportation and grocery vouchers. Emergency community support is one of the Coalition's and its affiliates' fundamental programmatic services. With the Revised Rule,

there will be an increase in demand for these services because of the increased number of transgender people who will be out of work, unable to pay rent, or afford other material necessities as result of delayed treatment of serious or semi-serious health conditions.

45. As more clients experience this ongoing harm precipitated by the Revised Rule, the TransLatin@ Coalition and its affiliated organizations will inevitably run out of resources to provide these emergency support services, completely undermining the Coalition's ability to perform one of its most fundamental programmatic services.

46. Furthermore, the COVID-19 pandemic has already put severe strain on the long-term availability of the TransLatin@ Coalition's fundamental programmatic services like emergency community support. To accommodate the lack of employment and economic stability facing many members and individuals whom the Coalition and its affiliates serve, the Coalition and its affiliates have been forced to shift resources in a way that would make the programmatic impact of the Revised Rule even more detrimental.

47. While providing these services is an important programmatic component of the TransLatin@ Coalition's work, it is only a part of the organization's overall activities. A significant redirection of funds required by the impact of the Revised Rule will impede the Coalition's ability to perform other programmatic activities like economic and workforce development training programs, coordinated human resources and cultural competency trainings, community research and education programs, and local and state advocacy campaigns for laws protecting the Coalition's members.

48. The Revised Rule also will significantly harm the Coalition's ability to conduct its re-entry services program—an important organizational activity that provides support to some of the most vulnerable of the Coalition's members and the individuals returning to their communities.

These transgender and gender nonconforming people will need immediate connections to medical services, which will be delayed by, or in some cases prevented altogether as a proximate fallout from the Revised Rule, due to the limited number of LGBTQ-affirming health care providers who will be (and already are) overwhelmed by demand.

49. The Revised Rule will also prevent the TransLatin@ Coalition from fully performing its programmatic activities that support members and individuals with LEP through ESL classes and other translation services.

50. The removal of language access measures from health care providers' offices and in health insurance communications will make it much more difficult for the TransLatin@ Coalition's members and individuals with LEP to be aware of their rights; which language services are available, if any; how to access such services; and how to handle discrimination and other complaints.

51. As a result of the Revised Rule's reconstruction of the language barrier once again preventing access to health care and insurance benefit communications, the Coalition and its affiliates will experience an unsustainable increase in demand for their ESL classes and translation services. They also will have to narrow their designed programmatic focus of these programs to understanding and navigating health care and related services, rather than the intended holistic language instruction addressing all facets of social interaction.

52. The Coalition will be in a difficult situation, as the demands for ESL classes and translation support focused on navigating health care settings increase exponentially, in concert with the increased demand for emergency financial support. The Coalition will be forced to make an impossible choice between which core programmatic activities to attempt to maintain. For the

Coalition, the only acceptable alternative is to provide severely limited services in both activities, which means the Revised Rule causes lasting injury to these desperately needed programs.

53. In addition to shifting much of the Coalition's and its affiliates' already limited budgets to emergency services and services to support members and individuals with LEP, the impact of the Revised Rule will also require shifting an unexpected amount of limited resources to education programs and community outreach. The efforts will be necessary to support the Coalition's members, and the individuals and communities we collectively serve in finding non-discriminatory health care providers, devising individual solutions for health insurance exclusions for gender confirming care, and securing non-discriminatory mental health treatment for the trauma resulting from widespread discrimination.

54. The Coalition will also attempt to devote a dwindling amount of resources to working with health care providers, insurers and other related organizations to educate and remind them of the importance of providing health care and insurance coverage to all patients in a nondiscriminatory manner. This will be especially difficult in states where the Coalition has a presence but which have no state-level anti-discrimination protections that include sexual orientation, gender identity, or transgender status, such as Texas, Florida, Arizona, and Georgia.

55. The Revised Rule threatens to completely overwhelm the programs and activities that the Coalition, our affiliated organizations, and the Coalition's individual members have been doing for more than a decade to uplift, support, and improve the lives of transgender, gender nonconforming, and intersex Latinx people in the United States. The harm to the TransLatin@ Coalition will be long-lasting and difficult, if not near impossible, to undo.

* * * * *

56. The Revised Rule poses serious and ongoing threats to the health and overall wellbeing of transgender and gender nonconforming people like the TransLatin@ Coalition's

members and the thousands of transgender and gender nonconforming individuals the Coalition and its affiliated organizations collectively serve in communities across the United States. The Revised Rule also threatens the ability of the TransLatin@ Coalition to fulfill its mission and engage in core programmatic activities.

[*Signature on next page*.]

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

Dated this 6th day of July, 2020.

Bamby Salcedo, M.A.
President/CEO
The TransLatin@ Coalition

EXHIBIT A

2015 U.S. Transgender Survey: Report on the Experiences of Latino/a Respondents

2015
U.S.
TRANSGENDER
SURVEY
Report on the
Experiences of
Latino/a Respondents
THE VOICE OF TRANSLATIN@S
TransLatin@
COALITION
IN THE USA
National Center for
TRANSGENDER
EQUALITY

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Introduction

The 2015 U.S. Transgender Survey (USTS) is the largest survey examining the experiences of transgender people in the United States, with 27,715 respondents nationwide. The USTS was conducted by the National Center for Transgender Equality in the summer of 2015 and was offered online in English and Spanish. The results provide a detailed look at the experiences of transgender people across a wide range of categories, such as education, employment, family life, health, housing, and interactions with the criminal justice system.

The Report of the 2015 U.S. Transgender Survey documented the experiences of USTS respondents, including differences based on demographic and other characteristics.[1] Among the most important findings was that many respondents were impacted by the compounding effects of multiple forms of discrimination, and transgender people of color who completed the survey experienced deeper and broader forms of discrimination than white USTS respondents and people in the U.S. population overall.

This report focuses on the unique experiences of the 1,473 USTS respondents who identified as Latino/a or Hispanic,[2] highlighting disparities between the experiences of Latino/a transgender people, other USTS respondents, and the U.S. population.[3] While the findings in this report reflect a range of Latino/a transgender people in the United States, the survey likely did not fully capture the experiences of those who were most affected by factors that may limit access to online surveys, such as factors related to language, education, economic and housing stability, and disabilities. All findings in this report are presented as weighted percentages.[4]

Key Findings

- **21% of Latino/a respondents were unemployed**, three times the rate among Latino/a people in the U.S. population (7%).
- **43% of Latino/a respondents were living in poverty**, compared to 18% of Latino/a people in the U.S. population.
- **31% of Latino/a respondents have experienced homelessness at some point in their lives** and **14% experienced homelessness in the past year because of being transgender.**
- **48% of Latino/a respondents have been sexually assaulted at some point in their lifetimes** and **12% of Latino/a respondents were sexually assaulted in the past year**.
- **59% of Latino/a respondents said they would feel somewhat or very uncomfortable asking the police for help**, compared to 53% of white respondents in the USTS sample.
- **32% of Latino/a respondents who saw a health care provider in the past year reported having at least one negative experience related to being transgender**, such as being refused treatment, being verbally harassed, being physically or sexually assaulted, or having to teach the provider about transgender people in order to get appropriate care.
- **1.6% of Latino/a respondents were living with HIV**, more than five times higher than the rate in the U.S. population (0.3%).
- **45% of Latino/a respondents experienced serious psychological distress in the month before completing the survey** (based on the Kessler 6 Psychological Distress Scale), nine times the rate in the U.S. population (5%).

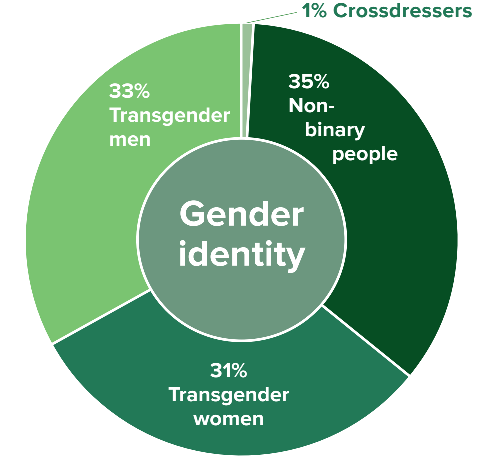
Portrait of Latino/a Respondents

This section outlines aspects of Latino/a respondents' identities and demographic characteristics, such as gender, age, geographic location, and educational attainment, to provide important context for their experiences.

Gender Identity

Thirty-five percent (35%) of Latino/a respondents were non-binary,[5] 33% were transgender men, 31% were transgender women, and 1% identified as crossdressers[6] (Figure 1).

Figure 1: Gender identity



Experiences with Transitioning

Sixty-one percent (61%) of Latino/a respondents were currently living full time in a gender that was different from the one on their original birth certificates, referred to in this report as having transitioned. This included 72% of transgender men and women and 42% of non-binary respondents. More than one in five (21%) respondents who had transitioned did so before the age of 18, nearly half (47%) transitioned between the ages of 18 and 24, 22% transitioned between ages 25 and 34, and 11% transitioned at age 35 or older.

Respondents were asked how much time had passed since they began transitioning. Nearly one-third (29%) began their transition within one year of taking the survey, 38% transitioned 2 to 5 years prior, 15% transitioned 6 to 9 years prior, and 18% transitioned 10 or more years prior.

Outness

Respondents were asked whether different groups of people in their lives knew that they were transgender to determine if they were "out" about their transgender identity to family members, friends, supervisors and coworkers, classmates, and health care providers. Specifically, they were asked whether all, most, some, or none of the people in each of those groups knew they were transgender.

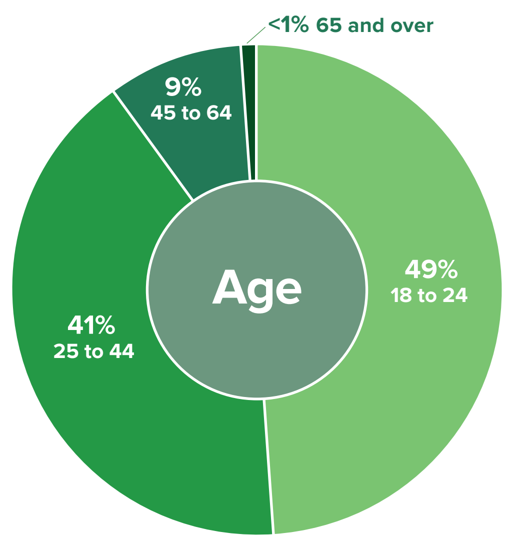
Results for outness to any particular group reflect only those respondents who had people from that group in their lives. Overall, 7% reported that they were out to all of the people in their lives, across all groups of people, 44% were out to most, 46% were out to some, and 2% were out to none of the people in their lives.

Sixty percent (60%) of respondents were out to all or most of the immediate family that they grew up with, and 36% were out to all or most of their extended family. Respondents were less likely to be out to at work or school: approximately one-half reported that none of their current supervisors (50%) or coworkers (42%) knew that they were transgender, and 51% reported that none of their classmates at their current school knew they were transgender.

Age

Most respondents were between the ages of 18 and 24 (49%) or 25 and 44 (41%) (Figure 2).

Figure 2: Age



Location

Respondents lived in 48 states, the District of Columbia, and Puerto Rico. The geographical distribution of USTS Latino/a respondents differed from the distribution in the USTS sample overall but was generally similar to the distribution of Latino/a people in the U.S. population. Latino/a respondents were more likely to live in the West (39%) than respondents in the USTS sample overall (31%), similar to the trend in the U.S. population, where Latino/a people were more likely to live in the West (40%) than the U.S. population overall (24%)[7] (Figure 3).

Figure 3: Location by region

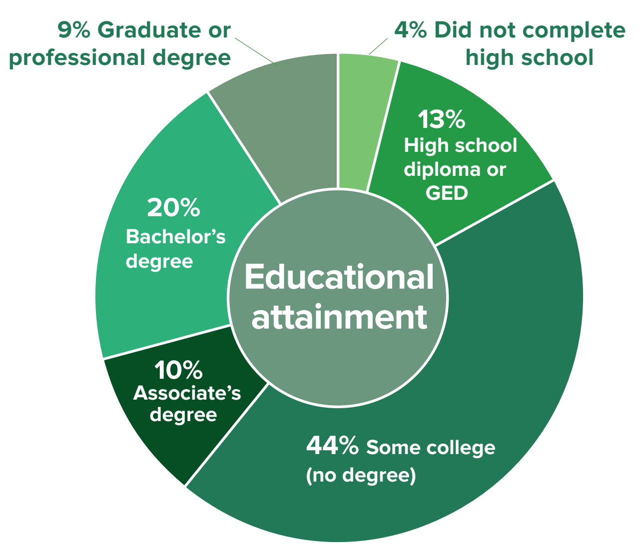
Region	% of Latino/a people in USTS	% in USTS	% in U.S. population (Census)	% of Latino/a people in U.S. population (Census)
Northeast	19%	20%	18%	15%
Midwest	11%	19%	21%	9%
South	31%	29%	38%	37%
West	39%	31%	24%	40%

Northeast: CT, ME, MA, NH, NJ, NY, PA, RI, VT
Midwest: IA, IN, IL, KS, MI, MN, MS, NE, ND, OH, SD, WI
South: AL, AR, DE, DC, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV
West: AK, AZ, CA, CO, HI, ID, MT, NM, NV, OR, UT, WA, WY

Educational Attainment

Respondents were asked about the highest level of education that they had completed. Seventeen percent (17%) had a high school diploma or GED or did not complete high school. Forty-four percent (44%) had completed some college but had not obtained a degree, and 29% had received a bachelor's degree or a higher degree (Figure 4).

Figure 4: Educational attainment



Disability

Respondents received questions about their disability status based on questions from the American Community Survey (ACS) in order to compare the USTS sample to the U.S. population. Disabilities listed in the ACS included (1) being deaf or having serious difficulty hearing, (2) being blind or having serious difficulty seeing even when wearing glasses, (3) having serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition, (4) having serious difficulty walking or climbing stairs, (5) having difficulty dressing or bathing, and (6) having difficulty doing errands alone, such as visiting a doctor's office or shopping because of a physical, mental, or emotional condition. Forty percent (40%) of Latino/a respondents indicated that they had one or more disabilities listed in the ACS, similar to the rate in the USTS sample overall (39%). In contrast, only 15% in the U.S. population had a disability listed in the ACS.[8]

Respondents were also asked if they identified as a person with a disability to better capture disabilities that were not included in the ACS. One in four (25%)

Latino/a respondents identified as people with disabilities, compared to 28% in the USTS sample overall. The term "people with disabilities" used in this report refers to respondents who identified as people with disabilities.

Relationship Status

Twenty-seven percent (27%) of respondents were living with a partner, 20% were partnered and living separately, 51% were single, 1% were in a polyamorous relationship, and 1% had a relationship status that was not listed. Respondents were asked about their current legal marital status for the purpose of comparison to the U.S. population. Fourteen percent (14%) of Latino/a respondents were currently married, in contrast to 46% of Latino/a people in the U.S. population.[9] Eighty-one percent (81%) of respondents had never been married, which is nearly twice the rate among Latino/a people in the U.S. population (42%).

Sexual Orientation

Respondents were asked which terms best described their sexual orientation. Respondents were most likely to identify as queer (21%), straight (19%), or pansexual (19%). They also identified as gay, lesbian, or same-gender-loving (13%), bisexual (13%), and asexual (11%).

Citizenship and Immigration Status

Respondents were asked about their citizenship or immigration status. Ninety-two percent (92%) of Latino/a respondents were citizens, including 7% who were naturalized citizens. Latino/a respondents also reported a range of immigration statuses, including being permanent residents (3%), undocumented residents (2%), Deferred Action for Childhood Arrival (DACA) recipients (1%), and visa holders (1%).

Family Life and Faith Communities

Family Life

Eighty-seven percent (87%) of respondents were out as transgender to a current or former partner. Of those who were out to a current or former partner, 24% had a partner end their relationship solely or partly because they were transgender, including 10% who had a partner end their relationship solely because they were transgender. Nearly two-thirds (62%) of respondents who had children were out to one or more of their children, and 15% of those respondents had a child stop speaking to them or spending time with them after coming out as transgender.

Sixty percent (60%) of respondents who were out to at least some of the immediate family they grew up with reported that their family was generally supportive, 19% had unsupportive families, and 21% had families that were neither supportive nor unsupportive. Nearly one-half (49%) experienced at least one form of family rejection outlined in the survey, such as having a family member who stopped speaking to them for a long time or ended the relationship, experiencing violence by a family member, or being kicked out of the house for being transgender (Table 1).

Table 1: Forms of family rejection

(of those out to immediate family)	% of Latino/a people in USTS	% in USTS
Stopped speaking to them or ended relationship	28%	26%
Did not allow them to wear clothes that matched gender	32%	27%
Sent them to a professional to stop them from being transgender	16%	14%
Were violent towards them	12%	10%
Kicked them out of the house	11%	8%
One or more experiences listed	**49%**	**44%**

Transgender women (37%) were more likely to have an immediate family member stop speaking to them for a long time or end a relationship because they were transgender, compared to transgender men (30%) and non-binary people (14%). Transgender women (16%) were more likely to experience violence by a family member because they were transgender than non-binary people (13%) and transgender men (10%). Transgender women (15%) were also more likely to have been kicked out of the house than transgender men (10%) and non-binary people (6%).

Additionally, 12% of those who were out to their immediate family ran away from home because they were transgender, with transgender women (17%) being more likely to have run away than transgender men (10%) and non-binary people (10%).

Although approximately half of those who were out to their immediate family reported at least one experience of rejection from a family member, 81% reported that at least one immediate family member supported them through one or more specific acts, such as using their preferred name or pronouns, giving them money to support their transition, or helping them to change the name or gender on an identity document (Table 2).

Table 2: Supportive family behaviors

(of those out to immediate family)	% of Latino/a people in USTS	% in USTS
Told respondent they respect or support them	66%	65%
Used their preferred name	56%	58%
Used the correct pronouns	54%	55%
Stood up for them with family, friends, or others	38%	36%
Did research to learn how to best support them	29%	33%
Gave money to help with gender transition	19%	18%
Helped them change their name and/or gender on an identity document	11%	10%
Supported them in another way	10%	11%
One or more experiences listed	**81%**	**82%**

Faith Communities

Nearly two-thirds (62%) of Latino/a respondents had been part of a spiritual or religious community ("faith community") at some point in their lives. Of these, more than one in five (21%) left a faith community because they were rejected as a transgender person. That experience was more likely among transgender women (33%) than transgender men (22%) and non-binary people (13%). Thirty-seven percent (37%) of those who had been rejected by a faith community found a new faith community that welcomed them as a transgender person.

More than one-quarter (27%) of respondents who had ever been part of a faith community were part of one in the year prior to taking the survey. These respondents reported a range of experiences within their faith communities. Ninety-seven percent (97%) experienced one or more accepting behaviors from members of their faith community, such as having a community leader or member who accepted them or made them feel welcome as a transgender person or being told that their religion or faith accepts them as a transgender

person. However, 20% had one or more experiences of rejection, such as being asked to stop coming to services or faith community functions or having a community member tell them that being transgender is a sin or that their religion does not approve of them.[10]

Income and Employment

Unemployment

More than one in five (21%) Latino/a respondents were unemployed, compared to 15% in the USTS sample overall. The unemployment rate among Latino/a respondents was more than four times higher than the unemployment rate in the U.S. population overall (5%)[11] and three times the rate among Latino/a people in the U.S. population (7%) (Figure 5).[12] The unemployment rate differed by gender, with transgender Latinas (27%) being more likely to be unemployed (Figure 6). Respondents with disabilities (27%) were also more likely to be unemployed.

Figure 5: Unemployment

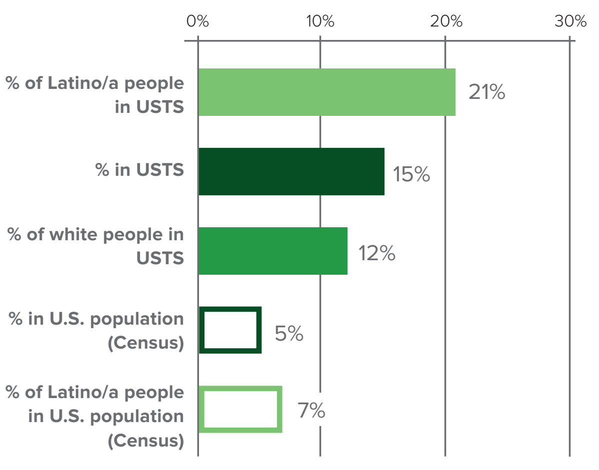
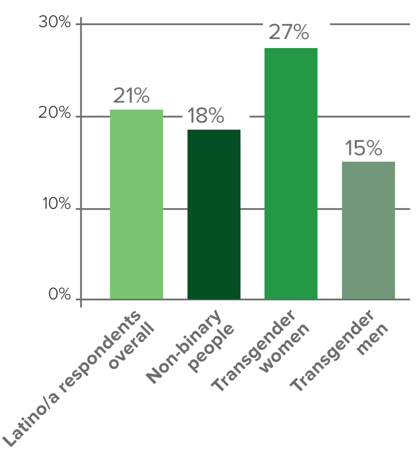


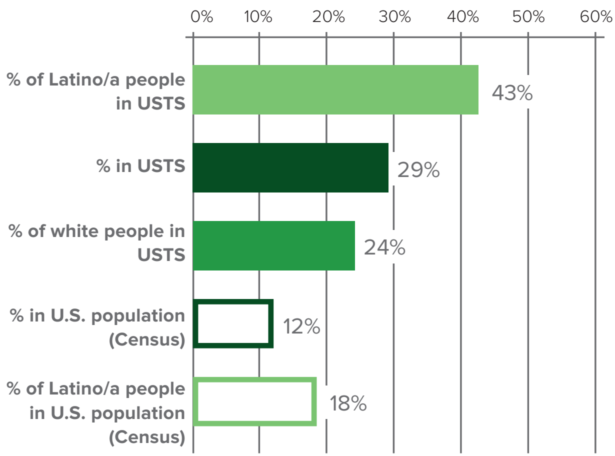
Figure 6: Unemployment (by gender)



Poverty

More than four out of ten (43%) Latino/a respondents were living in poverty,[13] compared to 29% in the USTS sample overall. This was substantially higher than the poverty rate in the U.S. population overall (12%)[14] and the poverty rate among Latino/a people in the U.S. population (18%) (Figure 7).[15] The poverty rate was higher among transgender women (45%) and non-binary people (43%) than among transgender men (36%).

Figure 7: Living in poverty



Sources of Income

Latino/a respondents' most common source of income was from their own employment or a partner's employment alone (40%), compared to those in the USTS sample overall (36%). More than one-third (35%) of Latino/a respondents reported that they received income from multiple sources, in contrast to 45% in the USTS sample overall. One in ten (10%) Latino/a respondents reported that their sole source of income was Supplemental Security Income (SSI) or disability benefits, compared to 9% in the USTS sample overall (Table 3).

Table 3: Current sources of income

Sources of income	% of Latino/a people in USTS	% in USTS
Employment only (from their own employment, partner's employment, or self-employment)	40%	36%
Supplemental Security Income (SSI) or disability benefits only	10%	9%
Pension or retirement income only	3%	3%
Unemployment benefits or public cash assistance program only	2%	1%
Pay from sex work, drug sales, or other work that is currently criminalized only	2%	1%
Other sources only	6%	3%
No income	2%	2%
Multiple sources	35%	45%

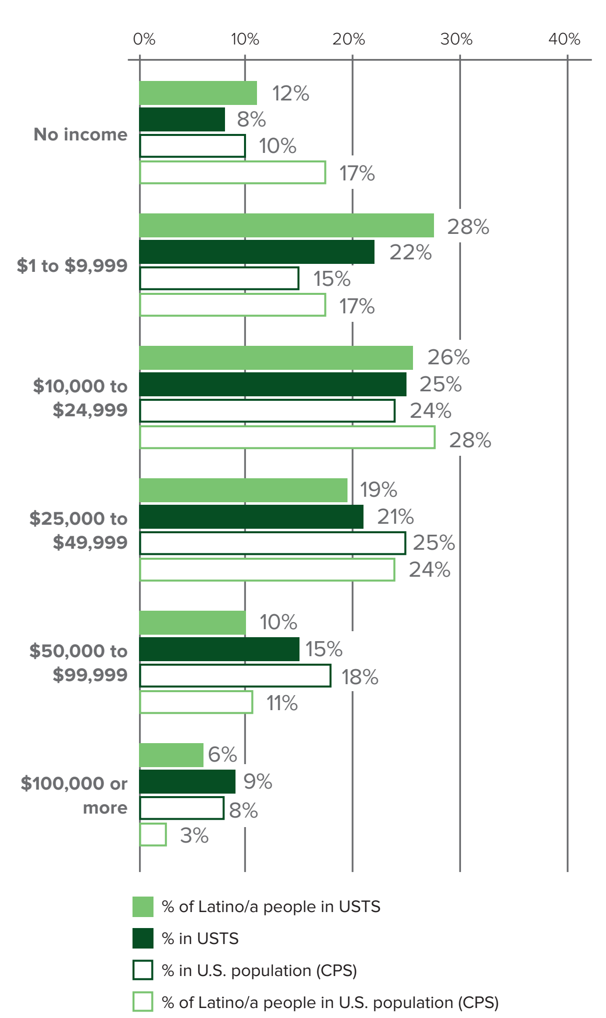
Military Service

Seven percent (7%) of Latino/a respondents have served in the military, including respondents who were currently serving in the military on active duty (<1%) and those who were currently on active duty for training in the Reserves or National Guard (1%). Six percent (6%) of respondents were veterans, similar to the rate in the U.S. population overall (8%), but higher than the rate among Latino/a people in the U.S. population (3%).[16]

Individual and Household Income

Respondents reported their annual individual and household income levels from 2014, the last full year prior to completing the survey. More than one-quarter (28%) of Latino/a respondents reported an *individual income* of $1 to $9,999, compared to 22% in the USTS sample overall.

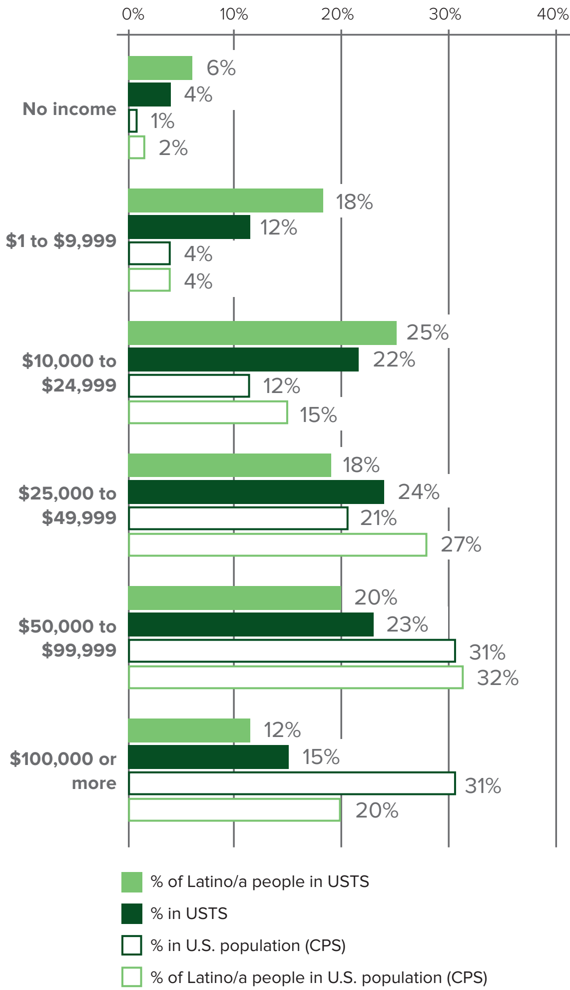
Figure 8: Annual individual income (2014)



Latino/a respondents were also substantially more likely to report this low individual income than Latino/a people in the U.S. population (17%)[17] (Figure 8).

Nearly one in five (18%) Latino/a respondents reported a *household income* of $1 to $9,999, compared to 12% in the USTS sample overall, and nearly five times the rate among Latino/a people in the U.S. population (4%) (Figure 9).

Figure 9: Annual household income (2014)

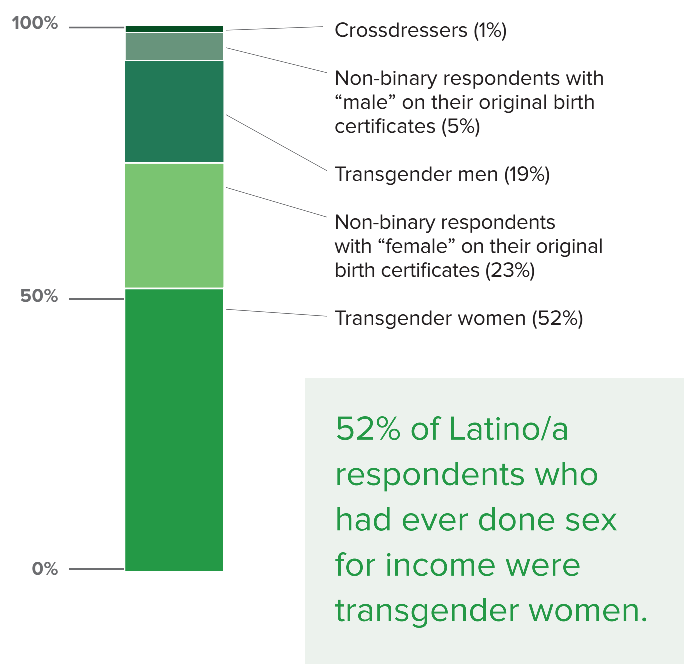


Sex Work and Other Underground Economy Work

Nearly one-quarter (22%) of Latino/a respondents have participated in the underground economy for income at some point in their lives, including in sex work, drug sales, and other currently criminalized work, similarly to 20% in the USTS sample overall. One in ten (10%) Latino/a respondents participated in the underground economy for income in the past year.

Thirteen percent (13%) of Latino/a respondents participated in sex work for income, compared to 12% in the USTS sample overall and 9% of white respondents. Examining the composition of those who have done sex work, transgender women represent more than one-half (52%) of Latino/a respondents who have done sex work for money in their lifetimes. Although Latinas represent a disproportionately high percentage of those who have done sex work, it is also important to recognize that non-binary people with "female" on their original birth certificates and transgender men account for a large proportion of those who have done sex work. Non-binary people with "female" on their original birth certificates represent nearly one-quarter (23%) of respondents who have done sex work for money in their lifetimes, and transgender men represent 19% (Figure 10).

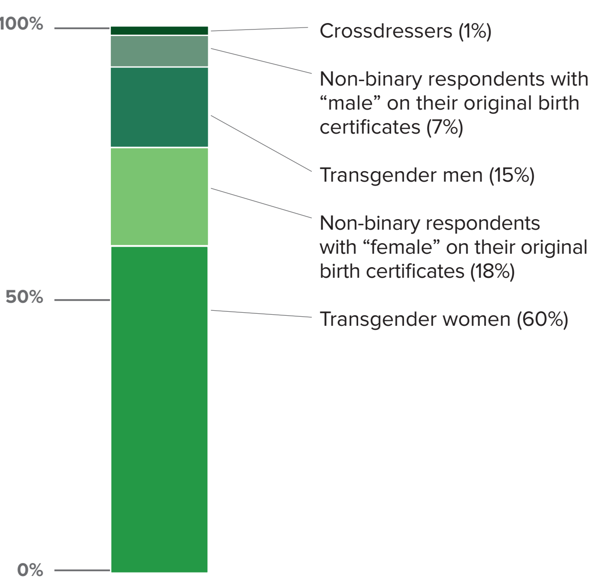
Figure 10: Gender identity of those who have done sex work for income in their lifetimes



52% of Latino/a respondents who had ever done sex for income were transgender women.

Six percent (6%) of Latino/a respondents participated in sex work for income in the past year. Examining the makeup of those who did sex work for income in the past year, transgender women represent more than one-half (60%), 18% were non-binary people with "female" on their original birth certificates, and 15% were transgender men (Figure 11).

Figure 11: Gender identity of those who have done sex work for income in the past year



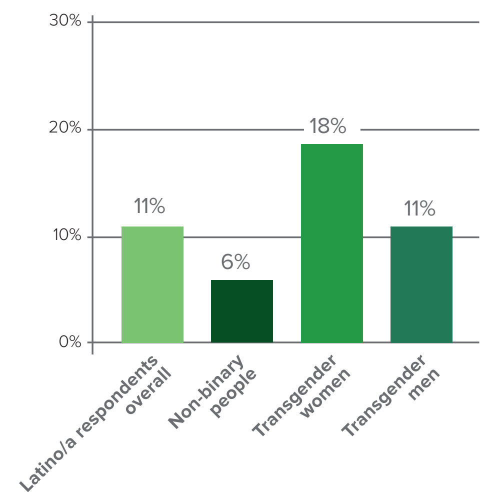
One in five (20%) respondents participated in sex work for money, food, a place to sleep, or other goods or services, compared to 19% in the USTS sample overall and 16% of white respondents.

Survey respondents were asked if they had ever interacted with police either while doing sex work or when police thought they were doing sex work. Of Latino/a respondents who had interacted with the police while doing or thought to be doing sex work, 84% reported some form of police harassment, abuse, or mistreatment, including being verbally harassed, physically attacked, or sexually assaulted by police, compared to 86% in the USTS sample overall and 82% of white respondents.

Experiences in the Workplace

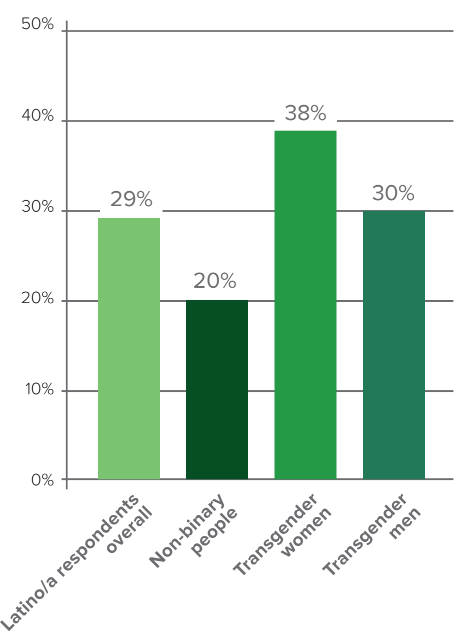
Fifteen percent (15%) of Latino/a respondents who have ever been employed reported losing a job at some point in their lives because of being transgender. This represents 11% of all Latino/a respondents, compared to 13% all respondents in the USTS. Transgender women (18%) were more likely to report being fired because of being transgender (Figure 12).

Figure 12: Ever lost job because of being transgender (by gender)



In the past year, 29% of those who held or applied for a job during that year reported being fired, being denied a promotion, or not being hired for a job they applied for because of being transgender, compared to 27% in the USTS sample overall. Transgender women (38%) were more likely to report this experience than transgender men (30%) and non-binary people (20%) (Figure 13).

Figure 13: Fired, denied promotion, and/or not hired in the past year because of being transgender (by gender)



Many respondents who had a job in the past year reported that they had been verbally harassed (14%), physically attacked (1%), and sexually assaulted (2%) at work during that year because of being transgender. More than one-quarter (27%) of respondents who were employed reported other forms of mistreatment based on their gender identity or expression during the past year, such as being forced to use a restroom that did not match their gender identity, being told to present in the wrong gender in order to keep their job, or having a boss or coworker share information about their transgender status with others without their permission.

Education

Nearly three-quarters (74%) of Latino/a respondents who were out or perceived as transgender at some point between Kindergarten and Grade 12 (K–12) experienced mistreatment, such as being verbally harassed, prohibited from dressing according to their gender identity, disciplined more harshly, or physically or sexually assaulted because people thought they were transgender. More than half (52%) of those who were out or perceived as transgender in K–12 were verbally harassed, 24% were physically attacked, and 16% were sexually assaulted in K–12 because of being transgender. Sixteen percent (16%) faced such severe mistreatment as a transgender person that they left a K–12 school, and 7% were expelled from school (Table 4).

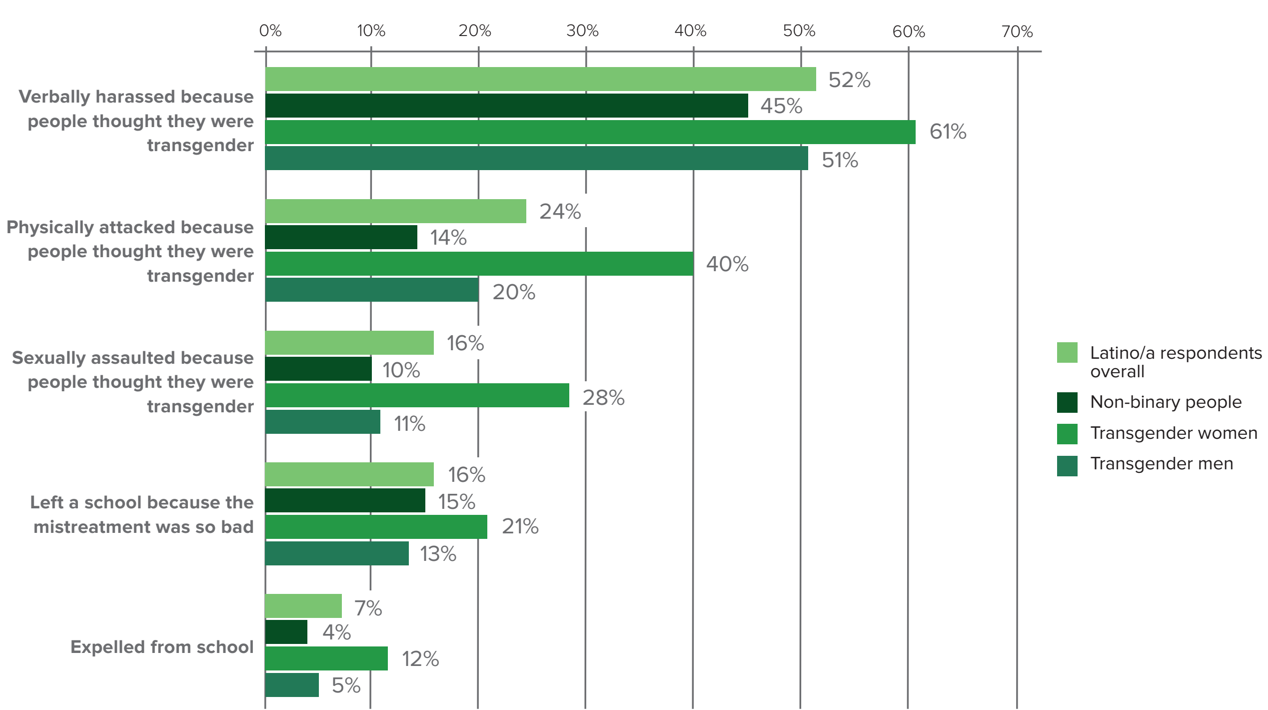
Table 4: Experiences of people who were out as transgender in K–12 or believed classmates, teachers, or school staff thought they were transgender

Negative experiences in school (out of those who were out or perceived as transgender)	% of Latino/a people in USTS	% in USTS
Not allowed to dress in a way that fit their gender identity or expression	55%	52%
Verbally harassed because people thought they were transgender	52%	54%
Disciplined for fighting back against bullies	35%	36%
Physically attacked because people thought they were transgender	24%	24%
Believe they were disciplined more harshly because teachers or staff thought they were transgender	24%	20%
Left a school because the mistreatment was so bad	16%	17%
Sexually assaulted because people thought they were transgender	16%	13%
Expelled from school	7%	6%
One or more experiences listed	**74%**	**77%**

Transgender women were more likely to have been verbally harassed (61%), physically attacked (40%), and sexually assaulted (28%) because people thought they were transgender in K–12. Transgender women were also more likely to have left a school because of mistreatment (21%) and to have been expelled from school (12%) (Figure 14).

Latino/a respondents also reported high levels of mistreatment in post-secondary schools. Nearly one-quarter (23%) of those who were out or perceived as transgender in college or vocational school were verbally, physically, or sexually harassed because of being transgender.

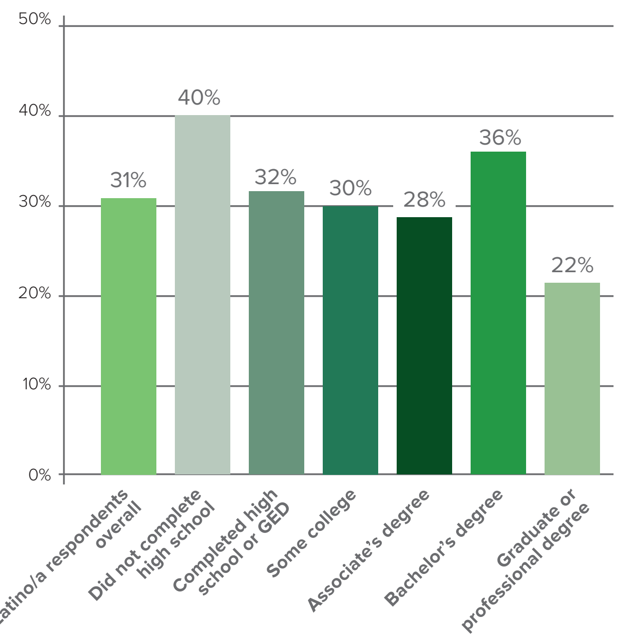
Figure 14: Experiences of people who were out as transgender in K–12 or believed classmates, teachers, or school staff thought they were transgender (by gender)



Housing, Homelessness, and Shelter Access

Nearly one-third (31%) of Latino/a respondents have experienced homelessness at some point in their lives. The rate of homelessness differed by educational attainment, with respondents who did not complete high school (40%) being more likely to have experienced homelessness (Figure 15). People with disabilities (39%) were also more likely to have experienced homelessness in their lifetimes.

Figure 15: Lifetime homelessness rate (by educational attainment)



In the past year, one-third (33%) of respondents experienced some form of housing discrimination or instability, such as being evicted from their home or denied a home or apartment because of being transgender.[18] Fourteen percent (14%) experienced homelessness in the past year because of being transgender, 6% were denied a home or apartment, and 6% were evicted because of being transgender (Table 5).

Table 5: Housing situations that occurred in the past year because of being transgender

Housing situation (out of those to whom situation applied)	% of Latino/a people in USTS	% in USTS
Had to move back in with family or friends	23%	20%
Slept in different places for short periods of time	17%	15%
Had to move into a less expensive home or apartment	16%	13%
Experienced homelessness	14%	12%
Denied a home or apartment	6%	6%
Evicted from a home or apartment	6%	5%
One or more experiences listed	**33%**	**30%**

More than one in five (22%) respondents who experienced homelessness in the past year avoided staying in a shelter because they feared being mistreated as a transgender person.

Public Accommodations

Respondents reported being denied equal treatment or service, verbally harassed, or physically attacked at many places of public accommodation—places that provide services to the public, like retail stores, hotels, and government offices. In the past year, out of respondents who visited a place of public accommodation where staff or employees thought or knew they were transgender, 30% experienced at least one type of mistreatment. This included 15% who were denied equal treatment or service, 23% who were verbally harassed, and 1% who were physically attacked because of being transgender (Table 6).

Transgender women (21%) were more likely to have been denied equal treatment or service compared to transgender men (11%) and non-binary people (12%). Transgender women (27%) and non-binary people (26%) were more likely to have experienced verbal harassment than transgender men (17%).

Table 6: Experiences in places of public accommodation in the past year due to being transgender

Experience at a place of public accommodation (out of those who believe staff knew or thought they were transgender)	% of Latino/a people in USTS
Denied equal treatment or service	15%
Verbally harassed	23%
Physically attacked	1%
One or more experiences listed	**30%**

Harassment and Violence

Overall Experiences of Unequal Treatment, Harassment, and Physical Attack

Nearly one-half (48%) of respondents reported being denied equal treatment, verbally harassed, and/or physically attacked in the past year because of being transgender. Fifteen percent (15%) were denied equal treatment or service in a public place and 45% were verbally harassed in the past year because of being transgender. Nearly one in ten (9%) were physically attacked in the past year because of being transgender (Table 7).

Transgender women (49%) and non-binary people (48%) were more likely to be verbally harassed in the past year because of being transgender than transgender men (40%). Transgender women (12%) and non-binary people (10%) were also more likely to be physically attacked in the past year because of being transgender, compared to transgender men (7%).

Table 7: Denial of equal treatment or service, verbal harassment, and physical attack in the past year because of being transgender

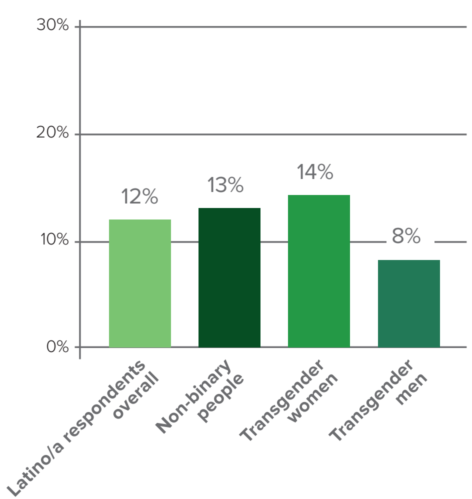
Experience in the past year due to being transgender	% of Latino/a people in USTS
Denied equal treatment or service	15%
Verbally harassed	45%
Physically attacked	9%
One or more experiences listed	**48%**

Sexual Assault

Nearly half (48%) of Latino/a respondents have been sexually assaulted at some point in their lifetimes, compared to 47% in the USTS sample overall and 45% of white respondents. People with disabilities (60%) reported a substantially higher rate of sexual assault in their lifetimes. Non-binary people with "female" on their original birth certificates (55%) were also more likely to have been sexually assaulted in their lifetimes (Figure 16).

Twelve percent (12%) of Latino/a respondents were sexually assaulted in the past year, compared to 10% in the USTS sample overall and 9% of white respondents. Transgender women (14%) and non-binary people (13%) were nearly twice as likely to have been sexually assaulted in the past year as transgender men (8%) (Figure 17). More than one-quarter (28%) of respondents who worked in the underground economy (such as in sex work, drug sales, and other currently criminalized activities) in the past year were sexually assaulted during that year.

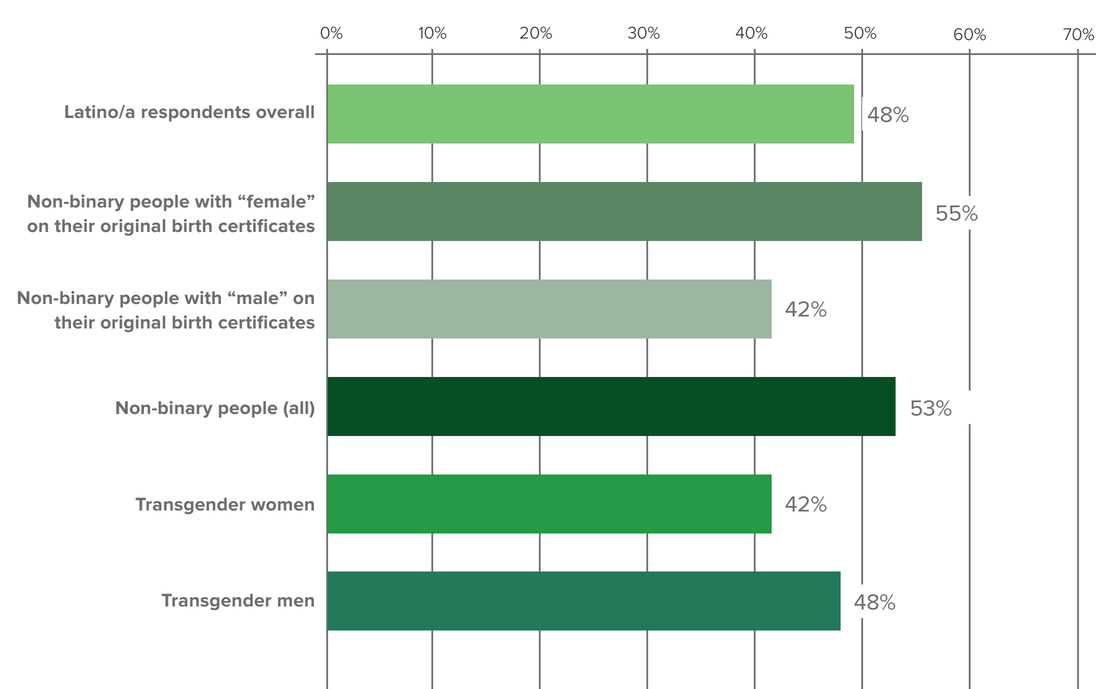
Figure 17: Sexual assault in the past year (by gender)



Intimate Partner Violence

Fifty-four percent (54%) of respondents experienced some form of intimate partner violence, including acts of coercive control[19] and physical violence. Transgender men (58%) were more likely to have experienced some form of

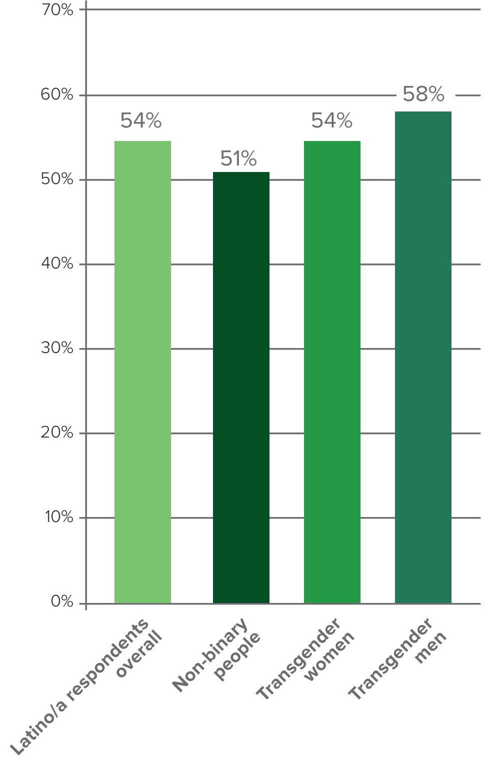
Figure 16: Sexual assault in lifetime (by gender)



intimate partner violence (Figure 18). Nearly three-quarters (74%) of respondents who have worked in the underground economy experienced intimate partner violence, and people with disabilities (62%) were also more likely to have experienced intimate partner violence.

More than one-quarter (27%) of respondents reported acts of coercive control by an intimate partner related to their transgender status, including being told that they were not a "real" woman or man, threatened with being "outed" by having their transgender status revealed to others, or prevented from taking their hormones. Forty-three percent (43%) experienced physical violence by an intimate partner.

Figure 18: Experienced intimate partner violence (by gender)



Police Interactions, Prisons, and Immigration Detention

Latino/a respondents experienced high levels of mistreatment and harassment by police. In the past year, out of respondents who interacted with police or other law enforcement officers who thought or knew they were transgender, 66% experienced some form of mistreatment, compared to 58% of USTS respondents overall and 55% of white respondents. This included being verbally harassed, repeatedly referred to as the wrong gender, or physically or sexually assaulted (Table 8).

Table 8: Mistreatment by police or other law enforcement officers in past year

Experience of mistreatment in the past year	% of Latino/a people in USTS	% in USTS	% of white people in USTS
Officers kept using the wrong gender pronouns (such as he/him or she/her) or wrong title (such as Mr. or Ms.)	55%	49%	46%
Verbally harassed by officers	29%	20%	17%
Officers asked questions about gender transition (such as about hormones or surgical status)	26%	19%	16%
Officers assumed they were sex workers	14%	11%	8%
Physically attacked by officers	5%	4%	2%
Sexually assaulted by officers	5%	3%	2%
Forced by officers to engage in sexual activity to avoid arrest	1%	1%	<1%
One or more experiences listed	**66%**	**58%**	**55%**

Fifty-nine percent (59%) of Latino/a respondents said they would feel somewhat or very uncomfortable asking the police for help if they needed it, compared to 57% of respondents in the USTS sample overall and 53% of white USTS respondents (Figure 19). Non-binary people (73%) were more likely to be uncomfortable asking the police for help, in contrast to transgender men (55%) and women (52%) (Figure 20). Nearly three-quarters (73%) of people with disabilities were uncomfortable asking the police for help.

Four percent (4%) of Latino/a respondents were arrested in the past year, compared to 2% in the USTS sample. Two percent (2%) of Latino/a respondents were incarcerated—held in jail, prison, or juvenile detention—in the past year, compared to 0.9% in the U.S. population overall.[20]

Latino/a respondents who were held in jail, prison, or juvenile detention in the past year faced high rates of physical and sexual assault by facility

Figure 19: Comfort asking the police for help

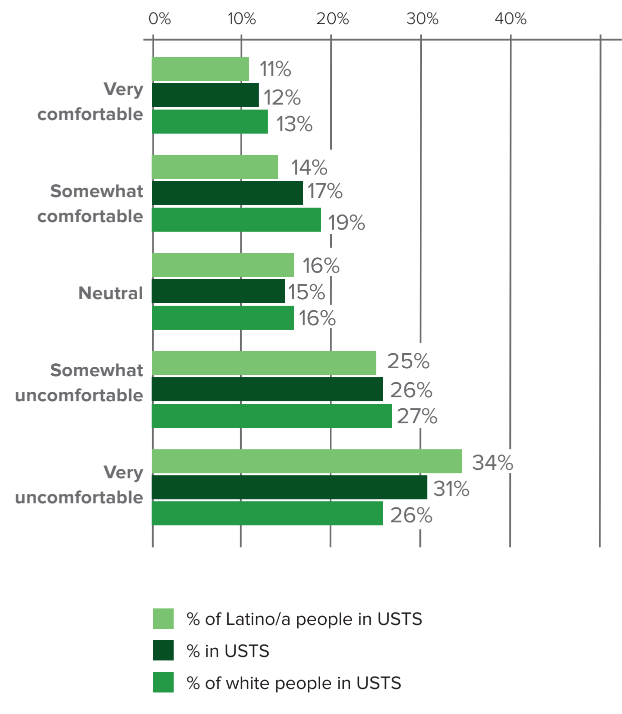
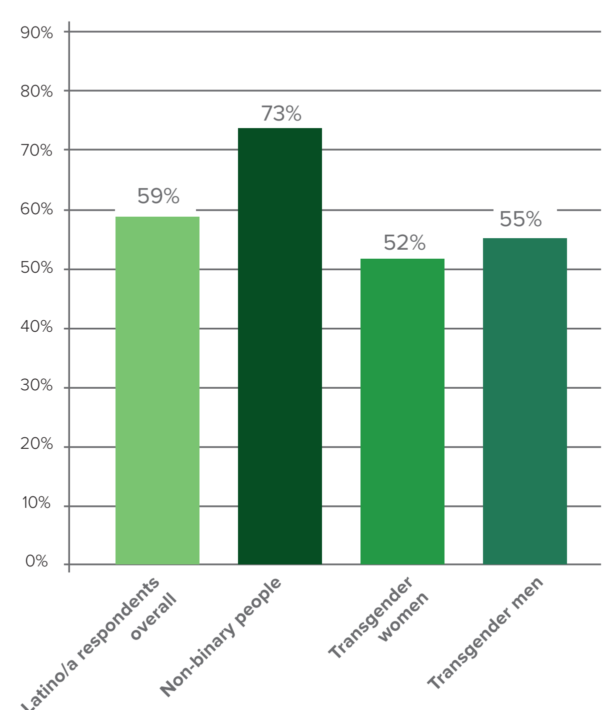


Figure 20: Somewhat or very uncomfortable asking the police for help (by gender)



staff and other inmates. In the past year, 18% were physically assaulted by *staff or other inmates*, compared to 23% in the USTS sample overall. More than one-quarter (27%) were sexually assaulted by *staff or other inmates*, compared to 20% in the USTS sample overall.

Fourteen percent (14%) of Latino/a respondents were sexually assaulted by *facility staff* in the past year during their time in jail, prison, or juvenile detention, compared to the rate in the USTS sample overall (11%). This was seven times higher than the rate in the incarcerated U.S. population in prisons (2%) and in jails (2%).[21]

Additionally, five percent (5%) of Latino/a respondents who were not U.S. citizens at the time of their birth have been held in immigration detention, such as in an Immigration and Customs Enforcement (ICE) detention center or a local jail just for immigration court proceedings. This represents 1% of all Latino/a respondents.

Health

Insurance

Seventeen percent (17%) of Latino/a respondents did not have health insurance, compared to 14% in the USTS sample overall and 12% of white respondents. This was higher than the rate in U.S. population overall (11%) but lower than the rate among Latino/a people in the U.S. population (25%).[22] The most common forms of insurance reported by Latino/a respondents included coverage they or a family member received through an employer (50%), followed by Medicaid (16%) (Table 9).

One-quarter (25%) of respondents experienced a problem in the past year with their insurance related to being transgender, such as being denied coverage for care related to gender transition or being denied coverage for other kinds of health care because they were transgender.

Experiences with Providers

Nearly one-third (32%) of respondents who saw a health care provider in the past year reported having at least one negative experience related to being transgender. This included being refused treatment, being verbally harassed, being

Table 9: Type of health insurance or health coverage plan

Health insurance source	% of Latino/a people in USTS	% in USTS	% in U.S. population (ACS)
Insurance through current or former employer or union (belonging to respondent or a family member)	50%	53%	56%
Medicaid	16%	13%	15%
Insurance they or someone else purchased directly from an insurance company or through a health insurance marketplace (such as healthcare.gov)	14%	14%	16%
Medicare	2%	5%	22%
VA	2%	2%	3%
TRICARE or other military health care	1%	2%	3%
Another type of insurance	6%	6%	---

physically or sexually assaulted, or having to teach the provider about transgender people in order to get appropriate care.

In the past year, more than a quarter (26%) of respondents did not see a doctor when they needed to because of fear of being mistreated as a transgender person, and 37% did not see a doctor when needed because they could not afford it.

HIV Status

Fifty-four percent (54%) of Latino/a respondents had been tested for HIV, a rate similar to the USTS sample overall (55%) but higher than in the U.S. population (34%).[23] Among those who had not been tested, 83% of Latino/a respondents said that it was primarily because they were unlikely to have been exposed to HIV. Latino/a respondents who had not been tested were slightly less likely to cite this reason than USTS respondents overall (86%) and those in the general U.S. population (86%).[24]

Among Latino/a respondents, 1.6% reported that they were living with HIV, compared to the rate in the USTS sample overall (1.4%) and among white respondents (0.4%). This was more than five times higher than the rate in the U.S. population (0.3%)[25] and more than three times higher than the rate among Latino/a people in the U.S. population (0.5%).[26] Transgender women (4.4%) were nearly three times more likely than Latino/a USTS respondents overall to be living with HIV (Figure 21) and respondents who did not complete high school (9.3%) were nearly six times more likely to be living with HIV (Figure 22). Additionally, 52% of Latino/a respondents were HIV negative, and 46% had not been tested or did not know the results of their HIV test.

Psychological Distress

Forty-five percent (45%) of Latino/a respondents experienced serious psychological distress in the month before completing the survey (based on

1.6% of Latino/a USTS respondents were living with HIV.

- **4X** higher than the rate among white USTS respondents (0.4%)
- **5X** higher than the rate in the U.S. population overall (0.3%)
- **3X** higher than the rate among Latino/a people in the U.S. population (0.5%)

4.4% of transgender Latinas were living with HIV, 15X the rate in the U.S. population (0.3%).

Figure 21: Living with HIV (by gender)

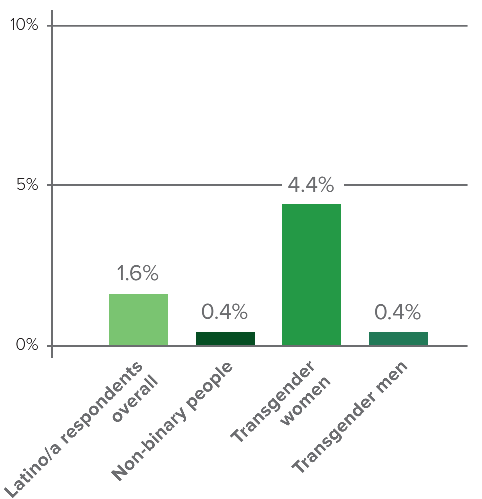
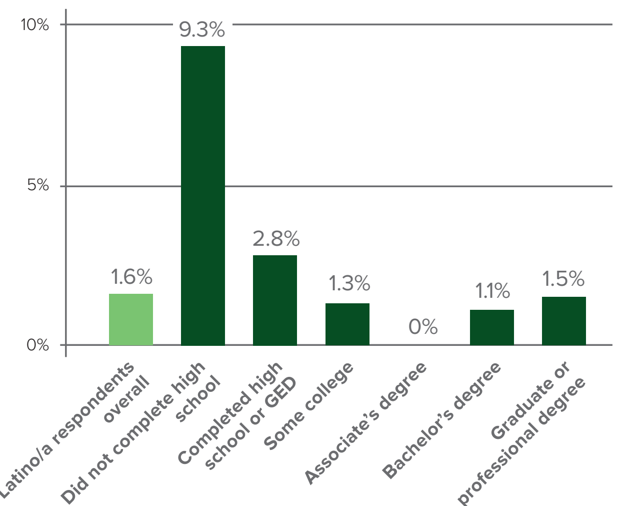


Figure 22: Living with HIV (by educational attainment)



the Kessler 6 Psychological Distress Scale),[27] nine times higher than the rate in the U.S. population (5%) and the rate among Latino/a people in the U.S. population (5%).[28]

Conversion Therapy

One in eight (12%) reported that a professional, such as a psychologist, counselor, or religious advisor, tried to stop them from being transgender.

Suicidal Thoughts and Behaviors

Nearly half (45%) of Latino/a respondents have attempted suicide at some point in their lives, compared to 40% in the USTS sample overall and 37% of white respondents. This rate was nearly ten times higher than the rate in the U.S. population (4.6%).[29] Latino/a respondents with disabilities (60%) were substantially more likely to have attempted suicide in their lifetimes.

Nearly one in ten (9%) Latino/a respondents attempted suicide in the past year, compared to 7% in the USTS sample overall and 6% of white respondents. This rate was fifteen times higher than the rate in the U.S. population (0.6%) and the rate among Latino/a people in the U.S. population (0.6%).[30] Latino/a respondents with disabilities (14%) were more likely to have attempted suicide in the past year.

Identity Documents

Only 10% of respondents reported that *all* of their identity documents (IDs) had the name and gender they preferred, while 71% reported that *none* of their IDs had the name and gender they preferred. The cost of changing IDs was one of the main barriers respondents faced, with 42% of those who have not changed their legal name and 38% of those who have not updated the gender on their IDs reporting that it was because they could not afford it.

More than one-third (35%) of respondents who have shown an ID with a name or gender that did not match their gender presentation were verbally harassed, denied benefits or service, asked to leave, or assaulted.

Experiences of Multiracial Latino/a Respondents

In addition to respondents who identified as Latino/a alone in the USTS, 549 respondents identified as multiracial and Latino/a or "a racial/ethnic identity not listed" and Latino/a. This section provides a brief overview of the experiences of these respondents, referred to here as multiracial Latino/a respondents. Additional research is needed to further examine the experiences of multiracial respondents.

- 21% of multiracial Latino/a respondents were unemployed.
- 50% were living in poverty.
- 23% of multiracial Latino/a respondents who have been employed reported losing a job at some point in their lives because of being transgender.
- In the past year, 34% of those who held or applied for a job during that year reported being fired, being denied a promotion, or not being hired for a job they applied for because of being transgender.
- In the past year, 17% were denied equal treatment or service in a public place and 57% were verbally harassed because of being transgender.
- In the past year, 12% were physically attacked because of being transgender and 15% were sexually assaulted. More than half (59%) have been sexually assaulted at some point in their lives.
- In the past year, out of respondents who interacted with police or other law enforcement officers who thought or knew they were transgender, 78% experienced some form of mistreatment. This included being verbally harassed, repeatedly referred to as the wrong gender, physically assaulted, or sexually assaulted.
- 80% of those who were out or perceived as transgender at some point between Kindergarten and Grade 12 (K–12) experienced some form of mistreatment, such as being verbally harassed (58%), physically attacked (31%), or sexually assaulted (16%) in K–12 because of being transgender.

Experiences of Multiracial Latino/a Respondents (continued)

- 42% of multiracial Latino/a respondents have experienced homelessness at some point in their lives.
- 20% experienced homelessness in the past year because of being transgender.
- In the past year, 29% of multiracial Latino/a respondents did not see a doctor when they needed to because of fear of being mistreated as a transgender person, and 43% did not see a doctor when needed because they could not afford it.
- 34% of those who saw a health care provider in the past year reported having at least one negative experience related to being transgender, such as being refused treatment, being verbally harassed, being physically or sexually assaulted, or having to teach the provider about transgender people in order to get appropriate care.

Endnotes

1. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The Report of the U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality. Available at: www.USTransSurvey.org.
2. Throughout this report, respondents who identified as Latino/a or Hispanic are referred to as Latino/a. For additional information about terminology and conventions used throughout the report, see the *Guide to Report and Terminology* chapter in the full USTS report. The findings for Latino/a respondents reflect the experiences of respondents who identified as Latino/a alone and do not include the experiences of those who identified as multiracial and Latino/a. Some findings for respondents who identified as multiracial and Latino/a are included on page 22 of this report.
3. The U.S. Census Bureau defines and asks about race and ethnicity separately, with ethnicity being categorized as "Hispanic or Latino" and "Not Hispanic or Latino." U.S. Census Bureau surveys, such as the Decennial Census, American Community Survey, and Current Population Survey, first ask whether a respondent is of Hispanic or Latino origin to determine their ethnicity and then ask respondents their race. See e.g., U.S. Census Bureau. (2017). *Race and Ethnicity.* Available at: https://www.census.gov/mso/www/training/pdf/race-ethnicity-onepager.pdf. In contrast, USTS respondents received a question about their "racial/ethnic identity" and could select "Latino/a/Hispanic" as a racial/ethnic category. Therefore, comparisons to Latino/a people in the U.S. population presented throughout this report should be interpreted with caution.
4. The number of Latino/a respondents (n=1,473) is an unweighted value. All reported percentages are weighted to allow for comparison to the U.S. population when appropriate. Findings related to income, unemployment, and poverty are weighted differently than other reported percentages. For more information on the weighting procedures used to report 2015 U.S. Transgender Survey data, see the full survey report. Findings from statistical tests are not included in this report.
5. "Non-binary" is a term often used to describe people whose gender is not exclusively male or female, including those who identify with a gender other than male or female, as more than one gender, or as no gender.
6. Due to a low sample size, it was often not possible to include the experiences of crossdressers in gender-based comparisons in this report.
7. U.S. Census Bureau. (2015). *2015 American Community Survey 5-Year Estimates: Sex by Age.* Available at: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_15_SPT_B01001&prodType=table.
8. U.S. Census Bureau. (2015). *2015 American Survey 1-Year Estimates: Disability Characteristics.* Available at: http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_15_1YR_ S1810&prodType=table. Calculations were completed by the research team.
9. U.S. Census Bureau. (2015). *2015 American Community Survey 1-Year Estimates: Sex by Marital Status by Age for the Population 15 Years and Over (Hispanic or Latino).* Available at: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_15_1YR_B12002I&prodType=table. These findings include adults who are currently married and living with a spouse and those who are married but separated, based on the ACS definitions. See the full report for more information. The percentage of Latino/a people in the U.S. who are currently married and who have never been married include those who are 15 years of age and older, in contrast to the USTS sample, which includes respondents who are 18 and older. Therefore, the comparison to USTS Latino/a respondents should be interpreted with caution.
10. Latino/a respondents' experiences of rejection also included being asked to meet with faith leaders or seek medical help to stop them from being transgender.
11. Bureau of Labor Statistics. (2015). *The Employment Situation—August 2015.* Available at: http://www.bls.gov/news.release/archives/empsit_09042015.pdf; Bureau of Labor Statistics. (2015). *The Employment Situation—September 2015.* Available at: http://www.bls.gov/news.release/archives/empsit_10022015.pdf.
12. The unemployment rate by race and ethnicity among adults in the U.S. population was calculated by the research team using CPS data available via the CPS Table Creator (http://www.census.gov/cps/data/cpstablecreator.html). CPS Table Creator data utilizes data from the March 2015 Current Population Survey Annual Social and Economic Supplement, in which the overall U.S. unemployment rate was 5.5%. See the full USTS report for more information about unemployment rate calculations and interpretation.
13. "Living in poverty" means living at or near the poverty line. The research team calculated the USTS poverty measure using the official poverty measure, as defined by the U.S. Census Bureau. USTS respondents were designated as living in poverty if their total family income fell under 125% of the official U.S. poverty line. See the full report for more information about this calculation.
14. Proctor, B. D., Semega, J. L., & Kollar, M. A. (2016). *Income and Poverty in the United States: 2015*. (p. 13). Washington, DC: U.S. Census Bureau. Available at: https://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-256.pdf.

15. Proctor, B. D., Semega, J. L., & Kollar, M. A. (2016). *Income and Poverty in the United States: 2015*. (p. 55). Washington, DC: U.S. Census Bureau. Available at: https://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-256.pdf.

16. U.S. Census Bureau. (2015). *American Community Survey 1-Year Estimates: Veteran Status*. Available at: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_15_1YR_ S2101&prodType=table.

17. U.S. Census Bureau (2014). *Current Population Survey Annual Social and Economic Supplement*. Available at: https://www.census.gov/data/tables/time-series/demo/income-poverty/cps-pinc/pinc-01.2014.html.

18. For each form of housing discrimination or instability listed, respondents could select "does not apply to me" if the housing situation could not have happened to them in the past year. For example, those who did not attempt to rent or buy a home in the past year could not have been denied a home or apartment, and were instructed to select "does not apply to me" for that question. The results for each form of discrimination or instability do not include those who answered "does not apply to me."

19. Intimate partner violence involving coercive control included acts of intimidation, emotional and financial harm, and physical harm to others who were important to respondents.

20. Kaeble, D. & Glaze, L. (2016). *Correctional Populations in the United States, 2015.* (p. 4). Washington, DC: Bureau of Justice Statistics. Available at: https://www.bjs.gov/content/pub/pdf/cpus15.pdf.

21. Beck, A. J., Berzofsky, M., Caspar, R., & Krebs, C. (2013). *Sexual Victimization in Prisons and Jails Reported by Inmates 2011–12*. DC: Bureau of Justice Statistics. Available at: https://www.bjs.gov/content/pub/pdf/svpjri1112.pdf. Rates of physical assault by facility staff was not available. The Bureau of Justice Statistics (BJS) presents data separately for people incarcerated in state and federal prisons and people incarcerated in jails, but they do not present data for those held in juvenile detention facilities. Data from the U.S. incarcerated population in this section is provided as a benchmark for experiences among USTS respondents and should be interpreted with caution. See full report for more information about this comparison.

22. U.S. Census Bureau. (2015). *2015 American Community Survey 1-Year Estimates: Health Insurance Coverage Status by Age (Hispanic or Latino)*. Available at: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_15_1YR_B27001I&prodType=table.

23. Centers for Disease Control and Prevention. (2015). *BRFSS Prevalence & Trends Data.* Available at: http://www.cdc.gov/brfss/brfssprevalence.

24. Centers for Disease Control and Prevention. (2016). *2015 National Health Interview Survey: Sample Adult File.* Available at: https://www.cdc.gov/nchs/nhis/nhis_2015_data_release.htm.

25. Centers for Disease Control and Prevention. (2015). Diagnoses of HIV infections in the United States and dependent areas, 2015: Table 20b. *HIV Surveillance Report* (vol. 27). Available at: https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2015-vol-27.pdf. The HIV Surveillance Report provides data for those who were living with diagnosed HIV infection in the U.S. population in 2014. The U.S. population data includes those who are 15 years of age and older and does not include the rate for adults aged 18 and older alone, so it was not possible to exactly match the USTS sample with the U.S. population data. See the full report for more information on use of the U.S. population figure.

26. Centers for Disease Control and Prevention. (2015). Diagnoses of HIV infections in the United States and dependent areas, 2015: Table 20b. *HIV Surveillance Report* (vol. 27). Available at: https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2015-vol-27.pdf. See also note 25.

27. The Kessler Psychological Distress Scale, or K6, uses a series of questions to assess psychological distress based on how often in the past 30 days respondents felt so sad that nothing could cheer them up, nervous, restless or fidgety, hopeless, that everything was an effort, or worthless. See the National Health Interview Survey for additional information about the K6 mental health screening instrument and measure of serious psychological distress in adults (available at: http://www.healthindicators.gov/Indicators/Serious-psychological-distress-adults-percent_50055/Profile).

28. Center for Behavioral Health Statistics and Quality. (2016). *Results from the 2015 National Survey on Drug Use and Health: Detailed Tables.* Table 8.87B. Rockville, MD: Substance Abuse and Mental Health Services Administration. Available at: https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.pdf.

29. Kessler, R. C., Borges, G., & Walters, E. E. (1999). Prevalence of and risk factors for lifetime suicide attempts in the National Comorbidity Survey. *Archives of General Psychiatry*, 56(7), 617–626.

30. Center for Behavioral Health Statistics and Quality. (2016). *Results from the 2015 National Survey on Drug Use and Health: Detailed Tables.* Table 8.73B. Rockville, MD: Substance Abuse and Mental Health Services Administration. Available at: https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.pdf.

2015 U.S. Transgender Survey:
Report on the Experiences of Latino/a Respondents

by: Sandy E. James and Bamby Salcedo*

October 2017

The full report and Executive Summary of the 2015 U.S. Transgender Survey are available at www.USTransSurvey.org.

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*Bamby Salcedo is the President & CEO of the TransLatin@ Coalition. Sandy E. James is the Research Director at the National Center for Transgender Equality.

Updated November 2017

EXHIBIT B

The State of Trans Health: TransLatin@s and Their Healthcare Needs

THE STATE OF TRANS HEALTH

TRANS LATIN@S AND THEIR HEALTHCARE NEEDS

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ABOUT THE TRANSLATIN@ COALITION

THE VOICE OF TRANSLATIN@S IN THE USA

MISSION

The mission of TransLatin@ Coalition is to advocate for the specific needs of the Trans Latin@ community that resides in the U.S.A. and to plan strategies that improve our quality of life.

VALUES

- Altruism, respect, and dignity for everyone
- Transparency, integrity, and honesty
- Pluralism and diversity
- Collaboration, inclusivity, and social justice
- Good resource administration

VISION

The vision of TransLatin@ Coalition is to amplify education and resources to promote the empowerment of Trans leaders.

In this study, Trans Latin@ refers to: *a person over the age of 18 who was assigned male or female at birth and does not identify with that assigned sex and gender, and uses the term(s) Transgender, Trans, Transwoman, Transman, Transmasculine, or Transfeminine, and who reside in the southern part of the state of California, and identifies as Latin@.*

FOREWORD

California leads the country in anti-discrimination laws in employment, housing, and public accommodations; which include medical and health care. While anti-discrimination laws have been in place for over a decade in California, Trans individuals in the state continue to face high levels of unemployment, and discrimination in housing, and receiving health related care due to their gender identity and expression[1]. For Trans Latin@s who face transphobia and racism, marginalization is often exacerbated. In order to understand the needs of Trans Latin@s, TransLatin@ Coalition conducted the first ever study to shed light on the needs of Trans Latin@s in Southern California IN 2016.

It is important to survey the Trans community in order to understand the components of their lives that allow them to be physically, socioeconomically, and emotionally healthy individuals. Understanding these components and where they are lacking will allow service providers to help fill in the gaps that are inhibiting the health and well-being of this vulnerable community.

The TransLatin@ Coalition has begun to fill these needs through the creation of the Center for Violence and Transgender Wellness. The TransLatin@ Coalition seeks to improve the health outcomes of Trans people in California. This report will provide evidence of the specific healthcare needs of Trans Latin@s and what makes Trans Latin@s healthy individuals in the southern part of the golden state. California is recognized across the nation as a model state that provides the most comprehensive legislation and protections towards Trans people. However, there is still a lot of work that needs to be done to address the basic social supportive needs of Trans Latin@ people. We hope that this report provides a road map to assess what is it that supports trans Latin@s to fully realize their humanity, health, and happiness here in California.

JACQUELINE CARAVES, M.A.
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Ph.D. Candidate
Chicana and Chicano Studies
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Co-Principal Investigator
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[1] Hartzell, E., Frazer, M. S., Wertz, K. and Davis, M. (2009). The State of Transgender California: Results from the 2008 California Transgender Economic Health Survey. Transgender Law Center

ACKNOWLEDGMENTS

A THANK YOU TO THOSE WHO HAVE HELPED US

This report became a reality thanks to the support from The California Endowment and the hard work and dedication of the members of the TransLatin@ Coalition.

Because of the members of TransLatin@ Coalition, we gathered 129 surveys with Trans Latin@ individuals in six different critical points in Southern California. We would like to give a special acknowledgment to those individuals and groups who were crucial to the success of this data collection and who organized people to participate in completing the surveys: Erika De La Cruz, Johanna Wallace and Maria Roman from TransLatin@ Coalition in Los Angeles; Madeline Ambrosini and Somos Familia Valle in the San Fernando Valley; Grupo Transgenero 2000 in San Diego, Alexa Castañon from TransLatin@ Coalition in Long Beach, Pastor Carol Jackson from Spiritual Truth Church in Long Beach, The Long Beach LGBT Center, Zulma Velasquez and Sasha Navarro TransLatin@ Coalition in El Monte, Adriel Rodriguez and Trans Union de OC in Orange County, Paolo Jara-Riveros (videographer), Steve Landaverde (graphic design – cucupan.com), Leisy Abrego, Feliz Quiñones, and Anisha Gandhi.

In addition, the research team would like to thank the anonymous respondents who shared their valuable time with us. Often reliving negative experiences to give voice to the continuous discrimination and marginalization they resist on daily basis in an effort to become healthy individuals. Through the sharing of the intimate details of their everyday lives and their experiences in relation to their mental, physical, and emotional health and well-being as Trans individuals living in Southern California we have been able to put together this very important and timely report. The results of this survey are dedicated to all of you and to the younger generations of Trans Latin@s in Southern California as well as those across the state and the nation.

EXECUTIVE SUMMARY

THROUGHOUT THE COUNTRY, TRANS AND GENDER NON-CONFORMING INDIVIDUALS FACE DISCRIMINATION IN EVERY REALM OF THEIR LIVES.

Transgender and gender non-conforming individuals experience marginalization in employment, housing, health care, and education based on their gender identity and /or gender expression[2]. Transgender people of color in the U.S. experience racism and therefore experience heightened vulnerabilities in comparison to their white counterparts. For example, according to the National Center for Trans Equality, "Latino/a Trans people often live in extreme poverty with 28% reporting a household income of less than $10,000/year. This is nearly double the rate for Trans people of all races (15%), over five times the general Latino/a community rate (5%), and seven times the general U.S. community rate (4%). The rate for Latino/non-citizen respondents was 43%.[3]"

Given the urgent nature of these statistics, the TransLatin@ Coalition joined with researcher Jacqueline Caraves to conduct a more in–depth study focusing on the lives of Trans Latin@s who reside in Southern California and the social factors that support their health. Considering the vulnerabilities that Trans Latin@s experience, we identified the key areas that impact one's overall health, and asked questions related to their access and needs concerning gaps in those areas. Those areas include: housing, employment, health care, sexual health, mental health, and spiritual services.

The findings presented in this study were compiled from the surveys that were gathered from 129 Trans Latin@s living in different parts of southern California with greater concentration in Los Angeles, Orange County and San Diego Counties. While the survey was open to all Trans Latin@s, 91% of participants were assigned male at birth (transwomen) while 9% of participants were assigned female at birth (transmen). The surveys were anonymous. The surveys were composed of various forms of questions. There were dichotomous questions, Likert scale questions, as well as open-ended questions. This report shares the participants' views as to how these issues affect their lives as Trans Latin@s in Southern California. We hope that this report will serve as a tool to advance the rights of Trans Latin@s in the United States and informs policies that will improve the health and wellness needs of Trans Latin@s in the nation. We offer this report to the Trans community, the Latin@ community, and social service organizations as well as policy makers, service providers and scholars working toward social justice.

[2] Hartzell, E., Frazer, M. S., Wertz, K. and Davis, M. (2009). The State of Transgender California: Results from the 2008 California Transgender Economic Health Survey. Transgender Law Center.
[3] Harrison-Quintana, J., Perez, D., Grant, J. (2011). Injustice at every turn: A look at Latina/o respondents in the National Transgender Discrimination Survey. National Center for Transgender Equality.

RESEARCH TEAM

JACQUELINE "JACKIE" CARAVES, CO-PRINCIPAL INVESTIGATOR

Jackie is a gender non-conforming queer Latina and a Ph.D. Candidate in the César E. Chávez Department of Chicana and Chicano Studies at the University of California, Los Angeles (UCLA) where she also received her Master of Arts degree in Chicana/o Studies and is in the process of completing her graduate certificate in Gender Studies. Jacqueline holds a Bachelor of Arts degree in Latin American & Latino Studies and Politics form the University of California, Santa Cruz (UCSC). Jackie's dissertation work centers the experiences of Trans and gender non-conforming Latin@s and the role of family and spirituality in serving as spaces of empowerment and resistance. Jackie hopes to lend visibility to the Trans and gender non-conforming community and to show how this community survives and thrives in the most beautiful ways.

BAMBY SALCEDO, CO-PRINCIPAL INVESTIGATOR

Bamby is an internationally recognized leader and educator. Bamby is a proud Trans Latina woman whose commitment to the multiple communities that her life intersects has been the driving force of her success. Bamby is pursuing a master's degree in Latino/a Studies. Bamby is the President and CEO of the TransLatin@ Coalition, a national organization that focuses on addressing the issues of Trans Latin@s in the US. Bamby is currently developing the Center for Violence Prevention & Transgender Wellness, a multipurpose, multi-service space for Trans people in Los Angeles. Her powerful, sobering and inspiring speeches and her warm, down-to-earth presence have provided emotional grounding and perspective for diverse gatherings. She speaks from the heart, as one who has been able to transcend many of her own issues, to truly drop ways of being and coping that no longer served her, issues that have derailed and paralyzed countless lives. Her words and experience evoke both tears and laughter, sobriety and inspiration through the documentary made about her life called TransVisible: Bamby Salcedo's Story. Bamby has been featured in multiple media outlets such as People en Español, Latina Magazine, Cosmopolitan, the Los Angeles Times, Los Angeles Magazine and 2015 OUT 100 and featured in the 2016 Trans List with HBO among many other. Bamby has also been recognized for her outstanding work by multiple national and local organizations.

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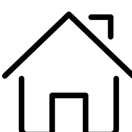
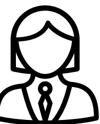


HOUSING

18.8 %

18.8% of participants are either **homeless or living in temporary housing** and 13.4% of participants rely on someone else to pay for their housing (i.e. spouse or partner, etc).



EMPLOYMENT

20 %

Only 20% of participants have **full-time employment**, while 80% of participants include participants who are self-employed (%), unemployed (26%), on disability (%) or other.

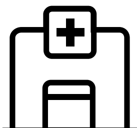
KEY FINDINGS

SPIRITUALITY

54.2% of participants report that having **access to regular spiritual services** is extremely important.

76.3% of participants believe that spirituality is important to their overall health.

HEALTH STATS



MEDICAL HEALTH

49.5 %

49.5% of participants are **covered under Medicare/Medicaid/Me-di-Cal**.

While 28.1% of participants have no health insurance coverage.

31.2% of participants go to the Emergency Room when in need of health care.

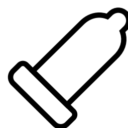
36% of participants strongly agree that it is because of a lack of per-sonal resources that their medical needs are not being met, while 35% of participants agree that it is because of a lack of Trans sensitive health care providers that their medical needs are not being met.

MENTAL HEALTH

50.5 %

50.5% of participants **currently experience anxiety**, while 26.4% of participants report that they are currently experiencing depression.

46.7% of participants strongly agree that their mental health needs are not being met because of a lack of personal resources while 43.7% of participants strongly agree that their mental health needs are not being met because of a lack of support groups.



SEXUAL HEALTH

90 %

90% of participants report that they **practice safe sex**.

32.2% of participants reported being HIV positive and 97.4% of HIV positive participants are receiving treatment.

METHODS

THIS REPORT IS ORGANIZED AROUND SIX CATEGORIES:

1. Access to Housing
2. Access to Employment
3. Access to Medical Care
4. Access to Sexual Health Care
5. Access to Mental Health Care
6. Access to Spiritual Services

THE RESEARCH METHOD THAT WAS USED TO CONDUCT THIS RESEARCH PROJECT WAS COMMUNITY-BASED PARTICIPATORY RESEARCH[4].

After consulting with members of the TransLatin@ Coalition (TLC), the members prioritized assessing the health care needs of Trans Latin@s was paramount. With this concept in mind, Bamby Salcedo approached Jackie Caraves to seek interest in partnering with the TLC to evaluate the needs of the Trans Latin@ community. After several conversations, Jackie agreed and understood the importance of having a community-engaged partnership. Jackie and Bamby formulated the type of questions that were relevant to collect, reviewed survey tools, and conducted pilot interviews with members of the target community.

After receiving feedback from community members about the survey instrument, the research team made modifications. The research team received Internal Review Board (IRB) approval from the University of California, Los Angeles, (Study #: 15-001883) went on to collect surveys between January 2016 and August 2016. The survey specifically targeted Trans Latin@s over the age of 18, who identify both as Trans and/or Transgender and Latin@. The survey was administered in cities and surrounding communities in El Monte, Long Beach, Los Angeles, San Diego, San Fernando Valley, and Santa Ana. These cities were chosen because of the established presence of Trans support groups that are linked and/or associated to TransLatin@ Coalition. The research team drew upon these six areas of concern to prepare the 70-question survey guiding this study.

8 MONTHS OF RESEARCH

70 SURVEY QUESTIONS

[4] Community based participatory research is a research approach that involves community members, organizational representatives in all aspects of the research process. All partners contribute their knowledge and expertise in the decision making process, in Wallerstein, N., & Duran, B. (2010). Community-based participatory research contributions to intervention research: the intersection of science and practice to improve health equity. American journal of public health, 100(S1), S40-S46.

SOCAL

DEMOGRAPHIC CHARACTERISTICS

THIS SECTION PROVIDES A DESCRIPTION OF THE DEMOGRAPHICS OF INDIVIDUALS WHO PARTICIPATED IN THIS NEEDS ASSESSMENT.

RECRUITMENT

Recruitment took place by members of the Trans Latin@ community throughout Southern California, with a specific focus in the areas where Trans Latin@ individuals thrive and are growing. The research team administered the surveys at each of these locations. The survey was available in both English and Spanish, and ninety-five participants answered the survey in Spanish. Participants took anywhere from half an hour to an hour to complete the survey. This report draws on the responses on 129 of survey participants who met the qualifications of being Trans, Latina@ and over the age of 18. Most participants were recruited during regular programing at local Trans support groups, or places where they frequently gathered. Survey participants who have no affiliation or connection to TransLatin@ Coalition were also recruited. The survey served an additional function as it connected these unaffiliated participants with Trans support groups. The surveys were distributed in private group settings on specific dates and times in each targeted city.

