No. 24-40568

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

STATE OF TEXAS; STATE OF MONTANA,

Plaintiff-Appellees,

v.

XAVIER BECERRA, *in his official capacity as Secretary of Health and Human Services*; MELANIE FONTES RANIER, *in her official capacity as the Director of the Office for Civil Rights*; CENTERS FOR MEDICARE AND MEDICAID SERVICES; CHIQUITA BROOKS-LASURE, *in her official capacity as Administrator of the Centers for Medicare and Medicaid Services*; *U.S. Dept. of Health and Human Services,*

Defendants-Appellants.

On Appeal from the United States District Court for the Easter District of Texas
Case No. 6:24-CV-211

BRIEF OF THE NATIONAL HEALTH LAW PROGRAM IN SUPPORT OF DEFENDANTS-APPELLANTS

Martha Jane Perkins*
Elizabeth Edwards
NATIONAL HEALTH LAW PROGRAM
1512 E. Franklin St., Suite 110
Chapel Hill, North Carolina 27514
Tel: (919) 968-6308 (x101)
perkins@healthlaw.org
* *Counsel of Record Amicus Curiae*

CORPORATE DISCLOSURE STATEMENT AND SUPPLEMENTAL STATEMENT OF INTERESTED PARTIES

Case No. 24-40568, *State of Texas; State of Montana v. Xavier Becerra, et al.*

The undersigned counsel of record certifies that the following listed persons and entities as described in Rule 28.2.1, in addition to those disclosed in the parties' statements of interested persons, have an interest in this case's outcome. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

1. National Health Law Program, *Amicus Curiae*. This organization is not a subsidiary of any other corporation and no publicly held corporation owns ten percent or more of the organization's stock.

2. Martha Jane Perkins is Counsel of Record for *Amicus Curiae.*

Date: December 4, 2024

/s/ Martha Jane Perkins
Martha Jane Perkins

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INTEREST OF AMICI[1]

The *amicus curiae* file this brief pursuant to Federal Rule of Appellate Procedure 29. All parties have consented to its filing. *Amicus* is the National Health Law Program (NHeLP). NHeLP is a public interest law firm working to advance access to quality health care and address health disparities. Throughout its more than 55-year history, NHeLP has fought to address discrimination in health care based on disability, gender, race, national origin, age, and other protected classes. As such, NHeLP has a strong interest in ensuring that non-discrimination regulations fully protect access to care and adhere to the language and purpose of Section 1557 of the Patient Protection and Affordable Care Act (ACA), Pub. L. No. 118-148 (2010), as amended in the Health Care and Education Reconciliation Act, Pub. L. No. 115-152 (2010). The ACA changed the landscape of lawful discrimination in health insurance and the provision of health care. Section 1557 is an important part of that change, and *amicus* has a strong interest in its implementation and enforcement to protect access to non-discriminatory care.

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[1] Pursuant to Fed. R. App. P. 29(a)(4)(E), counsel for *amicus curiae* states that no counsel for a party authored this brief in whole or in part, and no person other than *amicus curiae*, their members, or their counsel made a monetary contribution to its preparation or submission.

SUMMARY OF ARGUMENT

A decade ago, discrimination in health care was the normal course of business. The ACA said "no more" with provisions to end insurers denying coverage for people with disabilities or chronic health conditions, imposing annual and lifetime benefit limits, and charging drastically more expensive premiums for women and older adults. The ACA included other protections against discrimination and barriers to care, including Section 1557, which prohibits discrimination in health care based on race, sex, age, and disability. 42 U.S.C. § 18116. The challenged U.S. Department of Health and Human Services' (HHS) 2024 final rule, Nondiscrimination in Health Programs and Activities, provides critical protections to do exactly what the ACA intends—eliminate discriminatory activities that have long been embedded in health care. 89 Fed. Reg. 37,522 (May 6, 2024) ("2024 Final Rule"). If successful, the plaintiff-appellee states' challenge would limit access to necessary care and permit denials of care that go beyond protected refusals.

