Comments on Multi-Agency Proposed Rules on
Equal Participation of Faith-Based Organizations in Federally Assisted Programs and Activities: Implementation of Executive Order 13831

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Any updates to the Agencies' 2016 rules on "Fundamental Principles and Policymaking Criteria for Partnerships with Faith-Based and Other Neighborhood Organizations," adopted pursuant to Executive Order 13559, must not repeal or weaken any of those rules' rule protections for program beneficiaries. Any weakening of those core protections would create serious economic and non-economic costs, create inconsistencies with other federal laws and policies, undermine religious liberty rights and other important rights of beneficiaries, and be exceedingly difficult to justify.

Transgender people are more likely to need, and already face widespread discrimination in, safety-net programs.

An estimated 0.6% of the U.S. adult population is transgender, representing nearly 2 million Americans.[1] The medical and scientific community overwhelmingly recognizes that a person's innate experience of gender is an inherent aspect of the human experience for all people, including transgender people.[2] While being transgender need not and should not be a barrier to opportunity in the United States, today transgender Americans are more likely both to need, and to face barriers to accessing, assistance from the federal programs funded by the Agencies. For example:

- **DOL programs**: Transgender people are more likely to be need and be eligible for assistance through DOL programs because the transgender population faces high rates of unemployment and poverty.[3] Transgender individuals already face barriers to participating in employment-related programs due to widespread discrimination in employment, social services, and government services.[4]
- **HHS programs**: Transgender people are more likely to be need and be eligible for assistance through HHS's wide range of health and human service programs because the transgender population faces substantial physical and mental health disparities and high rates of childhood victimization, family rejection, and foster care involvement.[5] As the

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[1] Andrew R. Flores et al., *How Many Adults Identify as Transgender in the United States?* (2016), http://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf. *See also* Jody L. Herman et al. *Age of Individuals who Identify as Transgender in the United States* (2017), https://williamsinstitute.law.ucla.edu/wp-content/uploads/TransAgeReport.pdf (estimating that 0.7% of people in the United States between the ages of 13 and 17, or 150,000 adolescents, are transgender).

[2] *See, e.g.*, Am. Acad. of Pediatrics, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, PEDIATRICS Oct 2018, 142 (4) e20182162; Am. Psychological Ass'n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70 AMERICAN PSYCHOLOGIST 832, 834-35 (2015).

[3] *See, e.g.*, Sandy E. James et al., *The Report of the 2015 U.S. Transgender Survey* 141-44 (2016), www.ustranssurvey.org/report.

[4] *See, e.g.*, *id.* at 149-54.

[5] *See, e.g.*, Ilan H. Meyer et al., *Demographic Characteristics and Health Status of Transgender Adults in Select US Regions: Behavioral Risk Factor Surveillance System, 2014*, 107 AM. J. PUB. HEALTH 582 (2017); Sandy E. James et al., *The Report of the 2015 U.S. Transgender Survey* 69-76 (2016); Wilson, B. D. M. & Kastanis, A. A., *Sexual*

American Psychiatric Association has stated, "[b]eing transgender or gender variant implies no impairment in judgment, stability, reliability, or general social or vocational capabilities; however, these individuals often experience discrimination due to a lack of civil rights protections for their gender identity or expression."[6] Transgender individuals already face barriers to participating in these programs due to widespread discrimination in health care, social services, and government services.[7]

- **ED programs**: Transgender people are more likely to be need and be eligible for assistance through ED programs because transgender students face high rates of severe bullying, discrimination, expulsion, and dropout in both K-12 and postsecondary levels.[8] For the very same reasons, transgender individuals already face barriers to participating in these programs.
- **DOJ**: Transgender people are more likely to need and be eligible for assistance through DOJ programs because the transgender population faces high rates of violent victimization (including domestic violence and hate crimes), high rates of criminal and juvenile justice system involvement, and high rates of trauma while incarcerated or detained.[9] Transgender people already face barriers to participating in or benefiting from these programs due to widespread discrimination in government services, including victim services, and distrust of law enforcement.[10]
- **USDA programs**: Transgender people are more likely to need and be eligible for assistance from USDA programs due to high rates of poverty and low rates of homeownership.[11] Transgender people already face barriers to participating in these programs due to high rates of discrimination in social services and government services.[12]
- **HUD programs**: Transgender people are more likely to need and be eligible for assistance from HUD programs because the transgender population faces high rates of poverty and homelessness and low rates of homeownership.[13] Transgender people already face barriers to accessing HUD programs because of high rates of discrimination in housing and access to emergency shelter.[14]

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and Gender Minority Disproportionality and Disparities in Child Welfare: A Population-based Study, 58 CHILDREN & YOUTH SERVS. REV. 11-17 (2015); Inst. of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (2011).