DATA ANALYSIS

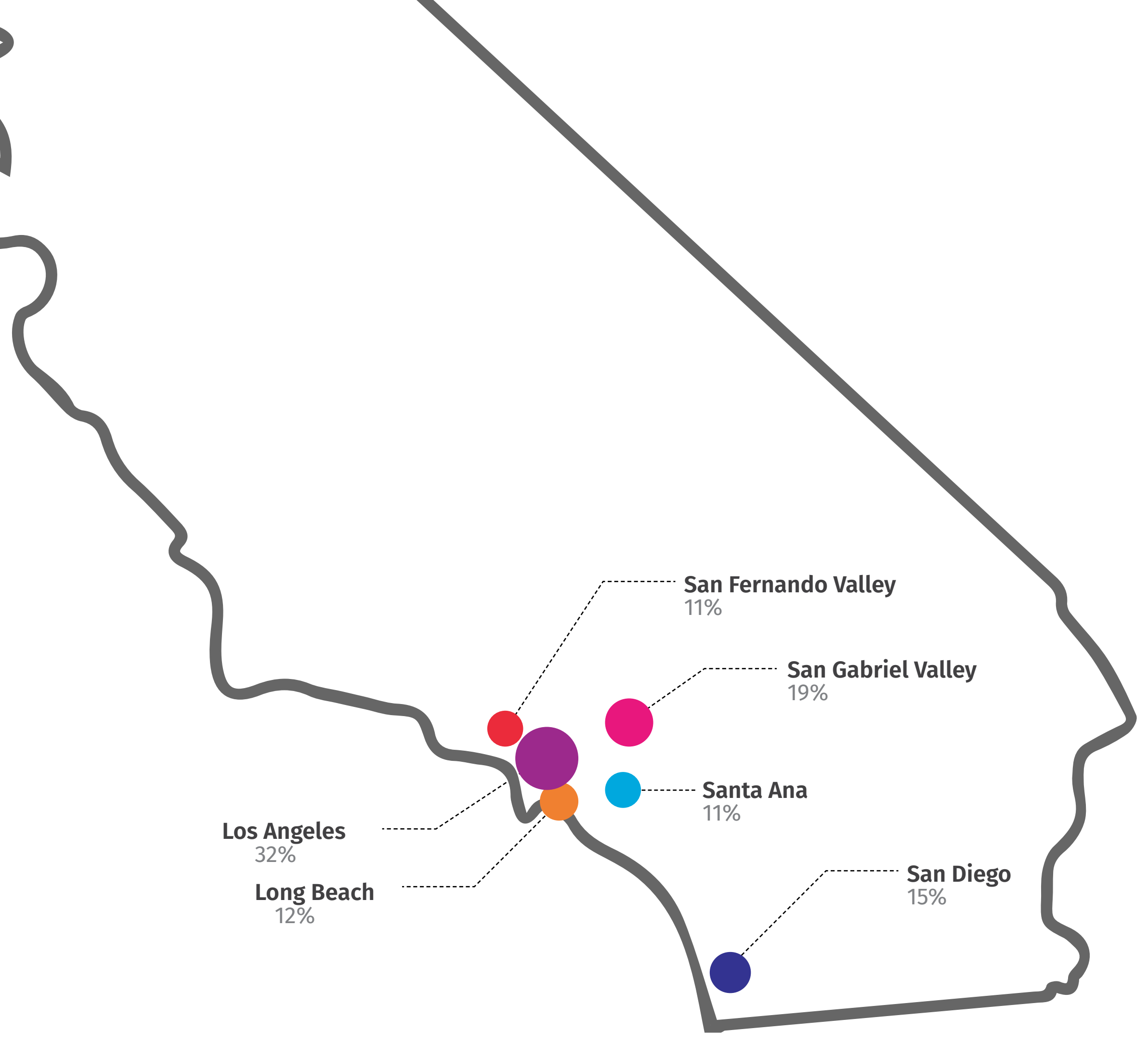
Upon gathering all surveys, the research team used Statistical Software (SPSS) to analyze the data, and worked collaboratively to draft charts/graphs, write, and design this report. This report benefits from the input, revisions, and approval of the TransLatin@ Coalition.

LIMITATIONS

The TransLatin@ Coalition is made of up members that identify as Transwomen, Transfeminine, and Woman. The TLC research team recruited participants from all members of the Trans Latin@ community. Due to the membership base of TransLatin@ Coalition it is important to note that Transmen/Transmasculine make up 9% of the participants in this study. It is important to look at Transmen in future research.

The 129 respondents of this study currently live in various regions throughout Southern California.

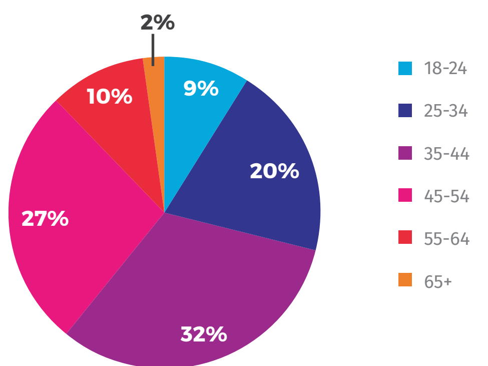
The following graph illustrates where interview participants geographic location based on the zip code or residence that they provided. As shown in the graph below, the largest percentage of Trans Latin@s in this needs assessment were from the city of Los Angeles, which accounted for 32% of the participants.



GENERAL FACTS

AGE

The following graph provides an overview of the age of Trans Latin@s who participated in the needs assessment.

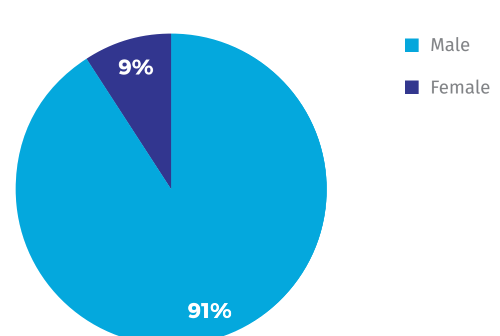


Age Data Analysis

A majority of the participants are between the ages of 35-54.

BIRTH SEX

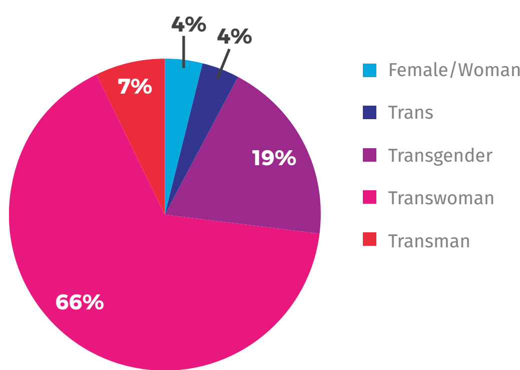
The following graph provides and overview of the sex assigned at birth of Trans Latin@s who participated in this needs assessment.



BACKGROUND

GENDER IDENTITY

The graph below illustrates the gender identity of Trans Latin@s who participated in this needs assessment.

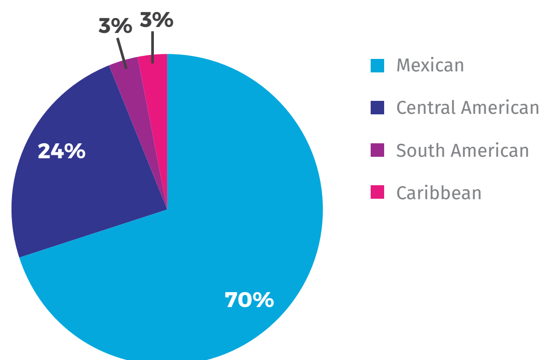


Gender Identity Data Analysis

The largest identity category for participants is Transwoman at 66% while Transman accounted for the smallest identity category at 7%. Twenty-three percent of participants identified as Trans or Transgender.

ETHNIC BACKGROUND

The following graph illustrates the ethnic background of Trans Latin@s who participated in this study.



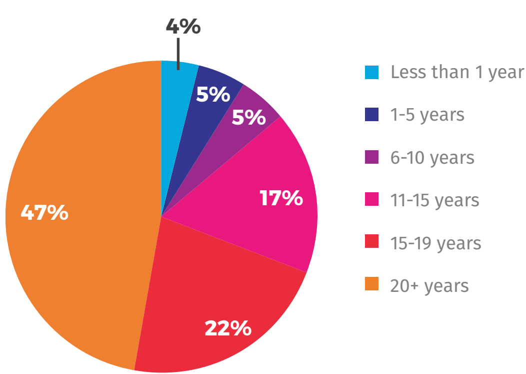
Ethnic Background Data Analysis

While Mexicans make up the majority of participants, Central Americans from El Salvador, Guatemala, and Honduras represent the second largest group.

IN THE USA

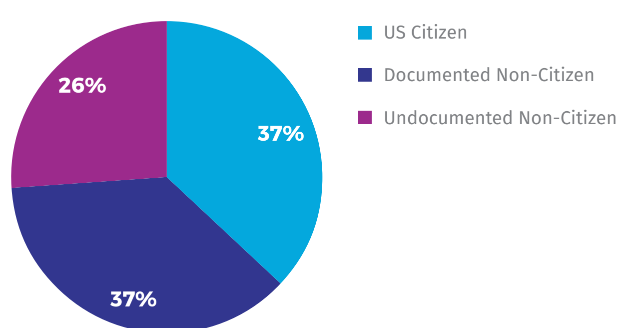
YEARS IN THE UNITED STATES

The following graph outlines the length of time that Trans Latin@s have been in living in the U.S.



CITIZENSHIP STATUS

The graph below highlights the citizenship status of Trans Latin@s who participated in this needs assessment.



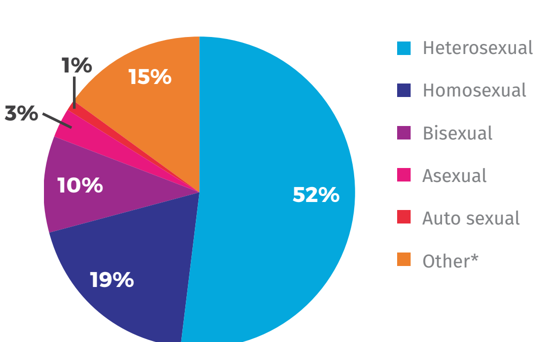
Years in US Data Analysis

A Total of 77% of participants reported having migrated to the U.S., 47% of those migrated reported living in the U.S. for over 20 years, and 4% percent of those living in the U.S. for less than one year.

SEXUALITY & RELATIONSHIPS

SEXUAL ORIENTATION

The following graphs highlight sexual orientation and relationship status from participants.

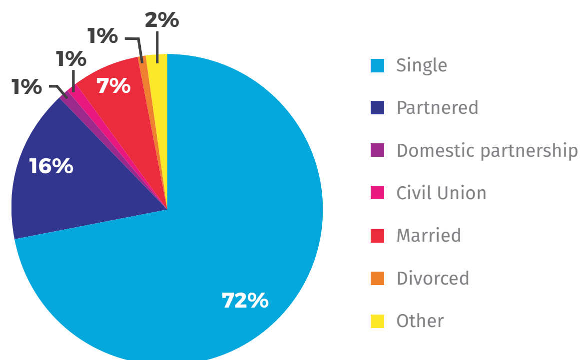


Sexual Orientation Data Analysis

Of those who answered "Other" for their sexuality, queer, pansexual and Transgender were among the most common responses.

RELATIONSHIP STATUS

The following graph highlights the relationship status of participants.

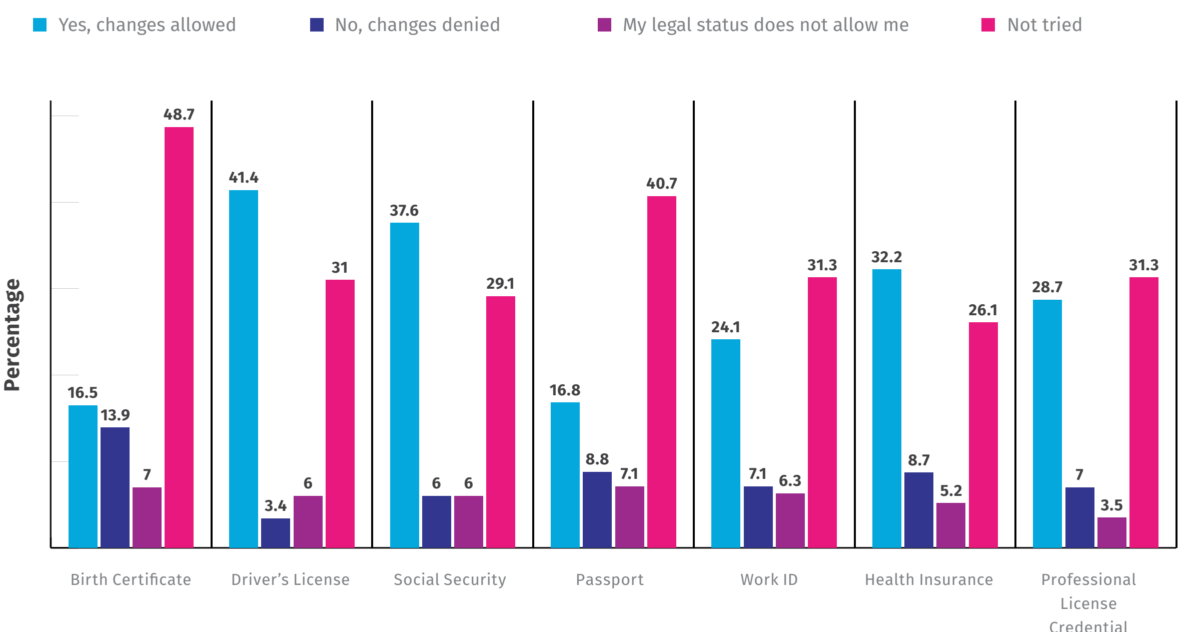


Relationship Status Data Analysis

Data shows a majority of participants who are single (72%), while 24% are either in a domestic partnership, partnered, civil union or married.

DOCUMENTS & RECORDS

HAVE YOU BEEN ABLE TO CHANGE THE DOCUMENTS OR RECORDS TO REFLECT YOUR CURRENT GENDER?



Documents/Records Gender Change Data Analysis

While many participants have been able to change their documents to reflect the gender they identify with, a great deal of Trans Latin@s have not tried at all. This may be due to the fact that there may be a lack of information on how to access these services/needs. There may be also a lack information and/or services in Spanish. It may have to do with lacking the time to access resources in order to begin processes that are time consuming. Because there is no streamlined process to access gender and name changes on all documents at once, it takes much time and money to make those changes.

SOCIOECONOMIC STATUS

INCOME DISTRIBUTION

The following section paints the picture of the social economic status of Trans Latin@s in Southern California.

Income	Percent
Less than $10,000	**57.4 %**
$10,000 - $19,999	20.9 %
$20,000 - $29,999	9.6 %
$30,000 - $39,999	7.8 %
$40,000 - $49,999	3.5 %
$70,000 - $79,999	0.9 %

Income Data Analysis

The **vast majority** of the people who participated in this needs assessment **live under the poverty level** making less than $10,000.00 per year.

EDUCATION DISTRIBUTION

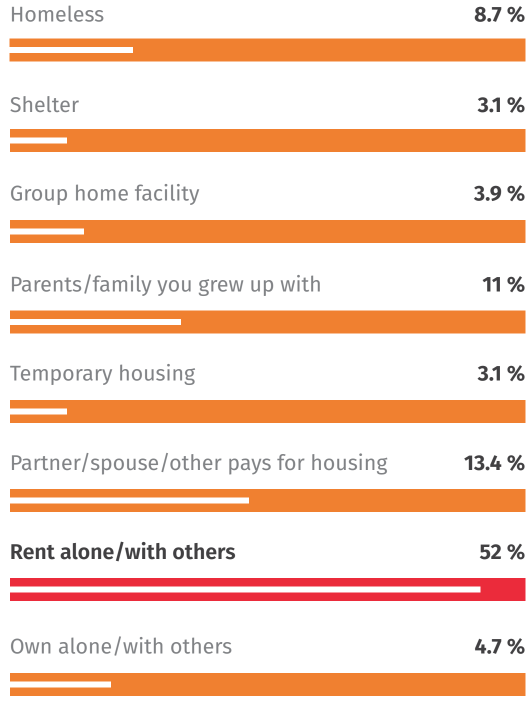
The following graph describes the educational attainment of Trans Latin@s in Southern California.

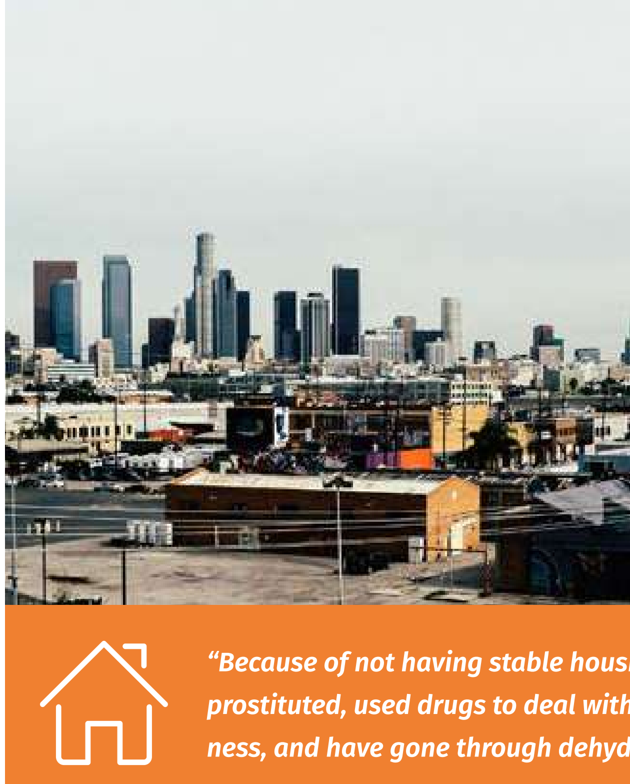
Education	Percent
No formal education	3.9 %
Elementary school	21.3 %
Some high school	**23.6 %**
HS Diploma	18.1 %
Some college credit	11.8 %
Technical school	5.5 %
A.A. Degree	8.7 %
B.A. Degree	6.3 %
M.A. Degree	0.8 %

HOUSING

CURRENT HOUSING

The following section paints the picture of the housing situation of Trans Latin@s in Southern California.





"Because of not having stable hous
prostituted, used drugs to deal with
ness, and have gone through dehyd

Housing is one of the basic needs that any individual within our society must have in order to be a stable person.

68%

of participants who do not have stable housing reported that they do not know of a shelter they can go to for help and feel safe as a Trans person.

98%

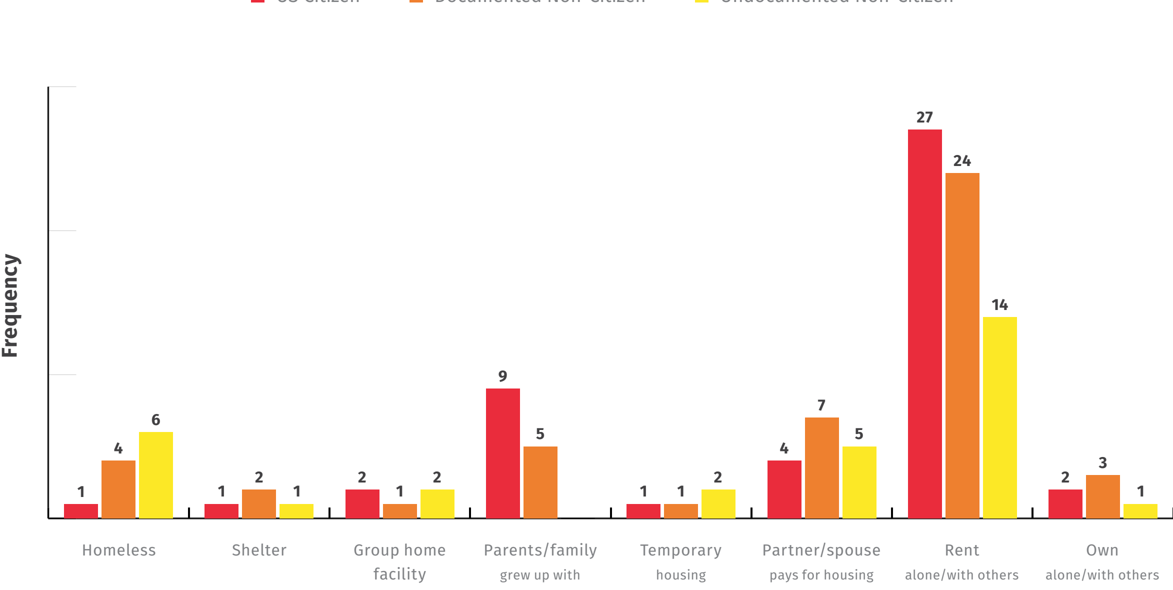
of participants acknowledged that housing is important to their overall health and well-being. The leading cause for participants who do not currently have stable housing is because they are unable to access work because of discrimination based on gender identity and/or their citizenship status.

ing I have
homeless-
ration”

“THE REASON WHY I AM HOMELESS IS BECAUSE I WAS RECENTLY RELEASED BY ICE (IMMIGRATION) AND THEY DON’T CARE IF I HAVE A PLACE TO LIVE OR FOOD TO EAT.”

HOUSING BY CITIZENSHIP STATUS

The graph below displays how citizenship status shapes housing outcomes for Trans Latin@s.



Housing by Citizenship Status Data Analysis

For all statuses, renting alone or with others is most common among participants. A total of 16 participants, from all statuses, reported being dependent on their partner or spouse for housing. For participants whom are U.S. Citizens or Documented Non-Citizens living with parents or family they grew up was prevalent. For Undocumented Non-Citizens who are vulnerable to being deported, housing especially of concern.

“I have feared and stressed out about my housing in the past due to fear of being accepted for my Trans identity. Stable housing is important because I need safety and a comfort zone after being out in the world, somewhere where I can be free to be myself.”

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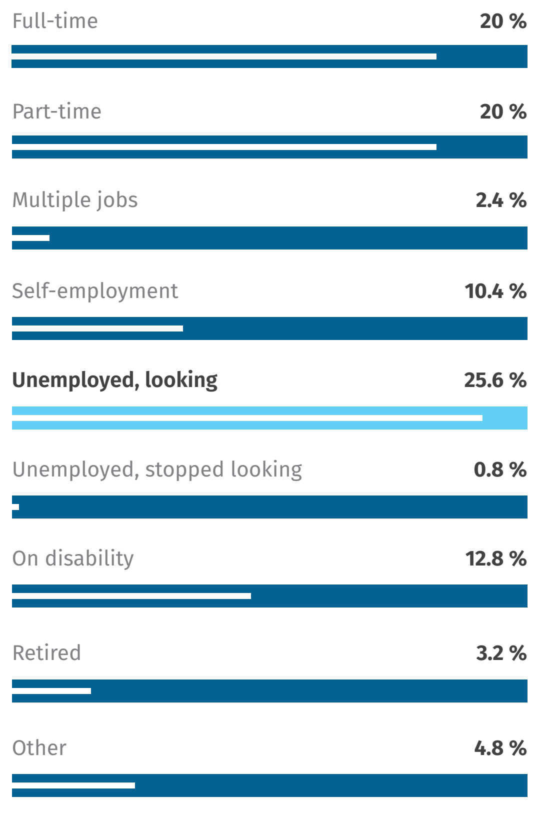
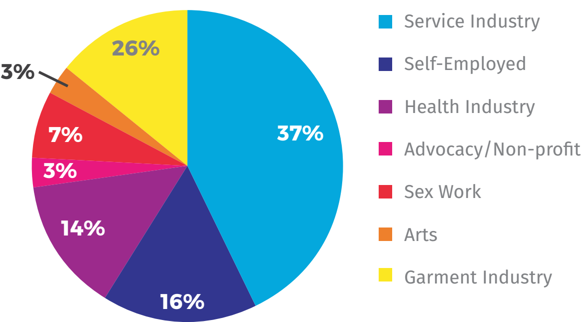
EMPLOYMENT

EMPLOYMENT STATUS

This section focuses on highlighting the employment needs of Trans Latin@s in Southern California.



EMPLOYMENT BY INDUSTRY



Employment Status Data Analysis

Only 20% of the participants reported having a full time job, and 20% have part time jobs. The largest portion of participants reported being "unemployed, but still looking for opportunities." There is much need of employment opportunities for Trans Latin@s in Southern California who often face discrimination. Additionally, as one participant notes below, other people whether partner, family member or friend are often dependent on Trans Latin@s income. Trans participants who reported "other" are qualify for Medicaid or General Relief (government assistance) due to their low-income status.

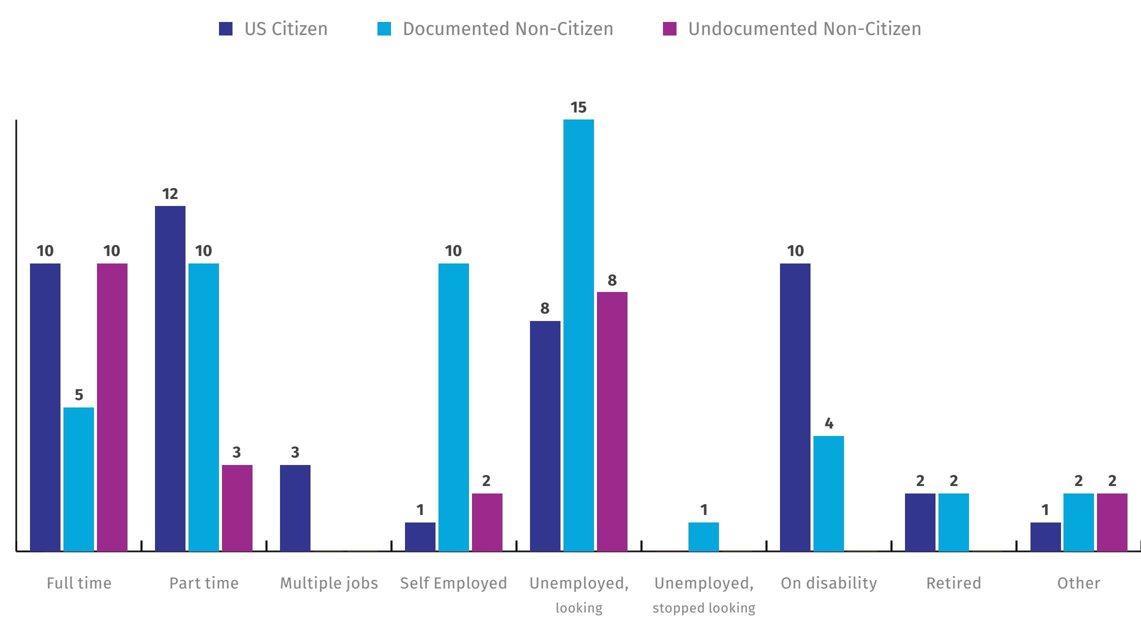
Employment by Industry Data Analysis

A large portion of participants mentioned working in the service industry included anything from being a stylist in a salon, to house keeping, and being cashier. For the 16% those are self-employed jobs varied from consulting to street vending.

"EMPLOYMENT IS IMPORTANT TO MY OVERALL HEALTH BECAUSE IT WOULD HELP STABILIZE ME AND GET ME ON MY FEET [AND] AWAY FROM PROSTITUTION AND DRUGS"

EMPLOYMENT BY CITIZENSHIP STATUS

The following graph below shows employment based on citizenship status.



Housing by Citizenship Status Data Analysis

For all statuses, renting alone or with others is most common among participants. A total of 16 participants, from all statuses, reported being dependent on their partner or spouse for housing. For participants whom are U.S. Citizens or Documented Non-Citizens living with parents or family they grew up was prevalent. For Undocumented Non-Citizens who are vulnerable to being deported, housing especially of concern.

"I support both myself and my partner financially, employment is necessary to be able to have a home, food, other necessities as well as to take care of my partner who is physically disabled and chronically ill."

MEDICAL CARE

HEALTH INSURANCE COVERAGE

The following section provides an overview of participant's status when it comes to accessing medical care.

Coverage	Percent
No health insurance	28.1 %
Insurance through employer	11.6 %
Insurance my family purchased	1.7 %
Medicare	10.7 %
Medicaid/Medi-Cal	**38.8 %**
Other public program	4.1 %
Other	5 %

Health Insurance Coverage Data Analysis

28.1 percent of participants have no health insurance coverage whatsoever. On the other hand, 53.6% of participants are covered by Medicare, Medicaid or other public insurance program, most commonly due to their low-income status. For some it is their low-income status along with being HIV positive that gains them access to health insurance.

LOCATION FOR MEDICAL CARE

The largest go to place for all Trans Latin@s is the emergency room.

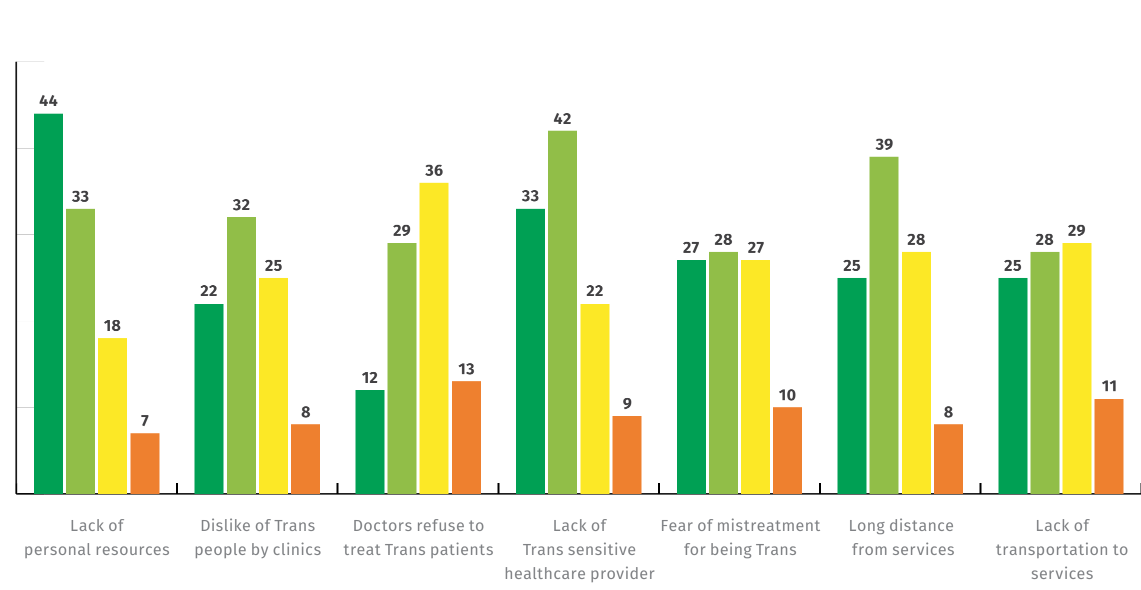
Location	Percent
Emergency room	**31.2 %**
Private doctor's office	9.6 %
Health clinic/center covered by insurance	23.2 %
Free health clinic	20 %
VA clinic or hospital	0.8 %
Alt. medicine (herbalist, acupuncture, etc.)	4 %
Not applicable	8 %
Other	3.2 %

Location for Medical Care Data Analysis

For those who may not have access to insurance, or face discrimination, the emergency room may be the only answer when pain is no longer the option.

REASONS WHY MEDICAL CARE IS NOT BEING MET

Participants were asked about the possible reasons why they were not receiving medical health. For Trans Latin@s lack of personal resources and lack of Trans sensitive health care providers, and long distance to services that are among the strongest reasons for why they may not be getting the health care they need.

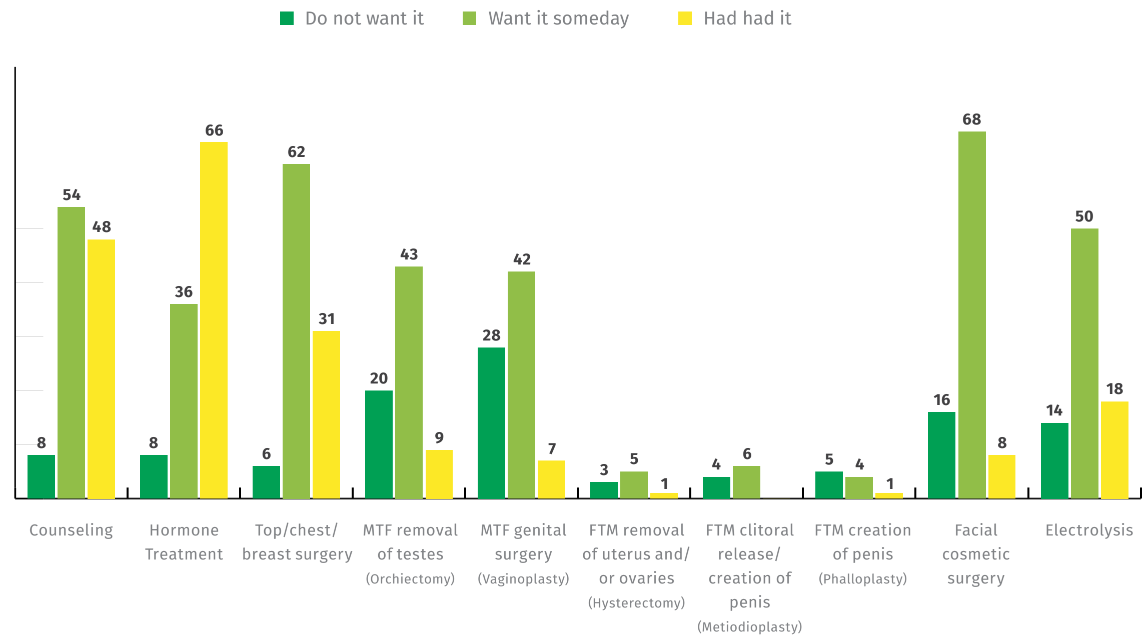


"Being physically and mentally healthy is important because that way I could function better within society."

MEDICAL CARE
(CONTINUED)

TRANS RELATED CARE

The graph below addresses the Trans related care that participants have either had, want to have someday, or do not want at all.



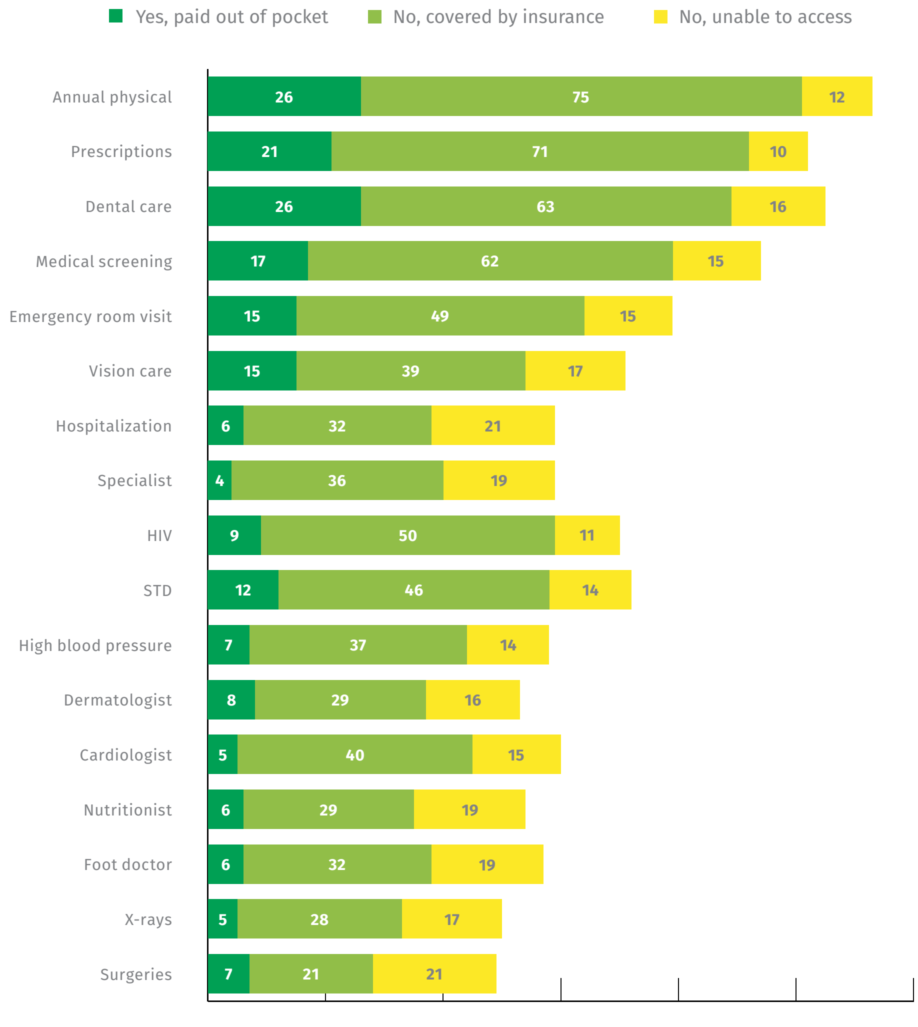
Trans Related Care Data Analysis

About **15% of participants** mentioned having to **pay for Trans related care out of pocket**. Often times this included hormones and top surgery. For those who paid out of pocket, participants mentioned that the money they used came from their savings, financial help from family or friend or doing sex work. Some participants reported getting hormones from friends who were already on hormones and others discussed crossing the border in Mexico gain access to Trans Related care.

"Feeling aligned with oneself physically has a large impact mentally and socially for us to thrive."

SERVICES ACCESSED IN THE LAST 12 MONTHS

The graph below shows the services that participants have accessed in the past 12 months.



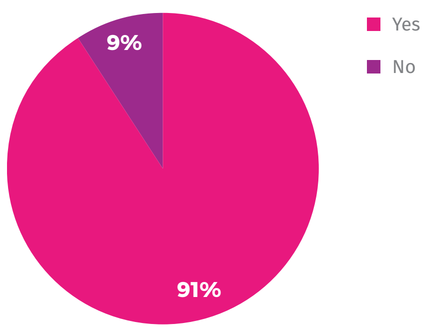
Services Accessed (12 Months) Data Analysis

As mentioned above many participants have access to health care through Medi-Cal or Medicaid. A large amount of other participants have access to other forms of public health programs because of their HIV status. A total of 39 participants reported being HIV positive and receiving health insurance through Medi-Cal or another public program. For participants, who are not HIV positive or are not citizens, it may be very difficult to get the medical care you need.

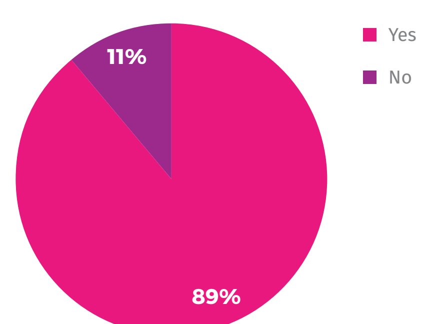
SEXUAL HEALTH

DO YOU USE PROTECTION WHEN ENGAGING IN SEXUAL ACTIVITY?

This section captures a snapshot of the sexual health of Trans Latin@s.



DO YOU KNOW WHERE TO LEARN ABOUT SAFE SEX PRACTICES?



Safe Sex Data Analysis

Participates where asked if they practice safe sex when they engage in sexuality activity, including penetration and oral, and over **90% of participants** reported that they do **use protection**.

92% of participants said that they feel knowledgeable about practicing safe sex.

89% of participants know where to learn about safe sex.

“By using protection I am respecting myself and my body.”

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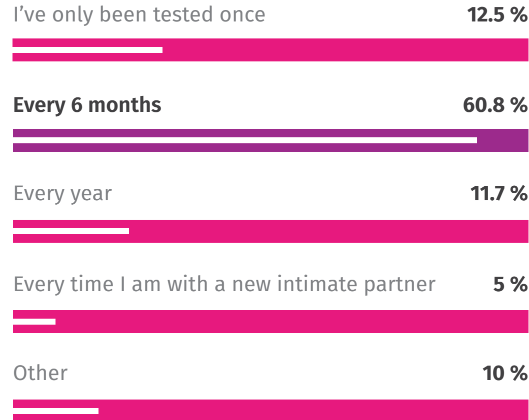
HIV & STD TESTING FREQUENCY

Participants were asked how often they get tested for HIV and STDs.



Testing Frequency Data Analysis

A **majority** of participants reported that they get **tested every six months**.

For those who reported other, most commonly they were tested every three months.

REASON FOR NOT GETTING TESTED FOR HIV

Participants were asked about possible reasons for why they may not be going to get tested for HIV.

I feel healthy 44.9 %

I always practice safe sex 40.6 %

I don't know where I can get tested 1.4 %

I don't want to experience shame 2.9 %

I'd rather not know 1.4 %

Other 8.7 %

Reason for Not Getting Tested Data Analysis

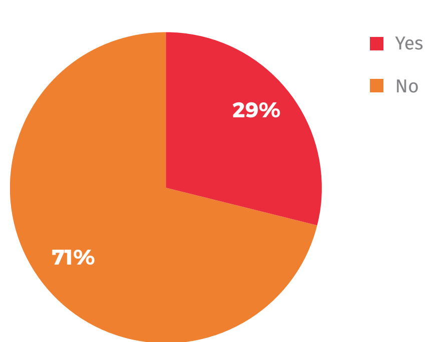
Majority of participants reported that they either felt healthy (44%) or they always practice safe sex (40.6%) so there would be no need to get tested.

A much smaller percentage mentioned not knowing where to get tested (1.4%), feeling shame (2.9%) and not wanting to know (1.4%).

MENTAL HEALTH

GENDER RELATED DIAGNOSIS

The section below is a snapshot of how Trans Latin@s fare when it comes to their mental health.



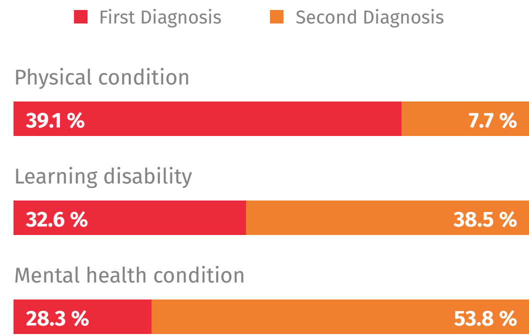
Mental Health Diagnosis Data Analysis

Mental health is important for our emotional, psychological and over all well-being. Getting the mental health care needs that Trans Latin@s need may be challenging to access due to their lack of health insurance, Trans sensitive care providers and groups, and financial resources.

Only 35 participants (28.7%) have been diagnosed with a gender related mental health issue. 87 participants (71.3%) mentioned that they have not been diagnosed with a gender related mental health issue.

MENTAL/PHYSICAL DISABILITY

Participants were asked if they had any non-gender related diagnosis, including mental health condition, physical disability, or learning disability.



Mental/Physical Disability Data Analysis

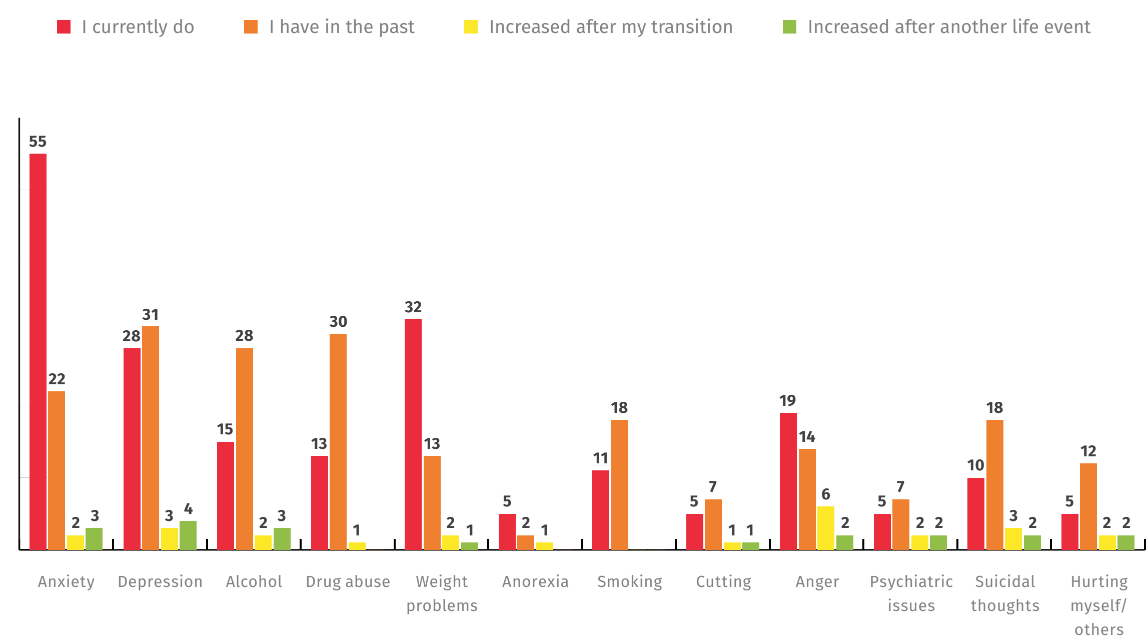
A total of 31% reported that they did have another diagnoses. Some participants have multiple diagnoses; the graph below shows percentage of first diagnoses, and second diagnoses for participants.

"It's important for me to have access to mental health, because I have depression, anxiety and many other things. Therapy and medication help me a great deal."

"HAVING ACCESS TO MENTAL HEALTH HELPS ME TO SEE, UNDERSTAND, AND ACCEPT THE DIFFERENT SITUATIONS AND ADVERSITIES IN MY LIFE. IT HELPS ME TO FIND AND REACH A PLACE OF BALANCE AND PEACE."

WHAT DO YOU STRUGGLE WITH?

Participants were asked if they were struggling with any of the following.



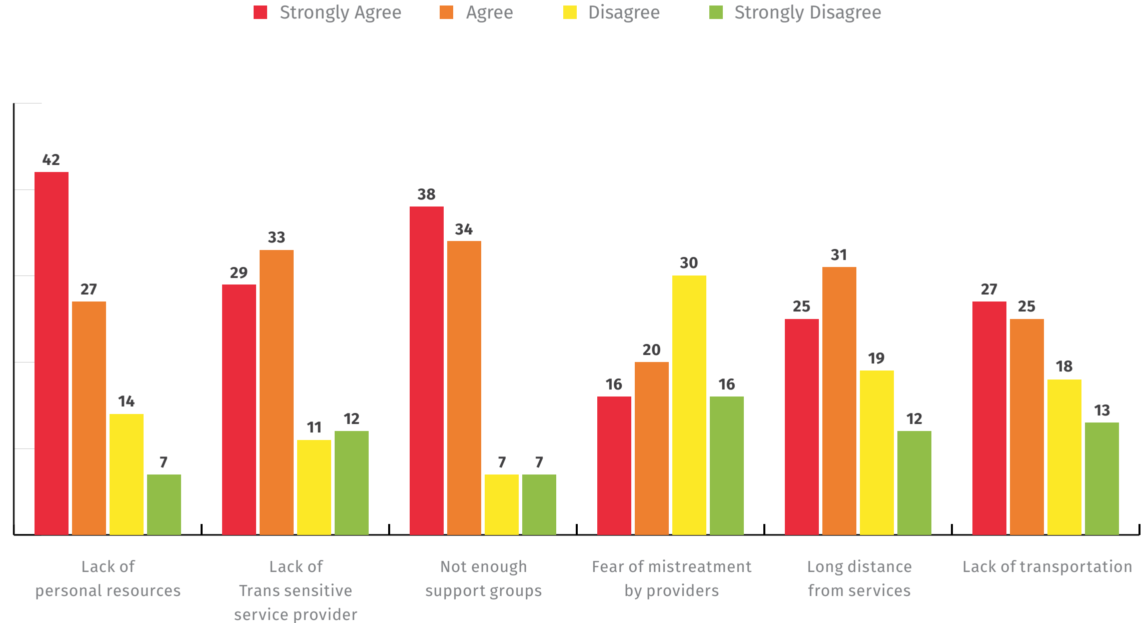
Struggles Data Analysis

A total of 42% participants reported that they currently struggling with anxiety. Overall, 49% of participants are reported receiving assistance for their current struggle listed below, while 51% are not getting the care they need.

MENTAL HEALTH (CONTINUED)

REASONS WHY MENTAL HEALTH NEEDS ARE NOT BEING MET

Participants were asked about reasons for why they may not be getting the mental health care they need.



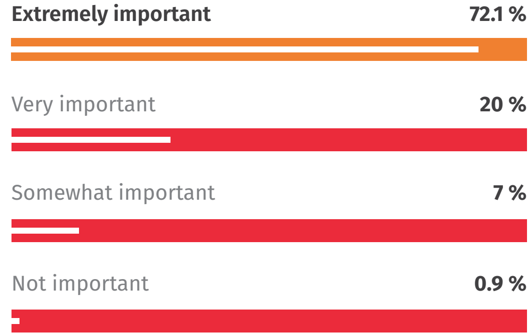
Mental Health Reasons Data Analysis

Lack of personal resources, not enough support groups available, and long distances to services stand out as the main reasons for why Trans Latin@s are not receiving the mental health care they need.

"It's important for me to have access to mental health, because I have depression, anxiety and many other things. Therapy and medication help me a great deal."

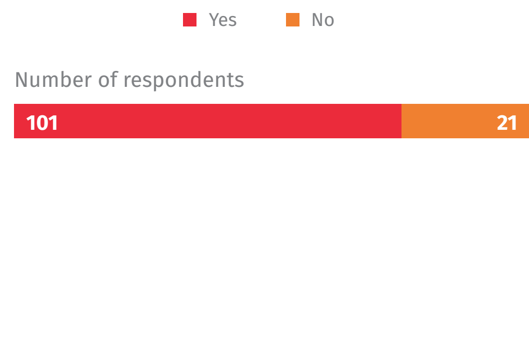
IMPORTANCE OF MENTAL HEALTH

Mental healthcare is either extremely important (72.1%) or very important (20%) the Trans Latin@ community.



DO YOU HAVE A SUPPORT SYSTEM?

We asked participants if they had a social support system, including friends, family, other Trans friends, etc that they could rely on.



"ACCESS TO MENTAL HEALTH SERVICES HELPS ME COPE WITH MY STRESS AND ANY DEPRESSION, DYSPHORIA, AND BAD THOUGHTS I MIGHT HAVE."

Support System Data Analysis

For the **82% of participants** that indicated they **had someone in their life they felt supported by**, most often it was a family member, partner, friends, Trans support group, another Trans friend(s), and/or co-workers.

or many participants reported that having a support system helps with their mental health. Often times support goes beyond emotional mental well-being, and support from friends and family entail providing a place to stay and food to eat.

SPIRITUAL SERVICES

SPIRITUAL AFFILIATION

The section addresses the role of spirituality in Trans Latin@s lives.

Affiliation	Percent
Christian	**56.7 %**
Other Non-Christian faith	16.7 %
Unaffiliated	23.3 %
Don't know	3.3 %

HOW IMPORTANT ARE SPIRITUAL SERVICES TO YOU?

Response	Percent
Extremely important	**54.2 %**
Very important	18.3 %
Somewhat important	13.3 %
Not important	14.2 %

Spiritual Data Analysis

Spiritual services prove to be something that is very important for the Trans Latin@ community and it is often tied to their overall health and well being.

The majority of Trans Latin@s report being affiliated to a Christian faith, while 23.3 are unaffiliated to any religious institution.

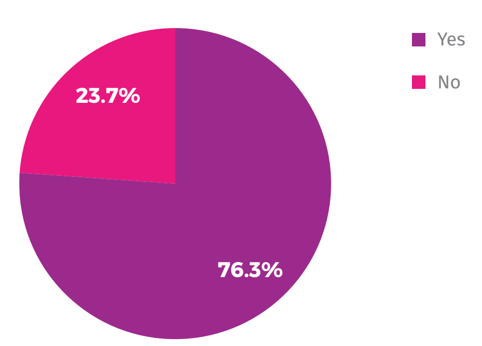
A total of 16.7% of participants reported practicing something other than Christianity, including Santeria, Native American practices, Buddhism and Judaism.

Close to 73% of participants reported that spiritual services are either extremely important or very important to them. Accordingly, 66.4% of participants mentioned that they do not need to hide who they are because of their religion.

Lastly, 68.2% participants feel welcome and accepted by their religion.

"MY BUDDHIST PRACTICE HAS EXTREMELY HELPED ME AND PULLED ME OUT OF MY DEPRESSION AND HAS LESSENED MY ANXIETY. IT HAS GIVEN ME THE CONFIDENCE AND ABILITY TO LOVE MYSELF."

IS SPIRITUALITY IMPORTANT TO YOUR OVERALL HEALTH?

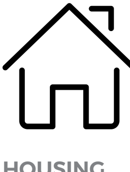


Importance of Spirituality Data Analysis

When asked if spirituality is important to your overall health, a total of **90 participants** (76.3%) responded that **spirituality was important** to their overall health and well being.

"...[My church] gives me hope... I get all the support in this Church. I'm blessed with God and having people that care NOW...just the hugs we get, the conversations that picks me up and keeps me moving...So I'm okay."

RECOMMENDATIONS



HOUSING

HOUSING IS AN ESSENTIAL NEED FOR ANYONE TO BE ABLE TO HAVE A DECENT LIFE. EMERGENCY HOUSING THAT LEADS TO STABLE PERMANENT HOUSING IS SOMETHING THAT IS VERY MUCH NEEDED FOR TRANS LATIN@S. ACCESS TO STABLE AND PERMANENT HOUSING WILL ALLOW TRANS LATIN@S TO BE HEALTHY INDIVIDUALS, THEREFORE ENSURING A HIGHER QUALITY OF LIFE. THE FOLLOWING ARE OUR RECOMMENDATIONS FOR HOUSING:

- We recommend that legislators and policy makers fund an emergency shelter in key area(s). An emergency shelter will support Trans Latin@s in Southern California to start a path toward a healthy way of living. Having an emergency shelter will support Trans Latin@s in finding a safe place to deal with whatever they may be going through. Safe and secure housing for Trans Latin@s will reduce stress related to being homeless. It can eliminate other potential health risks such as the involvement in the sex trade for survival, and lessen the incidents of HIV and STDs among Trans Latin@s.

- Intentionally invest and develop transitional housing programs that will support Trans Latin@s to attain stability. A transitional housing program can provide the opportunity for Trans Latin@s to learn technical skills that will support them to get jobs and long term stability. These transitional housing programs should be of one to two years maximum depending on the needs of the individual. Transitional housing programs are a path for a permanent housing opportunities and programs and must be available for Trans Latin@s in key areas in Southern California.

- Government and service providing agencies, government elected officials and policy makers, must intentionally invest in permanent and affordable housing opportunities for Trans Latin@s residing in Southern California. Local Latin@, social justice, housing rights, immigrant and Trans organizing groups, must continue to organize and demand permanent housing opportunities to be met for Trans Latin@s in Southern California. In order for housing disparities to be addressed, organizing groups, agencies (both government and service providing) must work together to ensure Trans Latin@s become healthy through permanent housing.

EMPLOYMENT

EMPLOYMENT IS ONE OF THE BASIC NECESSITIES FOR PEOPLE TO HAVE A WAY TO SUSTAIN AND TO THEMSELVES AND ACQUIRE BASIC NEEDS. FOR TRANS LATIN@S, HAVING EMPLOYMENT OPPORTUNITIES IS VERY CHALLENGING BECAUSE OF THE CONTINUOUS DISCRIMINATION THEY FACE AS A COMMUNITY. THESE RECOMMENDATIONS ARE POSSIBLE WAYS TO ADDRESS THE EMPLOYMENT DISPARITIES AMONG TRANS LATIN@S IN SOUTHERN CALIFORNIA:

- The State of California Workforce Development Board must fund Trans led organizations and programs in Southern California to work with workforce development agencies to provide training and capacity building on Trans culture and inclusivity.

- The California State Workforce Development Board must mandate all workforce development centers and government agencies that they fund, (city and county) to take a minimum of eight (8) hours of Trans cultural sensitivity trainings to be able to understand issues related to Trans individuals. These trainings must be taken at least once a year and must receive some type of acknowledgment documenting that they had received this training. This should be part of their annual review and agency requirements to be able to obtain funding from the State of California Workforce Development Board.

- The California Workforce Development Board must allocate funding to work with Trans led groups and organizations to develop the work force and technical abilities in Trans Latin@ communities to gain skills and obtain jobs in different industry sectors.

- Local Workforce development agencies must obtain training on Trans sensitivity and inclusivity in the workplace. Local Workforce development boards have the ability to fund and contract with local Trans led groups and organizations to be able to do these trainings.

- Workforce development centers and nonprofit organizations must develop programs that support Trans Latin@s in attaining employment. These agencies must develop relationships with different industries to be able to have an array of employment options for Trans Latin@s in Southern California

MEDICAL HEALTH

MEDICAL HEALTH PERTAINS TO ONE'S OVERALL PHYSICAL HEALTH. HISTORICALLY, TRANS PEOPLE HAVE BEEN PATHOLOGIZED IN THE MEDICAL ESTABLISHMENT. AS A RESULT, TRANS PEOPLE HAVE OFTEN BEEN DISCRIMINATED AGAINST WHEN TRYING TO ACCESS BASIC MEDICAL NEEDS. THESE ARE OUR RECOMMENDATIONS RELATED TO THE MEDICAL HEALTH FOR TRANS LATIN@S:

- An individual's gender may not "align" with the patient's genitalia, we ask that medical practitioners and staff respect the dignity of each patient, and ask patients to identify their preferred gender identity.
- Develop and pass legislation that supports Trans Latin@s to cover expenses when accessing emergency rooms, clinics or hospitals.
- Intentionally allocate funding streams to provide training to doctors and staff on Trans health to be able to provide culturally competent healthcare to Trans Latin@s and their needs. We highly recommend that at least on person who is knowledgeable about Trans health care and is bilingual be scheduled to work at any given shift.
- Create and develop a statewide standard training curriculum to be used to train in medical schools, emergency rooms, and in hospitals about Trans Latin@s health.
- Educate and train Trans Latin@s in Southern California about their rights when it comes to medical care so that Trans Latin@s can empower themselves on how to advocate for themselves on their rights in the medical establishment
- Develop programs related to sexual health for Trans Latin@s that can be integrated into their HIV prevention programs.
- Create programs in clinics or medical services that provide transportation services to Trans Latin@s in Southern California so that they can have better accessibility to basic medical services.
- Develop programs that will support Trans Latin@s with dental health care and hygiene.
- Develop programs and services that could provide medicinal alternatives for Trans Latin@s in Southern California.

SEXUAL HEALTH

SEXUAL HEALTH IS AN IMPORTANT COMPONENT OF A PERSON'S QUALITY OF LIFE. IT IS SHAPED BY MANY FACTORS THAT INCLUDE PHYSICAL, SOCIAL AND MENTAL WELL-BEING. FOR TRANS LATIN@S SEXUAL HEALTH CAN BE PUT AT RISK DUE TO TRYING CIRCUMSTANCES .

» Sexual health care providers should be trained on cultural competence and non-discrimination. Clinics and sexual health providers should be trained in Trans appropriate care and inclusivity.

» Providers should create gender inclusive services to Trans individuals.

» An individual's gender may not "align" with the patient's genitalia, we ask that sexual health care providers and staff respect the dignity of each patient, and ask patients to identify their preferred gender identity.

» Intentionally allocate funding streams to provide training to sexual health care providers to provide culturally competent healthcare to Trans Latin@s and their sexual health needs. We highly recommend that at least on person who is knowledgeable about Trans sexual health and is bilingual be scheduled to work at any given shift.

MENTAL HEALTH

MENTAL HEALTH IS ONE OF THE ISSUES THAT AFFECT MANY PEOPLE. THE CALIFORNIA HEALTH CARE FOUNDATION STATES THAT AT LEAST 1 IN 20 INDIVIDUALS IN CALIFORNIA SUFFER FROM MENTAL HEALTH ILLNESS . ALTHOUGH THERE IS NO SPECIFIC INFORMATION ABOUT TRANS INDIVIDUALS IN CALIFORNIA AND ISSUES RELATED TO THEIR MENTAL HEALTH NEEDS, WE ARE PROVIDING RECOMMENDATIONS FOR CONSIDERATION BASED ON THE RESULTS OF THIS REPORT. THESE ARE OUR RECOMMENDATIONS:

- We recommend that legislators and policy makers intentionally allocate funding to pursue research on the mental health needs and issues related to Trans individuals in the state of California.
- Anxiety is one of the issues that affect Trans Latin@s in Southern California. We recommend that local mental health departments work with local Trans led groups and organizations to provide mental health services and counseling to Trans Latin@s.
- Look at alternatives programming that will support Trans Latin@s in lowering their levels of anxiety. Such as art programs like painting, theater, spoken word, etc.
- Creation of programs around smoking cessation targeting Trans Latin@s in Southern California. Programs should include culturally competent Trans Latin@ counseling sessions and providing strategies for reducing smoking habits.
- We recommend the creation of support groups that are Trans led by Trans led organizations so that members of the Trans Latin@ community can see themselves reflected. We need to develop Trans Latin@s leaders so that they can lead the proposed support groups. This is crucial because Trans Latin@s stated that having peer support is very important to them.
- Trans Latin@s need to have mental health services that are easily accessible to get to. Mental health services must be Trans competent and sensitive. Having easy access to mental health services would add to the support network that Trans Latin@s have.

[5] California Health Care Foundation: http://www.chcf.org/publications/2013/07/data-viz-mental-health

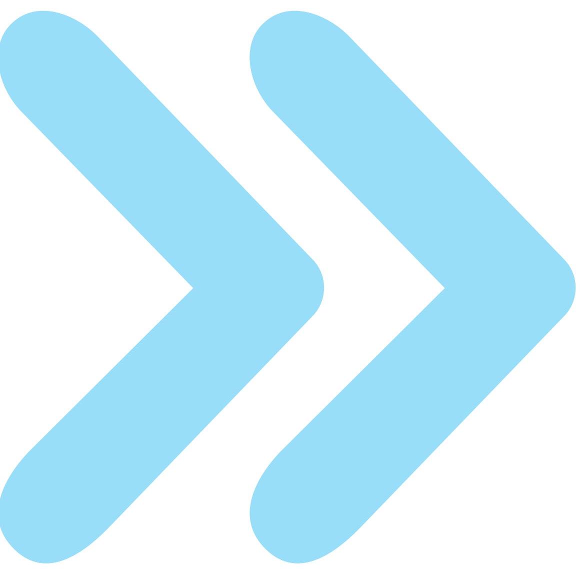
SPIRITUAL HEALTH

"RELATED TO SPIRITUALITY IS THE POWER OF HOPE AND POSITIVE THINKING."[6] IN THIS REPORT, SPIRITUAL SERVICES WERE EXTREMELY IMPORTANT TO TRANS LATIN@S. SPIRITUALITY IS OFTEN ASSOCIATED WITH HEALING AND EMPOWERING INDIVIDUALS WHO EXPERIENCE TRAUMA. THESE ARE SOME OF OUR RECOMMENDATIONS:

- Create and develop programs that have a spiritual component to them. Integrating spiritual components into social services and health care settings will support Trans Latin@s to see themselves represented in a different way.
- Trans Latin@s must be well informed about the spiritual services that exist and where they are welcome, such as LGBTQ specific churches, as well as other denominations. While a good percentage of Trans Latin@s feel welcome in their place of worship, many stated that they do not feel welcome.
- We recommend that service providers work together with LGBTQ spiritual leaders in the Southern California area to bridge their services to Trans Latin@s who feel marginalized or isolated from spirituality.

[6] Puchalski, Christina M. (2001) "The Role of Spirituality in Health Care." Proceedings (Baylor University. Medical Center) 14.4: 352–357. Print.

FUTURE RESEARCH



- We recommend that organizations and institutions of higher learning continue to provide support for additional research projects in order to access a wider range of Trans Latin@ participants. It is important to assess additional needs and perspectives of this diverse community so that service providers and policy makers get a better understanding of the needs of this community. Our hope is that members of the community can access much needed resources in order to improve their quality of life and health.

- We recommend that scholars conduct further research in areas such as family acceptance, HIV incidence and prevalence, matters that contribute to depression and suicide, the impact of sex work on the lives of TransLatin@s, the role of sexual health and pleasure in the lives of Trans Latin@s, reproductive health, as well as look to experiences of Latin@ transmen.

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SURVEY APPENDIX

TRANS LATIN@S IN SOUTHERN CALIFORNIA: SURVEY PROTOCOL

1. What is your age?
   - ☐18-24
   - ☐25-34
   - ☐35-44
   - ☐45-54
   - ☐55-64
   - ☐65+
2. What is your zip code?
   Zip: ____________
3. Do you consider yourself Latina/o?
   - ☐Yes
   - ☐No
   - ☐Other: ___________________________
4. What is your U.S. Citizenship status?
   - ☐U.S. Citizen
   - ☐Documented non-citizen
   - ☐Undocumented non-citizen
5. If you did migrate, how long have you been in the U.S.?
   __________years
6. If applicable, what country/countries did you or your families migrate from?
7. Which sex was assigned to you at birth, on your birth certificate?
   - ☐Male
   - ☐Female
8. How do you identify now?
   - ☐Male/man
   - ☐Female/woman
   - ☐Trans
   - ☐Transgender
   - ☐Transwoman
   - ☐Transman
   - ☐Other: __________________________
9. People can tell I am transgender/gender non-conforming even if I do not tell them?
   - ☐Always
   - ☐Most of the time
   - ☐Sometimes
   - ☐Occasionally
   - ☐Never
10. How many people know that you are transgender?

	None	A few	Some	Most	All	Not applicable
At home	☐	☐	☐	☐	☐	☐
On the job	☐	☐	☐	☐	☐	☐
At school	☐	☐	☐	☐	☐	☐
In private social setting	☐	☐	☐	☐	☐	☐
In public social settings	☐	☐	☐	☐	☐	☐
When seeking medical care	☐	☐	☐	☐	☐	☐

11. To the best of your ability, please estimate the following ages. If it does not apply to you, or you have no desire to transition, mark "N.A." for not applicable.

	Age in Years	N/A
a. Age you first recognized you were different in terms of your gender.		☐
b. Age you began to live part time as a transgender/gender non-conforming person		☐
c. Age you began to live full time as a transgender/gender non-conforming person.		☐
d. Age that you first got any kind of transgender-related medical treatment.		☐

12. For each of the following documents, please check whether of not you have been able (allowed) to change the documents or records to reflect your current gender. Mark "N/A" if you have no desire to change the gender on the document list.

	Yes, changes allowed	No, changes denied	My legal status does not allow me	Not tried	N/A
Birth certificate	☐	☐	☐	☐	☐
Drivers License and/or state issues non-driver ID	☐	☐	☐	☐	☐
Social security records	☐	☐	☐	☐	☐
Passport	☐	☐	☐	☐	☐
Work ID	☐	☐	☐	☐	☐
Military discharge papers (DD 214 or DD 215)	☐	☐	☐	☐	☐
Health Insurance Records	☐	☐	☐	☐	☐
Student records	☐	☐	☐	☐	☐
Professional licenses or credentials	☐	☐	☐	☐	☐

13. What is the highest level of education you have completed (either in the U.S. or country of origin)?
    - ☐ No formal education
    - ☐ Elementary School
    - ☐ Some high school
    - ☐ High school graduate –HS Diploma or equivalent (GED)
    - ☐ Some college credit
    - ☐ Technical school degree (such as cosmetology, computer technician, or mechanic)
    - ☐ Bachelor's Degree
    - ☐ Associate's Degree (AA, AS)
    - ☐ Master's Degree (MA, MS, ME, Med, MSW, MBA)
    - ☐ Professional Degree (Md, DDS, DVM, JD)
    - ☐ Doctorate Degree (PhD, EdD)
    - ☐ Other:____________________
14. What is your **individual** income (before taxes)?
    - ☐ Less than $10,000
    - ☐ $10,000 to $19,999
    - ☐ $20,000 to $29,999
    - ☐ $30,000 to $39,999
    - ☐ $40,000 to $49,999
    - ☐ $50,000 to $59,999
    - ☐ $60,000 to $69,999
    - ☐ $70,000 to $79,999
    - ☐ More than $80,000
15. How many individuals currently rely/depend on your income? (Mark all that apply)
    - ☐ My child/children, if so how many: ____________
    - ☐ My parent(s), if so, how many: ______________
    - ☐ My sibling(s), if so, how many: ______________
    - ☐ Other relatives under 18, if so how many: ________
    - ☐ Other relatives over 18, if so how many: _________
    - ☐ Friend(s), if so how many: ___________________
    - ☐ Spouse/Partner

☐Other: ____

16. What is your sexual orientation?
    - ☐Heterosexual
    - ☐Homosexual
    - ☐Bisexual
    - ☐Asexual
    - ☐Auto sexual
    - ☐Other:________________________
17. What is your relationship status?
    - ☐Single
    - ☐Partnered
    - ☐Domestic Partnership
    - ☐Civil Union
    - ☐Married
    - ☐Separated
    - ☐Divorced
    - ☐Widowed
    - ☐Other: __________________
18. What is your current living situation?
    - ☐Homeless (This includes if you are sleeping on a friends couch)
    - ☐Living in a shelter
    - ☐Living in a group home facility
    - ☐Living in a nursing/adult care facility
    - ☐Living on campus/university
    - ☐Living with parents or family you grew up with
    - ☐Staying with friends or family temporarily
    - ☐Living with a partner, spouse or other person who pays for housing
    - ☐Living in house/apartment/condo | RENT alone or with other
    - ☐Living in house/apartment/condo | OWN alone or with others
19. If you are currently homeless, do you know where there is a shelter where you feel you will be respected for who you are and will sleep at peace tonight?
    - ☐Yes
    - ☐No

    If yes, please tell us the name of this place
20. Have you been homeless in the past 12 months? (being homeless means sleeping at a friend's couch, or temporarily staying at someone's house that is not your permanent place of living)
    - ☐Yes
    - ☐No
21. If you have experienced homelessness in the past 12 months, please briefly tell us what caused you to be homeless: Please explain below
22. If you are or have experienced homelessness, what do you need order to secure stable housing? Please explain below
23. Do you believe that having stable housing is important to your health?
    - ☐Yes
    - ☐No

    Please explain why **it is** important or why **is not** important.
24. What is your current employment status? (Mark all that apply)
    - ☐Full-time
    - ☐Part-time
    - ☐More than one job
    - ☐Self-employed, own your business
    - ☐Unemployed but looking
    - ☐Unemployed and stopped looking
    - ☐On disability
    - ☐Retired
    - ☐Other, please specify:___________________
25. If you are currently employed please describe your work or vocation:
26. If you do not have what is typically called employment, please describe how you sustain yourself.
27. Do you have employment that provides you with health care insurance

☐Yes
☐No

28. If you do have health insurance through your employer, does your insurance and/or doctor provide trans-related care and coverage?
    ☐Yes
    ☐No
29. If yes, please explain what your insurance covers under trans related care.
30. Do you believe that having permanent employment is important to your overall health?
    ☐Yes
    ☐No
    Please explain why you think having employment **is important** to your health or why is **not important** to your health.
31. Please describe what would be the ideal job that you would like to have in the next three years.
32. What type of health insurance do you have? If you have more than one type of coverage, check the one that you usually use to cover doctor and/or hospital bills.
    ☐I have NO health insurance coverage
    ☐Insurance through a current or former employer (employee health plan, COBRA, retiree benefits)
    ☐Insurance through someone else's employer (spouse, partner, parents, etc.)
    ☐Insurance you or someone in your family purchased
    ☐Medicare
    ☐Medicaid/Medi-Cal
    ☐Military health care/Champus/Veterans/Tri-Care
    ☐Student insurance through college or university
    ☐Other public (such as state or county level health plan, etc.)
    ☐Other, please specify:_______________________________
33. Are currently enrolled in health insurance through Covered California?
    ☐Yes,
    ☐No
    If no, why not?
34. What kind of place do you go to most often when you are sick or need advice about your health?
    ☐Emergency room
    ☐Private Doctor's office
    ☐Health clinic or health center that my insurance pays for
    ☐Free health clinic
    ☐V.A. (veteran's) clinic or hospital
    ☐Alternative medicine provider (acupuncture, herbalist), specify: _______________
    ☐Not applicable, I do not use any health care providers
    ☐Other: ____
35. The following are a list of possible reasons why you may not get the health care you need. Based on your own situation, please rate your agreement or disagreement.

	Strongly agree	Agree	Disagree	Strongly disagree	N/A
a. Lack of personal resources	☐	☐	☐	☐	☐
b. Clinics having fear about Trans people or dislike of Trans people	☐	☐	☐	☐	☐
c. Lack of health professionals adequately trained to deliver healthcare to Trans people	☐	☐	☐	☐	☐
d. Long distances to Trans sensitive medical care facilities	☐	☐	☐	☐	☐
e. Doctors and other healthcare workers who refuse to provide services to Trans people	☐	☐	☐	☐	☐
f. Fear that if medical personnel find out I'm Trans, they will treat me different	☐	☐	☐	☐	☐
g. Lack of transportation to get to the services I need	☐	☐	☐	☐	☐

36. Please mark below the overall medical services that you have had access to in the past 12 months.

	Yes, I paid out of pocket	Yes, my insurance covers	No, Was unable to access	Do not know what this is
Annual Physical Exam				
Routine Prescriptions				
Dental Care				
Routine Medical Screening				
Emergency Room Visits				
Vision Care				
Routine Hospitalization				
Specialist Care				
Gynecological Care				
HIV Care				
High blood pressure				
Cardiologist				
STD testing				
Dermatologist				
Nutritionist				
Foot doctor				
X-Rays				
Surgeries (what type: write in below)				
Endocrinologist				

Other (please specify): ____

37. Please mark below if you received or want to receive health care related to being transgender/ gender non-conforming. If you have no desire to do so, please mark not applicable.

	Do not want it	Want it someday	Have had it	Not applicable
Counseling	☐	☐	☐	☐
Hormone Treatment	☐	☐	☐	☐
Top/chest/breast surgery (chest reduction, enlargement, or reconstruction)	☐	☐	☐	☐
Male-to-female removal of the testes (orchiectomy,	☐	☐	☐	☐
Male-to-female genital surgery (vaginoplasty; removal of penis and creation of a vagina, labia, etc.)	☐	☐	☐	☐
Female-to-male hysterectomy (removal of the uterus and/of ovaries)	☐	☐	☐	☐
Female-to-male genital surgery (clitoral release/metiodioplasty/creation of testes)	☐	☐	☐	☐
Female-to-male phalloplasty (creation of penis)	☐	☐	☐	☐
Facial cosmetic surgery	☐	☐	☐	☐
Electrolysis	☐	☐	☐	☐

38. If you have marked had any of the procedures done in Question 37, please tell us how you have/ or are you accessing those services:
39. Do you believe that having access to the procedures listed above (Question 37) are important for your overall wellbeing?
    - ☐Yes
    - ☐No

    a. Please explain why yes **it is important** or why not, is **not important**?
40. Do you believe that having access to a doctor on a regular basis is important to your health?
    - ☐Yes

☐No

a. Please explain why yes **it is important** or why not, is **not important**?

41. How important is it to you to have a regular doctor that supports your health goals?
    ☐Extremely Important
    ☐Very Important
    ☐Somewhat important
    ☐Not important at all, I can be healthy even if I don't have a regular doctor
42. Do you use protection when engaging in sexual activity (penetration/oral)?
    ☐Yes
    ☐No
    a. Why or why not
43. Do you feel knowleagble about practicing safe sex?
    ☐Yes
    ☐No
44. Do you know where to learn about safe sex practices?
    ☐Yes
    ☐No
45. Have you ever been tested for HIV and STDs?
    ☐Yes
    ☐No
46. If yes, how often do you get tested for HIV and STDs?
    ☐I've only been tested once
    ☐Every six months
    ☐Every year
    ☐Every time I am with a new intimate partner
    ☐Other:______________________________
    a. If yes, where do you go get tested for HIV and STDs?
47. Have you not been tested for HIV because of any of the following reasons (mark all that apply.)
    ☐I feel healthy
    ☐I always practice safe sex
    ☐I don't know where I can get tested
    ☐I don't want to experience shame
    ☐I'd rather not know my status
    ☐Other:____________________
48. What is your HIV status?
    ☐HIV positive
    ☐HIV negative
    ☐Don't' know
49. If you are HIV positive, are you currently receiving treatment?
    ☐Yes
    ☐No
50. If you are receiving treatment, is it covered by your insurance?
    ☐Yes
    ☐No
51. If you don't have insurance, how are you obtaining HIV treatment/prescriptions?
52. Have you ever received a gender-related mental health diagnosis?
    ☐No
    ☐Yes. My diagnosis is:_____________________________
53. Not including a gender-related mental health diagnosis, do you have a disability (physical, learning, mental health) that substantially affects a major life activity?
    ☐Yes
    ☐NO
54. If yes, what is your disability? (Mark all that apply.)
    ☐Physical condition
    ☐Learning disability
    ☐Mental health condition
55. Have you ever been a victim of domestic violence or intimate partner violence because of being transgender?
    ☐Yes

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☐No

56. Do you struggle with any of the following to cope?

	I currently do	I have in the past	This increased after my transition	This increased after another life event (job loss, death, etc)	Not applicable
Anxiety					
Clinical or severe depression					
Alcohol abuse					
Drug abuse					
Weight problems					
Anorexia					
Auto-immune problems					
Smoking					
Cutting					
Anger					
Psychiatric issues					
Thoughts of Suicide					
Hurting myself or others					
Other:					

57. For those boxes that you marked and you are currently struggling with, are you getting any assistance/ help?
    ☐Yes
    ☐No
58. If not, would you like to get a referral?
    ☐Yes
    ☐No
59. The following are a list of possible reasons why you may not get the mental health care you need. Based on your own situation, please rate your agreement or disagreement.

	Strongly agree	Agree	Disagree	Strongly disagree	N/A
a. Lack of personal resources	☐	☐	☐	☐	☐
b. Long distances to Trans sensitive mental health care facilities	☐	☐	☐	☐	☐
c. Fear that if mental health professionals find out I'm Trans, they will treat me different	☐	☐	☐	☐	☐
d. Lack of psychologists, social workers, and mental health counselors who can help Trans individuals with mental health issues	☐	☐	☐	☐	☐
e. Not enough psychological support groups for trans people	☐	☐	☐	☐	☐
f. Lack of transportation to get to the services I need	☐	☐	☐	☐	☐

60. Please let us know of any barriers that may keep you from accessing mental health help and support.
61. Do you currently have a social supportive system (including friends, family, other trans friends, etc.)?
    ☐Yes
    ☐No
    a. If yes, please explain who is your social support system, if not please explain why you do not have a social support system currently
    b. How does the social supportive system you have in place impact your overall wellness?
62. Do you believe that having access to Mental Health services on a regular basis is important to your health?
    ☐Yes
    ☐No
    Please explain why yes, it **is important** or why you think is **not important**
63. How important is to you to have regular Mental Health services that supports you to be a healthy individual
    ☐Extremely Important

- ☐Very Important
- ☐Somewhat important
- ☐Not important at all, I can be healthy even if I don't have a regular mental health services

64. I partake in the following spiritual practices:
    - ☐prayer
    - ☐faith healing
    - ☐homeopathy
    - ☐magnetic therapy
    - ☐numerology
    - ☐astrology/horoscopes
    - ☐gem-stone/crystals
    - ☐Palmistry
    - ☐Tarot
65. My religious affiliation is (Mark all that apply)
    - ☐Christian
        - ☐Protestant
        - ☐Evangelical
        - ☐Mainline
        - ☐Catholic
        - ☐Orthodox Christian
        - ☐Mormon
        - ☐Jehovah's Witness
        - ☐Other Christian faith, please specify________________________
    - ☐Other Non-Christian Faiths
        - ☐Santeria
        - ☐Native American religions/practices
        - ☐Buddhist
        - ☐Jewish
        - ☐Hindu
        - ☐Muslim
        - ☐Other non-Christian faith, please specify: _________________________
    - ☐Unaffiliated
        - ☐Atheist
        - ☐Agnostic
        - ☐Nothing in particular (believe in a higher power)
    - ☐Don't know
66. Do you feel welcome and accepted by your religion and/ or place of worship?
    - ☐Yes
    - ☐No
67. Do you feel that you have to hide who you are because of your religion?
    - ☐Yes
    - ☐No
68. How important is to you to have regular spiritual/religious services?
    - ☐Extremely Important
    - ☐Very Important
    - ☐Somewhat important
    - ☐Not important at all, I can be healthy even if I don't have regular spiritual/religious services
69. Do you believe that having access to spiritual/religious services on a regular basis is important to your health?
    - ☐Yes
    - ☐No

    Please explain why yes or why not:
70. Anything else you'd like to tell us about your needs as a Latina/o trans/transgender person?

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www.translatinacoalition.org

/TRANSLATINACOALITION
@translatina_c

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WHITMAN-WALKER CLINIC, INC., *et al.*, *Plaintiffs,* v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, *Defendants*.	Case No. 1:20-cv-01630

DECLARATION OF ARIANNA INURRITEGUI-LINT,
EXECUTIVE DIRECTOR OF ARIANNA'S CENTER

I, Arianna Inurritegui-Lint, hereby declare:

1. I am a 47-year-old transgender woman, an immigrant, and a person living with HIV.

2. I was born and raised in Lima, Peru, where I studied to become a lawyer. Seeking refuge from the discrimination I faced as an LGBTQ person in Peru, I immigrated to the United States in 1999. I initially settled in the New York metro area, before moving to Florida in November 2001.

3. English is my second language.

4. I am an individual member and the East Coast Co-Chair of the TransLatin@ Coalition.

5. I am also the founder and Executive Director of Arianna's Center.

6. Arianna's Center is a community-based 501(c)(3) nonprofit organization that provides advocacy, education and training, case management and linkage to care for transgender

Latinx men and women in South Florida and Puerto Rico. Our mission is to engage, empower and lift up the transgender community, with special emphasis on the most marginalized, including the transgender Latinx community, undocumented immigrants, people living with HIV and AIDS, and those who have experienced incarceration.

7. Arianna's Center is an affiliated organization of the TransLatin@ Coalition, meaning that as the leader of Arianna's Center, I serve on the board of the TransLatin@ Coalition. The Coalition is able to amplify its resources on a national basis by working closely with its affiliated, trans-led organizations across the United States that provide direct services to transgender and gender nonconforming Latinx people.

8. I founded Arianna's Center in 2015 to engage, empower, and uplift transgender and gender nonconforming Latinx people living in South Florida. Since its founding in 2015, Arianna's Center has expanded the reach of the organization to include transgender people living in Puerto Rico through the opening of a satellite office.

9. I currently live in South Florida and spend large amounts of time in Puerto Rico for my work. Neither the State of Florida nor the Commonwealth of Puerto Rico have state or territorial protections from discrimination on the basis of gender identity, transgender status, sexual orientation, or failure to conform with sex stereotypes in health care.

10. I am submitting this Declaration in support of Plaintiffs' Motion for a Preliminary Injunction to prevent the revised regulation under Section 1557 of the Affordable Care Act ("ACA"), published by the U.S. Department of Health and Human Services ("HHS") on June 19, 2020 (the "Revised Rule"), from taking effect. The Revised Rule eliminates explicit regulatory

protections for LGBT people in health care that were included in the 2016 Final Rule, which was promulgated under Section 1557 in May 2016.

11. Arianna's Center provides a variety of direct services to transgender and gender nonconforming Latinx people, with a focus on those who are most vulnerable to experiencing harm. This focus includes sex workers, people experiencing homelessness, persons living with HIV, people suffering from addiction, and transgender Latinx people who are immigrants or may be undocumented. Some of the Center's clients are also individual members of the TransLatin@ Coalition.

12. Arianna's Center provides free mobile testing for sexually transmitted infections and HIV and matches clients to follow-up health care and prevention services. The Center also connects clients to safe and affirming general medical and mental health care in the South Florida and Puerto Rico communities.

13. Arianna's Center also provides case management to help clients secure legal name changes, legal gender marker changes, and referrals for other legal support. The Center also provides emergency safe housing for transgender people in distress and those recently released from incarceration and Immigration and Customs Enforcement ("ICE") detention.

14. Arianna's Center also provides a 24/7 hotline number for community members to access whenever an emergency situation arises. This service allows the Center to meet crucial and time-sensitive needs, like access to post-exposure prophylaxis ("PEP") medication in cases of recent HIV exposure, or community crisis intervention services for situations of intimate partner violence.

15. Arianna's Center also provides education and employment services, including scholarships for GED completion programs and technical school certifications and coaching for transgender people preparing to enter the formal workforce.

16. Many of the people Arianna's Center serves have faced discrimination in trying to access gender affirming medical care and health care related to HIV management and prevention. These patrons have also been turned away from receiving health care because of their limited English proficiency or because of doctors' personal biases about transgender people. As an openly transgender woman living with HIV, I have experienced persistent discrimination from both health care providers and insurers during my life.

17. When I first moved to the New York metro area from Peru, I worked as a cashier because my license to practice law did not transfer to the United States. Despite being secure in my identity as a transgender woman, and knowing the medical transition steps I needed and desired to take, my health insurance did not cover hormone replacement therapy or gender confirming surgery – an exclusion that the 2016 Final Rule prohibited and is now seemingly permitted by the Revised Rule. Like many transgender people, I could not afford these treatments out-of-pocket on my cashier's salary.

18. As a result of the limited income available to me as a transgender Latinx immigrant and the discrimination I faced from my health insurance company, I had to work as an escort in order to make sufficient income so that I could afford the gender affirming medical care I needed, including informal treatments, like silicone injections.

19. I saved a great deal of money during my time doing sex work in New York City and was able to move to Orlando, Florida a few months after September 11, 2001.

20. After arriving in Orlando, I opened a construction company and was able to purchase a home but still could not afford health insurance or the out-of-pocket costs for gender affirming medical care through licensed providers.

21. Due to the lack of nondiscriminatory health insurance coverage and lack of access to affirming health care providers, I had to access gender affirming medical treatments through informal and unlicensed channels, where I could pay reduced prices for breast augmentation and additional silicone augmentation. I also continued to access hormone replacement therapy through these same channels because when I met a health care provider to discuss this treatment, I was told I would need a year's worth of psychotherapy before I would be prescribed hormones and I could not afford the out-of-pocket costs for a year's worth of therapy that insurance would not cover.

22. It was around this time I learned I was HIV positive. I believe I was exposed to HIV through the silicone injections I was accessing because I was diligent about safer sex practices.

23. I now have to live with HIV for the rest of my life, due in large part to discriminatory barriers in health care and health insurance for medically-necessary care for transgender people like myself.

24. I have found that being a transgender woman living with HIV carries a double dose of stigma when trying to access health care or utilize health insurance coverage. When I tried to access health care through public clinics, I found that health care providers would ask me uncomfortable questions about how I contracted HIV and my identity as a transgender woman.

25. In order to avoid issues related to discrimination in health care, I started working as a volunteer with a public health clinic in Orlando to allow me to educate providers about how to respectfully treat transgender people and ensure that I would not be subjected to as much discrimination myself.

26. I worked as a volunteer with an Orange County Health Department-run clinic in Orlando from 2006 to 2008 and was hired on as a full-time employee from 2008 to 2014.

27. During my time as a clinic volunteer and employee, I observed many instances of nursing staff and administrative employees not treating transgender people with the respect and dignity that they deserve. I often intervened in situations of discrimination against transgender people and worked to educate health care providers about how to respectfully treat transgender patients. This included explaining the impact of legal and financial barriers transgender patients face and the different forms of discrimination we encounter.

28. For example, a staff member often misgendered or called transgender patients by their birth name, rather than their preferred name, also known as "deadnaming." "Misgendering" is when someone refers to a person as the wrong gender or uses language to describe a person that does not align with that person's affirmed gender. "Deadnaming" occurs when someone calls or refers to a transgender individual by the name that the individual was assigned at birth even though that person has chosen a new name consistent with their gender identity. These are verbal acts of discrimination against transgender and gender nonconforming individuals that stigmatize, dehumanize, and even "out" the individual to others in the vicinity. These acts of discrimination cause significant distress, undermine a person's identity and sense of self-definition, have negative impact on a person's self-esteem and sense of self, and expose

people to risk of physical or bodily harm.

29. More systemically, only one of the five doctors in the clinic would prescribe hormones to transgender patients, as the other doctors refused to provide gender affirming treatment. As a result, there was a huge backlog and waiting list for transgender patients because only one doctor could properly care for them; they would have to wait as long as a year because the only doctor that prescribed hormones was overwhelmed.

30. I have also experienced discrimination in healthcare outside of that clinic, simultaneously because of my transgender identity, my HIV status, and my limited proficiency with speaking English.

31. For example, on one occasion at an emergency room, a health care provider misgendered me and had difficulty understanding me because of my limited English proficiency. When the provider understood that I was HIV-positive, the provider accused me of withholding the information from her, even though that I had been trying to explain it to her, and then threatened to call the police on me. As a transgender woman and immigrant, such threats carry even more weight because transgender people of color and immigrants face disproportionate rates of police violence and misconduct. Moreover, as an immigrant, any interaction with law enforcement can have significant immigration consequences.