Upholding the broad stay issued by the District Court of the 2024 Final Rule's protections against discrimination on the basis of sex to include, but not be limited to, sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes, is contrary to the ACA's sweeping changes to address embedded discriminatory health care practices, ensure access to essential care, and protect against other harmful practices. The challenged provisions of the 2024 Final Rule are based on well-established research and evidence regarding the harms related to sex discrimination that shows such discrimination is not limited to distinctions between male and female. Without the protections of the 2024 Final Rule people will face barriers to care that delay and

deny care, leading to health disparities, emotional and financial harm, and long-term health effects.

ARGUMENT

I. THE ACA WAS ENACTED TO PROTECT EQUAL ACCESS TO CARE.

Prior to the ACA, health care entities like health insurers could discriminate in the administration and design of health care benefits without significant consequence. Denying care was accepted practice. Different access to care based on characteristics like gender, age, and diagnoses was built into many health care business models, incentivizing entities to "lemon drop and cherry pick" by denying coverage or treatment to individuals with high health needs or who would otherwise be costly. Often, access to care was based on presumptions about care costs or needs, leading to extensive harm from care denied or delayed. *See generally* Valarie K. Blake, *An Opening for Civil Rights in Health Insurance After the Affordable Care* Act, B.C. J. L. & Soc. Just. 235 (2016) (discussing the ACA's efforts to address harms from health care discrimination).

The ACA drastically changed the health care landscape, and not just for health insurance. The ACA prohibition on denying coverage for pre-existing conditions is a well-known ACA protection, but the ACA included numerous corrections to limiting care based on gender, age, and other factors. *See, e.g.,* 42 U.S.C. §§ 300gg-3; 300gg(a)(1)(A). Many of the provisions of the ACA explicitly targeted

discrimination in their title. *See, e.g.,* 42 U.S.C. §§ 300gg-3 ("Prohibition of Preexisting Condition Exclusions or Other Discrimination Based on Health Status"), 300gg(a) ("Prohibiting Discriminatory Premium Rates"), 300gg-4 ("Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status"), 18116 ("Nondiscrimination").

Section 1557, which is the focus of the 2024 Final Rule, created a health care-specific, broad protection against discriminatory practices by covered entities. *Id.* § 18116. As compared to other ACA provisions that focus on requirements for health care entities, Section 1557 focuses on protections for individuals. *Compare, e.g.,* 42 U.S.C. §§ 300gg-3 (prohibiting plans from imposing pre-existing condition exclusions) *with* § 18116 ("an individual shall not…be denied the benefits of, or be subjected to discrimination under, any health program or activity"). The protections of Section 1557 were "necessary to remedy the shameful history of invidious discrimination and the stark disparities in outcomes in our health care system based on traditionally protected factors such as race and gender." 156 Cong. Rec. S1821-06, S1842 (Mar. 23, 2010) (statement of Sen. Patrick Leahy).

A. The ACA Reformed Access to Care.

Prior to the ACA, widespread discrimination on the basis of sex impeded access to insurance and care and caused financial harm. *See* Nat'l Women's Law

Ctr., *Nowhere to Turn: How the Individual Health Insurance Market Fails Women* (2008), https://nwlc.org/wp-content/uploads/2015/08/NWLCReport-NowhereToTurn-81309w.pdf [hereinafter NWLC, Nowhere to Turn]. For example, use of gender ratings by 92 percent of the best-selling plans on the individual market annually cost women approximately $1 billion more than they would have paid if they were men, even when a plan excluded maternity coverage. *See* Nat'l Women's Law Ctr., *Case Against the ACA Threatens to Devastate Women's Health and Economic Security* 1 (May 2021), https://nwlc.org/wpcontent/uploads/2020/11/ACA-2020-11-09-1.pdf [hereinafter NWLC, ACA Factsheet]. The ACA's list of allowable factors for setting premium rates does not include gender. *See* 42 U.S.C. § 300gg(a)(1)(A). Plans prior to the ACA would also deny enrollment because of prior cesarean delivery, prior pregnancy, or receiving treatment for domestic or sexual violence. *See* NWLC, ACA Factsheet, *supra*, at 1. The prohibitions against the use of pre-existing conditions to deny enrollment or coverage prevents plans from such enrollment and service denials. 42 U.S.C. § 300gg-4. Other provisions, such as coverage of essential health benefits and preventive services without out-of-pocket expenses, ameliorated existing differences between men and women accessing needed care. *See* NWLC, ACA Factsheet, *supra*.