[6] Am. Psychiatric Ass'n, *Position Statement on Discrimination Against Transgender and Gender Variant Individuals* (2012).

[7] Sandy E. James et al., *The Report of the 2015 U.S. Transgender Survey* 96–97 (2016), www.ustranssurvey.org/report.

[8] Ilan H. Meyer et al., *Demographic Characteristics and Health Status of Transgender Adults in Select US Regions: Behavioral Risk Factor Surveillance System, 2014*, 107 AM. J. PUB. HEALTH 582 (2017); Sandy E. James et al., *The Report of the 2015 U.S. Transgender Survey* 130-38 (2016), www.ustranssurvey.org/report.

[9] *See, e.g.* Ilan H. Meyer et al., *Demographic Characteristics and Health Status of Transgender Adults in Select US Regions: Behavioral Risk Factor Surveillance System, 2014*, 107 AM. J. PUB. HEALTH 582 (2017); Sandy E. James et al., *The Report of the 2015 U.S. Transgender Survey* 184-211 (2016); A. J. Beck, *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12: Supplemental Tables: Prevalence of Sexual Victimization Among Transgender Adult Inmates* (Washington, DC: Bureau of Justice Statistics, 2014), available at https://www.bjs.gov/content/pub/pdf/svpjri1112_st.pdf.

[10] *See, e.g.*, Sandy E. James et al., *The Report of the 2015 U.S. Transgender Survey* 184-96, 212-20 (2016), www.ustranssurvey.org/report.

[11] *See, e.g.*, *id.* at 141-44, 175-83.

[12] *See, e.g.*, *id.* at 212-20.

[13] *See, e.g.*, *id.* at 141-44, 175-83.

[14] *See, e.g.*, *id.* at 175-83.

- **VA programs:** Transgender people are more likely to need and be eligible for assistance from VA programs because the transgender population are significantly more likely to have served in the military, to be living with a disability, and to experience homelessness.[15]
- **AID programs:** Transgender people are more likely to need and be eligible for assistance AID programs because transgender populations face extreme levels of victimization and discrimination in many countries.[16]

The 2016 rules strike an appropriate balance to avoid discrimination because of an organization's religious nature while prioritizing the statutorily mandated goals of serving program beneficiaries. Their core beneficiary protections must be preserved, including that:

- Government may not discriminate for or against an entity based on its religious nature.[17]
- Organizations may not discriminate against beneficiaries on the basis of religion, religious belief, or refusal to hold a religious belief or participate in a religious practice.[18]
- Explicitly religious activities must be offered voluntarily, separately, and without federal funds.[19]
- Organizations must make efforts to provide referrals for objecting beneficiaries.
- Organization must provide beneficiaries notice of these rights in order to safeguard their religious freedom.[20]
- Requiring all organizations to comply with all nondiscrimination and other programs requirements under applicable statutes and regulations.[21]

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[15] *See, e.g., id.* 57-58, 166-83.

[16] *See, e.g.*, U.S. Dep't of State, *2018 Country Reports on Human Rights Practices* (2018), https://www.state.gov/reports/2018-country-reports-on-human-rights-practices/; U.S. Dep't of State, *At-Risk Populations* (visited Nov. 12, 2019), https://www.state.gov/other-policy-issues/at-risk-populations ("In many parts of the world, LGBTI persons face discrimination due to their sexual orientation or gender identity").

[17] *See, e.g.*, 45 C.F.R. § 87.3(a) ("Neither the HHS awarding agency, nor any State or local government and other pass-through entity receiving funds under any HHS awarding agency program shall, in the selection of service providers, discriminate for or against an organization on the basis of the organization's religious character or affiliation"). *Accord*, Trinity Lutheran Church of Columbia, Inc. v. Comer, 137 S.Ct. 2012 (2017).

[18] *See, e.g.*, 45 C.F.R. § 87.3(d) ("An organization that participates in any programs funded by financial assistance from an HHS awarding agency shall not, in providing services or in outreach activities related to such services, discriminate against a program beneficiary or prospective program beneficiary on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to attend or participate in a religious practice").

