August 13, 2019

Office for Civil Rights
Department of Health and Human Services

RE: Request for Comment "Nondiscrimination in Health and Health Education Programs or Activities" (RIN 0945-AA11)

To Whom It May Concern:

The Jim Collins Foundation, Inc. (JCF) submits the following comments to assist the Department in its work enforcing our nation's robust, remedial nondiscrimination laws with an eye towards maximizing transgender Americans' access to healthcare free of discrimination.

INTEREST

JCF is a Connecticut nonprofit with a national reach. Since our launch in 2010, our work has narrowly focused on awarding need-based grants to transgender persons who cannot financially access medically necessary surgery. We offer two grant types each year. Our Founders' Grant covers 100% of the surgical costs. Our Krysallis Anne Kembrough Legacy Fund covers 50% of surgical costs. Since 2011, we have received more than 3,600 unique applications and have awarded 26 grants. Our grant awards are made possible by a combination of modest direct donations from community members and allies, donations of services by medical providers, proceeds from grassroots community fundraisers, and direct financial contributions by our board members.

JCF has a unique perspective on the proposed amended regulations. Though we are a modestly-sized organization, our work brings us into direct contact with a broad cross-section of transgender Americans, most of whom directly report experiencing untoward barriers to obtaining insurance coverage for medically necessary, life-saving surgical care and who, lacking other viable means of paying for care out of pocket, come to

us for assistance. We also work with a significant segment of transgender Americans who lack access to insurance due to life circumstances but who nonetheless experience the repercussions of national and state level policies affecting insurance access. Additionally, our work and advocacy with cooperating surgeons gives us a unique perspective as to how federal policies affecting healthcare access impact transgender Americans.

Lastly, although we are not a legal advocacy organization, one of our co-founders and many of our past and present board members specialize in transgender civil rights work which, in turn, has informed how JCF has tailored its work and targeted our grants over the years. Most certainly, how federal courts and agencies apply civil rights laws to transgender Americans informs our work and thus we've developed a special expertise in this area. Moreover, JCF and the community members we directly serve are deeply invested in ensuring federal courts and agencies fairly interpret civil rights laws that, for many of us, are the difference between life and death.

ANALYSIS

We appreciate this opportunity to provide comments in response to the Notice of Proposed Rulemaking Regarding Nondiscrimination in Health and Health Education Programs or Activities. Our comments proceed in three parts.

First, we present background information speaking to the dire need for the federal government to take decisive action to protect transgender Americans. In this part, we share information concerning gender dysphoria (GD), a treatable though highly stigmatized medical condition. We proceed to describe and highlight the ways in which insurers use transgender exclusions to deprive our community of health benefits otherwise available to other patients. We also highlight disturbing statistics and patient experiences of discrimination in healthcare settings. We close this part by connecting the high incidence of discrimination our community endures with known health disparities.

Second, we endeavor to explain how and why our nation's discrimination laws protect everyone, including transgender Americans. We open by defining and explaining the transgender exceptionalism myth, a phenomena that for far too long drove judges to quite literally treat transgender persons as strangers to the law. We then proceed to contextualize stale-dated sex discrimination cases that erroneously deemed transgender persons unprotected. From there, we present a cursory survey of how courts have switched gears in the last few decades. We then briefly survey different legal theories courts have invoked to sustain transgender-inclusive constructions of sex discrimination laws. We close this section by pointing to key errors of analysis in OCR's Proposed Rule and, separately, point to fatal infirmities in the *Franciscan Alliance* preliminary injunction opinion.

Third, we acknowledge that the original 1557 Rule opened OCR up to litigation risks, but we nonetheless, we urge you to not scrap it. We do not believe that a bare desire to mitigate litigation risk justifies artificial restrictions of our civil rights. Moreover, we have serious concerns that there will be dire consequences for our community and the federal government alike if OCR capitulates to the demands of the *Franciscan Alliance* plaintiffs vis-à-vis the rulemaking process rather than fighting the case in court.

I. The Federal Government should take decisive action to protect transgender Americans from discrimination in healthcare.

A. Gender Dysphoria is a treatable medical condition.

Gender Dysphoria ("GD") is a widely recognized medical condition. Persons with GD experience a profound disconnect between their internal sense of gender (gender identity) and the sex they are assigned at birth.[1] Because a person's gender identity cannot be changed, GD treatments, such as hormone therapy and surgery, are administered to align the patient's secondary sex characteristics with their gender identity. These treatments are colloquially termed transgender healthcare.

Hormone blockers are pharmaceuticals that suppress the production of internally produced sex hormones such as estrogen, progesterone, and testosterone. For adult patients, hormone blockers serve many clinical purposes, including suspending post-pubertal maturation of secondary sex characteristics and suppressing internal sex hormone production that interferes with exogenous sex hormone therapy.[2] In transgender youth, administration of hormone blockers suspends puberty,[3] which prevents the development of identity-discordant secondary sex characteristics and has been shown to decrease depressive symptoms and significantly improve general functioning.[4]

Exogenous sex hormones induce the development of secondary sex characteristics that match the patient's gender identity. For transgender adults, testosterone therapy triggers deepening of the voice, development

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[1] Am. Psych. Ass'n, The Diagnostic and Statistical Manual of Mental Disorders: DSM-V § 302.85 (2013).

[2] Wylie Hembree et al., *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, 94 J. Clin. Endocrinological Metabolism 3132, 3143 (2009).

[3] *Id.* at 3139–42.

[4] Annelou L.C. de Vries et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 Pediatrics 696 (2014) [hereinafter de Vries et al., Pediatrics *Outcome*] (finding transgender youth treated with hormone blockers and exogenous hormones had similar or better psychological functioning than same-age youth in the general population).

of male-typical facial hair and body hair, fat redistribution into male-typical patterns, and cessation of menses.[5] Similarly, estrogen and progesterone therapies trigger female-typical breast development, reduce male-typical pattern hair growth, and induce body fat redistribution into female-typical patterns.[6] For transgender youth who have received hormone blockers, exogenous sex hormones induce identity-congruent puberty. A growing body of research shows that transgender youth treated with exogenous hormones lead happy, healthy lives and have similar or better psychological functioning than their non-transgender peers.[7]

Reconstructive surgeries, sometimes referred to as gender or sex reassignment surgeries, are surgical procedures that either alter secondary sex characteristics or reconstruct sex organs to align these features with the patient's gender identity. There are a variety of procedures that fall under this umbrella, including but not limited to chest reconstruction surgery (i.e., removing or reconstructing breasts), hysterectomy, orchiectomy, phalloplasty (creation of a phallus), vaginoplasty (creation of a vagina), hysterectomy (removal of the uterus and related structures), and orchiectomy (removal of the testes).[8] Decades of research evidence that these procedures are a safe and effective means of treating GD.[9]

The efficacy of transgender healthcare is undisputed by experts in the field. The American Medical Association, the American College of Obstetricians and Gynecologists, the American Psychological Association, the Endocrine Society, the World Medical Association and myriad number of other national and international professional

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[5] Louis J. Gooren, *Care of Transsexual Persons*, 364 New Eng. J. Med. 1251, 1253 (2011).

[6] *Id.*

[7] *See, e.g.*, de Vries et al., Pediatrics *Outcome*.

[8] *See Standards of Care* at 200–05 (discussing surgical treatments).

[9] *See, e.g.*, Esther Gómez-Gil et al., *Hormone-Treated Transsexuals Report Less Social Distress, Anxiety and Depression*, 37 Psychoneuroendocrinology 662 (2012); Griet De Cuypere et al., *Sexual and Physical Health After Sex Reassignment Surgery*, 34 Archives Sexual Behavior 679 (2005) (noting high levels of satisfaction with treatment).

associations recognize the efficacy of transgender healthcare.[10] Leading health plan administrators throughout the country also recognize the efficacy of transgender healthcare and have promulgated broad and inclusive coverage guidelines.[11]

[10] *See, e.g.*, Am. Med. Ass'n, *H-185.950 Removing Financial Barriers to Care for Transgender Patients*, *available at* http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glbt-advisory-committee/ama-policy-regarding-sexual-orientation.page (last visited Oct. 11, 2016) ("Our AMA supports public and private health insurance coverage for treatment of gender identity disorder as recommended by the patient's physician."); Am. Med. Ass'n, *H-180.980 Sexual Orientation and/or Gender Identity as Health Insurance Criteria*, *available at* http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glbt-advisory-committee/ama-policy-regarding-sexual-orientation.page (last visited Oct. 11, 2016) ("The AMA opposes the denial of health insurance on the basis of sexual orientation or gender identity."); Am. Psychol. Ass'n, *Policy Statement: Transgender, Gender Identity, & Gender Expression Non-Discrimination* (Aug. 2008); Am. Coll. Obstetricians & Gynecologists, *Committee Opinion, Care for Transgender Individuals 1* (Dec. 2011), *reprinted at* http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Health%20Care%20for%20Underserved%20Women/co512.pdf?dmc=1&ts=20140826T1734594637; Wylie Hembree et al., *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, 94 J. Clin. Endocrinological Metabolism 3132 (2009); World Med. Ass'n, *Statement on Transgender People* (Oct. 2015), *reprinted at* http://www.wma.net/en/30publications/10policies/t13/).