For people with disabilities and chronic conditions, the ACA changed access to coverage, as well as the care and services available within a plan. For example, pre-ACA, insurers commonly imposed caps on the amount of services or total costs of benefits for a particular condition. Although such discriminatory limits were challenged in court, the practices were upheld. *See, e.g., McNeil v. Time Ins. Co.,* 205 F.3d 179, 182 (5th Cir. 2000) (upholding $10,000 limit on coverage for AIDS-related care); *Modderno v. King,* 82 F.3d 1059, 1062 (D.C. Cir. 1996) (permitting $75,000 lifetime cap on mental health benefits with no such limit on physical health benefits). While the ACA did not require that all treatments be covered for all people, it required comprehensive, affordable coverage that does not deny or limit services on an arbitrary or discriminatory basis. 42 U.S.C. § 300gg-6; *see also id.* at § 18022 (requiring broad array of necessary services and nondiscrimination in the provision of such services for certain health plans); *see generally* Sara Rosenbaum et al., *Crossing the Rubicon: The Impact of the Affordable Care Act on the Content of Insurance Coverage for Persons with Disabilities,* 25 Notre Dame J. L. Ethics & Pub. Pol'y 235 (2014).

The ACA also addressed age-related discrimination. Many adults aged 50-64 who did not have coverage through an employer had difficulty obtaining health coverage prior to the ACA. If an insurer was willing to offer individual coverage to

someone in this group, the rates charged were very high based on age or preexisting conditions, often making the coverage unaffordable. *See* Jane Sung, AARP, *Protecting Affordable Health Insurance for Older Adults: The Affordable Care Act's Limit on Age Rating* 1 (Jan. 2017), https://www.aarp.org/content/dam/aarp/ppi/2017-01/Protecting-Affordable-Health-Insurance-for-Older.pdf. Average out-of-pocket premium and health care costs for this coverage in the individual market were two and half times higher than for employer coverage. *Id.* at 2. The ACA limited the extent to which age can be factored into premiums. 42 U.S.C. §§ 300gg(a)(1)(A) (limiting age rating to 3:1, meaning that adults 50-64 cannot be charged more than three times the amount a younger adult is charged for the same coverage). Such changes, along with the Act's preexisting conditions protections, have a significant impact on availability of coverage and cost. *See* NWLC, ACA Factsheet, *supra,* at 1-2; AARP, Protecting Health Insurance for Older Adults, *supra*, at 1-3.

Many of the provisions of the ACA targeted discriminatory health insurance practices, but the ACA also included broad individual protections against discriminatory care. For example, Section 1554 prohibits HHS from issuing regulations that create unreasonable barriers to obtaining appropriate medical care, impede timely access to care, interfere with communications between patient and

provider, and limit the availability of health care for the full duration a person needs. 42 U.S.C. § 18114.

B. Section 1557 Enforces the Broad Protections of the ACA.

Section 1557 is a cornerstone of Congress's efforts to address discriminatory barriers to care. Members of Congress recognized that existing non-discrimination laws had not addressed the barriers to care that were to be remedied by the ACA. *See, e.g.,* 156 Cong. Reg. S1923-08, S1983 (Mar. 24, 2010) (statement of Sen. Tom Harkin) ("We are ending the last shameful bastion of legal discrimination and exclusion in our country"), *id.* (statement of Sen. Orrin Hatch) ("We took up that fight and ended those abusive practices in this bill.") (referencing stories regarding sex discrimination, including requiring women to get sterilized before receiving health care coverage because they had previously had a Cesarean section and premature child), 156 Cong. Reg. S1821-06, S1842 (Mar. 23, 2010) (remarks of Sen. Patrick Leahy) ("[These protections] ensure that all Americans are able to reap the benefits of health insurance reform equally, without discrimination."), 155 Cong. Rec. S11907-02, S11963-64 (Nov. 21, 2009) (statement of Sen. Max Baucus) ("No longer will insurance companies be able to discriminate based on gender or health status."). Members of Congress also noted the importance of including the individual enforcement mechanism that became Section 1557 to address discrimination. *See,*