[19] *See, e.g.*, 45 C.F.R. § 87.3(b) ("If an organization conducts such activities, the activities must be offered separately, in time or location, from the programs or services funded with direct financial assistance from the HHS awarding agency, and participation must be voluntary for beneficiaries of the programs or services funded with such assistance").

[20] *See, e.g.*, 45 C.F.R. § 87.39(i) ("Faith-based or religious organizations providing social services in the United States to beneficiaries under an HHS program that is supported by direct Federal financial assistance must give written notice to beneficiaries or prospective beneficiaries of certain protections").

[21] *See, e.g.*, 45 C.F.R. § 87.39(e) ("All organizations that participate in HHS awarding agency programs, including organizations with religious character or affiliations, must carry out eligible activities in accordance with all program requirements and other applicable requirements governing the conduct of HHS awarding agency-funded activities").

OMB must consider consistency with other laws, regulations, and Executive Orders.

Consistent with the principles of other Executive Orders on the regulatory process, Executive Order 13559 directs Agencies to follow the principle that: "Federal financial assistance for social service programs should be distributed in the most effective and efficient manner possible."[22] Repealing or weakening any of the core beneficiary protections in the 2016 rules **would be inconsistent with Executive Order 13559**, which continues to bind the agencies and which the 2016 rules simply implement.[23] Executive Order 13831 made minor modifications to Executive Order 13559, but did not alter these core requirements.

Repealing or weakening any of the core beneficiary protections in the 2016 rules could also **create inconsistency with numerous statutes authorizing federal programs,** which require that agencies ensure those programs are administered on the basis of congressionally prescribed purposes and eligibility criteria, and that individuals are not turned away based on non-merit factors. OMB should ensure that each agency analyzes all relevant program statutes to avoid any such inconsistency. Similarly, OMB should **ensure that each agency analyzes all nondiscrimination statutes applicable to its programs to avoid any inconsistency.**

Repealing or weakening any of the core beneficiary protections in the 2016 rules **would infringe on the religious liberty rights of beneficiaries.** The 2016 rules were designed to advance "a key policy goal articulated by Executive Order 13559—strengthening religious liberty protections for beneficiaries."[24] Allowing an organization implementing a federally assisted program to discriminate on the basis of a beneficiary's adherence to a religious belief or lack thereof, or fail to provide a referral in the face of a religious objection, would effectively condition participation in critical safety-net programs on religious beliefs. While the religious freedom of faith-based organizations is important, there is no absolute right to a federal grant or contract, and the religious freedom of the intended beneficiaries of federal programs must be paramount.

Repealing or weakening any of the core beneficiary protections in the 2016 rules would also **infringe on other constitutional rights of beneficiaries**. For example, "The Constitution

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[22] Exec. Order 13559 § 2(a) (Nov. 17, 2010)

[23] *See id.* at § 2(c) ("No organization should be discriminated against on the basis of religion or religious belief in the administration or distribution of Federal financial assistance under social service programs"); *id.* at § 2(d) ("organizations, in providing services supported in whole or in part with Federal financial assistance, and in their outreach activities related to such services, should not be allowed to discriminate against current or prospective program beneficiaries on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to attend or participate in a religious practice"); *id.* at 2(f) ("Organizations that engage in explicitly religious activities … must perform such activities and offer such services outside of programs that are supported with direct Federal financial assistance …, separately in time or location …, and participation in any such explicitly religious activities must be voluntary"); *id.* at § 2(h)(i) ("If a beneficiary or prospective beneficiary of a social service program supported by Federal financial assistance objects to the religious character of an organization that provides services under the program, that organization shall, within a reasonable time after the date of the objection, refer the beneficiary to an alternative provider"); *id.* at § 2(h)(ii) ("Each agency responsible … shall establish policies and procedures designed to ensure that … each beneficiary of a social service program receives written notice of the protections set forth in this subsection").