[11] Aetna, Gender Reassignment Surgery, Policy No. 0615 (revised Jan. 2019), *reprinted at* http://www.aetna.com/cpb/medical/data/600_699/0615.html (last visited July 15, 2019); Cigna, *Gender Reassignment Surgery*, Policy No. 0266 (revised April 15, 2019), *available at* https://cignaforhcp.cigna.com/public/content/pdf/coveragePolicies/medical/mm_0266_coverageposition criteria_gender_reassignment_surgery.pdf (last visited July 15, 2019); UnitedHealthcare, *Gender Dysphoria (Gender Identity Disorder) Treatment,* Guideline Number: MPG365.03 (revised April 10, 2019), *reprinted at* https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medadv-guidelines/d/dysphoria-gender-reassignment-surgery.pdf (last visited July 15, 2019).

B. Too many transgender Americans are discriminatorily denied care by their insurers.

Transgender Americans widely report health insurance discrimination. In one of the largest national surveys to date, an astounding 1 in 4 transgender Americans report being denied coverage for transition related care or non-GD routine care in the past year.[12]

The high incidence of insurance denials is driven primarily by what are colloquially known as transgender exclusions. These exclusions take different forms, but ultimately aim to except from coverage care sought by transgender persons to treat GD. Some exclusions impose categorical bars—meaning they except from coverage all treatments for GD. Some exclusions are partial—meaning they cover a sub-set of care but totally bar other care without regard to a patient's showing of medical necessity. Whether categorical or partial, these exclusions bar health benefits to transgender persons that are otherwise covered by the plan.

It is a common misunderstanding that GD treatments or "transgender healthcare" is medically distinct from other kinds of care and that difference justifies transgender exclusions. Nothing can be further from the truth. The treatments some health plans label as "transgender healthcare" are routinely administered to nontransgender people. It is the existence of the transgender exclusion, not the kind of the care sought, that compels plans to subject transgender patients to disparate treatment.

As discussed *supra* Part I-A, there are a range of treatments for GD including hormone blockers, exogenous hormones, and reconstructive surgeries. Though, in the transgender population, these treatments are indicated by a GD diagnosis, the exact same care is administered to nontransgender persons to treat other conditions. For example, nontransgender adults are regularly prescribed hormone blockers to treat prostate cancer and certain forms of ovarian cancer; nontransgender children diagnosed with precocious puberty are also

[12] Sandy E. James et al., Nat'l Ctr. For Transgender Rts., *The Report of the 2015 U.S. Transgender Survey* 95 (2016) [hereinafter *2015 Transgender Survey*], https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.

routinely prescribed hormone blockers.[13] Exogenous sex hormones testosterone and estrogen are commonly administered to nontransgender persons with hypogonadism.[14] Double mastectomies are frequently performed to treat breast cancer in nontransgender women. Phalloplasty is a go-to treatment for many nontransgender men who have experienced severe genito-urinary injuries.[15] Vaginoplasty is performed on nontransgender women with Mayer-Rokitansky-Kuster-Hauser (MRKH) syndrome.[16]

Experts have long recognized that transgender exclusions are medically unsound and, in many instances, reflect ignorance and prejudice. Myths about GD care are often invoked as cover to justify the existence of transgender exclusions. But "[n]egative attitudes towards [this care] largely do not originate with health care providers treating transgender patients; rather, they result from discrimination and public mis-understanding of the medical necessity and effectiveness of such treatments."[17] Indeed, "[t]he lack of medical or fiscal justifications suggests that the insurance policies' [transgender] exclusion clauses operate as a pretext for other purposes."[18]

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[13] Gooren, *Care of Transsexual Persons* at 1253 (noting similarity between cancer treatment and GD); *id.* at 1255 (noting similarity between precocious puberty treatment and GD).

[14] Eva Moore et al., *Endocrine Treatment of Transsexual People: A Review of Treatment Regimens, Outcomes, and Adverse Effects*, 88 J. Clinical Endocrinology & Metabolism 3467, 3470 (2003) (describing similarities in testosterone regimens for transgender men and nontransgender men with hypogonadism); *id.* at 3472 (comparing estrogen regimens for transgender women and nontransgender women with hypogonadism).

[15] *See* Jessica Firger, *Penile Reconstruction Surgery Has High Success Rate and Outcomes*, Newsweek (May 7, 2016), http://www.newsweek.com/penile-reconstruction-outcomes-transgender-phalloplasty-456931.

[16] Liron Eldor & Jeffrey Friedman, *Reconstruction of Congenital Defects of the Vagina*, 25 Seminars Plastic Surgery 142 (2011) (discussing vaginoplasty techniques for MRKH syndrome patients). Hysterectomies are quite common; between 2011 and 2013 an estimated 10.4 percent of American women between the ages of 40 and 44 had had a hysterectomy. Ctrs. Disease Control & Prevention, *Key Statistics from the National Survey of Family Growth*, http://www.cdc.gov/nchs/nsfg/key_statistics/h.htm#hysterectomy (last visited Oct. 11, 2016).

[17] Nick Gorton, *Transgender Health Benefits: Collateral Damage in the Resolution of the National Health Care Financing Dilemma*, 4 Sexuality Res. & Soc. Pol'y 81, 81 (2007).

[18] *See* Kari E. Hong, *Categorical Exclusions: Exploring Legal Responses to Health Care Discrimination Against Transsexuals*, 11 Colum. J. Gender & L. 88, 96 (2002).

C. Healthcare setting discrimination is also common.

A trip to the doctor's office or the emergency room should not be an invitation for abuse. No patient should feel forced to delay or forego medical care altogether because they fear mistreatment.

Unfortunately, transgender Americans are at heightened risk for mistreatment in healthcare settings. For instance,

- Transgender Americans face an inordinate risk to assault and rough handling in healthcare settings. Nationally, just over 1% of all transgender patients report being physically assaulted in emergency rooms, with even higher rates in vulnerable sub-populations.[19] An alarming 7.8% of transgender people endure physically rough or abusive treatment from health providers.[20]

- Verbal harassment in health settings is alarmingly common. One national survey found that 28% percent of transgender patients were verbally harassed in a doctor's office, emergency room, or other medical setting.[21] Another national survey found that 20.9% of transgender patients were subjected to harsh or abusive language from health providers.[22]

- Transgender patients are routinely denied medically necessary care by health providers. One national survey alarmingly found that 3% of transgender patients report being denied care unrelated to GD treatment (such as physicals or care for the flu or diabetes).[23]

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[19] Jamie Grant et al., Nat'l Ctr. for Transgender Equality & Nat'l Gay & Lesbian Task Force, *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey* 74 (2011) [hereinafter *Injustice at Every Turn*] (noting assaults rates of 6% for undocumented patients, 5% for patients who have worked in the underground economy, 4% for Asian patients, and 4% for patients who lost their jobs).

[20] Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV* 11 (2010), www.lambdalegal.org/health-care-report [hereinafter Lambda Legal, *When Health Care Isn't Caring*].

[21] *Injustice at Every Turn* at 74.

[22] Lambda Legal, *When Health Care Isn't Caring* at 11.

[23] *2015 Transgender Survey* at 97.

In that same survey, 8% of patients reported being denied GD treatment.[24]

We encourage OCR and other divisions of HHS to further study these problems. Such study will invariably help map these problems and, we hope, assist in efforts to improve transgender Americans' access to healthcare.

We also encourage OCR to holistically study the patient experiences behind these statistics. Indeed, patient stories, many of which are absolutely horrifying, reflect the dire stakes. For instance,

- Some of the most disturbing stories of physical assault and mistreatment occur at large health facilities that hold themselves out as being allies to the transgender community. For example, in a federal lawsuit filed earlier this year in the Eastern District of Pennsylvania, a transgender woman, proceeding anonymously as Jane Doe, alleges that after she woke up disoriented and confused from anesthesia after a routine medical procedure at the University of Pennsylvania's Hospital, hospital personnel physically restrained her and called the police who in turn physically assaulted Doe and, eventually, wheeled her through the hospital totally naked and dumped her on the street.[25]

- Outright denials of care can have deadly consequences. As famously portrayed in the award-winning documentary *Southern Comfort* (2001), Robert Eads, a transgender man diagnosed with ovarian cancer, was denied care by a dozen doctors delaying his access to treatment for the better part of a year. By the time Eads found a doctor willing to treat him, the cancer had metastasized to other parts of his body and aggressive treatments proved ineffective. Eads died at age 53.

- Providers' hesitation to care for transgender patients in emergency situations can prove fatal. For example, Tyra Hunter,

[24] *Id.*

[25] *See* Tim Cwiek, Trans Woman Sues Penn Hospital, Philadelphia Gay News (July 8, 2019), http://www.epgn.com/news/local/14898-transwoman-sues-penn-hospital.

a Black transgender woman who was severely injured in a car accident in Washington, D.C., died because first responders and later emergency department personnel were so shocked by the fact that she was transgender that they delayed treating her injuries.[26] For Ms. Hunter, a few minutes of hesitation was the difference between life and death.