32. For many immigrants like myself, the importance of having forms written in languages besides English, as well as qualified interpreters who speak languages besides English, can mean the difference between being able to access health care and not.

33. My personal experiences as an immigrant and a transgender woman who speaks English as her second language motivated in large part my founding of Arianna's Center in 2015

in Ft. Lauderdale, Florida. Arianna's Center exists to support other transgender Latinx people who are navigating barriers to health care like I did, but also to help ensure that no one else has to experience life-altering discrimination in health care and health insurance.

34. For these reasons, I am very concerned about the negative impacts the Revised Rule will have on transgender, gender nonconforming, and Latinx people. I fear that, as a result of the Revised Rule, I will experience even more discrimination by health care providers and insurers because of my sex, transgender status, national origin, disability, LEP status or some combination of these characteristics.

35. This fear is compounded because I live in Florida and spend considerable time in Puerto Rico, neither of which have state-level antidiscrimination protections for LGBTQ people in health care. Without federal protections like the regulatory protections being eliminated by the Revised Rule, transgender people like me will have little recourse to address the health care discrimination we will likely face and will be deprived of the clear nondiscrimination guidance the 2016 Final Rule provides to health care providers and insurers.

36. Not only do I worry about the personal harm I will experience as a result of the Revised Rule, but I worry about the significant harm to the transgender and gender nonconforming Latinx people Arianna's Center serves in South Florida and Puerto Rico, as well as the ability of Arianna's Center to carry out its activities on behalf the community it serves and the diversion of the Center's already limited financial resources in order to respond to those harms.

The Revised Rule's Negative Effects on the Transgender Latinx People

37. Arianna's Center clients are primarily transgender and gender nonconforming Latinx people, who are immigrants to the United States and/or who are currently residing in Puerto Rico. Many of our clients are also living with HIV/AIDS. The Revised Rule invites health care providers to discriminate against individuals served by Arianna's Center because of their sex, gender identity, transgender status, national origin, and/or LEP status.

38. Many of Arianna's Center clients live in communities in which English is not the primary language spoken and many individuals served in these communities speak, read or write English less than very well.

39. Arianna's Center clients have also experienced, or fear they may experience, discrimination from health care providers and insurers based on their sex, gender identity, transgender status, national origin, LEP, disability, or some combination of these characteristics.

40. The Revised Rule threatens these clients by inviting discriminatory behavior by healthcare providers and insurers based on sex, transgender status, national origin, disability, LEP status, or a combination of these intersecting characteristics.

41. The findings of a 2018 Human Rights Watch report published in collaboration with help from Arianna's Center entitled, "Living At Risk: Transgender Women, HIV, and Human Rights in South Florida," help explain how and why the Revised Rule will cause even more harm to our clients living in South Florida and Puerto Rico. The report "Living At Risk" is attached to this declaration as **Exhibit A**.

42. The researchers of "Living At Risk" administered surveys with 125 questions to transgender women living in Miami-Dade and Broward counties, two counties with the highest rates of new HIV infection in the United States. The study found that despite already substantial

and year over year increases in government funding for HIV prevention medication and treatments through the Ryan White Act programs, transgender women living with HIV in Miami-Dade and Broward counties face significant discrimination and lack of access to necessary health care.

43. Many of the transgender women surveyed, a significant proportion of whom are Latinx, reported experiencing disrespect, harassment, and denial of services in health care settings. They also reported such experiences often result in avoidance of health care altogether.

44. With the help of Arianna's Center, Human Rights Watch performed more than 100 interviews with transgender women, local HIV service providers, and advocates like myself, which demonstrated the reality in South Florida that transgender women of color experience higher rates of HIV infection due to the intersecting risk factors of poverty and lack of health insurance coverage.

45. Of the transgender women surveyed, 45% had no health insurance. More than 63% reported income of less than $10,000 a year, and more than half were unemployed.

46. Without a doubt, a contributing factor to the high rate of underinsured transgender women of color in South Florida, many of whom are clients of Arianna's Center, is the State of Florida's refusal to expand Medicaid coverage under the Affordable Care Act, which would extend Medicaid coverage to adults without dependents.

47. As the findings of the "Living At Risk" report demonstrate, the Revised Rule's invitation to health care providers and insurers to discriminate against Arianna's Center clients based on sex, gender identity, transgender status, national origin, disability, and LEP status will

worsen the health and wellbeing of transgender people and of transgender women of color in particular.

48. With the Revised Rule's removal of nondiscrimination protections on the basis of sexual orientation, gender identity, and transgender status, Arianna's Center's vulnerable clients risk even greater unmet health care needs. These transgender and gender nonconforming people will likely delay necessary health care and preventative screenings due to fear of discrimination and will face reduced access to care as a result of discrimination. In addition, they will face barriers to coverage of gender affirming care because of the Revised Rule's guidance that insurers may exclude such care from coverage.

49. As Arianna's Center's clients and other transgender and gender nonconforming people avoid necessary, routine, and preventative health care for fear of discrimination, they will face an increase in preventable health problems which will severely impede their ability to work, maintain housing, and afford other material necessities.

50. Under the Revised Rule, Arianna's Center's clients will be forced to pay considerable out-of-pocket medical expenses because insurers refuse to pay for life-saving and medically necessary care.

51. Because of the desire to avoid discrimination the Revised Rule invites and encourages, Arianna's Center's clients in South Florida and Puerto Rico will likely seek informal medical care from unlicensed providers. This inevitable reality will create another nexus of physical harm, for which people will again avoid seeking licensed medical care for fear of discrimination, until their physical condition is most dire, creating lasting physical and mental harm.

52. Arianna's Center's clients are not just transgender or gender nonconforming Latinx people but also immigrants, people living with HIV/AIDS, and people who speak, read, or write English less than very well. These intersecting characteristics position them to experience increased harm from the Revised Rule's elimination of a single legal standard to govern the intersectional discrimination they may face. 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 identities are at issue. This change will have a particularly harmful effect because discrimination based on sexual orientation, gender identity, transgender status, national origin, disability, and LEP status does not occur in an identity vacuum.

53. The Revised Rule's removal of language access protections, such as notice and tagline requirements, will also make it much more difficult for Arianna's Center's clients to be aware of their rights, which language services are available, how to access such services and how to handle discrimination and other complaints.

54. Arianna's Center has heard from clients that verbal and written interpretation services at medical appointments and in insurance coverage documents and communications remove an intimidating barrier to accessing preventative and necessary health care services.

55. The removal of language support services will likely cause individuals to delay seeking treatment for health conditions until they have attained a certain level of English proficiency, which will worsen underlying health issues as well as create additional complications requiring treatment.

56. Arianna's Center also understands that the Revised Rule attempts to change nondiscrimination regulations within the Center for Medicare and Medicaid Services ("CMS") to no longer prohibit discrimination on the basis of sexual orientation and gender identity.

57. This change, specifically to public health insurance programs, will significantly harm Arianna's Center's clients because many transgender and gender nonconforming people in South Florida and Puerto Rico rely on Medicaid or Medicare for their primary health insurance coverage. For example, according to a 2018 study, 39% of transgender women in South Florida receive health insurance coverage through Medicaid.

58. If nondiscrimination protections are removed from CMS through the Revised Rule, our clients who rely on public health insurance coverage through Medicare and/or Medicaid, will have reduced to no access to nondiscriminatory health care insurance coverage.

The Revised Rule's Harms to Arianna's Center

59. In addition to the harms to Arianna's Center's clients (some of whom are also individual members of the TransLatin@ Coalition), the Revised Rule will also harm Arianna's Center as an organization. As a small, community-based organization with only four staff members, Arianna's Center provides a panoply of services to the community with very limited resources. The discrimination the Revised Rule invites, the Revised Rule's direct harms, and the downstream effects of the Revised Rule will greatly affect our ability to meet our clients' needs and, given the resource diversion it will cause, undermine our ability to carry some of our critical programmatic services like our 24/7 emergency hotline, mobile sexual health testing, and providing safe emergency housing for transgender people in distress and those recently release from incarceration or immigration detention.

60. As a direct result of the Revised Rule, Arianna's Center will see a significant increase in requests for referrals to health care providers who will provide affirming and welcoming health care services. In turn, Arianna's Center will be required to divert additional resources, such as those used to provide for our GED and technical college scholarship programs to vet further additional health care providers, as the already-known affirming providers will become overwhelmed themselves.

61. This increase in referral requests for a limited number of providers who are affirming and welcoming will result in a substantial backlog in available providers and appointments. Many people whom Arianna's Center serves will therefore experience critical delays in receiving treatment for potentially serious health conditions because they will avoid seeing a provider who may discriminate against them based on their sex, transgender status, national origin, and/or LEP status.

62. Due to this delay in seeking treatment, many individuals will also face serious financial difficulties as they will have to pay for the expensive treatment required to address worsened health conditions and because of their inability to work while ill. As a result, Arianna's Center will be forced to divert significant financial resources away from other programs like our case management and employment coaching services to emergency support services, including housing support, mobile HIV testing and the 24/7 emergency hotline in order to meet increased and more serious demands. There is a real risk that Arianna's Center will run out of resources to provide these emergency services. These services will be necessary, however, given the increase in transgender people who will be out of work, and unable to pay rent or afford other material necessities as result of delayed treatment of serious or semi-serious health conditions.

63. Moreover, the COVID-19 pandemic has already put a severe strain on the long-term availability of Arianna's Center's fundamental programmatic services like emergency housing support. To accommodate the lack of employment and economic stability facing many members and individuals served by Arianna's Center, the organization already has been forced to shift resources. The effects of the Revised Rule will require Arianna's Center to provide additional emergency support services, further straining and burdening the Center.

64. While providing these emergency support services is an important programmatic component of Arianna's Center's work, it is only a part of the organization's overall activities. A significant redirection of funds required by the impact of the Revised Rule will impede Arianna's Center's ability to perform other programmatic activities like case management, legal name and gender marker change referrals, scholarships for GED completion and technical school tuitions, workforce development training programs, community research and education programs, and local and state advocacy campaigns for laws protecting the organization's clients.

65. The removal of language access measures from health care providers' offices and in health insurance bulletins and communications will make it much more difficult for Arianna's Center members and individuals with LEP to be aware of their rights; which language services are available, if any; and how to access such services; and how to handle discrimination and other complaints.

66. In addition to shifting much of our already limited budget to emergency services and services to support members and individuals with LEP, the impact of the Revised Rule will also require shifting an unexpected amount of limited resources to supporting our clients in finding nondiscriminatory health care providers, devising individual solutions for health

insurance exclusions for gender affirming care, and securing nondiscriminatory mental health treatment for the trauma that will occur because of widespread discrimination.

67. Arianna's Center will also be forced to devote a dwindling amount of resources to working with health care providers, insurers and other related organizations to educate and remind them of the importance of providing health care and insurance coverage to all patients on non-discriminatory terms.

68. The Revised Rule threatens to completely overwhelm the programs and activities Arianna's Center has been undertaking over the last few years to engage, uplift and improve the lives of transgender, gender nonconforming and intersex Latinx people in South Florida and in Puerto Rico. The harm to Arianna's Center will be long-lasting and difficult, if not impossible, to undo.

* * * * *

69. The Revised Rule poses serious and ongoing threats to the health and overall wellbeing of transgender and gender nonconforming Latinx people, like those served by Arianna's Center in South Florida and Puerto Rico. The Revised Rule also threatens the ability of Arianna's Center to fulfill its mission and provide critical programmatic services to the community it serves.

[*Signature on next page*.]

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

Dated this 6th day of July, 2020.

____
Arianna Inurritegui-Lint

EXHIBIT A

Living at Risk: Transgender Women, HIV, and Human Rights in South Florida

HUMAN RIGHTS WATCH

LIVING AT RISK

Transgender Women, HIV, and Human Rights in South Florida

Living at Risk

Transgender Women, HIV, and Human Rights in South Florida

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Living at Risk

Transgender Women, HIV, and Human Rights in South Florida

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Summary

> This woman shouted for 'Kevin' to come to the desk. I shrunk in my seat, hoping she would see the note on the chart about my gender change. But she just kept yelling for Kevin. I finally had to get up and cross the room in a walk of shame. Will I ever go back there? No way.
>
> **– Connie, 31, Miami, Florida**

Connie is HIV-positive, one of many transgender women in Florida facing the challenge of finding health care that is safe, gender-affirming, and affordable. The 1.4 million transgender and gender-non-conforming people in the United States generally face multiple barriers, from family rejection to non-acceptance and abuse at school, and pervasive discrimination in employment, housing, and health care. Social and economic marginalization as a result of these factors lead to higher rates of suicide, poverty, violence, and incarceration, particularly for trans people of color. This is a severe and compound environment of risk for HIV that demands a robust response – one that the state of Florida, and the federal government, are failing to deliver.

Nationally, rates of HIV are declining as treatment becomes more effective and, if administered regularly, can eliminate the potential for transmission of the virus. Rates of HIV among transgender men appear to be low, though more study is needed. But among transgender women, rates of new HIV infection have remained at crisis levels for more than a decade. One of four trans women, and more than half of African-American trans women are living with HIV, rates that are far higher than the overall prevalence of HIV in the US of less than one percent. Transgender women are testing positive for HIV at rates higher than cisgender men or women, and racial disparities are stark: HIV prevalence is more than three times higher among African-American transgender women than their white or Latina counterparts.

Since 2010, the National HIV/AIDS Strategy has recognized trans women as a "key" population whose needs must be addressed. Trans people frequently experience disrespect, harassment, and denial of care in health care settings, and many avoid seeking health care as a result. HIV policymakers know what to do: ample evidence indicates that to be effective, health care services for trans individuals must be affordable, gender-affirming, and should be integrated with transition-related care. This is particularly important for HIV care. If forced to choose, trans women will frequently prioritize Hormone

Replacement Therapy (HRT) over HIV care, making it essential to combine these services in a “one-stop shop.”

Numerous pilot programs across the country have demonstrated that providing integrated HIV care that engages and respects trans women is feasible and successful in reducing HIV risk and improving health outcomes. But this investigation of HIV prevention and care for trans women in south Florida found that trans women are navigating a difficult landscape that state and federal authorities have not done nearly enough to address. Services are fragmented, integrated care is limited, and cost and lack of insurance leave medical and mental health care out of reach. To the extent that such services exist, they are more a result of community demand and local advocacy efforts rather than federal or state policy, which contain no targeted requirements or standards to ensure that trans women are receiving the services they need.

The problem is not money. As a state with one of the country’s highest rates of HIV infection, Florida receives hundreds of millions of dollars from the Ryan White program, the federal government’s primary vehicle for funding HIV prevention and treatment services. The state HIV budget has increased more than 15 percent in the last three years. Nationwide and in Florida, more than half of people living with HIV receive care through a Ryan White funded program. Ryan White services are important for transgender women – when they stay in treatment in Ryan White programs, their health outcomes are significantly better than when they do not.

Despite a wide network of public and private providers in the metropolitan areas of Miami and Fort Lauderdale, only a handful of HIV clinics are consistently identified as providing what is recognized best practice, and to some experts, the standard of care, for transgender women. State HIV officials told Human Rights Watch that all Ryan White funded clinics “welcome” trans patients, but there was no systemic monitoring of the issue to determine whether this is the case, and evidence from the ground suggests otherwise. In fact, Human Rights Watch found that many transgender women experienced disrespect, harassment, and denial of services in health care settings, and that such experiences often result in avoidance of health care altogether.

The Ryan White program covers medications for patients under the AIDS Drug Assistance Program (ADAP). The federal government sets core criteria, but states can also cover medications for needs and conditions related to HIV, such as mental health and hepatitis C medications. In 21 states, ADAP covers hormone replacement medications for the purpose of gender transition – an important part of ensuring that HIV care meets the health

needs of transgender women. Florida is not one of these states, and federal policy does not require it to do so.

Underlying this lack of targeted government policy is the lack of accurate information about HIV risk and infection among trans women in Florida. The failure to collect accurate or complete HIV data among trans people is an ongoing problem. Decades into the epidemic, neither the state nor the federal government know how many trans women are living with HIV. Most states, including Florida, have only partially implemented federal recommendations for how to improve data collection for HIV among trans populations, and though Florida's data on trans women is improving, they remain incomplete. Estimates developed from other experts indicate that the number of transgender people living with HIV in Florida may be five to ten times higher than reported by the state.

Given that government response is driven by data, the undercounting of HIV prevalence means trans women are left out of many federal and state programs intended to monitor or improve HIV services. Often perceived by policymakers as a population too small to help, conditions for trans women on the ground remain unknown, unchanged, or inadequate. Over thirty years into the epidemic, the stark reality is that trans women are at an extremely high risk of HIV, but as a distinct population remain largely invisible to the federal and state HIV surveillance and monitoring systems that guide government response.

For this report, Human Rights Watch investigated access to health care, including HIV prevention and treatment, for women of trans experience in south Florida. We administered 125 survey questionnaires among trans women in Miami-Dade and Broward counties, two counties with the highest rates of new HIV infections in the country. These questionnaires, and the more than 100 interviews with trans women, their advocates, and HIV service providers indicated that many trans women in south Florida, particularly women of color, experience high HIV risk as a result of multiple factors, with poverty and lack of health insurance standing out as primary vulnerabilities. More than 63 percent of survey participants reported income of less than $10,000 per year, more than half were unemployed, and one of three were in "unstable" housing situations. This data is consistent with national surveys showing that many trans people live in extreme poverty and are three times more likely to be unemployed than those in the general population.

Nearly half of survey participants – 45 percent – had no health insurance. This alarming reality is tied to Florida's refusal to expand its Medicaid program under the Affordable Care Act, a decision that has left hundreds of thousands of low income and working Floridians

without access to health insurance. It is a decision that has a severe impact on transgender women, who are among the most impoverished residents of the state. Medicaid expansion could dramatically improve access to health care for trans individuals, many of whom would be included in its coverage of adults without dependents. Access to Medicaid could increase options for trans women as they attempt to locate gender-affirming health care in their community, providing vital access to HIV prevention and treatment.

Nationally, one of five trans women has been incarcerated, with African-American trans women three times more likely to face arrest than their white counterparts. Many trans women often turn to sex work in order to survive, leaving them vulnerable to police abuse and criminal charges that can begin, and perpetuate, a cycle of unemployment and lack of income. In the Human Rights Watch survey, more than half of respondents said they had been arrested at least once. Involvement in the criminal justice system increases HIV risk – even short jail stays have been shown to have negative health outcomes. Jails and prisons are also dangerous places for trans women, who report alarming rates of sexual assault in detention.

As trans women in Florida and throughout the US are struggling to access HIV prevention and care, the Trump administration has pressed forward with policies that will erode key LGBT rights protections and erect new barriers to their enjoyment of the right to health. The right to health does not guarantee to everyone a right to be healthy. Rather, its realization requires governments to implement policies that promote access to health care without discrimination, with particular attention to those facing the most barriers to care – low income persons, women, minorities, people with disabilities, and others.

Since Inauguration Day 2017, President Trump has moved in the opposite direction with a policy agenda that has sought repeal of the Affordable Care Act, restrictions on Medicaid access, and the rollback of regulations that protect LGBT Americans from discrimination. The rights of trans people are specifically threatened, with attempts to ban trans soldiers from the military, eliminate protections in federal law and policy that protect trans people from discrimination in employment and health care on the basis of gender identity, and weaken protections for transgender federal prisoners. For trans women, who face pervasive discrimination in employment and health care settings, the rollback of existing protections could have a particularly devastating impact.

In this increasingly hostile environment, trans women are in greater danger than ever and in greater need of federal and state support. For health officials, few questions remain

about what to do to reduce HIV infection among trans women. But without commitment by both federal and state policymakers to take these steps and remain accountable for doing so, the lives and health of trans women will remain at risk, and the crisis will continue.

Recommendations

To the President of the United States:

- Re-establish federal leadership addressing the HIV epidemic in the United States, including appointment of a director and staff for the Office of National HIV/AIDS Strategy and making appointments to the President's Advisory Council on HIV/AIDS comprised of public health experts, community leaders, and representatives of groups most heavily impacted by HIV, including trans women.
- Withdraw the executive order issued October 12, 2017 that permits unregulated health insurance plans inconsistent with the requirements of the Affordable Care Act.
- Withdraw the executive order issued May 4, 2017 instructing the Department of Health and Human Services to amend regulations for conscience-based objections to preventive care provisions of the Affordable Care Act.

To the Department of Health and Human Services:

- Protect and support expansion of the Medicaid program to ensure access to health care for low income people. Withdraw support for state waiver provisions that would reduce access to health services.
- Either defend the interpretation of section 1557 of the Affordable Care Act to protect against discrimination on the basis of gender identity, or introduce new legislation codifying those same protections.
- To the Health Resources and Services Administration (HRSA):
    - Implement policy regulations and guidance to states ensuring the protection of LGBT individuals from discrimination in insurance coverage. This includes the revision of Medicaid regulations to address denials on the basis of perceived gender incongruity.
    - Establish policies, monitoring, and evaluation procedures to promote gender-affirming care, including hormone replacement therapy, in all sites receiving Ryan White program funds, and support coverage of hormone replacement therapy in the AIDS Drug Assistance Program.

To the Centers for Disease Control and Prevention:

- Conduct a systematic review of implementation of the CDC Guidance for Working with Transgender HIV Data to ensure that states are taking effective steps to implement the Guidance and improve HIV data collection for trans communities.
- Identify states in need of technical assistance and prioritize provision of services accordingly.
- Report on steps taken and progress toward development of a national "indicator" for data collection on HIV among transgender communities as set forth in the National HIV/AIDS Strategy Update for 2020.

To the US Bureau of Prisons:

- Withdraw revisions to the Bureau of Prisons Transgender Offender Manual that weaken protections for transgender prisoners.
- Ensure that all regulations comply with Prison Rape Elimination Act requirements in order to reduce sexual assault in detention.

To the Congress of the United States:

- Stop attempts to repeal or further dismantle the Affordable Care Act without an adequate replacement.
- Support expansion of the Medicaid program to ensure access to health care for low income people.
- Pass legislation protecting LGBT persons from discrimination in health care, employment, and public accommodation.
- To the Senate: ratify the International Covenant on Economic, Social, and Cultural Rights.

To the State of Florida:

- To the Governor of the State of Florida:
    - Expand Medicaid under the Affordable Care Act to ensure access to health care for low income people including adults living in poverty with no dependents, and to reduce poverty in the state.
- To the Florida State Legislature:
    - Repeal HIV-specific criminalization laws.

  - Support criminal justice reform including alternatives to incarceration and decriminalization of consensual, adult sex work.
- To the Department of Health:
  - Issue a public report on progress to date and timelines for implementation of CDC Guidance for Working with Transgender HIV Data.
  - Establish policies, procedures, and monitoring systems to ensure that gender-affirming care is integrated with HIV care and services in all health care settings, including all sites receiving Ryan White funds.
  - Participate in the federal ECHO program to evaluate and improve the quality of HIV services for transgender people.
  - Ensure coverage for hormone replacement therapy in the AIDS Drug Assistance Program in all geographic areas and increase awareness of its availability.
- To the Office of Health Care Administration:
  - Develop explicit policy ensuring Medicaid coverage for transgender health care.

Methodology

This report is based on research conducted between June 2017 and June 2018 in the south Florida counties of Miami-Dade and Broward. Human Rights Watch utilized a mixed-method approach that combined quantitative survey and qualitative interviews and legal and policy analysis. The research focuses on access to health care, including HIV prevention, for individuals who self-identified as women of trans experience – a term that was intended to reflect a variety of experiences and expressions – and that was left to the individual to define.

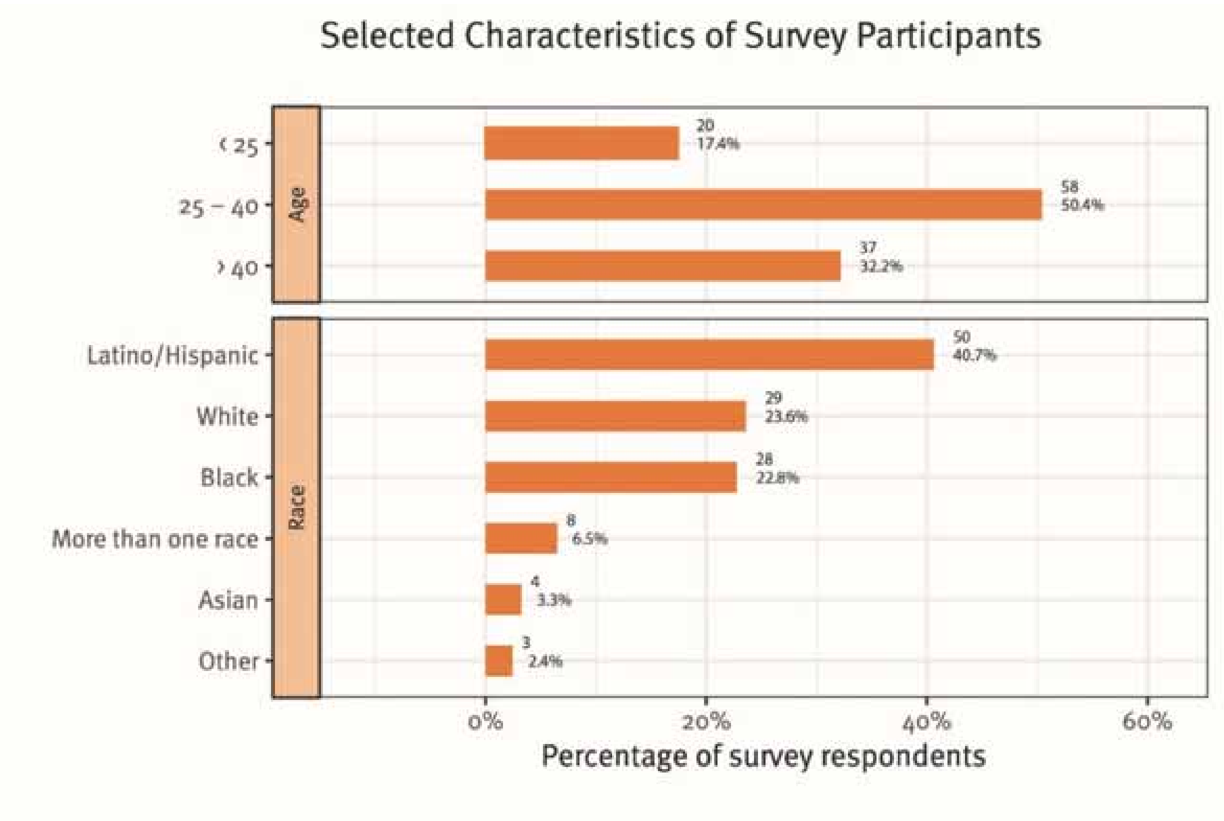
In addition to basic demographic information, the questions emphasized access to health care, including HIV care, access to HIV prevention, and interaction with the criminal justice system. Human Rights Watch identified respondents primarily through organizations providing social services to transgender people in the two counties and through the personal networks of peer interviewers. This approach produced a diverse group of respondents but should not be considered a representative sample of trans individuals in these counties, as survey participants were likely to be connected to health and HIV services.

For the quantitative component of the research, Human Rights Watch trained 15 peer interviewers in the administration of a survey, human rights documentation, and research ethics, including the importance of informed consent and confidentiality. Peer interviewers were diverse in age, gender identification, and ethnicity and were selected on the recommendation of, and in some cases were themselves representatives of, organizations providing services for transgender people in Miami-Dade and Broward counties. Of 125 questionnaires, 81 were administered by peer interviewers and 44 were administered directly by Human Rights Watch.

Survey participants were all Florida residents in Miami-Dade or Broward Counties who self-identified as women of trans experience; the survey tool made no inquiry into the definition of that term. The responses to the survey's demographic options showed that 41 percent identified as Latina/Hispanic, 24 percent as White/Caucasian, 23 percent as Black/African-American, 4 percent as Asian and 7 percent as other or as "more than one race;" ages reported ranged between 19 and 70 (see Graph I).[1]

[1] All survey results are on file with Human Rights Watch. Percentages may not total 100 due to rounding. Not all responses were valid for every question; percentages reflect total of valid responses. Latina/Hispanic women can be of more than one race.

Graph I.



Peer interviewers were paid a nominal stipend for their training time and administration of the survey. Gift cards were provided to interviewees to reimburse them for travel and related expenses.

All participants were informed of the purpose of the survey, its voluntary nature, and the ways in which the information would be used. All participants provided oral consent to be interviewed and consent was noted on each survey form. Participants were assured Human Rights Watch would not publish their names; all names of survey participants reported are pseudonyms. Survey results were tabulated and analyzed by Human Rights Watch.

Human Rights Watch also interviewed more than 100 advocates, health care providers, public defenders, sheriff and jail officials, members of state HIV planning councils, federal health and criminal justice officials, and national experts on transgender health. The Florida Department of Health HIV/AIDS Section responded to written questions in writing and responded on behalf of Miami-Dade and Broward County departments of health; Broward County Department of Health officials also met with Human Rights Watch in person. Documents were obtained from the Florida Department of Health, Broward County

Department of Health, Broward County Sheriff's Office, and Hollywood, Florida Police Department. All documents cited are publicly available or on file with Human Rights Watch. Pseudonyms are used for anyone not interviewed in their official capacity to protect privacy and confidentiality.

Background

Discrimination, Abuse, and Health Risks Among Transgender People

In the United States, an estimated 1.4 million people (0.6 percent of the population) identify as transgender. Transgender or "trans" is an umbrella term intended to be inclusive of the full range of nuance and diversity of gender expression and identity among those who may not identify with the sex they were assigned at birth.[2] Trans women were assigned male sex at birth but identify as women; trans men were assigned female sex at birth but identify as men.

Trans and gender-non-conforming people tend to face barriers in multiple aspects of life, from family rejection to non-acceptance and abuse at school, and pervasive discrimination in employment, housing and health care. Social and economic marginalization as a result of these factors are linked to higher rates of suicide, poverty, and incarceration, particularly for trans people of color. According to a survey conducted in 2015 by the National Center for Transgender Equality (NCTE), trans people were more than twice as likely as the US population as a whole to live in poverty and three times as likely to be unemployed.[3] A staggering 40 percent of respondents had attempted suicide, compared to 1.6 percent in the US population.[4] Violence was a fact of everyday life, with nearly half reporting having been sexually assaulted at one point and one in ten reporting sexual assault within the last year.[5]

In the national survey, African-American and Latino/a trans respondents fared worse than their white counterparts nearly across the board, reporting lower income, less access to health care and health insurance, as well as higher rates of homelessness, employment discrimination, and incarceration.[6] Trans people of color were more likely than white trans

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[2] National Center for Transgender Equality, "FAQs: Transgender People," https://transequality.org/issues/resources/frequently-asked-questions-about-transgender-people (accessed August 17, 2018).

[3] National Center for Transgender Equality (NCTE), *US Transgender Survey 2015,* https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf, (accessed August 17, 2018); see also National Center for Transgender Equality and National Gay and Lesbian Taskforce, *Injustice at Every Turn*, 2011, http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf (accessed August 17, 2018).

[4] NCTE, National Transgender Survey 2015.

[5] Ibid.

[6] NCTE, *Black Respondent Report,* http://www.transequality.org/sites/default/files/docs/usts/USTSBlackRespondentsReport-Nov17.pdf (accessed August 17, 2018). The NCTE survey included "Black or African-American" and Latino/a or Hispanic" as racial/ethnic classification categories.

people to report abuse by the police as well as victimization while in jail or prison.[7] This is consistent with data collected under the federal Prison Rape Elimination Act indicating that African-American and Latina trans women report sexual assault in detention at higher rates than white women.[8] Violence and hate crimes against trans people have increased in recent years, though accurate data is hindered by lack of reporting and misinformation regarding the gender identity of victims.[9] FBI data show that reported hate crimes against trans people increased by 44 percent between 2015 and 2016.[10] At least 21 trans individuals, mostly women of color, have been killed in 2018, five of them in Florida.[11]

Barriers to Health Care and Services

Trans people in the US face both socio-economic barriers and discrimination in access to health care and services. Trans people are less likely than the general population to have health insurance and more likely to rely on publicly funded insurance than private or employer-provided coverage.[12] The 2015 US Transgender Survey indicated that one of three trans people had needed to see a doctor in the last year but could not afford to do so.[13] Trans people face outright denial of services as well as harassment in health care settings. A 2017 national survey by the Center for American Progress found that one in three trans respondents said that they had been turned away by a medical provider on the basis of their gender identity; one in five reported being subject to harsh or abusive language in a health care setting; and one in three reported unwanted physical or sexual contact by a medical provider.[14] A common response to these conditions is avoidance of health care altogether – one national survey found that one in four trans people stopped seeking health care as a result of bad experiences in health care settings.[15]

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[7] NCTE, Black Respondent Report; Sevelius and Jenness, "Challenges and Opportunities for Gender-Affirming Healthcare for Transgender Women in Prison," *Journal of Prisoner Health*, (2017) 13, pp. 32-40.

[8] Sevelius and Jenness; US Bureau of Justice Statistics, PREA Data Collection Activities 2015," https://www.bjs.gov/content/pub/pdf/pdca15.pdf accessed August 17, 2018.

[9] Astor, Maggie. "Violence Against Transgender People is on the Rise, Advocates Say," New York Times, November 9, 2017.

[10] Voice of America, " FBI: Hate Crimes Increased by 4.6 percent in 2016," November 13, 2017, https://www.voanews.com/a/fbi-hate-crimes-increased-in-2016/4112929.html (accessed October 3, 2018).

[11] Human Rights Campaign, "Violence Against the Transgender Community in 2018," (accessed October 3, 2018).

[12] Trudy Ring, "Trans People Less Likely to Have Needed Health Care," The Advocate, July 6, 2017, https://www.advocate.com/current-issue/2017/7/06/trans-people-less-likely-have-needed-health-care (accessed October 3, 2018).

[13] NCTE, *US Transgender Survey* 2015.

[14] Center for American Progress, "Discrimination Prevents LGBT People from Accessing Health Care," https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/ (accessed August 17, 2018).

[15]NCTE, *US Transgender Survey* 2015.

Health Care for Transgender People

As do all people, transgender individuals have diverse physical and mental health concerns, some that are related to their trans experience and some that are not. Standards of care for medical and mental health providers to treat transgender patients have evolved significantly in the last decade. The World Professional Association for Transgender Health (WPATH) takes care to distinguish gender non-conformity from the clinical diagnosis of gender dysphoria.[16] According to WPATH and the American Psychiatric Association, there is nothing inherently pathological about gender non-conformity; gender dysphoria is a mental health condition in which one is experiencing clinically significant distress or social/occupational impairment as a result of gender non-conformity.[17] This diagnosis remains controversial as it is perceived as stigmatizing and pathologizes distress which, in the view of many, originates largely from societal prejudice and discrimination.[18] However, the diagnosis remains relevant as a basis for medical and surgical interventions for transgender and gender non-conforming people who wish to pursue them, and in many cases, as a prerequisite for insurance coverage for these treatments.[19]

One principle that is widely accepted is that effective health care for trans people should be respectful, safe, and culturally appropriate – a large number of health experts, provider organizations, and transgender advocates have published detailed guidelines on how to provide "gender-affirming" services in health care settings.[20] Recommendations for best practices not only include clinical standards for care but emphasize the importance of respectful and knowledgeable staff interaction with patients – use of gender-affirming pronouns, avoiding assumptions about gender identity or expression, recognizing that a patient's official identity documents may not match their gender expression, and other considerations.[21] Underpinning these practices is a recognition of the evidence that failure to implement gender-affirming services will result in avoidance of health care for

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[16] World Professional Association for Transgender Health (WPATH), Standards of Care, https://www.wpath.org/media/cms/Documents/Web%20Transfer/SOC/Standards%20of%20Care%20V7%20-%202011%20WPATH.pdf (accessed August 17, 2018).

[17] WPATH; American Psychiatric Association, "What is Gender Dysphoria," https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria (accessed August 17, 2018).

[18] Ibid; National LGBTQ Taskforce, "(In)validating Transgender Identities: Progress and Trouble in the DSM-5," http://www.thetaskforce.org/invalidating-transgender-identities-progress-and-trouble-in-the-dsm-5/ (accessed August 17, 2018); Aiken, J., "Promoting an Integrated Approach to Ensuring Access to Gender Incongruent Health Care," *Berkeley Journal of Gender, Law and Justice*, 31 (1), 2016.

[19] Ibid.

[20] Fenway Institute, "Meeting the Health Care Needs of Transgender People," http://www.lgbthealtheducation.org/wp-content/uploads/Sari-slides_final1.pdf (accessed August 17, 2018); University of California at San Francisco, Center for Excellence in Transgender Health (CETH), "Overview of Gender-Affirming Treatments and Procedures," http://transhealth.ucsf.edu/trans?page=guidelines-overview (accessed August 17, 2018).

[21] Ibid.

transgender patients. As stated by the University of California at San Francisco Center for Excellence in Transgender Health Care (CETH), "Providing a safe, welcoming, and culturally appropriate clinic environment is essential to ensure that transgender people not only seek care but return for follow up."[22]

An example of the importance of gender-affirming policies in health settings is provided by Connie, a 31-year-old trans woman living in Miami, Florida. Connie's driver's license does not yet reflect her transition to female, so in her first visit to a local health clinic she asked them to note her current name and gender identity on the chart. However, on her second visit she was in the waiting room with other patients, and she heard her birth name called out loudly to summon her to the reception desk. Connie recalled:

> This woman shouted for 'Kevin' to come to the desk. I shrunk in my seat, hoping she would see the note on the chart about my gender change. But she just kept yelling for Kevin. I finally had to get up and cross the room in a walk of shame. Will I ever go back there? No way.[23]

Transgender Women and HIV

Data are scarce and incomplete but alarming — both globally and domestically, trans women are heavily burdened by the HIV epidemic. According to the World Health Organization (WHO), existing studies show that nearly one of five transgender women around the world are living with HIV – this is a prevalence rate of 19 percent, compared to a rate of 0.8 percent in the general global adult population.[24] Globally, transgender women are 49 times more likely to acquire HIV during their lifetime than the general population of reproductive age.[25] HIV prevalence among trans men appears to be much lower, but data remain limited and more research is needed (see text box). WHO and UNAIDS, the leading international agencies charged with addressing the HIV epidemic worldwide, have designated transgender women as a "key population" along with men who have sex with men, prisoners, people who inject drugs, and sex workers. Because HIV among people within these groups (and their intimate partners) account for 40-50 percent of the global

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[22] CETH, "Creating a Safe and Welcoming Clinic Environment," http://www.transhealth.ucsf.edu/trans?page=guidelines-clinic-environment (accessed August 17, 2018).

[23] Human Rights Watch interview with Connie L., Miami, Florida, February 6, 2018.

[24] UNAIDS, "Transgender and HIV Risk,"http://www.unaids.org/en/resources/infographics/transgender-and-HIV-risk (accessed August 20, 2018); Avert https://www.avert.org/global-hiv-and-aids-statistics (accessed November 6, 2018).

[25] UNAIDS, "Transgender and HIV Risk."

HIV epidemic, WHO and UNAIDS have declared that "without addressing the needs of key populations, a sustainable response to HIV will not be achieved."[26]

In the United States, the National HIV/AIDS Strategy also designates transgender women as a "high-risk" and "key" population as studies indicate an HIV prevalence ranging from 22 percent to as high as 56 percent among transgender women of color.[27] This is grossly disproportionate to the overall prevalence of HIV in the US, which is under one percent.[28] In a recent survey of nine million HIV tests nationwide, transgender women had the highest percentage of positive results of any gender category.[29] Racial disparities are stark: HIV prevalence is more than three times higher among African-American transgender women than their white or Latina counterparts.[30]

HIV in the United States

More than 1.1 million people in the US are living with HIV, and one in seven are unaware of their infection.[31] Over the past decade, the number of people living with HIV has increased as treatment has become more effective. For the first time in the history of the epidemic, the number of new infections has begun to decrease overall, but still remains high among specific populations.[32]

In recent years, treatment has become the cornerstone of both HIV prevention and care. Public health and HIV experts have increasingly emphasized the importance of early and universal access to anti-retroviral medication not only to improve individual outcomes, but to reduce the risk of transmission to others. The approach characterized as "Treatment as

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[26] World Health Organization, "Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations,"2016 Update, http://apps.who.int/iris/bitstream/handle/10665/128048/9789241507431_eng.pdf;jsessionid=9261E742088B27F210C3747AB38F995B?sequence=1 (accessed August 22, 2018).

[27] US Centers for Disease Control, "HIV Among Transgender People," https://www.cdc.gov/hiv/group/gender/transgender/index.html (accessed August 22, 2018) and "HIV among Transgender People Fact Sheet," https://www.cdc.gov/hiv/pdf/group/gender/transgender/cdc-hiv-transgender-factsheet.pdf (accessed August 22, 2018); US Office of National HIV/AIDS Strategy, "National HIV/AIDS Strategy for the United States, Updated to 2020," https://files.hiv.gov/s3fs-public/nhas-update.pdf (accessed August 22, 2018).

[28] Avert, "HIV and AIDS in the United States of America," https://www.avert.org/professionals/hiv-around-world/western-central-europe-north-america/usa (accessed August 22, 2018).

[29] CDC, Morbidity and Mortality Weekly Report, "HIV Testing Among Transgender Women and Men- 27 States and Guam, 2014-15," https://www.cdc.gov/mmwr/volumes/66/wr/mm6633a3.htm (accessed August 22, 2018).

[30] AmfAR Issue Brief, "Trans Populations and HIV: Time to End the Neglect," http://www.amfar.org/uploadedFiles/_amfarorg/Articles/On_The_Hill/2014/IB%20Trans%20Population%20040114%20final.pdf (accessed August 22, 2018).

[31] CDC, "HIV/AIDS Basic Statistics," https://www.cdc.gov/hiv/basics/statistics.html (accessed August 22, 2018).

[32] US Department of Health and Human Services, "National HIV/AIDS Strategy for the United States 2017 Progress Report," https://www.hiv.gov/blog/2017-national-hivaids-strategy-nhas-progress-report-released (accessed August 22, 2018).

Prevention" has gained traction globally and in the US as research confirms that sufficient suppression of the virus through anti-retroviral therapy can effectively eliminate the risk of transmission from one person to another and in communities as a whole.[33] Key to the success of this approach is the ability of the person to become aware of their status and to sustain a lifetime course of anti-retroviral medication that must be taken on a daily basis.[34]

Increased access to treatment has reduced new infections nationwide, but rates of infection remain high among certain groups, including gay, bisexual, or other men who have sex with men; African-American men and women; Latino men and women; people who inject drugs; youth 13-24 years old; people in the southern United States; and transgender women.[35]

Race and Poverty

Many factors combine to place trans women, and particularly women of color, at high risk of HIV. In the United States, HIV has become a disease of social, economic, and racial exclusion. Trans women are disproportionately impacted by many of these forces of marginalization, facing what has been characterized by HIV experts as "multiple, concurrent HIV risks and underlying vulnerabilities."[36]

In the US HIV epidemic, racial disparities are extreme, with African-Americans comprising 12 percent of the US population, but 44 percent of new HIV infections. Though new infections have decreased among Americans overall, they continue to increase among African-Americans.[37] Indeed, African-Americans comprise the highest percentage of people living with HIV, people becoming newly infected, and people living with AIDS.[38]

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[33] CDC. "Evidence of HIV Treatment and Viral Suppression in Preventing the Sexual Transmission of HIV," December 2017, https://www.cdc.gov/hiv/pdf/risk/art/cdc-hiv-art-viral-suppression.pdf (accessed August 22, 2018).

[34] Ibid.

[35] US Department of Health and Human Services, "National HIV/AIDS Strategy for the United States 2017 Progress Report," https://www.hiv.gov/blog/2017-national-hivaids-strategy-nhas-progress-report-released (accessed August 22, 2018); US Office of National HIV/AIDS Strategy, "National HIV/AIDS Strategy for the United States, Updated to 2020," https://files.hiv.gov/s3fs-public/nhas-update.pdf (accessed August 22, 2018).

[36] Escudero, D.J. et al., "Inclusion of Trans Women in Pre-Exposure Prophylactis (PrEP): A Review, *AIDS Care*, 27 (5) 2015, pp. 637-641, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4336598/ (accessed August 22, 2018).

[37] Ibid.

[38] CDC, "HIV Among African-Americans," https://www.cdc.gov/hiv/group/racialethnic/africanamericans/index.html (accessed August 22, 2018).

African-American people in the US are more likely to be poor than white people, and poverty is one of the primary drivers of the HIV epidemic.[39] In contrast to sub-Saharan Africa's HIV epidemic affecting the entire population, HIV in the United States is concentrated in impoverished urban areas and small towns, with the highest concentration of people living with HIV and new HIV infections occurring in the US South.[40] In some impoverished areas of the US, HIV prevalence has been found to be higher than in many African countries where the HIV epidemic is severe.[41]

As noted above, many transgender people live in poverty – the 2015 US Transgender Survey indicated that nearly one in three had an income of less than $10,000 per year, with 55 percent living on less than $25,000 per year.[42] In their 2015 report, "Paying an Unfair Price: Financial Penalties for Being Transgender in America," the Center for American Progress found that discrimination in school, employment, housing and health care, as well as an inability to obtain gender-affirming identity documentation, combined to force many transgender people into poverty and into underground economies such as sex work for daily survival.[43]

Sex Work and Incarceration

People who exchange sex for money or life necessities are at increased risk for HIV, a risk that impacts some trans women who engage in sex work. This risk results from not only a higher number of sexual partners but, in many cases, from environmental factors such as poverty, homelessness, and substance use – all factors that have been independently associated with HIV risk and poor health outcomes.[44] In addition, Human Rights Watch and others have documented increased HIV risk to sex workers from the harmful consequences of criminalization: police harassment, arrest, and incarceration have been found to be

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[39] Kaiser Family Foundation, "Poverty Rates by Race/Ethnicity," https://www.kff.org/other/state-indicator/poverty-rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (accessed August 22, 2018); Wiewel, E., et al., "The Association Between Neighborhood Poverty and HIV Diagnoses Among Males and Females in New York City, 2010-2011, *Public Health Reports*, 131 (2), 2016, pp. 290-302; Denning, P and DiNenno, E., "Is there a generalized HIV epidemic in impoverished urban areas of the United States?" CDC 2014, https://www.law.berkeley.edu/files/DenningandDiNenno_XXXX-1.pdf (accessed August 22, 2018).

[40] Reif, S., et al., "State of HIV in the US Deep South," *Journal of Community Health*, 42 (5) 2017, pp. 844-853; for extensive research and materials on HIV in the US South, see Southern AIDS Strategy Initiative, https://southernaidsstrategy.org/deepsouthhiv/ (accessed August 22, 2018).

[41] Pellowski, J., et al., "A Pandemic of the Poor: Social Disadvantage and US HIV Epidemic," *American Psychologist,* 68 (4), 2013, 197-2019.

[42] NCTE, National Transgender Survey 2015.

[43] Center for American Progress, Paying an Unfair Price: The Financial Penalty for Being Transgender in America, 2015, http://www.lgbtmap.org/file/paying-an-unfair-price-transgender.pdf (accessed August 2018).

[44] CDC, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, " Atlas Plus Social Determinants of Health Data" https://www.cdc.gov/nchhstp/dear_colleague/2018/dcl-061818-AtlasPlus.html (accessed August 22, 2018).

associated with higher HIV risk, less access to medical care, and impaired ability to manage HIV medications.[45] A criminal history after conviction on prostitution charges creates a significant barrier to employment that perpetuates poverty and the necessity of sex work in order to meet one's basic needs.

Trans women experience high rates of incarceration, with one in five trans women reporting having been in jail or prison.[46] The rate of incarceration for African-American trans women is three times as high as it is for white trans women – some studies indicate that half of African-American trans women report a history of incarceration.[47] Incarceration creates numerous barriers to HIV prevention and care – condoms are not available in the majority of prisons and jails in the United States; access to HIV medications and treatment is often inadequate or in many jails, non-existent; and linkage to medical care upon re-entry is uneven at best.[48]

In addition to incarceration itself as an HIV risk factor, transgender women experience alarming rates of sexual assault in prison. According to federal Prison Rape Elimination Act data for 2015, more than one-third of incarcerated trans women reported assault by other prisoners or staff.[49] African-American and Latina trans women are more likely to be victims of assault in jail or prison than their white counterparts.[50] Most HIV-positive prisoners were HIV-positive prior to their incarceration. However, a lack of HIV prevention measures and failure to provide safe environments for trans prisoners – such as the widespread practice

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45 Human Rights Watch, Sex Workers at Risk: Condoms as Evidence of Prostitution in Four US Cities, July 2012, https://www.hrw.org/report/2012/07/19/sex-workers-risk/condoms-evidence-prostitution-four-us-cities; Human Rights Watch, Paying the Price: Failure to Deliver HIV Services in Louisiana Parish Jails, March 2016, https://www.hrw.org/report/2016/03/29/paying-price/failure-deliver-hiv-services-louisiana-parish-jails; Ginny Shubert, National Minority AIDS Council and Housing Works, "Mass Incarceration, Housing Instability and HIV/AIDS," 2013, https://www.hivlawandpolicy.org/resources/mass-incarceration-housing-instability-and-hivaids-research-findings-and-policy (accessed August 22, 2018); "HIV and Related Infections in Prisoners," *The Lancet*, Special Issue, July 2016.

46 Reisner, S et al., "Racial/Ethnic Disparities in History of Incarceration, Experiences of Victimization, and Associated Health Indicators Among Transgender Women in the US," *Women and Health*, 54 (8) 2014, 750-767; Jae Sevelius and Valerie Jenness, " Challenges and Opportunities for Gender-Affirming Health Care for Transgender Women in Prison," *International Journal of Prisoner Health*," 13 (1) 2017, pp. 32-40.

47 Ibid; Lambda Legal, "Transgender Incarcerated People in Crisis," https://www.lambdalegal.org/sites/default/files/2015_transgender-incarcerated-people-in-crisis-fs-v5-singlepages.pdf (accessed August 22, 2018).

48 "HIV and Related Infections in Prisoners," *The Lancet*, Special Issue, July 2016.

49 US Bureau of Justice Statistics, "PREA Data Collection Activities 2015," https://www.bjs.gov/content/pub/pdf/pdca15.pdf (accessed August 22, 2018).

50 Reisner, S et al., "Racial/Ethnic Disparities in History of Incarceration, Experiences of Victimization, and Associated Health Indicators Among Transgender Women in the US," *Women and Health*, 54 (8) 2014, 750-767; Jae Sevelius and Valerie Jenness, " Challenges and Opportunities for Gender-Affirming Health Care for Transgender Women in Prison," *International Journal of Prisoner Health*," 13 (1) 2017, pp. 32-40.

of placing trans women in male prison facilities — increases HIV risk in correctional settings.[51]

Mental Health Issues and HIV

Trans people report experiencing high rates of mental health conditions including anxiety, depression, and substance use disorders. Many report anxiety, depression, and trauma resulting from societal factors – including stigma, discrimination, harassment, violence, and other mistreatment based on their gender non-conformity.[52] While cautioning against assuming that all mental health issues are related to gender identity, transgender health experts have identified distress and trauma from familial and societal non-acceptance as key to understanding and treating trans individuals.[53] Many transgender people seek mental health services to help them cope with the effects of prolonged concealment of their gender identity and harms resulting from attempts to express this identity in hostile environments.[54]

Mental health issues have been correlated with increased risk of HIV and poorer outcomes once infected. Depression, anxiety, low self-esteem, sexual abuse, post-traumatic stress disorder, and substance use disorders all have been associated with higher risk of acquiring and transmitting HIV in men who have sex with men, youth, people who use drugs, and transgender women.[55] People living with HIV experience higher rates of anxiety, depression, and substance use disorders than people without HIV, with trans women reporting higher rates of anxiety and depression, and reporting lower quality of life, than other groups living with HIV.[56]

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[51] Rubenstein, L., et al., "HIV, Prisoners and Human Rights," *The Lancet*, July 2016, pp. 44-56; Lambda Legal, "Transgender Incarcerated People in Crisis", https://www.lambdalegal.org/sites/default/files/2015_transgender-incarcerated-people-in-crisis-fs-v5-singlepages.pdf (accessed August 22, 2018).

[52] NCTE, National Transgender Survey 2015; National Center for Transgender Equality and National Gay and Lesbian Taskforce, *Injustice at Every Turn*, 2011, http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf (accessed August 17, 2018).

[53] CETH, "Mental Health Considerations with Transgender and Gender Non-Conforming Clients," http://transhealth.ucsf.edu/trans?page=guidelines-mental-health (accessed August 22, 2018.); Sevelius, J., "Gender Affirmation: A Framework for Conceptualizing Risk Behavior Among Transgender Women of Color," *Sex Roles*, 68: July 2013, pp. 675-689.

[54] Rood, B, et al., "Identity Concealment in Transgender Adults: A Qualitative Assessment of Minority Stress and Gender Affirmation," *American Journal of Orthopsychiatry*, 87 (6): pp. 704-13.

[55] US Department of Health and Human Services, AIDS Info, "HIV and Mental Health," https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/27/92/hiv-and-mental-health (accessed August 22, 2018.)

[56] Ibid; http://www.apa.org/pi/aids/resources/exchange/2013/01/comorbidities.aspx; Mascolini, M., "More Depression, Worse Quality of Life In Transgender Women v. Men with HIV," 9th International AIDS Society Conference on HIV Science, July 2017, http://www.natap.org/2017/IAS/IAS_108.htm (accessed August 22, 2018.).

Anxiety, depression and other mental health issues reduce one's ability to adhere to a daily regimen of anti-retroviral medications, a key determinant of maintaining one's health and wellbeing while living with HIV. For this reason, access to mental health services is considered an integral component of HIV care.[57]

Transgender Men and Barriers to Health Care

Trans men face many of the same barriers to health care as trans women: a shortage of gender-affirming health settings, lack of knowledgeable providers, and denials of insurance coverage for basic health services – pap smears, mammograms and other services – that are perceived as "gender incongruent." Trans men are significantly more likely to live in poverty and to lack health insurance than cis-gender men.[58] Research on health issues for trans men, including HIV research, remains extremely limited.

The prevalence of HIV among trans men appears to be significantly lower than that among trans women – ranging from one to three percent in most studies – but still higher than in the general US population.[59] Many trans men have sex with cis-gender men who identify as gay or bisexual, placing them at increased risk of HIV infection.[60] Engaging in sex work and the use of alcohol or drugs also increase HIV risk. However, HIV testing among trans men remains low.[61] For trans men, sex with cis-gender men can be a complex issue, especially for those who are navigating the gay and bisexual community for the first time.

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57 National Institutes of Mental Health, "HIV/AIDS and Mental Health," https://www.nimh.nih.gov/health/topics/hiv-aids/index.shtml (accessed August 22, 2018.)

58 Lambda Legal, "When Health Care Isn't Caring,"2010, https://www.lambdalegal.org/publications/when-health-care-isnt-caring (accessed September 7, 2018); National Center for Transgender Equality (NCTE), US Transgender Survey 2015, https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf, (accessed August 17, 2018).

59 Herbst JH et al., "Estimating HIV Prevalence and Risk Behaviors in Transgender Persons in the United States: A Systematic Review," AIDS Behavior, 12(1) January 2008; McFarland, W., et al., "HIV Prevalence, Sexual Partners, Sexual Behavior and HIV Acquisition Risk Among Trans Men, San Francisco 2014," *AIDS Behavior*, 21(12) December 2017; Scheim, A., et al., "Inequities in Access to HIV Prevention Services For Transgender Men: Results of a Global Survey of Men Who Have Sex With Men," Journal of the International AIDS Society, 19 (Supp 2) 2016.

60 Scheim, A., et al., "Inequities in Access to HIV Prevention Services For Transgender Men: Results of a Global Survey of Men Who Have Sex With Men," *Journal of the International AIDS Society,* 19 (Supp 2) 2016; Rowniak, S., and Selix, N., "Attitudes, Beliefs and Barriers to PrEP Among Trans Men," AIDS Education and Prevention," August 2017.

61 CDC, "HIV Among Transgender People," https://www.cdc.gov/hiv/group/gender/transgender/index.html (accessed September 7, 2018).

Santi Aguirre is the director of transgender programs at Sunserve, a non-profit organization serving the LGBT community in Broward County. Aguirre told Human Rights Watch that many trans men are secretive about engaging in sex with cis-gender men, making HIV screening and referrals to prevention or treatment services difficult.

Lots of trans men are having sex with men, but they do not feel comfortable being open about it. The community is not that supportive of it. Some fear homophobia, and for others it contradicts the 'masculine' identity that they are working to develop.

> There are guys that I know that have a lot of sexual partners, some for money – they need PrEP and HIV testing but won't do it.[62]

In addition, many trans men having sex with men report preferring to get health services in settings that focus on men who have sex with men, but often feel excluded or unwelcome in these environments. This may contribute to lower HIV testing rates and lower access to condoms, lubricant, and other methods of HIV prevention among trans men than among cis-gender men.[63]

To date, HIV risk among trans men has not been accurately assessed or prioritized by federal or state HIV policymakers. Inadequate data as well as barriers to health care, including lack of access to affordable, gender-affirming care and HIV prevention services jeopardize the health of trans men.

Barriers to Access to Medical and Mental Health Care

Trans people generally face formidable barriers in accessing gender-affirming health care. For many trans women with HIV, medical and mental health services remain out of reach. A national survey published in 2016 by the Transgender Law Center's Positively Trans Project examined the health needs and concerns of trans people living with HIV. The majority (84 percent) of respondents were women, and 41 percent of respondents had a history of incarceration in prison, jail, or immigration detention. Forty-three percent reported income

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[62] Human Rights Watch telephone interview with Santi Aguirre, Fort Lauderdale, FL, July 19, 2018.

[63] Scheim, A., et al., "Inequities in Access to HIV Prevention Services for Transgender Men: Results of a Global Survey of Men Who Have Sex with Men," *Journal of the International AIDS Society*, 19 (Supp 2) 2016.

of less than $12,000 per year.[64] The methodology of the survey skewed toward respondents who were likely to be connected with some type of health care rather than those who might be more isolated. Even so, 41 percent of respondents had not seen a doctor for six or more months following their HIV diagnosis.

The primary reason given for not seeing a doctor after their diagnosis was a previous or anticipated discrimination by a health care provider. Cost was also cited as a major factor in failing to access care. African-American and Latino/a respondents reported lower income and were less likely to have health insurance than white respondents. When asked to list their number one health concern, the top concern identified by more than 60 percent of respondents was a need for "gender-affirming and non-discriminatory health care." The next-highest concerns were hormone therapy and mental health care, including trauma recovery. HIV care was fifth on the list of concerns.[65]

For trans women with HIV, the first priority in addressing their needs is to ensure access to health care that provides them with fundamental respect and dignity. In 2017, a nationwide group of HIV-positive transgender leaders convened by AIDS United issued recommendations for best practices in health care. These leaders stated, "Due to the disproportionate impact of HIV on transgender and gender expansive communities, it is critical that clinics and support services are welcoming, inclusive and competent in serving this population."[66]

For trans people, services that support them in transition or maintenance of their gender identity are not optional aspects of health care – they are fundamental to affirming individual identity and meeting established standards of transgender health care. The World Professional Association for Transgender Health (WPATH), for example, includes as its core principles:

- Exhibit respect for patients with non-conforming gender identities
- Provide care that affirms patients' gender identities and reduces gender dysphoria, when present

[64] Transgender Law Center, "Positively Trans Needs Assessment Reports 1-3," 2016, https://transgenderlawcenter.org/programs/positively-trans/research (accessed August 22, 2018). Categories utilized for racial classification included "African-American" and "Latino/a."

[65] Ibid.

[66] AIDS United, "Stepping Up: Best Practices In Providing HIV Medical Care, Support Services and Funding To Trans Communities," https://www.aidsunited.org/resources/stepping-up-a-consensus-statement-by-trans-leaders (accessed August 22, 2018).

- Become knowledgeable about the health care needs of gender non-conforming people
- Match the treatment to the specific needs of patients, particularly their gender expression and their need for relief from gender dysphoria
- Seek patients' informed consent before providing treatment[67]

Trans women frequently prioritize hormone replacement therapy over other health concerns.[68] For this reason, access to hormone therapy is of the utmost importance for trans women living with HIV.[69] Public health and HIV experts, experts in transgender HIV care and, most importantly, trans women living with HIV identify access to transition care, including HRT, as fundamental to effective HIV care for trans women. The Center for Excellence in Transgender Health recommends "bundling" HIV care with HRT and other health services sought by trans women.[70] The AIDS United statement emphasizes the importance of a "one-stop shop" where trans people can receive HIV care as well as comprehensive transgender-focused health services.[71] The WHO states that for transgender women living with HIV, "transition care was perceived as vital pre-requisite for subsequent health care" and recommends that governments prioritize gender-affirming care in developing their plans for addressing HIV in this key population.[72]

The availability of hormone replacement therapy is an essential component of the standard of care for transgender people, and HRT plays an important role in HIV prevention and treatment. As CETH states, "HIV and its treatment are not contraindications to hormone therapy. In fact, providing hormone therapy in the context of HIV care may improve engagement in and retention in care as well as decrease viral load and increase adherence."[73] Hormone therapy reduces anxiety and depression, factors known to increase

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[67] World Professional Association for Transgender Health, Standards of Care, https://www.wpath.org/media/cms/Documents/Web%20Transfer/SOC/Standards%20of%20Care%20V7%20-%202011%20WPATH.pdf (accessed August 17, 2018).

[68] Sevelius, J., et al., "The Future of PrEP among Transgender Women: The Critical Role of Gender Affirmation in Research and Clinical Practices," Journal of the International AIDS Society, 19 (7 Supp. 6) 2016, published online https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5071750/ (accessed August 22, 2018); Sevelius, J., "Gender Affirmation: A Framework for Conceptualizing Risk Behavior Among Transgender Women of Color," *Sex Roles*, 68: July 2013, pp. 675-689.

[69] CETH, "Transgender Health and HIV," http://transhealth.ucsf.edu/trans?page=guidelines-hiv (accessed August 22, 2018).

[70] Ibid; Sevelius, J., et al., "The Future of PrEP Among Transgender Women."

[71] AIDS United, "Stepping Up: Best Practices In Providing HIV Medical Care, Support Services and Funding To Trans Communities," file:///C:/Users/Megan%20McLemore/Downloads/Stepping_Up__A_Consensus_Statement_by_Trans_Leaders%20(2).pdf (accessed August 22, 2018).

[72] WHO Policy Brief, "HIV and Transgender People," http://www.who.int/hiv/mediacentre/news/transgender-hiv-policy-feature/en/ (accessed August 22, 2018).

[73] CETH, "Transgender Health and HIV," http://transhealth.ucsf.edu/trans?page=guidelines-hiv (accessed August 22, 2018).

HIV risk as well as to interfere with adherence to HIV medications.[74] The National Association of State and Territorial AIDS Directors stated, "Medication adherence among transgender people is heavily dependent on the availability of gender-affirming health services and continued hormone therapy."[75]

Evidence suggests that in addition to reducing anxiety and depression, access to HRT can be an important factor in reducing HIV-related risk behaviors for trans women. Transition therapy has been found to increase quality of life for trans people including improved employment prospects that may reduce the necessity to engage in sex work.[76] Moreover, for trans women, sex with men can provide gender validation.[77] Numerous studies among trans women indicate that HIV-related risk behaviors – including unprotected sex and sex work – are often related to what has been characterized as an "unmet need for gender affirmation."[78] Some trans women describe taking risks to have sex with men in order to confirm femininity and affirm their identity as women. Women also describe the relief obtained by access to HRT and other gender-affirming services, either under medical supervision or from street hormones for those who could not access health care.[79] For trans individuals, ensuring access to hormone replacement therapy is an indispensable element of the standard of care for both HIV prevention and treatment.

Federal Policies Contribute to HIV Risk for Transgender Women

Throughout the course of the HIV epidemic, federal agencies have been slow to respond to issues of HIV among transgender people. In 2010 the first US National HIV/AIDS Strategy announced its vision:

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[74] Ibid; Remien, R., "Addressing Mental Health: A Critical Component To Ending the HIV Epidemic," presentation at Conference on Retroviruses and Opportunistic Infections (CROI), 2018, http://www.natap.org/2018/CROI/croi_205.htm (accessed August 22, 2018).

[75] National Association of State and Territorial AIDS Directors, "Issue Brief: ADAP Considerations for Transgender Health," https://www.nastad.org/sites/default/files/Crossroads-Trans-Health.pdf (accessed August 22, 2018).

[76] Bockting, W., et al., "Adult Development and Quality of Life of Transgender and Gender Non-Conforming People," *Current Opinion in Endocrinology, Diabetes and Obesity*, 23(2): 2016, pp. 188-197 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4809047/ (accessed August 22, 2018).

[77] Poteat, T., et al., "HIV Risk and Preventive Interventions in Transgender Women Sex Workers," *The Lancet*, 385 (9964), 2015: pp. 274-286.

[78] Sevelius, J., "Gender Affirmation: A Framework for Conceptualizing Risk Behavior Among Transgender Women of Color," *Sex Roles*, 68: July 2013, pp. 675-689.

[79] Ibid; Poteat, T., "HIV Risk and Preventive Interventions in Transgender Women Sex Workers;" Keatley, J., et al., "Perceived Risks and Benefits of Sex Work Among Transgender Women of Color in San Francisco, *Archives of Sexual Behavior*, 36 (2007) 768-777.

> The United States will become a place where new HIV infections are rare and when they do occur, every person regardless of age, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high-quality, life-extending care, free from stigma and discrimination.[80]

The Strategy established three primary goals: 1) reducing new HIV infections; 2) increasing access to care and optimizing health outcomes for people living with HIV; and 3) reducing health-related disparities. In 2015, the Office of National HIV/AIDS Policy released the National HIV/AIDS Strategy Updated to 2020, a document that reaffirms the vision of the original strategy and summarizes progress made toward the three goals using a group of 17 "indicators" for measurement of whether specific targets had been reached.[81] Overall, most people who stay in medical care are achieving viral suppression, but the failure to effectively link people to care after diagnosis and retain them in care for treatment adherence are recognized as key problem areas that are having a severe impact on continued high rates of HIV infection among certain groups. As a consequence, the Update identifies linkage to, and retention in, medical care as top priorities for agencies involved in the nation's HIV response.[82]

The Strategy identified HIV among transgender women as a serious concern and acknowledged the problem of inadequate access to gender-affirming health care:

> Transgender individuals are particularly challenged in finding providers who respect them and with whom they can have honest discussions about hormone use and other practices, and this results in lower satisfaction with their care providers, less trust and poorer health outcomes.[83]

Stating that "historically, efforts targeting this specific population have been minimal," the 2010 Strategy identified transgender women, particularly women of color, as a "high-risk" population and urged that Congress and relevant federal agencies fund and implement targeted programs for prevention, treatment and support services.[84]

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[80] National HIV/AIDS Strategy for the United States, 2010.

[81] National HIV/AIDS Strategy for the United States, Updated to 2020.

[82] Ibid.

[83] National HIV/AIDS Strategy for the United States, 2010, p 26.

[84] Ibid, pp. 15-20.

In this context, the needs of transgender women are addressed in numerous provisions of the Update, including a continuing recognition that the dearth of "culturally competent" care for transgender individuals that results in poor health outcomes and a call to establish a new "indicator" for improved data collection of HIV among the transgender population.[85]

But the reality is that despite ample, even overwhelming, evidence of the need to implement culturally competent care and how to do so effectively, implementation of these intentions on the ground is incomplete, fragmented and not incorporated into policy requirements, monitoring, or evaluation.

Some concrete steps were taken under the Obama administration to address trans health care and the alarming risk of HIV infection for trans women. Medicaid expansion was offered to states with the federal government footing most of the bill. The anti-discrimination protections in the Affordable Care Act were interpreted by the Department of Health and Human Services to include discrimination based on gender identity. The CDC issued technical guidance to states to improve their HIV data collection for trans populations and federally funded initiatives such as the Ryan White program, the nation's largest source of funding for HIV care and services, began to utilize a two-step gender identification process for its clients.[86] But implementation was incomplete, new HIV infections among trans women continued to rise, and the Trump administration is taking numerous steps to undo progress in increasing access to health care.

For example, Medicaid coverage, essential to access to health care generally as well as to HIV prevention, is being undermined by the Trump administration and Congress in a variety of ways. Government respect for transgender rights, including the right to health, is moving in the wrong direction. The burdens faced by transgender women in nearly every aspect of life are occurring in an environment of federal policy that not only remains insufficiently protective of LGBT people's rights but has also seen the rollback of many recent gains.

LGBT people are protected by a patchwork of laws and regulations that vary in scope and geography. There are no federal laws that explicitly protect persons from discrimination on

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[85] National HIV/AIDS Strategy for the United States, Updated to 2020.

[86] CDC, "Guidance for HIV Surveillance Programs: Working with Transgender Specific Data" Version 2.0, 2015; Health Resources and Services Administration, "Ryan White HIV/AIDS Program Annual Client-Level Data Report 2016," https://hab.hrsa.gov/sites/default/files/hab/data/datareports/RWHAP-annual-client-level-data-report-2016.pdf (accessed September 7, 2018).

the basis of either sexual orientation or gender identity. However, under the Obama administration, federal agencies issued a series of rules and regulations based on sexual orientation and gender identity to decrease discrimination in federally funded programs. The departments of Education, Justice, Housing and Urban Development, and Health and Human Services, among others, issued guidance or regulations clarifying that discrimination based on sexual orientation and/or gender identity is impermissible under federal law.[87]

Since 2017, the Trump administration has reversed many of those positions, withdrawing anti-discrimination protections and opposing inclusive interpretations of federal anti-discrimination laws in court.[88] Most recently, the administration has enacted two rules that significantly weaken anti-discrimination protections in federally funded health care activities and programs. These actions are likely to exacerbate health disparities for a population that is already significantly at risk. The first is proposed changes to the protections offered to LGBT people under the Affordable Care Act. Section 1557 prohibits discrimination in health care based on race, color, national origin, sex, age, or disability. In 2016, the Department of Health and Human Services issued a rule clarifying that discrimination based on "sex" includes discrimination based on gender identity and pregnancy status.[89]

The rule would have ensured that transgender people could not be denied care or coverage – including for transition-related services – because of their gender identity. However, shortly after the rule was introduced, eight states and religiously affiliated health care providers challenged it in court, and a federal judge in Texas enjoined it from taking effect.[90] Reversing the Obama administration's decision to defend this interpretation in court, the Trump administration has indicated that it no longer considers section 1557 to protect against discrimination based on gender identity or pregnancy status.[91] Though the text of section 1557 has not changed, the administration's re-interpretation of the rule has left transgender people without legal protection and signaled that federal agencies will no longer advance trans-inclusive interpretations of provisions prohibiting discrimination on

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[87] White House, "Obama Administration's Record and the LGBT Community," June 9, 2016, https://obamawhitehouse.archives.gov/the-press-office/2016/06/09/fact-sheet-obama-administrations-record-and-lgbt-community (accessed August 29, 2018).

[88] Dan Diamond, "Trump Administration Dismantles LGBT-Friendly Policies," *Politico*, February 19, 2018, https://www.politico.com/story/2018/02/19/trump-lgbt-rights-discrimination-353774 (accessed August 29, 2018).

[89] "Nondiscrimination in Health Programs and Activities; Final Rule," 45 CFR 92, Federal Register Vol. 81, No. 96, May 18, 2016, https://www.gpo.gov/fdsys/pkg/FR-2016-05-18/pdf/2016-11458.pdf (accessed August 29, 2018).

[90] *Franciscan Alliance v. Price*, US District Court, Northern District of Texas, (7:16-cv-00108).

[91] US Department of Health and Human Services, "Section 1557: Frequently Asked Questions," https://www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/index.html (accessed August 29, 2018).

the basis of sex. In October 2018, the New York Times reported that the administration is considering narrowing the definition of "sex" to male and female for all federal agencies, a move that could eliminate protection against discrimination for transgender and intersex people in employment, education, health care and other areas of life.[92]

The Department of Health and Human Services issued a proposed rule that would give sweeping discretion to providers to discriminate against LGBT people on the grounds of moral and religious belief.[93] The regulation would broaden existing protections for religious objectors by codifying vague, open-ended definitions that would invite discrimination against LGBT people, women and others.[94] In the absence of any provisions that would mitigate harm, these redefinitions risk greatly exacerbating discrimination and barriers to access women and LGBT people already experience. Other actions by the Trump administration include attempts to bar transgender persons from military service and weakening protections for transgender prisoners in the federal Bureau of Prisons. Passage of laws in numerous states that invite discrimination against LGBT persons in health care, adoption, and public accommodations combine with federal action to create a hostile environment that jeopardizes the health of transgender women.[95]

JoAnne Keatley, Director Emeritus of the UCSF Center for Excellence in Transgender Health, is concerned that any momentum for trans women with HIV that did exist will be lost as the Trump administration creates, what she calls, an environment that is "hostile to LGBT rights, but particularly hostile to transgender people."[96]

In June 2018, the Trump administration released a report on the National HIV/AIDS Strategy indicating that on several key fronts progress had been made and reaffirming the commitment to end the nation's HIV epidemic.[97] But, as noted by leading HIV advocacy

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[92] Erica L. Green, Katie Benner and Robert Pear, "Transgender Could Be Defined Out of Existence Under Trump Administration," *New York Times*, October 21, 2018.

[93] "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority," 45 CFR 88, Federal Register Vol. 83, No. 18, January 26, 2018, https://www.gpo.gov/fdsys/pkg/FR-2018-01-26/pdf/2018-01226.pdf (accessed August 29, 2018).

[94] Human Rights Watch, "Human Rights Watch Letter to US Secretary of Health and Human Services Alex Azar," March 27, 2018, https://www.hrw.org/news/2018/03/27/human-rights-watch-letter-us-secretary-health-and-human-services-alex-azar

[95] Human Rights Watch, "All We Want is Equality": Religious Exemptions and Discrimination Against LGBT People in the United States," February 2018, https://www.hrw.org/report/2018/02/19/all-we-want-equality/religious-exemptions-and-discrimination-against-lgbt-people; National Center for Transgender Equality, "The Discrimination Administration: Trump's Record of Action Against Transgender People," https://transequality.org/the-discrimination-administration (accessed November 6, 2018).

[96] Human Rights Watch telephone interview with JoAnne Keatley, Director Emeritus, Center for Excellence in Transgender Health, San Francisco, CA, June 28, 2018.

[97] US Department of Health and Human Services, "National HIV/AIDS Strategy for the United States 2017 Progress Report," https://www.hiv.gov/blog/2017-national-hivaids-strategy-nhas-progress-report-released (accessed August 22, 2018).

organizations, the administration report did not acknowledge the major policy shifts that threaten continued progress, from attacks on Medicaid to the failure to appoint a director for the Office of National HIV/AIDS Strategy or members to the President's Advisory Council in HIV/AIDS (PACHA). As noted in an AIDS United press release, "HIV policy does not occur in a vacuum."[98] Cecilia Chung is a trans woman, national HIV policy advocate, and former member of PACHA. Chung told Human Rights Watch, "Without health care, and without respect for trans people's rights, we will never end the HIV epidemic in this country.[99]

The federal response has produced some visibility for HIV risk among trans women as well as a patchwork of initiatives and grants. But the crucial issue of whether HIV care is integrated with trans health care and provided in a gender-affirming setting has not been translated into federal policy.

This policy void is most problematic in relation to the Ryan White HIV/AIDS program, a statutory program that since 1996 has provided the majority of national funding for medical care, medication and support services for people living with HIV.[100] Administered by HRSA and implemented by the states, Ryan White is a safety net program – eligibility for Ryan White programs, including the AIDS Drug Assistance Program (ADAP) that helps pay for medications, is based on income and availability of health insurance. Ryan White patients must have an HIV diagnosis and income of less than 400 percent of the federal poverty level.[101] Ryan White is intended to be the provider of last resort – the program is available for those who have no insurance, but it can also supplement services that are left uncovered by insurance and, in the case of medications, help pay some premium costs and co-pays to ensure access to HIV medications.[102] Care and services offered through Ryan White funded programs are critical to the US HIV response: an estimated 52 percent of people living with HIV — 550,462 people in 2016 — utilize Ryan White. Ryan White patients have significantly better health outcomes, as these services have proven to be vital to their health; 85 percent of Ryan White patients have achieved viral suppression compared to 49 percent nationwide.[103]

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[98] AIDS United, "A Promising Progress Report on the National HIV/AIDS Strategy Only Tells Half of the Story," https://www.aidsunited.org/Blog/?id=3746 (accessed August 29, 2018).

[99] Human Rights Watch interview with Cecilia Chung, Orlando, FL, September 7, 2018.

[100] Ryan White Comprehensive AIDS Resources Emergency Act, P.L. 101-381, 104 Stat. 576, Enacted August 18, 1990.

[101] Florida Department of Health, HIV/AIDS Patient Care Programs, "Core Eligibility Requirements," http://www.floridahealth.gov/diseases-and-conditions/aids/patient-care/_documents/eligibility-information/attachment-c1-brochure-englishc.pdf (accessed August 30, 2018).

[102] National Association of State and Territorial AIDS Directors, "National RWHAP Part B and ADAP Monitoring Project: 2018 Annual Report," https://www.nastad.org/PartBADAPreport (accessed August 30, 2018).

[103] AIDS Watch, "Access to Care," file:///C:/Users/Megan%20McLemore/Downloads/Health_Care_Acess.pdf (accessed August 30, 2018).

The purpose of the Ryan White program is to ensure care for those who have no other options, and in states like Florida with limited access to Medicaid, the program is of lifesaving importance for trans women living with HIV. According to HRSA's annual Ryan White report for 2016, there are 7,166 transgender clients in Ryan White programs nationwide, 355 of whom reside in Florida. Most are trans women (93 percent) and African-American (54 percent). An overwhelming majority live in extreme poverty: 78 percent live at or below the federal poverty level, earning less than $12,000 per year.[104] Though lower than for Ryan White clients overall, viral suppression rates for transgender clients are high (79 percent), much higher than the national average of viral suppression of 49 percent, illustrating the importance of the Ryan White program to transgender women living with HIV. Ryan White-funded clinics clearly help trans women once they enter and stay in the program – but as with other key groups impacted by the US HIV epidemic, there are troubling gaps in engagement and retention in care.

The necessity of gender-affirming care to engage and keep trans women in HIV care is well established, as is the feasibility of implementing this approach. In 2012, HRSA began funding a Special Project of National Significance (SPNS) project called the Transgender Women of Color Initiative (TWOC). TWOC was a demonstration project for improving HIV care at nine sites – both health facilities and community organizations. One of the primary elements of this project was the integration of trans-related health care, including HRT, with HIV care at several of the sites. None of the TWOC sites was in Florida, but for more than five years this project has demonstrated how a focus on providing gender-affirming care — from putting posters with images of trans people on the wall in a clinic to helping with documentation to ensuring availability of HRT — can improve HIV outcomes for trans women of color, and full results are expected to be published in fall of 2018.[105]

The quality of HIV care for trans individuals is included in one federal demonstration project, but participation by states and clinical providers is optional. HRSA is funding a project to offer technical assistance to state health departments and Ryan White-funded health care providers to improve the quality of HIV care to high-risk populations. The project, called the ECHO project, commenced in July 2018, and is designed to respond to

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[104] Health Resources and Services Administration (HRSA) , Ryan White HIV/AIDS Program Clients, Transgender Clients 2016, on file with Human Rights Watch; HRSA, Ryan White HIV/AIDS Program Client Level Data Report 2016, https://hab.hrsa.gov/sites/default/files/hab/data/datareports/RWHAP-annual-client-level-data-report-2016.pdf (accessed August 22, 2018).

[105] Human Rights Watch interview with Dr Greg Rebchook, Principal Investigator, San Francisco, CA, June 27 2018 and https://hab.hrsa.gov/sites/default/files/hab/data/biennialreports/2016_HRSA_Biennial_Report.pdf and https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2016.303582 , full results to be published in a special issue of AIDS and Behavior in the fall 2018.

requests for assistance from clinics whose data indicate health disparities for any of four groups, including transgender people. Transgender HIV experts will be available to consult on ways to increase trans engagement and retention in care. But whether entities will reach out for assistance with trans clients remains to be seen. According to one administrator for the HRSA ECHO program, response from providers is uncertain:

> We are not sure that trans issues will be addressed. It is a time commitment to participate – ten hours of training a month, data reports monthly, consultant involvement – this is a lot of time for a very small population.[106]

Another HRSA-funded project commencing in 2018 will support 26 clinics around the US to implement evidence-based approaches to HIV care for high risk populations, including transgender people. Yet no policies or standards require federally funded HIV care to be provided in a gender-affirming setting and there is no systematic monitoring or evaluation of this issue by the federal government.

JoAnne Keatley has published extensively on the importance of integration of care and provided technical assistance for the TWOC project. According to Keatley, “Even before the TWOC project, we had the evidence we need – we know what to do to improve HIV outcomes for trans women. We have been working for decades to incorporate these findings into federal policy.”[107]

In the absence of federal standards or guidance, integration of HIV care with trans health care remains aspirational, limited, and incomplete in many states such as Florida. As discussed in detail below, Florida HIV officials provide funding to clinics that promote and offer gender-affirming care, but information from the ground indicates that they are also funding sites that do not. The AIDS Drug Assistance Program (ADAP) provides HIV medications to those without health insurance, but in many states, including Florida, medications necessary for gender transition care are missing. Although millions of federal dollars are being administered, states implement Ryan White funding without policy guidance or compliance standards from the federal government for ensuring that gender-affirming care is implemented. According to Florida Department of Health HIV program officials:

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[106] Human Rights Watch telephone interview with Kevin Garrett, Senior Quality Manager, HRSA Ryan White HIV/AIDS Program Center for Quality Improvement and Innovation, New York, NY, June 21, 2018.

[107] Human Rights Watch telephone interview with JoAnne Keatley, Director Emeritus, Center for Excellence in Transgender Health, San Francisco, CA, June 28, 2018.

After a thorough search we could find no HRSA or Ryan White regulations that addressed gender-affirming care for transgender women living with HIV.[108]

HIV in Florida

The state of Florida, along with the rest of the US south, lies at the center of the nation's HIV epidemic. With more than 116,000 people known to be living with HIV, Florida accounts for 11 percent of HIV cases in the US.[109] Florida has the nation's third highest rate of new HIV infections, and the epidemic is concentrated in urban areas of the state. The cities of Miami, Fort Lauderdale and West Palm Beach accounted for 47 percent of the state's new HIV infections in 2016.[110] The rates of HIV infection in Miami-Dade and Broward counties are the highest in the nation. In 2017, the metropolitan areas that included Miami-Dade and Broward counties ranked first and second in the US in the rate of new HIV infections.[111]

Racial disparities are stark. In Florida, one in every 151 adults is known to be living with HIV; one in 295 whites, one in 49 African-Americans and one in 155 Hispanics.[112] African-Americans are 15 percent of the state's population, but account for 42 percent of adult HIV infection cases and 50 percent of adult AIDS diagnoses. Hispanic people comprise 24 percent of Florida's adult population but represent 31 percent of HIV infection cases and 24 percent of AIDS cases.[113] The rate of HIV infection in Florida is five times higher for Black men than white men, and 12 times higher for Black women than white.[114]

Florida surveillance data indicate that male-to-male sexual contact is the primary mode of transmission for both those living with HIV and new infections, followed by heterosexual

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[108] Human Rights Watch email communications with Devin Galetta, Interim Communications Director, Florida Department of Health, June 22, 2018 and July 25, 2018 ("FDOH Responses").

[109] State of Florida Integrated HIV Prevention and Care Plan 2017-21"; Washington DC's rate of new infections is higher than any state; Florida's rate of new HIV infection is third behind Georgia and Louisiana. Florida Department of Health, HIV/AIDS Section, "State of the Epidemic in Florida, 2017.

[110] CDC. "HIV in the United States by Geography," https://www.cdc.gov/hiv/statistics/overview/geographicdistribution.html (accessed August 30, 2018); Florida Department of Health, "State of Florida Integrated HIV Prevention and Care Plan 2017-21," http://www.floridahealth.gov/diseases-and-conditions/aids/Prevention/_documents/State-of-Florida-Integrated-HIV-Prevention-and-Care-Plan-09-29-16_FINAL-Combined.pdf (accessed August 30, 2018).

[111] Florida Department of Health, HIV/AIDS Section, "State of the HIV Epidemic in Florida, 2017." State HIV data utilize "Black" and "Hispanic" as categories for racial classification.

[112] Ibid.

[113] Ibid.

[114] Florida Department of Health, "State of Florida Integrated HIV Prevention and Care Plan 2017-21."

contact and injection drug use.[115] As discussed in detail below, this data does not accurately reflect either cases or transmission modes among the transgender population.

State Response to HIV

In the US, the federal government is the primary source of funding for state HIV response, and the severity of the epidemic in Florida has resulted in what the statewide HIV Prevention and Care Plan calls "one of the nation's most comprehensive programs for HIV/AIDS surveillance, education, prevention, counseling, testing, care, and treatment."[116] In fiscal year 2017-2018, Florida's HIV budget totaled nearly $300 million, mostly from federal sources. This budget has increased in the last three years by 15.6 percent. [117]

In Florida, lack of other insurance options has resulted in a significant reliance on Ryan White. One in five people in Florida is uninsured, the third-highest percentage in the nation.[118] More than half of people living with HIV in the state rely on care and services from the Ryan White Program.[119] Florida has a very restrictive Medicaid program and many people cannot afford to purchase private insurance, do not receive it from their employer, or are not eligible for federally subsidized insurance premiums under the Affordable Care Act. An estimated 384,000 people fall into this "coverage gap" in the state.[120] In Florida, the majority of Ryan White clients are African-American men, have incomes under 100 percent of the federal poverty level (less than $13,860 per year for an individual), and have no insurance.[121]

Florida's extensive public HIV program has produced mixed results. Significant improvement has occurred over the last decade: Between 2008 and 2017, there was an 18

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[115] Florida Department of Health, HIV/AIDS Section, "State of the HIV Epidemic in Florida, 2017."

[116] Florida Department of Health, "State of Florida Integrated HIV Prevention and Care Plan 2017-21."

[117] FDOH Responses.

[118] David K. Jones and Paula S. Atkinson, "At Stake in the 2018 Midterms: Medicaid Expansion in Florida and Maine," Health Affairs Blog, July 27, 2018, https://www.healthaffairs.org/do/10.1377/hblog20180726.267396/full/?utm_campaign=Health+Affairs+Today+Newsletter&utm_medium=email&utm_content=email&utm_source=Act-On_2018-07-27&cm_mmc=Act-On+Software-_-email-_-Medicaid+Expansion+and+The+2018+Midterms%3B+Hospital+OPPS+Proposed+Rule-_-At+Stake+In+The+2018+Midterms%3A+Medicaid+Expansion+In+Florida+And+Maine&utm_term=At+Stake+In+The+2018+Midterms%3A+Medicaid+Expansion+In+Florida+And+Maine (accessed August 30, 2018).

[119] Health Resources and Services Administration, "Ryan White HIV/AIDS Clients Served by State, 2015" https://hab.hrsa.gov/stateprofiles2015/#/ (accessed August 30, 2018).

[120] David K. Jones and Paula S. Atkinson, "At Stake in the 2018 Midterms: Medicaid Expansion in Florida and Maine,"; Southern AIDS Strategy Initiative," Medicaid Expansion in the South," https://southernaids.files.wordpress.com/2016/03/medicaid-expansion-in-the-south-report-final1.pdf (accessed August 30, 2018.)