e.g., 156 Cong. Reg. S1821-06, S1842 (Mar. 23, 2010) (remarks of Sen. Patrick Leahy).

Section 1557 broadly applies the enforcement mechanisms that are "provided for and available under" the referenced statutes. 42 U.S.C. § 18116(a) (referencing Titles VI and VII of the Civil Rights Act of 1964, Title IX of the Education Amendments Act of 1972, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1974). The ACA and Section 1557 were intended to correct barriers to care based on an individual's characteristics.[2] An overly narrow reading of the statutes referenced in Section 1557 misses the congressional intent to right long-standing wrongs that cause people to be denied needed health care. The

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[2] For example, for nearly five decades the regulations implementing Title IX have explicitly defined "on the basis of sex" to include discrimination on the basis of "pregnancy, childbirth, false pregnancy, termination of pregnancy, or recovery therefrom." Department of Health, Education, and Welfare, General Administration, 40 Fed. Reg. 24,128, 24,135, 24,140, 24,142 (June 4, 1975), codified at C.F.R. pt. 86; *see also, e.g.*, *Conley v. Nw. Fla. State Coll.*, 145 F. Supp. 3d 1073, 1076–79 (N.D. Fla. 2015) ("In light of the legislative history of Title IX, the broad sweep of its language, and the fact that the term 'sex' is understood in common usage to encompass pregnancy, . . . Congress's prohibition of discrimination 'on the basis of sex' unambiguously includes pregnancy-based discrimination within its purview"). Congress approved this definition in 1975 when the original Title IX regulations were presented to Congress to determine whether they were "consistent with the law and with the intent of the Congress in enacting the law" and the regulations were permitted to go into effect without congressional intervention. *Sex Discrimination Regulations: Hearings before the Subcomm. on Postsecondary Education of the House Committee on Education and Labor,* 94th Cong., 1st Sess. (1975) at 1 (remarks of Rep. O'Hara).

ACA changed what is acceptable discrimination in health care. Although Section 1557 references non-discrimination statutes, interpretation of the meaning of those statutes in the context of health care cannot merely apply previously existing case law without recognition of this change. The 2024 Final Rule issued by HHS, including the definition of sex discrimination to include gender identity, reflects the broad intent of the ACA and the enforcement mechanism of Section 1557.

II. THE 2024 FINAL RULE ADDRESS THE TYPE OF HARM GENERATING CONDUCT THE ACA WAS DESIGNED TO ADDRESS.

The 2024 Final Rule includes protections against discrimination on the basis of sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes. g *See, e.g.,* 45 C.F.R §§ 92.206, 92.207. Although much of the focus in the parties' briefs is on gender affirming care, defining sex discrimination as HHS did in the 2024 Final Rule prevents a much broader array of discriminatory practices that harm people across the country.[3] The inclusion of gender identity and pregnancy or related conditions,

[3] The parties' briefing in the District Court was specific to the provision of gender-affirming care and in its broadest interpretation, the inclusion of gender identity in the definition of sex discrimination and other provisions, but the District Court's order to stay the effective date of the 2024 Final Rule stayed specific provisions, including 45 C.F.R. § 92.206(b), that included other protections, such as including pregnancy and related conditions in the definition of sex discrimination.

among others, follows in the footsteps of the ACA, which as discussed above, targeted gender-related discrimination.

A. Sex Discrimination as Defined in the 2024 Final Rule is the Type of Well-Established Health Care Barrier the ACA Remediates.