[24] Federal Agency Final Regulations Implementing Executive Order 13559: Fundamental Principles and Policymaking Criteria for Partnerships With Faith-Based and Other Neighborhood Organizations; Final Rule, 81 Fed. Reg. 19355, 19361 (Apr. 4, 2016)

promises liberty to all within its reach, a liberty that includes certain specific rights that allow persons, within a lawful realm, to define and express their identity."[25] These rights include the First Amendment right to express one's deeply and sincerely held gender identity through speech and appearance,[26] the right to make deeply personal decisions regarding one's social gender role and one's medical care,[27] and the right to maintain privacy regarding deeply personal information about sex characteristics or medical care.[28]

OMB must consider consistency with "action[s] taken or planned by another agency."[29]

The Proposed Rule would also create inconsistency with ***Home, Together: The Federal Strategic Plan to Prevent and End Homelessness***, adopted by the U.S. Interagency Council on Homelessness, of which most of the Agencies are members.[30] The Plan identifies providing immediate access to emergency shelter and permanent housing with "few to no treatment preconditions, behavioral contingencies, or other barriers" as one of the keys to progress on ending homelessness.[31] Among four factors for "Defining Success," the Plan states that every community must be able to "Provide people with immediate access to shelter and crisis services without barriers to entry."[32] Goal 2 of the Plan is to "Ensure Homelessness is a Brief Experience."[33] Objective 2.1 of the Plan is to "Identify and Engage All People Experiencing Homelessness as Quickly as Possible."[34] The Plan explains that: "Many individuals experiencing homelessness are disengaged from—and may be distrustful of—public and private programs, agencies, and systems, and they may be reluctant to seek assistance," and that "overcome[ing] these barriers often requires significant outreach time and effort."[35] Beneficiary protections help to build that trust, so that communities can "identify every individual and family that is unsheltered."[36] Similarly, Objective 2.2 is to "Provide Immediate Access to Low-Barrier Emergency Shelter or Other Temporary

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[25] *Obergefell v. Hodges*, 135 S.Ct. 2584, 2593 (2015). *See also Roberts v. U.S. Jaycees*, 468 U.S. 609, 619 (1984) (due process "safeguards the ability independently to define one's identity that is central to any concept of liberty").
[26] *See, e.g., Zalewska v. County of Sullivan*, 316 F.3d 314, 320 (2d Cir. 2003) (*citing Doe ex rel. Doe v. Yunits*, No. 001060A, 2000 WL 33162199 (Mass.Super.Oct.11, 2000)).
[27] *See, e.g., See, e.g., Karnoski v. Trump*, No. C17-1297, 2017 WL 6311305, at *8 (W.D. Wash Dec. 11, 2017), *appeal dismissed*, No. 17-36009, 2017 WL 8229552 (9th Cir. Dec. 30, 2017) (holding Due Process Clause protects individual's "ability to define and express their gender identity"); *Doe v. McConn*, 489 F.Supp. 76 S.D. Tex. 1980) (holding application of anti-cross-dressing ordinance to transgender people violated substantive liberty interests); *City of Chicago v. Wilson*, 389 N.E.2d 522 (Ill. 1978) (same).
[28] *See, e.g., Powell v. Schriver*, 175 F.3d 107, 112 (2d Cir. 1999) (holding that individuals have a constitutional right to privacy concerning transgender status); *Love v. Johnson*, 146 F.Supp.3d 848, 855 (E.D. Mich. 2015) (holding privacy concerns regarding transgender status "cut at the 'very essence of personhood' protected under the substantive component of the Due Process Clause"); *Arroyo Gonzalez v. Rossello Nevares*, 305 F.Supp.3d 327, 333 (D.P.R. 2018) ("there are few areas which more closely intimate facts of a personal nature than one's transgender status").
[29] Exec. Order 12866 § 3(f)(2).
[30] U.S. Interagency Council on Homelessness, *Home, Together: The Federal Strategic Plan to Prevent and End Homelessness* (2018), https://www.usich.gov/resources/uploads/asset_library/Home-Together-Federal-Strategic-Plan-to-Prevent-and-End-Homelessness.pdf.
[31] *Id.* at 4.
[32] *Id.* at 7.
[33] *Id.* at 15.
[34] *Id.*
[35] *Id.* at 16.
[36] *Id.* at 15.

Accommodations to All Who Need It."[37] Among its strategies for this objective is to "Improve access to emergency assistance, housing, and supports for historically underserved and overrepresented groups, such as … people who identify as LGBTQ; people who are gender-non-conforming; people living with HIV/AIDS; youth that are pregnant or parenting; people with mental health needs; and racial and ethnic minorities."[38] Objective 2.3 urges communities to develop entry processes that "take into account the unique needs of different populations, including … populations that are disproportionately represented among people experiencing homelessness."[39] The 2016 rules advance these objectives by ensuring vulnerable individuals can quickly gain access to appropriate shelter and services, and weakening them would undermine these objectives of the *Federal Strategic Plan*.