- Cultural incompetence can imperil the lives of transgender persons and their loved ones. Earlier this year the *New England Journal of Medicine* reported that an emergency room nurse's failure to apprehend that a transgender man retained his natal reproductive organs led to a fatal oversight—the nurse missed otherwise clear signs of pregnancy and that error led the patient to miscarry.[27] In a federal lawsuit pending in the Southeastern District of California, a mother alleges that her 15-year old transgender son committed suicide shortly after being discharged from an area children's hospital. The cause? She claims her child "went into a spiral" after a 72-hour suicide hold because hospital staff repeatedly dishonored his male identity. In his mother's own words, "[t]hey were making him worse. They were completely traumatizing him."[28]

D. Health disparities contribute to marginalization of transgender Americans across the arc of life.

Transgender Americans endure staggering rates of discrimination throughout the arc of life.[29] But healthcare discrimination is often the most devastating. Indeed, research suggests that healthcare

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[26] *See generally* Scott Bowles, *A Death Robbed of Dignity Mobilizes a Community*, Wash. Post (Dec. 10, 1995), https://www.washingtonpost.com/archive/local/1995/12/10/a-death-robbed-of-dignity-mobilizes-a-community/2ca40566-9d67-47a2-80f2-e5756b2753a6/?utm_term=.352e115365e7.

[27] Daphna Stoumsa et al., *The Power and Limits of Classification—A 32-Year-Old Man with Abdominal Pain*, 380 New Eng. J. Med. 1885–88 (2019).

[28] Lindsey Bever, *Transgender Boy's Mom Sues Hospital, Saying He 'Went Into Spiral' After Staff Called Him a Girl*, Wash. Post, Oct. 3, 2016, https://www.washingtonpost.com/news/to-your-health/wp/2016/10/03/mother-sues-hospital-for-discrimination-after-staff-kept-calling-her-transgender-son-a-girl/.

[29] *Adkins v. City of New York*, 143 F.Supp.3d 134, 139 (S.D.N.Y. 2015) (Rakoff, J.).

discrimination plays an outsized role in depressing outcomes in the transgender community, with clear, measurable effects that imperil public health.

The transgender community faces high rates of mental health distress and suicidality, substance use, cigarette smoking, and HIV and other sexually transmitted infections.[30] A growing body of evidence links these and other transgender health disparities to structural, institutional, and interpersonal healthcare discrimination.[31]

Transgender exclusions are a major problem. Exclusions directly contribute to stigma and reinforce discriminatory attitudes towards this already vulnerable population.[32] Transgender healthcare exclusions single out transgender persons for disparate treatment and signal to broader society that the healthcare needs of transgender people are unimportant.[33] A growing body of research also evidences that these

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[30] *See* Sari L. Reisner et al., *Transgender Health Disparities: Comparing Full Cohort and Nested Matched-Pair Study Designs in a Community Health Center*, 1 LGBT Health 177, 177 (2014) (summarizing findings of other studies). *See also* Ann P. Haas et al., Am. Found. for Suicide Prevention & Williams Inst., *Suicide Attempts Among Transgender and Gender Non-Conforming Adults* 8 (2014), http://williamsinstitute.law.ucla.edu/wp-content/uploads/AFSP-Williams-Suicide-Report-Final.pdf (noting that 46% of transgender men and 42% of transgender women attempted suicide in their lifetime).

[31] *See, e.g.*, Cameron Donald & Jesse M. Ehrenfeld, *The Opportunity for Medical Systems to Reduce Health Disparities Among Lesbian, Gay, Bisexual, Transgender and Intersex Patients*, 39 J. Med. Sys. 178, 178–79 (2015) (linking disparities to structural and legal factors, social discrimination, and a lack of affirming and sensitive health care provision).

[32] *See generally* Jaclyn White Hughto et al., *Transgender Stigma and Health: A Critical Review of Stigma Determinants, Mechanisms, and Interventions*, 147 Soc. Sci. & Med. 222 (2015).

[33] Joe Davidson, *State Department Ends Transgender Exclusion from Health Plan*, Wash. Post (Oct. 13, 2014), https://www.washingtonpost.com/news/federal-eye/wp/2014/10/13/state-department-ends-transgender-exclusion-from-health-plan/. Secretary of State John Kerry provided the following rationale for removing exclusions from the Department's health plan:

> It's tough to tell other countries to provide equal opportunity if we're not living that out ourselves. . . . I've met transgender colleagues at the Department and in addition to being brave and strong, they're just good officers. Why should they have it any different when it comes to health care?

exclusions increase distress.[34] Indeed, public health studies investigating the consequences of laws and policies that single out minority populations for disparate treatment reveal that institutional discrimination of this ilk measurably increases incidence of psychiatric disorders.[35]

Transgender exclusions also inordinately burden providers, making it more difficult for them to appropriately treat transgender persons for GD and non-GD conditions. Providers routinely identify exclusions as a key impediment to providing patients adequate care.[36] Indeed, the ubiquity of exclusions has stymied institutional investment in provider training and artificially constricted capacity for treatment for decades.[37]

Research also reflects that transgender exclusions are costly for employers and needlessly exacerbates the rising cost of healthcare in the United States. A critical mass of transgender Americans depend upon employer provided health plans to meet their healthcare needs.[38] While 62% of Fortune 500 companies and many local and state government employers provide their employees with health plans without transgender exclusions, exclusionary plans continue to burden employers and beneficiaries alike.[39] It is commonly assumed that transgender exclusions help employers reign in costs. Not so. Research shows that transgender exclusions *increase* plan costs because when GD patients

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[34] *See, e.g.*, White Hughto et al., *Transgender Stigma and Health*.

[35] *See, e.g.*, Mark Hatzenbuehler et al., *The Impact of Institutional Discrimination on Psychiatric Disorders in Lesbian, Gay, and Bisexual Populations: A Prospective Study*, 100 Am. J. Pub. Health 452 (2010).

[36] *See, e.g.*, Stanley Vance et al., *Health Care Providers' Comfort With Barriers to Care for Transgender Youth*, 56 J. Adolescent Health 251 (2015) (observing that one of the chief barriers to providing care to transgender youth is insurance reimbursement).

[37] *See, e.g.*, Sumathi Reddy, *With Insurers on Board, More Hospitals Offer Transgender Surgery*, Wall St. J. (Sept. 26, 2016), *reprinted at* http://www.wsj.com/articles/with-insurers-on-board-more-hospitals-offer-transgender-surgery-1474907475 (noting that coverage levels are directly linked to institutional investments in building capacity for care).

[38] *Injustice at Every Turn* at 77 (noting that 51% of the persons surveyed said they were dependent on employer-provided health benefits).

[39] Melissa Gomez, *Although Transgender Workers Face Steep Barriers, Corporate America Wants to Hire Them*, L.A. Times (Apr. 8, 2019), https://www.latimes.com/business/la-fi-corporate-transgender-job-fair-20190408-story.html.

forego care, the failure to treat GD exacerbates other health conditions which, in turn, are more expensive to treat absent appropriate GD care.[40]

Transgender exclusions also imperil wellness. Where transgender people cannot access GD treatment, the distress of living with untreated GD taxes the body and mind. GD patients report that the experience of living in a body that does not match their gender identity is immensely distressing, and for some it is akin to torture.[41] Unsurprisingly, the profound distress caused by untreated GD leads many to engage in self-harm.[42] Additional consequences of inadequate GD treatment include heightened incidence of risky behavior, underutilization of primary care and preventative treatments, high rates of self-medication, and heightened suicidality.[43]

Healthcare setting discrimination also drives health disparities. Entrenched bias within the medical profession suppresses efforts to increase provider education and makes large-scale efforts to build cultural competency across the profession difficult. Bias is a real, measurable threat to public health.

Due to a paucity of openly friendly health providers and facilities, many patients are forced to navigate health care settings that maintain policies

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[40] *See, e.g.*, W. Padula et al., *Societal Implications for Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis*, 31 J. Gen. Intern. Med. 394, 398 (2016) (finding it is more cost effective for insurers to cover transgender healthcare because provision of care reduces incidence of HIV, depression, suicidality, and drug abuse resulting in a effective cost savings). *See also* Jody L. Herman et al., Williams Inst., *Costs and Benefits of Providing Transition-Related Health Care Coverage in Employee Health Benefits Plans* 3 (2013) (finding that "there was no relationship between scope of the coverage provided and reported costs of adding the coverage, meaning providing broader coverage did not result in higher costs for surveyed employers").

[41] *See, e.g.*, Sarah Karlan, *We Asked People to Illustrate Their Gender Dysphoria*, BuzzFeed (Mar. 10, 2016), https://www.buzzfeed.com/skarlan/we-asked-people-to-illustrate-what-their-gender-dysphoria-fe?utm_term=.xcMvq3qlv#.agbJKmKgJ.

[42] *See, e.g.*, Sam Winter et al., *Transgender People: Health at the Margins of Society*, 388 Lancet 390, 394 (2016).