The ACA targeted gender-based discrimination and barriers to care generally. Research has repeatedly shown that sex discrimination in a variety of forms is a key barrier to health care access. Importantly, the barriers are not limited to gender-transition or even gender-based care but to the full range of health care services. Discrimination against people of diverse gender and sexualities, including through structural stigma, has long been a barrier to access health care, contributing to significant health inequities. Nat'l Acads. of Scis., Eng'g & Med., *Consensus Study Report: Understanding the Well-Being of LGBTQI+ Populations* (2020), https://nap.nationalacademies.org/catalog/25877/understanding-the-well-being-of-lgbtqi-populations. In a study of the intersection of gender identity, sexual orientation, race, and economic factors in health care access, discrimination as well as insensitivity or disrespect on the part of health care providers were key barriers to health care access. Ning Hsieh & Matt Ruther, *Despite Increased Insurance Coverage, Nonwhite Sexual Minorities Still Experience Disparities in Access to Care,* 36 Health Aff. 1786 (2017). A systemic literature review "found robust discrimination on the basis of sexual orientation or gender identity is associated with

harms to the health of LGBT people." What We Know Project, Cornell U., *What Does the Scholarly Research Say about the Effects of Discrimination on the Health of LGBT People* (2019). Research also identified the need for strengthening nondiscrimination protections because of care denials or delays due to discrimination by health care providers. *See generally* Jennifer M. Taber et al., *Why Do People Avoid Medical Care? A Qualitative Study Using national Data*, 30 J. Gen. Internal Med. 290 (2015), https://link.springer.com/article/10.1007/s11606-014-3089-1 (noting that "[a]voiding medical care may result in late detection of disease, reduced survival, and potentially preventable human suffering"). One report found that 32 percent of Transgender or Non-Binary respondents to the survey, including 46 percent of Transgender or Non-Binary respondents of color, reported that they experienced at least one kind of care refusal by a health care provider in the past year. Carolina Medina & Lindsay Mahowald, Ctr. for Am. Progress, *Advancing Health Care Nondiscrimination Protections for LGBTQI+ Communities* (Sept. 8, 2022), https://www.americanprogress.org/article/advancing-health-care-nondiscrimination-protections-for-lgbtqi-communities/. That same study showed that 55 percent of intersex respondents reported a health care provider refused to see them because of their sex characteristics or intersex variation *Id.* The effect of the ACA and the issuance of the first Section 1557 regulations in 2016 on access to care

for transgender individuals and others impacted by gender identity discrimination also showed the necessity of robust Section 1557 protections.[4] *See, e.g.,* Endocrine Soc'y, Comment HHS-OS-2022-0012-42034, at 2 (discussing studies tracking the high prevalence of maltreatment, harassment, and violence transgender individuals face when accessing care, and the consequences); Transgender Legal Defense & Educ. Fund (TLDEF), Comment HHS-OS-2022-0012-64895 (discussing harm from the 2020 version of the Section 1557 rule). In issuing the 2024 Final Rule, HHS recognized such research and evidence, as well as the harms illustrated therein. 2024 Final Rule, 89 Fed. Reg. at 37,573-75.

As discussed above, several ACA reforms were targeted at sex discrimination to include pregnancy discrimination, with insurers regularly rejecting applicants for a variety of gender-related reasons, including if the application was pregnant or had a history of Cesarean deliveries, with significant impacts on health outcomes. NWLC, Nowhere to Turn, *supra*.

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[4] All comments received by HHS during the 2024 Final Rule rulemaking process can be found at Regulations.gov, Nondiscrimination in Health Programs and Activities, Docket HHS-OS-2022-012, https://www.regulations.gov/document/HHS-OS-2022-0012-0001/. In this brief, individual comments have been identified by the comment ID number the first time they are cited and then by the organization's name thereafter.