Weakening beneficiary protections could create inconsistency with the President's ***Ending the HIV Epidemic: A Plan for America*** initiative, which seeks to reduce new HIV infections by 75% in five years and by 90% in ten years. Among the strategies identified to meet those goals are: to target communities "where HIV is spreading most rapidly" to expand prevention, care, and treatment; to "provide medicine to protect persons at highest risk from getting HIV"; "to follow up with individuals no longer receiving care" and "re-engage them in effective HIV care and treatment"; and to combat "stigma – which can be a debilitating barrier preventing someone living with HIV or at risk for HIV from receiving the healthcare, services and respect they need and deserve."[40] According to the Centers for Disease Control, transgender people are among the most vulnerable populations with respect to HIV and AIDS.[41] Weakening beneficiaries protections will undermine each of these strategies by promoting stigma, increasing discrimination, and deterring individuals from connecting or re-connecting with care among some of the most critical populations that must be reached to meet the goals of the federal plan.

Weakening beneficiary protections could also create inconsistency with HHS's ***Strategy to Combat Opioid Abuse, Misuse, and Overdose,*** which seeks to "use[ ] the best science and evidence to directly address this public health emergency."[42] The *Strategy* seeks to meet this goal by, among other things, "eliminat[ing] stigma associated with the disease" and with seeking treatment, and "[i]dentify[ing] individuals who are at risk of opioid use disorder and mak[ing] available prevention and early intervention services and other supportive services."[43] Studies indicate that transgender people are at especially high risk for opioid use disorder. For example, an analysis of the CDC's 2017 Youth Risk Behavior Survey found that transgender youth were more likely than their peers to have used drugs in their lifetime, including 36% who reported misusing prescription opioids (compared to 11.5% of non-transgender boys and 12% of non-transgender girls), and 26% who reported using heroin (compared to 2% of non-transgender boys

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[37] *Id*. at 17.
[38] *Id.*
[39] *Id.*
[40] Sec. Alex Azar, *Ending the HIV Epidemic: A Plan for America*, U.S. Health and Human Services Blog (Feb. 5, 2019), https://www.hhs.gov/blog/2019/02/05/ending-the-hiv-epidemic-a-plan-for-america.html.
[41] *See* Ctrs. for Disease Control & Prevention, *HIV and Transgender Communities* (2016), https://www.cdc.gov/hiv/pdf/policies/cdc-hiv-transgender-brief.pdf
[42] Dept. of Health & Hum. Servs., *Strategy to Combat Opioid Abuse, Misuse, and Overdose: A Framework Based on the Five-Point Strategy* (Sept. 17, 2018), https://www.hhs.gov/opioids/sites/default/files/2018-09/opioid-fivepoint-strategy-20180917-508compliant.pdf.
[43] *Id*. at 3.

and less than 1% of non-transgender girls).[44] In addition, actual and anticipated discrimination are associated both with delays in seeking care and with increased substance use among transgender people.[45] Weakening beneficiary protections would undermine the goals of the this strategy by potentially increasing risk factors for substance use and delayed care-seeking among a population already at heightened risk.

Finally, weakening beneficiary protections could also create inconsistency with HHS's **Healthy People 2030 (HP 2030)** initiative. The mission of HP 2030 is "[t]o promote, strengthen and evaluate the Nation's efforts to improve the health and well-being of all people."[46] HP 2030 seeks to achieve this mission by providing goals and objectives that can guide policies and action by local, state, and federal governments and entities, including the Department.[47] Among the "Overarching Goals" of HP 2030 are to "[e]liminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all," and to "[c]reate social, physical, and economic environments that promote attaining full potential for health and well-being for all."[48] While measurable HP 2030 objectives are still being developed, it is clear that the weakening beneficiary protections would undermine the goals of HP 2030 by exacerbating health care discrimination and health disparities and contributing to a social environment that perpetuates stigma against transgender people and other vulnerable populations.

OMB must consider APA standards for regulatory repeals or reversals that require a "reasoned analysis" for each change, taking account of the reasons and fact findings behind the existing rule and articulating clear reasons for deviating from them.