[43] *See generally* Nelson F. Sanchez, *Health Care Utilization, Barriers to Care, and Hormone Use Among Male-to-Female Transgender Persons*, 99 Am. J. Pub. Health 713 (2009); Amaya Perez-Brumer et al., *Individual- and Structural-Level Risk Factors for Suicide Attempts Among Transgender Adults*, 41 Behavioral Med. 164 (2015).

and practices that are ill-suited to serving transgender people.[44] In many instances, transgender patient's medical privacy is compromised by intake processes devised for nontransgender patients.[45] Similarly, medical records systems designed for nontransgender patients often fail to capture accurate identification information and introduce offensive, erroneous notations.[46]

A growing body of evidence suggests that the high rates of poor treatment reported by transgender patients are driven in part by knowledge gaps that are exacerbated by unchecked anti-transgender implicit bias. Implicit bias[47] regularly leads to discrete discrimination that actors have difficulty identifying as being bias-motivated. "Unlike *explicit bias* (which reflects the attitudes or beliefs that one endorses at a conscious level), *implicit bias* is the bias in judgment and/or behavior that results from subtle cognitive processes (e.g., implicit attitudes and implicit stereotypes) that often operate at a level below conscious awareness and without intentional control."[48]

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[44] *See, e.g.*, Lewis A. Raynor et al., *Exploratory Spatial Analysis of Transgender Individuals' Access to Health Care Providers in the State of Minnesota*, 15 Int'l J. Transgenderism 129 (2014) (noting that in many areas in Minnesota there are no self-identified transgender friendly providers).

[45] *See, e.g.*, J. Michael Wilkerson et al., Univ. Minn. Sch. Pub. Health, *Results of a Qualitative Assessment of Inclusive Healthcare in the Twin Cities* 4 (2009), http://www.rainbowhealth.org/files/8313/6319/9596/Assessment_of_Inclusive_Healthcare.pdf (noting frequent occurrence of clinical staff in Twin Cities region asking transgender patients questions that forced patient to out themselves during intake process in front of other patients or staff who did not need to know about it).

[46] *See* Madeline B. Deutsch et al., *Electronic Medical Records and the Transgender Patient: Recommendations from the World Professional Association for Transgender Health EMR Working Group*, 20 J. Am. Med. Info. Assoc. 700 (2013) (advising that electronic medical records should collect the patient's legal name, preferred name [if different from legal name], gender identity, sex assigned at birth, and inventory reproductive organs as a means to accurately record medically necessary data pertinent to treatment).

[47] A growing body of social science research and case law covering a wide array of biases evidences that decision-maker's implicit biases, driven by unconscious stereotyping about historically marginalized minority groups, regularly lead to discrete act discrimination which actors having troubling difficulty identifying as being bias-motivated. For a thorough account of the state of implicit bias research, see *State v. Saintcalle*, 178 Wash.2d 34, 46–49 (Wash. 2013) (*en banc*). For discussion concerning general acceptability of social framework analysis and implicit bias and use thereof to prove discrimination, see *Apilado v. N.A. Gay Amateur Athletic Alliance*, 2011 WL 13100729, *2–*3 (W.D.Wash. July 1, 2011).

[48] Nat'l Ctr. for State Courts, *Helping Courts Address Implicit Bias: Frequently Asked Questions* (2012).

Outside of the small subset that specialize in transition related care, many providers lack basic knowledge of the effects of transition related care and basic cultural competency. In one national survey, an alarming 50% of transgender patients reported having to teach health providers about transgender people in the course of receiving treatment.[49] Provider knowledge gaps are more than an inconvenience for transgender patients. Researchers have linked provider knowledge gaps to poor treatment. For example, knowledge gaps upset typical power imbalances between patients and providers, leading some providers to stigmatize their transgender patients to reinforce expected patient-provider power inequalities.[50]

Health care facility administrators' implicit biases also negatively impact transgender patients' health. Many administrators are primed to undervalue the needs of transgender patients due to decades of anti-transgender discrimination in the medical profession.[51] Much like providers who fail to take steps to obtain basic cultural competency, administrators with unchecked anti-transgender implicit bias may make decisions which negatively impact transgender patients and fail to identify these decisions as being discriminatory. Such bias-ridden policy decisions have deleterious effects on patient care.[52]

Lastly, research reflects that providers' failure to implement culturally competent practices has deleterious consequences. Studies reveal that

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[49] *Injustice at Every Turn* at 76.

[50] *See, e.g.*, Tonia Poteat et al., *Managing Uncertainty: A Grounded Theory of Stigma in Transgender Health Care Encounters*, 84 Soc. Sci. & Med. 22, 28 (2013) ("Interpersonal stigma and discrimination during transgender health care encounters served to reinforce the authority of the medical provider in the face of his or her uncertainty and ambivalence about transgender people and their care as well as the transgender patient's uncertainty about the provider's competence.").

[51] *See generally* Keisa Fallin-Bennett, *Implicit Bias Against Sexual Minorities in Medicine: Cycles of Professional Influence and the Role of the Hidden Curriculum*, 90 Academic Med. 549 (2015) (observing that physicians' implicit bias against LGBT patients has created a cycle that perpetuates professional climate reinforcing the bias).

[52] *See, e.g.*, Jaclyn M. White Hughto et al., *Transgender Stigma and Health: A Critical Review of Stigma Determinants, Mechanisms, and Interventions*, 147 Soc. Sci. & Med. 222, 224 (2015) (providing an operative definition of structural-level stigma and further observing that transgender disfavoring institutional policies and practices are a barrier to health care).

transgender patients who have had bad experiences in healthcare settings are more likely to delay or forego care altogether. In a 2014 study an alarming 33% of transgender patients reported postponing preventative care because they feared discrimination and disrespect from providers.[53] In a 2015 national survey, 23% of transgender respondents reported not seeing any health provider in the past year due to fear of mistreatment.[54] For patients who seek out care and encounter discrimination, negative experiences reinforce stigma, exacting a toll on transgender patients' mental and physical health.[55]

II. Our nation's discrimination laws protect everyone, including transgender Americans.

A. Understanding the myth of transgender exceptionalism.

For several decades, American jurisprudence was infected by the transgender exceptionalism myth. That is, many (but not all) federal and state courts and agencies assumed in the first instance that broadly applicable laws did not protect transgender people. This position was neither commanded by fidelity of law or based on logic and, where statutes were involved, did not naturally flow from text interpreted by the usual means. In many cases, the exceptionalism myth pushed decisionmakers to stake out otherwise odd and incongruent legal positions that led to profoundly absurd results.

Legal commentators have long recognized the phenomenon.[56] Although commentators have used different terms and phrases to label it in a variety of legal contexts, they all point to the same doctrinal error—the

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[53] Daphna Stroumsa, *The State of Transgender Health Care: Policy, Law, and Medical Frameworks*, 104 Am. J. Pub. Health e31, e32 (2014).

[54] *2015 Transgender Survey* at 98.

[55] *See, e.g.*, Amaya Perez-Brumer et al., *Individual- and Structural-Level Risk Factors for Suicide Attempts Among Transgender Adults*, 41 Behavioral Med. 164 (2015) (finding individual and structural forms of stigma to be risk factors for suicide attempts).

[56] *See generally* Paisley Currah & Shannon Minter, *Unprincipled Exclusions: The Struggle to Achieve Judicial and Legislative Equality for Transgender People*, 7 Wm. & Mary J. Race, Gender, and Social Just. 37 (2000); Abigail Lloyd, *Defining the Human: Are Transgender People Strangers to the Law*, 20 Berkeley J. Gender & Just. 150 (2005).

decisionmakers' assumption that there is something *exceptional* about transgender persons drove them to conclude that generally applicable laws must expressly indicate transgender people are protected and, barring that, laws were construed to exclude transgender persons or, in some instances, emboldened judges to legislate from the bench and erect special burdens only applicable to transgender people.[57]

B. Historically, some courts erroneously deemed transgender people categorically unprotected by sex discrimination laws.

For a time, the transgender exceptionalism myth sowed doctrinal errors that infected federal sex discrimination caselaw. Taken as a whole, transgender sex discrimination opinions of this period were marked by tautologies and curious invocations of otherwise disfavored canons of statutory interpretation. In practice, transgender Americans were deemed categorically unprotected not because any statute's text required that conclusion, but because sex discrimination itself was conceived only as that which is experienced by nontransgender persons. These opinions are seriously flawed and should be relegated to the dustbins of history. For instance,

- In *Holloway v. Arthur Andersen & Co.*, the Ninth Circuit construed Title VII's sex discrimination proscription to have a transgender exception.[58] Even though Title VII broadly prohibits discrimination "because of . . . sex"[59] and the term "sex" is not defined, the *Holloway* majority spuriously reasoned that because Congress was silent as to whether transgender persons are protected, a transgender

[57] *See, e.g.*, Lloyd, *Defining the Human* at 154 ("No matter how a transgender plaintiff articulates his injury, he is likely to encounter a court that draws a line in a way that makes him a stranger to all the laws that could protect him."); Jennifer L. Levi, *Paving the Road, a Charles Hamilton Houston Approach to Securing Trans Rights*, 7 Wm. & Mary J. Women & L. 5, 6 (2000) ("[T]he Orwellian rhetoric in [transgender] cases suggests that it is bias and bigotry, rather than logic, that determined the outcomes.").