[121] Health Resources and Services Administration, "Ryan White HIV/AIDS Clients Served by State, 2015" https://hab.hrsa.gov/stateprofiles2015/#/ (accessed August 30, 2018).

percent decline in HIV cases diagnosed, a 51 percent decline in AIDS cases diagnosed, and a 47 percent decline in HIV-related deaths.[122] Some recent trends are promising. Between 2014 and 2016, more Floridians with HIV entered medical care, remained in care, and became virally suppressed.[123] In the state ADAP program, 9 of 10 clients have achieved viral suppression.[124]

However, new infections have increased since 2013. Rates of new infection are highest among men who have sex with men (a category that erroneously includes many trans women), particularly young men of color.[125] The number of patients who fail to remain in treatment for HIV is concerning; of persons diagnosed with HIV, 92 percent are linked to care, but only 66 percent remain in care and 60 percent become virally suppressed.[126] Despite improvement in some areas, Florida is still struggling to bring its HIV epidemic under control.[127] In 2018, state HIV officials reported that many of the targets set in the previous year – including reducing new HIV infections, reducing new infections among African-American and Hispanic people, and reducing rates of infection among Hispanics – had not been met.[128]

Florida faces many challenges in effectively managing HIV. With 20 million people, it is the fourth most populous state in the US, a vast geographical area both urban and rural. Floridians are multi-ethnic (17 percent African-American and 24 percent Hispanic or Latino, according to 2017 census estimates) and there is a considerable transient population comprised of migrant workers as well as seasonal and part-time residents.[129] Its fiscal policy is conservative, with a constitution that prohibits state income taxes – the last tax increase occurred in 1988 and increased the sales tax by one percent.[130] Under Republican

[122] Florida Department of Health, HIV/AIDS Section, "State of the HIV Epidemic in Florida, 2017,"; Florida Department of Health, "State of Florida Integrated HIV Prevention and Care Plan 2017-21."

[123] Ibid.

[124] Ibid.

[125] Ibid.

[126] Ibid.

[127] Cohen, J. "We're In a Mess'- Why Florida Is Struggling With an Unusually Severe HIV/AIDS Problem,"*Science*, June 13, 2018.

[128] Florida Department of Health, HIV/AIDS Section, "Agency Performance Management Council Meeting, Performance Review," April 12, 2018, on file with Human Rights Watch.

[129] United States Census Bureau, "State of Florida Quick Facts," https://www.census.gov/quickfacts/FL (accessed August 30, 2018). The Census utilizes "Latino" as a classification category.

[130] George Mason University, Mercatus Center, "Florida Fiscal Policy: Responsible Budgeting in a Growing State," https://www.mercatus.org/publication/florida-fiscal-policy-responsible-budgeting-growing-state (accessed August 30, 2018).

Governor Rick Scott, health and education budgets have experienced deep cuts.[131] In 2017, public health funding in Florida as a percentage of the budget ranked 40th in the nation; effective health care policy, comprised of factors such as percent uninsured, health spending, and vaccination coverage, ranked 46th among 50 states.[132]

In 2018, the legislature failed to pass a bill that would have permitted syringe exchange programs to operate statewide, leaving Miami-Dade as the only county with a syringe exchange program. Rejection by conservative legislators of proven public health and harm reduction approaches to injection drug use are problematic as the state, and the US, faces an unprecedented epidemic of drug overdose and increasing rates of HIV, hepatitis C, and other illnesses from injection drug use.[133]

The policy most detrimental to Florida's ability to manage its HIV epidemic is the state's failure to expand its Medicaid program. Under the Affordable Care Act, states have the option to expand eligibility guidelines for their Medicaid programs with payment largely covered by the federal government.[134] Florida is one of 18 states that have rejected this option despite Florida's very restrictive Medicaid eligibility guidelines for its state program. Florida limits Medicaid eligibility both categorically (one must be disabled, parents of dependent children, a pregnant woman, or in need of long-term care) and income (for example, parents and caretakers' income cannot be higher than 29 percent of the federal poverty level, or more than $7,380 per year).[135]

Medicaid expansion has benefited people living with HIV, primarily by ensuring coverage for a core group of comprehensive medical services without exclusion for pre-existing

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[131] Ryan Benk, "Lawmakers Unveil Budget Proposals Containing Punishing Cuts to Hospitals," *Health News Florida*, March 29, 2017, John Kennedy, "At Height of Opioid Crisis, Some Florida Treatment Programs Face Deep Cuts," *Sarasota Herald Tribune*, May 8, 2018; Kate Santich, "Cuts to Mental Health Care Could Leave Thousands Without Help, Advocates Say," *Orlando Sentinel*, August 7, 2017.

[132] United Health Foundation, "America's Health Rankings, Florida in 2017," https://www.americashealthrankings.org/explore/annual/state/FL (accessed August 30, 2018).

[133] CDC, "Increasing Rates of Hepatitis C Linked to Worsening Opioid Crisis," https://www.cdc.gov/nchhstp/newsroom/2017/hepatitis-c-and-opioid-injection-press-release.html (accessed August 30, 2018).

[134] Center for American Progress, "10 Frequently Asked Questions About Medicaid Expansion," https://www.americanprogress.org/issues/healthcare/news/2013/04/02/58922/10-frequently-asked-questions-about-medicaid-expansion/ (accessed August 30, 2018).

[135] Florida Policy Institute, "Medicaid Premiums and Work Requirements: A Prescription for Higher Costs and Lower Health Insurance Coverage," https://www.fpi.institute/wp-content/uploads/2017/11/MedicaidWorkReq.pdf (accessed August 30, 2018).

conditions.[136] In Medicaid expansion states, Medicaid coverage for people living with HIV rose 11 percent, with the most significant gains in coverage experienced by people with the lowest incomes and people of color.[137] Medicaid expansion has the potential to significantly mitigate HIV risk as well; expansion has been shown not only to increase access to comprehensive health services but to reduce poverty, a primary driver of HIV risk in the US.[138] Because Medicaid expansion regulations incorporate the anti-discrimination provisions of the Affordable Care Act, expansion is particularly important for LGBT people and other groups experiencing discrimination in health care.[139]

Broader eligibility under Medicaid expansion extends not only to working people with higher incomes, but to adults without dependent children. For Floridians, and for many trans women, this is a key factor as the Florida Medicaid program is limited to adults with dependent children, pregnant women or people with disabilities. In Florida, 87 percent of people who fall into the health insurance "coverage gap" as a result of failure to expand Medicaid are adults without dependent children, and 47 percent are people of color.[140]

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[136] Center for American Progress, "The Medicaid Program and LGBT Communities," https://www.americanprogress.org/issues/lgbt/reports/2016/08/09/142424/the-medicaid-program-and-lgbt-communities-overview-and-policy-recommendations/ (accessed August 30, 2018).

[137] Kaiser Family Foundation, "ACA Medicaid Expansion Drove Nationwide Increase in Health Coverage for People with HIV, First National Analysis Finds," https://www.kff.org/health-reform/press-release/aca-medicaid-expansion-drove-nationwide-increase-in-health-coverage-for-people-with-hiv-first-national-analysis-finds/ (accessed August 30, 2018).

[138] Chicago Policy Review, "Reducing Poverty: How Medicaid Does More Than Just Improve Access to Health Care in Cities," http://chicagopolicyreview.org/2014/01/20/reducing-poverty-how-medicaid-does-more-than-just-improve-access-to-healthcare-in-cities/ (accessed August 30, 2108).

[139] Center for American Progress, "The Medicaid Program and LGBT Communities," https://www.americanprogress.org/issues/lgbt/reports/2016/08/09/142424/the-medicaid-program-and-lgbt-communities-overview-and-policy-recommendations/ (accessed August 30, 2018).

[140] Kaiser Family Foundation, Medicaid Issue Brief, "The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid," https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/ (accessed August 30, 2018).

Findings

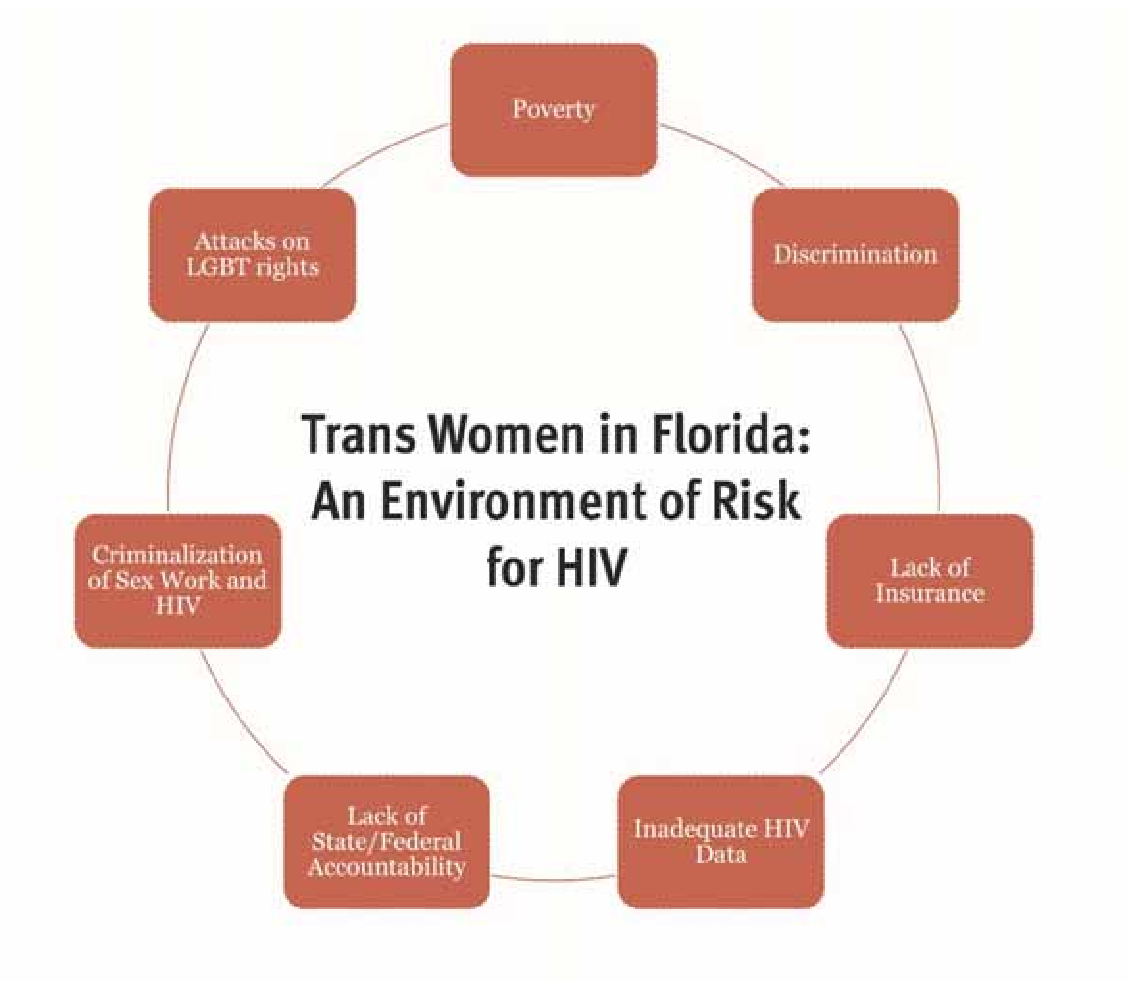
For this report, Human Rights Watch administered 125 questionnaires to women of trans experience in Miami-Dade and Broward counties, gathering demographic information as well as information related to access to health care, including HIV prevention and treatment. The surveys and additional interviews with trans women, their advocates, HIV providers, and others indicated that many trans women in south Florida, particularly Latina and African-American women, live in an environment of high HIV risk as a result of multiple factors, with poverty and lack of health insurance standing out as primary vulnerabilities. Lack of income was associated with high rates of participation in sex work and with high rates of involvement with the criminal justice system – factors that increase HIV risk. These findings are consistent with other surveys of trans women in Florida, such as the one conducted by the 2015 US Transgender Survey, showing high rates of poverty and criminal justice involvement for trans women, particularly women of color.[141]

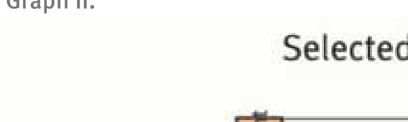
This severe and compound environment of risk for HIV demands a robust response from both state and federal government. There is ample evidence of how to provide effective health care, including HIV care, for trans women. But in south Florida, trans women face a fragmented landscape for health care that fails to ensure that effective, integrated HIV care is available at a cost that transgender women can afford. With no explicit or coordinated policies to ensure systematic monitoring and evaluation of HIV prevention or care for trans women, accountability is lacking. Policy development is hindered by lack of accurate or complete data regarding HIV among transgender women, a continuing problem that perpetuates a cycle of perceiving this at-risk population as "too small to help" at both the state and federal levels. Criminalization of sex work and HIV promote unemployment, poverty, and stigma that make access to health services more difficult. Few questions remain about what needs to be done, but without commitment by policymakers to do it, trans women will continue to experience grossly disproportionate disparities in access to health and HIV prevention and care.

[141] NCTE, National Transgender Survey, 2015.

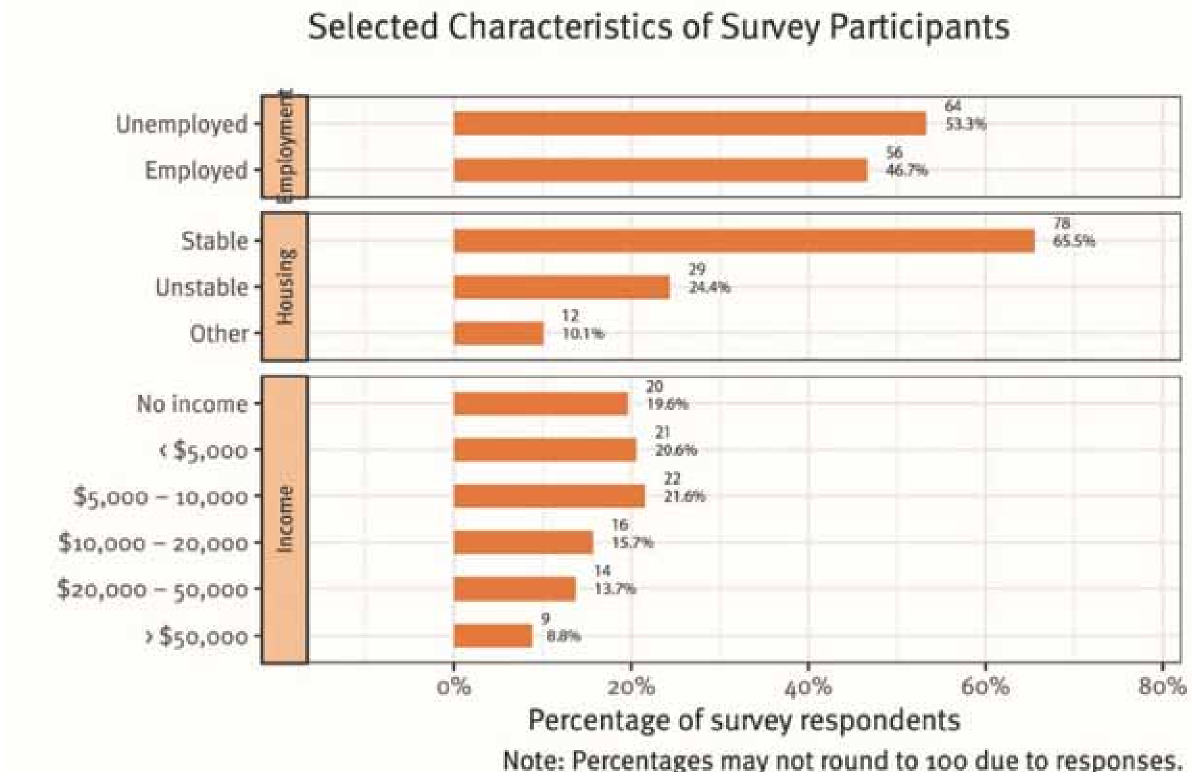
Trans Women Face Barriers to Health Care in Florida

Trans women in Miami-Dade and Broward counties face multiple challenges that impact access to health care. As part of the research for this report, Human Rights Watch conducted a survey of 125 trans women with the assistance of local organizations and trans health advocates. The results below indicate severe socio-economic deprivation and a fragile existence for the majority of trans women interviewed.





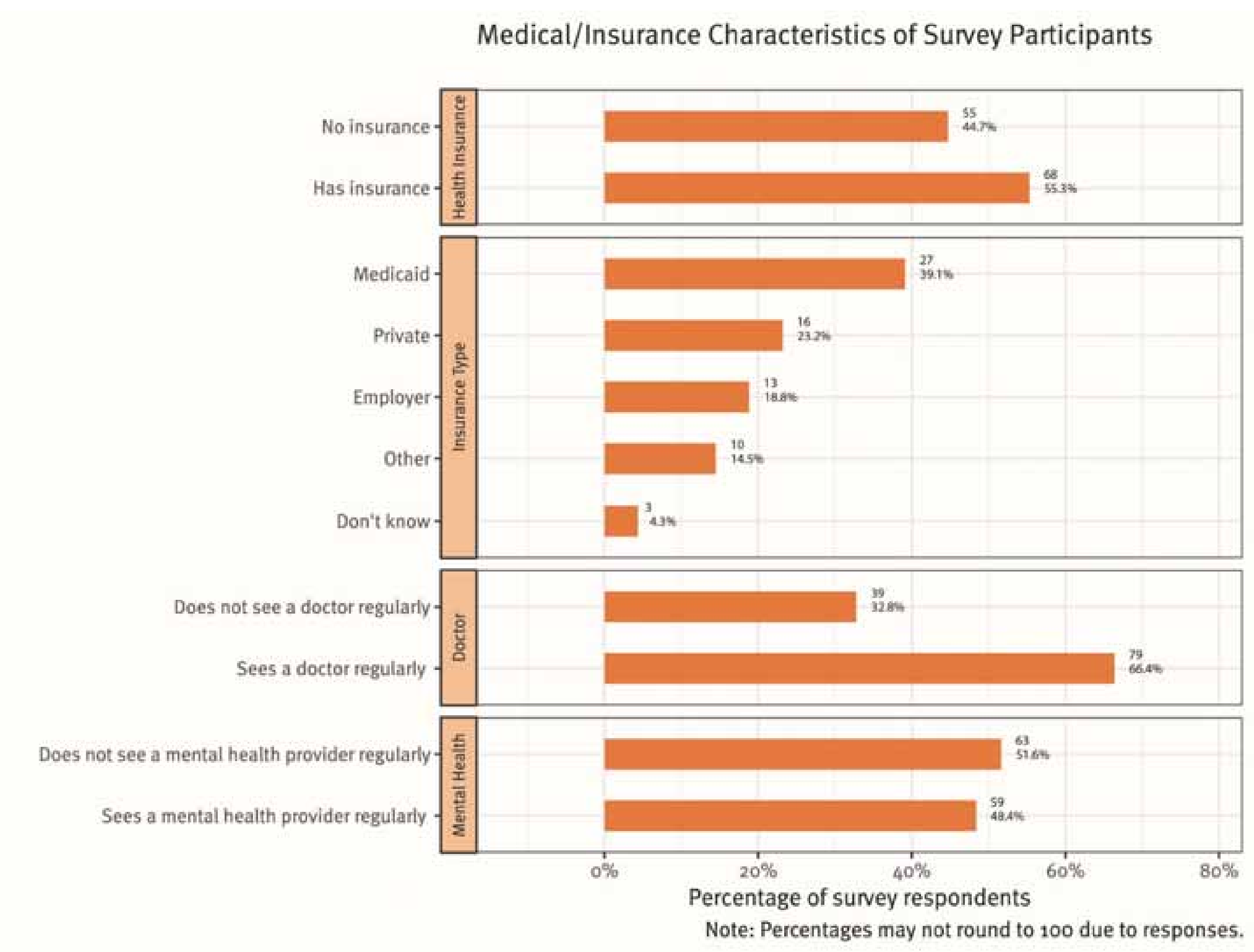
Graph II.



The survey results reveal many trans women experience extreme poverty, with 63 percent of participants reporting income of less than $10,000 per year (20 percent of survey participants had no income; 21 percent reported income under $5,000 per year; 22 percent reported income between $5000 and $10,000 per year). More than half (53 percent) were unemployed. One third reported that their housing situation was “unstable” or “other” than stable (see Graph II).

These were not the most marginalized trans women living in areas with scarce resources. The survey was distributed through organizations providing services to trans women and participants were more likely to be connected to health care than in a more randomized sample. Also, the surveys were distributed in two major metropolitan areas with extensive health and HIV care infrastructure. Yet the results below indicate significant gaps in coverage and access to health insurance or care (see Graph III).

Graph III.



Of trans women surveyed, 45 percent had no health insurance. Of those that had health insurance, 39 percent had Medicaid and 23 percent reported having private insurance. Sixty-six percent see a doctor regularly (defined as twice a year or more) and 48 percent see a mental health provider regularly. Of those who did not see a doctor regularly, 38 percent said they could not afford it.

In detailed survey responses, many women described bad experiences with medical providers and their struggles to access gender-affirming care:

"Every time you walk into the doctor's office, you become a science experiment." – Ellen, age 44.[142]

[142] Human Rights Watch interview with Ellen A., Fort Lauderdale, FL, December 11, 2017.

"When I transitioned, my doctor wouldn't see me after that. I couldn't get in to see them. I had an infection and they wouldn't call in the antibiotics. It was an ordeal. It was scary. I just felt bad about how they treated me." Susan, age 22.[143]

"I used to go to Jackson hospital, but I haven't been there in over a year. They are terrible. Not knowledgeable about trans health. They misgendered me. I don't feel comfortable or trust them." – Barbie, age 65.[144]

Many described cost and lack of insurance as the key factor in lack of health care:

"I made $450 a month and was working for ten years. Was denied Obamacare. Very hard to find insurance in Florida." – Valerie, age 50.[145]

"I have diabetes. Hormones and diabetes medications cost $500 a month, I can't afford that." – Diana, age 54.[146]

Knowledge of where to get an HIV test was high, with 91 percent reporting that they knew where they could get tested. Nearly one quarter (23 percent) of survey participants reported that they were HIV-positive. To place this result in context, many surveys were distributed through agencies that provide referrals for HIV-related services. More than one in three (35 percent) trans women living with HIV had no health insurance. However, 88 percent of women living with HIV reported seeing a doctor regularly, and most were taking HIV medications (92 percent). With 77 percent of women living with HIV reporting that they had achieved an undetectable viral load, these results indicate the importance of the Ryan White safety net in states such as Florida, where many are without insurance and Medicaid has not been expanded.

Many of the women, including those living with HIV, described a difficult process for finding care that centered around safety and trust concerns.

Misty Eyez is a trans woman who works as an educator, trainer and case manager for trans women at Sunserve, an NGO in Broward County. Eyez described the fear of going to the doctor:

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[143] Human Rights Watch interview with Susan B., Fort Lauderdale, FL, April 25, 2018.

[144] Human Rights Watch survey response, Miami, March 27, 2018.

[145] Human Rights Watch interview with Valerie N., Miami, Florida, March 30, 2018.

[146] Human Rights Watch interview with Diana A., Fort Lauderdale, April 25, 2018.

> Many trans women are not comfortable leaving their house during the day. Therefore, going to the doctor can be an ordeal. For many reasons, some feel they have to put themselves totally together with the dress, the wig, the makeup in order to go out of the house, and then will they be safe in public, on the street, or on the bus? And how will they be treated when they get there? It is very lonely and isolating.[147]

Lack of Gender-Affirming Care Impedes HIV Response

For trans women, including those living with HIV, gender-affirming health care is not optional. Not all trans women want hormone replacement therapy (HRT), but for many it is central to their wellbeing and their number one health care priority. As Morgan Mayfaire, a trans man and co-director of TransSOCIAL, an advocacy organization for trans people living with HIV in Broward and Miami-Dade counties, told Human Rights Watch: "In this community, HRT is all. You will walk through a moat full of alligators to get your hormones."[148]

This is true even for women living with HIV, which is one reason that HIV and trans health experts consider integration of HRT and HIV care to be critically important. The WHO, the Center for Excellence in Transgender Health at the University of California at San Francisco, the Fenway Institute, and others clearly identify integration of HRT and HIV care to be a best practice for HIV care for trans individuals.[149] The trans leaders convened by AIDS United emphasized the importance of a "one-stop shop" providing HRT and HIV treatment:

> Due to financial hardship, housing instability, trauma due to a very real fear of violence in their lives, and distrust of medical personnel, trans people often fall out of care. If trans people are to successfully engage in and remain retained in care, clinical settings must design care that accounts for this reality. [As a best practice] Providers should consider establishing trans medical homes that address all health needs in a "one-stop shop" to

[147] Human Rights Watch telephone interview with Misty Eyez, Sunserve, Fort Lauderdale, FL, July 24, 2018.

[148] Human Rights Watch interview with Morgan Mayfaire, co-director of Transsocial, Fort Lauderdale, FL, November 17, 2017.

[149] The Fenway Institute, "Retaining Transgender Women in HIV Care," http://fenwayhealth.org/wp-content/uploads/TFIR46_RetainingTransgenderWomenInHIVCare_BestPractices_webready.pdf (accessed August 31, 2018).

> retain and engage people in a consistent level of preventive and primary care.[150]

According to Dr. Madeline Deutsch, an expert in transgender health at the University of California at San Francisco, integration of HRT with HIV treatment should be considered not only a best practice, but the standard of care for trans people living with HIV:

> Hormone therapy can increase engagement in care and increase adherence to anti-retroviral medication. It may not yet be considered a standard of care, but it should be. Not providing hormone therapy with HIV care is akin to providing HIV care in a Latina neighborhood without any Spanish speakers available.[151]

In south Florida, finding health care in a gender-affirming environment is difficult, and for trans people living with HIV the options are limited. Human Rights Watch interviewed trans women and their advocates, Ryan White providers, public health officials, and organizations in each county whose primary mission includes directing trans people either recently diagnosed with, or living with, HIV to appropriate medical services. These latter resources, many of which are small non-profit agencies, make it their priority to stay abreast of which clinics offer gender-affirming care, including HRT, to trans HIV patients so they can make effective referrals for care. It is a fluid situation that often depends on the presence of an individual trans-friendly or trans doctor, case manager, or another key employee. Based upon these sources, three to five clinics in each county were consistently identified as providing gender-affirming integrated HIV care to transgender people.

HIV care is widely available in Miami-Dade and Broward counties. An extensive, federally funded network of private, public and community-based providers offer prevention, medical care, case management and support services. The Health Resources Services Administration (HRSA) administers the Ryan White program funding in the US. HRSA designates priority funding for primary medical services under Part A of the program to metropolitan areas throughout the country. Due to the severity of their local HIV epidemics, Broward and Miami-Dade counties are two of six Florida metropolitan areas

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[150] AIDS United, "Stepping Up: Best Practices In Providing HIV Medical Care, Support Services and Funding To Trans Communities," file:///C:/Users/Megan%20McLemore/Downloads/Stepping_Up__A_Consensus_Statement_by_Trans_Leaders%20(2).pdf (accessed August 22, 2018).

[151] Human Rights Watch telephone interview with Madeline Deutsch, MD, Assistant Clinical Professor, UCSF, San Francisco, CA, May 17, 2018.

that receive Ryan White funds for primary medical services under Part A of the Ryan White program. In fiscal year 2017-18, Miami received more than $26 million in Part A funding for treatment and care and Fort Lauderdale received more than $15 million. This does not include separate funding received by both counties for Part B services which include the AIDS Drug Assistance Program (ADAP) for HIV-related medications.[152]

In Broward County, there are 13 providers of primary medical care for HIV that are entirely or partially funded by Ryan White. In Miami-Dade County, there are 24 providers of primary medical care for HIV entirely or partially funded by Ryan White. These range in type from private non-profit organizations such as the AIDS Healthcare Foundation to the University of Miami Comprehensive AIDS Program at the Miller School of Medicine. In both counties, clinics are available in all regions of the county, though most services are concentrated in the cities of Fort Lauderdale and Miami.[153]

However, finding gender-affirming health services is a challenge. Arianna Lint is a Latina trans woman and director of Arianna's Center, a non-profit organization whose mission is to provide support services, outreach, and advocacy for Latina trans women in both Miami-Dade and Broward counties. Arianna is a woman living with HIV and, as part of the national Positively Trans initiative sponsored by the Transgender Law Center, about one third of Arianna's 350 clients are HIV-positive trans women. Arianna explains that in south Florida, finding a clinic where Spanish language services are available is not a problem, but HRT availability is limited, making referrals difficult for many of her clients.

> For the girls who are HIV-positive I help them in every way – I counsel them about HIV, I get them connected to medical care that they can afford, and I help them stay on their HIV medications. I know which clinics in the area are trans-friendly, and they can either start or get onto hormones if they want them. Unfortunately, there are very few clinics that provide both hormones and HIV care, but I know which ones they are, so that is where I send women when they call me for help.[154]

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[152] Health Resources and Services Administration, "FY 2017 Ryan White HIV/AIDS Program Part A Final Awards," https://hab.hrsa.gov/awards/fy-2017-ryan-white-hivaids-program-part-a-final-awards (accessed August 31, 2018) and FDOH Responses.

[153] Florida Department of Health, "State of Florida Integrated HIV Prevention and Care Plan 2017-21," and Miami-Dade HIV/AIDS Partnership materials, on file with Human Rights Watch.

[154] Human Rights Watch interview with Arianna Lint, Executive Director of Arianna's Center, Wilton Manors, FL, July 13, 2017.

As co-director of TransSOCIAL, a non-profit organization that provides a wide array of support, Morgan Mayfaire refers hundreds of trans people to services in both Broward and Miami-Dade counties each year. TransSOCIAL also provides cultural competence trainings to businesses, health centers, and HIV providers in an effort to expand safe and affirming resources for the trans community. Mayfaire is also a member of the state HIV Comprehensive Planning Network (FCPN), and he told Human Rights Watch:

> There is a severe lack of HIV providers who are willing to prescribe hormones or offer a trans-friendly environment. We refer to a handful of clinics and that covers both Miami-Dade and Broward counties. It's a big problem because there are many more HIV providers than HRT providers, but most HIV providers do not want to prescribe hormones, or people have had bad experiences going to that location. We spend a lot of time working on trying to make HRT and ART available in the same place.[155]

Dr. Sheryl Zayas is the Medical Director of Care Resource Community Health Center in Fort Lauderdale, a full-service health center that is partially funded by Ryan White to provide HIV care in the community. Dr. Zayas estimates that between 10 and 15 percent of her several hundred patients are trans women, many of them HIV-positive. Dr. Zayas describes Care Resource as a gender-affirming environment, an opinion that was confirmed by trans survey participants and those who refer trans patients for HIV care. At Care Resource Fort Lauderdale, services are offered on a sliding scale for income, staff are trained regularly on trans-sensitive issues, low thresholds are set for documentation and it need not be conforming to one's gender identity, and a trans woman is employed in an outreach program to inform trans women about HIV services at the clinic. Dr. Zayas told Human Rights Watch that she considers offering hormone replacement therapy to be "essential" to keeping people in care:

> This is a community under stress. Homelessness, lack of jobs, lots of having to do sex work to survive. All of my trans clients don't want hormones, but most do, and I have a better chance to keep them in health care if I can prescribe it.[156]

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[155] Human Rights Watch interview with Morgan Mayfaire, co-director of TransSOCIAL, Fort Lauderdale, FL, November 17, 2017.
[156] Human Rights Watch interview with Sheryl Zayas, MD, Fort Lauderdale, FL, February 7, 2018.

However, not all of the Care Resource locations offer this level of service to trans patients. At one clinic, for example, Dr. Zayas said, "We have one provider who treats HIV patients but doesn't want to do HRT. I don't know why. It might be for religious reasons."[157]

Dr. Zayas believes training of medical professionals can go a long way toward reducing reluctance to provide hormone therapy. She is not an endocrinologist, but finds it sufficient to follow the WPATH guidelines for transgender primary care and the standards for hormone treatment established by the Endocrine Society Clinical Guidelines. She participates in medical training symposia that address transgender health issues and clinical practice.

Dr. Maureen Greenwood's practice at the AIDS Healthcare Foundation clinic in Oakland Park, Broward County, focuses on HIV. Dr. Greenwood has approximately 200 transgender patients. Dr. Greenwood, a Doctor of Nursing Practice, said she follows the WPATH guidelines for transgender clinical care and consults their staff endocrinologist in more complex cases, but that that situation is rare. Dr. Greenwood also stated that training for medical practitioners in transgender health issues is essential to increasing the availability of services.[158]

Some medical providers may not be aware that standards and best practices for transgender health have evolved, moving away from specialist care for hormone therapy and eliminating the need for a mental health referral to initiate hormone replacement therapy. Historically, a mental health provider had to approve an individual for HRT before a primary care physician could prescribe the medication. Though this approach is still accepted by WPATH as valid, an "informed consent" model is now widely implemented that lowers the threshold and focuses on the elements of informed consent that are ethically required for administration of all other medications: an individual's understanding of the risks, benefits and consequences of taking, and of not taking, gender-affirming medications. This model is endorsed by WPATH, CETH, and other experts as appropriate for medical providers to implement on their own.[159] Under current standards, doctors, nurse practitioners, physicians' assistants, and other providers qualified to assess and diagnose gender dysphoria and assess informed consent can

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[157] Ibid.

[158] Human Rights Watch interview with Maureen Greenwood, DNP, Oakland Park, FL, November 10, 2017.

[159] World Professional Association for Transgender Health, Standards of Care, https://www.wpath.org/media/cms/Documents/Web%20Transfer/SOC/Standards%20of%20Care%20V7%20-%202011%20WPATH.pdf (accessed August 17, 2018.);); University of California at San Francisco, Center for Excellence in Transgender Health (CETH), "Overview of Gender Affirming Treatments and Procedures," http://transhealth.ucsf.edu/trans?page=guidelines-overview (accessed August 17, 2018).

prescribe hormone replacement therapy for gender transition. As stated in an article by Dr. Madeline Deutsch of CETH:

> Prescribing gender-affirming hormones is well within the scope of a range of medical providers… Most medications used in gender-affirming hormone therapy are commonly used substances with which most prescribers are already familiar due to their use in the management of menopause, contraception, hirsutism, male pattern baldness, prostatism, or abnormal uterine bleeding.[160]

Florida State Response

The Florida state HIV Plan for 2017-21 identifies transgender people, particularly women of color, as a "high priority" population, and the state has taken a variety of steps to address HIV among transgender women. Between 2013 and 2017, statewide programs provided HIV testing for more than 2,500 transgender individuals, identifying 85 trans persons as living with HIV. Since 2012, $8 million in federally funded HIV grants have been distributed to community-based organizations statewide for prevention activities focused on all priority populations, including transgender women. Because prevention efforts now include ensuring that people living with HIV are in treatment, these programs offer traditional prevention activities such as education and condoms as well as linkage to treatment services for people living with HIV. During 2016 and 2017, prevention services were provided to more than 1,000 transgender women in the state through these programs.[161]

In Broward and Miami-Dade counties, federal and state funds support at least seven agencies that provide HIV prevention and supportive activities and events for transgender communities.[162] Since 2016, the state has used federal and state funds to conduct eight trainings to improve LGBT cultural competency for both DOH staff and community providers in various cities in Florida, including two in Miami. To the credit of state HIV officials, HRW survey results show that most trans women participants living with HIV were receiving HIV care. This result likely reflects the methodology of the survey, which was administered largely through organizations that provide services to trans women, including referrals to HIV treatment and support.

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[160] CETH, "Initiating Hormone Therapy," http://transhealth.ucsf.edu/trans?page=guidelines-initiating-hormone-therapy (accessed August 31, 2018).

[161] FDOH Responses.

[162] Ibid.

Retention in Ryan White care, however, is a significant issue in Florida, and the state has very incomplete information regarding how many trans women living with HIV are actually in care, why they are not receiving care, or why they fail to remain in care. The problem is not a fiscal one; federal funding for HIV care has remained stable, and unlike many other states in the Deep South, state funding also contributes to HIV prevention, care, and support services.[163] The Department of Health told Human Rights Watch that there is no shortage of funds for transgender related services.[164] Rather, the problem is a policy void. There is no mention of gender-affirming HIV care in the State HIV Plan and there is no systematic approach – no policy, no guidelines, no monitoring, no evaluation – of whether the multiple medical care providers in Miami-Dade and Broward counties are providing gender-affirming care or making hormone replacement therapy available.

State HIV officials told Human Rights Watch:

> The Ryan White program does not specifically fund transgender-specific services. However, both Part A and Part B programs fund agencies that provide transgender-friendly services... Several clinics in Broward County provide gender-affirming care… There are a few in Miami-Dade as well.[165]

According to state HIV officials, "transgender individuals are always welcome at any Ryan-White supported medical provider."[166] But in reality, there are no mechanisms in place to ensure that that is true, and evidence from the ground suggests otherwise. Multiple survey participants described bad experiences at local Ryan White clinics, and trans health advocates described their unwillingness to refer clients to most of the Ryan White clinics in Miami-Dade and Broward counties. Arianna Lint stated:

> Most of the Ryan White clinics I would not refer [clients] to – women tell me about rude staff and doctors who won't give hormones or don't understand their bodies. Many bad stories. One clinic told me 'transgenders are not a priority.'[167]

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[163] Ibid.
[164] Ibid.
[165] FDOH Responses.
[166] FDOH Responses.
[167] A Human Rights Watch interview with Arianna Lint, Executive Director of Arianna's Center, Wilton Manors, FL, July 13, 2017.

Morgan Mayfaire told Human Rights Watch, "We recently called a Ryan White clinic in Fort Lauderdale to ask if they offer gender-affirming care. They hung up on us. [168] Ashley Mayfaire of TransSocial said, "Another Ryan White clinic we called recently told us they don't have a doctor at that location that treats trans patients."[169]

Joey Wynn is Community Relations Director at Empower-U, a federally qualified health center in north Miami. Empower-U is one of the few clinics in Miami that provide gender-affirming care, including hormone replacement therapy, to transgender clients with HIV. According to Wynn, "We serve many transgender clients with HIV and we use Ryan White funds to partially support our HIV services. But state involvement in the quality of care for our trans clients is minimal – it is not something they are following closely."[170]

Three to five clinics offering HIV and HRT services meets the needs of some trans women in Miami and Fort Lauderdale. But the fact that these represent a fraction of the federally and state funded HIV clinics is cause for concern. Consistent with principles of non-discrimination, all Ryan White clinics should accept trans patients.[171] Moreover, more trans-competent providers are needed. Many trans women not connected to referral services may not find these clinics or may face transportation and other barriers to accessing care at these locations. When service is disrupted, as is not uncommon when doctors leave or stop taking new patients, delays and waiting lists can leave women without care. Ashley Mayfaire stated, "Just in the last few months we have had doctors leave two of our clinics that we most often refer people to – we are not sure if or when these will be replaced."[172] Pressure on these few locations is increased by the shortage of gender-affirming health care services elsewhere in the state, which brings trans people from throughout Florida to Miami-Dade and Broward counties for care.[173] "We get calls all the time from all over the state – these clinics are a 'mecca' for trans people who can't find care where they live."[174]

[168] Human Rights Watch telephone interview with Morgan Mayfaire, Fort Lauderdale, FL, August 13, 2018.

[169] Human Rights Watch telephone interview with Ashley Mayfaire, Fort Lauderdale, FL, October 3, 2018.

[170] HRW email communication with Joey Wynn, August 17, 2018.

[171] Section 1557 of the Affordable Care Act prohibits discrimination on the basis of race, color, national origin, sex, age or disability in programs and activities funded by the US Department of Health and Human Services; HHS.gov, "Section 1557 of the Patient Protection and Affordable Care Act," https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html (accessed October 3, 2018).

[172] Human Rights Watch telephone interview with Ashley Mayfaire, Fort Lauderdale, FL, October 3, 2018.

[173] Ibid.

[174] Ibid.

According to state HIV officials, much of the problem is a failure of federal Ryan White policy to prioritize transgender care:

> It has been difficult to fund services for the trans community, because many of the services that are needed are not allowable (e.g. surgery) under the Ryan White legislation. Some areas of the state have included HRT (hormone replacement therapy) in their formularies. But other body transformation services (implants, lip enhancements, etc.) cannot be supported by Ryan White funds. Serving the transgender community has been a challenge in many areas and is one of the top issues identified for training and technical assistance for providers throughout the state. This is an issue that the patient care program continues to struggle with, and continuously works to improve on.[175]

State officials are correct in pointing to deficiencies in Ryan White coverage for transgender health issues, as discussed in detail below. But gender-affirming care comprises more than funding for surgeries. Many of its components – staff awareness of trans issues, knowledgeable providers, trans employees and involvement, and other factors that create a safe space – could, and should, be a focus of state HIV policy, planning, and evaluation. As they noted, provider training is of the utmost importance, but eight trainings statewide in 2.5 years does not signal a commitment to ensuring that all trans women are "welcome" at Ryan White facilities and services.

State leadership could also make a huge difference to trans women living with HIV by ensuring that hormone replacement therapy is available through the Ryan White ADAP program.

Cost and Lack of Insurance Coverage for Hormone Replacement Therapy (HRT)

In the insurance-based health care system in the United States, lack of insurance coverage is a major barrier to accessing care. As reflected in the Human Rights Watch survey, many trans people lack insurance altogether. For those who do have insurance, the issue of coverage for transgender people's health care is complex and characterized by harmful gaps in coverage. Claims for care are often denied by both private and public insurers, whether for services and medications related to gender affirmation or for primary care such

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[175] FDOH Responses.

as pap smears, prostate tests, and other procedures not related to transgender identity.[176] Providers bill for services using codes for diagnosis and procedure, and claims denial or delay often originates due to perceived gender incongruity between gender and diagnosis or procedure codes.

For example, pap smears for a patient whose gender is reported as male in the medical record may be automatically denied by the insurer or sent back for clarification.[177] To address chronic denials of care on the basis of gender, legal protections have been established in recent years at the federal level for transgender patients. Most important of these is section 1557 of the Affordable Care Act that prohibits discrimination in both federally funded and private insurance coverage based on factors that include "sex," a category interpreted by the Obama administration to include gender identity.[178] Federal regulations for the Medicare program also explicitly address the issue of gender incongruity denials and provide a special billing code intended to prevent the practice and an appeal process if a claim is erroneously denied.[179] Enforcement and implementation of these protections, however, was incomplete and discrimination in coverage remained widespread, a situation expected to worsen under the Trump administration's plan to abandon gender identity entirely as a protected category under 1557.

In contrast to Medicare, no such protections exist for the Medicaid program, a gap that significantly impacts many trans people living with HIV. Federal Medicaid regulations are silent when it comes to transgender health issues and coverage, leaving coverage determinations for transgender patients to the states and to a "case-by-case basis."[180] Although 18 states and the District of Colombia specifically prohibit discrimination against transgender patients in their Medicaid plans, Florida is not one of them – state Medicaid regulations are silent on the issue. There is no explicit state Medicaid policy that excludes or includes trans health care. This leaves coverage of transition-related care, from HRT to

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[176] National Center for Transgender Equality, "The Stigma and Bias Making Health Insurance Terrible for Trans People," August 13, 2018, https://transequality.org/blog/the-stigma-and-bias-making-health-insurance-terrible-for-trans-people (accessed September 4, 2018); AmfAR Issue Brief, "Trans Populations and HIV: Time to End the Neglect," http://www.amfar.org/uploadedFiles/_amfarorg/Articles/On_The_Hill/2014/IB%20Trans%20Population%20040114%20final.pdf (accessed August 22, 2018); Department of Health and Human Services, healthcare.gov, "Transgender Health Care," https://www.healthcare.gov/transgender-health-care/ (accessed August 31, 2018).

[177] Jordan Aiken, "Promoting an Integrated Approach to Ensuring Access to Gender Incongruent Health Care," *Berkeley Journal of Gender, Law and Justice,* 31(1) 2016, 1-59.

[178] 45 CFR 92, May 18, 2016.

[179] Proctor, K., et al., "Identifying the Transgender Population in the Medicare Program," *Transgender Health,* 1:1, 2016, https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Identifying-the-Transgender-Population-in-the-Medicare-Program.pdf (accessed September 4, 2018).

[180] Dean Spade, "Medicaid Policy and Gender-Confirming Health Care for Trans People: An Interview with Advocates," *Seattle Journal for Social Justice,* 2:8, 2010.

body transformation surgeries, to be decided by the state Medicaid office on a case by case basis. This lack of policy guidance creates inconsistencies and confusion among both patients and providers regarding coding, billing, and coverage. Advocates have pressed state Medicaid officials and the state Insurance Commissioner for policy guidance but to date have not been successful.[181]

Even when a trans woman finds a doctor to prescribe hormone replacement therapy, cost can be a significant barrier.[182] In the Human Rights Watch survey, 45 percent of those without a doctor identified cost as a barrier to health care and many commented on their inability to afford HRT. As one survey participant commented, "I have no access to hormones, insurance doesn't cover them."[183] Another said, "I am taking pills (hormones) informally – I can't afford them from the doctor and they aren't covered by insurance."[184] Indeed, many trans women turn to the street for hormones due to cost barriers, a practice that carries health risks including lack of dosage monitoring, unknown substances, and the possibility of shared needles for injected hormones.[185]

In their survey responses, some trans women expressed despair about the obstacles faced in obtaining hormone therapy:

> I am afraid because cost is so high; all the girls say it is so expensive. When am I going to be able to see my real self? To be my real self? Very fearful that I will never be able to be my real self because I can't afford it.[186]

Trans patients whose doctors will prescribe hormones often struggle to pay for them. In addition to medication cost, hormone levels must be regularly monitored, and the lab work

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[181] Movement Advancement Project, "Healthcare Laws and Policies," http://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies/medicaid (accessed September 4, 2018); Human Rights Watch email communication with Jen Laws, health policy consultant, Fort Lauderdale, FL, September 10, 2018.

[182] Medications and dosages vary for each patient, but the retail cost of the medications identified as most common for hormone replacement therapy in the report National Association of State and Territorial AIDS Directors, "Issue Brief: ADAP Considerations for Transgender Health," https://www.nastad.org/sites/default/files/Crossroads-Trans-Health.pdf (accessed August 22, 2018), range from 60 to 140 dollars per unit on retail pharmaceutical sales websites such as wwwGoodrx.com and wwwwellrx.com.

[183] Human Rights Watch survey response, Fort Lauderdale, December 11, 2017.

[184] Human Rights Watch survey response, Miami, October 17, 2017.

[185] Denson, D., et al., « Health Care Use and HIV-Related Behaviors of Black and Latina Transgender Women in 3 Metropolitan Areas : Results from the Transgender HIV Behavioral Survey, » *Journal of Acquired Immune Deficiency Syndrome*, 1(75) 2017, Supp. 3, s. 268-275; Sevelius, J., "Gender Affirmation: A Framework for Conceptualizing Risk Behavior Among Transgender Women of Color," *Sex Roles*, 68: July 2013, pp. 675-689.

[186] HRW survey response, Wilton Manors, FL, December 17, 2018.

can cost as much as $250.[187] Even at clinics where hormones were prescribed for trans patients and services were offered on a sliding scale to those who had no insurance, providers described issues with cost for hormone treatment.

Amethyst St. John, director of Behavioral Health at the Empower-U clinic in Miami, said that 90 percent of their transgender patients have the goal of starting hormone replacement therapy. However, according to St. John, lack of insurance coverage for the treatment forces out-of-pocket payments, which few patients can afford. “Without the proper finances in place, or an insurance plan that will adequately cover the cost of this therapy, clients are stalled for months or years waiting to begin hormones.”[188]

Dr. Michelle Powell at the AIDS Healthcare Foundation clinic at Mercy Hospital in Miami-Dade County stated, “I will prescribe hormones, but cost is a problem. Medicaid only covers hormones for cisgender people. Ryan White doesn’t cover it.”[189]

Dr. Maureen Greenwood at the AIDS Healthcare Foundation in the Oakland Park clinic in Broward County said that some hormones are covered by Medicaid and other insurance providers for cisgender patients. “But the same claim will be denied for trans patients, and most of my patients pay for their hormones out of pocket as a result. Once insurance companies find out it is for a transgender person, they won’t cover it.”[190]

For trans women living with HIV, access to HRT through the Ryan White program would address a primary health care need as well as improve HIV outcomes for a population at high risk. However, the Ryan White program fails to ensure coverage for hormone replacement therapy medications under its AIDS Drug Assistance Program (ADAP). The program, funded under Part B of the Ryan White legislation, is a lifeline for the more than 200,000 Ryan White clients nationwide, including 20,000 in Florida, whose medications are covered by ADAP, either directly or through assistance with insurance premiums or medication costs. Importantly, ADAP covers more than just anti-retroviral medications for people living with HIV. ADAP regulations establish minimum criteria that require state formularies to 1) include at least one medication from each class of anti-retroviral medication, 2) be FDA-approved, 3) be consistent with HHS Adult HIV/AIDS Treatment

[187] FDOH Responses.

[188] HRW email communication with Amethyst St. John, director of behavioral health, Empower-U, August 17, 2018.

[189] Human Rights Watch interview with Michelle Powell, MD, Coral Gables, FL, November 6, 2017.

[190] Human Rights Watch telephone interview with Maureen Greenwood, DNP, Oakland Park, FL, November 10, 2017.

Guidelines, and 4) be available on an equitable basis to all ADAP clients within the jurisdiction.[191]

Consistent with this criteria, ADAP formularies in all 50 states cover some number of medications in addition to anti-retroviral medications, including drugs for co-occurring infections, anxiety and depression, hepatitis C, and other conditions for patients living with HIV. As stated by the National Association of State and Territorial AIDS Directors (NASTAD), an organization that issues a major annual analysis and evaluation of ADAP programs nationwide, "ADAP's inclusion of treatment medications for co-occurring needs demonstrates a commitment to addressing the full physical and mental health of the clients they serve."[192]

Ryan White program data indicates that approximately 1 percent of ADAP clients are identified as transgender, yet coverage of hormone replacement therapy for trans patients is limited.[193] In an issue brief addressing ADAP policies regarding transgender patients, NASTAD highlighted the importance of adding gender-affirming hormone medications to state ADAP formularies:

> Medication adherence among transgender people is heavily dependent on the availability of gender-affirming health services and continued hormone therapy. Although the extent to which members of the transgender community may avail themselves of various gender-affirming health services changes by the individual's experience, it is integral for ADAPs to assess plans to include coverage of care and treatment for the needs of transgender people.[194]

According to NASTAD, 29 states provide some hormone medications on their formulary, but only 21 states designate those medications for use in gender transitioning, an important distinction in several respects. Florida has a state drug formulary and formularies that apply in its Part A jurisdictions (for urban areas with high HIV prevalence,

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[191] National Association of State and Territorial AIDS Directors, "Issue Brief: ADAP Considerations for Transgender Health," https://www.nastad.org/sites/default/files/Crossroads-Trans-Health.pdf (accessed August 22, 2018).

[192] Ibid.

[193] HRSA, Ryan White HIV/AIDS Program Client Level Data Report 2016, https://hab.hrsa.gov/sites/default/files/hab/data/datareports/RWHAP-annual-client-level-data-report-2016.pdf (accessed August 22, 2018).

[194] National Association of State and Territorial AIDS Directors, "Issue Brief: ADAP Considerations for Transgender Health," https://www.nastad.org/sites/default/files/Crossroads-Trans-Health.pdf (accessed August 22, 2018).

including Miami-Dade and Broward counties). The state and the Part A formularies list some hormone medications, but many of the medications used for gender transition are missing.[195] None of the formularies indicate that these medications are designated for gender transition treatment rather than to address wasting, weight loss, and other conditions in cisgender people resulting from HIV or AIDS. This is an omission that limits awareness on the part of patients and providers that these medications could be covered by ADAP and results in unnecessary denials from insurance companies.[196]

When asked about the failure to include HRT on ADAP formularies, federal officials referred Human Rights Watch to the state ADAP program.[197] The federal regulations do leave to the states discretion to add medications for co-occurring needs – but as NASTAD noted in its brief, HRSA has taken steps to encourage states to add certain medications such as hepatitis C treatment medications, and should do the same for hormone replacement therapies.[198] State officials also disclaimed responsibility, stating that they do not have jurisdiction over Ryan White Part A medication formularies as these formularies are administered by local county government.[199] This is another area where state leadership could establish a clear policy that would improve coverage and awareness of a vital component of HIV care for trans women in Florida.

Trans Women Face Barriers to Key HIV Prevention Medication

Pre-exposure prophylaxis (PrEP) is a combination of two medicines (tenofovir and emtricitabine) in one pill that, if taken every day, has demonstrated significant results in HIV prevention for people who are HIV-negative. This key biomedical intervention has been shown to reduce the risk of getting HIV from sex by as much as 90 percent. If combined with other prevention methods such as condoms, the risk of acquiring HIV can be even lower.[200] Federal agencies tasked with reducing new HIV infections have made increased awareness of and access to PrEP a top priority. The CDC, HRSA, SAMHSA, and other agencies have called for a 500 percent increase in access to PrEP by 2020. A framework

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[195] National Association of State and Territorial AIDS Directors, "Issue Brief: ADAP Considerations for Transgender Health," https://www.nastad.org/sites/default/files/Crossroads-Trans-Health.pdf (accessed August 22, 2018); Human Rights Watch email communication with Madeline Deutsch, MD, May 28, 2017.

[196] Human Rights Watch telephone interview with Madeline Deutsch, MD, San Francisco, CA, May 17, 2018; Human Rights Watch email communication with Brittany Pund, NASTAD, May 31, 2018.

[197] Human Rights Watch email communication with Jennifer Moore, HRSA, Washington DC, June 28, 2018.

[198] National Association of State and Territorial AIDS Directors, "Issue Brief: ADAP Considerations for Transgender Health," https://www.nastad.org/sites/default/files/Crossroads-Trans-Health.pdf (accessed August 22, 2018).

[199] FDOH Responses.

[200] US Department of Health and Human Services, HIV.gov, "Pre-exposure Prophylaxis," https://www.hiv.gov/hiv-basics/hiv-prevention/using-hiv-medication-to-reduce-risk/pre-exposure-prophylaxis (accessed September 4, 2018).

document outlines a broad array of federal initiatives intended to raise awareness, provide technical assistance and training for medical personnel and fund community-based and public health departments to provide PrEP to groups at high risk of HIV.[201]

Trans women are one of the groups at highest risk for HIV in the US. Yet attention to transgender people in both research and distribution of PrEP has been limited and taken a back seat to a focus on men who have sex with men (MSM). The first clinical trial of PrEP, published in 2010, included both MSM and trans women and was the only study with confirmed enrollment of trans women; other clinical trials for MSM are open to trans women but enrollment levels are unclear.[202] Overall, the study showed 44 percent decrease in risk of HIV acquisition, but no decrease among trans women.[203] The failure of the first PrEP study to show a decrease in risk for trans women has been attributed primarily to lack of adherence to the daily medication regimen; negative interaction of PrEP with hormone medications was not observed but requires further study.[204]

Federally funded projects that distribute PrEP through community organizations and public health entities also show very low participation of trans women.[205] The first CDC guidelines for prescription of PrEP by medical providers, issued in 2014, did not mention transgender women at all; the updated guidelines, issued in 2017, note lack of research into efficacy of PrEP for trans women but recommend that they be included in consideration for PrEP as a group at high risk of HIV from sexual transmission.[206] In 2015, CDC published a report finding that PrEP would be an indicated prevention for 1.2 million people at high risk for HIV, but this report addressed only MSM, cisgender heterosexual women and people who inject drugs, failing to make any mention of transgender people.[207]

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[201] US Department of Health and Human Services, "HIV PrEP Framework Federal Activities," https://files.hiv.gov/s3fs-public/PrEP-framework.pdf (accessed September 5, 2018).

[202] Sevelius, J., et al., "The Future of PrEP Among Transgender Women: The Critical Role of Gender Affirmation in Research and Clinical Practices," *Journal of the International AIDS Society*, 197 (6) 2016.

[203] Deutsch, MB et al., "HIV Pre-exposure Prophylaxis in Transgender Women: A Sub-Group Analysis of the iPrEx Trial," *Lancet HIV,* 2(12) 2015, e512-9.

[204] Sevelius, J., et al., "The Future of PrEP Among Transgender Women: The Critical Role of Gender Affirmation in Research and Clinical Practices," *Journal of the International AIDS Society*, 197 (6) 2016.

[205] Ibid.

[206] US Public Health Service, Preexposure Prophylaxis for the Prevention of HIV Infection in the United States 2014: A Clinical Practice Guideline, https://www.cdc.gov/hiv/pdf/guidelines/PrEPguidelines2014.pdf (accessed September 5, 2018); US Public Health Service, Preexposure Prophylaxis for the Prevention of HIV Infection in the United States 2017: A Clinical Practice Guideline, https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf (accessed September 5, 2018).

[207] CDC, Weekly Morbidity and Mortality Report, "Vital Signs: Estimated Percentages and Numbers of Adults with Indications for Preexposure Prophylaxis to Prevent HIV Acquisition- United States, 2015," November 27, 2015. https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6446a4.htm (accessed September 5, 2018).

PrEP has tremendous potential to make a difference in lowering new HIV infections for trans women. In a 2016 study in San Francisco, knowledge of PrEP was low but once introduced to it, interest among trans women was strong.[208] But trans health experts emphasize that PrEP implementation guidelines must consider and address trans women's unique barriers and facilitators to uptake and adherence. On the ground, integration of PrEP distribution with gender-affirming health care is fundamental to successful uptake of PrEP among trans women. One trans health expert put it bluntly:

> Gender-affirming providers and clinic environments are essential components of any sexual health programme that aims to serve trans women, as they will largely avoid settings that may result in stigmatizing encounters and threats to their identities.[209]

Race is another barrier to PrEP access and represents another burden for trans women of color seeking to access PrEP.

Federal efforts to increase access to PrEP have been incomplete and problematic even for the groups it prioritizes, with evidence of wide racial disparities in coverage for MSM, heterosexual women and people who inject drugs. According to the CDC, of the estimated 1.2 million people who are in need of PrEP, 69 percent are people of color; 44 percent are Black and 25 percent, Hispanic. However, only one percent of Black people who need it are on PrEP, creating what CDC has called "an urgent" need to increase PrEP coverage for this population, noting that most Black people who are in need of PrEP, but not taking it, live in the US South.[210]

HRW survey results in south Florida indicate that awareness of PrEP was high among participants – 82 percent of survey participants indicated that they were familiar with PrEP. But few women were taking PrEP: of those who were HIV-negative, only ten percent were on PrEP, with 62 percent of participants indicating they "didn't need it" and 19 percent (nearly one of four) stating they "did not know enough about it" to take it. Other reasons given for not taking PrEP included cost issues, too much stigma, and mistrust, with one woman

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[208] Sevelius, J., et al., "I Am Not a Man: Trans-specific Barriers and Facilitators to PrEP Acceptability Among Transgender Women," *Global Public Health*, 11 (7-8) 2016, 1060-75.

[209] Sevelius, J., et al., "The Future of PrEP Among Transgender Women: The Critical Role of Gender Affirmation in Research and Clinical Practices," *Journal of the International AIDS Society*, 197 (6) 2016.

[210] Conference on Retroviruses and Opportunistic Infections 2018, Updates on PrEP, http://www.natap.org/2018/CROI/croi_188.htm (accessed September 5, 2018). These studies utilized the term Black in discussion racial categories.

stating, "I don't want to be part of an experiment."[211] Need for PrEP, however, was demonstrated; of survey participants who were HIV negative and not taking PrEP, 38 percent said they have exchanged sex for money, drugs, or life necessities in the last year.

In 2016, Florida began a campaign to increase access to PrEP as part of a plan to reduce new HIV infections. The State Surgeon General issued a mandate that by the end of 2018, PrEP should be available at no cost in each of the 67 county health departments. As part of this campaign the state made efforts to increase education and infrastructure to distribute PrEP, compiled a resource guide and directory for sites that offer PrEP statewide, made PrEP available through the central pharmacy system that serves state Medicaid and Medicare patients, and launched targeted social media campaigns aimed at increasing PrEP awareness among minority populations.[212] A series of intensive PrEP training courses were presented in partnership with the University of California at San Francisco (UCSF) and other organizations throughout 2018 with the goal of reaching every county health department as well as providers and interested community organizations in that area.[213] According to Dr. Jonathan Fuchs of USCF, Florida's effort to make PrEP available in all county health departments is broader and more ambitious than in any other state, and the commitment from Florida Department of Health has been exemplary. Fuchs described the training curriculum as including substantive components on the experience of transgender women and the issues they may face in relation to PrEP.[214]

The campaign, supported primarily with state funds, has already achieved significant results. As of May 2018, 37 of 67 county health departments, including Miami-Dade and Broward counties, were implementing a PrEP distribution program. Between July 2017 and April 2018, the number of PrEP clients served by county health departments has increased from 18 to 632.[215]

The state provided no data on how many trans women were enrolled in these programs, however. Both Miami-Dade and Broward county health departments have created PrEP programs as part of this statewide campaign, but transgender participation in both of these programs remains low.[216] In Miami-Dade County, Dr. Susanne Doblecki-Lewis is one of the medical advisors to the county PrEP program. Dr. Doblecki-Lewis said that the PrEP

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[211] Human Rights Watch interview with Ellen D., Wilton Manors, FL, December 11, 2017.

[212] FDOH Responses.

[213] Ibid.

[214] Human Rights Watch telephone interview with Jonathan Fuchs, MD-MPH, San Francisco, CA, July 25, 2018.

[215] FDOH Responses.

[216] FDOH Responses; Human Rights Watch interview with Susanne Doblecki-Lewis, MD, Miami, FL, February 7, 2018; Human Rights Watch telephone interview with Regina Gerbier, Fort Lauderdale, FL, August 2, 2018.

clinic at the department of health does not have many trans women clients. She attributed this to many factors, including the cost of PrEP and mistrust of a health department setting. “Health departments may not provide the most comfortable environment for trans women.”[217]

The Miami-Dade program has made efforts to increase the participation of trans women, specifically by engaging a local and trusted community organization that provides a variety of services to trans women to encourage referrals to the county program. According to state HIV officials, the involvement of Survivor’s Pathway, which is located near to the department of health PrEP clinic, has increased trans women’s engagement, though no data was provided regarding trans participation in the program.[218]

In Broward County, the department of health PrEP program hired Regina Gerbier, a trans woman, to act as Coordinator of Transgender Programs for the HIV Prevention unit. According to Ross, trans women’s participation in the PrEP program remains low, again as a result of numerous factors including reluctance to engage with a county health department, low knowledge of PrEP, lack of “readiness” for PrEP and cost barriers. According to Gerbier:

> PrEP is not a pill, it is a program. It requires someone to see a doctor every three months to get labwork. This is a commitment, and it is expensive if you don’t have insurance.[219]

Cost is a major barrier to PrEP roll out nationwide, as a one month course of PrEP can cost up to $2000 per month for the uninsured.[220] The Ryan White and ADAP programs do not cover it as they serve people already living with HIV. Primary sources of funding for the medication are limited to donations from the manufacturer and as in the case of Florida, states themselves. Gilead Pharmaceuticals, the manufacturer of Truvada, will subsidize PrEP coverage for six months for those who meet low income requirements, but one must re-apply every six months. “Even for trans women who do want to take PrEP, paying for it is still a problem. I spend a lot of my time trying to help women find a place they can get it paid for,” said Gerbier.[221]

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[217] Human Rights Watch interview with Susanne Doblecki-Lewis MD, Miami, FL, February 7, 2018.

[218] FDOH Responses.

[219] Human Rights Watch telephone interview with Regina Gerbier, Fort Lauderdale, FL, April 25, 2018.

[220] George Citroner, “Cost of HIV Prevention Drug Discouraging People from Doing PrEP Therapy,” Healthline, July 11, 2018, (accessed October 3, 2018).

[221] Ibid.

Insurance coverage, including Medicaid, has been found to significantly increase PrEP participation and adherence.[222] Medicaid covers PrEP, but in states like Florida that have not expanded Medicaid, access remains limited for low income people. Dr. Doblecki-Lewis has conducted numerous clinical trials involving PrEP accessibility and found lack of insurance coverage in Florida contributes to lower PrEP adherence compared to that in other locations. Dr. Doblecki-Lewis stated, "In Florida, Medicaid expansion would make a huge difference to PrEP access-given their socio-economic status, it would be very important for trans women."[223] For trans women, availability of Medicaid would alleviate some of the cost concerns as well as provide options for finding PrEP outside of county health departments, sites where they may not feel safe or comfortable.

In Broward County, PrEP availability for trans women has begun to improve, according to Misty Eyez who provides many referrals for trans women to HIV prevention and care services through Sunserve. In the spring and summer of 2018, two health clinics began to offer PrEP to people without insurance, and most importantly, they also offer hormone replacement therapy at no or low cost to PrEP patients who are transitioning. Eyez stated, "This is the model that works for trans women. If they can get their hormones at the same time, they are much more likely to go. However, some of these clinics already have waiting lists, creating long waits for an appointment.[224]

In June 2018, Broward County Health Department took steps to address cost issues by establishing a PrEP partnership with the AIDS Healthcare Foundation (AHF) in Fort Lauderdale. AHF will provide patients with an immediate supply of PrEP medication as well as cover the cost for doctor visits and labwork. The ability of Broward County to refer clients to a no-cost clinic has significantly increased participation in the PrEP program – between June and August 2018 more than 300 patients enrolled in the program, more than during the entire previous year before the no-cost option became available. Participation by trans women, however, remains low – only a handful of these new AHF patients are trans women.[225] AHF does not provide hormone replacement therapy as part of the PrEP program, and Gerbier heard feedback that some trans women had bad experiences there in the past. Gerbier hopes to address these issues in the coming months, including by

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[222] Patel, R., et al., "Impact of Insurance Coverage on Utilization of Pre-Exposure Prophylaxis for HIV Prevention", PLOS One, May 30, 2017, http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0178737 (accessed September 7, 2018); CDC, Weekly Morbidity and Mortality Report, November 27, 2015, "Vital Signs: Increased Medicaid Prescriptions for Pre-Exposure Prophylaxis Against HIV Infection- New York 2012-2015," https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6446a5.htm?s_cid=mm6446a5_w (accessed September 7, 2018).

[223] Human Rights Watch interview with Susanne Doblecki-Lewis MD, Miami, FL, February 7, 2018.

[224] Human Rights Watch telephone interview with Misty Eyez, Fort Lauderdale, FL, July 25, 2018.

[225] Human Rights Watch telephone interview with Regina Gerbier, Fort Lauderdale, FL, August 2, 2018.

launching a social media campaign to make sure than trans women know about the new program and provide reassurance that it is trans-friendly.[226]

Latina Trans Women and HIV

Latina trans women share many of the social determinants of health with Black trans women that place both groups at higher risk for HIV than their white counterparts, including higher rates of poverty, lack of insurance, pervasive intersectional discrimination, unemployment and involvement in the criminal justice system.[227] However, Latina trans women often face unique circumstances that impact access to health care and increase HIV risk. Chief among these are language barriers, lack of awareness of social services and, for undocumented immigrants, avoidance of health care services due to fear of deportation.[228] Each of these factors impact HIV risk for Latina trans women in Florida, a highly diverse state where three-quarters of immigrants originate from Mexico, Central America and the Caribbean.[229]

HIV disparities are significant among Latinx people; despite comprising 18 percent of the US population, Latinx people represent one quarter of those living with HIV.[230] New HIV infections continue to increase among young Latino men who have sex with men, a category that often incorrectly includes trans women. Latinx people are more likely to delay HIV testing, to receive an AIDS-related diagnosis once tested, and to die within one year of HIV diagnosis than non-Latinx African-Americans or white populations.[231]

In the Human Rights Watch survey, Latina trans women comprised 41 percent of participants. Survey results indicated that Latina trans women surveyed were more

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[226] Ibid.

[227] Denson, D., et al., "Health Care Use and HIV-Related Behaviors of Black and Latina Transgender Women in 3 Metropolitan Areas : Results from the Transgender HIV Behavioral Survey," *Journal of Acquired Immune Deficiency Syndrome*, 1(75) 2017, Supp. 3, s. 268-275.

[228] MM Morales-Aleman and MY Sutton, "Hispanics/Latinos and the HIV Continuum of Care in the Southern USA: A Qualitative Review of the Literature, 2002-2013," *AIDS Care*, 26(12) 2014, pp. 1592-604.

[229] Lopez-Quintero C., et al., "HIV Testing Practices Among Latina Women at Risk of Getting Infected: A Five Year Follow Up of a Community Sample in South Florida," *AIDS Care*, 28(2) 2016 137-146; Migration Policy Institute, "Florida: Demographics and Social," https://www.migrationpolicy.org/data/state-profiles/state/demographics/FL (accessed September 13, 2018); Florida Department of Health, "State of Florida Integrated HIV Prevention and Care Plan 2017-21."

[230] Latinx is a term intended to encompass people of Latin origin across the spectrum of gender identities. CDC, "HIV and Hispanics," https://www.cdc.gov/hiv/group/racialethnic/hispaniclatinos/index.html (accessed September 7, 2018).

[231] Lopez-Quintero C., et al., "HIV Testing Practices Among Latina Women at Risk of Getting Infected: A Five Year Follow Up of a Community Sample in South Florida," *AIDS Care*, 28(2) 2016 137-146.

likely to be HIV-positive than non-Latina respondents, but if HIV-negative, were more likely to be on PrEP. They were insured at the same rate—45 percent—as non-Latina participants, but were more likely to be unemployed, more likely to have engaged in sex work, and more likely to have been arrested.

Francesco Duberli is Executive Director of Survivors' Pathway in Miami, an organization providing social, psychological, legal and other support services to the LGBT and Latinx communities. According to Duberli, "Trans Latina women are under many pressures and for most of them HIV is not their primary concern even though they are at risk. Immigration issues, poverty, domestic violence, and human trafficking are all common stressors for our clients."[232]

Survivors' Pathway in Miami-Dade County and Arianna's Center in Broward County work closely with the Florida Department of Health to provide HIV testing and linkage to PrEP, programs that are helping to address HIV risk in the Latinx trans community and should be expanded.

Lack of Data Impedes Government Response

For trans women living with HIV, the legal and policy environment is worsening, but has long been characterized by government neglect. The clearest example of this is the failure for decades of federal and state governments to collect accurate data related to HIV infection among the transgender population. Accurate data collection on HIV among specific populations is vitally important to developing effective government funding and support for prevention, treatment and services related to HIV. As stated by one evaluator of the federal HIV data collection system, this information is used for "allocation of funding, program evaluation, and as a driver for public health action."[233]

Since 1981, the federal Centers for Disease Control (CDC) has collected data on a multitude of aspects of the HIV epidemic including incidence (new infections occurring), prevalence (how many people are living with HIV), modes of transmission, deaths from AIDS and other categories. There are numerous sources for this information: the National HIV Surveillance System (NHSS) is the primary source, supplemented by other programs such as the Medical Monitoring Project (funded in approximately 30 states to collect data on people

[232] Human Rights Watch interview with Francesco Duberli, Miami, FL, July 11, 2017.

[233] Karch, D., et al., "Evaluation of the National Human Immunodeficiency Virus Surveillance System for the 2011 Diagnosis Year," *Journal of Public Health Management and Practice*, 20(6) 2014, pp.598-607.

living with HIV who are in care) and the Behavioral HIV Surveillance System that gathers information on specific populations at risk for HIV such as people who inject drugs and men having sex with men.[234]

All states and territories require HIV diagnoses to be reported to the local health departments and this information is then provided to the state.[235] States receive HIV-related information from a variety of sources – clinical reports, lab tests, death certificates, and other documents. This information is transferred into a standardized database called eHARS (electronic HIV/AIDS reporting system), available to all states for the purpose of reporting this information to the CDC.[236]

For many decades, transgender people were invisible to the national and local HIV surveillance system; to the extent that data was collected for transgender women, they were incorrectly grouped into the category of "men who have sex with men." It was not until 2009 that states had the option to submit "current gender identity" as well as "male" and "female" into eHARS. In 2011, the CDC reporting forms used to transfer information into eHARS were revised and eHARS fields were updated to reflect current gender identity as well as sex assigned at birth. In 2012, the CDC issued its first guidance document to states regarding this two-step process for more accurate collection of data regarding transgender persons and this guidance was updated in 2015.[237] The guidance emphasized the importance of utilizing numerous sources for identification of transgender people among those reported to be living with HIV; for example, state surveillance staff should attempt to flag discrepancies between the sex assigned at birth on a birth certificate and the information recorded on the standardized reporting form in order to make an accurate input of gender identity into eHARS.[238]

However, state implementation of these optional guidelines varies widely; 26 states provide no publicly available surveillance data relating to HIV among transgender people. Numbers that do exist are likely to be grossly underestimated. A 2015 analysis of national surveillance HIV data for transgender persons during the years 2009-2014 found that, "Diagnosed HIV among transgender populations may be vastly underestimated or

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[234] Human Rights Watch telephone interview with Angela Hernandez, CDC, Chief of HIV Incidence and Case Surveillance Branch, Atlanta, GA, December 7, 2017.

[235] CDC, Weekly Morbidity and Mortality Report, July 21, 1989, https://www.cdc.gov/mmwr/preview/mmwrhtml/00001425.htm (accessed September 7, 2018).

[236] Karch, D., et al., "Evaluation of the National Human Immunodeficiency Virus Surveillance System for the 2011 Diagnosis Year," *Journal of Public Health Management and Practice*, 20(6) 2014, pp.598-607.

[237] CDC, "Guidance for HIV Surveillance Programs: Working with Transgender Specific Data" Version 2.0, 2015.

[238] Ibid.

misclassified due to data collection challenges for jurisdictions, including correctly identifying current gender identity from documentation in medical records and other data sources."[239]

The absence of data related to HIV among transgender people is a nationwide problem, not limited to the state of Florida. The CDC has stated that, "Because there is no reliable system for collecting and sharing sex and gender identity information in health records, our nation currently lacks reliable HIV surveillance data for transgender populations."[240] Largely ignored as an issue for decades, the National HIV/AIDS Strategy Updated for 2020 acknowledges that transgender HIV data is so scarce that the federal government has no way to systematically evaluate the collection process or the data itself, and recommends that such an "indicator" be developed.[241] Collecting data and developing such an indicator are essential first steps, but without more urgent and coordinated attention from federal policymakers it is a goal that will remain out of reach, leaving transgender women at a huge disadvantage in funding, programming and support for HIV prevention and care.[242]

Incomplete Data Collection in Florida

A key factor hindering Florida from implementing an effective HIV policy for trans women is lack of accurate and complete data. Without knowing how many trans women are living with HIV, where they are located and to what extent current programs are effectively serving trans women and identifying unmet need, Florida trans women will continue to navigate a fragmented and inadequate health care system for both HIV prevention and treatment.

Florida officials have emphasized that accurate data and surveillance information is key to the state's HIV response:

> The Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section collects, analyzes and disseminates surveillance data on HIV infection. These surveillance data are one of the primary sources of information on HIV and AIDS in Florida. For instance, HIV and AIDS

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[239] Clark, H., et al., "Diagnosed HIV Infection in Transgender Adults and Adolescents: Results from the National HIV Surveillance System 2009-2014," *AIDS and Behavior*, 21 (9), September 2017, pp. 2774-83.

[240] CDC Issue Brief, "HIV and Transgender Communities," https://www.cdc.gov/hiv/pdf/policies/cdc-hiv-transgender-brief.pdf (accessed September 7, 2018).

[241] US Office of National HIV/AIDS Strategy, "National HIV/AIDS Strategy for the United States, Updated to 2020," https://files.hiv.gov/s3fs-public/nhas-update.pdf (accessed August 22, 2018).

[242] Ibid.

> surveillance data are used by the Department's public health partners in local health departments, federal agencies, non-profit organizations, academic institutions, and the general public to help focus prevention efforts, plan services, allocate resources, and monitor trends in HIV infection.[243]

According to the Williams Institute, an estimated 100,000 transgender people reside in the state of Florida, largely located in Broward, Miami-Dade, Orange, Pinellas and Hillsborough counties. The Williams Institute estimate indicates that 50 percent of trans people in Florida are white; 26 percent are Hispanic or Latino; 19 percent are Black, non-Hispanic and four percent fall into other racial or ethnic categories.[244] Yet transgender people are largely invisible in Florida state HIV surveillance data. In the most recent report publicly available, "The State of the HIV Epidemic in Florida 2017," genders are limited to "male" and "female" for every component of the epidemic that is addressed in the report.[245]

The 2017 surveillance data does include one slide referencing transgender persons and HIV (see Table I) [246]:

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[243] Florida Department of Health, "State of Florida Integrated HIV Prevention and Care Plan 2017-21."

[244] UCLA School of Law, Williams Institute, "How Many Adults Identify as Transgender in the United States?" https://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf (accessed September 7, 2018).

[245] Florida Department of Health, HIV/AIDS Section, "State of the HIV Epidemic in Florida 2017," on file with Human Rights Watch.

[246] Ibid, slide 53. Human Rights Watch does not consider people aged 13-17 to be adults, but they are so counted in national and state HIV surveillance data.

Table I. Transgender Adults (Age 13+) Living with HIV, Year-end 2017, Florida

Race/Ethnicity	Transgender Men (Number)	Transgender Men (Percent)	Transgender Women (Number)	Transgender Women (Percent)
White	4	40%	54	18%
Black	4	40%	150	50%
Hispanic	2	20%	86	29%
Other	0	0%	10	3%
Age Group				
13 – 19	0	0%	2	1%
20 – 29	6	60%	73	24%
30 – 39	1	10%	111	37%
40 – 49	1	10%	54	18%
50 +	2	20%	60	20%
Mode of Exposure				
Sexual Transmission	9	90%	267	89%
IDU	0	0%	0	0%
Sexual Transmission/IDU	--	--	33	11%
Other Risk	1	10%	0	0%
TOTAL	10	100%	300	100%

Limitations: Transgender data were not aggressively collected or recorded until 2013 therefore numbers may be underrepresented.

According to this slide, there were 310 transgender people living with HIV in the state of Florida in 2017. The text at the bottom acknowledges the limitations of the information presented, both in gender identification and modes of transmission. State HIV officials told Human Rights Watch that their data on HIV among transgender persons is likely to be underestimated.[247] Also, this number is significantly lower than that shown in the Ryan White program report issued by HRSA showing 355 transgender clients enrolled in the Florida Ryan White program in 2016.[248]

The state data sets can only be as accurate as the information relied upon. As noted above, the CDC's primary form for reporting HIV cases, the Adult Case Reporting Form (ACRF) has included a two-step gender identification question since 2013. But according to state officials, most information received is from providers and laboratories who may not provide accurate information on current gender identity.[249]

[247] FDOH Responses.

[248] Health Resources and Services Administration, "Ryan White HIV/AIDS Program Annual Client-Level Data Report 2016," https://hab.hrsa.gov/sites/default/files/hab/data/datareports/RWHAP-annual-client-level-data-report-2016.pdf (accessed September 7, 2018).

[249] FDOH Responses.

The state does monthly reviews of data in the eHARS system to identify discrepancies in gender reporting such as birth certificates that do not match the gender in medical records. But if medical providers, HIV testing and counseling sites, and other sources do not report accurately, gaps in eHARS will remain. Also, the state does not yet match the eHARS data with that from other databases such as the Ryan White system that uses a two-step gender process for patients, or ADAP records, other state electronic health records and other sources. According to state officials, these cross-database matches are planned but the timeline is unclear.[250]

In the meantime, the state's information regarding HIV among trans people is incomplete and not reliable. For example, the state's transgender data slide fails to accurately record how people acquired HIV. For 87 percent of male to female transgender individuals, the mode of exposure listed is "men having sex with men," and the slide indicates that mode of exposure is categorized by sex assigned at birth. In order to distinguish modes of exposure for trans women from men who have sex with men, the CDC Guidance document for working with transgender data states that "transmission categories correspond to a person's sex assigned at birth and therefore may not accurately describe the mode of transmission for a transgender person with diagnosed HIV infection." The Guidance recommends that states consider using alternative categories such as "sexual transmission" instead of "male to male sexual contact" or "heterosexual contact."[251] Ryan White providers are utilizing this category; the 2016 Ryan White report indicates "sexual contact" as the mode of transmission for 97 percent of transgender Ryan White clients in Florida, but the state has not yet matched its eHARS database to the Ryan White data to capture this information.[252]

Perhaps most important is state surveillance data indicating health outcomes for trans people with HIV. Nationally and statewide, public health decisions are made based upon HIV surveillance data known as the "continuum of care" — a chart that shows how many people diagnosed with HIV are in medical care, stay in medical care, and become virally suppressed. Continuum of care data are typically shown in the aggregate as well as broken down by race, gender, age and mode of transmission. The most recent continuum of care for the state of Florida shows that statewide, 93 percent of people diagnosed with HIV were in care at one time, 68 percent have been retained in care, and 62 percent are virally

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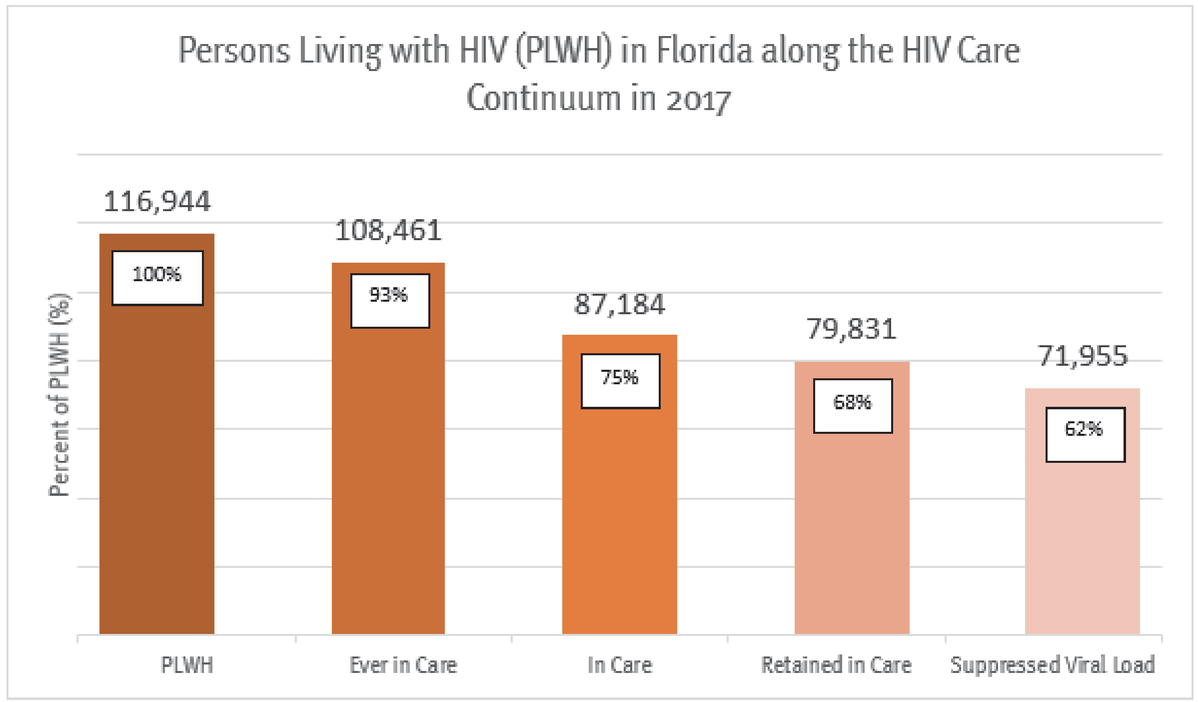
[250] Ibid.

[251] CDC, "Guidance for HIV Surveillance Programs: Working with Transgender Specific Data," Version 2.0, 2015.

[252] Health Resources and Services Administration, "Ryan White HIV/AIDS Program Annual Client-Level Data Report 2016," https://hab.hrsa.gov/sites/default/files/hab/data/datareports/RWHAP-annual-client-level-data-report-2016.pdf (accessed September 7, 2018).

Graph IV.



suppressed (see Graph IV).[253] In 2016, of people living with HIV who are out of care, 73 percent were identified as male, and 27 percent as female; 40 percent were Black, 26 percent were White, and 23 percent were Hispanic.[254]

Continuum of care data for trans women is important as they are a population that is likely to be lost to follow up. Given their difficulty in accessing health care, their frequent failure to return to care after a bad health care experience, and lower rates of adherence to HIV medications than other groups, trans women are at high risk of falling out of HIV care and not achieving viral suppression.[255] Outcomes are likely to be particularly poor for African-American trans women; in Florida, African-Americans are less likely than either whites or

[253] Florida Department of Health, HIV/AIDS Section, "State of the HIV Epidemic in Florida 2017," on file with Human Rights Watch. This document indicates that "in care" is defined as a person living with HIV who had lab work, medical visit or a prescription since diagnosis; "retained in care" is defined as two instances of lab work, a medical visit or a prescription at least 3 months apart in the previous 15-month period.

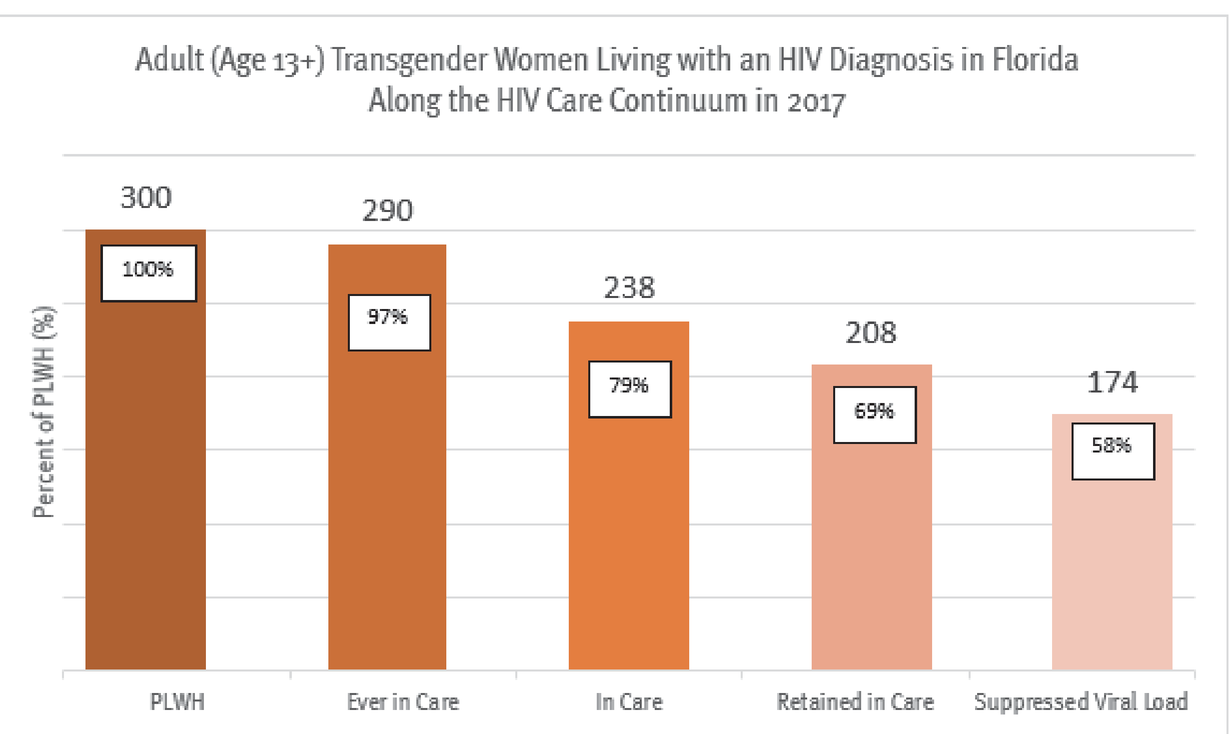
[254] Florida Department of Health, "Persons Living with HIV Out of Care in Florida, 2018" on file with Human Rights Watch.

[255] Sevelius, J., et al., "Antiretroviral Therapy Adherence Among Transgender Women Living With HIV," *Journal of Association of Nurses in AIDS Care*, 21(3) May-June 2010, 256-64.

Hispanics to be linked to care, to stay in care, and to achieve viral suppression.[256] Lack of accurate transgender data hinders the state's ability to address these issues among trans women of color.

In 2017, the state reported that of the 300 transgender women living with HIV in the state of Florida, 79 percent were in care at one time, 69 percent were retained in care and 58 percent had achieved viral suppression or an "undetectable" viral load.[257] In 2016, the most recent data available show that in Miami-Dade County, there are 53 trans women identified as living with HIV; 70 percent are said to be in care, and 66 percent have achieved viral suppression. In Broward County, 43 trans women are identified as living with HIV; 72 percent are retained in care however, viral suppression is only 47% (see Graphs V[258], VI[259], VII[260]).