B. The 2024 Final Rule's Definition of Sex Discrimination Addresses Significant Harm.

Sex discrimination is not as simple as male versus female treatment as mistreatment based on sex delays and denies all types of health care services, causing great physical, emotional, and financial harm to individuals. The administrative record for the 2024 Final Rule is replete with comments reflecting examples of individuals denied care because of sex discrimination, including gender identity and pregnancy status.

For example, the comments noted that many of those impacted by sex discrimination do not receive the level or type of treatment they would have otherwise received. A health care provider's comments included stories of their patients' experiences at other providers, including transgender woman who underwent a procedure to treat bunions and toe alignment to address foot problems and mobility issues commented that her treatment did not adhere to protocols. Whitman-Walker Health & Whitman-Walker Institute, Comment HHS-OS-2022-0112-69163, at 9. Despite conversations with hospital staff, she was repeatedly misgendered and encountered hostility from staff. *Id.* She was discharged with pain medication, but no antibiotics. Her wounds were not stitched; her calls regarding follow up care and other support were not returned. *Id.* Because of these experiences, she did not return. *Id. See generally* NHeLP, *supra,* at 94-100 (collecting studies and

examples about gender and sexual orientation-related barriers to care leading to treatment delays, increased costs, and lack of treatment for an array of health issues).

Comments also reflect neglect during hospital stays and lack of usual follow up care. *Id.* at 9-10; Nat'l Ctr. for Transgender Equality (NCTE) et al., Comment HHS-OS-2022-0012-74199, at 692. People also shared stories of hiding their gender identity when seeking care so that they could get the care they needed. *See, e.g.,* NCTE, *supra,* at 59 (hid gender identity so a hysterectomy to treat uterine fibroids would not be denied as gender transition-related care), 139 (fearful being a non-binary person will impact their ability to get a mastectomy as recommended to treat a high risk of breast cancer).

Gender identity discrimination in health care also leads to the death of those impacted. For example, when a 14-year-old transgender boy sought treatment for his suicidal ideation associated with gender dysphoria, hospital staff repeatedly addressed and referred to him as a girl, causing extreme distress. Instead of treating him, the hospital discharged him before his medical hold expired. He died five days later by suicide. NHeLP, Comment ID HHS-OS-2022-0012-67192, at 55 (gathering examples from *amicus* briefs filed regarding gender identity discrimination). Comments also collected examples from reports, such as an instance of paramedics and emergency room providers delaying treatment after discovering a passenger in

a car crash was a transgender woman of color, leading to her death. Williams Inst. Scholars, Comment ID HHS-OS-2022-0012-67798, at 8-9.

Care delays cause grave harm. When a transgender man presented to the emergency room with severe pain and a high temperature, he experienced a notably abnormal delay in being admitted after speaking with staff about his gender. A doctor later told his mother that he would have been septic within 12 to 24 hours when he was brought in and could have died. NHeLP, *supra*, at 55. A transgender man with multiple sclerosis was told they were "too weird" by a nurse at a neurology office where the doctor then proceeded to blame hormone therapy for unrelated MS symptoms and misled the man seeking treatment. Ultimately the individual switched providers and was able to receive treatment. However, the failure to diagnosis and treat by the previous doctor led to the MS progressing more than it would have, affecting both health and well-being. NCTE, *supra,* at 49-50; *see also id.* at 354 (describing struggles getting cancer treatment covered because the individual is transgender). A doctor delayed treatment of a transgender man with aggressive cancer, because he was uncomfortable with the patient's transgender status, and his first impulse was to recommend psychiatry rather than cancer treatment. NHeLP, *supra*, at 55. Another a transgender man learned of his breast cancer diagnosis only after a lab technician "accidentally" called to ask how he was doing with his

diagnosis. Williams Inst. Scholars, *supra*, at 8-9. *See generally* NHeLP, *supra,* 91-92 (collecting articles about pharmacy barriers after the Supreme Court's decision in *Dobbs*). Administrative burdens delay necessary care and can cause significant pain and potentially dangerous flare ups of chronic health conditions. *Id.*; *see also Rule v. Braiman,* No. 1:23-cv-01218, 2024 WL 4042135 (N.D.N.Y. Sept. 4, 2024) (holding plaintiff had stated a claim of sex discrimination under Section 1557 based on a new provider's refusal to continue patient's effective. Discrimination based on pregnancy and related conditions can also limit access to care in areas with limited provider options, often causing patients to go without needed care or delaying care. NHeLP, *supra*, at 92. treatment for a chronic condition because of the patient's capacity for pregnancy).