[58] 556 F.2d 659 (9th Cir. 1977).

[59] 42 U.S.C. §2000e-2(a)(1).

exception is necessarily inferred.[60] (Today, invocation of the canon of congressional silence is supremely disfavored.[61]) In dissent, Judge Goodwin, a Nixon appointee, lambasted his colleagues' shoddy reasoning. Among other things, Judge Goodwin presciently explained that the majority misapprehended its task. One need not craft a definition of discrete sex classes, let alone endeavor to assign victims to any particular class. To paraphrase Judge Goodwin's nuanced analysis—everyone has a sex, the only issue is whether, as a matter of fact, the victim's sex (whatever it is) was illicitly taken into account.[62]

- In *Sommers v. Budget Marketing, Inc.*, the Eighth Circuit, also construing Title VII in a transgender woman's case, reasoned that Congress' then recent failures to amend Title VII to expressly protect lesbian, gay, and bisexual workers evidenced its intent to categorically bar transgender persons from protection.[63] (Today, the canon of congressional inaction is broadly disfavored.[64])

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[60] *Holloway*, 556 F.2d at 663 ("Congress has not shown any intent other than to restrict the term 'sex' to its traditional meaning. Therefore, this court will not expand Title VII's application in the absence of Congressional mandate.").

[61] *See, e.g.*, *Dellmuth v. Muth*, 481 U.S. 223, 230 (1989) ("evidence of congressional intent must be both unequivocal and textual").

[62] *Holloway*, 566 F.2d at 664 (Goodwin, J. dissenting) ("By its language, the statute proscribes discrimination among employees because of their sex. When a transsexual completes his or her transition from one sexual identity to another, that person will have a sexual classification. [] It seems to me irrelevant under Title VII whether the plaintiff was born female or was born ambiguous and chose to become female. The relevant fact is that she was, on the day she was fired, a purported female. She says she was fired for having become a female under controversial circumstances. The employer says these circumstances are disconcerting to other employees. That may or may not be true. Plaintiff says that how she became female is not her employer's business. That may or may not be true. Those are questions that ought to be answered in court, in a trial; they should not be precluded by summary judgment or Rule 12 dismissal.").

[63] 667 F.2d 748 (8th Cir. 1982).

[64] *See, e.g.*, *Pension Benefit Guar. Corp. v. LTV Corp.*, 496 U.S. 633, 650 (1990) (canon of congressional inaction "lacks persuasive significance because several equally tenable inferences may be drawn from such inaction, including the inference that the existing legislation already incorporated the offered change"); *Prostar v. Massachi*, 239 F.3d 669, 677 (5th Cir. 2001) ("Congress's failure to subsequently amend the statute . . . may only betoken unawareness, preoccupation, or paralysis. Inertia is endemic to the legislative process, rendering congressional inaction a problematic interpretive guide.") (quotations omitted).

- In *Ulane v. Eastern Airlines, Inc.*, the Seventh Circuit, also construing Title VII in a transgender woman's case, invoked the canon of Congressional inaction, holding that until Congress affirmatively passed new legislation to define the term "sex" to include transgender persons, it would construe Title VII to have a transgender exception.[65]

Federal courts abruptly changed course in the wake of two seminal Supreme Court cases. The first, *Price Waterhouse v. Hopkins*, held that Title VII's sex discrimination reaches discrimination on the basis of one's status as male or female as well as discrimination animated by sex stereotypes.[66] The second, *Oncale v. Sundowner Offshore Servs., Inc.*, further expanded the reach of Title VII's sex proscription to all forms of sex discrimination that alter the terms or conditions of employment, even permutations that are "not the principal evil Congress was concerned with when it enacted Title VII."[67]

In the aftermath of *Hopkins* and *Oncale*, the overwhelming majority of federal courts have construed remedial civil rights statutes to reach sex discrimination experienced by transgender people. At the appellate level,

[65] 742 F.2d 1081, 1086 (7th Cir. 1984) ("If Congress believes that transsexuals should enjoy the protection of Title VII, it may so provide. Until that time, however, we decline in behalf of Congress to judicially expand the definition of sex as used in Title VII beyond its common and traditional interpretation.").

[66] 490 U.S. 228 (1989).

[67] 523 U.S. 75, 79 (1998) (Scalia, J.).

the First Circuit,[68] Sixth Circuit,[69] Seventh Circuit,[70] Eighth Circuit,[71] Ninth Circuit,[72] Tenth Circuit,[73] and Eleventh Circuit[74] have all affirmatively recognized that transgender people are protected by sex discrimination laws.

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[68] *Rosa v. Park West Bank & Trust Co.*, 214 F.3d 213, 214–15 (1st Cir. 2000) (Equal Credit Opportunity Act reaches transgender person's sex stereotyping claim).

[69] *See, e.g.*, *Smith v. City of Salem*, 378 F.3d 566, 575 (6th Cir. 2004) ("Sex stereotyping based on a person's gender non-conforming behavior is impermissible discrimination, irrespective of the cause of that behavior; a label, such as 'transsexual', is not fatal to a sex discrimination claim where the victim has suffered discrimination because of his or her gender non-conformity."); *EEOC v. Harris Funeral Homes*, 884 F.3d 560, 576–77 (6th Cir. 2018) ("[A]n employer cannot discriminate on the basis of transgender status without imposing its stereotypical notions of how sexual organs and gender identity ought to align. There is no way to disaggregate discrimination on the basis of transgender status from discrimination on the basis of gender non-conformity, and we see no reason to try.").

[70] *Whitaker v. Kenosha Sch. Dist.*, 858 F.3d 1034 (7th Cir. 2017) (construing Title IX to prohibit sex stereotype discrimination experienced by transgender student and further deeming *Ulane* as a dead-letter post *Price Waterhouse*).

[71] *Hunter v. UPS*, 697 F.3d 697, 702 (8th Cir. 2012) (recognizing that gender stereotyping of transgender worker can give rise to Title VII violation).

[72] *Schwenk v. Hartford*, 204 F.3d 1187, 1201–02 (9th Cir. 2000) (interpreting the Gender Motivated Violence Act to reach sex discrimination experienced by transgender people and recognizing *Holloway* as totally abrogated by *Price Waterhouse*); *Kastl v. Maricopa Cmty. Coll.*, 325 Fed.Appx. 492 (9th Cir. 2009) (per curium) (Gorsuch, J. on panel) ("After *Hopkins* and *Schwenk*, it is unlawful to discriminate against a transgender (or any other) person because he or she does not behave in accordance with an employer's expectations for men or women.").

[73] *Etsitty v. Utah Transit Authority*, 502 F.3d 1215, 1222 (10th Cir. 2007) ("[T]ranssexuals may not claim protection under Title VII from discrimination based solely on their status as a transsexual. Rather, like all other employees, such protection extends to transsexual employees only if they are discriminated against because they are male or because they are female.").

[74] *Chavez v. Credit Nation Auto Sales*, 641 Fed.Appx. 883, 883 (11th Cir. 2016) ("Sex discrimination includes discrimination against a transgender person for gender nonconformity."); *Glenn v. Brumby*, 663 F.3d 1312, 1318 (11th Cir. 2011) ("All persons, whether transgender or not, are protected from discrimination on the basis of gender stereotype.").

C. There are different theories that sustain transgender-inclusive constructions of sex discrimination laws.

At present, not a single Circuit Court holds transgender persons are totally unprotected by sex discrimination laws. *See* discussion *supra* Part II-B. However, the Circuits and many federal trial courts have adopted different, complementary theories to sustain transgender-inclusive constructions of sex discrimination laws. Our own survey of the caselaw reveals at least seven discrete theories invoked by federal courts:

- Sex stereotyping[75]
- Gender[76]
- Gender transition[77]
- Gender nonconformity[78]
- *Per se* sex discrimination[79]

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[75] *See, e.g.*, *Lopez v. River Oaks Imaging & Diagnostic Group, Inc.*, 542 F.Supp.2d 653, 660 (S.D. Tex. 2008) (holding that while discrimination based on transgender status did not violate Title VII, transgender individuals could still bring sex stereotyping claims).

[76] *Schwenk*, 204 F.3d at 1201–02 ("The initial judicial approach taken in cases such as *Holloway* has been overruled by the logic and language of *Price Waterhouse*. '[S]ex' under Title VII encompasses both sex—that is, the biological differences between men and women—and gender.").

[77] *See, e.g.*, *Hart v. Lew*, 973 F.Supp.2d 561, 580–81 (D.Md. 2013) (construing employers attempts to interfere with employee's "gender transition" as cognizable sex discrimination).