Graph V.



Transgender women are defined as those whose birth sex is male but who live and identify as female.

[256] Florida Department of Health, HIV/AIDS Section, "State of the HIV Epidemic in Florida 2017," on file with Human Rights Watch.

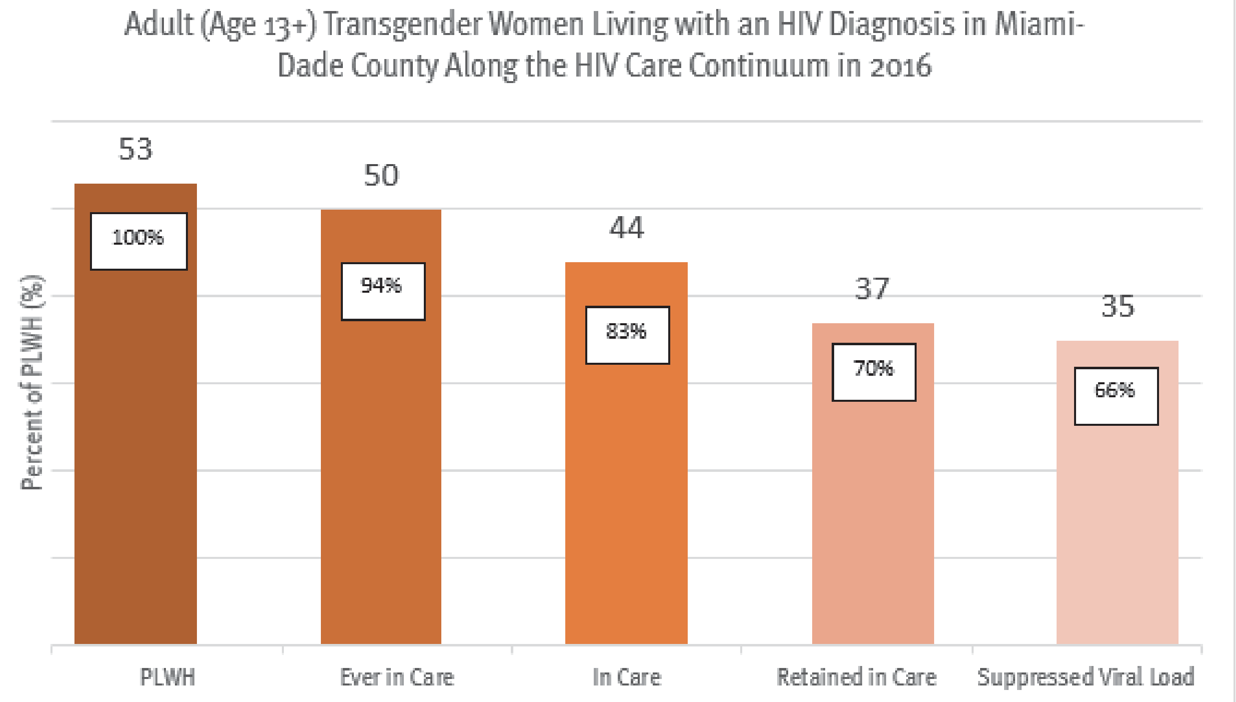
[257] Ibid.

[258] FDOH Responses.

[259] FDOH Responses.

[260] FDOH Responses.

Graph VI.



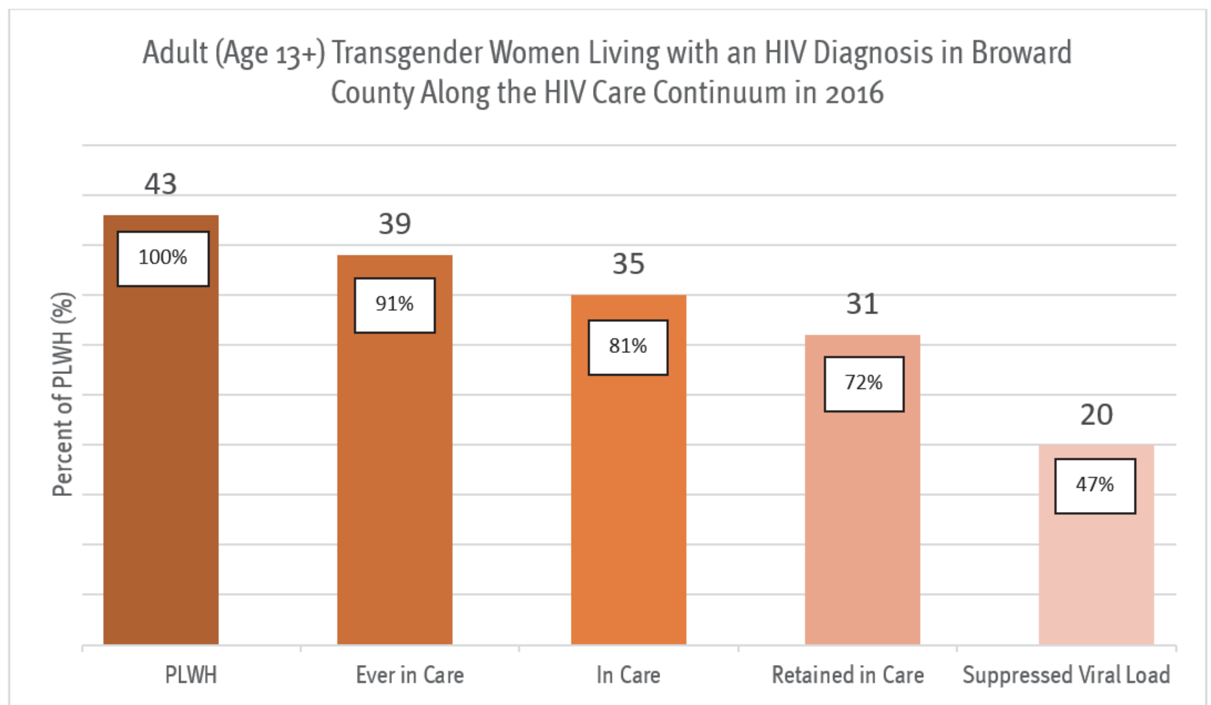
Transgender women are defined as those whose birth sex is male but who live and identify as female.

Given the limitations on data collection for trans individuals in Florida, the numbers of trans women living with HIV are likely to be significantly underestimated. This data shows that high numbers of trans women are initially engaging in care, but significantly fewer women remaining in treatment and achieving viral suppression. This reflects the larger problem of retention in care that is occurring at the state and national levels for people living with HIV. However, Florida may be missing opportunities to obtain valuable information to supplement their surveillance data to learn more about why trans women may be lost to care.

For example, Florida has a specific program dedicated to identifying people who have been diagnosed with HIV but fallen out of care. The "Data to Care" Program is a federally funded initiative for states to use multiple data sources to identify, contact and support persons with an HIV diagnosis who are not in care. In 2017, 20 percent of people identified in Florida through this program were connected to medical care. The state tracked the percentage of males and females in the program and showed that those most likely to drop out of care are Black men, but there is no data on transgender clients.[261] State HIV officials

[261] FDOH Responses.

Graph VII. Transgender HIV Data Provided to Human Rights Watch from Florida Department of Health



Transgender women are defined as those whose birth sex is male but who live and identify as female.

told Human Rights Watch that any transgender persons identified as out of care or never linked to care would be "added automatically to our Data To Care lists for linkage/ re-engagement" and that "as we work to improve and automate the D2C process, we constantly evaluate priority populations including Transgender persons who need linkage/re-engagement services."[262] Yet the state provided no information about how many transgender people had been identified as out of care as part of the Data To Care program or the results of any evaluations conducted.

Another missed opportunity occurred in a retention in care study in Miami. In 2017, the Miami-Dade County Department of Health, concerned about high rates of people dropping out of Ryan White programs, undertook a study to examine retention issues. However, according to the state, "a separate retention analysis for transgender clients was not undertaken due to too few clients being represented in the sample. Analysis found lower retention rates among Blacks/African-Americans."[263] Despite evidence indicating that trans women of color are at high risk of dropping out of care, trans individuals were excluded from this study. This illustrates the circular and problematic "too small to be

[262] FDOH Responses.
[263] FDOH Responses.

included" argument that impedes many efforts to address a grossly disproportionate HIV burden among a population whose numbers are acknowledged to be underestimated.

In Broward County, the Department of Health called the lack of information on HIV among the county's trans population "horrible – we have very few pieces of the puzzle," and explained that lack of data leads to lack of targeted programs, a vicious cycle that impedes their ability to address the needs of a vulnerable population.[264] Broward County officials said they had conducted trainings for two-step gender identification for HIV testing and care providers funded by Ryan White or by the state or county health departments, but those not funded were considered to be out of their control.[265] They expressed a strong desire to improve the situation, describing plans to partner with Florida International University to conduct community-led research into how to improve HIV data collection in an effective, culturally competent manner.[266]

Trans and HIV advocates in Florida frustrated with the lack of progress on data collection at the federal and state levels are taking steps to address it. Jen Laws, a health policy consultant and member of the state HIV Comprehensive Planning Network (FCPN) told Human Rights Watch, "We are tired of excuses, and the data the state is presenting is obviously flawed and incomplete. But the lives of trans people are at stake."[267] Laws and other trans advocates are moving ahead on their own – at a statewide planning meeting in April 2018 several trans members of FCHN presented data estimating more accurate numbers for trans people living with HIV in the state of Florida. This data was developed using a synthesis of available information on national and state estimates of transgender population, the national transgender survey, Florida population-level data on race and ethnicity, and epidemiological and HIV surveillance data from the state of Florida. Based upon these sources, Laws estimates that between 1,404 and 2,808 transgender people are living with HIV in Florida, five to ten times more than the 291 reported by the state of Florida Department of Health (see Graph VIII).[268]

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[264] Human Rights Watch interview with Janelle Tavares, Broward County Department of Health, Fort Lauderdale, FL, April 26, 2018.

[265] Ibid.

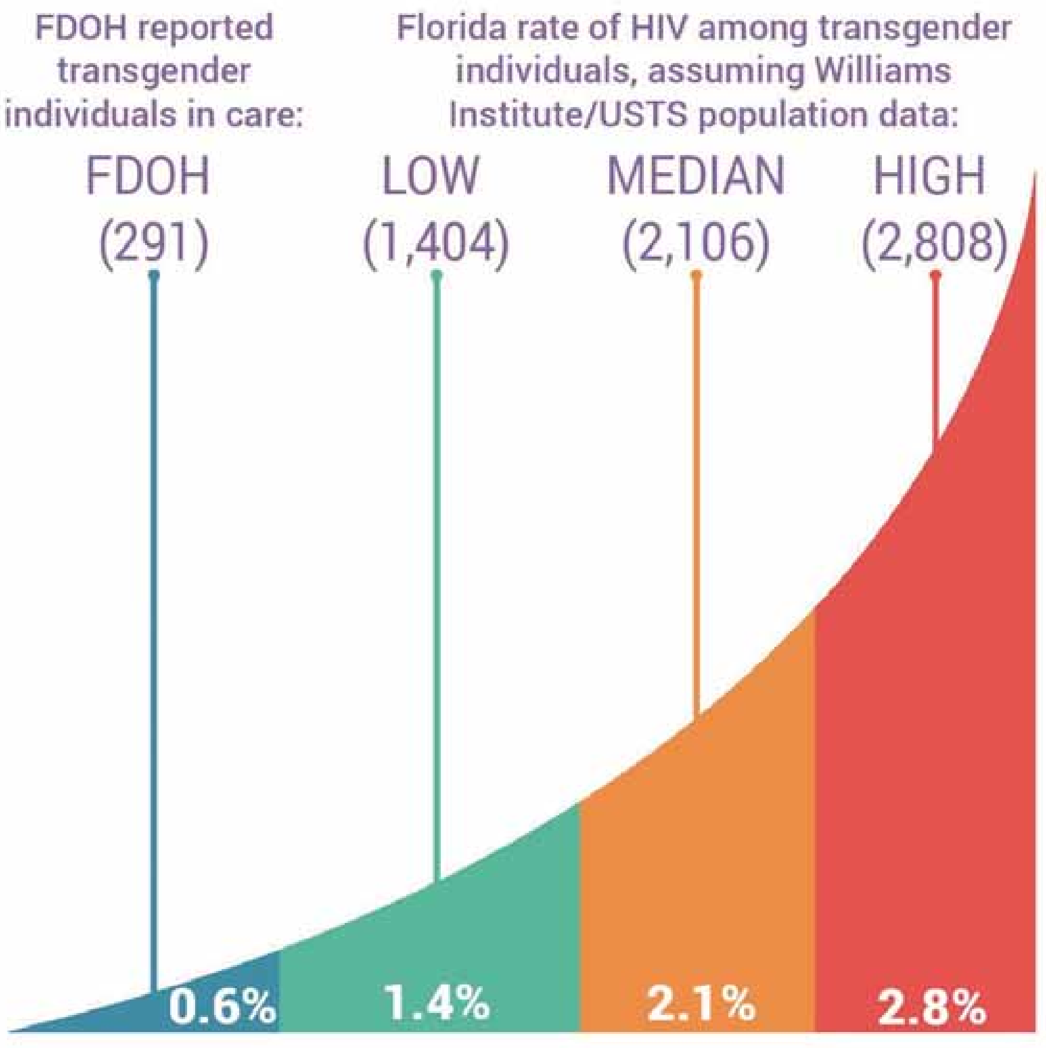
[266] Ibid.

[267] Human Rights Watch interview with Jen Laws, health policy consultant, Fort Lauderdale, FL, April 24, 2018.

[268] Ibid; according to Laws, these revised numbers are still likely to underestimate the extent of the HIV epidemic among trans people in Florida due to chronic undercounting of this population as well as steadily increasing self-identification by people in the US as LGBT, see Gallup, "In US, Estimate of LGBT Population Rises to 4.5%," https://news.gallup.com/poll/234863/estimate-lgbt-population-rises.aspx (accessed September 7, 2018).

Graph VIII.

FDOH vs. Williams Institute/USTS HIV Prevalence Estimates



SOURCES:
Williams Institute (2014 Collection, 2016 Report):
General Reports: https://williamsinstitute.law.ucla.edu/research/cesus-lgbt-demographics-studies/estimates-of-transgender-populations-in-states-with-legislation-impacting-transgender-people/
FL Reports: https://williamsinstitute.law.ucla.edu/uncategorized/florida/
FDOH Data (2016 Year-End Reporting): http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/_documents/hiv-aids-slide-sets/State_of_Epidemic-2016.pptx
United States Trans Survey (USTS) Reports (2015 Collection, 2016 Reports):
Florida Specific Statistics: http://www.transequality.org/sites/default/files/docs/usts/USTSFLStateReport%281017%29.pdf
National Statistics: http://www.transequality.org/sites/default/files/docs/usts/USTS%Full%20Report%20%FINAL%201.6.17.pdf

Work Product of RAD Remedy and TransSOCIAL, Inc. / DESIGN: ASHLEY MAYFAIRE

The Florida Department of Health has expressed concern about the accuracy of these much higher estimates; the complete text of their response to these estimates is included in this report as Appendix A. Health officials and advocates agree, however, that current data attempts to quantify HIV among transgender people in Florida are incomplete, likely to be inaccurate and need to be improved.

HIV data collection is challenging, requiring synthesis of information received from hundreds, and in states as large as Florida, thousands, of independent and varied sources. Reporting systems are not uniform, and the state is taking some steps to address it. But the stark reality is that for a group known to be one of the most heavily burdened with HIV, neither the federal government nor the state of Florida has accurate, complete data on how many trans people have HIV, how they got it, how many are in medical care for it, and the effectiveness of such treatment. Thirty-plus years into the epidemic, lack of information continues to jeopardize the health, and lives, of a group known to be at high risk of HIV.

Criminal Justice Involvement Increases HIV Risk

Trans women experience high rates of incarceration, with one in five trans women reporting having been in jail or prison.[269] The rate of incarceration for African-American trans women is three times higher than for white trans women – some studies indicate that half of African-American trans women report a history of incarceration.[270] This experience was reflected in the surveys conducted by Human Rights Watch; 40 percent of trans women surveyed reported having been arrested at least once. Seven women reported being arrested five to ten times, and one woman reported more than 20 arrests. Nearly half (49 percent) of survey respondents said they had exchanged sex for money, drugs, or life necessities in the last year. Of these, 38 percent said they had been arrested for sex work. The survey indicated racial disparities, with white women reporting higher income, significantly less engagement in sex work and fewer arrests than their African-American or Latina counterparts.

The evidence continues to increase that involvement in the criminal justice system at every stage carries negative health consequences, particularly for LGBT individuals. Even short

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[269] Reisner, S., et al., "Racial/Ethnic Disparities in History of Incarceration, Experiences of Victimization, and Associated Health Indicators Among Transgender Women in the US," *Women and Health*, 54(8) 2014, pp. 750-67; Sevelius and Jenness, *Challenges and Opportunities for gender-affirming healthcare for transgender women in prison,* Journal of Prisoner Health, (2017) 13, pp. 32-40.

[270] Ibid; Lambda Legal, "Transgender Incarcerated People in Crisis," https://www.lambdalegal.org/sites/default/files/2015_transgender-incarcerated-people-in-crisis-fs-v5-singlepages.pdf (accessed September 7, 2018).

jail stays have been linked to negative health outcomes. Harassment and abuse at arrest and during pre-trial detention, lack of access to medical care while incarcerated, and the impact of a criminal record on employment and housing stability contribute to health disparities for members of minority and LGBT communities.[271] Incarceration also has been found to increase poverty, a major barrier to access to health care for trans women.[272]

Human Rights Watch has documented police harassment of trans women and profiling them as sex workers in major US cities, as well as police harassment for carrying condoms, which can be considered evidence to support prostitution charges.[273] In the Human Rights Watch survey conducted for this report, one third of those engaging in sex work reported harassment by police for carrying condoms and 43 percent reported harassment by police for other reasons. One woman described a recent experience in Miami when she was attempting to take an Uber and the police surrounded her, examined her purse, and said she was "prostituting." They called her a "puta" and said they would arrest her if they saw here around there again.[274]

Violence from clients increases HIV risk for sex workers, but fear of the police often leaves them without assistance. Of the women who exchanged sex for money, drugs or life necessities, half had been threatened or assaulted by clients, but only 15 percent called the police. One woman reported having been drugged and raped by a client in Miami, but never went to the hospital or called the police, saying she "did not feel safe" and expected to be harassed.[275]

Incarceration creates numerous barriers to HIV prevention and care – condoms are not available in the majority of prisons and jails in the United States; as Human Rights Watch

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[271] Bacak, V., et al., "Incarceration as a Health Determinant for Sexual Orientation and Gender Minority Persons," *American Journal of Public Health*, 108 (August 2018) pp. 994-999.

[272] Adam Looney, "5 Facts About Prisoners and Work, Before and After Incarceration," Brookings Institution, March 14, 2018, https://www.brookings.edu/blog/up-front/2018/03/14/5-facts-about-prisoners-and-work-before-and-after-incarceration/ (accessed September 10, 2018); Pew Charitable Trusts, "Collateral Costs: Incarceration's Effects on Economic Mobility, 2010 http://www.pewtrusts.org/~/media/legacy/uploadedfiles/pcs_assets/2010/collateralcosts1pdf.pdf (accessed September 10, 2018).

[273] Human Rights Watch, "Sex Workers at Risk: Condoms as Evidence of Prostitution in Four US Cities," July 2012, https://www.hrw.org/report/2012/07/19/sex-workers-risk/condoms-evidence-prostitution-four-us-cities; Human Rights Watch, "Paying the Price: Failure to Deliver HIV Services in Louisiana Parish Jails," March 2016 https://www.hrw.org/report/2016/03/29/paying-price/failure-deliver-hiv-services-louisiana-parish-jails

[274] Human Rights Watch survey response, Miami, FL, October 6, 2017.

[275] Human Rights Watch survey response, Wilton Manors, FL, April 25, 2018.

has documented, access to HIV medications and treatment is often inadequate or in many jails, non-existent and linkage to medical care upon re-entry is uneven at best.[276]

In addition to incarceration itself as an HIV risk factor, transgender women experience alarming rates of sexual assault in prison. According to federal data for 2015, more than one-third of trans women reported assault by other prisoners or staff.[277] African-American and Latina trans women are more likely to be victims of assault in jail or prison than their white counterparts.[278] Most prisoners were HIV-positive prior to their incarceration. However, lack of HIV prevention measures and failure to provide safe environments for trans prisoners – such as the widespread practice of placing trans women in male prison facilities – increases HIV risk in correctional settings.[279] Of the women surveyed by Human Rights Watch who had been jailed in Florida in the last year, 10 of 15 reported having been placed in a male facility; 6 of 10 reported abuse from jail staff and five reported abuse from other prisoners.

The Prison Rape Elimination Act (PREA) is a federal law, passed in 2003, that established standards for US prisons and jails for protection of prisoners from assault while incarcerated.[280] In 2012, the Department of Justice issued detailed guidelines for determining a gender-appropriate and safe housing assignment for trans and gender non-conforming prisoners, but these guidelines are non-binding and not implemented in many of the nation's prisons and jails.[281] The Trump administration has changed those guidelines to weaken consideration of gender identity in making housing determinations, an act challenged by advocates as undermining the purpose of the PREA legislation itself.[282] Both Miami-Dade and Broward County Jails have adopted PREA-mandated procedures for placement of trans prisoners, but survey responses and interviews with trans women indicate that concerns about safety remain. One woman wrote about her

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[276] Human Rights Watch, "Paying the Price: Failure to Deliver HIV Services in Louisiana Parish Jails," March 2016 https://www.hrw.org/report/2016/03/29/paying-price/failure-deliver-hiv-services-louisiana-parish-jails

[277] US Bureau of Justice Statistics, "PREA Data Collection Activities 2015" https://www.bjs.gov/content/pub/pdf/pdca15.pdf (accessed September 7, 2018).

[278] Sevelius and Jenness, "Challenges and Opportunities for Gender-affirming Healthcare for Transgender Women in Prison," *Journal of Prisoner Health*, (2017) 13, pp. 32-40.

[279] Prison HIV Lancet Cities; Lambda Legal, "Transgender Incarcerated People in Crisis", https://www.lambdalegal.org/sites/default/files/2015_transgender-incarcerated-people-in-crisis-fs-v5-singlepages.pdf (accessed August 22, 2018).

[280] Prison Rape Elimination Act of 2003, PL-108-79.

[281] National PREA Resource Center, "Does a Housing Policy That Houses Transgender or Intersex Inmates Based Exclusively on External Genital Anatomy Violate 115.42 c and (e)?" https://www.prearesourcecenter.org/node/3927 (accessed September 7, 2018).

[282] Human Rights Watch, "US Bureau of Prisons Policy Change Endangers Transgender Prisoners," May 14, 2018 https://www.hrw.org/news/2018/05/14/us-bureau-prisons-policy-change-endangers-transgender-prisoners

experience in two Miami jail facilities, "When I was arrested, they put me alone. Even times I was placed alone I was still harassed by inmates and staff.[283]

In Broward County Jail, most LGBT prisoners are placed in a separate "pod" where meals, activities, and recreation occur without encountering the general population. According to jail officials, the jail is organized into "pods" for all prisoners and there are no restrictions or limitations that result from placement in the what they call the "fragile" pod.[284] One trans woman, however, told Human Rights Watch that her experience in Broward County Jail in February and March of 2018 was "a nightmare." According to Savannah Cash, it began at intake when they would not recognize her California drivers' license that indicated her full and legal transition to female. Because they had booked her years before into the jail as a man, they insisted on calling her by her "dead name" the entire 40-plus days she was there.

In the "fragile" pod, Cash says she was harassed by staff and other prisoners, placed in solitary confinement – a punitive method with potentially harmful consequences for mental and physical health – as a result of conflicts with one staff member who threatened her.[285] According to Cash the staff member called her "sir" continually and said to her 'who do you think you are, you are a fucking man.' Cash also experienced delays in receiving her previously prescribed hormone replacement therapy for much of the time she was incarcerated.[286] Her attorney told Human Rights Watch that during a legal visit, he observed staff "cat-calling her and wolf whistling" while she walked to meet him in the visitation room.[287] Since release, Cash is working with her lawyer on possible legal action and Broward Sheriff's Office said they were unable to comment on the case.[288]

An arrest history or criminal record also carries negative consequences for trans women's employment prospects. For a community experiencing pervasive discrimination and with many living in extreme poverty, this can be devastating. There are no federal laws explicitly protecting LGBT people from employment discrimination, and the Trump administration has generally been unwilling to read such protections into existing laws. In 2017, the

[283] Human Rights Watch survey response, Miami, FL, October 15, 2017.

[284] Human Rights Watch interview with Major Angela Neely, Assistant Director; Yusi Arencibia, Health Care Manager; Deputy Jorge Velez, PREA Training Officer; Broward County Sheriff's Office, Department of Detention, Fort Lauderdale, FL, April 25, 2018.

[285] Human Rights Watch, "Solitary Confinement," https://www.hrw.org/tag/solitary-confinement

[286] Human Rights Watch telephone interview with Savannah Cash, New York, NY, June 19, 2018.

[287] Human Rights Watch telephone interview with Adam Goldberg, Broward County Public Defender, Fort Lauderdale, FL, June 12, 2018.

[288] Human Rights Watch email communication with Angela Neely, Assistant Director, Broward County Sheriff's Office, Department of Detention, Fort Lauderdale, FL, July 6, 2018.

Department of Justice adopted the position that Title VII's prohibition on sex discrimination does not include sexual orientation or gender identity.[289]

Florida has no state legislation explicitly protecting against employment discrimination on the basis of sexual orientation or gender identity. The National Transgender Discrimination Survey indicated "alarming" rates of employment discrimination in Florida, where 81 percent of respondents reported having experienced harassment or mistreatment on a job, 46 percent reported not being hired, and 36 percent reported losing a job due to their trans status.[290] A 2017 report by the Williams Institute at UCLA School of Law found pervasive stigma and discrimination against LGBT individuals in Florida including employment discrimination.[291] Both Broward County and the City of Miami have local ordinances prohibiting discrimination on the basis of sexual orientation and gender identity.[292] However, many trans women told Human Rights Watch of their experiences with employment discrimination in south Florida. One woman lost her job at a Broward County academic institution within days of announcing her gender transition. Another woman was demoted at a computer company in Broward County and isolated from her work colleagues: "Imagine 1,000 people in a cafeteria and no one will sit by you," she said. "Employment discrimination is trauma."[293] Another said, "I am looking for a job but hear 'the position has been filled.' Also, they ask on the application 'have you ever been known by any other name.'"[294]

In this difficult employment environment, a criminal record can be the end of job prospects altogether and it begins, and perpetuates, a cycle of engaging in sex work for many trans women in order to survive. Participants in the Human Rights Watch survey who had been arrested had lower incomes than those who had not. In Florida, prostitution is prohibited under a range of both misdemeanor and felony charges addressing solicitation as well as human trafficking.[295] Florida also imposes enhanced penalties for engaging in prostitution

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[289] Human Rights Watch, "US Reverses Position on Transgender Discrimination," October 5, 2017, https://www.hrw.org/news/2017/10/05/us-justice-department-reverses-position-transgender-discrimination; Lambda Legal, "Zarda v. Altitude Express," https://www.lambdalegal.org/in-court/cases/zarda-v-altitude-express (accessed September 7, 2018).

[290] National Center for Transgender Equality, "National Transgender Discrimination Survey, Florida Results," https://transequality.org/sites/default/files/docs/resources/ntds_state_fl.pdf (accessed September 10, 2018).

[291] Williams Institute, UCLA School of Law, "The Impact of Stigma and Discrimination Against LGBT People in Florida," https://williamsinstitute.law.ucla.edu/wp-content/uploads/Florida-Impact-Discrimination-Oct-2017.pdf (accessed September 7, 2018).

[292] City of Miami Charter, Part 1, section 52; Broward County Code section 16.5-33.

[293] Human Rights Watch interview with Ellen D., Fort Lauderdale, FL, December 11, 2017.

[294] Human Rights Watch interview with Gabriella A., Fort Lauderdale, FL, April 25, 2018.

[295] Florida Statutes, sections 796 and 787.

while knowingly HIV-positive.[296] Public health and HIV experts have found these and other laws criminalizing HIV exposure as unnecessary, stigmatizing and counterproductive in that they may discourage HIV testing and disclosure.[297]

Many of these laws, including those in the state of Florida, require no actual transmission of HIV, fail to account for current medical treatment that can eliminate any potential for transmission, and have been shown to be disproportionately enforced against people of color and sex workers.[298] Arianna Lint works with many trans women who engage in sex work and told Human Rights Watch, “The girls are aware of the laws about HIV and prostitution – they don’t want to get tested, and they don’t even want to get medications sometimes because they are afraid of felony charges.”[299]

In Florida, a criminal record also makes obtaining gender-affirming documentation from the state more difficult. For trans people, state-issued documentation that reflects their gender identity is fundamental to overcoming the obstacles they face in almost every area of life. A drivers’ license that shows a different gender than they are presenting can trigger negative encounters, keep one from getting a job, and lead to violence. In the national survey, one of three trans people reported experiencing physical or sexual assault, being asked to leave, or being denied benefits after showing a non-conforming identity card.[300]

In Florida, the law permitting name changes requires both a background check with fingerprints and disclosure of any conviction that has resulted in a suspension of civil rights.[301] Neither provision automatically disqualifies someone with a criminal record, but the statute grants wide discretion to the judge in case of a criminal record and trans women and their advocates described how having arrests or convictions for misdemeanors resulted in denials of name changes. Alisha Hurwood is an attorney at Broward County Legal Aid who assists trans people with changing their names and gender markers on state

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[296] Florida Statutes, section 796.08 (5).

[297] Lehman, JS et al., “Prevalence and Public Health Implications of State Laws that Criminalize Potential HIV Exposure in the United States,” *AIDS Behavior*, 18 (6) 2014; CDC, “HIV-Specific Criminal Laws,” https://www.cdc.gov/hiv/policies/law/states/exposure.html (accessed September 7, 2018).

[298] Williams Institute, UCLA School of Law, “HIV Criminalization and Sex Work in California,” October 2017, https://williamsinstitute.law.ucla.edu/wp-content/uploads/HIV-Criminalization-Sex-Work-Oct-2017.pdf (accessed September 7, 2018); Williams Institute, UCLA School of Law, “HIV Criminalization in Florida,” October 2018, https://williamsinstitute.law.ucla.edu/wp-content/uploads/HIV-Criminalization-Florida-Oct-2018.pdf (accessed October 3, 2018).

[299] Human Rights Watch interview with Arianna Lint, Wilton Manors, FL, July 13, 2017.

[300] National Women’s Law Center, “Transgender People are Facing Incredibly High Rates of Poverty,” https://nwlc.org/blog/income-security-is-elusive-for-many-transgender-people-according-to-u-s-transgender-survey/ (accessed September 7, 2018).

[301] Fla Statute 68.07 2(a) and 2 (l).

and federal documentation. "It is not a ground for automatic disqualification, but it makes it more complicated and gives judges an easy method to deny name change despite no reasonable grounds for denial."[302] The background check and fingerprinting also costs $65 and obtaining certified dispositions of past criminal cases can cost hundreds of dollars. Clients who are represented by counsel can get assistance in applying for indigent petitions to waive these fees, but many trans women do not have lawyers or advocates to assist them. As the first crucial step in obtaining a drivers' license and social security card with a marker that matches their gender identity, these can be daunting barriers in the gender transition process.

HIV officials both state and federal acknowledge sex work as a factor contributing to HIV risk for trans women. Inclusion of trans women in PrEP rollout efforts are based largely on recognition of high rates of engagement in sex work. But there is little reference in HIV planning or strategy documents to the role of the criminal justice system in increasing HIV risk for any of the populations that are at highest risk both for incarceration and for HIV – people of color, youth, LGBT persons, and people who use drugs. To the extent that criminal justice issues are addressed, they largely focus on ensuring linkage to HIV care at re-entry from jail or prison.[303] But this limited approach neglects the increased risk of HIV and other negative health outcomes that result from entering jail or prison in the first place.

Criminalization of adult, consensual sexual relations is incompatible with human rights protection for personal liberty and autonomy.[304] Human Rights Watch takes the position that this also holds true with regard to the commercial exchange of sexual services. In addition, Human Rights Watch has extensively documented the harmful consequences of criminalization, both globally and in the US.[305] Human Rights Watch also opposes criminal laws such as the Federal Online Sex Trafficking Act of 2018 that conflate human trafficking

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[302] Human Rights Watch telephone interview with Alisha Hurwood, Fort Lauderdale, FL, August 3, 2018.

[303] US Office of National HIV/AIDS Strategy, "National HIV/AIDS Strategy for the United States, Updated to 2020", https://files.hiv.gov/s3fs-public/nhas-update.pdf (accessed August 22, 2018).

[304] Rachel Marshall, "Sex Workers and Human Rights: A Critical Analysis of Laws Regarding Sex Work," *William and Mary Journal of Women and the Law,* 23(1), 2016.

[305] Human Rights Watch, *Swept Away: Abuses Against Sex Workers in China*, May 2013, https://www.hrw.org/news/2013/05/14/china-end-violence-against-sex-workers ; Human Rights Watch, *Sex Workers at Risk: Condoms as Evidence of Prostitution in Four US Cities*, July 2012, https://www.hrw.org/report/2012/07/19/sex-workers-risk/condoms-evidence-prostitution-four-us-cities ; Human Rights Watch, *In Harms Way: State Response to Sex Workers, Drug Users and HIV in New Orleans,* December 2013, https://www.hrw.org/report/2013/12/11/harms-way/state-response-sex-workers-drug-users-and-hiv-new-orleans ; Human Rights Watch, "Hopes of Decriminalizing Sex Work in South Africa," June 21, 2018 https://www.hrw.org/news/2018/06/21/hopes-decriminalizing-sex-work-south-africa.

– a serious violation of human rights – with adult, consensual sexual relations.[306] Failure to make this critical distinction interferes with the right of sex workers to work safely and to advocate for their rights. Decriminalization of adult, consensual sex work, as well as repeal of criminal laws that enhance penalties for HIV exposure, would be important steps toward reducing the many HIV risks for trans women that result from incarceration. There is ample evidence to support public health arguments for criminal justice reform, both nationally and in the state of Florida.[307] In addition, support for Medicaid expansion, a program shown to reduce poverty, could improve economic conditions for trans women and reduce engagement in sex work as a necessity.

[306] Human Rights Watch, https://www.hrw.org/news/2018/06/29/why-weve-filed-lawsuit-against-us-federal-law-targeting-sex-workers

[307] Wideman, C., Yang, E., "Mass Incarceration, Public Health and Widening Inequality in the USA," The Lancet, 389(10077), April 2018, pp. 1464-74; Manuel Villa, "The Mental Health Crisis Facing Women in Prison," The Marshall Project, June 22, 2017; Kaiser Health News, "Prisons Fail to Offer to 144,000 Inmates with Deadly Hepatitis C," July 9, 2018; Brendan Farrigan, "Florida Prisons to Cut Programs Due to Health care Cost Hike," Associated Press, May 2, 2018.

Human Rights Standards

For transgender women, socio-economic conditions combine with harmful or inadequate federal and state policies that undermine their human rights and contribute to an environment in which their risk of HIV infection is higher than among any other group. With a particularly devastating impact on African-American and Latina women, this is a public health crisis that federal and state governments are obligated under international law to address.

Right to Health

All people have the right to health, a principle established by numerous international instruments including the Universal Declaration of Human Rights (UDHR).[308] The UDHR, endorsed by all members of the United Nations, including the United States, and considered to be broadly reflective of customary international law, protects the right to health as part of the right to a "standard of living adequate for the health and well-being of one's self and one's family."[309] The International Covenant for Economic, Cultural and Social Rights (ICESCR) establishes that medical care, necessary social services and housing are integral components of human dignity.[310] The ICESCR treaty has been ratified by 166 countries but not by the United States. The United States has signed, but not ratified, the ICESCR.[311]

In addition, the right to health is inseparable from provisions on the right to life and the right to be free from discrimination, protections included in the International Covenant on Civil and Political Rights (ICCPR), a treaty the United States has signed and ratified.[312] Article 26 of the ICCPR states, "All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall

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[308] Universal Declaration of Human Rights (UDHR), G.A. Res 217, UN GAOR, 3rd Session, UN Doc A/810, (1948) art. 25(1); The International Covenant on Economic, Social and Cultural Rights, adopted December 16, 1966, GA Res. 2200A (XXI), UN GAOR (no. 16) at 49, UN Doc. A/6316 (1966), entered into force January 3, 1976, signed by the US on October 5, 1977.

[309] Universal Declaration of Human Rights, art. 25 (1).

[310] The International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted December 16, 1966, GA Res. 2200A (XXI), UN GAOR (no. 16) at 49, UN Doc. A/6316 (1966), entered into force January 3, 1976, signed by the US on October 5, 1977; Committee on Economic, Social and Cultural Rights, General Comment 14, The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4, adopted August 11, 2000.

[311] As a signatory, the US is obliged to refrain from taking steps that undermine the "object and purpose" of the treaty. Vienna Convention on the Law of Treaties, adopted May 23, 1969, entered into force January 27, 1980, article 18.

[312] The International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, GA Res. 2200A (XXI), 21 UN GAOR Supp. (No. 16) at 52, UN Doc A/6316 (1966), 999 UNTS 171, entered into force March 23, 1976, ratified by the US on June 8, 1992.

prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political, or other opinion, national or social origin, property, birth or other status."[313] Authoritative treaty bodies as well as UN special rapporteurs and other international legal experts interpreting this provision have determined that it prohibits discrimination on the basis of sexual orientation and gender identity.[314]

The right to health does not guarantee to everyone the right to be healthy. Rather, it obligates governments to enact policies that promote the availability and affordability of basic health care services, without discrimination against those most likely to face obstacles to access – the poor, minorities, LGBT persons, women, prisoners, people with disabilities, and others.[315] The Trump administration has promoted policies that would have the opposite impact, attempting to repeal and undermine the Affordable Care Act without an adequate replacement, reducing the reach of Medicaid programs and turning away from interpretations of existing federal laws and regulations that would protect LGBT individuals from discrimination. As of October 2018, the Trump administration was moving ahead with plans to expand the grounds for religious and moral objections to providing health care services.[316] Without adequate provisions to ensure protection against discrimination, these and other Administration moves are likely to worsen pervasive and well documented discrimination against LGBT people in access to health services.

A key component of promoting affordability and availability of health services for transgender people is ensuring access to transition-related care. Under the Yogyakarta Principles, a set of non-binding standards endorsed by international legal experts from 25 countries that apply existing international human rights law to sexual orientation and gender identity, states are obligated to protect LGBT persons from discrimination in health care settings. This obligation includes "ensuring that gender-affirming health care is

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[313] ICCPR, art. 26.

[314] United Nations, Office of the High Commissioner on Human Rights, "Embrace Diversity and Protect Trans and Gender Diverse Children and Adolescents," https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=21622&LangID=E (accessed September 7, 2018); UN Human Rights Committee, *Toonen v. Australia*, CCPR/C/50/D 1992 (March 31, 1994).

[315] Committee on Economic, Social and Cultural Rights, General Comment 14, The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4, adopted August 11, 2000.

[316] Human Rights Watch, "Human Rights Watch Letter to US Secretary of Health and Human Services Alex Azar," March 27, 2018, https://www.hrw.org/news/2018/03/27/human-rights-watch-letter-us-secretary-health-and-human-services-alex-azar

provided by the public health system or, if not so provided, ensuring that such services are covered under private and public insurance schemes."[317]

Right to Be Free from Racial Discrimination

The federal, state and local governments in the United States are obligated to address all forms of racial discrimination, including the stark disparities that characterize the domestic HIV epidemic. This duty is fundamental to upholding international human rights law, including the ICCPR and the International Convention on the Elimination of All Forms of Racial Discrimination (CERD).[318] CERD, to which the United States is a party, requires governments, when circumstances warrant, to take "special and concrete measures" to ensure the development and protection of racial groups "for the purpose of guaranteeing them the full enjoyment of human rights and fundamental freedoms."[319]

CERD obligates governments to address not only intentional racial discrimination but laws, policies and practices that result in disparate racial impact.[320] The UN Committee on Racial Discrimination, the international expert body responsible for interpreting the ICERD, has expressed its concern that the United States lacks appropriate mechanisms for implementation of the treaty at the state level.[321]

Right to an Adequate Standard of Living

The Universal Declaration of Human Rights states:

> Everyone has the right to a standard of living adequate for the health and well-being of one's self and one's family, including food, clothing, housing and medical care and necessary social services, and the right to security in the case of unemployment, sickness, disability, widowhood, old age or other lack of livelihood due to circumstances beyond his control.[322]

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[317] The Yogyakarta Principles on the Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity, March 2007, http://yogyakartaprinciples.org/relating-to-the-right-to-the-highest-attainable-standard-of-health-principle-17/ (accessed September 7, 2018).

[318] International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), adopted December 21, 1965, GA Res. 2106, (XX), annex, 20 UN GAOR Supp. (No. 14), at 47, UN Doc A/6014 (1966), 660 UNTS 195, entered into force January 4, 1969, ratified by the United States November 20, 19994, art. 5.

[319] ICERD, art. 2(2).

[320] ICERD, art. 1(1).

[321] Committee on the Elimination of Racial Discrimination, Concluding Observations of the Committee on the Elimination of Racial Discrimination in the United States, Geneva, May 8, 2008, UN Doc. CERD/C/USA/CO 6, paras 16, 32.

[322] UDHR, art. 25.

Disproportionately, trans women struggle to secure access to many of these basic necessities. Living in extreme poverty keeps many trans women on the margins of society and vulnerable to violence, stigma and discrimination. Circumstances beyond their control – including numerous federal and state policies – contribute to this condition, including lack of legal protection against discrimination in employment, health care and public accommodation. Health care policies that reduce access to care for low income people and criminal laws that make it more difficult to find a job expose trans women to the harms of arrest and incarceration and reduce their ability to seek HIV prevention and care.

The state of Florida's continued rejection of expanded Medicaid coverage is a key policy decision that helps to entrench these grim realities. In his report on the United States, the UN Special Rapporteur on Extreme Poverty and Human Rights documented the "shocking" extent of extreme poverty in the US and criticized federal and state health care policy to undermine and restrict the Affordable Care Act. [323]

[323] UN Human Rights Council, "Report of the Special Rapporteur on Extreme Poverty and Human Rights," May 4, 2018, A/HRC/38/33/Add.1, https://documents-dds-ny.un.org/doc/UNDOC/GEN/G18/125/30/PDF/G1812530.pdf?OpenElement (accessed September 7, 2018).

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We are especially grateful to the many courageous transgender women who shared their stories and participated in the survey for this report.

Appendix A – Florida Department of Health Response to Alternative HIV Prevalence Estimate (Graph IV)

We appreciate that the data limitations towards transgender persons are being discussed and being brought to the forefront, these discussions are also occurring internally as well as HIV surveillance using multiple sources outside of traditional surveillance to identify transgender persons living with HIV in Florida. We however, would like to point out a few limitations of the data estimates provided by Johnson and Mayfair.

Between 2009–2014, 2,351 transgender people had received a diagnosis of HIV in the United States (U.S.)[1], in 2016, 291 transgender persons were living with a diagnosis of HIV in Florida[2]. We recognize that these data may underreport the diagnoses of HIV among transgender people due to how HIV surveillance is conducted and the sources they report cases from (e.g. laboratory results that do not have current gender identity listed, or from provider reports which may or may not report current gender identity in medical record).

The total population of transgender persons in the U.S. are not well known due to the lack of official records (Department of Motor vehicles, etc.) collecting only sex at birth and not current gender identity, and any estimates are produced through meta-analysis of surveys and articles which may not be generalizable to the U.S. or Florida. Current estimates used by CDC estimate approximately 1 million transgender persons are living in the U.S.[1,3] or 0.39% of the U.S. population. The study that Johnson and Mayfair referenced for their estimate of transgender person living with HIV in Florida, suggested an estimated number of 0.60% of the U.S. population identifies as transgender (1.4 million people), with an estimate of 100,300 transgender persons living in Florida[4]. This study used data reported from 19 states who asked if a person identified as transgender on the Behavioral Risk Factor Surveillance System (BRFSS) survey and extrapolated results to estimate population for the U.S. and individual states. Florida did not participate in this BRFSS transgender optional module question, furthermore these studies only estimate the transgender population and not persons who identify as transgender who live with a diagnosis of HIV. Current estimates used by the CDC report that 22–28% of transgender individuals (approximately 220,000–280,000) are living with HIV in the U.S.[1,5]

As we do not know the exact methodology that was used by Johnson and Mayfair to calculate their estimated prevalence of transgender persons living with HIV in Florida, we can't comment on their estimate. We do not understand how they got a prevalence of 0.6% prevalence for transgender persons living with HIV in Florida.

[1] https://www.cdc.gov/hiv/pdf/group/gender/transgender/cdc-hiv-transgender-factsheet.pdf

[2] http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/epi-slide-sets.html

[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5227946/

[4] http://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf

[5] https://www.sciencedirect.com/science/article/pii/S1473309912703158?via%3Dihub

LIVING AT RISK

Transgender Women, HIV, and Human Rights in South Florida

The 1.4 million transgender and gender-non-conforming people in the United States generally face multiple barriers, from family rejection to non-acceptance and abuse at school, and pervasive discrimination in employment, housing, and health care. Nationally, rates of HIV infection are declining, but among transgender women, rates of new HIV infection have remained at crisis levels for more than a decade, particularly among women of color. This public health emergency demands a robust response – one that the state of Florida, and the federal government, are failing to deliver.

Living at Risk: Transgender Women, HIV and Human Rights in South Florida documents the harmful impact of federal and state policies on transgender women in two counties – Miami-Dade and Broward – with the highest rates of new HIV infection in the country. Based on hundreds of interviews with transgender women, their advocates, medical providers, public officials, and law enforcement, this report describes the failure of Florida to provide basic HIV prevention and treatment services to many transgender women, leaving them without affordable health care and contributing to the uncontrolled epidemic in the state. Neglected by HIV policymakers and undercounted in government HIV data, transgender women are left with limited options for HIV prevention and care.

Until federal and state policymakers ensure that transgender women have access to affordable health care that respects their identity and rights, HIV will continue to endanger the lives of the transgender community.

Rajee Narinesingh, a transgender human rights advocate, in Miami, Florida, October 2018.

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WHITMAN-WALKER CLINIC, INC., *et al.*, *Plaintiffs,* v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, *Defendants*.	Case No. 1:20-cv-1630

DECLARATION OF DARREL CUMMINGS, CHIEF OF STAFF,
LOS ANGELES LGBT CENTER

I, Darrel Cummings, hereby state as follows:

1. I am the Chief of Staff of the Los Angeles LGBT Center ("the Center"), a not-for-profit 501(c)(3) organization based in Los Angeles, California, that provides a variety of services to members of the lesbian, gay, bisexual, and transgender ("LGBT") communities. I have served in this capacity since 2003, and also previously served as Chief of Staff from 1993 through 1999. More broadly, I have been an advocate on LGBTQ issues since 1979.

2. I am submitting this Declaration in support of Plaintiffs' Motion for a Preliminary Injunction to prevent the revised regulation under Section 1557 of the Affordable Care Act, published by the Department of Health and Human Services on June 19, 2020 (the "Revised Rule"), from taking effect.

3. The Center was founded in 1969 and offers programs, services, and global advocacy that span four broad categories: health, social services and housing, culture and education, and leadership and advocacy. The mission of the Center is to fight bigotry and build a world where LGBTQ people thrive as healthy, equal, and complete members of society. Today the Center's

more than 650 employees provide services for more LGBTQ people than any other organization in the world, with about 500,000 client visits per year.

4. As the largest provider of services to LGBTQ people in the world, many of the Center's patients tell us that they come to the Center seeking culturally competent health care due to being denied care or being discriminated against based on their real or perceived sexual orientation, gender identity, transgender status, and HIV status. The Center's client population is disproportionately low-income and experiences high rates of chronic physical and mental conditions, homelessness, unstable housing, trauma and discrimination, and stigmatization in health care services. Many of these clients come to the Center from different areas of California, other states, and even other nations to seek services in a safe and affirming environment.

5. Many of the Center's clients live in states that do not have explicit nondiscrimination protections in health care on the basis of gender identity, transgender status, or sexual orientation. These clients travel long distances to the Center because they have even greater fear of discrimination by health care providers in their states. With the Trump Administration's constant attacks on the LGBTQ community, the Center has seen and will continue to see an increase in clients traveling from out of state, especially clients who reside in rural areas where there may not be *any* LGBT-affirming health care providers to treat them in their most desperate times of need. This has been especially true during the current COVID-19 pandemic.

6. The Center provides a wide spectrum of health care services, including, but not limited to, HIV treatment, testing, and prevention care, as well as treatment for gender dysphoria and mental health care. The Center has medical providers who specialize in the care of transgender patients and who provide a full range of primary care services in addition to hormone therapy, pre- and post-surgical care, and trans-sensitive pap smears, pelvic exams, and prostate exams. The

Center's broad array of health care services are all under one roof, from counseling and therapy to pharmaceutical and nutrition needs.

7. The Center is one of the nation's largest and most experienced providers of LGBTQ health and mental health care. As a federally qualified health center, the Center is required to serve anyone on a nondiscriminatory basis who walks into its doors. We accept a variety of health insurance plans, including Medi-Cal (California's Medicaid program), Medicare, and most private insurance plans. We also provide services to uninsured individuals. We work with these individuals to help them access insurance through Covered California (California's Affordable Care Act "exchange"), and/or navigate other medical- and drug-assistance programs. Where insurance is not available, our services are offered on a sliding-scale basis, based on ability to pay. We pride ourselves on providing leading-edge health care, regardless of individuals' ability to pay. Given our commitment to serve all clients regardless of their ability to pay, the Revised Rule's removal of insurance coverage and nondiscrimination requirements will cause the Center to be flooded with more clients and create significant financial strains on the Center.

8. The Center has remained open for services throughout the COVID-19 health crisis, which already stretched the Center's resources thin. Releasing this discriminatory Revised Rule during a time of pandemic is particularly egregious. The Revised Rule will deter patients from seeking testing and treatment for COVID-19, which will endanger the lives our patients' lives and will cause serious harm to the public at large. Testing and contact tracing are key to effectively respond to this and other health pandemics. Yet, when patients fear discrimination, testing and contact tracing cannot be implemented effectively.

9. Amidst existing stress from the COVID-19 pandemic, our clients and staff have become increasingly panicked and stressed about the Revised Rule. As a result, the Center needs

to devote significant resources to reaffirming its commitment to the LGBTQ community, educating about the effects of the Revised Rule. The Center also needs to devote significant resources to addressing our clients' increased need for medical services and for affirming medical referrals given their fears of the discrimination by other health care providers that the Revised Rule invites. There is no more important time than now for our clients to know that we are open for services and they will continue to receive affirming, nondiscriminatory care at the Center. Our community needs to know that they have a safe and affirming place to receive care, especially emergency care. However, the Center cannot—despite our best efforts—meet effectively the needs of all the LGBTQ people that will be harmed by the Revised Rule, in California and other states.

10. The Center receives various forms of Health and Human Services funding, including Public Health Service Act funding. Approximately 80 percent of the Center's funding originates from the federal government, including, but not limited to, funding under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, direct funding from the Centers for Disease Control and Prevention, discounts under the 340B Drug Discount Program, and Medicaid and Medicare reimbursements. The Center also receives federal funding for research programs, and is currently a participant in multiple federally-funded studies, including through National Heart, Lung, and Blood Institute; National Institute of Allergy and Infectious Diseases; National Institute of Child Health and Human Development; the National Institutes of Health; National Institute of Drug Abuse; and the Patient-Centered Outcomes Research Institute. The Center is, therefore, a covered entity under the Revised Rule and is subject to its provisions.

11. The Revised Rule eliminates the definition of "on the basis of sex" and the specific prohibitions on discrimination on the basis of gender identity, transgender status, and failure to

conform to sex stereotypes. The Revised Rule also eliminates specific provisions related to discrimination against transgender individuals, as well as the provision relating to the discrimination on the basis of association. The elimination of these provisions will result in direct harms to the LGBTQ patients that the Center serves.

12. The Revised Rule caused immediate panic from the Center's clients and staff about what the Revised Rule means and how it will affect the Center's clients' ability to obtain health care services. The Center's clients are and will continue to be confused and misled by the Revised Rule, which will further deter them from seeking care. The Center also refers its clients to other health care providers for many specialty health care services it does not provide. As a result of the Revised Rule, our clients who seek care by other health care providers outside of the Center, particularly those from other states but also those within California, will reasonably fear discrimination and be afraid to assert their rights if they are discriminated against. The Revised Rule creates confusion over what rights patients have and how patients may assert such rights. This is especially true given the Revised Rule's removal of a unitary legal standard that creates an additional barrier for clients to seek justice for the harms they experience, let alone finding a successful remedy for the harms.

13. In addition to the Revised Rule's elimination of the unitary standard, its removal of notice and tagline requirements will also make it much more difficult for transgender and gender nonconforming patients with Limited English Proficiency (LEP) to understand what rights they have, how to advocate for such rights, what language services are still available to them, how they can access such services and how to handle discrimination and other complaints. The Revised Rule appears to have been drafted to be purposefully sow chaos and confusion about what Section

1557 requires. That chaos and confusion is heightened for LEP patients who cannot reasonably be expected to understand what rights they still have if this discriminatory rule is implemented.

14. As a result of confusion and panic created by the Revised Rule, the Center has already and will continue to expend additional resources educating its clients and staff about their rights and reassuring them that the Center will continue providing nondiscriminatory services to all clients.

15. The Revised Rule will also worsen health disparities between the LGBTQ community and other communities. With existing health and health care disparities in the LGBTQ community – particularly the shortage of LGBTQ/HIV culturally competent providers – the Revised Rule's invitation to health care providers to discriminate will further exacerbate existing barriers to health care and result in negative community health outcomes.

16. The Center's providers have observed patients arriving at the Center with acute medical conditions that could have been avoided but-for the patients' reluctance to seek routine and necessary medical care for fear of discrimination and being turned away. A shocking number of LGBTQ patients fear going to a health care provider due to negative past experiences directly related to their sexual orientation, gender identity, or transgender status. The Revised Rule will exacerbate those numbers as a result of increased discrimination and denials of health care treatment. For example, we have had clients arrive at the Center with Stage 4 ovarian cancer because they were afraid to seek routine pap smears. The Revised Rule creates additional barriers to accessing affirming health care, increases patients' reluctance to seek care for both minor and serious conditions, and decreases trust between patients and their providers out of fear of judgment, discrimination, and denials of treatment. An increase in community members experiencing the

trauma of discriminatory or unwelcoming health care experiences will worsen community health outcomes among the population that the Center serves.

17. For similar reasons, LGBTQ people are less likely to have a primary care provider whom they consider their personal doctor. That means that in times of need, LGBTQ people are more likely to randomly select a health care provider with whom they do not have a relationship, and they are at increased risk of finding a provider who is not LGBTQ-affirming. With an increase in discrimination as a result of the Revised Rule, LGBTQ people will be far less likely to receive the health care treatment that they need because, after being discriminated against, they are unlikely to seek other care out of fear of repeated rejections.

18. The Revised Rule sends a message to the Center's LGBTQ clients that they do not have a right to equal access to health care and empowers health care providers to discriminate against them, which has caused and will continue to cause panic and fear within the Center's client community and staff. This fear will deter clients from seeking medically-necessary health care services out of fear of discrimination and will cause delays in treatment. This delay has serious medical ramifications for clients and public health at large. It also results in increased costs to the Center and the health care system at large.

19. Transgender and gender nonconforming clients are particularly likely to delay care as a result of the Revised Rule given the Rule's broad invitation to discriminate on the basis of any religious or moral beliefs in combination with the Rule's narrowing of insurance coverage options for transgender patients. The Revised Rule creates confusion over what treatments patients' insurance will cover and how they may access medically-necessary care. Discrimination by other outside health care providers will result in transgender patients delaying medical care, especially for medically-necessary treatment for gender dysphoria.

20. As a result of the discrimination and denials of care and coverage it will cause, the Revised Rule will increase demand for the Center's services and will cause financial strains on the Center. For some patients that the Center serves, especially those who live in regions with limited options for LGBTQ-affirming health care services, finding LGBTQ-inclusive health care options is already a struggle. Additionally, for some medical specialties, there are only a handful of health care providers in a patient's region who have the specialty necessary to treat the patient, so discrimination by even one provider could make it practically impossible for an LGBTQ patient to receive the specific health care service sought. This is even more concerning in regions where patients' only options are religiously-affiliated organizations that could claim religious or moral-based objections to providing any and all care to LGBTQ patients as a result of the Revised Rule, in contradiction to medical ethics and standards of care. This is especially true during the COVID-19 pandemic when medical services are more limited.

21. The Revised Rule eliminates explicit nondiscrimination regulatory protections and instead invites increased discrimination against LGBTQ people and people living with HIV at other health care centers, outside of the Center. By eliminating the explicit protections against discrimination based on gender identity, transgender status, and failure to conform with sex stereotypes, the Revised Rule invites an increase in discriminatory experiences for LGBTQ patients seeking health care services, such as those documented below. This results in harm to the patients and community that the Center serves.

22. The Center's health care providers – particularly its counselors, psychiatrists and other behavioral-health staff – have treated many patients who have experienced traumatic stigma and discrimination based on sexual orientation, gender identity, transgender status, HIV status, and/or

other factors. The stories that patients tell the Center's staff about their discriminatory experiences outside of the Center include:

a. One transgender patient was unable to find supportive mental-health housing due to discriminatory experiences based on gender identity, which led to the patient being homeless.

b. Another transgender patient, who developed profuse bleeding after surgery, was denied treatment at an emergency room where they were told by an emergency room doctor: "what do you want me to do about it?" They arrived at the Center in distress three days later, having lost a significant amount of blood.

c. A transgender patient needed to have a pelvic exam. The Center referred him to a specialist who denied services to him because he was transgender.

d. Patients have stated that their physicians told them that they do not need HIV testing because they are not engaging in same-sex sexual relationships. Not only is that conclusion contrary to medical guidelines, but when patients refuted assumptions about their sexual relationships, they were met with disapproval.

e. Patients have expressed concern about traveling outside of Los Angeles for business because if they are ever in need of emergency medical assistance, they will not know where to go to ensure that they will receive nondiscriminatory, proper health care services.

f. One patient recalled that when her late partner was in the hospital, she was there most of the time to care for her. There was a nurse who treated them

kindly and appropriately until the nurse heard them refer to each other by "Honey." The look on the nurse's face changed and she treated the couple "like trash" after that. The patient remarked that allowing health care employees (everyone from those working in food service and housekeeping to physicians and nurses) to express judgment or disapproval based on their religious or moral views when providing care to patients results in placing LGBTQ patients in a "lesser-than" category of patients.

g. Patients residing at assisted-living facilities have described discrimination and denials of care when their sexual orientation, gender identity, and HIV status were revealed. Patients who are transgender have described having to hide their gender identity and transgender status once they are no longer able to care for themselves and are required to find assisted-living arrangements.

h. Patients have described being intentionally referred to by names and pronouns other than their preferred names while seeking health care services elsewhere. There is no valid medical reason to not refer to a patient by their name and pronouns, consistent with their gender identity.

i. A patient described being given his positive HIV results by way of his provider placing a lab printout on the counter then leaving for 10 minutes and letting the patient read it. The patient was not given any further information, and was instead told to go to our Center.

j. Patients have reported that their primary care physicians do not feel comfortable prescribing HIV preventatives, such as Truvada for Pre-

Exposure Prophylaxis (PrEP), even when such medications are appropriate and should be provided according to current medical guidelines and standards of care. Patients also have reported that their physicians shame them for requesting PrEP medications and then deny them the medication, which is how they find their way to the Center. For example, when one patient asked his provider about Truvada, his physician questioned him as to why he needed it and proceeded to tell the patient that he would not need the medication if he were more careful. Another patient was denied PrEP altogether and lectured that he did not need PrEP unless he was having sex with sex workers.

k. Patients also have expressed reluctance to use their insurance for PrEP because they are afraid of having the drug documented on their insurance record. These patients fear that a history of using a medically necessary HIV preventative could be used against them in the future by making them targets for discrimination based on sexual orientation, gender identity and/or transgender status, and HIV status, given the current political climate and discrimination in the health care context.

l. A significant number of patients come to the Center's Sexual Health and Education Program for testing and sexual education rather than their primary care physicians because they do not feel comfortable talking about their sexual histories and choices out of fear of being treated negatively, judgmentally, and with bias and discrimination.

m. Multiple patients have stated that they come to the Center to be tested for sexually transmitted infections because the Center does rectal and throat swabs instead of only urine tests. Not all health care providers do all three forms of testing even though three-site testing provides the most accurate results for testing and treating sexually transmitted infections. This is especially true for gay men. Someone could test negative for a sexually transmitted infection with a urine test, for example, but test positive with a rectal swab. Patients report that when they specifically asked their outside provider to do rectal swabs, they were judged. When patients are judged by their physicians and/or cannot be out to their physicians about their sexual orientation and/or gender identity out of fear of discrimination, LGBTQ patients cannot receive the health care services that they need, including prophylactic treatments, and may experience delays in medically necessary treatments, resulting in more acute, life-threatening conditions.

23. Many of the Center's patients and LGBTQ people in general have reported that they are not out to their other medical providers about their sexual orientation and/or gender identity out of fear of discrimination and denial of health care. The Revised Rule's attempt to exclude sexual orientation, gender identity, and transgender status from the nondiscrimination protections under Section 1557 and its invitation to health care providers to discriminate on the basis of religious or moral beliefs will harm the Center's patients and puts the health of LGBTQ patients at risk.

24. The Revised Rule encourages LGBTQ patients to attempt to hide their LGBTQ identities when seeking health care services, especially from religiously-affiliated health care

organizations, in order to avoid discrimination. When patients are unwilling to disclose their sexual orientation and/or gender identity to health care providers out of fear of discrimination and being refused treatment, their mental and physical health is critically compromised.

25. The Revised Rule also adversely impacts the Center by necessitating the diversion and reallocation of resources to address the increase in the numbers of referrals requested by the Center's clients who seek LGBTQ-affirming services that the Center does not have sufficient resources to provide as a result of the Revised Rule. The Center will also have more difficulty finding LGBTQ-affirming health care providers, especially those with niche specialties, given that the Rule emboldens health care providers to refuse to treat LGBTQ patients.

26. As a result of the Revised Rule, the Center may need to hire additional staff to address the community's need for referrals to welcoming providers. A substantial part of the Center's staff and resources has already been spent engaging in advocacy, policy analysis, and services to address the ill-effects of the Revised Rule. The Center will also have to divert resources away from other programming to conduct informational sessions about the Revised Rule to answer patients' and staff members' questions about how the Rule will affect them and the services that the Center provides, as well as actually meet the increased demand for its services and the need to better vet referrals.

27. The increase in referral requests requires the Center to allocate additional staff time to pre-screen service referrals to ensure that staff are sending patients to LGBTQ-affirming providers and not to providers who themselves or whose staff would cause additional harm to the Center's patients. With the Revised Rule emboldening increased discrimination against LGBTQ patients, the Center will have to do additional checks on potential referrals to confirm with the providers that they will continue abiding by their obligation to provide nondiscriminatory care to all patients.

Additionally, the Rule's removal of accommodation requirements for LEP patients will make it increasingly difficult for the Center to find appropriate referrals for our LEP clients. Without requiring accommodations for our LEP clients, our clients are at an increased risk of receiving inferior care and improper testing and delayed diagnoses when they seek health care services from outside providers.

28. When a patient cannot communicate with and trust their health care provider, the provider has incomplete information to be able to properly diagnose, test and treat patients. This is especially true for patients who are unable to or fear disclosing their sexual orientation or gender identity to their providers out of fear of discrimination or denials of treatment. The Center will have to expend more resources on its health promotion campaigns to ensure that LGBTQ patients access necessary preventative screenings and testing (including for cancer, HIV and other STIs) given that the Revised Rule will change the health care landscape for the LGBTQ patient population.

29. Under the Revised Rule, covered entities will not be considered as discriminating on the basis of sex if they refuse to use a transgender patient's pronouns consistent with their gender identity; refuse them access to sex-specific facilities that are consistent with their gender identity and instead forces them into facilities/shared rooms based on the sex they were incorrectly assigned at birth; and identifies them by the sex they were incorrectly assigned at birth such as on patient identification bracelets and any signage outside the patient's room. These discriminatory actions, which as documented above, have been experienced by the Center's clients at other health care facilities, are inconsistent with the 2016 Final Rule and Section 1557 of the Affordable Care Act. They are also detrimental to transgender patients' health and wellbeing, and can lead to significant distress and hypertension. Moreover, HHS in the preamble to the Revised Rule warns

covered entities such as the Center that treating transgender patients consistent with their gender identity as it relates to sex-specific facilities may subject them to liability and enforcement by HHS. However, the Center treats each patient in accordance with their gender identity, consistent with the 2016 Final Rule and established case law. If the Center were to be sanctioned and lose federal funding as a result of the Revised Rule's enforcement, the impact would include massive service reduction if not closure.

30. The 2016 Final Rule protects against "categorical coverage exclusion[s] or limitation[s] for all health services related to gender transition" and denials, limitations, or restrictions "for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual," 81 Fed. Reg. at 31,472 (formerly codified as 45 C.F.R. § 92.207(b)). Affirming providers like the Center and their patients have been able to use the 2016 Final Rule to reinforce the obligations of Medicaid administrators, insurers, and employee health plan sponsors to provide services to LGBTQ people devoid of discrimination, including the need to cover procedures when supported by evidence of medical necessity. The Revised Rule, which eliminates these protections that we at the Center rely upon to advocate on behalf of our patients, invites health plans to discriminate through the exclusion of gender-affirming procedures, especially those used to treat transgender patients suffering from gender dysphoria, and through the reinstitution of insurance practices regarding the "tiering" of certain drugs that are of crucial for LGBTQ patients living with HIV and/or other medical conditions or disabilities that require expensive treatments.

31. The Revised Rule also exempts numerous forms of health insurance from Section 1557, subjecting LGBTQ patients who rely on those forms of insurance to discrimination based on sex, gender identity, transgender status, sexual orientation, race, national origin, age, or

disability. Additionally, the Revised Rule excludes HHS health-related programs and activities from Section 1557, unless a program was established under Title I of the ACA. This affects many programs, including those under the Centers for Medicare and Medicaid Services. The narrowing of covered entities under Section 1557 will increase discrimination against LGBTQ patients while at the same time limiting remedies available to address such discrimination.

32. In sum, the Revised Rule will exacerbate the acute health disparities LGBTQ people already face and send the message that discrimination on the basis of gender identity, transgender status, sexual orientation, and failure to conform with sex stereotypes is permissible under federal law, which will increase the number of the Center's LGBTQ patients who will be denied care outside the Center.

33. The Revised Rule makes it difficult, if not impossible, for the Center to continue providing the same level of social, mental, and physical health care to its patients. The Center's mission includes addressing the need for equity in health care for all of the Center's patients and the LGBTQ community generally. This mission will be frustrated by the Revised Rule as there will be a decline in overall LGBTQ-patient health and public health at large. By eliminating the regulatory protections and clear guidance provided in the 2016 Final Rule, the Revised Rule presents a grave threat to the health and wellbeing of the patient population that we serve, most specifically LGBTQ patients and patients with LEP. The Revised Rule also frustrates our ability to provide referrals to our patients and imposes increased costs on the Center.

[*Signature on next page.*]

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

Dated this 6th day of July, 2020.

____
Darrell Cummings

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

WHITMAN-WALKER CLINIC, INC., *et al.*,

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

Case No. 1:20-cv-1630

**DECLARATION OF DR. ROBERT BOLAN, MD
CHIEF MEDICAL OFFICER, LOS ANGELES LGBT CENTER**

I, Robert Bolan, declare as follows:

1. I am the Chief Medical Officer and Director of Clinical Research for the Los Angeles LGBT Center (the "Center" or "LA LGBT Center").

2. I oversee all medical care related services at the LA LGBT Center, as well as maintain a panel of patients for whom I provide direct care. In addition, I oversee the LA LGBT Center's Research Department, am the principal investigator for multiple HIV treatment and prevention trials, and have written and presented extensively on various matters related to the care and treatment of people living with or at risk of acquiring HIV and other sexually transmitted infections (STIs).

3. I am also Clinical Associate Professor of Family Medicine at the University of Southern California (USC) – Keck School of Medicine, and an Adjunct Clinical Professor of Pharmacy Practice at the Western University of Health Sciences. I received my medical degree from the University of Michigan Medical School, interned at St. Mary's Hospital Medical Center, and completed my residency at St. Michael Family Practice Residency. I was the Director of HIV Services in the Department of Family Medicine at the USC Keck School of

Medicine, and I have been honored with the Leadership Award from the San Francisco AIDS Foundation. I maintain active board certification with the American Board of Family Physicians and specialty certification with the American Academy of HIV Medicine. A copy of my curriculum vitae is attached as **Exhibit A**.

4. I am submitting this declaration in support of Plaintiffs' Motion for Preliminary Injunction to prevent the revised regulation under Section 1557 of the Affordable Care Act ("ACA"), published by the U.S. Department of Health and Human Services ("HHS") on June 19, 2020 (the "Revised Rule"), from taking effect. The Revised Rule eliminates explicit regulatory protections for LGBT people in health care that were included in the 2016 Final Rule, which was promulgated under Section 1557 in May 2016.

5. As the Chief Medical Officer, I oversee the delivery of health care for approximately 32,000 patients who come to the LA LGBT Center and have a panel of approximately 250 patients for whom I personally provide medical care. Over 90% of my patients identify as LGBTQ. My patient population is also disproportionately low-income and experiences high rates of chronic conditions, homelessness, unstable housing, trauma history, and discrimination and stigmatization in health care services. Many of these patients come to me from different areas of California, other states, and even other nations to seek services in a safe and affirming environment.

6. Our health care services span the full spectrum of primary health care services, including, but not limited to, HIV treatment and testing, treatment and prevention of sexually transmitted infections, as well as treatment for gender dysphoria, mental-health disorders, and substance-use disorders.

7. Many if not most of the individuals in our very diverse patient population face considerable stigma and discrimination – as people living with HIV, as sexual or gender minority people, and/or as people of color. In addition, there is a very high incidence of other social determinants of poor health outcomes among the patient population that we serve. These include homelessness, food insecurity, lack of access to transportation, and lack of employment opportunities.

8. There is every reason to believe that the Revised Rule will encourage health care providers to claim a right to discriminate, refuse care or opt out of serving patients with particular needs, which will result in more discrimination against LGBT patients and patients living with HIV at other clinics, doctors' offices, hospitals, pharmacies, and other health care facilities outside of the LA LGBT Center. I, and the other providers whom I supervise at the Center, treat patients who have experienced traumatic stigma and discrimination – based on their sexual orientation, gender identity, transgender status, HIV status, and/or other factors – even before the Revised Rule was proposed or finalized. Based on the stories that my patients have shared with me, this discrimination, mistreatment, and denial of health care services has on many occasions been motivated by the moral or religious beliefs of other health care providers and staff outside of the Center.

9. In the more than twenty years that I have been at the Center, I have listened to the stories of countless individuals who have suffered overtly homophobic remarks from health care providers and who were either refused care or given clearly inadequate and inappropriate care because of their sexual orientation or gender identity. One of the most egregious examples was a transgender woman who needed extensive surgery to repair diffuse damage done by silicone injections into her breasts several years earlier. In 2009, she was turned away from an academic

plastic surgery center in Los Angeles after the surgeon said her problem was caused by her own poor decision-making and she would therefore not be considered for treatment.

10. Incidents like this reveal that many health care providers and other staff harbor explicit or implicit biases against LGBTQ people. Because of legal requirements, health care facility nondiscrimination policies, and professional norms, many of them have kept their personal biases and feelings in check. By empowering health care staff to think that they have the legal right to act on their personal beliefs, even at the expense of patient needs, the Revised Rule will result in many more incidents of discrimination and greater harm to LGBTQ individuals struggling with mental-health or substance-use issues, including the patients whom I treat and whose treatment I supervise.

11. Such experiences are not only insulting and demoralizing for the patient, but can jeopardize the patient's health, especially, for example, when a screening or treatment is denied or postponed, or the patient is discouraged from seeking medical care out of fear of repeated discrimination. Many, if not most, of my transgender patients and the LA LGBT Center's transgender patients express strong distrust of the health care system generally and are reluctant to seek care outside the Center unless they are in a crisis or suffer from severe physical or mental stress. This is because they want to avoid discrimination or belittlement. Such incentives to avoid regular check-ups and other medical care can result in disease processes that are more advanced at diagnosis, less responsive to treatment, or even no longer curable in the case of some cancers.

12. In the case of the transgender woman I described above, her general medical condition gradually deteriorated over the several years it took for me to finally identify a surgeon who would take her case. She was suffering from systemic metabolic complications from the

chronic inflammation and skin breakdown caused by the hardened subcutaneous silicone injections. I feared for her survival. Fortunately, the surgeon who cared for her did so with kindness, respect, and compassion, and the patient has had an excellent result. The affirming surgeon saved her life. Nevertheless, the ultimate tragedy in my patient's case was that after the humiliating and callous abuse to which she was subjected by the academic center's specialists, she was completely unwilling to even consider seeing another surgeon for the next six-and-a-half years. Her suffering during that time was completely avoidable had she been treated with basic human respect from the beginning.

13. With existing health and health care disparities affecting the LGBTQ community – particularly the shortage of LGBTQ/HIV culturally competent providers – confusion and chaos resulting from the Revised Rule will further exacerbate existing barriers to health care and result in negative community health outcomes. The Revised Rule will remove any expectation that a provider will approach LGBTQ patients with compassion and respect for their dignity. Good medical care is based on trust as well as frank and full communication between the patient and their provider. Such communication will not happen if the patient is made to feel like a supplicant. It is the providers' responsibility to non-judgmentally elicit the patient's relevant health history, sexual history, substance-use history, lifestyle, and gender identity in order to provide appropriate care for the patients' health, both physical and mental. Incomplete communication, or miscommunication, can have dangerous consequences.

14. For instance, a patient who conceals or fails to disclose a same-sex sexual history may not be screened for HIV or other infections or cancers; and a patient who fails to fully disclose their gender identity and sex assigned at birth may not undergo medically-indicated tests or screenings (*e.g.*, some transgender men may require tests for cervical or breast cancer, and

some transgender women may require tests for testicular or prostate cancer). Patients need to be encouraged to fully disclose all information relevant to their health care and potential treatment, and they are unlikely to do so unless they are assured that the information they provide will be treated confidentially and with respect. The Revised Rule endangers the provider-patient relationship, and is likely to harm many patients' health, by discouraging patients from full disclosure, and by encouraging providers to discriminate and avoid topics that may offend their personal moral or religious beliefs in their encounters with patients.

15. Patients often receive delayed care or misdiagnoses when patients are reluctant to reveal their LGBTQ identity to health care providers out of fear of discrimination or disapproval. Another example of this involved a patient who suffered from a respiratory cough and increasing shortness of breath, which developed over several weeks. The patient was reluctant to go to the emergency room because of distrust of health care providers. After two weeks of suffering from severe symptoms at home, he was persuaded by his boyfriend to go the ER. When he arrived at the ER, the providers were so focused on COVID-19 that they failed to even consider the possibility of HIV-related illness. Had they asked about his health history, sexual history, or sexual orientation, they would have suspected HIV as a cause for his symptoms. Instead, the patient received an incorrect diagnosis and treatment. After two weeks of further decline, he presented at another LGBTQ-affirming clinic where they saw that he had a classic presentation of HIV-related pneumonia. Tragically, even though he was rushed immediately to another hospital where proper treatment was started, it was too late and he died shortly after admission. The nature of a health crisis like COVID-19 is that it inherently creates additional barriers to care for patients. The Revised Rule increases those barriers to treatment.

16. Not only is the Revised Rule discriminatory and harmful to my patients and to public health, but the timing of publication of the Revised Rule makes it especially egregious. We cannot afford additional discrimination in health care when patients are in their most desperate times of need for proper and nondiscriminatory health care. We need people to trust their health care providers, especially when their lives and the lives of those around them are at stake. In order to beat this virus, public health requires that all patients seek medical treatment and testing without hesitation or delay should they experience symptoms of COVID-19. By inviting discrimination against LGBTQ patients, the Revised Rule does the exact opposite, harming both patients and the general public.

17. The Revised Rule will cause LGBTQ patients and patients living with HIV to lose trust in their health care providers. The Rule will cause LGBTQ patients to attempt to hide their LGBTQ identities to an even greater degree when seeking health care services, especially from religiously-affiliated health care organizations, in order to avoid discrimination. The Revised Rule endangers the provider-patient relationship and is likely to harm many patients' health by discouraging patients from full disclosure about their gender identity, sexual orientation, or related medical histories. Patients will avoid raising any topics, questions, facts that they fear could possibly offend their health care providers' personal beliefs, resulting in harm to patients.

18. The Revised Rule is also likely to cause an increase in demand for my health care services. I have seen a spike in behavioral and mental-health issues resulting from discrimination and denials of health care services, and I will undoubtedly see an uptick in requests for my services and the services of the providers that I oversee at the LA LGBT Center because patients will come to us seeking affirming health care out of fear of discrimination elsewhere or because they were already discriminated against elsewhere. The Revised Rule

invites discriminatory behavior that is in direct conflict with the oath I swore as a doctor and many of the federal, state, and insurance rules, regulations, and statutes that I and other health care providers are required to follow.

19. Additionally, the Rule's removal of language access protections for Limited English Proficiency (LEP) patients will make it increasingly difficult for the LA LGBT Center and its health care providers, including me, to find appropriate referrals for our LEP clients. Without requiring accommodations for our limited English proficiency clients, our clients are at an increased risk of receiving inferior care and improper testing and delayed diagnoses when they seek health care services from outside providers. In addition, as discussed above, LGBTQ people already fear discrimination from their medical providers and have immense distrust of the health system. That distrust increases for LEP patients who are not provided with necessary translation services to communicate with their health care providers. Without necessary translations services, LEP patients tend to remain silent during consultations because they either cannot articulate the problems that they are experiencing, cannot comprehend what is being asked of them, or fear being open and honest with their providers about their difficulty understanding the providers' English. Patients may be reticent or worried about asking for a translation or articulating that they do not understand because they may want to present as and feel self-sufficient. One's ability to communicate subtly and precisely is hampered by the Revised Rule's removal of LEP accommodations. Health care is highly personal and has emotional impacts. This is heightened for LEP patients who as a result of the Revised Rule will be left navigating the system and care without the assistance of a translator.

20. The removal of LEP accommodations also will likely result in family members and friends of patients accompanying the LEP patients to their appointments. Many people think that

a family member or friend translating for a patient is sufficient, but that could not be further from the truth. There are a whole host of problems with having friends or family accompany a patient into the examining room, including, but not limited to, confidentiality issues, concerns about potential domestic violence, and concerns that patients, especially youth, may not be out about their LGBTQ identities to their family and friends. Relying on family or friends for translations is particularly dangerous for non-affirming families of transgender patients who would then create a barrier to health care. The end result is misdiagnoses, improper testing, and delay in treatments. In order to provide proper care to patients, there must be open lines of communication between physicians and their patients. The Revised Rule cuts off the line of communication and trust between providers and their patients.

21. These issues are amplified by COVID-19. It is hard enough for LEP patients or LGBTQ patients who fear discrimination in health care to communicate with their providers in person, let alone via telehealth. Each time a patient has their first telehealth visit, there is a learning curve. It is much more difficult for people to feel comfortable sharing information over the phone or video as opposed to in person consultations. The Revised Rule exacerbates these issues by inviting discrimination against LGBTQ patients and decreasing resources for LEP patients. The result is inferior medical care to patients and additional costs to the system, especially during a public health crisis like COVID-19.

22. The Revised Rule also adversely impacts the Center and its individual health care providers by necessitating the diversion and reallocation of resources to address the increase in the numbers of referral requests resulting from the Revised Rule. As a result of the Revised Rule's invitation to discriminate against LGBTQ patients, the LA LGBT Center is and will continue to be flooded with referral requests for LGBTQ-affirming services that the Center does not have

sufficient resources to provide. The Center will also have more difficulty finding LGBTQ-affirming health care providers, especially those with niche specialties, given that the Revised Rule emboldens health care providers to discriminate against and refuse services to LGBTQ patients in complete contradiction to medical and ethical standards of care.

23. For example, just a few weeks ago we received a call from a transgender patient whom we referred to an outside surgeon for an ear/nose/throat (ENT) issue because we do not provide those services at the Center. The patient later notified us that the physician conducted a breast exam on the transgender woman when the patient was very clear that she was only there for ENT-related issues. There was no reason for the physician to remove the patient's shirt and check her breasts. Such inappropriate professional behavior will increase because the Revised Rule sends a message to the medical field that LGBTQ people are unworthy of protections and quality care in accordance with medical and ethical standards of care. For that reason, we will have to divert our time and resources to vetting potential referrals to ensure that we are not sending our patients to outside health care providers that will discriminate or behave inappropriately and do more harm to our patients.

24. The Revised Rule is inherently demeaning and codifies our government's belief that the health care needs of LGBTQ people are unimportant. This proposed rule is shameful. As LA LGBT Center's Chief Medical Officer and Director of Clinical Research, my responsibility includes enforcing our nondiscrimination mandate with respect to all of our providers and staff. The Revised Rule is in direct contradiction with our obligations as physicians and health care providers. We have an obligation to treat all patients in a manner consistent with their best interests to achieve the best possible health results for our patients. The Revised Rule invites health care

providers to do the exact opposite. The increased discrimination resulting from the Revised Rule will harm our patients' health and public health at large.

[*Signature on next page.*]

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

Dated this 6th day of July, 2020.

DocuSigned by:
Dr. Robert Bolan
5C5159E12C514C6...
Robert Bolan, MD

EXHIBIT A

Curriculum Vitae of Robert K. Bolan, MD

1/13/2020
CURRICULUM VITAE

A. PERSONAL INFORMATION

Name	**Robert Key Bolan, M.D., AAHIVS**
Business Address	Los Angeles LGBT Center 1625 N. Schrader Blvd. Los Angeles, CA 90028
Business Phone	(323) 993-7577

B. EDUCATION

College or University	University of Detroit Detroit, Michigan B.S. Biology 1968 With Honors
Medical School	University of Michigan Medical School Ann Arbor, Michigan M.D. 1972
Internship	St. Mary's Hospital Medical Center Madison, Wisconsin 1972-1973
Residency	St. Michael Family Practice Residency Milwaukee, Wisconsin 1975-1977
Honors and Awards	Leadership Award, San Francisco A2IDS Foundation May 1992
Licensure	California G39301
Board Certification	American Board of Family Physicians 1978, 1983, 1990, 1997, 2005, 2012
Specialty Certification	American Academy of HIV Medicine (AAHIVS)

C. PROFESSIONAL BACKGROUND

TEACHING RESPONSIBILITIES and ACADEMIC APPOINTMENTS:
Clinical Associate Professor of Family Medicine
University of Southern California (USC) – Keck School of Medicine
September 1995 – Present

Adjunct Clinical Professor of Pharmacy Practice
Western University of Health Sciences
February 2008 - Present

Assistant Clinical Professor

University of California San Francisco
Department of Family and Community Medicine
June 1981 - December 1996

Course Organizer and Clinical Faculty
"Clinical Approach to Gay and Lesbian Health Care"
An elective two hour credit course offered by the
University of California, San Francisco Medical School
June 1979 - April 1982

ADMINISTRATIVE RESPONSIBILITIES:
Acting (administrative) Director of Health & Mental Health Services
LA Gay & Lesbian Center
1625 N. Schrader Blvd.
Los Angeles, CA 90028
July 2001 – September 2002

Chief Medical Officer and Director of Clinical Research
Los Angeles LGBT Center
1625 N. Schrader Blvd.
Los Angeles, CA 90028
May 1996-Present

Director of HIV Services
USC School of Medicine
Department of Family Medicine
September 1995-December 2004

Acting Chair
Department of Family Practice
California Pacific Medical Center, San Francisco
January 1991-November1992

Medical Director
Gay Health Clinic
Presbyterian Medical Center, San Francisco
March 1982 – June 1983

Attending Physician
Presbyterian Medical Center Clinic, San Francisco
October 1979- August 1980

HOSPITAL AFFILIATIONS
Queen of Angeles/Hollywood Presbyterian Hospital, Los Angeles
January 1999- 2006

Cedars-Sinai Medical Center, Los Angeles
July 1999-Present

USC University Hospital, Los Angeles
September 1995- 2004

North Hollywood Medical Center, North Hollywood
May 1996-August 1998

California Pacific Medical Center, San Francisco
1979-1996

OTHER ACTIVITIES
Family Practice
Pacific Family Practice Medical Group
San Francisco, California
1979-September 1995

Family Practice
Hartland Clinic, S.C.
Hartland, Wisconsin
August 1977-July 1979

Emergency Medicine
Madison General Hospital
Madison, Wisconsin
June 1974-June 1975

Three-week intensive post-graduate course in Emergency Medicine
Philadelphia, Pennsylvania
April 1974

General Practice
Dells Clinic
Wisconsin Dells, Wisconsin
September 1973-June1974

Emergency Medicine
St. Clare Hospital
Baraboo, Wisconsin
June 1973-September1973

D. SOCIETY MEMBERSHIPS

NATIONAL AND INTERNATIONAL
American Academy of Family Physicians

American Academy of HIV Medicine
Member of Board for California/Hawaii Chapter
2004- Present

E. ACTIVIES IN AREA OF INTEREST

Core Curriculum Committee, American Academy of HIV Medicine
2001– 2009

CME Committee, L.A. HIV Inter-City Rounds

2000 - Present

Organizer and Supervisor, HIV Medicine Fellowship, a Post-Residency one-year training program
LA Gay & Lesbian Center, Jeffrey Goodman Special Care Program.
December 1998 – 2005

Chair, Research Committee, Los Angeles LGBT Center
Los Angeles, California
March 1998 – Present

Chair, Peer Review, LA Gay & Lesbian Center
Los Angeles, California
March 1998 - Present

Member, Mayor's AIDS Advisory Task Force
San Francisco, California
January 1985-April 1988

President and Chairman of the Board, San Francisco AIDS Foundation
San Francisco, California
June 1983-January 1986

Member, AIDS Advisory Task Force of the Director
San Francisco Department of Public Health
San Francisco, California
April 1983-January 1986

Member, Board of Directors, San Francisco AIDS Foundation
San Francisco, California
June 1983-June 1986

President – Elect, Bay Area Physicians for Human Rights (BAPHR)
July 1983-June 1984

Chair, BAPHR Research Committee
March 1983-1983

Chair, BAPHR Task Force on Kaposi's Sarcoma
June 1981-June 1983

Secretary, BAPHR
San Francisco, California
June 1980-June 1981

Director and Organizer, "Current Aspects of Sexually Transmitted Diseases II", a Symposium,
San Francisco State University
San Francisco, California
June 1980

Medical Director, Gay People's Union Venereal Disease Clinic
Milwaukee, Wisconsin
September 1977-July1979

F. RESEARCH ACTIVITIES

Site Principal Investigator, ATN 147, 148, 149: A Comprehensive Community-Based Strategy to Optimize the HIV Prevention and Treatment Continuum for Youth at HIV Risk, Acutely Infected, and with Established Infection. PI: Mary Jane Rotheram-Borus. Sponsor: ATN/NICHD 2017 - 2021

Site Principal Investigator, Performance Evaluation of the DPP HIV Syphilis Assay in the Intended User Setting. Protocol CP-HIV-SYPH03. Funder: Chembio. 2018 – 2019.

Co-Investigator, Four Corners: TGNC Health Research Advisory Network. Funder: Patient Centered Outcomes Research Institute. PI: Andie Baker, Howard Brown University. 2019 – 2021.

Co-Investigator, Understanding tobacco and cannabis use among LGBT emerging adults. PI: Ian Holloway, UCLA. Funder: Tobacco Related Diseases Research Program. 2018 – 2020.