Under the Administrative Procedure Act and binding Supreme Court precedent, when an agency seeks to change regulations in a manner that departs from prior policy, the agency must provide a "reasoned analysis for the change."[49] This requirement reflects the practical reality that "the revocation of an extant regulation is substantially different than a failure to act" in its impact on covered entities and the law's intended beneficiaries, because it upsets a "settled course of behavior."[50] In a recent Supreme Court case addressing an agency change in policy, the Court emphasized that an agency explanation for such change "must examine the relevant data and

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[44] Michelle M. Johns et al., *Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors Among High School Students—19 States and Large Urban School Districts,* (2017), 63 MORBIDITY AND MORTALITY WEEKLY REPORT 67, 69 (Jan. 25, 2019), https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6803a3-H.pdf. *See also* James et al., *supra* note **Error! Bookmark not defined.** at 119 (finding higher rate of illicit drug use among transgender adults than the general adult population).

[45] Sari L. Reisner et al., *Substance Use to Cope with Stigma in Healthcare Among U.S. Female-to-Male Trans Masculine Adults*, 2 LGBT HEALTH, 324–332, doi:10.1089/lgbt.2015.0001; James et al., *supra* note **Error! Bookmark not defined.** at 219 (finding that 22% of transgender adults who went to a drug or alcohol treatment facility were denied equal treatment, harassed, or assaulted because of being transgender).

[46] Office of Disease Prevention & Health Promotion, *Healthy People 2030 Framework* (last visited Aug. 13, 2019), https://www.healthypeople.gov/2020/About-Healthy-People/Development-Healthy-People-2030/Framework.

[47] *Id.*

[48] *Id.*

[49] *State Farm*, 463 U.S. at 30. *See also Washington v. Azar*, 376 F.Supp.3d 1119, 1131 (E.D. Wash. 2019) (a health care rule was "arbitrary and capricious because it reverses long-standing positions of the Department without proper consideration of sound medical opinions and the economic and non-economic consequences").

[50] *State Farm Ins.*, 463 U.S. at 41 (*quoting Atchison, T. & S. F. R. Co. v. Wichita Bd. of Trade*, 412 U.S. 800, 807–08 (1973)).

articulate a satisfactory explanation for its action."[51] This includes providing a reasoned explanation that engages with the facts and circumstances that underlay an earlier action when an agency is changing prior regulation.[52] Agencies have ample latitude to change existing policies; however, when agencies change course, the presumption is "*against* changes in current policy that are not justified by the rulemaking record."[53]

As Justice Kennedy wrote in *FCC v. Fox Television Stations, Inc.*:

> Where there is a policy change the record may be much more developed because the agency based its prior policy on factual findings. In that instance, an agency's decision to change course may be arbitrary and capricious if the agency ignores or countermands its earlier factual findings without reasoned explanation for doing so. An agency cannot simply disregard contrary or inconvenient factual determinations that it made in the past, any more than it can ignore inconvenient facts when it writes on a blank slate.[54]

This is particularly true with respect to the 2016 rules, which were developed over eight years, based on the public 2010 recommendations of a diverse presidential advisory council,[55] the public 2012 recommendations of an interagency working group, and the 2015 notice and comment periods by the nine agencies.

Today, there is no evidence the current rules are not working or that any change to beneficiary protections would have benefits that outweigh the costs to beneficiaries and society.

OMB must consider all potential economic and non-economic costs.

Potential costs of weakening the beneficiary protections of the 2016 Rules could include:

- **Direct health and financial costs of beneficiaries experiencing discrimination and other barriers in accessing critical safety-net programs.** The Agencies administer a wide array of programs that help individuals obtain adequate shelter, nutrition, medical care, credit and lending, education, employment, victim services, emergency assistance, and other critical supports, and that otherwise serve to protect public health, safety, and opportunity. Weakening beneficiary protections could prevent or delay individuals from

[51] *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125 (2017) (quoting *State Farm,* 463 U.S. at 43).
[52] *See Encino*, 136 S. Ct. at 2125-26. *See also Fox Television Stations,* 556 U.S. at 515.
[53] *State Farm*, 463 U.S. at 42 (emphasis in original).
[54] 556 U.S. at 537 (Kennedy, J., concurring in part and in judgment).
[55] *See, e.g.*, President's Advisory Council on Faith-Based and Neighborhood Partnerships, A New Era of Partnerships: Report of Recommendations to the President, 94 (Mar. 2010) ("all U.S. Government funding must be predicated on achieving secular results. Such funding must be awarded based on neutral performance-based criteria and must be open to faith-based and non-faith-based entities on equal terms"); *id.* at 182 (discussing the "clear precedent and consensus for the vigorous protection of the religious liberties of beneficiaries of federally funded programs" and recommending the federal governments strengthen existing rules "in order to provide adequate protection for the fundamental religious liberty rights of social service beneficiaries").

accessing needed services in a timely fashion, with numerous costs for individuals, families, and communities.