[78] *See, e.g.*, *Dodds v. U.S. Dep't Edu.*, 845 F.3d 217, 221 (6th Cir. 2016) (recognizing that "gender nonconformity" is a form of actionable sex discrimination under settled circuit precedents, and deeming these precedents applicable in Title IX context); *Chavez*, 2016 WL 158820 at *1 (11th Cir. 2016) ("Sex discrimination includes discrimination against a transgender person for gender nonconformity."); *Myers v. Cuyahoga County, Ohio*, 182 Fed.Appx. 510 (2006) (transsexual label not fatal to sex discrimination claim where the victim has suffered discrimination because of his or her gender nonconformity).

[79] *See, e.g.*, *Schroer v. Billington*, 577 F. Supp.2d 293, 308 (D.D.C. 2008) (holding that refusal to hire prospective transgender employee after learning of her plan to have sex reassignment surgery was *literally* discrimination "because of . . . sex").

- Gender identity[80]
- Transgender status[81]
- Genital configuration stereotypes[82]
- Treating someone as if they are a sex they are not[83]

At bottom, we think it is incumbent on OCR to carefully study the diverse array of court opinions that coalesce with a transgender-inclusive construction of sex discrimination laws.

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[80] *See, e.g.*, *Rumble v. Fairview Health Servs.*, 2015 WL 1197415 at *7 (D.Minn. Mar. 16, 2015) (interpreting the 1557 statute to reach "gender identity" discrimination as one form of sex discrimination).

[81] *See, e.g.*, *Evancho v. Pine-Richland Sch. Dist.*, 2017 WL 770619 at *11 (W.D.Pa. Feb. 27, 2017) ("discrimination based on transgender status in these circumstances is essentially the epitome of discrimination based on gender nonconformity, making differentiation based on transgender status akin to discrimination based on sex").

[82] *See, e.g.*, *Roberts v. Clark Cnty. Sch. Dist.*, 2016 WL 5843046 at *9 (D.Nev. Oct. 4, 2016) ("Although [Defendant] contends that it discriminated against Roberts based on his genitalia, not his status as a transgender person, this is a distinction without a different here. Roberts was clearly treated differently than persons of both his biological sex and the gender he identifies as—in sum, because of his transgender status.").

[83] *See, e.g.*, *U.S. and Rachel Tudor v. Southeastern Okla. State Univ. and Reg'l Univ. Sys. of Okla.*, 2015 WL 4606079 at *2 (W.D.Okla. July 10, 2015) ("Here, it is clear that Defendants' actions as alleged by Dr. Tudor occurred because she was female, yet Defendants regarded her as male. Thus, the actions Dr. Tudor alleges Defendants took against her were based upon their dislike of her presented gender. . . . The factual allegations raised by Dr. Tudor bring her claims squarely within the Sixth Circuit's reasoning as adopted by the Tenth Circuit in *Etsitty*. Consequently, the Court finds that the discrimination occurred because of Dr. Tudor's gender, and she falls within a protected class.").

D. OCR's legal analysis proffered in support of removing language from the 1557 Rule, which expressly protects transgender persons, is fatally flawed.

The legal analysis OCR invokes to justify the Proposed Rule's deletion of the 1557 Rule's provisions defining the terms "gender identity"[84] and "sex stereotypes"[85] is fatally flawed. Likewise, OCR's proposal to delete a provision which delineates a handful of discrete examples of sex discrimination disproportionately experienced by transgender persons[86] is similarly infirm. Indeed, OCR's legal analysis bespeaks a fundamental misapprehension of sex discrimination jurisprudence in this arena.

First, OCR's analysis reflects it does not understand there are several distinct theories that may sustain a transgender-inclusive construction of federal sex discrimination laws. Indeed, OCR appears to have assumed that the only theory available is "gender identity." That is incorrect. As we discussed *supra* Part II-C, "gender identity" is but one of several legal theories that has been embraced by federal courts. Unfortunately, it appears that OCR's error has skewed its analysis. If OCR only looked for decisions that invoked the gender identity theory, it missed the many cases that embrace transgender-inclusive constructions of sex discrimination laws premised on different theories.

Second, OCR fundamentally misconstrued the holdings of some of the cases it cites in support of the proposition that sex discrimination laws

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[84] 45 CFR 92.4 (defining "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").

[85] 45 CFR 92.4 (defining "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. These stereotypes can include the expectation that individuals will consistently identity with only one gender and that they will act in conformity with the gender-related expression stereotypically associated with that gender. Sex stereotypes also include gender expectations related to the appropriate roles of a certain sex.").

[86] 45 CFR 92.206 and 92.207(b)(3) (requiring that covered entities treat individuals "consistent with their gender identity" and further noting that covered entities "may not deny or limit health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that the individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available.").

do not protect transgender persons. We are deeply concerned that these mistakes led OCR to miscalculate the viability of transgender-inclusive constructions of the law.

As one example, OCR's analysis claims that the Tenth Circuit's opinion in *Etsitty v. Utah Transit Authority* held that "Title IX does not prohibit gender identity discrimination."[87] Not so. At the threshold, *Etsitty* is a Title VII, not a Title IX case. Of deeper concern, the *Etsitty* Court did not consider the gender identity theory. Rather, the *Etsitty* Court famously rejected the *per se* theory claiming a lack of medical evidence in the record to sustain it[88] but nonetheless went on to embrace the sex stereotyping theory. In pertinent part, the *Etsitty* Court held that,

> The conclusion that transsexuals are not protected under Title VII *as transsexuals* should not be read to allow employers to deny transsexual employees the legal protection other employees enjoy merely by labeling them as transsexuals. *See Smith v. City of Salem*, 378 F.3d 566, 575 (6th Cir. 2004) ("Sex stereotyping based on a person's gender non-conforming behavior is impermissible discrimination, irrespective of the cause of that behavior; a label, such as 'transsexual,' is not fatal to a sex discrimination claim where the victim has suffered discrimination because of his or her gender nonconformity.").[89]

If that statement weren't enough, OCR could have dug a bit deeper and discovered that, since 2007, every single district court in the Tenth Circuit presented with the question of whether transgender persons can bring sex discrimination claims has answered in the affirmative and deemed that result compelled by *Etsitty*.[90]

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[87] 84 FR at 27855 n.64.

[88] *Etsitty*, 502 F.3d 1215, 1222 (10th Cir. 2007) ("Scientific research may someday cause a shift in the plain meaning of the term 'sex' so that it extends beyond the two starkly defined categories of male and female. At this point in time and with the record and arguments before this court, however, we conclude discrimination against a transsexual because she is a transsexual is not 'discrimination because of sex'.").

[89] *Id.* at 1222 n.2.

[90] *Michaels v. Akal Sec., Inc.*, 2010 WL 2573988 (D. Colo. 2010) (federal courthouse employee demonstrated that employer's proffered reason for restricting her usage of certain

Third, OCR's legal analysis repeatedly invokes disfavored canons of statutory construction in support of the proposition that sex discrimination laws should be construed to impliedly exclude transgender persons from coverage. For instance, OCR argues that Congress' failure to amend Title VII and Title IX to cover "gender identity" weighs against a transgender-inclusive construction.[91] Though OCR is correct that there have been some efforts to amend these statutes, it fails to consider whether Congress declined to take action for reasons that have no bearing on the proper interpretation of these civil rights laws. Indeed, to state the obvious, vulnerable communities often lack the political power to obtain special legislation.

Fourth, we are deeply confused by OCR's contention that the 1557 Rule's definition of sex discrimination must be reconciled with technical and idiosyncratic uses of the term "sex" deployed by other sub-divisions of HHS in wildly different contexts.[92]

As one example, we do not see why OCR's maintenance of a transgender-inclusive construction of sex discrimination laws conflicts with the National Institutes of Health's (NIH) direction that bio-medical researchers in some areas take sex differences into account in certain animal and human studies.[93] Moreover, OCR appears to have overlooked a growing body of literature that suggests researchers cease referring to transgender patients by their birth sex because, among other things, it is

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bathrooms was pretextual and thus stated a Title VII claim on the basis of gender-based stereotyping); *Smith v. Avanti*, 249 F.Supp.3d 1194, 1200 (D. Colo. 2017) (recognizing that *Etsitty* allows the Smiths' sex discrimination claim to proceed under a gender stereotyping theory); *EEOC v. A&E Tire, Inc.*, 325 F.Supp.3d 1129, 1133 (D. Colo. 2018) ("Title VII protects all persons, including transgender persons, from discrimination based on gender nonconformity."); *Tudor*, 2015 WL 4606079 at *2 ("The factual allegations raised by Dr. Tudor bring her claims squarely within the Sixth Circuit's reasoning as adopted by the Tenth Circuit in *Etsitty*. Consequently, the Court finds that the discrimination occurred because of Dr. Tudor's gender, and she falls within a protected class.").

[91] 84 FR 27853.

[92] *See generally* 84 FR 27853–54.