Site Principal Investigator, Performance of Nucleic Acid Amplification Tests for the Detection of Neisseria gonorrhoeae and Chlamydia trachomatis in Extragenital Sites. Antibacterial Resistance Leadership Group Protocol ARLG_pNAAT-Yr3. PI: Jeffrey Klausner. Sponsor: National Institute of Allergy and Infectious Disease.2016-2018.

Site Principal Investigator, Randomized Trial to Prevent Vascular Events in HIV (REPREIVE) – ACTG Protocol A5332. PI (Grinspoon) AIDS Clinical Trial Group Investigators (Overton/Fichenbaum/Aberg/Zanni) Sponsor: National Heart, Lung, and Blood Institute, National Institute of Allergy and Infectious Diseases, National Institute of Diabetes and Digestive and Kidney Diseases. 2015-2022

Site Investigator, Men Who Have Sex with men & Substance Use Cohort at UCLA, Linking Infections, Noting Effects (mSTUDY). PI: Shoptaw/Gorbach. Sponsor: National Institute on Drug Abuse, National Institutes of Health. 2012-2023

Site Principal Investigator, Gilead 2920112. A Phase 3 Open-Label Safety Study of Elvitegravir/Cobicistat/Emtricitabine/Tenofovir Alafenamide Sintle-Table Regimen in HIV-1 Postitive Patients with Mild to Moderate Renal Impairment. 2013 – 2015.

Site Principal Investigator, Gilead 2920109. A Phase 3, Open-Label Study to Evaluate Switching from a TDF-Containing Regimen to a TAF-Containing Combination Single Tablet Regimen (STR) in Virologically-Suppressed, HIV-1 Positive Subjects. 2012 - 2016

Site Investigator, Protocol DMID 15-0090: Clinical Validation of Molecular Test for Ciprofloxacin-Susceptibility in *Neisseria gonorrhoeae*. PI Jeffrey Klausner Sponsor: Division of Microbiology and Infectious Diseases, National Institute of Allergy and Infectious Diseases, National Institutes of Health.. 2015-2019.

Site Investigator, CCTG 603: Randomized Controlled Trial of iTAB plus Motivational Interviewing for PrEP Adherence in Transgender Individuals: A Multicenter Trial of the California Collaborative Treatment Group. Funded by California HIV Research Program. 2015-2020.

A Phase 2b Randomized, Double-Blind, Double-Dummy Trial of 100 or 200 mg Once-Daily Doses of Cenicriviroc (CVC, TBR-652) or Once-Daily EFV, Each With Open-Label FTC/TDF, in HIV-1-Infected, Antiretroviral Treatment-Naïve, Adult Patients With Only CCR5-Tropic Virus. Funded by Tobira. 2011 – 2012.

Site Investigator, Los Angeles County PATH: PrEP and TLC+ for HIV Prevention. A California HIV Research Program (CHRP) Epidemic Interventions Demonstration Research Award. 4/2012 – 3/2016

Sub-investigator, Gilead 263-0110. A phase 3b randomized, open label study to evaluate the safety and efficacy of a single tablet regimen of emtricitabine/rilpivirine/tenofovir disoproxil fumarate compared with a single tablet regimen of efavirenz/emtricitabine/tenofovir disoproxil fumurate in HIV-1 infected, ARV-naïve adults. 2010 – present.

Sub-investigator, Gilead 264-0106. A phase 3 randomized, open label study to evaluate switching from regimens consisting of a ritonavir boosted protease inhibitor and two nucleoside reverse transcriptase inhibitors to emtricitabine/rilpivirine/tenofovir disoproxil fumurate fixed dose regimen in virologically suppressed HIV-1 infected patients. 2010 – present.

Co-Principal Investigator, Doxycycline Prophylaxis or Incentive Payments to Reduce Incident Syphilis among HIV-infected MSM who Continue to Engage in High Risk Sex: A Pilot Study funded by UCLA Center for HIV Identification, Prevention, and Treatment Services (CHIPTS) 2011. 8/1/2011 – present.

Principal Investigator, A Phase 3, Randomized, Double-Blind Study to Evaluate the Safety and Efficacy of GS-9350-boosted Atazanavir Versus Ritonavir-boosted Atazanavir Each Administered with Emtricitabine/Tenofovir Disoproxil Fumarate in HIV-1Infected, Antiretroviral Treatment-Naïve Adults. (GS-US-216-0114). Funded by Gilead, 5/2010 – present.

Principal Investigator, A Phase 3, Randomized, Double-Blind Study to Evaluate the Safety and Efficacy of Elvitegravir/Emtricitabine/Tenofovir Disoproxil Fumarate/GS-9350 Versus Efavirenz/Emtricitabine/Tenofovir Disoproxil Fumarate in HIV-1 Infected, Antiretroviral Treatment-Naïve Adults. (GS-US-236-0102). Funded by Gilead, 6/2010 – present.

Principal Investigator, A Phase 3, Randomized, Double-Blind Study to Evaluate the Safety and Efficacy of Elvitegravir/Emtricitabine/Tenofovir Disoproxil Fumarate/GS-9350 Versus Ritonavir-Boosted Atazanavir Plus Emtricitabine/Tenofovir Disoproxil Fumarate in HIV-1 Infected, Antiretroviral Treatment-Naïve Adults (GS-US-236-0103). Funded by Gilead, 4/2010 – present.

Site Investigator, Project AWARE: HIV Rapid Testing and Counseling in STD Clinics in the U.S.—an Adaptation of CTN 0032. Funded by NIDA, 12/2009 – 8/2011.

Principal Investigator, Evaluation of the Clinical Performance of the Determine® HIV- 1/2 Ag/Ab Combo Test (Clinical Protocol Number 0924401. Funded by Inverness Medical Innovations, Inc. Scarborough, ME, 9/2010 – 6/2011

Co-Investigator, Metromates: Transmission Behavior in Partnerships of Newly HIV Infected Southern Californians. Funded by NIH. 2008-present.

Principal Investigator, Correlation of Short-term Response of Viral Load to Maraviroc Added to a Failing Regimen, with Tropism Assay (A4001060). Funded by Pfizer, 2008 - present

Principal Investigator, A Multicenter, Double-Blind, Randomized, Placebo-Controlled Study to Evaluate the Safety and Antiretroviral Activity of MK-0518 in Combination With an Optimized Background Therapy (OBT), Versus Optimized Background Therapy Alone, in HIV-Infected Patients With Documented Resistance to at Least 1 Drug in Each of the 3 Classes of Licensed Oral Antiretroviral Therapies (019-00). Funded by Merck. 2006 - present

Principal Investigator, A Randomized, Multicenter, Double Blinded, Phase IV Study Comparing the Safety and Efficacy of Pegasys® 180µg plus Copegus® 1000 or 1200 mg to the Currently Approved Combination of Pegasys® 180µg plus Copegus® 800 mg in Interferon-naïve Patients with Chronic Hepatitis C Genotype 1 virus infection coinfected with human immunodeficiency virus (HIV-1) (PARADIGM). Funded by Roche. 2006 - 2008

Principal Investigator, A Multicenter, Randomized, Double-Blind, Placebo-Controlled Trial of A Novel CCR5 Antagonist, UK427,857, In Combination With Optimized Background Therapy Versus Optimized Background Therapy Alone For The Treatment of Antiretroviral-Experienced HIV-1 Infected Subjects (A4001027). Funded by Pfizer. 2004 – 2007

Co-Investigator, MWCCS (MACS/WIHS Combined Cohort Study) Funded by NIH/NHLBI, 2001 – present

Principal Investigator, Early Access of TMC125 in combination with other antiretrovirals in treatment-

experienced HIV-1 infected subjects with limited treatment options (TMC125-C214). Funded by Tibotec, 2007 - 2008

Principal Investigator, Early access of MK-0518 in Combination with an Optimized Background Antiretroviral Therapy (OBT) in Highly Treatment Experienced HIV-1 Infected Patients with Limited to No Treatment Options (023-00). Funded by Merck, 2007 - 2008

Principal Investigator, A Multi-center, Open-Label, Expanded Access Trial of Maraviroc (A4001050). Funded by Pfizer, 2007 - 2008

Principal Investigator, A Randomized, Double-Blind, Placebo-Controlled, Parallel-Group, Multi-center Trial of Pregabalin Versus Placebo in the Treatment of Neuropathic Pain Associated with HIV Neuropathy (A0081066). Funded by Pfizer, 2006 - 2008

Principal Investigator, An Open-label, Extension Safety and Efficacy Trial of Pregabalin in Subjects with Neuropathic Pain Associated with HIV Neuropathy (A0081095). Funded by Pfizer, 2006 - 2008

Principal Investigator, A Phase 3, Randomized, Open-label Study of Lopinavir/ritonavir Tablets 800/200 mg Once-daily Versus 400/100 mg Twice-daily when Coadministered with Nucleoside/Nucleotide Reverse Transcriptase Inhibitors in Antiretroviral-experienced, HIV-1 Infected Subjects (M06-802). Funded by Abbott, 2007 - 2008

Principal Investigator, Utilization of HIV Drug Resistance Testing in Treatment Experienced Patients (Utilize Study 1182.116). Funded by Boehringer Ingelheim, 2007

Principal Investigator, A Comparative Randomized, Double-Blind, Double-Dummy, Multicenter Study of the Efficacy and Safety of miconazole Lauriad® 50 mg Administered Once a Day and Mycelex® Troches (clotrimazole 10 mg) Administered Five Times a Day in the Treatment of Oropharyngeal Candidiasis in Immunocompromised Patients (SMiLES BA2004/01/04). Funded by BioAlliance Pharma, 2006 - 2007

Principal Investigator, A Multicenter, Open-Label Study Evaluating the Safety and Efficacy of a New Investigational Protease Inhibitor (PI) With FUZEON® (Enfuvirtide) Plus Optimized Background in HIV-1 Infected Triple-Class Treatment-Experienced, Enfuvirtide-Naïve Patients (BLQ Study, ML 19712). Funded by Roche. 2006 – 2007

Principal Investigator, Early access of TMC114 in combination with low-dose ritonavir (RTV) and other antiretrovirals (ARVs) in highly treatment experienced HIV-1 infected subjects with limited to no treatment options (TMC114-C226). Funded by Tibotec. 2006

Co-Principal Investigator, Open-Label, Multiple-Dose, Drug Interaction Study to Assess the Effect of Nevirapine on the Pharmacokinetics of Atazanavir in HIV-Infected Individuals (ANDI). Funded by Bristol-Myers Squibb. 2006

Principal Investigator, A Phase III randomized, double-blinded, placebo-controlled trial to investigate the efficacy, tolerability and safety of TMC125 as part of an ART including TMC114/RTV and an investigator-selected OBR in HIV-1 infected subjects with limited to no treatment options (TMC125-C206). Funded by Tibotec. 2006 - 2008

Principal Investigator, A 48-Week, Randomized, Open-Label, 2-Arm Study to Compare the Efficacy of Saquinavir/Ritonavir BID Plus Emtricitabine/Tenofovir QD Versus Lopinavir/Ritonavir BID Plus Emtricitabine/Tenofovir QD in Treatment-Naïve HIV-1 Infected Patients (Gemini ML18413). Funded by Roche. 2005 - 2007

Principal Investigator, A Multicenter, Randomized, Double-Blind, Placebo-Controlled Trial of A Novel CCR5 Antagonist, UK427,857, In Combination With Optimized Background Therapy Versus Optimized Background Therapy Alone For The Treatment of Antiretroviral-Experienced, Non CCR5-Tropic HIV-1 Infected Subjects (A4001029). Funded by Pfizer. 2004 – 2008

Co-Principal Investigator, A 48-week prospective study comparing the safety and efficacy of switching from a Combivir (Zidovudine/ZDV + Lamivudine/3TC) based HAART regimen to a Viread (Tenofovir DF/TDF) + Emtriva (Emtricitabine/FTC) based HAART regimen in HIV-infected adults with HIV RNA < 50copies/ml (COMET). Funded by Gilead. 2004 - 2005

Principal Investigator, Tipranavir Open Label Safety Study (Trial # 1182.58). Funded by Boehringer Ingelheim. 2004 - 2005

Principal Investigator, A Large, Simple Trial Comparing Two Strategies for Management of Anti-Retroviral Therapy (SMART). Funded by NIH, DAIDS number CPCRA 065. 2003 - 2008

Principal Investigator, A Phase III, 48-week, open label, randomized, multicenter study of the safety and efficacy of the Abacavir/Lamivudine fixed-dose combination tablet administered QD versus Abacavir + Lamivudine administered BID in combination with a PI or NNRTI in antiretroviral experienced patients (ESS 30008). Funded by GlaxoSmithKline, 2002

Principal Investigator, Post exposure prophylaxis as a biobehavioral HIV intervention (PEP). Funded by City of Los Angeles, 2002 - 2004

Co-Investigator, Short cycle intermittent versus continuous HAART for the treatment of chronic HIV infection (M77). Funded by FAIR Foundation, 2002

Principal Investigator, Genotype assisted initial Nelfinavir study (GAIN). Funded by Agouran, 2001

Co-Investigator, A double blind, phase III extension study of SGN-00101 in the treatment of high grade anal intraepithelial neoplasia (AIN 0002). Funded by StressGen, 2001 - 2002

Co-Investigator, A randomized, placebo-controlled, phase III trial of SGN-00101 in the treatment of high grade anal intraepithelial neoplasia (AIN 0001). Funded by StressGen, 2000 – 2001

Co-Investigator, The impact of a prescriptive barriers-to-adherence questionnaire on HIV patients' adherence to HAART medications. Funded through University of Nevada at Reno, 2000

Co-Principal Investigator, Exploratory investigation of medical literacy: meaning of illness, information-seeking, and medical knowledge among people living with HIV/AIDS. Sponsored by University of Southern California, 2001 - 2002

Co-Investigator, A randomized, open-label, two arm trial to compare the safety and antiviral efficacy of GW 433908/Ritonavir QD to Nelfinavir BID when used in combination with Abacavir and Lamivudine BID for 48 weeks in antiretroviral therapy naïve HIV-1 infected subjects (APV 30002). Funded by GlaxoSmithKline, 2001 - 2002

Co-Investigator, Tenofovir DF (tenofovir disoproxil fumarate) Expanded Access Program. Funded by Gilead, April - October 2001

Principal Investigator, A phase II, open-label randomized study to compare the efficacy and safety of Epivir/Ziagen/Zerit versus Epivir/Ziagen/Sustiva versus Epivir/Ziagen/GW433908/Norvir for 96 weeks in the treatment of HIV-1 infected subjects who are antiretroviral therapy naïve (ESS 40001). Funded by Glaxo Wellcome, 2000 - 2002

Principal Investigator, A phase III randomized placebo controlled and double blinded study of IM862 for patients with muco-cutaneous AIDS associated Kaposi's Sarcoma (AMC 013). Funded by Cytran, 2000 - 2001

Principal Investigator, The prevalence of anemia in HIV infected patients (Anemia). Funded by OrthoBiotech, 2000 - 2001

Co-Investigator, Ziagen optimal regimen and resistance observational study (ESS 40009, ZORRO). Funded by Glaxo Wellcome, 1999 - 2000

Co-Investigator, A 96 week, randomized, open-label, multi-center trial to evaluate the safety and tolerability of the antiretroviral activity of Stavudine (40mg BID) + 3TC (150mg BID) + Nelfinavir (1250mg BID) versus Abacavir (300mg BID) + Combivir (150mg/300mg BID) versus Combivir (150mg/300mg) + Nelfinavir (1250mg BID) in HIV-1 infected female subjects (ESS 40002). Funded by Glaxo Wellcome, 1999 - 2000

Co-Investigator, ABT 378/ritonavir Early Access Program. Funded by Abbott , 1999 - 2000

Principal Investigator, A randomized, controlled, open-label comparison of continuing Indinavir vs switching to Norvir/Indinavir 400mg/400mg BID (NICE). Funded by Abbott, 1999 - 2000

Co-Investigator, Preveon (adefovir dipivoxil) Expanded Access Program. Funded by Gilead, 1998 – 2000

Co-Investigator, Role of the oral environment in HIV transmission and pathogenesis (HOT). Funded by NIH/NIDR through UCSF, 1998-2000

Principal Investigator, Brief safer sex intervention for HIV outpatient clinics (Partnership for Health Study). Funded by NIMH through USC, 1997 – 2001

G. PUBLICATIONS

ABSTRACTS, POSTERS, ORAL PRESENTATIONS

Beymer MR, Weiss RE, Sugar CA, Bourque LB, Gee GC, Morisky DE, et al. Are CDC Guidelines for Pre-Exposure Prophylaxis Specific Enough? Formulation of a Personalized HIV Risk Score for Pre-Exposure Prophylaxis Initiation. *Presented at the International AIDS Society Conference, Durban, South Africa* (2016).

Beymer MR, Bolan RK, Flynn RP. It's Not Just Black and White: Determining Within Group Differences for HIV Infection among African-American Gay and Bisexual Men. *Presented at the American Public Health Association Conference, New Orleans, Louisiana* (2014).

Hernandez W, Beymer MR, Flynn RP, Carpenter W, Bolan RK. Elucidating Reasons for PEP Use among Transgender Women at a Community-Based Clinic in Los Angeles, California. *Presented at the Transgender Health Summit, San Francisco, California* (2015).

Landovitz RJ, Amico KR, Psaros C, et al. Real-time Biomarkers of TFV/FTC adherence support a staged-intensity adherence support intervention in a Pre-Exposure Prophylaxis demonstration Project. Abstract, National HIV Prevention Conference, 2015, Atlanta.

Beymer MR, Bolan RK, Flynn RP. Differential Rates in Diagnosis of Acute HIV Infection by Race. *Presented at the National STD Prevention Conference, Atlanta, Georgia* (2014).

Beymer MR, Weiss RE, Bolan RK, Rudy ET, Bourque LB, Rodriguez JP, Morisky DE. Sex On-Demand: Geosocial Networking Phone Apps and Risk of Sexually Transmitted Infections among a Sample of Men who have Sex with Men in Los Angeles County. *Sexually Transmitted Infections* (2doi: 10.1136/sextrans-2013-051494.

Beymer MR, Bolan RK, Flynn RP, Kerrone DR, Pieribone DL, Kulkarni, SP, Stitt JC, Mejia E, Landovitz RJ. Uptake and repeat use of post-exposure prophylaxis in a community-based clinic in Los Angeles, California. *AIDS Research and Human Retroviruses* (2014) doi: pending.

Beymer MR, Llata E, Stirland AM, Weinstock HS, Wigen CL, Guerry SL, Mejia E, Bolan RK. Evaluation of Gonorrhea Test of Cure at One Week for Men who have Sex with Men in a Community-Based Clinic in Los Angeles, California. *Sexually Transmitted Diseases* (2014) doi: pending.

Bolan RK, Beymer M, Weiss RE, Flynn R, Leibowitz A, Klausner JD. Doxycycline Prophylaxis or Incentive Payments to Reduce Incident Syphilis among HIV-infected MSM who Continue to Engage in High Risk Sex: A Pilot Study. Oral Poster Presentation, STI & AIDS World Congress 2013. Vienna. July 14-17, 2013.

Bolan RK, Beymer M, Flynn R, Mejia E, Rizzo M. Crystal Meth: Still Speeding Out of Control with Sexual Partners Along for the Ride. Poster Presentation, 2012 National STD Prevention Conference, Minneapolis, Minnesota, March 12-15, 2012.

RK Bolan, M Beymer, R Flynn, D Prock. Experience at a Community-based LGBT Organization with Integrated HIV/STI Testing and HIV Care. Oral Presentation, 6th International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention, Rome, Italy, July 17-20, 2011

Robert K Bolan, Ellen T Rudy, Kai-Jen Cheng, Swanand Tilekar, Christine Wigen, Peter Kerndt. Sexually Transmitted Infections among HIV Positive Persons Before and After Entry into HIV Care: the Need for Priority Interventions. Oral Presentation, National HIV Prevention Conference, Atlanta, August 23-26, 2009

Robert K. Bolan, MD, Ellen T. Rudy, PhD, Swanand D. Tilekar, MSc, MPH, Christine Wigen, MD, MPH, Peter R. Kerndt, MD, MPH. Collaboration between Health Departments and Community-Based Healthcare Organizations: A Case Study of Success. Oral Presentation, National HIV Prevention Conference, Atlanta, August 23-26, 2009

Shin SM, Scott JD, Bolan RK. Pharmacy refill rates of HAART as predictor of CD4 and VL values. 4th International Conference on HIV Treatment Adherence, Miami, FL, April 5-7, 2009, Abstr 0155.

Bolan RK, Tilekar S, Clay E, Uniyal A, Chein M, Kerndt PR. Increased Risk for Acute HIV Infection from Non-ulcerative STI's in MSM: Aggressive STI Eradication Programs Needed for Reduction in HIV Incidence. Poster Presentation, Ninth International Congress on Drug Therapy in HIV Infection. November, 2008: Glasgow, UK. J Int AIDS Soc. 2008, 11 (Suppl 1):P303

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LETTERS TO THE EDITOR

Joseph Davey DL, Beymer MR, Roberts C, et al. Regarding Suthar et al.'s article Programmatic Implications of Acute and Early HIV Infection. J Infec Dis. 2015 Nov1;212(9):1351-60.

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H. SCIENTIFIC MEETINGS AND PRESENTATIONS

PARTIAL AND REPRESENTATIVE ONLY (Guest lecturer, numerous speaking engagements concerning clinical and educational AIDS issues)

Lecture: Anal Dysplasia, Community Forum; December 15, 2005. The Village at Ed Gould Plaza.

LA Department of Health Services STD Grand Rounds: Lymphogranuloma venereum; June 15, 2005.

Grand Rounds: LA HIV Intercity Rounds: HIV and Hepatitis B, May 20, 2005.

Lecture: 10th Conference on Retroviruses and Opportunistic Infections, Community Update; March 3, 2003. The Village at Ed Gould Plaza.

Lecture: Conference on Retroviruses and Opportunistic Infections, Clinical Provider Update, Jeffrey Goodman Clinic, March 7, 2003.

Lecture: “HIV Dynamics” USC Keck School of Medicine, to first year medical students; October 1999, 2000

Grand Rounds: LA HIV Intercity Rounds- Primary Pulmonary Hypertension; August 4, 2000

Lecture: “HIV Update” USC Family Medicine Board Review Course; June 26, 1999

Lecture: “HIV 1999: An Update” USC Family Medicine Primary Care Review Course; March 23, 1999

Lecture: “Anemia and HIV Disease” USC Family Medicine Grand Rounds; December 6, 1998

Lecture: “Sexually Transmitted Diseases” USC Family Medicine Board Review Course; June 13, 1998

Symposium Organizer and Speaker: “HIV Treatment Adherence: Toward an Understanding of Harmful Intrusions into Effective HIV Treatment Strategies.” November 1, 1997; USC School of Medicine.

Lecture: “ The Challenge of Medication in the Age of Anti-HIV Combination Therapy in the Mentally Ill Client” North Hollywood Medical Center Continuing Education Series; June 18, 1997

Lecture: “Primary HIV Infection” North Hollywood Medical Center Continuing Education Series; March 19,1997

Faculty Advisor and lecturer: “HIV/AIDS: What They’re Not Teaching You in School” Student Organization for Medical AIDS Awareness and Los Angeles AIDS Forum, Saturday January 6, 1996. USC School of Medicine.

Workshop: “Automated Medical Records, HIV managed care, and Clinical Outcomes Analysis”: 6th Annual Symposium: Clinical Care Options for HIV; May 2, 1996; Scottsdale

Workshop: “Managed Care and AETC Training”: Faculty Development Conference, AIDS Education and Training Centers; April 16, 1996; Asilomar

Workshop: “HIV Risk Reduction and Test Counseling”: Common Problems in Primary Care: 22nd Annual Review Course, April 2, 1996

Lecture: “HIV: Early Care” USC Student Health Clinic, February 16,1996.

Bolan RK. Health Education Planning for AIDS Risk Reduction in the Gay/Bisexual Male Community: Use of the PRECEDE Framework. Poster session, International Conference on Acquired Immune Deficiency Syndrome. Atlanta, Georgia, April 14-17, 1985.

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WHITMAN-WALKER CLINIC, INC., *et al.*, *Plaintiffs,* v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, *Defendants*.	Case No. 1:20-cv-1630

DECLARATION OF DR. WARD CARPENTER, MD
CO-DIRECTOR OF HEALTH SERVICES, LOS ANGELES LGBT CENTER

I, Ward Carpenter, declare as follows:

1. I am the Co-Director of Health Services for the Los Angeles LGBT Center (LA LGBT Center), where I was formerly the Associate Chief Medical Officer as well as the Director of Primary and Transgender Care.

2. I received my medical degree from the Robert Wood Johnson Medical School and had my residency at St. Vincent's Hospital Manhattan. I am board-certified in Internal Medicine and I hold certification in HIV Medicine. I am licensed to practice in the state of California. At the LA LGBT Center, I oversee all operations of the Federally Qualified Health Center ("FQHC"), including personnel, finances, clinical programs (mental health, psychiatry, primary care, HIV care, transgender health, substance abuse, and sexual health), nursing, case management, quality, risk management, and clinical research. I also maintain a panel of patients for whom I provide direct care. A copy of my curriculum vitae is enclosed as **Exhibit A**.

3. I am submitting this Declaration in support of Plaintiffs' Motion for Preliminary Injunction to prevent the revised regulation under Section 1557 of the Affordable Care Act

("ACA"), published by the U.S. Department of Health and Human Services ("HHS") on June 19, 2020 (the "Revised Rule"), from taking effect.

4. As the Co-Director of Health Services, I oversee the health care of over 32,000 patients who come to the LA LGBT Center for their care; I personally provide care to a panel of 200 patients. All of my patients identify as LGBTQ, and approximately 30% of my patients are people living with HIV. My patient population is also disproportionately low-income and experiences high rates of chronic medical conditions, homelessness, unstable housing, extensive trauma history, and discrimination and stigmatization in health care services. Many of these patients come to me from different areas of California, other states, and even other nations to seek services in a safe and affirming environment.

5. I provide a wide spectrum of health care services, including, but not limited to, HIV treatment, testing and prevention; STD testing, treatment and prevention; general primary care with an LGBT focus; and comprehensive transgender care. I have worked in this field of medicine continuously since 2004 and have personally cared for over 4,000 people in that time. I have worked in two Federally Qualified Health Centers, in New York and Los Angeles, as well as a private practice in New York. I am a nationally-recognized expert in the field of transgender medicine.

6. Many if not most of the individuals in our very diverse patient population face considerable stigma and discrimination – as people living with HIV, as sexual or gender minority people, and/or as people of color. Transgender people have a 41% lifetime risk of attempting suicide. This shocking observation can be explained by the intense dysphoria inherent in living in a body and a society that does not reflect and validate who you know yourself to be at a core level. In order to avoid this tragic consequence, transgender people require compassionate, sensitive, and

competent care that often includes medical and/or surgical procedures. These patients have significantly improved mental health outcomes when able to proceed with the treatments they need. Treatments for gender dysphoria have been deemed medically necessary by the World Professional Association of Transgender Health (WPATH) and the Endocrine Society, as well as other major medical organizations, in the same way that the American College of Cardiology has deemed treatment for hypertension medically necessary. In fact, in the course of treating gender dysphoria, endocrinologists and other health care providers use the same medications to treat transgender people as they use to treat non-transgender people with hormone deficiencies.

7. Under the Revised Rule, not only are health care providers invited to discriminate against LGBTQ patients, but insurance providers are encouraged to stop providing coverage for medically necessary, life-saving procedures and medications to treat gender dysphoria. Medical personnel who are duty-bound to treat life-threatening conditions (*e.g.*, hypertension) are now being invited to refuse to treat or cover care for a condition that could become life-threatening if left untreated – gender dysphoria –despite having the necessary tools and expertise to do so. Health care discrimination like this will have immediate negative consequences for a distinct and oppressed minority group. It should not invited and encouraged, as it is in the Revised Rule.

8. There is every reason to believe that the Revised Rule encourages health care providers to claim a right to refuse care or opt out of serving patients with particular needs, based on religious or moral beliefs, and will result in more discrimination, mistreatment, and denials of health care services against LGBTQ patients and patients living with HIV at other clinics, doctors' offices, hospitals, pharmacies, and other health care facilities outside of the LA LGBT Center. Even before the Revised Rule was proposed or issued, I and the other providers that I supervise at the LA LGBT Center treated many patients who have experienced traumatic stigma and

discrimination – based on their sexual orientation, gender identity, HIV status, and/or other factors – when seeking care from other providers. For example:

a. A transgender patient went to a urologist due to uncomfortable urination lasting for several years after her vaginal surgery. She was repeatedly referred to as "sir" and "he" despite repeated requests to use the correct pronouns. When the patient confronted the clerk, the clerk said "this is what your ID says, so this is how we will refer to you." When she saw the doctor, he also called her "sir," completely humiliating her in the most unprofessional manner. He did not close the door to the exam room during their visit, so that the entire waiting room could hear his conversations with her, and he asked her to remove her pants in full view of the waiting room. She was so traumatized by this experience that four years later, she continues to live with daily pain rather than risk being subjected to discrimination by another transphobic urologist.

b. A transgender patient started bleeding profusely from her vagina one week after surgery. Because there are so few trans-competent surgeons in the United States, this patient's surgeon was thousands of miles away. When she finally spoke to an ER doctor, the physician looked disgusted and said "what do you want me to do about it?" then walked away. She had to pack her own vagina with gauze pads and leave the ER, not knowing if she would live or die, and only coming to see us three days later after having lost a significant amount of blood. These horrific incidents will increase as a result of the Revised Rule. The likely result: patients will die.

c. A gay male patient with a serious and concerning neurological condition went to a neurologist. At this visit, the doctor had religious brochures throughout the waiting room. On arrival in the exam room, he was given a brochure about a particular Christian faith and asked if he had any questions. The patient felt extremely uncomfortable with this insertion of religion into what he felt should be a neutral space. As a result, he did not return for care and experienced a delay of several more months trying to find a new doctor he could trust.

d. A person living with HIV was referred to a surgeon for a routine procedure. The surgeon sent a note back to the patient's primary care physician asking him to refer the patient to someone "who was more familiar with treating patients like him." Again, this patient waited another two months to have this surgery, which could have caused severe or life-threatening complications.

e. A lesbian woman went to her doctor and was told that lesbians are not at risk for HPV and, therefore, she did not need cervical cancer screening. This patient knew enough to find a new doctor, but many patients would accept this information as fact and never receive a Pap smear, significantly increasing their chances of dying from cervical cancer. This type of medical error based on discriminatory stereotypes demonstrates what will happen when medical personnel are invited to discriminate instead of focusing on the health needs of patients in their care.

f. A gay man went to his primary care physician with urinary burning and discharge. Because his health care provider did not ask, the provider did not know that this patient was sexually active with men. Therefore, the provider did only one test, which was negative, and sent him to a urologist. The urologist did another test, which was negative, then performed a procedure to look inside this man's bladder with a camera. It was not until he came to the LGBT Center that we performed a proper medical history and exam and were able to treat him immediately for his sexually transmitted infection. We also determined that he had sex with five other people from the time of his first symptoms to the time he was finally treated, weeks later. Had any of these providers stopped to ask the man about his sexual practices, they would have immediately tested him and treated him for a sexually transmitted disease. Instead, he saw three providers, received hundreds of dollars in unnecessary testing and passed his infection along to five other people who themselves had to go down similar testing and treatment paths.

9. In sum, the message of these examples is clear: when patients are discriminated against, stereotyped, and mistreated in medical establishments, patients stop seeking care or their care is detrimentally delayed out of fear of repeated discrimination and denials of care. As a result, their conditions remain untreated for a much longer period of time, if they ever get treatment, resulting in much more acute conditions, ultimately costing the health care system millions of dollars in unnecessary expenses while harming patients and public health, including by increasing costs on the Center. When medical staff fail to care for every patient in the best way that they can,

putting patients' best interests at the center of medical care, medical mistrust is worsened, care is delayed, and health care becomes more expensive.

10. These incidents reveal that many health care providers and other staff harbor explicit or implicit biases against LGBTQ people and people living with HIV. Because of legal requirements, health care facility nondiscrimination policies, and professional norms, many of them have kept their personal beliefs and feelings in check. By empowering health care staff to think that they have the right to act on their personal beliefs, even at the expense of patient needs, the Revised Rule is very likely to result in many more incidents of discrimination and greater harm to LGBTQ individuals and patients living with HIV who are struggling with mental health or substance use issues, including the patients whom I treat and whose treatment I supervise.

11. Such experiences are not only insulting and demoralizing for the patient, but can jeopardize the patient's health, when a screening or treatment is denied or postponed, or the patient is discouraged from seeking medical care out of fear of repeated discrimination. Many if not most of my and the LA LGBT Center's transgender patients express strong distrust of the health care system generally, and a demonstrative reluctance to seek care outside the LA LGBT Center unless they are in a crisis or in physical or mental stress. This is because they want to avoid discrimination or belittlement. Such incentives to avoid regular check-ups and other medical care can result in disease processes that are more advanced at diagnosis, less responsive to treatment, or even no longer curable in the case of some cancers. Already, my patients are arriving at the LA LGBT Center with more acute medical conditions than they would otherwise because anti-LGBTQ policies fomenting discrimination, like the Revised Rule, has caused patients to fear receiving necessary medical care.

12. It is extremely difficult to provide effective care after patients have been rejected or discriminated against by other providers. The patients' level of trust at that point is so low that they expect to mistreated, stereotyped, and discriminated against. This requires providers at the LA LGBT Center to spend a significant amount of time trying to undo the damage (often cumulative, particular with intersectional marginalized identities) of such care. Patients who have been discriminated against have lost complete trust in the system and in health care providers. The Revised Rule has caused and will continue to cause additional discrimination against our patients at other facilities. As a result, we physicians and the LA LGBT Center will need to hire extra mental health staff to assist in unpacking our patients' health care trauma so that our patients are able to engage in our services and trust our health care providers in a meaningful way. When patients are discriminated against elsewhere, every patient contact at our facility will need to spend more time and resources assisting those patients, from front desk to triage staff. Discrimination creates added health stressors that damage the patient-physician relationship, resulting in inferior health outcomes for patients. It takes a long time to re-earn the trust patients hope for, but are afraid to give us. The Revised Rule has and will continue to increase patient trauma, and in turn, increase the Center's workload, consume its resources and make it more difficult to provide patients with the care that they need.

13. With existing health and health care disparities that harm the LGBTQ community – particularly the shortage of LGBTQ/HIV culturally competent providers – the Revised Rule has and will continue to create chaos and confusion, which will further exacerbate existing barriers to health care and result in negative community health outcomes. I have already received countless calls and visits from LGBTQ patients, particularly transgender patients, concerned that their surgeries are canceled and that they will no longer have access to hormone therapy to treat gender

dysphoria as a result of the discriminatory Revised Rule. Patients are concerned that under the Revised Rule, they will no longer be able to access necessary medical services.

14. Good medical care is based on trust as well as frank and full communication between the patient and their provider. In many, if not most encounters, providers need patients to fully disclose all aspects of their health history, sexual history, substance-use history, lifestyle, and gender identity in order to provide appropriate care for the patients' health, both physical and mental. Incomplete communication, or miscommunication, can have dangerous 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. A patient who fails to fully 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). Patients need to be encouraged to fully disclose all information relevant to their health care and potential treatment, which can be achieved only when patients are assured that the information they provide will be treated confidentially and with respect.

15. The Revised Rule will cause LGBTQ patients to attempt to hide their LGBT identities when seeking health care services, especially from religiously-affiliated health care organizations, to avoid discrimination. The Revised Rule endangers the provider-patient relationship and is likely to harm many patients' health by discouraging patients from full disclosure about their gender identity, sexual orientation, or medical histories and encouraging providers to avoid topics that may offend their personal moral or religious beliefs in their encounters with patients. Patients will avoid raising any topics, questions, or facts that they fear could possibly offend their health care providers' personal beliefs, resulting in harm to patients. When patients are unwilling to disclose their sexual orientation and/or gender identity to health

care providers out of fear of discrimination and denial of treatment, their mental and physical health is critically compromised.

16. The Revised Rule will also cause an increase in demand for my health care services and the services of the providers whom I supervise. I have seen a spike in behavioral and mental-health issues resulting from discrimination and denials of health care services because discriminatory rules like the Revised Rule cause LGBTQ patients and patients living with HIV to lose trust in their health care providers (either out of fear of discrimination or on account of being denied care). As a result, there will be an increase in demand for my and my department's services that will limit my ability to provide adequate care and time to my patients. This will increase wait times for my patients, and the delays in care may worsen conditions for which my patients are seeking treatment and outcomes of care.

17. The Revised Rule is in direct conflict with the oath that I swore as a doctor and many of the federal, state, and insurance rules, regulations, and statutes that I am required to follow. Like all physicians, I swore an oath to do no harm and to care for the people who need me to the best of my ability. Physicians are not ethically allowed to refuse care even to someone because of who they are. The fact that the Revised Rule suggests that such discriminatory behavior is allowed, has personally caused me great confusion and stress. In light of the oath I took, it is unclear to me how I can work collaboratively with colleagues who may discriminate against my patients without violating current medical ethical and legal standards of care.

18. The Revised Rule makes it impossible for me and my patients to trust the specialists on whom we rely to serve as critical partners in the care team. Care for a patient cannot be effectively provided if there is no trust. A patient may not go to a specialist appointment outside the Center if they fear discrimination. And in such a situation, for example, a person who initially

had mild chest pain but who never received the proper care suddenly is in the ER with a massive heart attack, costing the workforce and the health care system hundreds of thousands of dollars.

19. The Revised Rule's removal of language access protections for Limited English Proficiency (LEP) patients will put our patients at an increased risk of receiving inferior care and improper testing and delayed diagnoses when they seek health care services from outside providers. This sea change is contrary to medical ethics and standards of care. Without necessary translations services, LEP patients tend to remain silent during consultations. For example, if translators are not required, LEP patients tend not to speak up and tell me that they are failing to take their medications or are feeling ill. Instead, the more typical patient response is "I'm fine, thank you," because of the difficulty of articulating in English their medical needs, concerns and pains. We sometimes do not even know that they are LEP patients until a translator is provided because patients are often embarrassed to mention their LEP. If health care providers are not mandated to provide translators, patients tend not to speak up about needing translation services. The result is that providers cannot provide proper services to such patients because they cannot understand the patients' full medical needs, histories, and the extent of their problems. This leads to misdiagnoses, delays in care, and improper treatment plans. And the end result is that our patients end up in the emergency room dying unnecessarily. By removing mandatory accommodations for LEP patients, the Revised Rule causes harm to patients and increases health care costs overall.

20. The Revised Rule is especially egregious and harmful during a pandemic like COVID-19 when patients most desperately need to know that they will have somewhere to go for nondiscriminatory health care should they contract the virus. During a pandemic, access to health care services is paramount. The Revised Rule's invitation for health care providers to discriminate

against LGBTQ people and LEP patients does the exact opposite. The Revised Rule sends a message to LGBTQ and LEP patients that they are not deserving of equal access to health care, deterring such populations from seeking care, even in cases of emergency. When you empower discrimination, people understand and believe "the health care system is not for me." This discrimination harms our patients and those around them during a global pandemic. People will not show up to the health care system, and they will then spread coronavirus to countless more people around them. We already have problem with transgender people avoiding the emergency room when they need care out of fear of discrimination. After a person has been told enough times by an ER: "we don't serve your kind here," they are not likely to go back even if it means they might die. I imagine LGBTQ people have died at home, avoiding an ER, out of fear of being subjected to such discrimination in their most vulnerable moments. The Revised Rule multiplies this very serious problem.

21. The Revised Rule will also adversely impact the LA LGBT Center and its individual health care providers, including me, by necessitating the diversion and reallocation of resources to address the increase in the numbers of referral requests resulting from the Revised Rule. The Revised Rule has increased requests for referrals to LGBTQ-affirming outside providers for services that the LA LGBT Center does not have sufficient resources to provide. The Center will also have more difficulty finding health care providers to refer patients to, especially those with niche specialties, given that the Revised Rule emboldens health care providers to discriminate against and refuse services to LGBTQ patients in complete contradiction to medical and ethical standards of care. There are cities or insurance networks with only 2 or 3 specialists of a certain type (e.g. electrophysiologists). If those few people discriminate, my patients could be in the very real position of having literally no access to that type of care.

22. This is also especially concerning for the Center's LGBTQ youth who may not even be out to many people. If our youth encounter providers who are homophobic or transphobic, this will result in serious suicide risks. In turn, we physicians will have to proactively call providers before referring patients to make sure that the outside providers will not discriminate against our patient and cause more harm than good. This effort will soak up more of the Center's time and money. Not having the 2016 Final Rule to reinforce health care providers' obligation to provide nondiscriminatory care will make these efforts much more difficult.

23. One of the guiding ethics of medicine is to treat all patients equally. We do not treat blue-eyed people better than brown-eyed people. We do not treat women better than men. We do not provide better care to blonde-haired people than red-haired people. Medical personnel see people in their most vulnerable states; the trust placed in us is sacred. Allowing the Revised Rule to go into effect will create division within the medical field, which must be united around values of inclusion and acceptance, especially at a time of a global pandemic. The Revised Rule frustrates the mission and activities of the LA LGBT Center, my mission and activities, medical ethics, and established standards of care.

[*Signature on next page*.]

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

Dated this 6th day of July, 2020.

DocuSigned by:
Ward Carpenter
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Ward Carpenter, MD

EXHIBIT A

Curriculum Vitae of Ward S. Carpenter, MD

Ward S. Carpenter, MD
4352 Forman Ave Toluca Lake, CA 91602
carpenwa@gmail.com
646-734-9697

Relevant Experience

Co-Director of Health Services, Associate Chief Medical Officer: *Los Angeles LGBT Center* March 2018-present

- 80% administration: responsible for oversight of entire operations of FQHC including personnel, finances, clinical programs (mental health, psychiatry, primary care, HIV care, transgender health, substance abuse), nursing, case management, quality, risk management
- 20% clinical: general primary care, HIV care, comprehensive transgender care, office-based opiate treatment

Associate Chief Medical Office, Dir of Primary and Transgender Care: *Los Angeles LGBT Center* March, 2016 – present

- 60% clinical: general primary care, HIV care, comprehensive transgender care, office-based opiate treatment
- 40% administration
  - Practice management lead clinician
  - Quality management lead clinician
  - Health Information Systems lead clinician
  - Clinical supervision of advanced practice providers
  - Creation and management of PREP program
  - Creation and management of MAT program
  - Creation and management of Transgender Pre-Surgery Program
  - Operations of primary care and transgender health programs

Director of Primary Care and Transgender Care Services: *Los Angeles LGBT Center* Oct 2013-March 2016

- General adult primary care
- Comprehensive HIV care
- Transgender care including hormone management and general primary care
- Administration of primary care program including strategic planning and execution of quality measures, program improvement measures, direct supervision of advanced practice providers
- Administration of transgender care program including strategic planning and execution of quality measures, program improvement measures, direct supervision of advanced practice providers

Member, Participant Advisory Committee: *PRIDE Study @ UCSF* Jan, 2016 – present

- Represent the voices of the Los Angeles LGBT Center, healthcare providers, gay cisgender men and the greater Southern California region as we design and implement this transformative longitudinal study of LGBTQ health

President and Primary Care Internist: *Ward Carpenter Integrative Medicine, NY, NY* March, 2009 – Sept 2013

- Full-time primary care to 2000 adult patients and additional 500 HIV patients
- Management of staff, accounts, billing, supplies and marketing for practice

Primary Care Internist: *Callen – Lorde Community Health Center, New York, NY* July, 2004 – Oct, 2010

- General adult primary care
- Comprehensive HIV care

Ward S. Carpenter, MD
4352 Forman Ave Toluca Lake, CA 91602
carpenwa@gmail.com
646-734-9697

- Transgender medicine
- Clinical supervision and instruction of rotating medical and physician assistant students

Director of Operations: *Fire Island Volunteer Medical Clinics, Brookhaven, NY* January – November, 2006

- Responsible for all aspects of clinic management including recruiting providers, credentialing providers, obtaining insurance, purchasing medicines and supplies, managing patient charts and billing, training and supervising providers, creating training manual. Additionally served as volunteer provider

Acting Associate Medical Director: *Callen – Lorde Community Health Center, New York, NY* January – April, 2006

- Responsible for running weekly provider meetings, creating provider schedules, addressing patient complaints, representing provider concerns to senior management, assisting the Medical Director with all aspects of clinic management

Education & Training

Residency in Internal Medicine-Pediatrics	*SVCMC – St Vincent's Hospital Manhattan*	June, 2004
MD	*UMDNJ – Robert Wood Johnson Medical School, Camden, NJ*	May, 2000
BS	*University of Richmond, Richmond, Va.*, Psychology with Honors	May, 1996
BA	*University of Richmond, Richmond, Va.*, History with Honors	May, 1996

Lectures

Plenary Session: *Update on Transgender Health.* HIV/AIDS on the Front Line Annual Conference at University of California, Irvine. April 27, 2016

Licensure & Certification

Certificate in HIV Medicine	2007 - present
Board Certified in Internal Medicine	2004-2024
Licensed in California	2012 - present
Licensed in New York State	2004 – 2014
X-waiver for Buprenophine	2016-present

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WHITMAN-WALKER CLINIC, INC., *et al.*,

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

Case No. 1:20-cv-1630

DECLARATION OF ADRIAN SHANKER, EXECUTIVE DIRECTOR, BRADBURY-SULLIVAN LGBT COMMUNITY CENTER

I, Adrian Shanker, declare as follows:

1. I am the Founder and Executive Director of Bradbury-Sullivan LGBT Community Center ("Bradbury-Sullivan Center").

2. I assumed that role in 2014 when Pennsylvania Diversity Network restructured into Bradbury-Sullivan Center. I received a Bachelor's degree from Muhlenberg College in Religion Studies and Political Science in 2009 and earned a Graduate Certificate in LGBT Health Policy & Practice from The George Washington University in 2017. I previously volunteered as Board President of Equality Pennsylvania, served on the Office of Health Equity Advisory Board for the Pennsylvania Department of Health, and co-chaired the community advisory committee for LGBT Healthlink, which was a CDC-funded national disparity network for LGBT tobacco and cancer disparity work.

3. Bradbury-Sullivan Center is a 501(c)(3) non-profit organization that is based in Allentown, Lehigh County, Pennsylvania, and incorporated in Pennsylvania. Bradbury-Sullivan Center is a comprehensive community center dedicated to advancing community and securing the health and well-being of the lesbian, gay, bisexual, and transgender (LGBT) people of the Greater

Lehigh Valley, a historically under-served region of Pennsylvania for the LGBT community. Bradbury-Sullivan Center provides programs and services to thousands of community members throughout the year.

4. At Bradbury-Sullivan Center, in addition to staff management, board development, fundraising, and strategic planning, I oversee administration of data collection for the Pennsylvania LGBT Health Needs Assessment. With Health Programs employees at Bradbury-Sullivan Center, I also develop health promotion campaigns to make behavioral, clinical, and policy changes to improve LGBT health. In 2017 and 2018, I led the successful community efforts to ban "conversion therapy" in the cities of Allentown, Bethlehem, and Reading, Pennsylvania. I currently serve as LGBTQ subcommittee chair of the Pennsylvania Department of Health's COVID-19 Health Equity Response Team.

5. I am submitting this Declaration in support of Plaintiffs' Motion for a Preliminary Injunction to prevent the revised regulation under Section 1557 of the Affordable Care Act ("ACA"), published by the U.S. Department of Health and Human Services ("HHS") on June 19, 2020 (the "Revised Rule"), from taking effect. The Revised Rule eliminates explicit regulatory protections for LGBT people in health care that were included in the 2016 Final Rule, which was promulgated under Section 1557 in May 2016.

6. Bradbury-Sullivan Center's programs and services for the LGBT community include arts and culture, health promotion, youth programs, pride programs, and supportive services. Youth services include healthy eating, active living, and HIV prevention in an every-day out-of-school program. Supportive services include providing non-judgmental HIV/STI testing, ACA open enrollment events, medical-marijuana enrollment assistance, and support groups, as well as hosting a free legal clinic. Bradbury-Sullivan Center also provides referrals to health care

providers, including providers engaged in services for transgender community members and family-planning services.

7. In addition to obtaining services from Bradbury-Sullivan Center, patrons of Bradbury-Sullivan Center often access health care services from health care providers in our area, including religiously-affiliated hospitals and organizations. Bradbury-Sullivan Center works with patrons who have experienced discriminatory treatment when accessing health care services from such organizations and advocates on behalf of those patrons by providing referrals to LGBT-welcoming health care providers and health care agencies, training agencies to provide LGBT-affirming health care services, and, when necessary, communicating with the agencies to inform them of their legal obligations to serve LGBT people. The Revised Rule has major effects on Bradbury-Sullivan Center's advocacy and ability to continue such services given that the Revised Rule invites health care providers to discriminate against LGBT patients and Pennsylvania has no explicit statutory protections against discrimination on the basis of sexual orientation, gender identity, or transgender status.

8. Bradbury-Sullivan Center has used the 2016 Final Rule's explicit regulatory protections for LGBT people and clear guidance in order to advocate on behalf of LGBT patrons and remind health care providers and insurance companies of their obligations to provide health care services in a nondiscriminatory manner. For example, last year Bradbury-Sullivan Center used the 2016 Final Rule to advocate on behalf of a transgender youth whose family insurer denied coverage for his hormone therapy to treat gender dysphoria. Only after the Bradbury-Sullivan Center contacted the insurer and advocated on the youth's behalf did the insurer reverse course, provide coverage for the child's medically necessary care, and apologize to our patron and their child for their discrimination. Bradbury-Sullivan Center used the 2016 Final Rule to inform the

insurer that its actions were at odds with the law and hold it accountable for its discrimination. If the Revised Rule takes effect, there will be additional instances of discrimination by health care providers and insurance companies,. At the same time, the Revised Rule's elimination of explicit nondiscrimination protections will make it more difficult for Bradbury-Sullivan Center to advocate for its patrons who encounter health care providers that discriminate against them or insurers that deny coverage for medically necessary treatments for LGBT patients.

9. Nondiscrimination protections in health care are necessary. Bradbury-Sullivan Center knows from its work with community members and from local and national research that we can never assume that care will be offered equitably to LGBT patients without these protections that reinforce health care providers' obligations to their patients. The 2016 Final Rule provided robust protections that strengthen Bradbury-Sullivan Center's ability to advocate for nondiscriminatory health care for its patrons who experience discrimination. The Revised Rule will make the success of our advocacy much more difficult if not impossible in many circumstances. Nondiscrimination protections in health care are essential to ensure that LGBT people receive health care necessary to survive.

10. Furthermore, it is particularly egregious for HHS to establish additional barriers to care for LGBT people during the global COVID-19 pandemic, when people may be in their most desperate times of need for medical care. Because of higher risk factors such as smoking, higher incidence of cancer and unsuppressed HIV, and decades of barriers to care that have caused many LGBT people to delay or avoid seeking healthcare when they are sick, LGBT people are uniquely vulnerable to COVID-19 and the worst effects of COVID-19.

11. Federal health care nondiscrimination protections, such as those in the 2016 Final Rule, are one of the most significant assurances Bradbury-Sullivan Center can provide to

community members to encourage them to seek care. For example, in late March 2020, early in the COVID-19 quarantine in Pennsylvania, a transgender community college student called Bradbury-Sullivan Center to ask if it would be safe to receive a COVID-19 test as a transgender person at one of the local hospitals in our region. Because of the 2016 Final Rule, I was able to assure the student that they should make an appointment for the COVID-19 test. I was then able to call an administrator at the hospital to remind them that the provision of COVID-19 testing and treatment must be done in a nondiscriminatory manner, in accordance with the 2016 Final Rule promulgated under Section 1557.

12. Because the Revised Rule will increase discrimination and, in turn, LGBT people's distrust in the health system, LGBT people are less likely to seek testing and treatment if they are experiencing symptoms potentially associated with COVID-19. This makes it harder for Bradbury-Sullivan Center and other health care organizations to help stem the pandemic, thereby potentially exposing more people to COVID-19, to which LGBT people are already more vulnerable.

13. Bradbury-Sullivan Center has already had to divert resources to educating the LGBT community about safety precautions necessary during the pandemic and their rights under the law to nondiscriminatory care should they need COVID-19 testing or emergency respiratory intervention. Bradbury-Sullivan Center also developed a specific webpage with local LGBT community information about COVID-19 and updated the site multiple times each week during the months of March, April, May, and June. And since the Revised Rule was published, given its invitation to discrimination against LGBT people, Bradbury-Sullivan Center has spent significant time contacting hospitals and treatment centers to ensure that they provide nondiscriminatory care

to LGBT patients throughout all of their practices, but particularly in their COVID-19 treatment and testing facilities.

14. The Revised Rule already has and will continue to frustrate the progress that Bradbury-Sullivan Center has made assisting access to health care for LGBT people. By increasing LGBT people's fear and distrust of health care providers, the Revised Rule has will continue to have devastating impacts on our patrons' lives and on the public health at large. Our patrons need to trust the health care system now more than ever during this pandemic. If people feel sick, we need them to receive a COVID-19 test and get treatment, if necessary. We cannot afford for people to avoid health care treatment when they are presenting COVID-19 symptoms out of fear of discrimination. The Pennsylvania Patient Safety Authority has already affirmed that "it is a patient safety issue if LGBT people delay or avoid seeking care due to a fear of mistreatment."

15. Bradbury-Sullivan Center knows from the 2018 Pennsylvania LGBT Health Needs Assessment that approximately 1 in 5 LGBT Pennsylvanians do not have a primary care physician to call if they fall ill. Patients right now are weighing the risk of COVID-19 versus the discrimination and attendant harms that they may face in the health care system when they arrive for COVID-19 treatment. In turn, Bradbury-Sullivan Center has had to redirect staff to focus on efforts to educate hospitals and patrons about COVID-19 and the importance of providing nondiscriminatory health care services to LGBT patients. The Revised Rule only increases people's fear and distrust of the health care system and causes them to further avoid testing and treatment, resulting in harm to our LGBT patrons, increased costs to the health care system, and harm to public health at large.

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16. Bradbury-Sullivan Center services a region of Pennsylvania with limited options for LGBT-specific health care services. Finding LGBT-affirming health care options is already a struggle for the LGBT community in the region and becomes more challenging when seeking care for an LGBT-specific concern. LGBT patients experience both geographic barriers to health care and barriers to accessing LGBT-affirming health care. For some medical specialties, often only one or very few health care providers in the region have the training and experience necessary to treat a patient. The discrimination fostered by the Revised Rule could make it practically impossible for a patient to receive any specialty care at all. This is especially concerning given that several of the region's health care providers, including a hospital in the City of Allentown, are religiously-affiliated organizations that could claim religious-based objections to providing any and all care to LGBT patients, invoking the Revised Rule to claim an exemption from existing nondiscrimination laws, relevant medical ethical rules, and standards of care. The Revised Rule will worsen health disparities affecting the LGBT community and exacerbate the difficulties that members of the LGBT community have in finding and accessing necessary and respectful health care.

17. Bradbury-Sullivan Center patrons are already experiencing negative effects from discrimination in the provision of health care, compromising their health and wellbeing. For example:

a. We heard from a community member whose family member was a patient in an inpatient-care setting and was forced to participate in a so-called "conversion therapy" support group. When the patient complained about such requirements, he faced harassment and retaliation.

b. Another community member visited Bradbury-Sullivan Center for HIV testing after experiencing judgmental treatment from his primary health care provider. He told our staff that he did not feel comfortable receiving the service from his original health care professional as a result of the judgmental treatment.

c. Additionally, a program participant in one of our transgender support groups shared with a staff member that her doctor made negative, religious-based comments to her three years ago and as a result she avoided medical care for those three years. She went back for a physical examination this year and the doctor refused to touch her during her physical.

d. One patron struggled for years to find affirming providers to treat her gender dysphoria. After scheduling her gender confirmation surgery and preparing herself emotionally for the surgery, she learned that her surgeon was *not* in fact affirming and she was forced to cancel her surgery. She was devastated and called Bradbury-Sullivan Center in tears for our assistance. She had been so excited to finally live in the body that affirmed who she is. However, her discriminatory experiences caused her significant depression and distrust of health care providers. It took her two years to find another provider and reschedule her surgery. The nearest available surgeon with the appropriate medical training was 2.5 hours away from her home. Then, her second scheduled gender confirmation surgery was canceled due to COVID-19. This patron is at a loss for what to do next due to the

devastating impact of cancellation of medically-necessary gender affirming care.

18. Bradbury-Sullivan Center also assists patrons who contact the Center because they have difficulty finding LGBT-affirming health care services. Bradbury-Sullivan Center recently received an increase in referral requests. As a result of issuance of the Revised Rule, and the inevitable increase in denials of care and discrimination that will follow, Bradbury-Sullivan Center may need to hire a case-manager to address the community's need for referrals to welcoming providers. Faced with the Rule's imminent implementation, Bradbury-Sullivan Center already has invested additional staff time to strengthen its referral process through the creation of a supportive services referral guide. It is increasingly difficult for Bradbury-Sullivan Center to find local LGBT-affirming health care providers for certain specialties in particular, and the Revised Rule will further diminish the number of specialists available by emboldening additional providers to refuse health care treatment to LGBT patients and emboldening insurance companies to avoid coverage of medically necessary care that the LGBT community needs. This harms the community members whom Bradbury-Sullivan Center serves and results in a major drain on its resources that need to be diverted from other programming.

19. Bradbury-Sullivan Center spends a significant amount of resources documenting health disparities in the LGBT community. A copy of the Pennsylvania 2018 LGBT Health Needs Assessment that Bradbury-Sullivan Center helped conduct is attached as **Exhibit A**. Data gathered from that work confirmed that only about 17% of LGBT Pennsylvanians in 2018 had a provider whom they considered to be their personal physician. That means that in times of need, LGBT people are more likely to randomly select a health care provider with whom they do not have a relationship, putting them at increased risk of finding a provider who is not LGBT-welcoming.

With an increase in discrimination and refusals of care as a result of the Revised Rule, LGBT people will be far less likely to receive the health care treatment that they need because, after being discriminated against, they are unlikely to seek other care out of fear of repeated rejections and discrimination. Data from 2018 also indicated that over 50% of LGB and 75% of the transgender community fear going to a health care provider due to negative past experiences directly related to the patients' sexual orientation or gender identities.

20. These numbers will increase because additional health care providers will refuse to provide care to the LGBT community as a result of the Revised Rule. This directly affects the Bradbury-Sullivan Center because more community members will seek referrals to LGBT-affirming health care providers, there will be an increase in community members experiencing the trauma of discriminatory or unwelcoming health care experiences who will turn to its support groups, and community health outcomes among the population that Bradbury-Sullivan Center serves will worsen.

21. Bradbury-Sullivan Center's research into health disparities facing the LGBT community reveals that approximately one in four members of the community in our region experience a negative reaction from a health care provider when they come out as LGBT. More than half of respondents report fear of a negative reaction by a health care provider if they come out. Indeed, approximately three quarters of all transgender respondents fear such a negative reaction. Our research also identifies pervasive health disparities between LGBT people and the majority population with respect to tobacco use, cancer, HIV, obesity, mental health, access to care, and more, with LGBT people consistently experiencing worsened health outcomes. The same is true during the COVID-19 pandemic, where LGBT people are uniquely vulnerable to COVID-19. In other words, LGBT people, who are disproportionately likely to need a wide range

of medical care, already have reason to fear, and often do fear, negative consequences of disclosing to health care providers their sexual orientation, history of sexual conduct, gender identity, transgender status, history of gender-confirming medical treatment, and related medical histories.

22. By inviting discrimination against LGBT people based on their LGBT status, the Revised Rule encourages LGBT people to remain closeted to the extent possible when seeking medical care. Bradbury-Sullivan Center's research demonstrates that more than a quarter of LGBT respondents are not out to *any* of their health care providers. Fewer than half are out to all of them. The Revised Rule's removal of nondiscrimination requirements and invitation to discriminate on the basis of a providers' religious or moral beliefs undoubtedly will exacerbate those numbers.

23. Remaining closeted to a health care provider can result in significant adverse health consequences. When patients are unwilling to disclose their sexual orientation and/or gender identity to health care providers out of fear of discrimination and being refused treatment, their mental and physical health is critically compromised.

24. Bradbury-Sullivan Center will have to expend more resources on its health promotion campaigns to ensure that LGBT people have access to preventative screenings for cancer, testing services for COVID-19, HIV and other STIs, and tobacco-cessation services given that the Revised Rule will drastically change the health care landscape for the LGBT patient population. This is especially true for the transgender community because existing data predict that the transgender community will be especially afraid to seek out such care out of fear of mistreatment or rejection as a result of the Revised Rule that removes explicit protections based on gender identity and sexual orientation. Bradbury-Sullivan Center also anticipates it will have to initiate many other new services, including, but not limited to, education and community outreach programs, as a result of the Revised Rule. For example, Bradbury-Sullivan Center will

have to increase community-education efforts about the importance of having a primary health care provider to ensure that LGBT patients have a health care provider whom they can trust and do not avoid seeking necessary care. This is especially important given that Bradbury-Sullivan Center's patrons may need emergency assistance related to COVID-19.

25. Bradbury-Sullivan Center also works with independent clinics to help them implement nondiscriminatory policies and practices. Bradbury-Sullivan Center will have to work harder to ensure that these clinics maintain and establish clear policies that prevent discrimination against the LGBT community, including correct signage that will signal to LGBT people that they are still welcome and will not be mistreated despite the Revised Rule.

26. Bradbury-Sullivan Center has a dedicated team of employees who focus on fostering a welcoming, nondiscriminatory atmosphere for patrons to access supportive services. Many employees of Bradbury-Sullivan Center may be negatively impacted by the Revised Rule in the form of increased demand on their time and resources by patrons (especially to meet increased demand for referrals), a diminished number of affirming resources to provide, and the need to develop new resources and training materials from scratch.

27. The Revised Rule's elimination the unitary standard, as well as its removal of notice and tagline requirements, will also make it much more difficult for transgender and gender nonconforming patrons of Bradbury-Sullivan Center to understand their rights and how to advocate for such rights. The Revised Rule appears to have been drafted in such a manner that it will create public chaos and confusion. Bradbury-Sullivan Center patrons are further confused about the ramifications of the Revised Rule given its publication four days after the Supreme Court's ruling in *Bostock v. Clayton County, Georgia*, 590 U.S. ___, 2020 WL 3146686 (June 15, 2020), which held sex discrimination prohibitions necessarily protect LGBTQ people. Our patrons

are extremely confused and have been contacting our Center in panic about the Revised Rule and in need of our services.

28. As a result of confusion and panic the Rule has created, Bradbury-Sullivan Center has already expended and will continue to expend additional resources educating its clients and staff about the ramifications of the Revised Rule—resources that were already strained as a result of the COVID-19 pandemic. Many patrons have come to Bradbury-Sullivan Center after having been denied insurance coverage for transition related care, hormone treatment, Pre-exposure Prophylaxis (PrEP), birth control, and other medically necessary care. Right after the Revised Rule was released, our transgender and gender nonconforming patrons were panicked about their ability to receive care for gender dysphoria and the effects of the Revised Rule on insurance coverage for treatments and medications related to gender dysphoria. In our entire region of 800,000 people, for example, we have only three health care clinics who will market that they prescribe and manage clients on PrEP. This means that LGBT patients are forced to wait months to receive even the most basic health care services. Likewise, we already know that many insurance companies have tried to find ways to avoid paying for transition-related health care services and medications. If the Revised Rule takes effect and removes coverage requirements for insurance providers, our transgender and gender nonconforming patrons will most certainly experience increased denials of coverage for their medically necessary health care. The Revised Rule will decrease options for care for LGBT people and will result in increased discrimination against our patrons on all fronts, resulting in severe harm to our patrons and to public health generally.

29. As a result of the Revised Rule, Bradbury-Sullivan Center will be required to redirect additional staff and resources from providing our own services to assisting patrons in

finding health care providers in the region who will serve LGBT patients in a nondiscriminatory manner. Bradbury-Sullivan Center's staff and resources have already been diverted from other program activities to engage in advocacy, policy analysis, and creation of resources to address the ill-effects of the Revised Rule. For LGBT people in the Lehigh Valley, where Bradbury-Sullivan LGBT Community Center is located, the Revised Rule will have a chilling effect on the community's ability to access healthcare.

[*Signature in next page.*]

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

Dated this 5th day of July, 2020.

DocuSigned by:
Adrian Shanker
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Adrian Shanker

EXHIBIT A

Pennsylvania 2018 LGBT Health Needs Assessment

Pennsylvania 2018 LGBT Health Needs Assessment – Summary Report

August 2018

Prepared for the Pennsylvania Department of Health
Division of Tobacco Prevention and Control

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Executive Summary

Background

Pennsylvania, like the nation and many states, has traditionally had limited data on LGBT health and wellness. In an effort to learn more about the health and wellness of Pennsylvania's LGBT communities, the Pennsylvania Department of Health partnered with LGBT centers across the state to gather health and wellness information in 2015/2016 and again in 2018. The 2018 Pennsylvania LGBT Health Needs Assessment collects data on LGBT health and supports identification of health disparities in tobacco use, cancer, HIV, obesity, mental health, access to care, and more.

In 2018, Pennsylvania partnered with Bradbury-Sullivan LGBT Community Center to reach a statewide purposeful sample. The Pennsylvania 2018 LGBT Health Needs Assessment was conducted in collaboration with LGBT HealthLink, a program of CenterLink. This collaboration allowed Pennsylvania to use a CDC-vetted tool, and opens future possibilities for improved trend analyses and state-to-state comparison data.

Key Findings

A total of 4,679 Pennsylvania LGBT respondents participated in the 2018 LGBT Health Needs Assessment. Respondents are from over 800 different ZIP codes across 64 of Pennsylvania's 67 counties.

One in four respondents sometimes, often, or always experience a health care provider react poorly when they come out as LGBT. In addition, more than half of all respondents sometimes, often or always fear a negative reaction by a health care provider if they come out as LGBT. Over a third of respondents report their health is fair, poor, or very poor. However, resiliency factors are strong and almost all respondents report at least some interest in incorporating healthy living strategies into their lives. While overall LGBT respondents report higher current smoking than the general population, smoking reports are even higher among transgender and gender non-conforming respondents. Health disparities also exist within LGBT communities in health screenings and other health areas. Respondents identify mental health needs as a priority when considering LGBT community health.

Recommendations

1. **Support Connection to LGBT-competent Providers**
2. **Encourage Health Screening Discussions**
3. **Prioritize Chronic Disease Prevention**
4. **Promote Tobacco Cessation Opportunities**
5. **Identify Community-wide Mental Health Supports**
6. **Continue and Enhance Data Collection**
7. **Partner with LGBT Community-Based Organizations**

Pennsylvania 2018 LGBT Health Needs Assessment Overview

Lesbian, gay, bisexual, transgender (LGBT) individuals and others in the LGBT community are disproportionately impacted by tobacco use.[1 2 3] Estimates across studies show LGBT adults smoke at rates between 35 and 200 percent higher than the general population.[4 5] The Center for Disease Control and Prevention (CDC) estimates over 30,000 LGBT people die each year of tobacco-related diseases.[6] Of course, tobacco use is not a standalone issue. Higher prevalence rates in other high-risk behaviors, psychosocial and structural barriers, and reduced access to trusted care impact overall risk for negative health outcomes in the LGBT community.[7 8 9]

Pennsylvania, like the nation and many states, has traditionally had limited data on LGBT health and wellness. In an effort to learn more about the health and wellness of Pennsylvania's LGBT communities, the Pennsylvania Department of Health partnered with LGBT centers across the state to gather health and wellness information. In 2015 and 2016, Pennsylvania Department of Health and Bradbury-Sullivan LGBT Community Center piloted regional health needs assessments to better measure LGBT health disparities in Pennsylvania. Regional findings identified pervasive health disparities in tobacco use, cancer, HIV, obesity, mental health, access to care, and more. In 2018, Pennsylvania expanded the scope of the assessment to include a statewide purposeful sample, again partnering with Bradbury-Sullivan LGBT Community Center to facilitate connection with a broad network of Pennsylvania LGBT-focused service agencies.

The Pennsylvania 2018 LGBT Health Needs Assessment was conducted in collaboration with LGBT HealthLink, a program of CenterLink. CenterLink's LGBT HealthLink program, one of eight CDC-funded cancer and tobacco disparity networks, is a community of experts and professionals working to advance LGBT health by eliminating tobacco use, reducing cancer incidence, and improving wellness within LGBT communities. This collaboration has allowed Pennsylvania to use a CDC-vetted tool, and opens future possibilities for improved trend analyses and state-to-state comparison data.

The 2018 findings presented here cover a variety of health topics, chronic disease risks, and healthcare experiences. These data are intended to identify needs and inform plans to close gaps. Opportunities remain for additional data analyses and future data collection.

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[1] CDC, Smoking and Tobacco use: https://www.cdc.gov/tobacco/disparities/lgbt/index.htm

[2] The DC Center for the LGBT Community: http://thedccenter.org/outtoquit/

[3] The Truth Initiative: https://truthinitiative.org/news/tobacco-social-justice-issue-smoking-and-lgbt-communities

[4] The Network for LGBT Health Equity, MPOWERED: http://www.lgbthealthlink.org/Assets/U/documents/mpowered.pdf

[5] Lee, J. G., Griffin, G. K., Melvin, C. L. (2009). Tobacco use among sexual minorities in the USA, 1987 to May 2007: a systematic review. Tobacco Control, 18(4), 275-282.

[6] CDC, Smoking and Tobacco use: https://www.cdc.gov/tobacco/disparities/lgbt/index.htm

[7] HealthyPeople2020: https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health

[8] Emlet, C. A. (2016). Social, Economic, and Health Disparities Among LGBT Older Adults. Generations (San Francisco, Calif.), 40(2), 16–22. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5373809/

[9] Hoffman, L., Delaharty, J., Johnson, S. E., and Zhao, X. (2018). Sexual and gender minority cigarette smoking disparities: An analysis of 2016 Behavioral Risk Factor Surveillance System dat. Preventative Medicine, 113, 109-115. Available at: https://www.sciencedirect.com/science/article/pii/S0091743518301646

Needs Assessment Methodology

In spring 2018, Pennsylvania Department of Health and Bradbury-Sullivan LGBT Community Center partnered to administer the 2018 LGBT HealthLink Wellness Needs Assessment. Over a seven-week period, the anonymous, internet-based survey was available for completion by any Pennsylvania resident who across their lifetime consider themselves to be lesbian, gay, bisexual, or transgender. LGBT HealthLink estimated the survey took approximately 15 minutes to complete.

The purposive, convenience, snowball style sample was supported by LGBT-focused community partners who distributed/posted the tool link and otherwise made the link available to their LGBT stakeholders. Additional indirect recruitment occurred via social media. No participant recruitment occurred in LGBT bars. Data collection partners are listed in Acknowledgment section of this report.

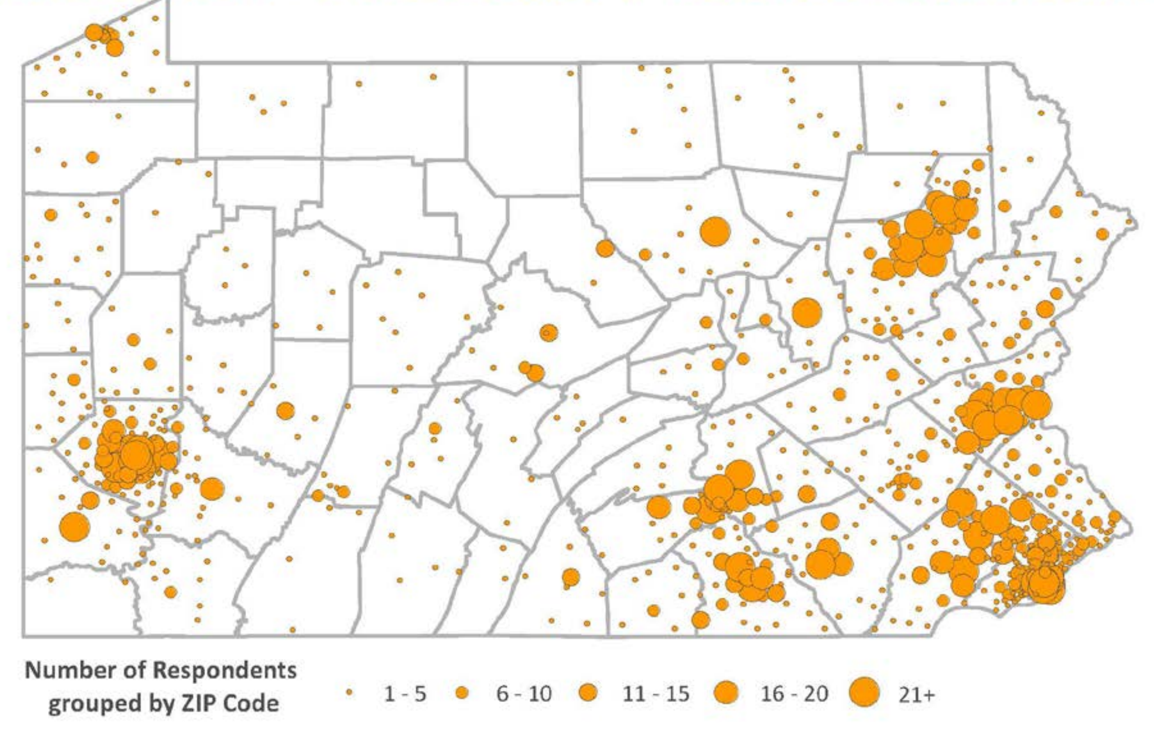
Method limitations include: online-only tool; English-only tool; cross sectional (single point in time) data collection.

Participants were informed the data they provided were being collected anonymously and they could stop the survey at any time or refuse to answer any questions. At the conclusion of the survey, participants were given the option to participate in an unlinked opportunity to be entered to win one of ten $50 gift cards for Amazon.[10]

[10] Raffle entries were at no point connected to needs assessment responses. All needs assessment responses remained anonymous regardless of entry into the incentive raffle.

Findings

A total of **4,679 Pennsylvania[11] LGBT[12] respondents participated** in the 2018 Needs Assessment. Respondents are from over 800 different ZIP codes across 64 of Pennsylvania's 67 counties.



Notes: 4,679 Pennsylvania LGBT+ respondents participated in the Needs Assessment. Respondents came from over 800 different Pennsylvania ZIP codes across 64 counties.

Considering Pennsylvania's health districts and two most populated counties, respondents are part of all regions.

Northwest	Southwest[13]	Allegheny County	North Central	South Central	Northeast	Southeast[14]	Philadelphia County
4.1% 191	5.5% 259	17.2% 802	4.8% 224	12.9% 604	24.0% 1,123	20.7% 967	10.7% 501

[11] Respondent provided a Pennsylvania ZIP code (150xx-196xx) and/or selected PA as state. County name alone was used as a PA qualifier in one case.

[12] Respondent selected Yes to question: Across your lifetime, do you consider yourself to be Lesbian, Gay, Bisexual or Transgender?

[13] Excluding Allegheny County.

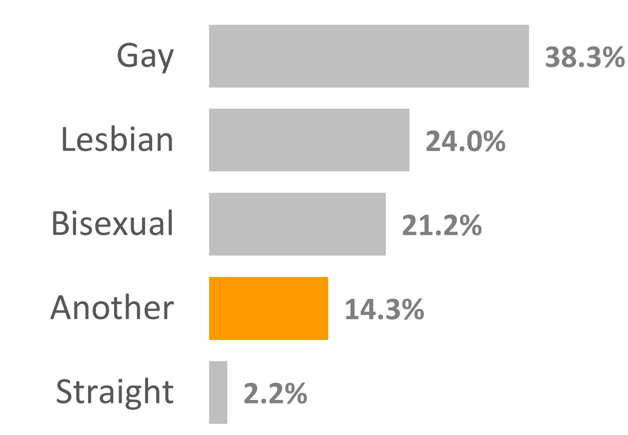
[14] Excluding Philadelphia County.

Sociodemographics

Respondents identify across LGBT communities. At the time of the survey, over a third of respondents identify as gay (38.3%), almost a quarter as lesbian (24.0%), bisexual (21.2%), another[15] (14.3%) and straight (2.2%).

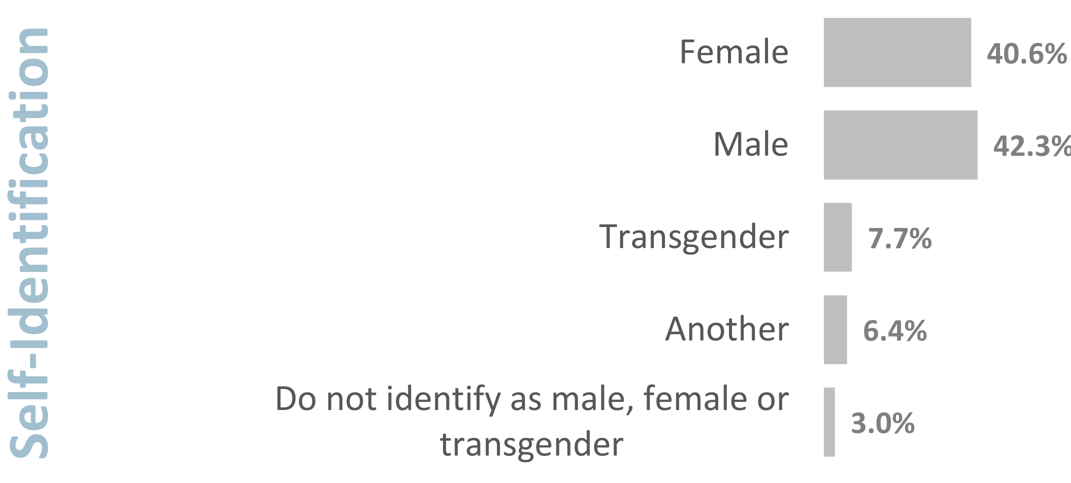
Sexual Orientation

538 respondents wrote-in their description, most commonly Pansexual, Queer, and Asexual.



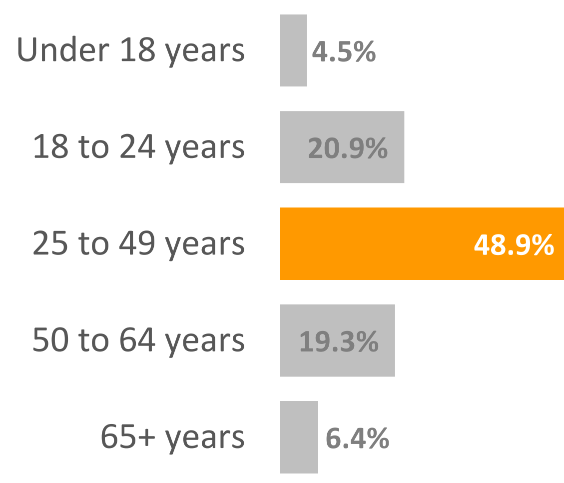
Respondents identify as female, male, transgender and gender non-conforming. Two hundred and forty respondents provided a write-in response to the question: How do you describe yourself? The most common write-in responses included, non-binary, genderqueer, and genderfluid. When considering reported sex at birth, the respondent sample includes 21.7 percent transgender and/or gender non-conforming respondents.

Self-Identification

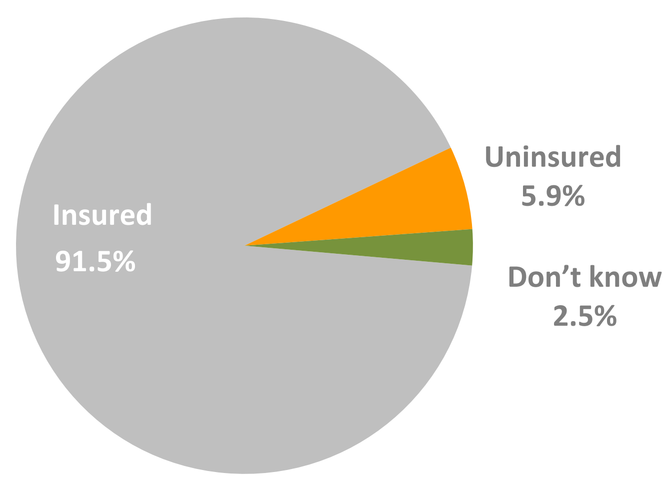


[15] "Other" category in the original survey tool has been modified to "Another" on this report in order to use more inclusive language.

Respondents vary in age from 10 to 87, with an average age of 37.6.[16] A quarter of respondents are over 50 years of age (n=1,203, 25.7%) and a quarter are under 25 years of age (25.4%).



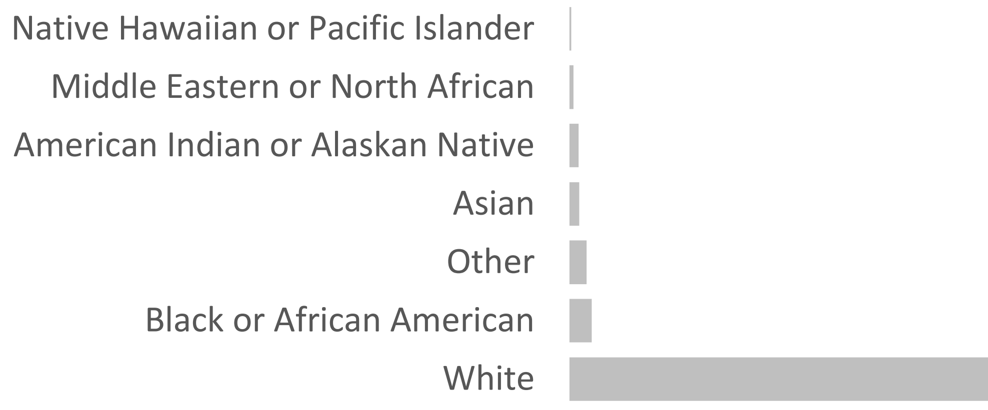
While the majority of respondents are insured, more than one in twenty are uninsured or are not sure of their insurance status. This is a slightly lower estimate than the Pennsylvania age 18-64 population, where 9 percent (CI:7-10%) have no health insurance (BRFSS[17], 2016).



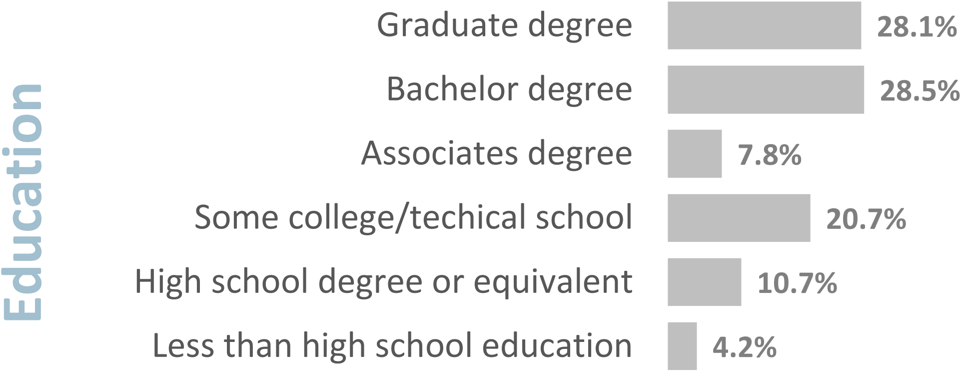
[16] Age was missing in only four cases.

[17] All Pennsylvania Behavioral Risk Factor Surveillance System (BRFSS) data in this report were provided by the Pennsylvania Department of Health. The Department specifically disclaims responsibility for any analyses, interpretations, or conclusions. Data available via https://www.phaim1.health.pa.gov/EDD/

The majority of respondents describe themselves as White (74.1%), but may also identify as another race. Six percent of respondents are Hispanic or Latino/a.



The vast majority of respondents have a high school degree or beyond for their education level. Three out of four respondents with less than a high school education are under 18 years of age.



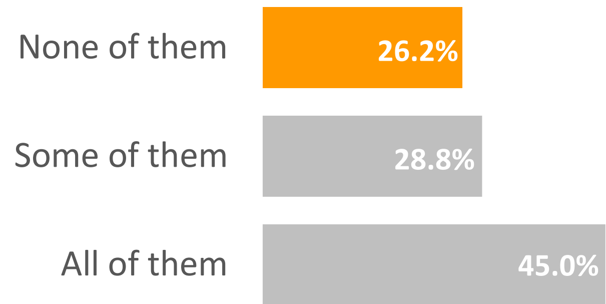
Additional data findings by select sociodemographic and geographic groups can be found in appendices.

Health Care

Most respondents had at least one personal doctor or health care provider, however, 17 percent do not or are unsure if they think of any provider as personal. This is a slightly higher estimate than the general Pennsylvania adult population, where 14 percent (CI:13-15%) do not have a personal health care provider (BRFSS, 2016). There is variation across respondents on whether they have advised their provider(s) that they are LGBT.

Communication with Providers

When asked: Have you advised your personal provider(s) that you are LGBT? **More than 1 in 4 report they have not advised any provider.**



One in four respondents sometimes, often, or always experience a health care provider react poorly when they come out as LGBT (25.1%). In addition, more than half of all respondents sometimes, often or always fear a negative reaction by a health care provider if they come out as LGBT (56.8%). While this proportion is high on its own, fear of a negative reaction is significantly higher for transgender and gender non-conforming respondents (p=.000). Three in four transgender and gender non-conforming respondents sometimes, often or always fear a negative reaction by a health care provider if they come out as LGBT (75.1%).

Fear

More than half of all respondents sometimes, often or always fear a negative reaction by a health care provider. **3 in 4 transgender and gender non-conforming respondents report this fear.**

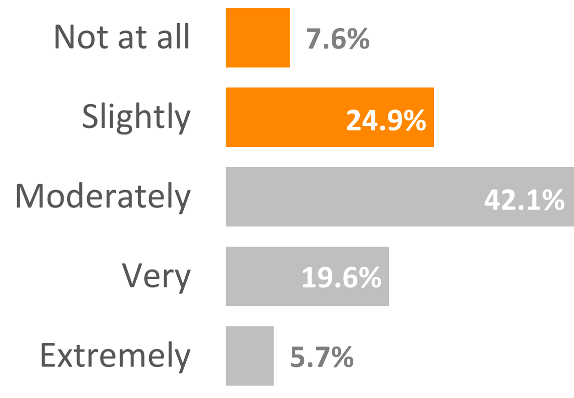
Sometimes, Often or Always fear a negative reaction	
Transgender and gender non-conforming	75.1%
Cisgender	52.3%

Respondents find their health care providers, on average, vary in their knowledge about LGBT issues. While just under a quarter consider their health care providers to be extremely (5.6%) or very (18.2%) knowledgeable, over a third report much room for improvement with health care provider knowledge on LGBT issues reported as slight

(26.9%) or none (7.3%). Similarly, respondents report varied average competency about LGBT issues among health care providers. Respondents identify opportunities for improvement among providers in competency about LGBT issues with three in four respondents reporting average competency as moderate, slight or none (74.6%).

Provider Competency

Respondents find their health care providers, on average, vary in their competency about LGBT issues. **Almost 1 in 3 report their provider is not at all or slightly competent**.

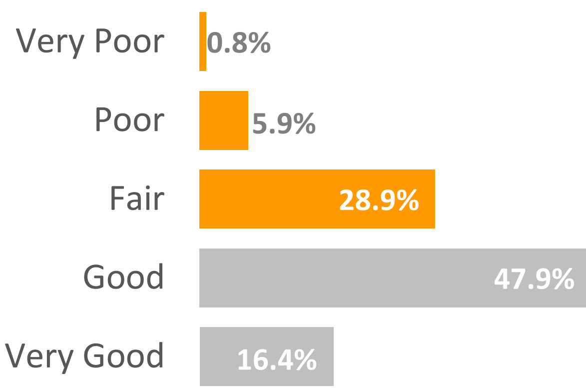


Personal Health

Respondents most commonly report their health as good (47.9%), but this leaves over a third of respondents who report their health is fair, poor, or very poor (35.6%). This is much higher than estimates for the general Pennsylvania adult population, with 17 percent (CI:15-18%) reporting being in fair or poor general health (BRFSS, 2016).