- **Health costs caused by individual experiences of discrimination.** Experiences of discrimination themselves are stressful events that can negatively affect mental and physical health. A robust body of literature demonstrates the effects of a well-recognized phenomenon known as "minority stress" on morbidity, mortality, and health care costs.[56] Research among stigmatized groups "reveal that stigma can affect health over the lifecourse," including through higher rates of hypertension, diabetes, depression, and substance use.[57] Among transgender people, discrimination is associated with increased rates of negative health outcomes such as depression[58] and attempted suicide.[59] One study found that discrimination in health care settings was associated with increased risk of adverse emotional and physical symptoms and a two- to three-fold risk of postponement of needed care when sick or injured.[60] Another found that both actual and anticipated experiences of discrimination in health care were highly associated with substance use.[61] A recent analysis by the Williams Institute found that "Experiencing discrimination or mistreatment in education, employment, housing, health care, in places of public accommodations, or from law enforcement is associated with higher prevalence of suicide thoughts and attempts."[62]
- **Health costs caused by the high-profile stigmatizing message of federal rules that permit discrimination.** A body of research also demonstrates that high-profile changes in public policy toward LGBTQ populations can have significant impacts on public health.[63] For example, a 2016 study based on Veterans Health Administration clinical data found

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[56] *See, e.g.*, Mark L. Hatzenbuehler, et al., *Stigma as a Fundamental Cause of Population Health Inequalities*, 103 AM. J. PUB. HEALTH 813, 816 (2013) (noting the corrosive impact of stigma on physical and mental health, social relationships, and self-esteem); Ilan H. Meyer, *Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence*, 129 PSYCHOL. BULLETIN 674, 679-85 (2003) (summarizing empirical evidence of "minority stress" in lesbian, gay, and bisexual populations and attendant health consequences); Vickie M. Mays & Susan D. Cochran, *Mental Health Correlates of Perceived Discrimination Among Lesbian, Gay, and Bisexual Adults in the United States*, 91 AM. J. PUB. HEALTH 1869, 1874 (2001) (finding "robust association between experiences of discrimination and indicators of psychiatric morbidity" and noting that "social factors, such as discrimination against gay individuals, function as important risk factors for psychiatric morbidity").

[57] Jaclyn M. White Hughto, Sari L. Reisner, & John E. Pachankis, *Transgender Stigma and Health: A Critical Review of Stigma Determinants, Mechanisms, and Interventions*, 147 SOCIAL SCIENCE & MEDICINE 222, 226 (2015), doi:10.1016/j.socscimed.2015.11.010.

[58] Tohru Nemoto, Birte Bödeker, & Mariko Iwamoto, *Social Support, Exposure to Violence and Transphobia, and Correlates of Depression Among Male-To-Female Transgender Women with a History of Sex Work*, 101 AM. J. PUBLIC HEALTH. 1980 (2011).

[59] Kristen Clements-Nolle, Rani Marx, & Mitchell Katz, *Attempted Suicide Among Transgender Persons: The Influence of Gender-Based Discrimination and Victimization.* 51 J. HOMOSEXUALITY 53 (2009).

[60] Sari L. Reisner et al. *Legal Protections in Public Accommodations Settings: A Critical Public Health Issue for Gender Minority People*, 93 MILBANK QUARTERLY 1–32 (2015).

[61] Sari L. Reisner et al., *Substance Use to Cope with Stigma in Healthcare Among U.S. Female-to-Male Trans Masculine Adults*, 2 LGBT HEALTH, 324–332, doi:10.1089/lgbt.2015.0001.

[62] Jody L. Herman, Taylor N.T. Brown, & Ann P. Haas, *Suicide Thoughts and Attempts Among Transgender Adults: Findings from the 2015 U.S. Transgender Survey* (2019); *see also* Meghan Romanelli, Wenhua Lu, & Michael A. Lindsey, *Examining Mechanisms and Moderators of the Relationship Between Discriminatory Health Care Encounters and Attempted Suicide Among U.S. Transgender Help-Seekers*, 45 ADMINISTRATION AND POLICY IN MENTAL HEALTH AND MENTAL HEALTH SERVICES RESEARCH 831 (Mar. 2018).