[93] *See* 84 FR 27854 n.50 (*citing* NIH Guidance, *Consideration of Sex as a Biological Variable in NIH-funded Research* at 1 (2017), https://orwh.od.nih.gov/sites/orwh/files/docs/NOT-OD-15-102_Guidance.pdf).

disrespectful to patients and needlessly confusing to readers.[94] It also ignores other literature that reflects that in many clinical settings, failure to take into account both birth sex and gender identity (the latter of which is a proxy for the patient having undergone hormonal or surgical treatments that alter the body) may lead to harmful mistakes.[95] It also ignores literature supporting the notion that a transgender person's birth sex, gender identity, and history of hormone and/or surgical treatment must be taken into account to accurately capture sex disparities.[96]

Similarly, we see no reason why OCR presently construes the 1557 Rule's transgender inclusive construction of sex discrimination laws to conflict with the Office of the National Coordinator for Health Information Technology's (ONC) 2015 regulations that set standards for coding certain health data.[97] Both the 1557 Rule and the ONC regulations embrace the notion that transgender persons exist,[98] that sex is not limited to a male/female binary,[99] and otherwise acknowledge that one's

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[94] *See, e.g.,* Sara Reardon, *The Largest Study Involving Transgender People is Provising Long-Sought Insights About Their Health*, Nature (Apr. 24, 2019), https://www.nature.com/articles/d41586-019-01237-z ("Making matters worse, the terminology used in the literature can be confusing; uninformed authors often swap gender terms, especially in older publications. 'They look at a transgender woman and call her a transgender man because they say, 'Oh, that's a man who thinks he's a woman,' says Safer. 'It's not only insulting, it's mixing us all up.'").

[95] *See, e.g.*, Joseph Gerth et al., *Agreement Between Medical Records and Self-Reports: Implications for Transgender Health Research*, 19 Reviews in Endocrine & Metabolic Disorders 263–69 (2018) (concluding that current electronic medical record protocols do a poor job of capturing whether a transgender patient has undergone chest and/or genital reconstruction surgeries, information that can prove critical to clinicians in some treatment contexts); Zil Goldstein et al., *When Gender Identity Doesn't Equal Sex Record at Birth: The Role of the Laboratory in Providing Effective Healthcare to the Transgender Community*, 63 Clinical Chemistry 1342–52 (2017) (literature review substantiating concern that in some instances neither birth sex nor gender identity set reliable baseline values for certain purposes).

[96] *See, e.g.*, Talal Alzahrani et al., *Cardiovascular Disease Risk Factors and Myocardial Infarction in the Transgender Population*, 12 Circulation: Cardiovascular Quality & Outcomes e005597 (2019) (reporting measurable sex differences with respect to susceptibility to cardiovascular disease among nontransgender men, nontransgender women, transgender men, and transgender women).

[97] 84 FR 27854–55 (*citing* 45 CFR 170.207(n)–(o)).

[98] 45 CFR 170.207(o)(iv)–(vii) (allowing six discrete gender classification options in addition to the option to not disclose gender).

[99] 45 CFR 170.207(n)(iii) (allowing for an "Unknown" input value as an alternative to male or female designations).

sex assigned at birth is not in all cases dispositive of identity or bodily configuration.

E. The *Franciscan Alliance* Court's opinion is fatally flawed.

The Proposed Rule repeatedly references the *Franciscan Alliance* Court's December 2016 preliminary injunction opinion as evidencing serious legal infirmities in components of the 1557 Rule which expressly recognize sex discrimination protections extend to transgender persons. However, the *Franciscan Alliance* opinion hinges on glaring logical errors and poor legal reasoning and thus should be afforded little if any weight.

To refresh, the *Franciscan Alliance* opinion construes 1557's sex discrimination proscription, which incorporates by reference status protections delineated in Title IX, as narrowly reaching sex classifications defined by "the biological and anatomical differences between male and female students as determined at their birth."[100] At best, that conclusion is nonsensical. At worst, it's indicative of legislating from the bench. Either way, OCR should afford it little weight.

First, the *Franciscan Alliance* Court need not and should not have endeavored to define what any individual's sex is as a matter of classification. That is to say—whether a person is male, female, or other has no bearing on whether they are protected by sex discrimination laws. Thus, it makes no sense to try to idiosyncratically define from the bench what kinds of people can (or should) be classified as male, female, or other. Rather, the only appropriate judicial task is to interpret the metes and bounds of sex discrimination protections—meaning the specific manifestations of harassment, disparate treatment, or disparate impact discrimination that violate the statute.

The *Franciscan Alliance* Court's fixation on defining sex for classification purposes belies its fundamental legal error. Title IX's text broadly prohibits discrimination "on the basis of sex."[101] Neither the statute nor regulations promulgated under it endeavor to define what sex itself is let

[100] *Franciscan Alliance*, 227 F.Supp.3d 660, 667 (N.D.Tex. 2016) (O'Connor, J.) (*citing Texas v. United States*, 201 F.Supp.3d 810, 833 (N.D. Tex. 2016) (O'Connor, J.)).

[101] 20 U.S.C. § 1681(a).

alone proscribe rules as to how individuals should be classified. That makes sense in light of the statutory purpose. Title IX is a remedial sex discrimination law. As with other similar laws, Congress endeavored to ensure that no American is mistreated because of who they are or outdated assumptions about how best to be a man or woman in our world. It certainly did not condition rights on a particular dictionary's definition of sex, let alone insist victims produce a birth certificate or submit to genital inspections or genetic testing to get through the courthouse doors. For good reason. The evil Congress put in its crosshairs isn't the victim's sex. The point is that one's sex shouldn't matter.

Indeed, the *Franciscan Alliance* Court presents a solution in search of a problem. We do not need to define sex classifications for our sex discrimination laws to work. Even if we can't agree a transgender woman is a woman or man a man, taking an adverse action against someone because of a conflict about their sex takes sex into account. That is discrimination. This isn't revolutionary, and this isn't a liberal talking point. Think of the same issue in a different way: if someone takes an adverse action against a Latter-Day Saint convert because he dislikes Catholics, and the actor deems her a Catholic since that was her faith at birth, that would nonetheless be religious discrimination.

Second, there are painful ironies to the *Franciscan Alliance* Court's opinion. Its sex definition leads to bizarre and unworkable outcomes. It intends to designate many people who live as, are recognized by their state and communities as being, and actually look and sound male or female to be the opposite. For example, it deems a bearded transgender man who has a penis and amended birth certificate recognizing him as male to be a woman. That makes no sense.

Third, the *Franciscan Alliance* opinion's reasoning is also out of line with accepted norms of statutory construction. For instance, the opinion seeks to resolve a statutory ambiguity by adding terms to the statute being interpreted. This is not statutory interpretation—it's legislating from the bench.[102]

[102] *See De Soto Secs. Co. v. C.I.R.*, 235 F.2d 409, 411 (7th Cir. 1956) ("Courts have no right, in the guise of construction of an act, to either add words to or eliminate words from the language used by congress.").

Fourth, the statutory construction adopted by the *Franciscan Alliance* Court treads in dangerous constitutional waters that OCR would be wise to avoid. The *Franciscan Alliance* opinion construes federal sex discrimination laws to specially except transgender people from protection. That construction is more than just offensive. It necessarily raises thorny constitutional questions.

Assuming for the sake of argument that Congress did in fact adopt a restrictive definition of "sex" that singles out transgender people for disparate treatment, neither courts (nor agencies for that matter) can give that exclusion effect. As the Supreme Court recently reiterated in *United States v. Windsor*, "[t]he Constitution's guarantee of equality must at the very least mean that a bare congressional desire to harm a politically unpopular group cannot justify disparate treatment of that group."[103] Nor can Congress create a statutory scheme that confers benefits unequally as between transgender and nontransgender persons premised on stereotyped understandings of what it means to be a man or a woman.[104]

Given the foregoing, even if OCR believes that a transgender exclusionary construction of sex discrimination is supported by the text of Title IX, it would be a wiser course to reassess whether any other construction is viable. Indeed, we think the better course for OCR (and any reviewing courts) is to abide by the canon of constitutional avoidance. Pursuant to that canon, where there are multiple permissible constructions of a statute, one should adopt a construction that does not force courts to decide whether Congress acted constitutionally.[105]

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[103] 570 U.S. 744, 770 (2013) (cleaned up).

[104] *See e.g., Miss. Univ. for Women v. Hogan*, 440 U.S. 268 (1979); *Orr v. Orr*, 440 U.S. 268 (1979); *Weinberger v. Wiesenfeld*, 420 U.S. 636 (1975).

[105] *See, e.g.*, *Edward J. DeBartolo Corp. v. Fla. Gulf Coast Bldg. & Const.*, 485 U.S. 568, 575 (1988).

III. A bare desire to mitigate litigation risk does not justify artificially restricting civil rights laws' coverage of vulnerable communities.

Our nation's civil rights laws should be fairly construed and, most certainly, the most vulnerable amongst us should be protected to the furthest extent permitted by law. As we discussed *supra* Parts I-B and I-C, transgender Americans face inordinate difficulties navigating healthcare settings and obtaining insurance coverage of medically necessary care. As highlighted in Part I-D, some of the most alarming health disparities within the transgender community are tied to discrimination and stigma. Further, as explored here in Part III, these very real and serious problems rightfully moved HHS to promulgate the 1557 Rule in 2016.