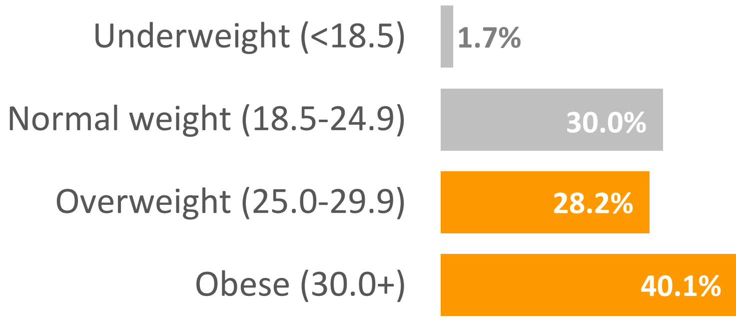
Over a third of respondents **report their health as fair, poor or very poor**.

Health



As an indicator of health, respondents self-report height and weight and body mass index (BMI) was calculated. While BMI is limited as a health indicator,[18] BMI reports show the majority of adult respondents (18+) are overweight or obese based on standard BMI category breaks (68.3%). This is slightly higher than estimates for the general Pennsylvania adult population, with 64 percent (CI:63-66%) identified as overweight or obese (BRFSS, 2016). Underweight respondents fall in largely similar proportions across cisgender males (32.3%), cisgender females (29.0%) and transgender and gender non-conforming individuals (38.7%).

While **BMI is limited**, BMI varies with more than **2 in 3** adult respondents classified as **overweight or obese**.

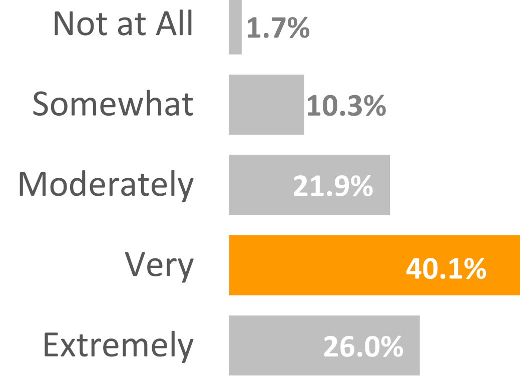


[18] National Heart Lung and Blood Institute (NIH): https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm

Another indicator of personal health and resiliency is interest in healthy living. Almost all respondents report at least some interest in incorporating healthy living strategies into their lives (98.3%).

Respondents are **interested in incorporating healthy living strategies** (such as healthy eating, exercise, tobacco cessation, etc.) into their lives.

Healthy Living



Respondents had the opportunity to report specific healthy living practices as well. During the past month, three in four respondents report physical activity or exercise outside of their job (75.4%). Respondents also report sugar sweetened beverage intake. While the sugar sweetened beverage consumption recommendations largely focus on reduction rather than a limit to a certain number of soda/pop or other sugar sweetened drinks per week, more than one in 20 respondents report 15 or more sugar sweetened beverages per week in the past month (5.6%). This estimate is conservative as almost an additional one in 20 report estimates that may exceed 14 beverages across the two sugar sweetened beverage categories (4.7%). Related to healthy living, outside of pregnancy, more than three in 20 respondents report having been told by a health care professional they have pre-diabetes or borderline diabetes (16.7%).

Health screenings may also serve as an indicator of personal health and/or access to care. Health screening recommendations vary and often have tailored conditions related to timing and frequency. Rates in chart below relate to ever being screened among the primary categories of eligible individuals. It is important to note individuals outside of the primary categories of eligible individuals may be recommended for screening based on personal health risk, family risk, gender-affirming hormone therapy or other hormone intake, and other discussions with care providers.

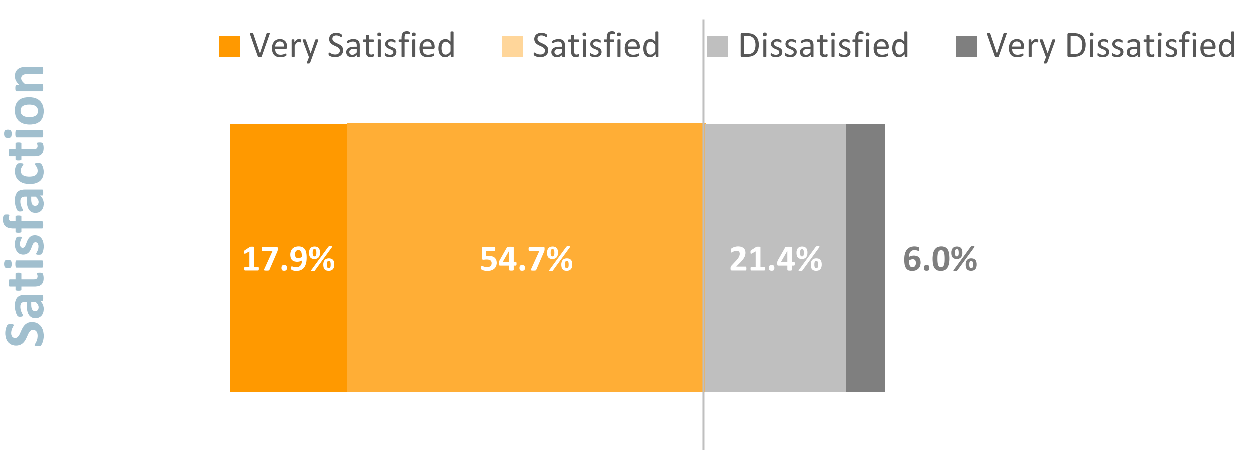
Health Screening

Screening	Group	Ever Screened	Never Screened
Diabetes test	All	58.6%	41.4%
	Among overweight/obese adults	66.1%	33.9%
HIV test	All	69.9%	30.1%
	Among those under 64 years	70.1%	29.9%
	Among gay respondents	85.7%	14.3%
	Among transgender respondents	58.7%	41.3%
Mammogram	Among 40+, assigned female at birth	87.0%	13.0%
	Among transgender/gender non-conforming, 40+, self-identifying as eligible	53.8%	46.2%
	Among transgender/gender non-conforming, any age, self-identifying as eligible	26.7%	73.3%
Cervical Pap test	Among 21+, assigned female at birth	92.6%	7.4%
	Among transgender/gender non-conforming, 21+, self-identifying as eligible	70.5%	29.5%
	Among transgender/gender non-conforming, any age, self-identifying as eligible	66.2%	33.8%
Prostate exam	Among 40+, assigned male at birth	79.5%	20.5%
Anal Pap test	Among all assigned male at birth	15.5%	84.5%
	Among gay respondents	16.3%	83.7%
	Among transgender respondents	11.5%	88.5%
	Among HIV+ respondents	52.2%	47.8%
Blood stool test	Among 45+	51.6%	48.4%
Sigmoidoscopy or Colonoscopy	Among 45+	68.8%	31.4%

Mental Health

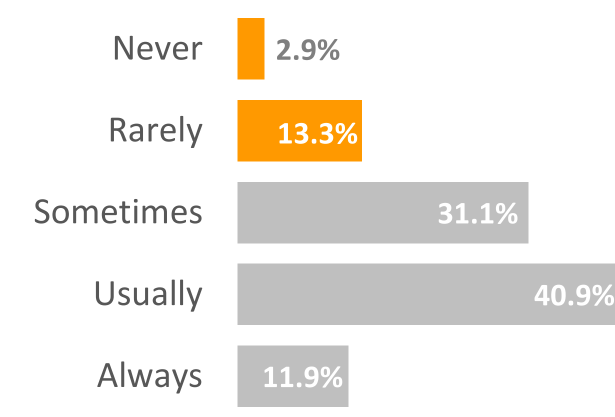
Several aspects of survey findings relate to mental health, both personally and among LGBT communities in general (see LGBT Community Health Section). While the majority of respondents report general satisfaction with their life (72.6%), more than one in four report not being satisfied with their life (27.4%).

In general, how satisfied are you with your life?

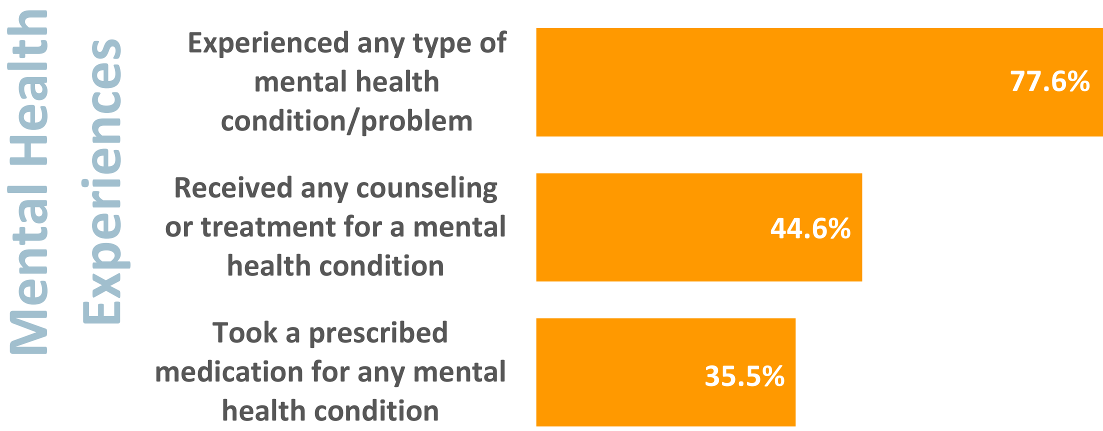


Respondents find it to be more common to get the social and emotional support they need than not, with just over half of respondents reporting they usually or always get the support they need (52.8%). Unfortunately, this leaves almost a third of respondents who get the support they need only some of the time (31.1%) and about one in six respondents who report not getting the support they need (16.2%).

1 in 6 report they rarely or never get the support they need.



When thinking about the past year, more than three in four respondents report experiences with a mental health condition or problem (77.6%). Counseling or treatment, as well as prescription medication for mental health conditions such as depression, anxiety, stress, suicidal ideation, etc. were also part of many respondents' recent experiences.



Experience with any type of mental health condition was more common among cisgender females, transgender, and gender non-conforming respondents. This same experience also shows a pattern by age group. The youngest age groups most often report experiencing a mental health condition/problem in the past year and reports decline with age group progression. Counseling or treatment was more than 1.5 times more likely among transgender and gender non-conforming respondents compared to cisgender counterparts and more common among younger age groups. Age group rates for taking prescribed medications hang together more closely and did not show the same ramp pattern.

HIV

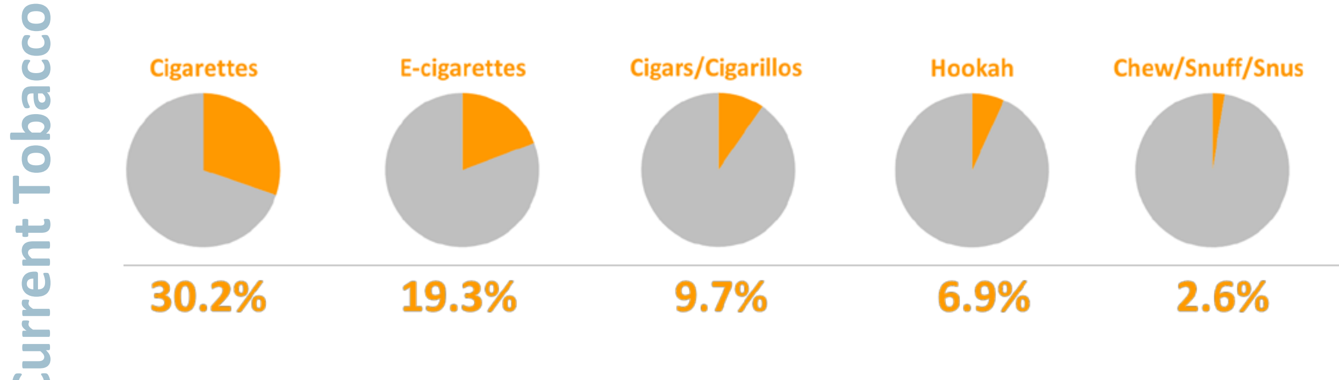
As reported in Health Screenings, three in ten respondents report never being tested for HIV (30.1%). HIV ever testing reports are highest among gay respondents (85.7%), followed by bisexual men (72.1%). HIV ever testing reports are lower among transgender respondents (58.7%). When considering most recent test, gay men (23.9%) and bisexual men (20.3%) were the most likely to report a test within the last three months. Almost half of gay men (48.6%) and more than two in five bisexual men (43.2%) report an HIV test within the past year. Just over one in 20 across all respondents report being HIV positive as of their last test. Respondents report feeling most comfortable getting an HIV test in an LGBT community-based setting and with a primary care provider.

Respondents report some risks for HIV at much higher rates than others. Most common risk reports include four or more partners in the past year (20.0%) and anal sex without a condom in the past year (26.8%). Less frequent risks among respondents include: intravenous drug use in past year (1.9%); past year exchange of sex for money or drugs (2.5%); and past year treatment for sexually transmitted disease (8.3%). Over one in three respondents have at least one of the BRFSS identified primary risk factors[19] for HIV (36.0%). Please note survey limitation: Risk factors questions did not account for PrEP usage.

[19] BRFSS primary risk factors are treated for STDs/VDs, traded money or drugs for sex, had anal sex without a condom or had 4+ sex partners in the past year.

Tobacco Use & Opinions

Cigarettes are the most commonly used tobacco product with almost a third of respondents reporting cigarette use every day or some days (30.2%). Based on this survey, current smoking among LGBT communities is well over the smoking rate estimate for all Pennsylvania adults at 18 percent (CI: 17-18%) (BRFSS, 2016).



While overall LGBT respondents report higher current smoking than the general population, smoking reports are even higher among transgender and gender non-conforming respondents (36.9%) than among cisgender males (28.8%) and cisgender females (28.1%).

Cigarette use reports also vary by age and region in Pennsylvania. Overall, the highest smoking rate estimates are among 18 to 24 year olds, averaging 42.6 percent. Regionally, the Northwest, Southwest, North Central, and Northeast have smoking estimates above the overall respondent estimate of 30.2 percent. All regions have rates higher than BRFSS 2016 estimates for all Pennsylvania adults.

	Under 18 years	18 to 24 years	25 to 49 years	50 to 64 years	65+ years	All LGBT	Transgender & Gender non-conforming
Northwest	n/a	50.0%	51.7%	40.9%	n/a	**42.9%**	n/a
Southwest[20]	n/a	62.5%	29.4%	38.5%	n/a	**35.4%**	n/a
Allegheny County	n/a	32.3%	29.8%	11.0%	n/a	**24.1%**	**33.8%**
North Central	n/a	38.5%	46.0%	30.4%	n/a	**40.4%**	**42.9%**
South Central	n/a	26.3%	38.6%	15.3%	n/a	**28.1%**	**34.2%**
Northeast	n/a	47.4%	42.0%	24.7%	n/a	**37.4%**	**44.9%**
Southeast[21]	n/a	52.8%	28.4%	20.0%	n/a	**27.3%**	**35.2%**
Philadelphia County	n/a	34.6%	23.1%	20.0%	n/a	**22.0%**	**31.8%**
Any Region	**n/a**	**42.6%**	**34.2%**	**21.3%**	**10.7%**	**30.2%**	**36.9%**

Note: Percent removed for categories with <5 respondents.

[20] Excluding Allegheny County.

[21] Excluding Philadelphia County.

Respondents have some interest in quitting, with about a one in four looking to quit within six months (24.3%). However, few are most likely to go to a Quitline for assistance (2.6%). When reporting where respondent would be most likely go for assistance to quit smoking, one in 20 respondents selected a cessation class or program at an LGBT organization (5.3%).

Respondents also share their opinions on several tobacco-related statements, demonstrating majority support for all smoke-free opportunities discussed. With greater than six in 10 respondents saying they would likely go to a smoke-free bar/club, pride event, or LGBT community center.

Tobacco Opinions

Statement	Agree	Neutral	Disagree
LGBT people smoke more than the general population.	44.9%	42.9%	12.3%
Pride celebrations should be smoke-free events.	52.8%	31.6%	15.6%
I would be likely to go to a smoke-free bar/club.	60.4%	28.4%	11.2%
I would be likely to go to a smoke-free Pride event.	65.2%	28.8%	6.0%
I would be likely to go to a smoke-free LGBT Community Center.	67.6%	27.8%	4.6%

Substance Use & Alcohol

More than four in ten respondents report 5 or more alcoholic drinks per day (commonly referred to as binge drinking) at some point in the past year (43.1%), with close to one in 10 reporting this daily or weekly (9.1%). Respondents report use of 12 other substances outside of alcohol with wide variation. Over a third of respondents report past year use of marijuana (36.6%), with one in ten reporting daily or almost daily use (10.4%). Past year usage of other drugs include: opioids (6.7%); inhalants (5.5%); cocaine (4.8%); ecstasy (3.3%); and crystal meth (2.1%). All other drugs listed were reported by less than two percent of respondents.

Cancer

As reported in Health Screenings, reports of cancer screenings vary by test and population. Among respondents 40 and over assigned female at birth, three in four had a mammogram within the last three years (75.3%). Similarly, among respondents 21 and over assigned female at birth, over three in four had a cervical Pap test within the last three years (77.5%). Over one in four respondents report HPV vaccination[22] (26.6%). Among those who have not had the HPV vaccine, a portion report their provider refused to give the vaccine when they asked (2.4%).

When asked about specific skin cancer risks, almost four in 10 report prior indoor tanning (38.9%). Prior indoor tanning is more common among cisgender males (43.6%) than among cisgender females (39.1%) or transgender and gender nonconforming respondents (23.0%). More than four in 10 report infrequent or never use of sun protection during peak hours (44.2%). One in 10 respondents reports a cancer diagnosis during their lifetime (11.2%). Skin cancer is by far the most common, however, each of the other six cancers[23] listed is reported by no fewer than three respondents.

Regardless of experience with cancer prevention, screening, or treatment, respondents overwhelmingly agree services are needed to help LGBT cancer survivors.

Survivor Supports

	Agree	Neutral	Disagree
LGBT tailored cancer information	81.3%	16.4%	2.3%
LGBT support group	89.8%	8.9%	1.3%
LGBT welcoming caregivers group	89.9%	9.0%	1.1%
LGBT welcoming providers	91.4%	7.6%	1.0%
LGBT welcoming policies at hospitals	92.4%	6.4%	1.2%
LGBT legal planning	92.8%	6.1%	1.1%

[22] Survey question included additional terms for the HPV vaccine, including: cervical cancer or genital warts vaccine, HPV shot, Gardisil or Cervarix.

[23] Cancers list included: lung, skin, prostate, breast, cervical, colorectal, anal, and other.

LGBT Community Health

Respondents' perceptions of priority health issues for LGBT communities was also collected. Across 15 answer options the top three selections for issues perceived to be the most impactful for LGBT communities in Pennsylvania all relate to mental health. **Depression** is the most common issue selected, with recognition as a top three issue by over half of respondents (58.1%). **Suicide** (36.3%) and **Loneliness/Isolation** (34.1%) round out the top three most commonly selected issues. Over a quarter of respondents rank **HIV/AIDS** (28.6%) and **Access to Welcoming Care** (27.6%) as top issues. Over 280 respondents also wrote in other issues and comments in the ranking question. A wide variety of issues were covered that were not on the original list of 15 options, including, but not limited to: domestic violence; eating disorders; employment discrimination; gender-affirming care; homelessness; and trauma-informed care.

Some topic areas are selected more often by certain age groups. Alcohol use, for example, grew steadily as a top three issue from younger to older groups, peaking among 65+ respondents at almost 30 percent (29.1%). Elder care followed this same pattern, peaking at about a third of 65+ respondents (34.4%). Bullying, on the other hand, as a top three classification ramped in the other direction with <18 respondents classifying as a top three issue at over 40 percent (43.9%). Depression as an overall top three selection, was more frequently selected by the younger age groups with ramped decline in older age groups as well, but never dipping below 44.5 percent for any age group.

Also of note, several respondents critiqued the break out of specific drugs in the original 15 options. The identification of the top three issues may have been impacted if all drugs or addiction (general) were available for selection. One respondent summarized this issue by responding, "**Addition in general**, I don't think it can be narrowed down to just one addiction."

Discussion & Recommendations

LGBT+ respondents from across Pennsylvania shared critical information on personal and community health opportunities. Service gaps can be closed and support systems can be reinforced/expanded. A variety of players must be part of addressing LGBT community needs, including government agencies, community-based agencies, advocates/allies, and LGBT individuals.

Recommendations

Support Connections to LGBT-competent Providers – Support connections to LGBT-welcoming care for LGBT communities. Support training on LGBT issues for healthcare professionals through improved cultural competency, continuing medical education on LGBT health issues, and training for medical students in LGBT health.

Encourage Health Screening Discussions – Identify strategies to facilitate discussions on improving access to and frequency of health screenings for the LGBT community. Consider development of an online health screening recommendation summary tool to support a range of screenings discussions acknowledging the diversity within the LGBT community. Develop tailored messages specific to the LGBT community.

Prioritize Chronic Disease Prevention – Continue work to raise awareness about tobacco, HIV, obesity and cancer as LGBT issues among LGBT communities and Pennsylvanians at-large. Support service expansion to address tobacco use, HIV, obesity and cancer risks for LGBT communities. Maximize interest among LGBT communities for incorporating healthy living strategies by sharing resources and facilitating connections to LGBT-welcoming statewide and community-based services.

Promote Tobacco Cessation Opportunities – Expand promotion of free cessation opportunities available to all Pennsylvanians, like the PA Free Quitline. Build skills among tobacco cessation professionals and promote use of evidence-based cessation and tobacco recovery supports among LGBT communities. Develop LGBT focused tobacco-free campaigns. Engage in direct outreach to the LGBT community. Partner with LGBT community centers, LGBT bars, and pride celebrations to effectively reach the LGBT community with tailored tobacco-free messages.

Identify Community-wide Mental Health Supports – Identify ongoing opportunities to support mental health services within LGBT communities. Prioritize training for mental health clinicians on LGBT issues. Plan to incorporate discussions about depression management, suicide prevention and social isolation mitigation into provider education. Post vetted mental health resources on LGBT community organization websites and social media platforms. Increase availability of mental health programs at LGBT community-based organizations.

Continue and Enhance Data Collection – Maintain a 2-year schedule of the Pennsylvania LGBT Health Needs Assessment with broad administration. Maintain a commitment to collection of LGBT health and wellness data among a large geographically and demographically diverse LGBT population. Support further research and data collection to focus specifically on LGBT people of color, transgender people, LGBT youth, LGBT older adults, and LGBT adults without a college degree. Consider opportunities to expand responses from Hispanic/Latinx LGBT populations, including a Spanish-language survey instrument. Improve all tools over time with feedback from LGBT stakeholders and informed the survey field.

Partner with LGBT Community-Based Organizations – Healthcare professionals, public health agencies, and health researchers should consider partnerships with LGBT community-based organizations to develop and implement strategies to promote a high-quality of health for the LGBT community.

Acknowledgements

Thank you to all respondents for your time, feedback, and ideas.

The Pennsylvania Department of Health and Bradbury-Sullivan LGBT Community Center would also like to thank all of the 2018 data collection partners:

- Equality Pennsylvania
- Erie Gay News
- Fighting AIDS Continuously Together
- Greater Erie Alliance for Equality
- Grindr for Equality
- Human Rights Campaign
- LGBT Center of Central PA
- LGBT Equality Alliance of Chester County
- LGBTQmunity Center of Montgomery County
- Metropolitan Community Church of Lehigh Valley
- Montgomery County LGBT Business Council
- Pennsylvania Youth Congress
- Persad Center
- Philadelphia Gay News
- Rainbow NEPA
- Triversity
- Washington County GSA
- William Way LGBT Community Center

Special thanks to CenterLink's LGBT HealthLink program, for survey oversight and administration, and to Adrian Shanker from Bradbury-Sullivan LGBT Community Center, for recruitment coordination and ongoing commitment to data dissemination and use.

Funding to complete the needs assessment and conduct analyses was provided by the Pennsylvania Department of Health. Analyses were completed by the Research & Evaluation Group at Public Health Management Corporation.

Research & Evaluation Group at Public Health Management Corporation. (2018). *Pennsylvania 2018 LGBT Health Needs Assessment.* Philadelphia, PA: Author.

Appendices

2018 Findings Summary
LGBT Health Needs Assessment

Pennsylvania has health and wellness feedback from 4,679 LGBT+ Pennsylvanians! These data can be used to inform program planning, outreach efforts, and service proposal. While these data have some limitations, we can use these data to better understand areas of resilience, health disparities and overall need. To collect these important data, Pennsylvania partnered with Bradbury-Sullivan LGBT Community Center to reach a statewide purposeful sample. The Pennsylvania 2018 LGBT Health Needs Assessment was conducted in collaboration with LGBT HealthLink, a program of CenterLink.

64.3% report good or very good health

98.3% have interest in healthy living strategies

44.6% report mental health treatment this year

30.2% are current smokers

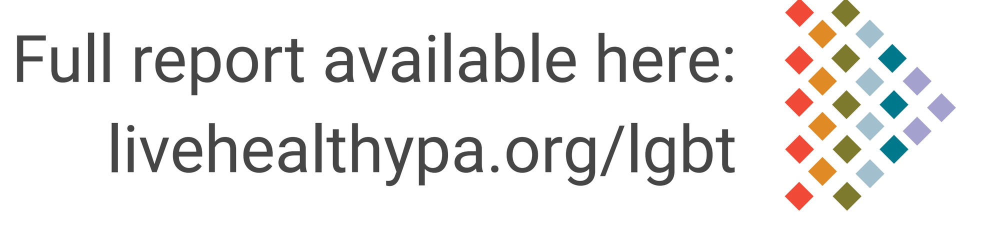
68.3% are overweight or obese

36.0% report a primary risk factor for HIV

LGBT+ respondents from across Pennsylvania shared critical information on personal and community health opportunities. Service gaps can be closed and support systems can be reinforced/expanded. A variety of players must be part of addressing LGBT community needs, including government agencies, community-based agencies, advocates/allies, and LGBT individuals. Data from the Pennsylvania 2018 LGBT Health Needs Assessment inform several recommendations for incorporation into future work:

1. **Support Connection to LGBT-competent Providers**
2. **Encourage Health Screening Discussions**
3. **Prioritize Chronic Disease Prevention**
4. **Promote Tobacco Cessation Opportunities**
5. **Identify Community-wide Mental Health Supports**
6. **Continue and Enhance Data Collection**
7. **Partner with LGBT Community-Based Organizations**

Full report available here:
livehealthypa.org/lgbt



2018 Regional Summary
LGBT Health Needs Assessment

We have 2018 health and wellness feedback from 4,679 LGBT+ Pennsylvanians! These data can be used to inform program planning, outreach efforts, and service proposals. While these data have some limitations, we can also explore data from different parts of Pennsylvania. The Northwest Health District in Pennsylvania has information from 191 respondents. Check out some highlights below!

Northwestern PA

42.9%
current smoking

18%
BRFSS 2016 comparison for all PA adults

76.3%
overweight or obese

64%
BRFSS 2016 comparison for all PA adults

30.1%
at least one primary risk factor for HIV*

7%
BRFSS 2016 comparison for PA adults 18-64

Interest in Healthy Living

Not at All	Somewhat	Moderately	**Very**	**Extremely**
2.4%	8.9%	26.2%	**41.7%**	**20.8%**

Northwestern Pennsylvania respondents also demonstrate resiliency and are **ready to incorporate healthy living strategies** into their lives (such as healthy eating, exercise, tobacco cessation, etc.)... **62.5% report being very or extremely interested!**

Data sources: Pennsylvania' 2018 LGBT Health Needs Assessment and Pennsylvania BRFSS 2016.

*Risk factors are: treated for STDs/VDs, traded money or drugs for sex, had anal sex without a condom or had 4+ sex partners in the past year, age 18-64

2018 Regional Summary
LGBT Health Needs Assessment

We have 2018 health and wellness feedback from 4,679 LGBT+ Pennsylvanians! These data can be used to inform program planning, outreach efforts, and service proposals. While these data have some limitations, we can also explore data from different parts of Pennsylvania. The Southwest Health District* in Pennsylvania has information from 259 respondents. Check out some highlights below!

Southwestern* PA

* Excluding Allegheny County

35.4%
current smoking

18%
BRFSS 2016 comparison for all PA adults

68.5%
overweight or obese

64%
BRFSS 2016 comparison for all PA adults

30.6%
at least one primary risk factor for HIV*

7%
BRFSS 2016 comparison for PA adults 18-64

Interest in Healthy Living

Not at All	Somewhat	Moderately	**Very**	**Extremely**
3.5%	9.3%	30.4%	**34.4%**	**22.5%**

Southwestern Pennsylvania respondents also demonstrate resiliency and are **ready to incorporate healthy living strategies** into their lives (such as healthy eating, exercise, tobacco cessation, etc.)... **56.9% report being very or extremely interested!**

Data sources: Pennsylvania' 2018 LGBT Health Needs Assessment and Pennsylvania BRFSS 2016.

*Risk factors are: treated for STDs/VDs, traded money or drugs for sex, had anal sex without a condom or had 4+ sex partners in the past year, age 18-64

2018 Regional Summary

LGBT Health Needs Assessment

We have 2018 health and wellness feedback from 4,679 LGBT+ Pennsylvanians! These data can be used to inform program planning, outreach efforts, and service proposals. While these data have some limitations, we can also explore data from different parts of Pennsylvania. Allegheny County, Pennsylvania has information from 802 respondents. Check out some highlights below!

24.1% current smoking

18% BRFSS 2016 comparison for all PA adults

65.1% overweight or obese

64% BRFSS 2016 comparison for all PA adults

38.4% at least one primary risk factor for HIV*

7% BRFSS 2016 comparison for PA adults 18-64

Interest in Healthy Living

Not at All	Somewhat	Moderately	Very	Extremely
1.8%	8.5%	19.8%	43.6%	26.3%

Allegheny County respondents also demonstrate resiliency and are **ready to incorporate healthy living strategies** into their lives (such as healthy eating, exercise, tobacco cessation, etc.)... **69.9% report being very or extremely interested!**

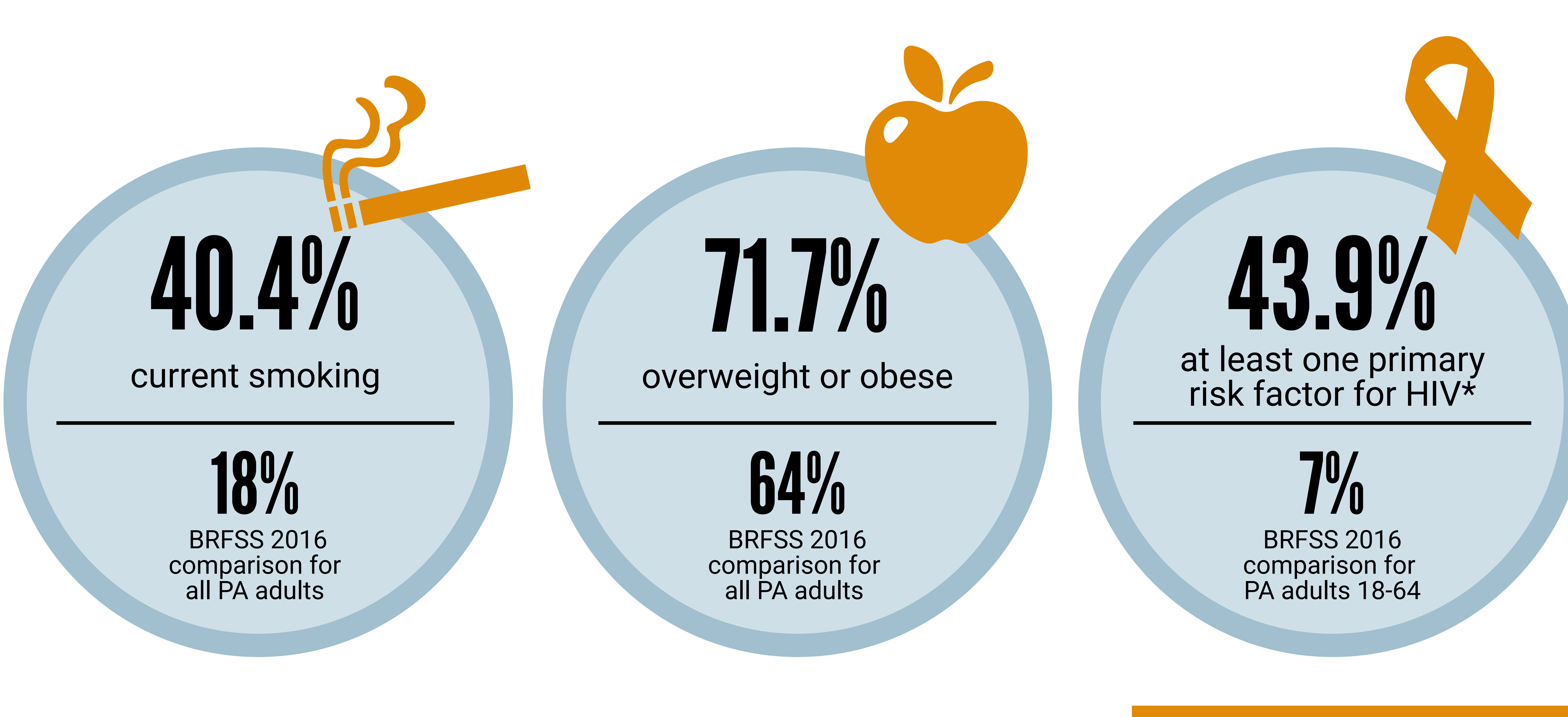
Data sources: Pennsylvania' 2018 LGBT Health Needs Assessment and Pennsylvania BRFSS 2016.

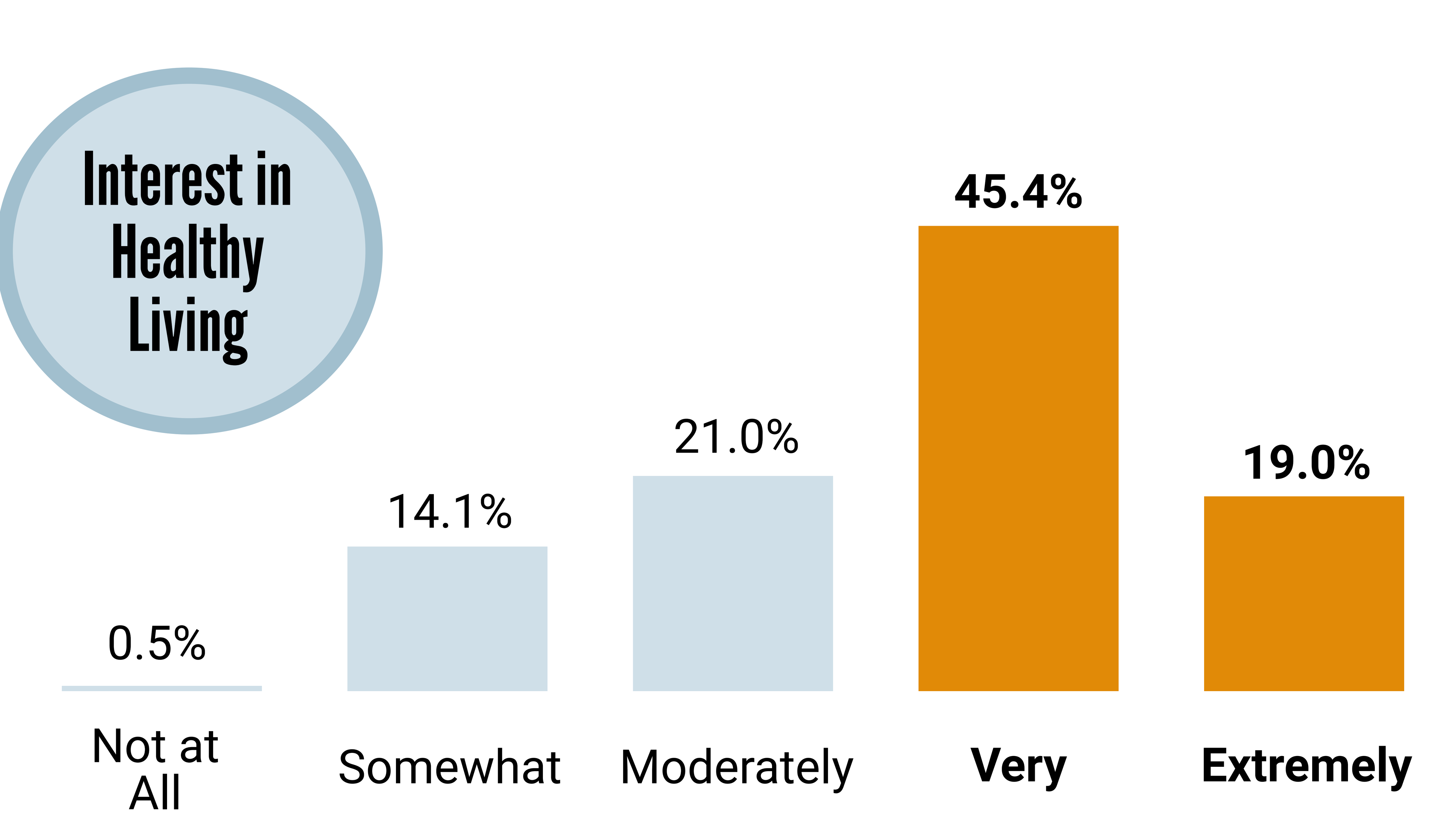
*Risk factors are: treated for STDs/VDs, traded money or drugs for sex, had anal sex without a condom or had 4+ sex partners in the past year, age 18-64

2018 Regional Summary
LGBT Health Needs Assessment

We have 2018 health and wellness feedback from 4,679 LGBT+ Pennsylvanians! These data can be used to inform program planning, outreach efforts, and service proposals. While these data have some limitations, we can also explore data from different parts of Pennsylvania. The North Central Health District in Pennsylvania has information from 224 respondents. Check out some highlights below!

North Central PA





North Central Pennsylvania respondents also demonstrate resiliency and are **ready to incorporate healthy living strategies** into their lives (such as healthy eating, exercise, tobacco cessation, etc.)... **64.4% report being very or extremely interested!**

Data sources: Pennsylvania' 2018 LGBT Health Needs Assessment and Pennsylvania BRFSS 2016.

*Risk factors are: treated for STDs/VDs, traded money or drugs for sex, had anal sex without a condom or had 4+ sex partners in the past year, age 18-64

2018 Regional Summary
LGBT Health Needs Assessment

We have 2018 health and wellness feedback from 4,679 LGBT+ Pennsylvanians! These data can be used to inform program planning, outreach efforts, and service proposals. While these data have some limitations, we can also explore data from different parts of Pennsylvania. The South Central Health District in Pennsylvania has information from 604 respondents. Check out some highlights below!

South Central PA

28.1% current smoking

18% BRFSS 2016 comparison for all PA adults

75.3% overweight or obese

64% BRFSS 2016 comparison for all PA adults

34.1% at least one primary risk factor for HIV*

7% BRFSS 2016 comparison for PA adults 18-64

Interest in Healthy Living

Not at All	Somewhat	Moderately	Very	Extremely
2.2%	12.0%	20.4%	40.9%	24.5%

South Central Pennsylvania respondents also demonstrate resiliency and are **ready to incorporate healthy living strategies** into their lives (such as healthy eating, exercise, tobacco cessation, etc.)... **65.4% report being very or extremely interested!**

Data sources: Pennsylvania' 2018 LGBT Health Needs Assessment and Pennsylvania BRFSS 2016.

*Risk factors are: treated for STDs/VDs, traded money or drugs for sex, had anal sex without a condom or had 4+ sex partners in the past year, age 18-64

2018 Regional Summary
LGBT Health Needs Assessment

We have 2018 health and wellness feedback from 4,679 LGBT+ Pennsylvanians! These data can be used to inform program planning, outreach efforts, and service proposals. While these data have some limitations, we can also explore data from different parts of Pennsylvania. The Northeast Health District in Pennsylvania has information from 1,123 respondents. Check out some highlights below!

Northeastern PA

37.4% current smoking

18% BRFSS 2016 comparison for all PA adults

70.9% overweight or obese

64% BRFSS 2016 comparison for all PA adults

35.4% at least one primary risk factor for HIV*

7% BRFSS 2016 comparison for PA adults 18-64

Interest in Healthy Living

Not at All	Somewhat	Moderately	Very	Extremely
2.0%	10.0%	23.2%	37.5%	27.3%

Northeastern Pennsylvania respondents also demonstrate resiliency and are **ready to incorporate healthy living strategies** into their lives (such as healthy eating, exercise, tobacco cessation, etc.)... **64.8% report being very or extremely interested!**

Data sources: Pennsylvania' 2018 LGBT Health Needs Assessment and Pennsylvania BRFSS 2016.

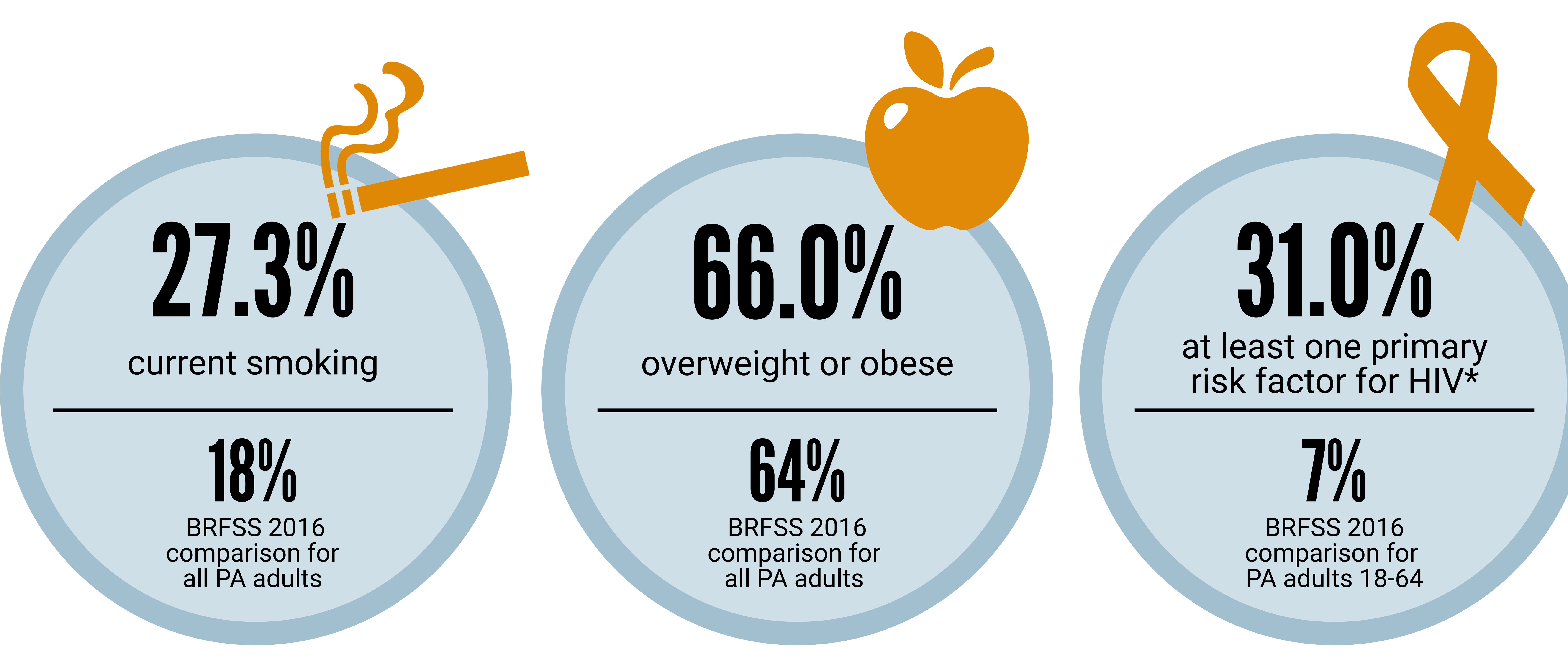
*Risk factors are: treated for STDs/VDs, traded money or drugs for sex, had anal sex without a condom or had 4+ sex partners in the past year, age 18-64

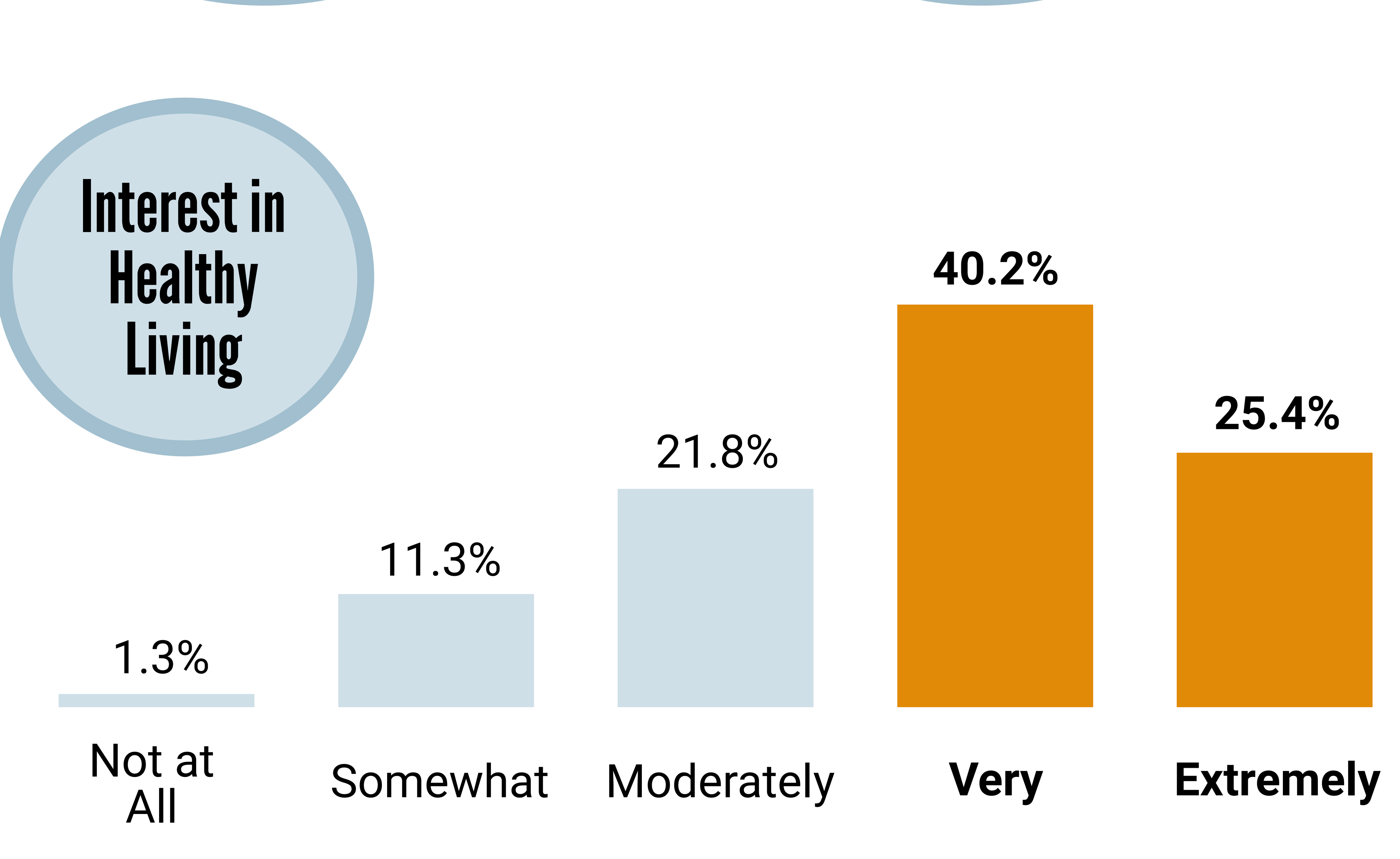
2018 Regional Summary
LGBT Health Needs Assessment

We have 2018 health and wellness feedback from 4,679 LGBT+ Pennsylvanians! These data can be used to inform program planning, outreach efforts, and service proposals. While these data have some limitations, we can also explore data from different parts of Pennsylvania. The Southeast Health District* in Pennsylvania has information from 967 respondents. Check out some highlights below!

Southeastern* PA

* Excluding Philadelphia County





Southeastern Pennsylvania respondents also demonstrate resiliency and are **ready to incorporate healthy living strategies** into their lives (such as healthy eating, exercise, tobacco cessation, etc.)... **65.6% report being very or extremely interested!**

Data sources: Pennsylvania' 2018 LGBT Health Needs Assessment and Pennsylvania BRFSS 2016.

*Risk factors are: treated for STDs/VDs, traded money or drugs for sex, had anal sex without a condom or had 4+ sex partners in the past year, age 18-64

2018 Regional Summary
LGBT Health Needs Assessment

We have 2018 health and wellness feedback from 4,679 LGBT+ Pennsylvanians! These data can be used to inform program planning, outreach efforts, and service proposals. While these data have some limitations, we can also explore data from different parts of Pennsylvania. Philadlephia County, Pennsylvania has information from 501 respondents. Check out some highlights below!

Philadelphia County PA

22.0% current smoking

18% BRFSS 2016 comparison for all PA adults

59.1% overweight or obese

64% BRFSS 2016 comparison for all PA adults

46.2% at least one primary risk factor for HIV*

7% BRFSS 2016 comparison for PA adults 18-64

Interest in Healthy Living

Not at All	Somewhat	Moderately	**Very**	**Extremely**
0.9%	8.6%	18.6%	**39.8%**	**32.1%**

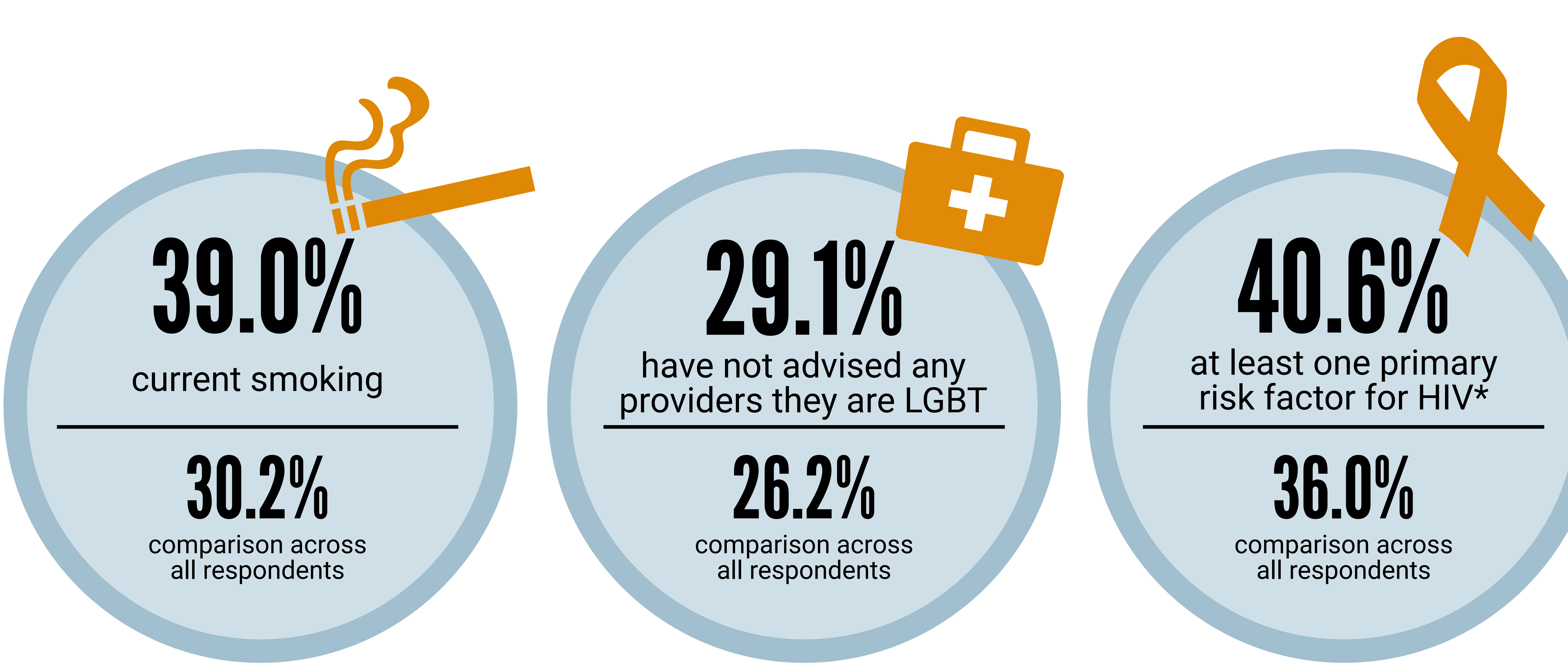
Philadelphia County respondents also demonstrate resiliency and are **ready to incorporate healthy living strategies** into their lives (such as healthy eating, exercise, tobacco cessation, etc.)... **71.9% report being very or extremely interested!**

Data sources: Pennsylvania' 2018 LGBT Health Needs Assessment and Pennsylvania BRFSS 2016.

*Risk factors are: treated for STDs/VDs, traded money or drugs for sex, had anal sex without a condom or had 4+ sex partners in the past year, age 18-64

2018 - Black & African American LGBT Health Needs Assessment

We have 2018 health and wellness feedback from 4,679 LGBT+ Pennsylvanians! These data can be used to inform program planning, outreach efforts, and service proposals. While these data have some limitations, we can explore health opportunities and differences within the LGBT community. One hundred eighty one of the 2018 needs assessment respondents are Black or African American. Below are a few data points specific to this subgroup and comparisons to all needs assessment respondents.



Priority Health Issues

Depression - 60.8%

HIV/AIDS - 40.9%

Priority of HIV/AIDS was recognized more often among Black and African American respondents than among respondents in general (28.6%)

Suicide - 40.3%

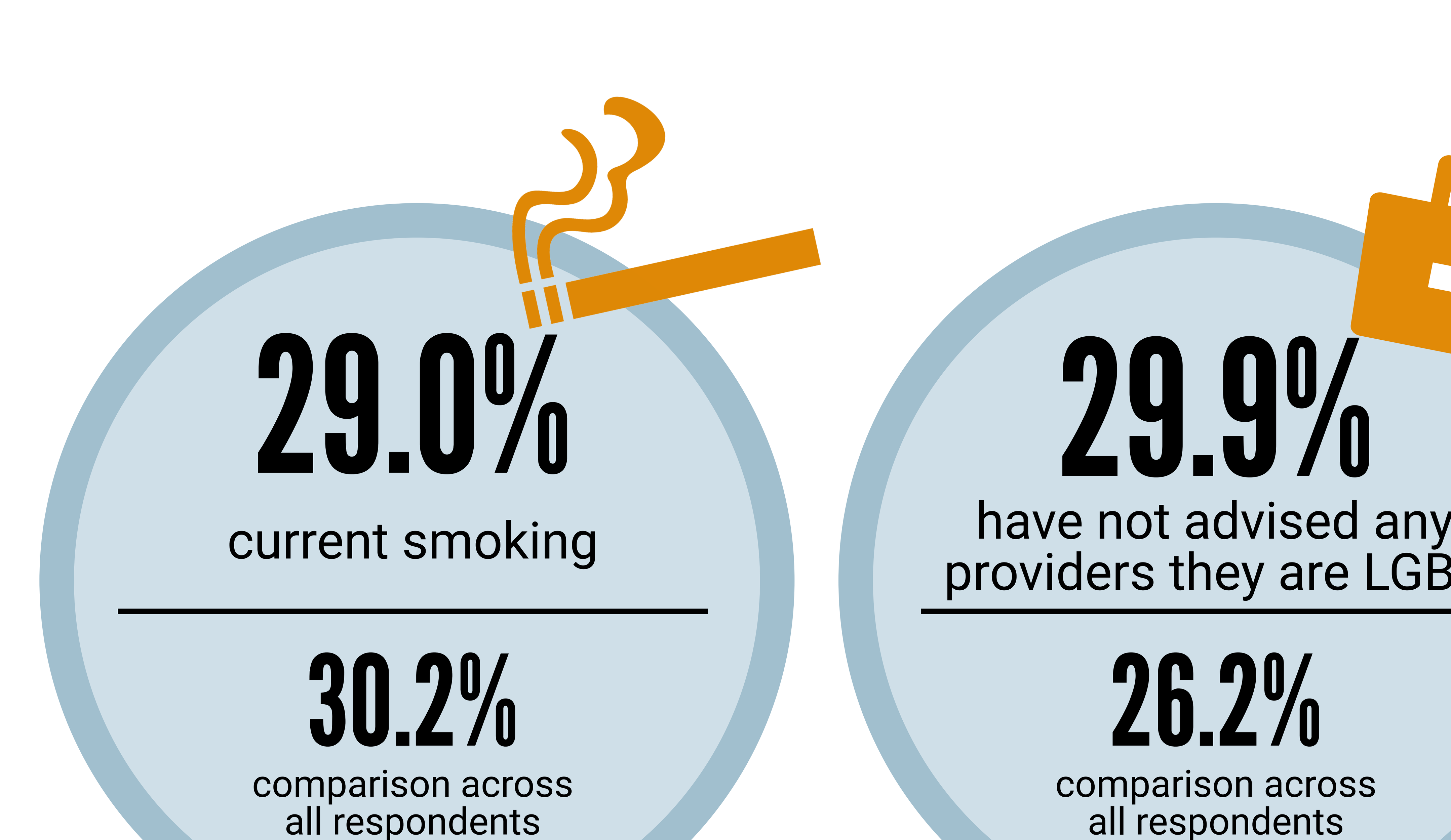
To better understand and address health opportunities and disparities, further research and data collection among LGBT people of color is needed.

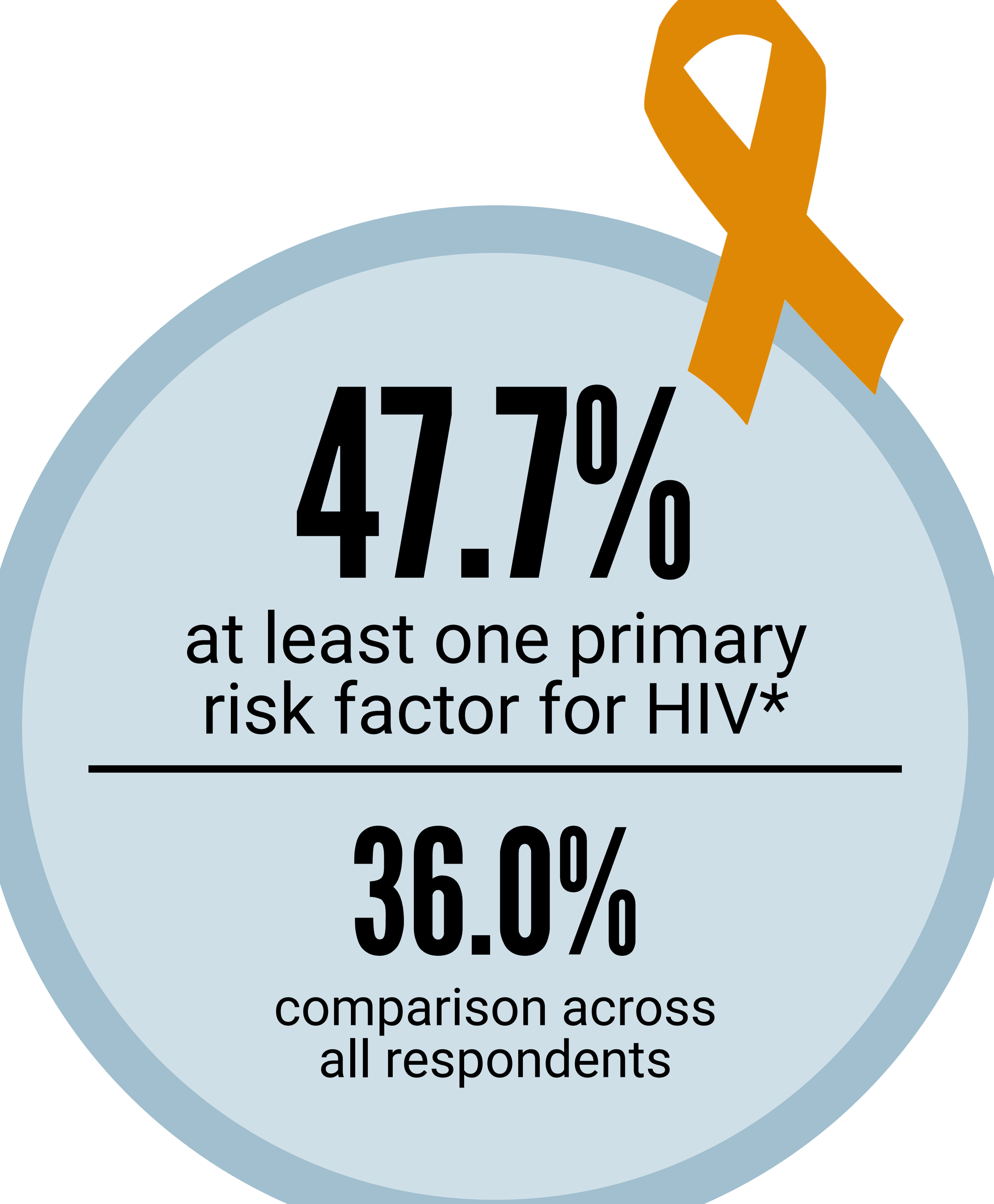
Data sources: Pennsylvania' 2018 LGBT Health Needs Assessment

*Risk factors are: treated for STDs/VDs, traded money or drugs for sex, had anal sex without a condom or had 4+ sex partners in the past year, age 18-64

2018 - Hispanic and Latinx LGBT Health Needs Assessment

We have 2018 health and wellness feedback from 4,679 LGBT+ Pennsylvanians! These data can be used to inform program planning, outreach efforts, and service proposals. While these data have some limitations, we can explore health opportunities and differences within the LGBT community. Two hundred twenty three of the 2018 needs assessment respondents are Hispanic or Latino/a. Below are a few data points specific to this subgroup and comparisons to all needs assessment respondents.





Priority Health Issues

Depression - 70.0%

Suicide - 50.2%

HIV/AIDS - 44.8%

Priority of HIV/AIDS was recognized more often among Hispanic and Latino/a respondents than among respondents in general (28.6%)

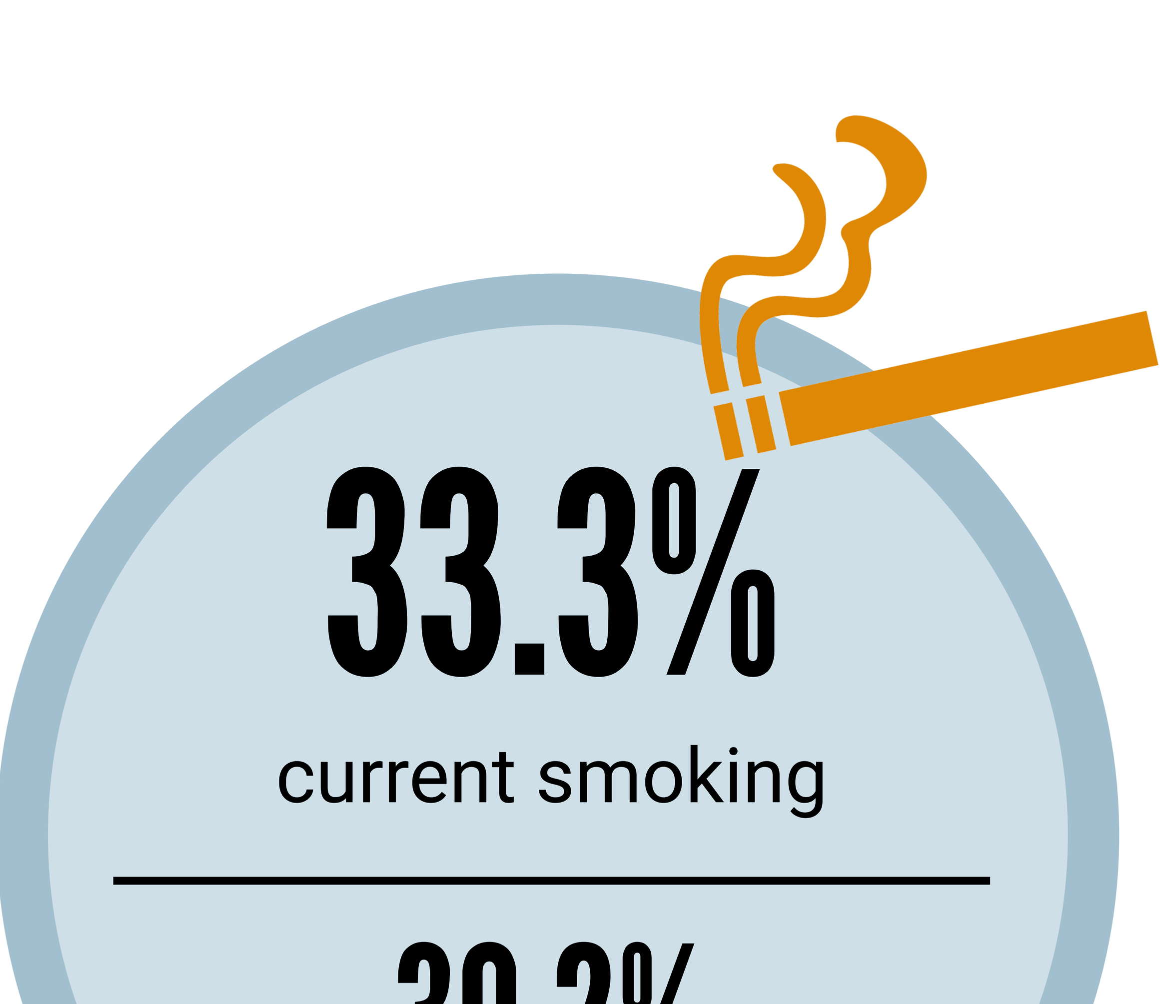
To better understand and address health opportunities and disparities, further research and data collection among Hispanic and Latinx LGBT is needed. Future LGBT needs assessments can incorporate Spanish survey tools.

Data sources: Pennsylvania' 2018 LGBT Health Needs Assessment

*Risk factors are: treated for STDs/VDs, traded money or drugs for sex, had anal sex without a condom or had 4+ sex partners in the past year, age 18-64

2018 - Transgender LGBT Health Needs Assessment

We have 2018 health and wellness feedback from 4,679 LGBT+ Pennsylvanians! These data can be used to inform program planning, outreach efforts, and service proposals. While these data have some limitations, we can explore health opportunities and differences within the LGBT community. Two hundred ninety one of the 2018 needs assessment respondents identify as transgender. Below are a few data points specific to this subgroup and comparisons to all needs assessment respondents.



33.3%
current smoking

30.2%
comparison across all respondents

90.4%
experienced any type of mental health issue in past 12 months

77.6%
comparison across all respondents

22.0%
at least one primary risk factor for HIV*

36.0%
comparison across all respondents

Priority Health Issues

Depression - 68.7%

Access to Welcoming Health Care- 55.0%

Priority of access to welcoming health care was recognized more often among transgender respondents than among respondents in general (27.6%)

Suicide - 50.9%

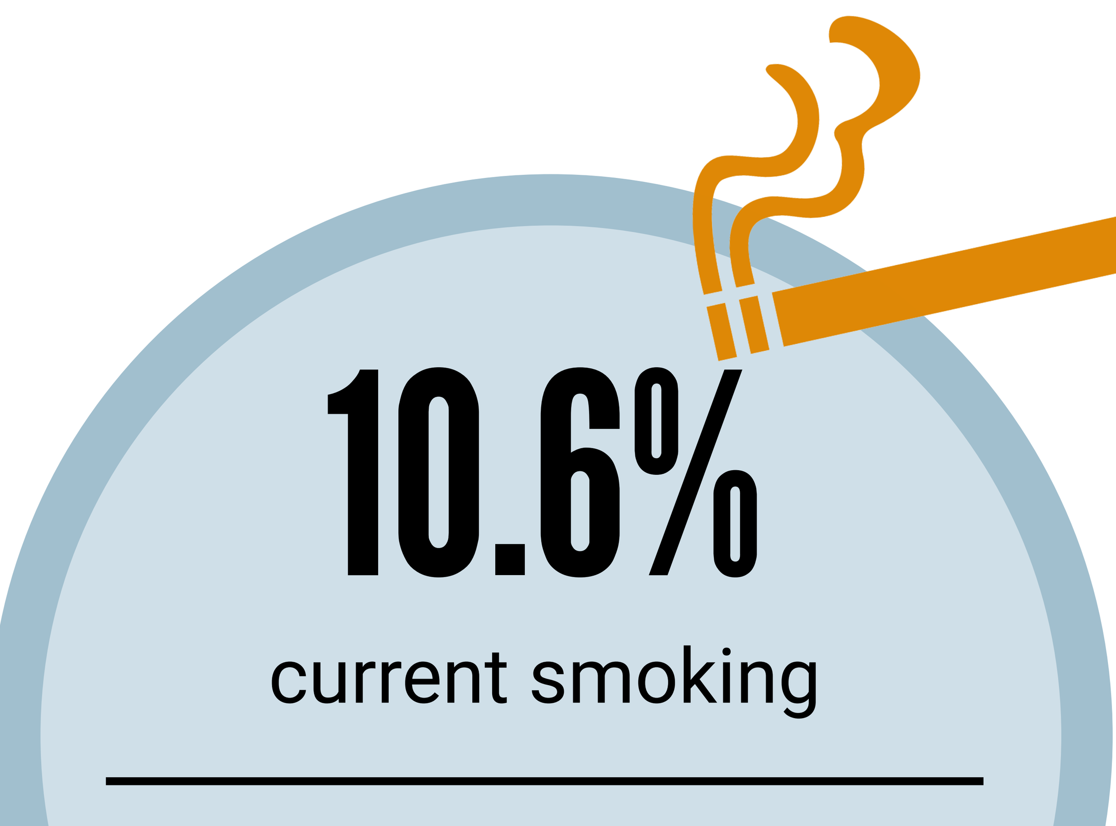
To better understand and address health opportunities and disparities, further research and data collection among transgender people is needed.

Data sources: Pennsylvania' 2018 LGBT Health Needs Assessment

*Risk factors are: treated for STDs/VDs, traded money or drugs for sex, had anal sex without a condom or had 4+ sex partners in the past year, age 18-64

2018 - Older Adults (65+ years)
LGBT Health Needs Assessment

We have 2018 health and wellness feedback from 4,679 LGBT+ Pennsylvanians! These data can be used to inform program planning, outreach efforts, and service proposals. While these data have some limitations, we can explore health opportunities and differences within the LGBT community. Two hundred ninety nine of the 2018 needs assessment respondents are 65 years or older. Below are a few data points specific to this subgroup and comparisons to all needs assessment respondents.



10.6%
current smoking

30.2%
comparison across all respondents

73.1%
overweight or obese

66.0%
comparison across all respondents

47.7%
experienced any type of mental health condition in the past 12 months

77.6%
comparison across all respondents

Priority Health Issues

Isolation - 45.8%

Depression - 44.5%

HIV/AIDS - 37.1%

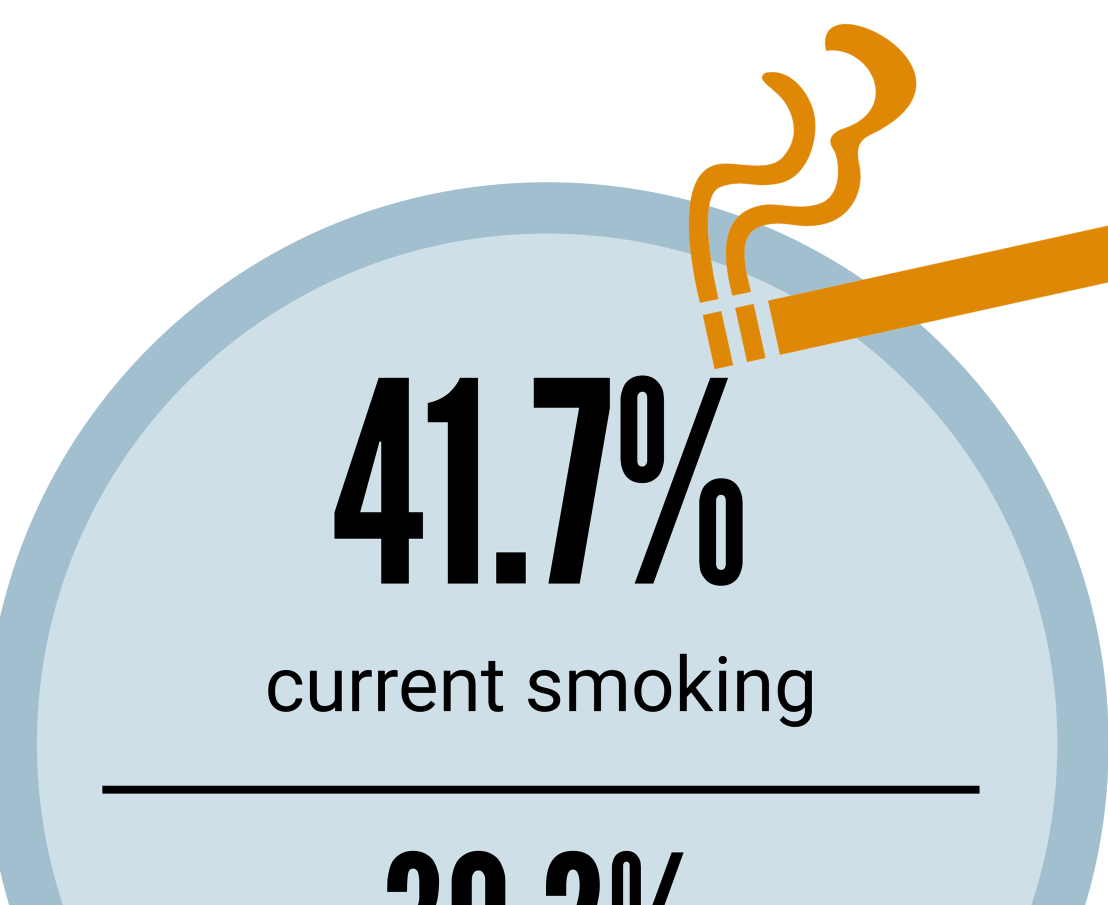
Elder Care - 34.4%

To better understand and address health opportunities and disparities, further research and data collection among LGBT older adults is needed.

Data sources: Pennsylvania' 2018 LGBT Health Needs Assessment

2018 - Young People (<25 years) LGBT Health Needs Assessment

We have 2018 health and wellness feedback from 4,679 LGBT+ Pennsylvanians! These data can be used to inform program planning, outreach efforts, and service proposals. While these data have some limitations, we can explore health opportunities and differences within the LGBT community. One thousand one hundred eighty eight of the 2018 needs assessment respondents are under age 25. Below are a few data points specific to this subgroup and comparisons to all needs assessment respondents.



46.4%
have not advised any providers they are LGBT

26.2%
comparison across all respondents

92.7%
experienced any type of mental health condition in the past 12 months

77.6%
comparison across all respondents

Depression - 63.6%

Suicide - 49.5%

Isolation - 32.2%

Bullying - 30.2%

To better understand and address health opportunities and disparities, further research and data collection among LGBT youth and young adults is needed.

Data sources: Pennsylvania' 2018 LGBT Health Needs Assessment

RESEARCH
& EVALUATION
GROUP
at PHMC

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WHITMAN-WALKER CLINIC, INC., *et al.*, *Plaintiffs,* v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, *Defendants*.	Case No. 1:20-cv-1630

DECLARATION OF HECTOR VARGAS, EXECUTIVE DIRECTOR, GLMA

I, Hector Vargas, hereby state as follows:

1. I am the Executive Director of the American Association of Physicians for Human Rights, Inc., d/b/a GLMA: Health Professionals Advancing LGBTQ Equality (f/k/a the Gay & Lesbian Medical Association) ("GLMA").

2. I received my Bachelor of Arts degree in political science and Spanish in 1989 and law degree in 1993 from the University of Georgia. I served on the Health Disparities Subcommittee of the Advisory Committee to the Director of the U.S. Centers for Disease Control and Prevention (CDC) and served for four years on President Obama's Advisory Commission on Asian Americans and Pacific Islanders. I have more than 20 years of LGBTQ and civil rights advocacy experience, including on staff with Lambda Legal, the National LGBTQ Task Force, and the American Bar Association's Section of Civil Rights and Social Justice.

3. I am submitting this Declaration in support of Plaintiffs' motion for preliminary injunction to prevent the revised regulation under Section 1557 of the Affordable Care Act ("ACA"), published by the U.S. Department of Health and Human Services ("HHS") on June 19,

2020 (the "Revised Rule"), from taking effect. The Revised Rule eliminates explicit regulatory protections for LGBT people in health care that were included in the 2016 Final Rule, which was promulgated under Section 1557 in May 2016.

4. GLMA is a 501(c)(3) national membership nonprofit organization based in Washington, D.C., and incorporated in California. GLMA's mission is to ensure health equity for lesbian, gay, bisexual, transgender, queer (LGBTQ) people and all sexual- and gender- minority (SGM) individuals, and equality for LGBTQ/SGM health professionals in their work and learning environments. To achieve this mission, GLMA utilizes the scientific expertise of its diverse multidisciplinary membership to inform and drive advocacy, education, and research. GLMA was founded in 1981 and its initial mission focused on responding with policy advocacy and public-health research to the growing medical crisis that would become the HIV/AIDS epidemic. Since then, GLMA's mission has broadened to address the full range of health concerns and issues affecting LGBTQ/SGM people, including ensuring that sound science and research inform health policy and practices regarding the LGBTQ community.

5. GLMA represents the interests of hundreds of thousands of LGBTQ health professionals, as well as millions of LGBTQ patients and families. GLMA's membership includes approximately 1,000 member physicians, nurses, advanced practice nurses, physician assistants, researchers and academics, behavioral health specialists, health profession students and other health professionals. GLMA's members reside and work across the United States, including states without any explicit protections against discrimination based on sexual orientation, gender identity, or transgender status, and in several other countries. Their practices represent the major health care disciplines and a wide range of health specialties, including internal medicine, family

practice, psychiatry, pediatrics, obstetrics/gynecology, emergency medicine, neurology, and infectious diseases.

6. GLMA's members who work for covered entities under Section 1557 are protected from discrimination with regards to terms and conditions of their employment, such as employee health benefits, pursuant to the 2016 Final Rule. In addition, many of GLMA's members are or work for covered entities subject to the Revised Rule.

7. The Revised Rule invites confusion about the meaning of the sex discrimination provision of Section 1557 of the ACA and directly conflicts HHS's previous guidance regarding the meaning of sex discrimination. In 2012, HHS Office of Civil Rights Director Leon Rodríguez wrote to me, among others, and clarified that "Section 1557's sex discrimination prohibition extends to claims of discrimination on the basis of gender identity or failure to conform to stereotypical notions of masculinity or femininity . . . sexual harassment and discrimination regardless of actual or perceived sexual orientation or gender identity of the individuals involved." A copy of OCR Director Rodríguez's letter is enclosed as **Exhibit A**.

8. The 2016 Final Rule, promulgated by HHS following a prolonged notice-and-comment process, reaffirmed this interpretation by defining discrimination "on the basis of sex" to include "discrimination on the basis of . . . sex stereotyping, and gender identity." 81 Fed. Reg. at 31,467.

9. The Revised Rule repeals entirely the 2016 Final Rule's definition of discrimination "on the basis of sex," without providing a different definition, while intimating that discrimination "on the basis of sex" is limited to discrimination based on the "biological binary of male and female that human beings share with other mammals." 85 Fed. Reg. at 37,161–62, 37,178– 79. These actions conflict with HHS's longstanding position regarding Section 1557, as noted in the 2012

letter and 2016 Final Rule, and creates confusion among health care providers, such as GLMA's members, and patients.

10. The Revised Rule also fosters greater discrimination against LGBTQ patients, who already experience widespread discrimination in obtaining health care and suffer significant health disparities in comparison to the general population. Research documents the history of this discrimination and the negative health outcomes that result. The majority of LGBTQ patients and patients living with HIV report having experienced providers refusing to touch them or using excessive precautions, providers using harsh or abusive language, providers being physically rough or abusive, and/or providers shaming LGBTQ patients and blaming these patients for their health status. A large percentage of transgender patients report having negative experiences related to their gender identity and transgender status when seeking medical care, including being exposed to verbal harassment or refusals of care.

11. LGBTQ patients face significant health disparities—higher risk factors for poor physical and mental health, higher rates of HIV, decreased access to appropriate health insurance, insufficient access to preventative medicine, and higher risk of poor treatment by health care providers. LGBTQ patients are vulnerable in other ways as well, including higher rates of poverty and limited access to LGBTQ-specific services, that present significant logistical and economic challenges to obtaining adequate health care. These harms are exacerbated by the Revised Rule. The Revised Rule will result in greater discrimination against LGBTQ patients, resulting in harm to patients and increased denials of services based not only on the medical services a patient seeks, but also on the patient's LGBTQ identity.

12. Among GLMA's strategic commitments is its ongoing collaboration with professional accreditation bodies, such as The Joint Commission, on the development,

implementation, and enforcement of sexual-orientation and gender-identity nondiscrimination policies as well as cultural-competency standards of care for the treatment of LGBTQ patients. Founded in 1951, The Joint Commission is the nation's oldest and largest standards-setting and accrediting body in health care. GLMA has worked with The Joint Commission and continues to work with similar professional bodies and health professional associations on standards, guidelines, and policies that address LGBTQ health, protecting individual patient health and public health in general.

13. The Revised Rule presents a direct conflict with nondiscrimination standards adopted by The Joint Commission and all major health professional associations, who have recognized the need to ensure LGBTQ patients are treated with respect and without bias or discrimination in hospitals, clinics, and other health care settings. Many of these efforts were prompted at least in part by GLMA's efforts through the years. For example, GLMA representatives, in coordination with other LGBTQ health experts, participated in the development and implementation of the hospital-accreditation nondiscrimination standards and guidelines developed by The Joint Commission to protect and ensure quality care for LGBTQ patients.

14. Similarly, GLMA has worked with the American Medical Association (AMA), among other health professional associations, over the last 15 years to ensure AMA policies prevent discrimination against LGBTQ patients and recognize the specific health needs of the LGBTQ community. All of the leading health professional associations—including the AMA, American Osteopathic Association, American Academy of PAs, American Nurses Association, American Academy of Nursing, American College of Physicians, American College of Obstetricians and Gynecologists, American Psychiatric Association, American Academy of Pediatricians, American Academy of Family Physicians, American Public Health Association,

American Psychological Association, National Association of Social Workers, and many more—have adopted policies articulating that health care providers should not discriminate in providing care to patients and clients because of patients' sexual orientation or gender identity. By carving out LGBTQ people from the regulatory health care nondiscrimination protections of the ACA and other regulations, the Revised Rule violates the ethical and medical standards of care that health care professionals are charged to uphold, and sends a confusing and conflicting message that such discrimination is acceptable.

15. In order for a health care organization to participate in and receive federal payment from Medicare or Medicaid programs, the organization must meet certain requirements, including a certification of compliance with health and safety requirements, which is achieved based on a survey conducted either by a state agency on behalf of the federal government or by a federally-recognized national accrediting organization. Accreditation surveys include standards that health care organizations do not discriminate based on sex, sexual orientation, or gender identity in the provision of services and in employment. A health care organization that discriminates on these bases in the provision of patient care or in employment, or that otherwise deviates from medical, professional and ethical standards of care is vulnerable to loss of accreditation. The Revised Rule conflicts with these requirements.

16. If not enjoined, the Revised Rule will harm GLMA members, the interests of the LGBTQ patients represented by GLMA, and GLMA members' patients. By removing explicit health care nondiscrimination regulatory protections for LGBTQ people, the Revised Rule prevents GLMA from achieving its goals with professional accreditation bodies. GLMA's goals include achieving and enforcing accreditation standards relating to nondiscrimination on the basis of sex, sexual orientation, and gender identity, and cultural-competency standards of care for

treatment of LGBTQ patients. GLMA also works with health professional associations to create nondiscrimination policies and ensure their members understand and adhere to such standards. However, the Revised Rule creates confusion among those professional accreditation bodies and health professional associations about health care providers accountable for discrimination against LGBTQ people and denials of care when the discriminatory conduct is justified on the basis of religious or moral beliefs. For example, the Revised Rule would prevent agencies, to the extent allowed by law, from recognizing the loss of accreditation of a health care organization due to a specified anti-LGBTQ belief. The Revised Rule also invites such facilities to discriminate against LGBTQ patients without concern about the impact such discrimination will have on the organization's ability to continue receiving federal funding. The revised rule, therefore, frustrates GLMA's goals, conflicts with professional accreditation standards, and invites discrimination against LGBTQ people in health care. GLMA will have to divert resources to address this frustrated goal.

17. The Revised Rule also impedes GLMA members' ability to do their jobs because nondiscrimination is core to the work of health care providers treating their patients. Some members of GLMA are employed by religiously-affiliated health care organizations (for example, hospitals, hospices, or ambulatory care centers) that receive federal funds and are covered entities under Section 1557. These health care providers also treat LGBTQ patients. The Revised Rule invites religiously-affiliated health care employers to discriminate against employees who are GLMA members for adhering to and enforcing their medical and ethical obligations to treat all patients in a nondiscriminatory manner, including providing all medically-necessary care that is in patients' best interests. The Revised Rule impinges on and conflicts with GLMA members' ethical

and medical standards of care that health care providers are charged to uphold and harms the patients that they serve.

18. The Revised Rule invites harassment and discriminatory treatment of GLMA members with regards to terms and conditions of employment based on their LGBTQ status. This is particular problematic for GLMA members who work for covered entities with fewer than 15 employees and that are therefore not subject to Title VII, and which are located in states without any statutory protections from discrimination based on sexual orientation, gender identity, or transgender status.

19. GLMA members and their LGBTQ patients are stigmatized and demeaned by the message, communicated by the Revised Rule, that their government privileges beliefs that result in the disapproval and disparagement of LGBTQ people in the health care context.

20. As an organization of health professionals who serve and care for patients from the LGBTQ community, GLMA knows that discrimination against LGBTQ individuals in health care access and coverage remains a pervasive problem. GLMA members have reported numerous instances of discrimination, especially those based on religious or moral objections to treating patients. Members have reported:

a. "I see patients nearly every day who have been treated poorly by providers with moral and religious objections. Patients with HIV who have been told that they somehow deserved this for not adhering to God's law. Patients who are transgender who have been told that 'we don't treat your kind here'. The psychological and physical damage is pervasive."

b. "[Some providers in my clinic] do not wish to have contact with transgender patients, mumbling religious incompatibilities when asked why. These

people have made our transgender patients feel very uncomfortable and unwelcome at times, making them potentially more hesitant to use the health services they may need."

c. "The impact on my patients who were directly denied care was both psychological and physical. With regard to their mental wellbeing they clearly felt marginalized and disrespected. With regard to their physical wellbeing, they experienced delay in care, and in some cases disruption of their routine medication dosing or diagnostic assessment."

21. GLMA members are also health care workers on the frontlines treating patients for COVID-19. GLMA members are, among other professionals, infectious disease specialists, residents, nurses, dentists, mental health providers and technicians treating COVID-19 patients in already overwhelmed health care systems. Discrimination against LGBTQ patients and health care providers is even more dangerous during this global health crisis. The pandemic is disproportionately affecting vulnerable communities, including LGBTQ people, for whom this Revised Rule adds another, often insurmountable, impediment to health care. Some GLMA members who are experiencing anti-LGBTQ animus on the frontlines fear sharing their stories for fear of being fired. Some GLMA members practice in workplaces with fewer than 15 employees and in states without explicit statutory protections on discrimination based on sexual orientation, gender identity, or transgender status. Those GLMA members who consented to share their stories explained that:

a. "During this pandemic, the curiosity of my genitalia struck a conversation while on shift and was brought to my attention. I made Human Resources

aware, no action has yet to be made. I am not protected from conversations like these at work."

b. "I am acutely aware of how COVID19 has in many ways disproportionately impacted the LGBTQ community. So many of my patients are no longer able to go to the support groups they joined to support them in the coming out process. Some are home from college and living in settings where they don't feel safe. Many remember the fear and isolation of living through the early days of the HIV epidemic."

c. "I am more concerned about discrimination towards LGBTQ+ patients, and stay on heightened awareness to call out ignorant comments or microaggressions that permeate the local culture, as well as systemic toxic masculinity."

d. "I actually had a few patients tell me that since 'the gays spread HIV' that 'the gays must be spreading this one too.'"

e. A transgender GLMA supporter on the frontlines during the pandemic reported that their own health care insurance refused to cover transition-related health care.