[63] *See generally* Inst. of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (2011).

that transgender patients living in states with explicit nondiscrimination protections were 26% less likely to be diagnosed with mood disorders and 43% less likely to suffer self-harm.[64] Similarly, another recent study found that, controlling for demographic and other factors, state marriage equality laws "were associated with a reduction in the proportion of high school students reporting suicide attempts."[65] The adoption of marriage equality in Massachusetts was also associated with a significant decrease in medical and mental health visits in the following year among sexual minority men.[66] Conversely, one study found that the passage of state constitutional bans on same-sex marriage was associated with increases in mood, anxiety, alcohol use, and other psychiatric diagnoses in those states among sexual minority adults, while states that did not pass such bans did not see comparable increases.[67] Even though these states already did not permit same-sex couples to marry, the public message of disapproval towards LGBTQ people caused measurable negative effects on health outcomes. Any broad rule change weakening protections for program beneficiaries across the government, in such a manner as to increase barriers and discrimination toward eligible LGBTQ beneficiaries, could send a similar stigmatizing message with negative public health effects.

- **Potential cost-shifting to other health or human service agencies,** whether federally assisted or not, who must expend additional resources to identify and serve individuals who are not being adequately served elsewhere.
- **Increased confusion and familiarization, administrative, and legal costs,** particularly if the proposed rules do not clearly conform to all applicable Executive Orders, program statutes, and federal and state nondiscrimination laws.
- **Decreased fairness, dignity, and respect for religious freedom and constitutional rights of program beneficiaries.** As noted previously, the 2016 rules protect the religious liberty rights of beneficiaries, as well as other important constitutional and moral rights such as those of free expression, equal protection, and personal privacy. Weakening these protections could have a significant cost to fairness, dignity, and respect for these rights.

The proposed rules are likely to be economically significant.

Collectively, these rules cover programs totaling hundreds of billions of dollars, with HHS grants alone comprising over $500 million. EO 12866 requires consideration of their "total effect on the economy"—not just direct costs to regulated entities.[68] This would include costs to beneficiaries, families, communities, and funded organizations. OMB should consider all of these potential costs in determining whether the rule is economically significant based on their total effect on the economy.

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[64] John R. Blosnich et al., *Mental Health of Transgender Veterans in US States With and Without Discrimination and Hate Crime Legal Protection*, 106 AM. J. PUB. HEALTH. 534 (2016), https://doi.org/10.2105/AJPH.2015.302981.
[65] Julia Raifman et al., *Difference-in-Differences Analysis of the Association Between State Same-Sex Marriage Policies and Adolescent Suicide Attempts*. 171 JAMA PEDIATR. 350 (2017). doi:10.1001/jamapediatrics.2016.4529.
[66] Mark L. Hatzenbuehler et al., *Effect of Same-Sex Marriage Laws on Health Care Use and Expenditures in Sexual Minority Men: A Quasi-Natural Experiment*, 102 AM. J. PUB. HEALTH 285 (2012), doi: 10.2105/AJPH.2011.300382.
[67] Mark L. Hatzenbuehler et al., *The Impact of Institutional Discrimination on Psychiatric Disorders in Lesbian, Gay, and Bisexual Populations: A Prospective Study*, 100 AM J. PUBLIC HEALTH, 452 (2010), doi:10.2105/AJPH.2009.168815.
[68] Exec. Order 12866 § 3(f)(1).

The 2016 rules are also economically significant because, even if OMB determines their total economic effects do not cross the $100 million threshold, they "may … adversely affect in a material way … public health or safety, or State, local, or tribal governments or communities" by shifting costs, increasing discrimination, and decreasing timely access to safety-net programs.[69]

OMB must ensure robust regulatory impact assessments and at least 60 days for public comment.

Given the breadth and significance of these rules, OMB should ensure each agency performs a robust regulatory impact assessment that addresses all the types of potential costs discussed above, as well as potential impacts on family well-being under Section 654 of the Treasury and General Government Appropriations Act of 1999.[70]

The Agencies should provide at least 60 days of public comment for changes to such broad and significant rules, as any form of "abbreviated notice and comment" in this case would likely violate the APA.[71] Deviations from the traditional notice and comment period of at least 60 days do not provide "full notice and comment," and there are not circumstances here that would satisfy the APA's "good cause" exception.[72]

[69] *Id.*
[70] Pub. L. 105–277, div. A, § 101(h) [title VI, § 654], codified at 5 U.S.C. § 601 note.
[71] *Id.* at 336.
[72] *Housing Study Group v. Kemp*, 736 F.Supp. 321, 334 (D.D.C. 1990).