Given the indisputable need for government action in this area and the robust legal support that sustains a transgender-inclusive construction of 1557's sex discrimination protections, we are deeply alarmed that OCR appears poised to reverse policy due to the supposed threat of litigation as epitomized by *Franciscan Alliance* and similar suits. While we appreciate that the federal government necessarily takes litigation-management assessments into account, we do not think OCR is empowered to curtail the civil rights of vulnerable minorities solely or primarily to lessen the risk of litigation. Unfortunately, OCR appears poised to do just that.

Much of the Proposed Rule's preliminary analysis is overly-preoccupied with crafting a shift in OCR policy that resolves the nationwide preliminary injunction issued in *Franciscan Alliance*. This is wrongheaded and a rationale that cannot survive arbitrary and capricious review.

Though litigation-management assessments can be a factor, OCR must also weigh competing policy considerations, including programmatic objectives and the reliance interests of those affected by a proposed rule change.[106] We believe that OCR failed to do just that. For instance, OCR's

[106] *Regents of Univ. of Cal. v. U.S. Dep't Homeland Sec.*, 279 F.Supp.3d 1011, 1044 (N.D.Cal. 2018). *See also Encino Motorcars, LLC v. Navarro*, 136 S.Ct. 2117, 2126 (2016) ("In

analysis of the Proposed Rule does not take into account any negative effects the policy shift will have on transgender Americans. As one example, OCR did not attempt to take into account the aggregate costs that will be passed along to consumers if covered entities deem themselves free to discriminate against transgender persons under federal law. Nor did OCR interrogate whether the policy shift will impose additional costs on employers who provide their workers and beneficiaries with health insurance as a fringe benefit. This is despite the fact that a growing body of studies reflects that employer policies with transgender exclusions tend to cost employers more than those without, since transgender beneficiaries end up over-utilizing covered care in attempts to treat comorbid conditions that are less well-managed in the absence of appropriate GD care.[107]

We also believe that OCR's litigation-management calculus rests on faulty premises. For instance, OCR's analysis presumes that if adopted, the Proposed Rule will ameliorate risk of transgender rights litigation.[108] Not so. Though the Proposed Rule's rollback of transgender protections would likely resolve the *Franciscan Alliance* injunction and copycat suits, if the Proposed Rule becomes final, HHS will open itself up to a whole host of new litigation liabilities, some of which may be even more costly

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explaining its changed position, an agency must also be cognizant that longstanding policies may have engendered serious reliance interests that must be taken into account. In such cases it is not that further justification is demanded by the mere fact of policy change; but that a reasoned explanation is needed for disregarding facts and circumstances that underlay or were engendered by the prior policy. It follows that an unexplained inconsistency in agency policy is a reason for holding an interpretation to be an arbitrary and capricious change from agency practice.").

[107] *See, e.g.*, W. Padula et al., *Societal Implications for Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis*, 31 J. Gen. Intern. Med. 394, 398 (2016) (finding it is more cost effective for insurers to cover transgender healthcare because provision of care reduces incidence of HIV, depression, suicidality, and drug abuse resulting in effective cost savings). *See also* Jody L. Herman et al., Williams Inst., *Costs and Benefits of Providing Transition-Related Health Care Coverage in Employee Health Benefits Plans* 3 (2013) (finding that "there was no relationship between scope of the coverage provided and reported costs of adding the coverage, meaning providing broader coverage did not result in higher costs for surveyed employers").

[108] *See, e.g.*, 84 FR 27849 ("The existence of lawsuits and court orders blocking enforcement of significant parts of the Final Rule for over two years indicates that changes in the proposed rule may minimize litigation risk.").

and cumbersome. Indeed, several states attorneys general and advocates have publicly vowed to file suit against HHS if the Proposed Rule becomes final.

Moreover, even if OCR seeks to mitigate litigation risks like those posed by *Franciscan Alliance*, the Proposed Rule is a poor choice as crafted. Put bluntly, the Proposed Rule is a disproportionate response to *Franciscan Alliance*. Among other things, the Proposed Rule goes further than the *Franciscan Alliance* Court's preliminary injunction. That opinion is quite narrow in scope. It enjoins the 1557 Rule's "command" prohibiting "discrimination on the basis of 'gender identity'" and otherwise makes plain that the only pertinent provision enjoined is 45 CFR 92.4, the provision which defines "gender identity." The injunction does not enjoin any other part of the 1557 regulation nor does it enjoin any part of the 1557 statute.[109]

If the *Franciscan Alliance* suit does, as OCR claims, represent the biggest litigation risk in this arena, then OCR's response is not well-calibrated. As one example, OCR's proposal to eliminate 45 CFR 92.206 and 92.207(b)(3), provisions of the 1557 Rule that define sex stereotyping and are not enjoined by the *Franciscan Alliance* opinion,[110] has no support from a litigation-management perspective. Indeed, OCR's over-correction bespeaks a failure to consider a less disruptive rule revision that leaves intact all provisions of the 1557 Rule not preliminarily or permanently enjoined at this time. That overcorrection may very well give fertile grounds to challengers of the Proposed Rule if it becomes final.[111]

We are also concerned that OCR failed to explore less disruptive alternative amendments to the 1557 Rule that could preserve protections for transgender Americans. For instance, OCR's analysis does not appear to have assessed whether appending a religious accommodation safety-

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[109] *Franciscan Alliance*, 227 F.Supp.3d at 695 ("Only the Rule's command this Court finds is contrary to law and excess statutory authority—the prohibition of discrimination on the basis of 'gender identity' and 'termination of pregnancy' is hereby enjoined").

[110] *Id.*

[111] *See Nat'l Shooting Sports Found., Inc. v. Jones*, 716 F.3d 200, 215 (D.C.Cir. 2013) (Court cannot "uphold agency action if it fails to consider significant and viable and obvious alternatives").

valve to the 1557 Rule would have been sufficient to resolve the threats posed by *Franciscan Alliance*. OCR's failure to consider such an obvious tweak to the 1557 Rule is suspect and, again, may serve as fertile grounds for a challenge if the Proposed Rule becomes final.[112]

In a similar vein, we find it odd that OCR failed to assess whether the litigation risks posed by *Franciscan Alliance* and its ilk have not been already ameliorated by HHS's religious conscience rulemaking which only became final in 2019. Though it is our understanding that HHS's religious conscience rules were promulgated with other suits, liabilities, and concerns in mind, we nonetheless understand that if broadly and aggressively enforced, those same rules may totally mollify the grievances at the heart of the *Franciscan Alliance* suit and others like it.

Lastly, we are concerned that the Proposed Rule will perversely incentivize nationwide injunctions against the federal government. Over the last several years, and across both the immediate-past and current administrations, interest groups and attorneys generals alike have invested considerable resources in bringing declaratory judgment suits designed to rollback transgender civil rights advances in federal courts against federal agencies. The *Franciscan Alliance* suit is but one example. *Franciscan Alliance* and other suits like it have been forum-shopped to appear in front of activist judges[113] who have, in turn, issued sweeping nationwide injunctions that have wasted federal resources and imperiled the health and livelihoods of transgender Americans whose rights are, quite literally, litigated without their input let alone consent.

We have few issues on which we agree with former Attorney General Sessions, but he was most certainly correct in setting federal policy against capitulating to nationwide injunction suits. The rationales

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[112] *See, e.g.*, *Int'l Ladies' Garment Workers' Union v. Donovan*, 722 F.2d 795, 818 (D.C.Cir. 1983) (The agency "is required to address common and known or otherwise reasonable options, and to explain any decision to reject such options.").

[113] *See, e.g.*, Adam Liptak, *Texas' One-Stop Shopping for Judge in Health Care Case*, N.Y. Times, Dec. 24, 2018, https://www.nytimes.com/2018/12/24/us/politics/texas-judge-obamacare.html.

delineated in General Sessions' 2018 Memorandum ring true here.[114] Indeed, we fear that if finalized, the Proposed Rule will perversely incentivize nationwide injunctions in the transgender rights arena, since OCR will be signaling to potential litigants that, contrary to federal policy, it capitulates to nationwide injunctions where transgender Americans and other vulnerable communities' rights are at stake.

CONCLUSION

Access to quality healthcare free from discrimination is of paramount importance to transgender Americans. OCR is uniquely situated to ensure that transgender patients are afforded the same basic respect and dignity every American deserves. We appreciate all too well that efforts to protect transgender Americans will, inevitably, be met with backlash. Nonetheless, we urge you to do the right thing. Lives hang in the balance.

"[I]n this world, with great power there must also come great responsibility."[115] We strongly urge you to reconsider the Proposed Rule in light of our comments.

Thank you for your consideration.

[114] Memorandum from Jeff Sessions, Attorney Gen., U.S. Dep't of Justice, on Litigation Guidelines for Cases Presenting the Possibility of Nationwide Injunctions (Sept. 13, 2018), https://www.justice.gov/opa/press-release/file/1093881/download.

[115] Stan Lee & Steve Ditko, Amazing Fantasy No. 15: "Spider-Man" 13 (1962).