22. Based on what patients have told GLMA members about their history and fear of discriminatory treatment, it is clear that the Revised Rule will cause LGBTQ patients to attempt to hide their LGBTQ identities when seeking health care services, especially from religiously-affiliated health care organizations, to avoid such discrimination. When patients are unwilling to disclose their sexual orientation and/or gender identity to health care providers out of fear of

discrimination and being refused treatment, their mental and physical health is critically compromised.

23. The Revised Rule also harms patients with limited English proficiency ("LEP") who may not receive real-time good quality translator services. GLMA members treat LEP patients and GLMA represents LEP LGBTQ patients' interests. The Revised Rule adds another barrier to these LEP patients' health care because they will not have access to life-saving information, including the resources to appropriately communicate about their health status, diagnoses, or treatment details. This communication barrier will create confusion and harm the health of LEP patients.

24. As a result of the Revised Rule, GLMA is required to divert its resources to educate and assist its members and the LGBTQ patients its members serve to defend against the harms that the Revised Rule causes. GLMA's staff and resources already have been diverted from other program activities to engage in advocacy, policy analysis, and program-development to address the ill-effects of the Revised Rule. GLMA has worked tirelessly to get medical and other health associations to express their disapproval of the Revised Rule, which has diverted large amounts of resources away from other proactive projects and outreach efforts that are core to GLMA's mission. For example, GLMA coordinated efforts to release a message from over 1,000 medical and mental health providers condemning the then-proposed Revised Rule. A copy of this message is attached as **Exhibit B**. GLMA also spends resources answering GLMA members' inquiries about the Revised Rule given the pervasive concern that the Revised Rule contradicts medical ethical requirements and standards of care. GLMA must spend resources educating its members and the general health care community about GLMA's position on the Revised Rule and its effects on health care practices and providers.

25. The Revised Rule will also adversely impact GLMA and its members by necessitating the diversion and reallocation of resources to maintain its online list of LGBTQ-affirming health care providers for patient referrals. As a result of the Revised Rule, GLMA and its members expect to see increases in the use of this online service and must allocate additional staff time to support this increase in website traffic. GLMA will have to contact providers listed on the list to ensure that they will continue to provide nondiscriminatory care to LGBTQ patients and will continue to adhere to their medical and ethical standards of care to treat all patients equally. Patients have even expressed concern about traveling outside of their home cities for business because if they are ever in need of emergency medical assistance, they will not know where to go to ensure that they will receive nondiscriminatory, proper health care services. This makes GLMA's referral list so important and GLMA will need to be a resource for these patients.

26. The Revised Rule empowers and invites religious-based discrimination against GLMA members and will contribute to discriminatory and even hostile work environments for GLMA members, LGBTQ health care providers, and LGBTQ-affirming health care providers. GLMA members who insist on treating patients equally and in accordance with medical and ethical standards of care are likely to be required to shoulder extra burdens as fellow employees decline to provide certain care. GLMA members also are likely to encounter push-back, hostility, and even adverse employment actions from their employers or fellow employees for trying to enforce nondiscrimination policies and provide appropriate care to patients. Because the vast majority of GLMA members are LGBTQ themselves, seeing LGBTQ patients treated in a discriminatory way by their colleagues and supported by their employers will have a profound impact on the environment in which they work.

27. GLMA, in turn, sees and will continue seeing an increase in health care providers seeking its assistance with addressing such discrimination. The increased demand for GLMA's services will drain GLMA's resources and hamper its other work, especially since GLMA already has a very limited bandwidth for such services.

[*Signature on next page.*]

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

Dated this 6th day of July, 2020.

Hector Vargas

EXHIBIT A

Letter from Leon Rodríguez, Director, Office for Civil Rights, U.S. Department of Health & Human Services (dated July 12, 2012)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Director
Office for Civil Rights
Washington, D.C. 20201

July 12, 2012

Maya Rupert, Esq.
Federal Policy Director
National Center for Lesbian Rights
1325 Massachusetts Ave. NW, Suite 700
Washington DC 20005

OCR Transaction Number: 12-000800

Dear Ms. Rupert:

Thank you for your letter to Secretary Kathleen Sebelius, which was forwarded for reply to the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR). In your letter, you requested that we issue guidance clarifying that sex-based discrimination includes discrimination on the basis of gender identity and sex stereotypes under Section 1557 of the Affordable Care Act.

As you may know, OCR enforces Section 1557 of the Affordable Care Act (42 U.S.C. 18116), which provides that an individual shall not be excluded from participation in, be denied the benefits of, or be subjected to discrimination on the grounds prohibited under Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d *et seq.* (race, color, national origin), Title IX of the Education Amendments of 1972, 20 U.S.C. 1681 *et seq.* (sex), the Age Discrimination Act of 1975, 42 U.S.C. 6101 *et seq.* (age), or Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794 (disability), under any health program or activity, any part of which is receiving Federal financial assistance, or under any program or activity that is administered by an Executive Agency or any entity established under Title I of the Affordable Care Act or its amendments. OCR has enforcement authority with respect to health programs and activities that receive Federal financial assistance from HHS or are administered by HHS or any entity established under Title I of the Affordable Care Act or its amendments.

We agree that Section 1557's sex discrimination prohibition extends to claims of discrimination based on gender identity or failure to conform to stereotypical notions of masculinity or femininity and will accept such complaints for investigation. Section 1557 also prohibits sexual harassment and discrimination regardless of the actual or perceived sexual orientation or gender identity of the individuals involved.

The HHS OCR is currently accepting and investigating complaints filed under Section 1557. We thoroughly review each complaint received; employ a case-by-case analysis of the facts and the relevant law; make a carefully considered decision on jurisdiction; and when warranted, issue a

finding that discrimination has (or has not) occurred. The HHS OCR intends to issue future guidance on Section 1557.

Until then, to make sure individuals, community organizations and providers know their rights and responsibilities, we ask you to help promote our website, www.hhs.gov/ocr, and:

- Learn about and connect with any one of our ten OCR regional offices http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html
- Learn how to file a complaint with OCR if you think your rights have been violated http://www.hhs.gov/ocr/civilrights/complaints/index.html
- Visit the HHS OCR You Tube channel (search for HHS OCR) for additional videos on topics like "Your Health Information, Your Rights" or "Communicating with Family, Friends and others Involved in Your Care".

I also want to underscore what we discussed and shared during OCR's January 30, 2012 LGBT/HIV Stakeholders Listening Session: my office is continuing and will continue to increase our outreach and education efforts with individuals, community organizations and providers regarding their rights and responsibilities under Section 1557. The Office for Civil Rights is absolutely committed to working with individuals and advocates to improving the health and well-being of members of the lesbian, gay, bisexual and transgender communities, and of course, the commitment to sincerely engage and partner with the LGBT community is a Department-wide commitment as demonstrated by the Secretary (see http://www.hhs.gov/secretary/about/lgbthealth.html) and the 2012 HHS LGBT Coordinating Committee Report which is available at http://www.hhs.gov/secretary/about/2012_lgbt_an_rpt.pdf.

Again, thank you for your leadership on these critical matters to the LGBT community and for your very thoughtful letter, and we look forward to our growing partnership and work together.

Sincerely,

Leon Rodriguez

cc:

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EXHIBIT B

Press Release, GLMA, 1,000+ Health Professionals Join Letter Opposing Healthcare Rights Law Rollback (dated May 29, 2020)

1,000+ Health Professionals Join Letter Opposing Healthcare Rights Law Rollback

PRESS RELEASE

CONTACT: press@glma.org or press@transequality.org

David Farmer (207) 557-5968

FOR IMMEDIATE RELEASE

May 29, 2020

Health Care Providers Urge Trump Administration To Delay Rule Change to the Affordable Care Act

WASHINGTON, D.C. – More than 1,000 medical and mental health providers have signed onto a letter in opposition to pending rules that would reinterpret nondiscrimination protections from the Affordable Care Act. The new rule sets the Trump administration's view that the law doesn't protect patients from discrimination because they are transgender, pregnant, or have a same-sex partner or family member. It also instructs hospitals and insurance companies that they are no longer required to provide patients with notices of their rights or how to get information in different languages.

The letter also urges the US Department of Health and Human Services to delay any rule change affecting access to health care until at least 90 days after the end of the COVID-19 public health emergency.

"As the death toll and hardships created by the COVID-19 pandemic continue to grow, the Trump administration and the Department of Health and Human Services should be working to expand access to health care, not creating excuses for providers to turn away transgender Americans," said Mara Keisling, executive director of the National Center for Transgender Equality, a co-organizer of the letter. "The pending rules are heartless and wrong-headed. The rules should be rejected. But the least the Trump administration could do to help protect the health of transgender people is to delay their implementation until we are through this crisis."

Section 1557 of the Affordable Care Act, also referred to as the Health Care Rights Law, prohibits discrimination on the basis of race, national origin, sex, age, or disability in health care programs or activities. It is the first federal civil rights law to prohibit discrimination based on sex in health care.

As proposed by the U.S. Department of Health and Human Services, this rule would falsely tell hospitals and health care insurance plans that they could:

- Refuse testing or treatment because a patient is transgender or doesn't conform to sex stereotypes.
- Refuse testing or treatment because a patient has had an abortion.
- Refuse testing or treatment to patients based on a provider or staff member's personal beliefs.
- Refuse testing or treatment based on sexual orientation, even in programs that have banned such discrimination since the G.W. Bush administration.

- Incorporate discriminatory plan benefit designs that eliminate/limit coverage critical to people with disabilities or preexisting conditions and place certain kinds of treatments needed by people with specific disabilities on the most expensive copay tiers.
- No longer notify patients of their right to receive information in their primary language.
- No longer notify patients of their right to file a grievance if they're mistreated.

"The pending rule changes will impede the delivery of life-saving health care even as the country grapples with more than 100,000 deaths with COVID-19," said Hector Vargas, executive director of GLMA: Health Professionals Advancing LGBTQ Equality and co-organizer of the letter. "Health care providers are the frontlines of this pandemic and know that our medical systems and essential workers are overwhelmed. We also know that Section 1557 is essential in our efforts to prevent deaths. The pending changes are irresponsible and unnecessary."

The letter addressed to Secretary Alex Azar of the US Department of Health and Human Services is below:

Re: Nondiscrimination in Health and Health Education Programs and Activities, Final Rule (RIN 0945-AA11)

On behalf of the more than 1,000 undersigned medical and mental health providers, we write to the administration in opposition to the pending final rule that would reinterpret the Affordable Care Act's nondiscrimination provisions so that the law will no longer protect patients from discrimination if they are transgender, pregnant, or have a same-sex partner or family member in a same-sex partnership. In addition, the new changes will direct hospitals and insurance providers that they will no longer have to provide notices of patient rights or instructions to get access to information in different languages.

As medical and mental health care providers, we vehemently oppose these rule changes and believe they will impede delivering of the highest quality of health care to the most marginalized, especially during a national public health crisis that has cost over 100,000 lives (1). We are on the frontlines of this pandemic and know firsthand that our medical systems and essential workers are heavily burdened and overwhelmed as the death toll continues to rise. We know that Section 1557 is essential in our efforts to prevent deaths during the current pandemic. Changes to this interpretation will be irresponsible and unnecessary as it will perpetuate discrimination and create unnecessary barriers for patients in accessing critical information about their rights and their health.

We know that this pandemic has already disproportionately impacted people of color. For example, data has already indicated that black and Latinx people in New York City are two times more likely to die compared to white people (2). In addition, we know that the LGBTQ community, especially LGBTQ people of color, are disproportionately impacted by this virus. This rule change will allow service providers to deny medical care, including testing and treatment for COVID-19, to many communities that are at greatest risk from this deadly virus and worsen health disparities. That's why we--and this nation's leading health professional associations, including the American Medical Association, American Nurses Association, American Academy of Pediatrics, American Psychiatric Association, American Psychological Association and National Association of Social Workers, among others -- have repeatedly opposed this proposal even before this current crisis.

As proposed by the U.S. Department of Health and Human Services, this rule would falsely tell hospitals and health plans that they could:

- Refuse testing or treatment because a patient is transgender or doesn't conform to sex stereotypes.
- Refuse testing or treatment because a patient has had an abortion.
- Refuse testing or treatment to patients based on a provider or staff member's personal beliefs.
- Refuse testing or treatment based on sexual orientation, even in programs that have banned such discrimination since the G.W. Bush administration.
- Incorporate discriminatory plan benefit designs that eliminate/limit coverage critical to people with disabilities or preexisting conditions and place certain kinds of treatments needed by people with specific disabilities on the most expensive copay tiers.
- No longer notify patients of their right to receive information in their primary language.
- No longer notify patients of their right to file a grievance if they're mistreated.

For all of these reasons, we urge the administration to suspend this rule change. At a minimum, this rulemaking process should be suspended until at least 90 days after the termination of the current COVID-19 Public Health Emergency declared by Secretary Azar on January 31, and after a large majority of states are no longer subject to stay-at-home orders and closure of non-essential businesses.

HHS has called this pandemic "an emergency of unprecedented magnitude"; yet this administration has continued to fail us and the people that have been directly impacted by this crisis by creating barriers to testing, contact tracing, personal protective equipment and other critical supplies to save lives. We urge you to focus on the current crisis instead of exacerbating negative health outcomes from this deadly pandemic. If you have any questions, please contact Hector Vargas of GLMA or Debbie Ojeda-Leitner of NCTE.

Sincerely,

The Undersigned

(1) "Cases in the US." CDC. May 19, 2020. Anchorhttps://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html.

(2) Crear-Perry, Joia and McAfee, Michael. "To Protect Black Americans from the Worst Impacts of COVID-19, Release Comprehensive Racial Data." Scientific American. April 24, 2020.https://blogs.scientificamerican.com/voices/to-protect-black-americans-from-the-worst-impacts-of-covid-19-release-comprehensive-racial-data/.

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WHITMAN-WALKER CLINIC, INC., *et al.*,

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

Case No. 1:20-cv-1630

**DECLARATION OF ROY HARKER, EXECUTIVE DIRECTOR,
AGLP: THE ASSOCIATION OF LGBTQ+ PSYCHIATRISTS**

I, Roy Harker, declare as follows:

1. I am the Executive Director of AGLP: The Association of LGBTQ+ Psychiatrists ("AGLP").

2. I have been the sole staff person for AGLP for over twenty-five years, first as National Office Director for five years, then as Executive Director since 1999. I am an alumnus of Drexel and Temple Universities in Philadelphia, and completed the American Society of Association Executives ("ASAE") Association Executive Certification in February of 2018, the highest professional credential for those engaged in association management.

3. I am submitting this Declaration in support of Plaintiffs' motion for a preliminary injunction to prevent the 1557 Revised Rule, published by the Department of Health and Human Services on June 19, 2020 (the "Revised Rule"), from taking effect.

4. AGLP: The Association of LGBTQ+ Psychiatrists is a 501(c)(3) national membership nonprofit organization based in Philadelphia, Pennsylvania, and incorporated in Pennsylvania. AGLP is a community of psychiatrists that educates and advocates on lesbian, gay, bisexual, and transgender mental health issues. AGLP's goals are to foster a fuller understanding of LGBTQ+

mental health issues; research and advocate for the best mental health care for LGBTQ+ people; develop resources to promote LGBTQ+ mental health; create a welcoming, safe, nurturing, and accepting environment for members; and provide valuable and accessible services to our members. AGLP strives to be a community for the personal and professional growth of all LGBTQ+ psychiatrists, and to be the recognized expert on LGBTQ+ mental health issues.

5. AGLP (formerly known as the Association of Gay and Lesbian Psychiatrists) represents the interests of about 450 LGBTQ+ psychiatrists who are members of the association. AGLP was founded in the 1970s when gay and lesbian members of the American Psychiatric Association (APA) met secretly at the annual meetings. At that time, in most states, homosexuality could be used as cause to rescind someone's license to practice medicine. In 1973, the APA removed homosexuality as a mental disorder from its Diagnostic and Statistical Manual of Mental Disorders (DSM). This allowed a more open association of lesbian and gay psychiatrists, who could be a little less fearful for their jobs if they were found out to be gay. Similarly, in 2012, the APA removed the term "Gender Identity Disorder," which had historically been used by mental health professionals to diagnose transgender individuals, from the DSM and instead added the term "Gender Dysphoria." The reason for the change was to emphasize that a person's identity is not disordered, but rather focus on the clinically significant distress they may suffer as a result of their experiences. The World Health Organization then removed gender dysphoria from psychiatric diagnosis in 2019. Even today, however, the mission of providing support and a safe space for LGBTQ psychiatrists to meet continues to be important to many of AGLP's members. AGLP is the oldest organized association of LGBTQ professionals in the country.

6. AGLP is an independent organization from American Psychiatric Association ("APA"), but works closely with APA through many projects, including but not limited to,

LGBTQ+ representation on the APA Assembly (the Minority Caucus of the APA and AGLP's own representative), APA position statements, LGBTQ+ Committees of the DSM, the creation and staffing of an AIDS Committee, and research and advocacy of particular interest to LGBTQ+ people through their quarterly *Journal of Gay and Lesbian Mental Health*, and seminars and discussion groups that are conducted concurrently with the APA's annual meeting. AGLP works within the APA to influence policies relevant to LGBTQ+ people, including issuing position statements educating about how discrimination and stigmatization of LGBTQ+ people adversely affects their mental health and right to happiness, as well as bringing awareness to and advocating against the misuse of religion to discriminate against LGBTQ+ people.

7. AGLP continues to work with APA and independently to support our members and advocate for LGBTQ+ patients. AGLP also assists medical students and residents in their professional development, encourages and facilitates the presentation of programs and publications relevant to gay and lesbian concerns at professional meetings; and serves as liaison with other minority and advocacy groups within the psychiatric community.

8. The Revised Rule fosters greater discrimination against LGBTQ+ patients, who already experience widespread discrimination in accessing health care. This discrimination increases negative health outcomes and results in health disparities in comparison to the non-LGBTQ+ population. AGLP's members inform us that their LGBTQ patients and patients living with HIV report having experienced frequent discrimination by other health care providers and suffer from more acute medical conditions resulting from such discrimination and fear of seeking medically-necessary health care services. A nationally representative survey from 2017 showed that 68.5% of LGBTQ people who experienced discrimination in the past year said it negatively

affected their psychological well-being, while 43.7% said it negatively affected their physical well-being.[1]

9. In addition, a large percentage of AGLP members' experiences are consistent with research findings that transgender patients report having negative experiences related to their gender identity when seeking medical care. A survey of almost 28,000 transgender people conducted in 2015 found that 33% of respondents had experienced a negative interaction with a health care provider because of their gender identity in the year preceding the survey.[2]

10. In comparison to other populations, LGBTQ patients face significant health disparities. For example, a nationally representative survey to collect data on sexual orientation found LGB people were at heightened risk of psychological distress, drinking, and smoking, and lesbian and bisexual women were at heightened risk of having multiple chronic conditions.[3] Data has also shown that transgender people in the United States are more likely to be overweight, be depressed, report cognitive difficulties, and forego treatment for health problems than cisgender people.

11. The Revised Rule will result in greater discrimination against LGBTQ+ patients, including those of AGLP's members, and in increased denials of services in violation of medical ethics and standards of care. The Revised Rule presents a direct conflict with nondiscrimination standards adopted by all the major health-professional associations, who have already recognized

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[1] Sejal Singh & Laura E. Durso, "Widespread Discrimination Continues to Shape LGBT People's Lives in Both Subtle and Significant Ways," *Center for American Progress*, May 2, 2017, https://www.americanprogress.org/issues/lgbt/news/2017/05/02/429529/widespread-discrimination-continues-shape-lgbt-peoples-lives-subtle-significant-ways.

[2] Sandy James et al., *Executive Summary of the Report of the 2015 U.S. Transgender Survey*, National Center for Transgender Equality (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Executive-Summary-Dec17.pdf.

[3] Human Rights Watch, "You Don't Want Second Best": Anti-LGBT Discrimination in US Health Care (2018), https://www.hrw.org/report/2018/07/23/you-dont-want-second-best/anti-lgbt-discrimination-us-health-care.

the need to ensure LGBTQ+ patients are treated with respect and without bias or discrimination in hospitals, clinics, and other health care settings. All of the leading health-professional associations—including the American Medical Association, American Osteopathic Association, American Academy of Physician Assistants, American Nurses Association, American Academy of Nursing, American College of Physicians, American College of Obstetricians and Gynecologists, American Psychiatric Association, American Academy of Pediatricians, American Academy of Family Physicians, American Public Health Association, American Psychological Association, National Association of Social Workers, and many more—have adopted policies articulating that health care providers should not discriminate in providing care for patients and clients because of their sexual orientation or gender identity.

12. There is a consensus amongst scientists that gender identity is part of the natural spectrum of human experience and expression. This includes major medical organizations like the APA. Transgender and gender nonconforming people have been marginalized and continue to fight for basic civil rights. Discrimination and harassment are especially significant sources of stress for transgender youth who are navigating an especially challenging period of their life and are vulnerable to depression and suicide when not supported by family and schools. This is especially true when even their health care providers, the people whom they turn to in their most vulnerable times of need, discriminate against them or deny them care. As an organization of psychiatrists who often serve and care for patients who are LGBTQ+, AGLP knows that discrimination against LGBTQ+ individuals in health care access and coverage remains a pervasive problem. Discrimination by health care providers has been detrimental to the health of LGBTQ patients, and these harms would be exacerbated by the Revised Rule.

13. AGLP has long strongly held and publicly asserted that all people, whether LGBTQ+ or not, deserve equal rights under federal law and the Constitution; that religious liberty justifications for denying health care are thinly disguised efforts to return to marginalization and stigmatization of same-sex and transgender orientations and identities; that virtually every major mental-health organization has concluded that there is no credible scientific evidence that LGBTQ+ citizens are psychologically impaired *per se* or can change who they are; that LGBTQ+ citizens represent no more burden on American society than any other minority group, and, in fact, have made substantive contributions to the arts, sciences, and businesses in America; and that discrimination and stigmatization of LGBTQ+ citizens adversely affects their mental health and right to happiness. Therefore, AGLP steadfastly condemns all legislative and administrative efforts, including the Revised Rule, to deny access to health care to and discriminate against LGBTQ+ citizens.

14. The Revised Rule eliminates the definition of "on the basis of sex" and the specific regulatory prohibition of discrimination on the basis of gender identity, transgender status, and failure to conform to sex stereotypes. The Revised Rule also eliminates specific regulatory provisions related to discrimination against transgender individuals, as well as the provision relating to the discrimination on the basis of association. The elimination of these provisions, in addition to the Revised Rule's invitation to health care providers to discriminate based on their religious or moral beliefs, will result in direct harms to the LGBTQ+ patients that our members serve and to our members who advocate on behalf of their patients and condemn discrimination resulting from the Revised Rule. Additionally, our members' workloads will increase as a result of the Revised Rule because more LGBTQ+ patients will seek out their care as a result of discrimination or fear of discrimination from other, non-affirming providers. By inviting

discrimination against patients based on patients' sexual orientation, gender identity, or transgender status, the Revised Rule cannot be reconciled with the ethical standards that health care professionals are charged to uphold.

15. If not enjoined, the Revised Rule will harm AGLP members, LGBTQ+ patients whose interests AGLP also represents, and the patients who AGLP members treat. The Revised Rule invites health care facilities to discriminate against LGBTQ+ employees and patients without concern about the impact on ensuring the provision of medically necessary care for patients, adherence with medical standards of care, ethical requirements, accreditation requirements, and nondiscrimination requirements in employment and in the provision of patient care. The Revised Rule, therefore, frustrates AGLP's mission of achieving and enforcing safe workspaces for LGBTQ+ psychiatrists and nondiscriminatory health care services to AGLP members' LGBTQ+ patients. The Revised Rule frustrates AGLP's mission of advocating for nondiscrimination standards of care for patients and nondiscriminatory work environments for its members that protect against discrimination on the basis of sexual orientation and gender identity and advocating for cultural competency standards of care for treatment of LGBTQ+ patients.

16. The 2016 Final Rule, promulgated by HHS in 2016 pursuant to Section 1557 of the ACA, prohibits discrimination with regards to certain terms or benefits of employment, including employee health benefit programs. As a result of the Revised Rule, some of AGLP's LGBTQ+ members could lose regulatory protections from discrimination regarding these employment benefits as their employers are covered entities under the Revised Rule but not large enough to be subject to Title VII of the Civil Rights Act.

17. Similarly, some members of AGLP who are employed by religiously-affiliated health care organizations may be subjected to discrimination as a result of the Revised Rule, whose

incorporation of overly broad religious exemptions are inapposite in the health care context and conflict and also conflict with Title VII. AGLP has members who are medical directors and administrators in hospitals and clinics all over the country and, in the course of their employment, these health care providers treat LGBTQ+ patients. The Revised Rule invites religiously-affiliated health care employers to discriminate against employees who are AGLP members for adhering to their medical and ethical obligations to treat all patients in a nondiscriminatory manner, including providing all medically necessary care in the patient's best interest, and for advocating on behalf of patients who are discriminated against by other providers or their employers. The Revised Rule impinges on and conflicts with AGLP members' medical and ethical obligations as health care providers and harms the patients that they serve.

18. AGLP members and their LGBTQ+ patients are stigmatized and demeaned by the message communicated by the Revised Rule that their government privileges beliefs that result in the disapproval and disparagement of LGBTQ+ people in the health care context and refused to protect LGBTQ+ people from discrimination in health care. The Revised Rule invites discrimination against AGLP members as well as their LGBTQ+ patients.

19. Based on their years of working with LGBTQ+ patients who have reported concealing their identities out of fear of discrimination, AGLP members know that the Rule will cause LGBTQ patients to attempt to hide their LGBTQ identities when seeking health care services, especially from religiously-affiliated health care organizations, in order to avoid discrimination. When patients are unwilling to disclose their sexual orientation and/or gender identity to health care providers out of fear of discrimination and being refused treatment, their mental and physical health is critically compromised.

20. AGLP will need to be a resource to its members and their patients, who may be in need of medical services but may no longer know where to go for LGBTQ+-affirming health care as a result of the Revised Rule. The Revised Rule will predictably result in more discrimination and denials of care, and, consequently, more requests for referrals. With an increase in referral requests as a result of the Revised Rule, AGLP will need to allocate additional resources to assisting AGLP members and their patients with health care referrals. AGLP offers an online referral service to patients seeking LGBTQ+-affirming psychotherapy, support, and psychiatric treatment. The Revised Rule adversely impacts AGLP by necessitating the diversion and reallocation of resources in order to provide referrals to increasing numbers of patients. The Revised Rule will make it more difficult and resource-intensive for AGLP to locate and monitor appropriate referrals that will not cause further harm to AGLP patients who have already been discriminated against or who fear discrimination on the basis of objections to the patients' gender identities or sexual orientation. AGLP will have to update its online referral search engine, especially because many health care providers currently listed on the website are affiliated with religious hospitals and organization. As a result of the Revised Rule, AGLP will have to allocate additional staff time to support the increase in referral requests.

21. AGLP will be required to expend its resources to educate and assist its members and the LGBTQ+ patients its members serve to defend against the harms that the Revised Rule causes. AGLP has been working with other medical and health associations, including the APA, to express disapproval of the Revised Rule. Such work has diverted resources away from other proactive projects and outreach efforts that are core to AGLP's mission. AGLP will also spend resources answering AGLP members' inquiries about the Revised Rule given the pervasive and real concern

that the Revised Rule invites behavior that contradicts medical ethical requirements and standards of care.

22. The Revised Rule empowers and invites discrimination against AGLP members and their patients and will create discriminatory work environments for AGLP members. AGLP, in turn, sees and will continue seeing an increase in psychiatrists seeking its assistance with addressing such discrimination. AGLP will need to help its members navigate through these hostile environments and may need to intervene on behalf of its members when necessary. The increased demand for such services will further hamper AGLP's other work because AGLP already has a very limited bandwidth for such services.

[*Signature on next page.*]

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

Dated this 6th day of July, 2020.

Roy Harker

Roy Harker

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WHITMAN-WALKER CLINIC, INC., *et al.*, *Plaintiffs,* v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, *Defendants.*	Case No. 1:20-cv-01630

DECLARATION OF DR. DEBORAH FABIAN, MD

I, Deborah Fabian, declare as follows:

1. I am a 70-year-old transgender woman.

2. I am an orthopedic surgeon and an employee of the Indian Health Service, a health care agency within the U.S. Department of Health and Human Services ("HHS"). The Indian Health Service is responsible for providing federal health care services to Native Americans and Alaska Natives.

3. I received my medical degree from Hahnemann Medical College (now part of Drexel University College of Medicine) in Pennsylvania in 1975. I was a resident in general surgery (1975-77), and later orthopedic surgery (1980-83) at Dartmouth Medical School in New Hampshire. I am board certified by the American Board of Orthopedic Surgery and am a Fellow in the American Academy of Orthopedic Surgeons.

4. I served in active duty in the United States Navy from 1977 to 1980, and served in the active reserves from 1991 to 1997.

5. I am a member of GLMA: Health Professionals Advancing LGBTQ Equality.

6. I currently work as an orthopedic surgeon at Gallup Indian Medical Center ("GIMC"), a 99-bed hospital in Gallup, New Mexico run by the Indian Health Service. GIMC is on the border of the Navajo Nation. Our patient population is over 99% Native Americans, primarily Navajo, as well as Apache and Pueblo. Clinical specialties at GIMC include Internal Medicine, Cardiology, Anesthesia, OB/GYN, General Surgery, Orthopedics, Ophthalmology, ENT, Radiology, Pathology, Pediatrics, Psychiatry, Emergency Medicine, and Urology. GIMC is the only hospital that provides these specialty health care services in over a 100-mile radius. The workload at GIMC is one of the largest within the Indian Health Service with 250,000 outpatient encounters and 5,800 inpatient admissions annually.

7. I am submitting this Declaration in support of Plaintiffs' Motion for a Preliminary Injunction to prevent the revised regulation under Section 1557 of the Affordable Care Act ("ACA"), published by HHS on June 19, 2020 (the "Revised Rule"), from taking effect. The Revised Rule eliminates explicit regulatory protections for LGBTQ people in health care that were included in the original regulation under Section 1557, which was promulgated in May 2016 ("2016 Final Rule").

8. I have practiced orthopedic surgery for nearly 40 years, including as the Chief of Surgery at Metrowest Medical Center in Framingham, Massachusetts.

9. I began to transition to live as the woman that I am in 2009. I was fortunate to have the loving support of my wife and family during this process. I began fully presenting as female in all aspects of my life, including my medical practice, in 2011.

10. As a result, however, my medical practice suffered and, notwithstanding my years of experience and credentials, it was difficult for me to secure employment as a transgender woman.

11. Women—let alone transgender women—are a rarity in the highly-specialized field of orthopedic surgery, where, according to a 2018 report from the Association of American Medical Colleges, women make up just 5% of the active physicians in orthopedic surgery.[1]

12. Based on my experience, I have a deep appreciation for the legal understanding that discrimination based on transgender status is discrimination based on sex. In March 2016, in a case in which I was a plaintiff, a federal district court held that "Employment discrimination on the basis of transgender identity is employment discrimination 'because of sex' and constitutes a violation of Title VII of the Civil Rights Act." *Fabian*, 172 F. Supp. 3d 509, 527 (D. Conn. 2016). This ruling is consistent with the 2016 Final Rule promulgated by HHS a few months later.

13. Having encountered difficulty securing employment after my transition to live openly as a transgender woman, I was finally able to secure employment as an orthopedic surgeon at Bayne-Jones Army Community Hospital at Fort Polk, a United States Army base in Vernon Parish, Louisiana.

14. Living and working in health care as a transgender woman in Louisiana was not easy.

15. I have had numerous former colleagues at Fort Polk tell me they did not want me to work there or were apprehensive about my becoming their colleague because of my transgender status, but that after meeting me and getting to see me work, they appreciated me as a colleague.

16. I encountered more overt forms of discrimination as well. In early 2017, following the start of the Trump Administration, a colleague rose up to speak during an all-staff meeting at the hospital at Fort Polk. There were approximately 350-400 staff members at this meeting. This

[1] Association of American Medical Colleges, *Physician Specialty Data Report: Active Physicians by Sex and Specialty, 2017* (2018), https://www.aamc.org/data-reports/workforce/interactive-data/active-physicians-sex-and-specialty-2017.

colleague then proceeded to refer to me by male pronouns—misgendering me—and to say that I was "disgusting" and that "God thinks you're disgusting."

17. In 2018, I moved to New Mexico and began working as an orthopedic surgeon at GIMC.

18. As a transgender physician, HHS's announcement of the Revised Rule has caused me a great deal of distress and frustration. Having had personal experience with discrimination and having had my right to be free from such discrimination recognized by a court because discrimination based on transgender status is discrimination based on sex, I have a unique appreciation for the regulatory protections contained in the 2016 Final Rule and what they mean for health care professionals like myself and for our LGBTQ patients.

19. As a result of the Revised Rule, I worry that LGBTQ health care professionals and patients will now face more discrimination in the course of their employment and health care, respectively. Indeed, the Revised Rule invites such discrimination and adopts the narrow view of discrimination "on the basis of sex" that was rejected in my case in 2016.

20. I also worry that the Revised Rule will cause patients to delay necessary health care as a result of fear of discrimination. This in turn will have negative health outcomes for the patients, whose conditions may worsen and become more acute.

21. In addition, the Revised Rule no longer treats the Indian Health Service, of which GIMC is a part, as a covered entity under Section 1557 of the ACA. This means that health care professionals like myself and our patients, including LGBTQ patients, will no longer, according to HHS, be protected from discrimination in health care pursuant to Section 1557. And while New Mexico has explicit statutory protections from discrimination based on sexual orientation and gender identity, such protections are inapplicable to a federal entity like GIMC.

22. GIMC provides health care services, including gender affirming care, to approximately 100-150 transgender, gender nonconforming, and two-spirit Native American patients. I have asked GIMC management what the Revised Rule will mean for these patients and whether GIMC will commit publicly not to discriminate on the basis of sexual orientation, gender identity, or transgender status. To date, I have been told only that GIMC is part of HHS and they cannot contradict what HHS has said.

23. I am particularly worried about how the Revised Rule will affect GIMC's and our nation's efforts to stem the COVID-19 pandemic.

24. GIMC has already seen a large shift in how it operates as a result of the COVID-19 pandemic. Over 90% of the hospital beds GIMC are currently full as a result of COVID-19. GIMC has also stopped providing some of its specialty services, directing patients to hospitals that are at least 2 hours away, and my colleagues and I have mostly been working on COVID-19 testing and the treatment of patients who test positive for COVID-19 and develop symptoms.

25. Just a couple of weeks ago, one of my transgender patients tested positive for COVID-19. I worry about what may happen to this patient if the Revised Rule were allowed to take effect and she were to develop COVID-19 symptoms.

* * * * *

26. As a health care professional, I have experienced discrimination on the basis of my transgender status. The Revised Rule defies the legal and medical understanding of discrimination "on the basis of sex," an understanding that encompasses discrimination based on gender identity or transgender status and from which I have previously benefited. The Revised Rule poses serious and ongoing threats to the health and overall wellbeing of transgender, gender nonconforming, and two-spirit people, including those I care for at GIMC.

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

Dated this 5 day of July, 2020.

Deborah Fabian, MD

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WHITMAN-WALKER CLINIC, INC., *et al.*, *Plaintiffs,* v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, *Defendants*.	Case No. 1:20-cv-1630

EXPERT DECLARATION OF DR. RANDI C. ETTNER, Ph.D.

I, Dr. Randi C. Ettner, declare as follows:

1. I am a licensed clinical and forensic psychologist with expertise concerning the diagnosis and treatment of gender dysphoria.

2. I have been retained by counsel for Plaintiffs Whitman-Walker Clinic, Inc. d/b/a Whitman-Walker Health, The TransLatin@ Coalition, Los Angeles LGBT Center, Bradbury-Sullivan LGBT Community Center, American Association of Physicians for Human Rights d/b/a GLMA: Health Professionals Advancing LGBTQ Equality, AGLP: The Association of LGBTQ+ Psychiatrists, Dr. Sarah Henn, Dr. Randy Pumphrey, Dr. Robert Bolan, and Dr. Ward Carpenter as an expert in connection with the above-captioned matter.

3. I submit this declaration in support of Plaintiffs' motion for a preliminary injunction to prevent the revised regulation under Section 1557, published by the U.S. Department of Health and Human Services ("HHS") on June 19, 2020 (the "Revised Rule"), from taking effect.

4. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

5. I prepared this declaration to set forth the opinions to which I may testify in this case and the bases for my opinions. The opinions expressed in this declaration are based on the information that I have reviewed to date. I reserve the right to revise and supplement this report if any new information becomes available in the future.

6. A copy of my curriculum vitae is attached to this declaration as **Exhibit A**. Materials that I considered in forming my opinions are listed in **Exhibit B** or referenced in this report.

7. The content and opinions set forth in this declaration reflect in large part information I conveyed to Defendant Roger Severino, Director of the Office of Civil Rights of HHS, and other members of his staff in November 2017 in a "listening session" Mr. Severino held regarding the health care needs of transgender people and the medical treatment of gender dysphoria. Documentation of my participation in this listening session is attached hereto as **Exhibit C**.

I. BACKGROUND AND QUALIFICATIONS

Qualifications and Basis for Opinion

8. I received my doctorate in psychology (with honors) from Northwestern University in 1979. I am a Fellow and Diplomate in Clinical Evaluation of the American Board of Psychological Specialties, and a Fellow and Diplomate in Trauma/Posttraumatic Stress Disorder (PTSD).

9. I was the chief psychologist at the Chicago Gender Center from 2005 to 2016, when it moved to Weiss Memorial Hospital. Since that time, I have held the sole psychologist position at the Center for Gender Confirmation Surgery at Weiss Memorial Hospital. The center specializes in the treatment of individuals with gender dysphoria.

10. I have been involved in the treatment of patients with gender dysphoria since 1977, when I was an intern at Cook County Hospital in Chicago. Over the course of my career, I have evaluated, diagnosed, and treated between 2,500 and 3,000 individuals with gender dysphoria and mental health issues related to gender variance.

11. I have published four books related to the treatment of individuals with gender dysphoria, including the medical text entitled *Principles of Transgender Medicine and Surgery* first edition (Ettner, Monstrey & Eyler, 2007) and second edition (Ettner, Monstrey & Coleman, 2016). I have also authored numerous articles in peer-reviewed journals regarding the provision of health care to this population. I serve as a member of the editorial boards for the International Journal of Transgenderism and Transgender Health.

12. I am the Secretary and member of the Executive Board of Directors of the World Professional Association for Transgender Health ("WPATH") and an author of the *WPATH Standards of Care for the Health of Transsexual, Transgender and Gender-nonconforming People* (7th version), published in 2011. The WPATH-promulgated *Standards of Care* ("*Standards of Care*") are the internationally recognized guidelines for the treatment of persons with gender dysphoria and serve to inform medical treatment in the United States and throughout the world.

13. I have lectured throughout North America, South America, Europe, and Asia on topics related to gender dysphoria and present grand rounds on gender dysphoria at university hospitals. I have been an invited guest at the National Institute of Health to participate in developing a strategic research plan to advance the health of sexual and gender minorities, and I received a commendation from the United States Congress House of Representatives on February 5, 2019 recognizing my work for WPATH and on gender dysphoria in Illinois.

14. I have been retained as an expert regarding gender dysphoria and its treatment in multiple court cases in both state and federal courts as well as administrative proceedings, and have repeatedly qualified as an expert. I have also been a consultant regarding appropriate care for incarcerated transgender people and for transgender people enrolled in Medicaid in the state of Illinois.

15. My Curriculum Vitae, attached hereto as **Exhibit A**, further documents my education, training, research, and years of experience in this field.

16. A bibliography of the materials reviewed in connection with this declaration is attached hereto as **Exhibit B**. The sources cited therein are authoritative, scientific peer-reviewed publications. I generally rely on these materials when I provide expert testimony, and they include the documents specifically cited as supportive examples in particular sections of this declaration. The materials I have relied on in preparing this declaration are the same type of materials that experts in my field of study regularly rely upon when forming opinions on the subject.

Compensation

17. I am being compensated for my work on this matter at a rate of $375.00 per hour for preparation of declarations and expert reports. I will be compensated $500.00 per hour for any pre-deposition and/or pre-trial preparation and any deposition testimony or trial testimony. I will receive a flat fee of $2,500.00 for any travel time to attend deposition or trial, and will be reimbursed for reasonable out-of-pocket travel expenses incurred for the purpose of providing expert testimony in this matter. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

Previous Testimony

18. In the last four years, I have testified as an expert at trial or by deposition in the following cases: *Eller v. Prince George's Cty. Public Sch.*, No. 8:18-cv-03649-TDC (D. Md. 2020); *Ray v. Acton*, No. 2:18-cv-00272 (S.D. Ohio 2019); *Monroe v. Jeffreys*, No. 3:18-cv-00156-NJR-MAB (S.D. Ill. 2019); *Soneeya v. Turco*, No. 07-12325-DPW (D. Mass. 2019); *Edmo v. Idaho Dep't of Correction*, No. 1:17-CV-00151-BLW, 2018 WL 2745898 (D. Idaho 2018); *Carillo v U.S. Dep't of Justice Exec.* (Office of Immig. Rev. 2017); *Broussard v. First Tower Loan, LLC*, 135 F. Supp. 3d 540 (E.D. La. 2016); *Faiella v. American Medical Response of Connecticut, Inc.*, No. HHD-CV15-6061263-S (Conn. Super. Ct. 2015).

II. EXPERT OPINIONS

Gender Identity and Gender Dysphoria

19. A person's sex is comprised of a number of components including, *inter alia*: chromosomal composition (detectible through karyotyping); gonads and internal reproductive organs (detectible by ultrasound, and occasionally by a physical pelvic exam); external genitalia (which are visible at birth); sexual differentiations in brain development and structure (detectible by functional magnetic resonance imaging studies and autopsy); and gender identity.

20. Gender identity is a well-established concept in medicine. Gender identity refers to a person's inner sense of belonging to a particular sex, such as male or female. It is a deeply felt and core component of human identity. All human beings develop this elemental internal view: the conviction of belonging to a particular gender, such as male or female. Gender identity is innate, has biological underpinnings, and is firmly established early in life.

21. When there is divergence between anatomy and identity, one's gender identity is paramount and the primary determinant of an individual's sex designation. Developmentally, it is

the overarching determinant of the self-system, influencing personality, a sense of mastery, relatedness, and emotional reactivity, across the life span. It is also the foremost predictor of satisfaction and quality of life. Efforts to change an individual's gender identity are harmful, futile, and unethical.

22. At birth, individuals are assigned a sex, typically male or female, based solely on the appearance of their external genitalia. For most people, that assignment turns out to be accurate, and their birth-assigned sex matches that person's actual sex. However, for transgender individuals, this is not the case.

23. For transgender individuals, the sense of one's self—one's gender identity—differs from the sex they were assigned at birth, giving rise to a sense of being "wrongly embodied."

24. The medical diagnosis for that feeling of incongruence and accompanying distress is gender dysphoria, a serious medical condition, formerly known as gender identity disorder ("GID"). Gender Dysphoria is a diagnosis codified in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* ("DSM-5").

25. The critical element of the Gender Dysphoria diagnosis is the presence of symptoms that meet the threshold for clinical impairment. This represents a change from GID, which focused on an individual's *identity* being disordered. This new diagnostic term, Gender Dysphoria, is also an acknowledgment that gender incongruence, in and of itself, does not constitute a mental disorder. As recently as June 16, 2018, the World Health Organization ("WHO") likewise announced it was reclassifying the gender incongruence diagnosis in the forthcoming International Classification of Diseases-11 ("ICD-11"). This is significant because it removes "gender identity disorder" from the chapter on mental and behavioral disorders,

recognizing that gender incongruence is not a mental illness, and instead incorporates it within a new chapter dedicated to sexual health.

26. Gender dysphoria is characterized by incongruence between one's experienced/expressed gender and assigned sex at birth, and clinically significant distress or impairment of functioning that results. Gender dysphoria is manifested by symptoms such as preoccupation with ridding oneself of the primary and/or secondary sex characteristics associated with one's birth-assigned sex. Untreated gender dysphoria can result in significant clinical distress, debilitating depression, and suicidality.

27. The diagnostic criteria for gender dysphoria in adults are as follows:

a. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 month's duration, as manifested by at least two of the following:

   i. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics.

   ii. A strong desire to be rid of one's primary and/or secondary sex characteristics.

   iii. A strong desire for the primary and/or secondary sex characteristics of the other gender.

   iv. A strong desire to be of the other gender.

   v. A strong desire to be treated as the other gender.

   vi. A strong conviction that one has the typical feelings and reactions of the other gender.

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

28. Gender dysphoria is a highly treatable condition. Without treatment, however, individuals with gender dysphoria experience anxiety, depression, suicidality, and other attendant mental health issues. They are also frequently isolated because they carry a burden of shame and low self-esteem, attributable to the feeling of being inherently "defective." This leads to stigmatization, and over time, ravages healthy personality development and interpersonal relationships. As a result, without treatment many such individuals are unable to function effectively in daily life. Studies show a 41%-43% rate of suicide attempts among this population, far above the baseline for North America (Haas et al., 2014).

29. Gender dysphoric patients who are assigned a male sex at birth but identify as female and lack access to appropriate care are often so desperate for relief that they may resort to life-threatening attempts at auto-castration—removal of the testicles—in the hopes of eliminating the major source of testosterone that kindles the distress (Brown, 2010; Brown & McDuffie, 2009).

30. Gender dysphoria generally intensifies with age. As gender dysphoric individuals approach middle age, they experience an exacerbation of symptoms (Ettner, 2013; Ettner & Wiley, 2013).

Treatment of Gender Dysphoria

31. The standards of care for treating gender dysphoria are set forth in the WPATH *Standards of Care*, first published in 1979. The *Standards of Care* are the internationally recognized guidelines for the treatment of persons with gender dysphoria, and inform medical treatment throughout the world, and in this country. The American Medical Association, the Endocrine Society, the American Psychological Association the American Psychiatric

Association, the World Health Organization, the American Academy of Family Physicians, the American Public Health Association, the National Association of Social Workers, the American College of Obstetrics and Gynecology and the American Society of Plastic Surgeons all endorse protocols in accordance with the WPATH standards. *See*, *e.g.*, American Medical Association (2008) Resolution 122 (A-08); *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline* (2017); American Psychological Association Policy Statement on Transgender, Gender Identity & Gender Expression Non-discrimination (2008).

32. The Standards of Care identify the following evidence-based protocols for the treatment of individuals with gender dysphoria:

- Changes in gender expression and role, consistent with one's gender identity (social role transition)
- Psychotherapy for purposes such as addressing the negative impact of stigma, alleviating internalized transphobia, enhancing social and peer support, improving body image, promoting resiliency, etc.
- Hormone therapy to feminize or masculinize the body
- Surgery to alter primary and/or secondary sex characteristics (e.g., breasts, external genitalia, facial features, body contouring)

33. The ability to live in a manner consistent with one's gender identity is critical to a person's health and well-being and is a key aspect in the treatment of gender dysphoria. The process by which transgender people come to live in a manner consistent with their gender identity, rather than the sex they were assigned at birth, is known as transition. The steps that each

transgender person takes to transition are not identical. Whether any particular treatment is medically necessary or even appropriate depends on the medical needs of the individual.

34. Once a diagnosis is established, a treatment plan should be developed based on the individualized assessment of the medical needs of the patient. WPATH specifies that treatment plans and provision of care must be undertaken by qualified professionals, with established competencies in the treatment of gender dysphoria.

35. **Psychotherapy:** Psychotherapy can provide support and help with many issues that arise in tandem with gender dysphoria. However, psychotherapy alone is not a substitute for medical intervention when medical interventions are required, nor is it a precondition for medically indicated treatment. By analogy, counseling can be useful for patients with diabetes by providing psychoeducation about living with chronic illness and nutritional information, but counseling does not obviate the need for insulin.

36. **Social Role Transition:** The *Standards of Care* establish the therapeutic importance of changes in gender expression and presentation—the ability to feminize or masculinize one's appearance—as a critical component of treatment. Known as the "real life experience," it requires dressing, grooming, and otherwise conveying, via social signifiers, a public face and role consistent with one's gender identity. This is an appropriate and essential part of identity consolidation. Through this experience, the transgender individual can begin to address the shame some experience of growing up living as a "false self" and the grief of being born in the "wrong body." (Greenberg and Laurence, 1981; Ettner, 1999; Devor, 2004; Bockting, 2007.)

37. **Hormone Therapy:** For individuals with persistent, well-documented gender dysphoria, hormone therapy is an essential, medically indicated treatment to alleviate the distress of the condition. Cross sex hormone administration is a well-established and effective treatment

modality for gender dysphoria. The American Medical Association, the Endocrine Society, the American Psychiatric Association and the American Psychological Association all concur that hormone therapy, provided in accordance with the WPATH *Standards of Care*, is the medically necessary, evidence-based, best practice care for most patients with gender dysphoria.

38. The goals of hormone therapy are (1) to significantly reduce hormone production associated with the person's birth sex, causing the unwanted secondary sex characteristics to recede, and (2) to replace the natal, circulating sex hormones with either feminizing or masculinizing hormones, using the principles of hormone replacement treatment developed for hypogonadal patients (i.e. those born with insufficient sex steroid hormones). *See Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline* (2017); *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline* (2009).

39. The therapeutic effects of hormone therapy are twofold: (1) with endocrine treatment, the patient acquires congruent secondary sex characteristics, i.e., breast development, redistribution of body fat, cessation of male pattern baldness, and reduction of body hair; and (2) hormones act directly on the brain, via receptor sites, attenuating the dysphoria and attendant psychiatric symptoms, and promoting a sense of well-being.

40. For many patients, hormones alone will not provide sufficient breast development to approximate the female torso. For these patients, breast augmentation has a dramatic, irreplaceable, and permanent effect on reducing gender dysphoria, and thus unquestionable therapeutic results.

41. **Surgical Treatment:** For individuals with severe gender dysphoria, hormone therapy alone is insufficient. In these cases, dysphoria does not abate without surgical intervention.

For transgender women, genital confirmation surgery has two therapeutic purposes. First, removal of the testicles eliminates the major source of testosterone in the body. Second, the patient attains body congruence resulting from the normal appearing and functioning female uro-genital structures. Both outcomes are crucial in attenuating or eliminating gender dysphoria. Additionally, breast augmentation procedures play the critical role in treatment mentioned in the paragraph immediately above.

42. Decades of methodologically sound and rigorous scientific research have demonstrated that gender confirmation surgery is a safe and effective treatment for severe gender dysphoria and, indeed, for many, it is the only effective treatment. The American Medical Association, the Endocrine Society, the American Psychological Association, and the American Psychiatric Association all endorse surgical therapy, in accordance with the WPATH *Standards of Care*, as medically necessary treatment for individuals with severe gender dysphoria. *See* American Medical Association (2008), Resolution 122 (A-08); *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline* (2017) ("For many transgender adults, genital gender-affirming surgery may be the necessary step toward achieving their ultimate goal of living successfully in their desired gender role."); American Psychological Association *Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination* (2009) (recognizing "the efficacy, benefit and medical necessity of gender transition treatments" and referencing studies demonstrating the effectiveness of sex-reassignment surgeries).

43. Surgeries are considered "effective" from a medical perspective, if they "have a therapeutic effect" (Monstrey et al. 2007). More than three decades of research confirms that gender confirmation surgery is therapeutic and therefore an effective treatment for gender

dysphoria. Indeed, for many patients with severe gender dysphoria, gender confirmation surgery is the only effective treatment.

44. In a 1998 meta-analysis, Pfafflin and Junge reviewed data from 80 studies, from 12 countries, spanning 30 years. They concluded that "reassignment procedures were effective in relieving gender dysphoria. There were few negative consequences and all aspects of the reassignment process contributed to overwhelmingly positive outcomes" (Pfafflin & Junge 1998).

45. Numerous subsequent studies confirm this conclusion. Researchers reporting on a large-scale prospective study of 325 individuals in the Netherlands concluded that after surgery there was "a virtual absence of gender dysphoria" in the cohort and "results substantiate previous conclusions that sex reassignment is effective" (Smith et al. 2005). Indeed, the authors of the study concluded that the surgery "appeared therapeutic and beneficial" across a wide spectrum of factors and "[t]he main symptom for which the patients had requested treatment, gender dysphoria, had decreased to such a degree that it had disappeared."

46. As a general matter, patient satisfaction is a relevant measure of effective treatment. Achieving functional and normal physical appearance consistent with gender identity alleviates the suffering of gender dysphoria and enables the patient to function in everyday life. Studies have shown that by alleviating the suffering and dysfunction caused by severe gender dysphoria, gender confirmation surgery improves virtually every facet of a patient's life. This includes satisfaction with interpersonal relationships and improved social functioning (Rehman et al., 1999; Johansson et al., 2010; Hepp et al.; 2002; Ainsworth & Spiegel, 2010; Smith et al., 2005); improvement in self-image and satisfaction with body and physical appearance (Lawrence, 2003; Smith et al., 2005; Weyers et al., 2009); and greater acceptance and integration into the family (Lobato et al., 2006).

47. Studies have also shown that surgery improves patients' abilities to initiate and maintain intimate relationships (Lobato et al., 2006; Lawrence, 2005; Lawrence, 2006; Imbimbo et al., 2009; Klein & Gorzalka, 2009; Jarolim et al., 2009; Smith et al., 2005; Rehman et al., 1999; DeCuypere et al., 2005).

48. Given the decades of extensive experience and research supporting the effectiveness of gender confirmation surgery, it is clear that reconstructive surgery is a medically necessary, not experimental, treatment for gender dysphoria. Therefore, decades of peer-reviewed research and a medical consensus support the inclusion of gender confirmation surgery as a medically necessary treatment in the WPATH *Standards of Care*.

49. In 2016 WPATH issued a "Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A." ("Position Statement"), affirming a statement originally issued in 2008. As the Position Statement explains, "These medical procedures and treatment protocols are not experimental: Decades of both clinical experience and medical research show they are essential to achieving well-being for the transsexual patient."

50. Similarly, Resolution 122 (A-08) of the American Medical Association states: "Health experts in GID, including WPATH, have rejected the myth that these treatments are 'cosmetic' or 'experimental' and have recognized that these treatments can provide safe and effective treatment for a serious health condition."

51. On May 30, 2014, the Appellate Division of the Departmental Appeals Board of HHS issued decision number 2576, in which the Board determined that Medicare's policy barring coverage for transition-related surgeries was not valid under the "reasonableness standard." The Board found that the ban "was based principally on" a report from 1981 that has been rendered obsolete by numerous "medical studies published in the more than 32 years since issuance of the

1981 report." The Board specifically concluded that transition-related surgeries are "safe and effective and not experimental." As a result, Medicare's exclusion was struck down and Medicare was directed to consider surgeries on a case-by-case basis.

52. Transition-related health care (also known as gender-affirming health care), such a cross sex hormones or gender confirmation surgery (previously known as gender reassignment surgery), *are not* sterilization procedures because they are not performed for the purpose of contraception.

53. The overwhelming scientific evidence indicates that transition-related care, including gender confirmation surgery, is medically necessary for the treatment of gender dysphoria in some patients.

The Harmful Effects of the Revised Rule on Transgender People

54. On June 19, 2020, HHS issued that the Revised Rule, which removes robust regulatory nondiscrimination protections for LGBTQ people, particularly transgender people, in the provision of health care and health insurance.

55. The Revised Rule attempts to diminish nondiscrimination protections in health care and health insurance for vulnerable patients, which will result in both specific denials of medically-necessary care, including gender affirming health care, and more general discrimination against LGBTQ people in health care settings. In so doing, the Revised Rule poses lifelong health risks to transgender and gender nonconforming individuals, including depression, posttraumatic stress disorder, cardiovascular and other disease, premature death, and suicide.

56. In addition, the Revised Rule directly and negatively affects the health and wellbeing of LGBTQ people, particularly transgender people, by sending a governmental message that they are not worthy of protection, that their identities need not be recognized, and that their

health care needs may be disregarded. The governmental message directly communicated through the Revised Rule is likely to result in significant distress, hopelessness, hypervigilance, depression, generalized anxiety disorder, and trauma for LGBTQ people, and more specifically for transgender people (Brown & Keller, 2018; Gonzalez et al., 2018; Rostosky, 2010; Russell, et al., 2011; Veldhuis et al., 2017).

57. The overarching goal of treatment for gender dysphoria is to eliminate clinically significant distress by aligning an individual patient's body and presentation with their internal sense of self, thereby consolidating identity. Developing and integrating a positive sense of self-identity formation is a fundamental undertaking for all human beings. Denial of medically-indicated care to transgender people, whether based on moral or religious objections or on other animus toward transgender people, signals that such people are "inferior" or "unworthy," and triggers shame.

58. Denying gender affirming care not only frustrates those treatment goals, but exacerbates gender dysphoria and its associated depression and suicidality. Conversely, Bauer et al. found a 62% reduction in risk of suicide ideation with the completion of medical transition. That corresponds to a potential prevention of 240 suicide attempts per 1,000 per year. Longitudinal studies have also shown that gender confirmation surgery has been linked with a reduction in the need for mental health treatment for transgender patients (Branstrom, et al., 2019). Withholding this care results in serious negative health outcomes for transgender patients.

59. More broadly, the negative effects of discrimination impacts transgender people throughout their lives. A wealth of research establishes that transgender people suffer from discrimination, stigma, and shame. The "minority stress model" explains that the negative impact of the stress attached to being stigmatized is socially based. The stress process can be both external,

i.e., actual experiences of rejection and discrimination (enacted stigma), and because of such experiences, internal, *i.e.*, perceived rejection and the expectation of being rejected or discriminated against (felt stigma). A 2015 study of 28,000 transgender and gender nonconforming individuals found that 30% reported being fired, discriminated or otherwise experiencing mistreatment in the workplace (James, et al., 2016). Similarly, 31% of respondents had been mistreated in a public place, including 14% who were denied service, 24% who were verbally harassed and 2% who were physically attacked.

60. Experiencing discrimination, including in health care settings, has negative impacts on patients' mental health and wellbeing. This discrimination, which often occurs in the form of violence, abuse, or harassment, as well as the fear thereof, is thus directly related to negative health outcomes. A 2012 study of transgender adults found fear of discrimination increased the risk of developing hypertension by 100%, owing to the intersectionality of shame and cardiovascular reactivity. Another 2012 study of discrimination and implications for health concluded that "living in states with discriminatory policies … was associated with a statistically significant increase in the number of psychiatric disorder diagnoses." And a 2019 study found that experiencing discrimination in health care settings posed a unique risk factor for heightened suicidality among transgender individuals, a population already at heightened risk compared with the general population (Herman et al., 2019). These negative outcomes are exacerbated when people experience discrimination based on intersectional identities, such as LGBTQ Latinx individuals (Schmitz et al., 2019).

61. Until recently, it was not fully understood that these experiences of shame and discrimination could have serious and enduring consequences. But it is now known that marginalization, stigmatization, and victimization are some of the most powerful predictors of

current and future mental health problems, including the development of psychiatric disorders. The social problems that young transgender people face actually create the blueprint for future mental health, life satisfaction, and even physical health. A recent study of 245 gender-nonconforming adults found that stress and victimization during childhood and adolescence was associated with a greater risk for post-traumatic stress disorder, depression, life dissatisfaction, anxiety, and suicidality in adulthood. A 2011 Institute of Medicine (IOM) report concurs: "the marginalization of transgender people from society is having a devastating effect on their physical and mental health." And the American Journal of Public Health recently reported that more than half of transgender women "struggle with depression from the stigma, shame and isolation caused by how others treat them."

62. While a growing body of research documents that structural forms of stigma (namely, policies sanctioning discrimination) harm the health of transgender people, a 2010 study was the first to show that structural stigma is associated with *all-cause mortality* (i.e. deaths from any cause). In other words, stigma—a chronic source of psychological stress—disrupts physiological pathways, increasing disease vulnerability, and leading to premature death.

63. Adding to the corpus of research in this area is a relatively new approach to the investigation of the relationship between discrimination and health. Neuroscientists have discovered that, in addition to causing serious emotional difficulties and physical harms, discrimination, harassment, and verbal abuse permanently alter the architecture of the brain. Deviations in the myelin sheathing of the corpus callosum and damage to the hippocampus cause cognitive difficulties in individuals who have been routinely subjected to humiliation and ostracism (Nickel, 2018; Ohashi et al., 2017; Teicher et al., 2010).

64. Transgender individuals currently face significant discrimination in health care settings and barriers to care. Forty percent (40%) fear accessing care, and forego routine screening and preventative care. A 2017 report by the Center for American Progress of 7,500 transgender adults found 29 % were refused treatment based on their gender identity and 21 % were verbally abused when seeking healthcare. The report also found that transgender individuals often had to travel to other states to find medical providers. A 2018 survey of 6,450 participants found 24% were denied treatment in doctor's offices or hospitals, 13% in emergency rooms, 11% in mental health clinics and 5% for ambulance or emergency medical services. As a result, transgender individuals have poorer health, greater stress, and higher rates of obesity, even when compared to lesbian and gay populations. Indeed, 23% of respondents to a 2015 study did not see a doctor when they needed to because of fear of being mistreated as a transgender person. These findings led to the Association of American Medical Colleges to convene an advisory committee to develop curricula based on competencies for medical education.

65. By contrast, the existence of nondiscrimination protections for transgender patients results in better health outcomes. A newly released, multi-year study of nearly 29,000 transgender and gender diverse people found that in the year immediately following the implementation of nondiscrimination policies in private health insurance, both suicidality and inpatient mental health hospitalization rates decreased across the survey population (McDowell, et al., 2020). Maintaining nondiscrimination protections for transgender patients is critical for their health and wellbeing.

III. CONCLUSION

66. The Revised Rule endangers the health and wellbeing of LGBTQ people, particularly transgender people. Should it become effective, the Revised Rule will cause distress on these vulnerable populations, as well as increased fear, hopelessness, trauma, and

hypervigilance. These negative health consequences can become intractable. In addition, by diminishing protections from discrimination in health care and health insurance, the Revised Rule exposes transgender people to increased discrimination which negatively affects health, exacerbates minority stress, and results in the denial medically-necessary and life-saving health care. The harms that will befall transgender people are predictable and dire: the exacerbation of symptoms of gender dysphoria, grave damage to mental and physical health, and the undermining of clearly established, evidence-based treatment protocols.

* * * * *

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

Dated on this 2nd day of July, 2020.

Randi C Ettner PhD

Randi C. Ettner, Ph.D.

EXHIBIT A

Curriculum Vitae of Randi C. Ettner, Ph.D.

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POSITIONS HELD

Clinical Psychologist
Forensic Psychologist
Fellow and Diplomate in Clinical Evaluation, American Board of Psychological Specialties
Fellow and Diplomate in Trauma/PTSD
President, New Health Foundation Worldwide
Secretary, World Professional Association for Transgender Health (WPATH)
Chair, Committee for Institutionalized Persons, WPATH
Global Education Initiative Committee, WPATH
University of Minnesota Medical Foundation: Leadership Council
Psychologist, Center for Gender Confirmation Surgery, Weiss Memorial Hospital
Adjunct Faculty, Prescott College
Editorial Board, *International Journal of Transgender Health*
Editorial Board, *Transgender Health*
Television and radio guest (more than 100 national and international appearances)
Internationally syndicated columnist
Private practitioner
Medical adjunct staff; Department of Medicine: Weiss Memorial Hospital, Chicago IL
Advisory Council, National Center for Gender Spectrum Health

EDUCATION

PhD, 1979	Northwestern University (with honors) Evanston, Illinois
MA, 1976	Roosevelt University (with honors) Chicago, Illinois
BA, 1969-73	Indiana University Bloomington, Indiana Cum Laude Major: Clinical Psychology; Minor: Sociology
1972	Moray College of Education Edinburgh, Scotland International Education Program
1970	Harvard University Cambridge, Massachusetts Social Relations Undergraduate Summer Study Program in Group Dynamics and Processes

CLINICAL AND PROFESSIONAL EXPERIENCE

2016-present	Psychologist: Weiss Memorial Hospital Center for Gender Confirmation Surgery
	Consultant: Walgreens; Tawani Enterprises Private practitioner
2011	Instructor, Prescott College: Gender-A multidimensional approach
2000	Instructor, Illinois Professional School of Psychology
1995-present	Supervision of clinicians in counseling gender non conforming clients
1993	Post-doctoral continuing education with Dr. James Butcher in MMPI-2 Interpretation, University of Minnesota
1992	Continuing advanced tutorial with Dr. Leah Schaefer in psychotherapy
1983-1984	Staff psychologist, Women's Health Center, St. Francis Hospital, Evanston, Illinois
1981-1984	Instructor, Roosevelt University, Department of Psychology: Psychology of Women, Tests and Measurements, Clinical Psychology, Personal Growth, Personality Theories, Abnormal Psychology
1976-1978	Research Associate, Cook County Hospital, Chicago, Illinois, Department of Psychiatry
1975-1977	Clinical Internship, Cook County Hospital, Chicago, Illinois, Department of Psychiatry
1971	Research Associate, Department of Psychology, Indiana University
1970-1972	Teaching Assistant in Experimental and Introductory Psychology Department of Psychology, Indiana University
1969-1971	Experimental Psychology Laboratory Assistant, Department of Psychology, Indiana University

INVITED PRESENTATIONS AND HOSPITAL GRAND ROUNDS

Legal Issues Facing the Transgender Community, Illinois State Bar Association, Chicago, IL, 2020

Providing Gender Affirming Care to Transgender Patients, American Medical Student Association, webinar presentation, 2020

Foundations in Mental Health for Working with Transgender Clients; Advanced Mental Health Issues, Ethical Issues in the Delivery of Care, Center for Supporting Community Development Initiatives, Vietduc University Hospital, Hanoi, Vietnam, 2020

The Transgender Surgical Patient, American Society of Plastic Surgeons, Miami, FL 2019

Mental health issues in transgender health care, American Medical Student Association, webinar presentation, 2019

Sticks and stones: Childhood bullying experiences in lesbian women and transmen, Buenos Aires, 2018

Gender identity and the Standards of Care, American College of Surgeons, Boston, MA, 2018

The mental health professional in the multi-disciplinary team, pre-operative evaluation and assessment for gender confirmation surgery, American Society of Plastic Surgeons, Chicago, IL, 2018; Buenos Aires, 2018

Navigating Transference and Countertransference Issues, WPATH global education initiative, Portland, OR; 2018

Psychological aspects of gender confirmation surgery International Continence Society, Philadelphia, PA 2018

The role of the mental health professional in gender confirmation surgeries, Mt. Sinai Hospital, New York City, NY, 2018

Mental health evaluation for gender confirmation surgery, Gender Confirmation Surgical Team, Weiss Memorial Hospital, Chicago, IL 2018

Transitioning; Bathrooms are only the beginning, American College of Legal Medicine, Charleston, SC, 2018

Gender Dysphoria: A medical perspective, Department of Health and Human Services, Office for Civil Rights, Washington, D.C, 2017

Multi-disciplinary health care for transgender patients, James A. Lovell Federal Health Care Center, North Chicago, IL, 2017

Psychological and Social Issues in the Aging Transgender Person, Weiss Memorial Hospital, Chicago, IL, 2017.

Psychiatric and Legal Issues for Transgender Inmates, USPATH, Los Angeles, CA, 2017

Transgender 101 for Surgeons, American Society of Plastic Surgeons, Chicago, IL, 2017.

Healthcare for transgender inmates in the US, Erasmus Medical Center, Rotterdam, Netherlands, 2016.

Tomboys Revisited: Replication and Implication; Models of Care; Orange Isn't the New Black Yet- WPATH symposium, Amsterdam, Netherlands, 2016.

Foundations in mental health; role of the mental health professional in legal and policy issues, healthcare for transgender inmates; children of transgender parents; transfeminine genital surgery assessment: WPATH global education initiative, Chicago, IL, 2015; Atlanta, GA, 2016; Columbia, MO, 2016; Ft. Lauderdale, FL, 2016; Washington, D.C., 2016, Los Angeles, CA, 2017, Minneapolis, MN, 2017, Chicago, IL, 2017; Columbus, Ohio, 2017; Portland, OR, 2018; Cincinnati, OH, 2018, Buenos Aires, 2018

*Pre-operative evaluation in gender-affirming surgery-*American Society of Plastic Surgeons, Boston, MA, 2015

Gender affirming psychotherapy; Assessment and referrals for surgery-Standards of Care- Fenway Health Clinic, Boston, 2015*Gender reassignment surgery*- Midwestern Association of Plastic Surgeons, 2015

Adult development and quality of life in transgender healthcare- Eunice Kennedy Shriver National Institute of Child Health and Human Development, 2015

Healthcare for transgender inmates- American Academy of Psychiatry and the Law, 2014

Supporting transgender students: best school practices for success- American Civil Liberties Union of Illinois and Illinois Safe School Alliance, 2014

Addressing the needs of transgender students on campus- Prescott College, 2014

The role of the behavioral psychologist in transgender healthcare – Gay and Lesbian Medical Association, 2013

Understanding transgender- Nielsen Corporation, Chicago, Illinois, 2013

Role of the forensic psychologist in transgender care; *Care of the aging transgender patient-* University of California San Francisco, Center for Excellence, 2013

Evidence-based care of transgender patients- North Shore University Health Systems, University of Chicago, Illinois, 2011; Roosevelt-St. Vincent Hospital, New York; Columbia Presbyterian Hospital, Columbia University, New York, 2011

Children of Transsexuals-International Association of Sex Researchers, Ottawa, Canada, 2005; Chicago School of Professional Psychology, 2005

Gender and the Law- DePaul University College of Law, Chicago, Illinois, 2003; American Bar Association annual meeting, New York, 2000

Gender Identity, Gender Dysphoria and Clinical Issues –WPATH Symposium, Bangkok, Thailand, 2014; Argosy College, Chicago, Illinois, 2010; Cultural Impact Conference, Chicago, Illinois, 2005; Weiss Hospital, Department of Surgery, Chicago, Illinois, 2005; Resurrection Hospital Ethics Committee, Evanston, Illinois, 2005; Wisconsin Public Schools, Sheboygan, Wisconsin, 2004, 2006, 2009; Rush North Shore Hospital, Skokie, Illinois, 2004; Nine Circles Community Health Centre, University of Winnipeg, Winnipeg, Canada, 2003; James H. Quillen VA Medical Center, East Tennessee State University, Johnson City, Tennessee, 2002; Sixth European Federation of Sexology, Cyprus, 2002; Fifteenth World Congress of Sexology, Paris, France, 2001; Illinois School of Professional Psychology, Chicago, Illinois 2001; Lesbian Community Cancer Project, Chicago, Illinois 2000; Emory University Student Residence Hall, Atlanta, Georgia, 1999; Parents, Families and Friends of Lesbians and Gays National Convention, Chicago, Illinois, 1998; In the Family Psychotherapy Network National Convention, San Francisco, California, 1998; Evanston City Council, Evanston, Illinois 1997; Howard Brown Community Center, Chicago, Illinois, 1995; YWCA Women's Shelter, Evanston, Illinois, 1995; Center for Addictive Problems, Chicago, 1994

Psychosocial Assessment of Risk and Intervention Strategies in Prenatal Patients- St. Francis Hospital, Center for Women's Health, Evanston, Illinois, 1984; Purdue University School of Nursing, West Layette, Indiana, 1980

Psychonueroimmunology and Cancer Treatment- St. Francis Hospital, Evanston, Illinois, 1984

Psychosexual Factors in Women's Health- St. Francis Hospital, Center for Women's Health, Evanston, Illinois, 1984

Sexual Dysfunction in Medical Practice- St. Francis Hospital, Dept. of OB/GYN, Evanston, Illinois, 1980

Sleep Apnea - St. Francis Hospital, Evanston, Illinois, 1996; Lincolnwood Public Library, Lincolnwood, Illinois, 1996

The Role of Denial in Dialysis Patients - Cook County Hospital, Department of Psychiatry, Chicago, Illinois, 1977

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"Compensation for Mental Injury," *Chicago Daily Law Bulletin*, 1994.

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PROFESSIONAL AFFILIATIONS

University of Minnesota Medical School–Leadership Council
American College of Forensic Psychologists
World Professional Association for Transgender Health
World Health Organization (WHO) Global Access Practice Network
TransNet national network for transgender research
American Psychological Association
American College of Forensic Examiners
Society for the Scientific Study of Sexuality
Screenwriters and Actors Guild
Phi Beta Kappa

AWARDS AND HONORS

Letter of commendation from United States Congress for contributions to public health in Illinois, 2019
WPATH Distinguished Education and Advocacy Award, 2018
The Randi and Fred Ettner Transgender Health Fellowship-Program in Human Sexuality, University of Minnesota, 2016
Phi Beta Kappa, 1972
Indiana University Women's Honor Society, 1970-1972
Indiana University Honors Program, 1970-1972
Merit Scholarship Recipient, 1970-1972
Indiana University Department of Psychology Outstanding Undergraduate Award Recipient, 1970-1972
Representative, Student Governing Commission, Indiana University, 1970

LICENSE

Clinical Psychologist, State of Illinois, 1980

EXHIBIT B

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EXHIBIT C

Documentation of Meeting with HHS

From:	Frohboese, Robinsue (HHS/OCR) </O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=57B8853F66DA4CB99818C9E2632F77F8-FROHBOESE,>
To:	Severino, Roger (HHS/OCR) </o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=47bbbf66a9ec4d4b8b74ed8cb2029b31-Severino, R>; Bell, March (HHS/OCR) </o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=b058f58ea03648bfbb1631467db5ff6d-Bell, March>; Brown, Louis (HHS/OCR) </o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=7b54bffae1d54fe7b32b8e7d91223d0b-Brown, Loui>; Hanrahan, Eileen (HHS/OCR) </o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=user81e42d7e>
Subject:	2 new additions to listening session
Date:	2017/11/14 14:54:51
Importance:	High
Priority:	Urgent
Type:	Note

In addition to Dr. Hall and Dr. Levine, Dr. Levine's assistant, Parker Beene, as well as Dr. Randi Ettner are here. (Dr Leveine and Parker Beene were attending an Opiod event in DC this morning).

Randi Ettner, Ph.D., is a clinical and forensic psychologist based in Chicago, IL. Ettner specializes in treatment of gender conditions and has seen ~2500 persons who have been diagnosed with gender dysphoria.

Dr. Alexandra Hall is an adjunct faculty member and staff physician at the University of Wisconsin-Stout. Dr. Hall is a family physician who has been working in college health for over a decade and teaching undergraduates for the past four years. She is the author of the 2013 journal article, "Electronic medical records and the transgender patient: recommendations from the World Professional Association for Transgender Health EMR Working Group, *Journal of the American Medical Informatics Association* , *20*(4), 700-703. Her presentations include several on transgender health including: Transgender Care at the Student Health Center, half-day workshop for professionals, (2015); The Role of the Mental Health Provider in Transgender Health. Half-day workshop for area professionals, (2014), and Transgender Health: Tools to Providing Health Care and Advocacy on College Campuses, (2011). She is a member of the World Professionals for Transgender Health (WPATH).

Dr. Rachel Levine is currently the Acting Secretary of Health and Physician General for the Commonwealth of Pennsylvania and Professor of Pediatrics and Psychiatry at the Penn State College of Medicine. As Physician General, Dr. Levine has made significant strides combating the opioid epidemic and advocating on behalf of the LGBTQ population. She spearheaded the efforts to establish opioid prescribing guidelines and establish opioid prescribing education for medical students. She has also led an LGBTQ workgroup for the governor's office which has worked to create programs and processes that are fair and inclusive in healthcare, insurance, and many other areas. Her previous posts included: Vice -Chair for Clinical Affairs for the Department of Pediatrics and Chief of the Division of Adolescent Medicine and Eating Disorders at the

Penn State Hershey Children's Hospital-Milton S. Hershey Medical Center. Dr. Levine teaches at the Penn State College of Medicine on topics in adolescent medicine, eating disorders and transgender medicine. In addition, she has lectured nationally and internationally and has published articles and chapters on these topics.

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WHITMAN-WALKER CLINIC, INC., *et al.*, *Plaintiffs,* v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, *Defendants*.	Case No. 1:20-cv-01630

DECLARATION OF ELENA ROSE VERA,
EXECUTIVE DIRECTOR, TRANS LIFELINE

I, Elena Rose Vera, declare as follows:

1. I am the Executive Director of Trans Lifeline.

2. I am submitting this declaration in support of Plaintiffs' Motion for a Preliminary Injunction to prevent the revised regulation under Section 1557 of the Affordable Care Act ("ACA"), published by the U.S. Department of Health and Human Services ("HHS") on June 19, 2020 (the "Revised Rule"), from taking effect.

3. Founded in 2014 as a peer-support crisis hotline, Trans Lifeline is a peer support and crisis hotline 501(c)(3) non-profit organization offering direct emotional and financial support to transgender people in crisis. It is the first transgender-specific crisis hotline in the United States or Canada. It is also the only hotline whose operators are all transgender or nonbinary. Currently, the organization operates thanks to the assistance of almost 100 volunteers in addition to a small number of paid staff. Our operators have logged thousands of hours of often life-saving talk time with trans people in our community, and, with new volunteers signing up all the time, our capacity is only growing.

4. Trans Lifeline's hotline is open 24 hours a day, seven days a week. It is the key component of the organization and helps to connect transgender people to the community, support, and resources they need to survive and thrive. Each month the hotline receives on average 4,506 calls from all over the country, as well as Canada.

5. On July 1, 2020, the hotline began providing our 24/7 peer support and crisis helpline service in Spanish due to receiving 23 times more calls from transgender Spanish speakers in 2019 as compared to 2018. The hotline also recorded a 146% spike in calls from transgender immigrants and a 386% increase in calls from Latinx transgender people during that same time.

6. Since HHS announced the finalization of the Revised Rule on June 12, 2020, the hotline has seen a remarkable increase in calls, up from 155 in a typical day in the first five-and-a-half months of 2020, to 534 calls per day between June 12, 2020 and June 19, 2020.

7. Of the calls received between June 12, 2020 and June 19, 2020, callers brought up the Revised Rule approximately 10% of the time. This increase strongly suggests widespread concerns about the implications of the Revised Rule for the transgender community.

8. In addition, for the month of June 2020, we received 200% more calls than the previous month, even when taking into account that the last few months have been unusual as result of the COVID-19 pandemic. We also received approximately 400% more first time callers than the previous month. And from May to June, calls in which the caller noted they "cannot access medical treatment" increased by over 85%.

9. Where appropriate, Trans Lifeline operators refer callers to public services to address their concerns. For example, operators may refer callers to state agencies that address

discrimination complaints. Callers in need of health care services might be referred to state agencies for coverage and services, such as state Medicaid offices, if income eligible.

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

Dated this 8th day of July 2020.

Elena Rose Vera

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WHITMAN-WALKER CLINIC, INC., *et al.*, *Plaintiffs,* v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, *Defendants*.	Case No. 1:20-cv-1630

DECLARATION OF CARRIE DAVIS,
CHIEF COMMUNITY OFFICER, THE TREVOR PROJECT

I, Carrie Davis, declare as follows:

1. I am the Chief Community Officer of The Trevor Project.

2. I am submitting this Declaration in support of Plaintiffs' Motion for a Preliminary Injunction to prevent the revised regulation under Section 1557 of the Affordable Care Act ("ACA"), published by the U.S. Department of Health and Human Services ("HHS") on June 19, 2020 (the "Revised Rule"), from taking effect.

3. The Trevor Project is a 501(c)(3) nonprofit organization incorporated in California with offices in Los Angeles, California; New York, New York; and Washington, DC. The Trevor Project is the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) young people under age 25. The Trevor Project directly serves over 200,000 young people every year through their crisis services, suicide prevention, and peer support programs.

4. In order to fulfill its mission to end suicide among LGBTQ young people, The Trevor Project provides a wide array of programs and services for LGBTQ young people, including:

emergency crisis support and counseling available via phone, text, or online messaging; suicide prevention trainings for youths and adults; resources for LGBTQ youth and allies; creation of public service announcements; and online social networking for LGBTQ youth between the ages of 13-24. The Trevor Project also advocates for laws and policies that will reduce suicide among LGBTQ young people.

5. Many of the LGBTQ youth who need The Trevor Project's services often face discriminatory barriers to access to health care services from religiously affiliated organizations. In addition, some of the LGBTQ youth who call The Trevor Project in crisis live in foster care placements, or access services from programs for youth experiencing homelessness.

6. In addition to the direct services it provides to LGBTQ youth, The Trevor Project is also committed to producing innovative research that brings new knowledge and clinical implications to the field of suicidology. To accomplish this, The Trevor Project: (1) partners with external research organizations (such as academic institutions); and (2) analyzes and evaluates existing data collected from Trevor-served youth to produce insights into vulnerable populations, suicidal risk factors, and social factors influencing suicidal ideation and attempts. As part of this work, we know that internalization of anti-LGBTQ animus is a major contributor to depression and other mental health issues among LGBTQ people, and especially LGBTQ youth.

7. The statistics regarding young LGBTQ people and mental health are particularly sobering. Last year, The Trevor Project released the results of its 2019 National LGBTQ Youth Mental Health Survey.[1] With over 25,000 respondents, it is the largest survey of LGBTQ youth

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[1] The Trevor Project. (2019). National Survey on LGBTQ Mental Health. New York, New York: The Trevor Project. https://www.thetrevorproject.org/wp-content/uploads/2019/06/The-Trevor-Project-National-Survey-Results-2019.pdf.

mental health ever conducted and provides a critical understanding of the experiences impacting their lives. Among some of the key findings of the report from LGBTQ youth in the survey:

a. 39% of LGBTQ youth seriously considered attempting suicide in the past twelve months, with more than half of transgender and nonbinary youth having seriously considered it;

b. 71% of LGBTQ youth reported feeling sad or hopeless for at least two weeks in the past year; and

c. 87% of LGBTQ youth said it was important to them to reach out to a crisis intervention organization that focuses on LGBTQ youth.

8. In the weeks following the 2016 election, The Trevor Project saw a large spike in the number of calls, texts, and online chats to its crisis lines with LGBTQ youth expressing fear and anxiety that they would be discriminated against, that so-called "conversion therapy" would be permitted or promoted, or that they could be targeted to become a victim of hate crimes due to anti-LGBTQ animus. Indeed, in the days immediately following the election on November 8, 2016, The Trevor Project received more calls, texts, and online chats than it had ever received in a single day in four years, more than double its normal daily volume. Many callers worried that their rights would be taken away and they would be subjected to animus-fueled violence. Many callers, especially transgender and gender nonconforming youth, expressed that they were thinking about going back into the closet out of fear.

9. The past few years have proven some of the fears expressed following the 2016 election to be well-founded. The Revised Rule is just one of the latest examples of the current administration's efforts to roll back the rights of LGBTQ people, and it could not have come out at a worst time. The Revised Rule sends a dangerous and confusing message to health care

providers and LGBTQ patients. In the midst of a global pandemic with serious implications for the LGBTQ youth whom The Trevor Project serves, the last thing our nation needs is for the current administration to suggest, contrary to the Affordable Care Act, that health care providers do not have to treat LGBTQ people, particularly transgender persons, with the same care and respect as everybody else.

10. Following the announcement of the Revised Rule on June 12, 2019 and subsequent publication on June 19, 2019, The Trevor Project has seen a significant number of calls, texts, and online chats to its crisis lines from LGBTQ youth that specifically mention the Revised Rule as a source of worry and distress.

11. Unless enjoined, the Revised Rule will likely further increase the number of LGBTQ youth who need to access The Trevor Project's services. The Trevor Project will receive increased calls from LGBTQ youth who are in crisis because of discrimination and a denial of services from health care providers and due to general stigmatization and deprivation of dignity. In particular, The Trevor Project is already seeing an increased need for crisis services as a result of the COVID-19 pandemic, with many youth expressing anxiety and fear around having or getting COVID-19 specifically because LGBTQ youth are often unable to access affirming or adequate medical care, which can make seeking treatment for potential COVID-19 related symptoms more challenging or stressful than for non-LGBTQ youth.

12. By fostering the impression that providers may discriminate based on gender identity or sexual orientation, the Revised Rule leaves hundreds of thousands of people vulnerable to experiencing discrimination while seeking essential, life-saving care. In particular, the Revised Rule creates confusion and stigma that will adversely affect the mental health of at-risk LGBTQ

youth, many of whom are already reaching out to The Trevor Project in moments of suicidal ideation or crisis, in part because of their lack of faith in healthcare providers.

[*Signature on next page.*]

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

Dated this 9th day of July, 2020.

Carrie Davis

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WHITMAN-WALKER CLINIC, INC., *et al.*, *Plaintiffs,* v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, *Defendants*.	Case No. 1:20-cv-01630 (JEB)

[PROPOSED] ORDER

Upon consideration of plaintiffs' Motion for a Preliminary Injunction or, in the Alternative, a Stay Pending Judicial Review Pursuant to 5 U.S.C. § 705 ("Motion"), the Memorandum of Points and Authorities, and the Declarations and exhibits in support, any opposition, any reply, and any oral argument, and for the reasons stated in the accompanying Memorandum Opinion, it is hereby:

ORDERED that plaintiffs' Motion is **GRANTED**.

The Court finds that each of the necessary elements for issuing a preliminary injunction or stay are met and that a postponement of the effective date of the rule published by the U.S. Department of Health and Human Services entitled 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 and 45 C.F.R. pts. 86, 92, 147, 155, & 156) (the "Revised Rule"), is necessary to prevent irreparable injury. In particular, the Court finds that plaintiffs have established they are likely to succeed on the merits of their claims under the Administrative Procedure Act and their constitutional claims, they would suffer irreparable harm

absent preliminary relief, and the balance of equities and the public interest weigh in favor of an injunction or stay.

Pursuant to 5 U.S.C. § 705, the Court **POSTPONES** the effective date of the Revised Rule pending entry of a final judgment on plaintiffs' claims. The Court also **STAYS** implementation of the Revised Rule pending conclusion of these review proceedings.

The Court **ORDERS** that defendants U.S. 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 of Civil Rights, U.S. Department of Health and Human Services; and Seema Verma, in her official capacity as Administrator for the Centers of Medicare and Medicaid Service, U.S. Department of Health and Human Services, and their officers, agents, servants, employees, and attorneys, and any other persons who are in active concert or participation with them, are **ENJOINED** from applying, implementing, or enforcing the Revised Rule in its entirety, including issuing any guidance relating to the Revised Rule, during the pendency of this action until further order of the Court.

DATE: ________________, 2020

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James E. Boasberg
United States District Judge

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

WHITMAN-WALKER CLINIC, INC., *et al.*, *Plaintiffs,* v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, *Defendants*.	Case No. 1:20-cv-1630 (JEB)

CERTIFICATE OF SERVICE

This is to certify that on the 9th day of July, 2020, Plaintiffs' Motion for a Preliminary Injunction or, in the Alternative, a Stay Pending Judicial Review Pursuant to 5 U.S.C. § 705, the accompanying Memorandum of Points and Authorities in Support, Index of Declarations, Declarations and attached Exhibits, and Proposed Order were electronically filed with the Clerk of Court using the Court's CM/ECF system.

Copies of the foregoing were served also by first-class U.S. mail on the following:

U.S. Department of Health and Human Services
Office of the General Counsel
200 Independence Avenue SW, Room 713-F
Washington, D.C. 20201

Alex M. Azar II
United States Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 120-F
Washington, D.C. 20201

Roger Severino
Director of the Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 515-F
Washington, D.C. 20201

Seema Verma
Administrator of the Centers for Medicare and Medicaid Services
200 Independence Avenue SW
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