Gender identity discrimination also occurs when transgender individuals cannot access standard preventive care services related to their sex assigned at birth. Endocrine Soc'y, *supra*, at 1. Commenters also explained that even something as simple as treatment for the flu can be difficult to obtain, as one transgender women in Mississippi reported that multiple providers refused her treatment. NHeLP, *supra,* at 55; *see also* TLDEF, *supra,* at 28-29 (collecting individual stories of difficulty accessing care for mammograms and urinary tract infection screenings).

Sex discrimination is harmful not only at the time, but in how people seek care moving forward. Past experiences of discrimination can cause people to avoid future care due to concern about being negatively judged, with nearly 18 percent of LGBTQ people in one survey expressing this concern and 22 percent of transgender individuals in another study. Williams Inst. Scholars, *supra*, at 11. A mother with a terminal illness sought care for her two 12-year old children, both of whom identify as non-binary. At the appointment, the physician immediately questioned how the children dressed, then separated them from their mother and sent them to a local hospital under suicide watch. When questioned, the doctor stated that how they dressed and presented was not "right." Negative consequences of discriminatory care can leave a lasting impact on individuals and their family members, leading to mistrust of health care professionals and delayed care. LGBT Ctr. of Greater Reading, Comment HHS0S-2022-012-37358, at 2-3.

As noted in numerous comments, the protections regarding gender identity can be life changing for people, at negligible cost for insurance companies and other entities. *See, e.g.,* TLDEF, *supra*; State Ins. Comm'rs in Support of Adopting Gender Identity Protections, Comment HHS-OS-2022-0012-55688 (discussing importance of gender identity protections and the de minimus costs of gender affirming care).

The harm from denying the 2024 Final Rule's sex discrimination protections is significant. It is not only appropriate but necessary to include the listed categories in the definition of sex discrimination in the 2024 Final Rule. The preliminary injunction and stay of the gender identity protections in the final rule are contrary to Section 1557 and the ACA and will cause significant harm.

CONCLUSION

WHEREFORE, *Amici* ask that the Court to vacate the preliminary injunction and stay order regarding the 2024 Nondiscrimination in Health Programs and Activities final rule.

Dated: December 4, 2024

Respectfully submitted,

/s/ Martha Jane Perkins
Martha Jane Perkins*
Elizabeth Edwards
National Health Law Program
1512 East Franklin St., Ste. 110
Chapel Hill, NC 27514
(919) 968-6308
perkins@healthlaw.org

* Counsel of record

CERTIFICATE OF SERVICE

I certify that on this day, December 4, 2024 I electronically filed the forgoing brief with the Clerk of the Court by using the CM/ECF system.

Date: December 4, 2024

/s/Martha Jane Perkins
Martha Jane Perkins

CERTIFICATE OF COMPLIANCE

I hereby certify that this brief complies with the requirements of Fed. R. App. P. 32(a)(5) and (6) because it has been prepared in 14-point Times New Roman, a proportionally spaced font. I certify that the foregoing brief complies with the requirements of Fed. R. App. P. 32(a)(7)(B) and 29(a)(5), and that the total number of words in this brief is 4,168 according to the count of Microsoft Word, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

Date: December 4, 2024

/s/Martha Jane Perkins
Martha Jane Perkins

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Pursuant to paragraph A(6) of this Court's ECF Filing Standards, I hereby certify that (1) required privacy redactions have been made, 5th Cir. R. 25.2.13; (2) the electronic submission is an exact copy of the paper document, 5th Cir. R. 25.2.1; and (3) the document has been scanned for viruses with the most recent version of a commercial virus scanning program and is free of viruses

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