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**IN THE UNITED STATES COURT OF APPEALS  
FOR THE FOURTH CIRCUIT**

**No. 25-1569**

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**JOHN DOE,**

*Plaintiff-Appellee,*

**v.**

**CATHOLIC RELIEF SERVICES,**

*Defendant-Appellant.*

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**BRIEF OF *AMICI CURIAE***

**THE PUBLIC JUSTICE CENTER; FREESTATE JUSTICE; EQUALITY  
CALIFORNIA; JUSTICE IN AGING; LEGAL AID AT WORK; NATIONAL  
EMPLOYMENT LAW PROJECT; NATIONAL LGBTQ+ BAR  
ASSOCIATION; SERVICES AND ADVOCACY FOR GAY, LESBIAN,  
BISEXUAL, AND TRANSGENDER ELDERS, INC.; AND SILVER SPRING  
UNITED METHODIST CHURCH**

**IN SUPPORT OF APPELLEE BY WRITTEN CONSENT**

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January 20, 2026

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4. Is there any other publicly held corporation or other publicly held entity that has a direct financial interest in the outcome of the litigation?  YES  NO  
If yes, identify entity and nature of interest:
5. Is party a trade association? (amici curiae do not complete this question)  YES  NO  
If yes, identify any publicly held member whose stock or equity value could be affected substantially by the outcome of the proceeding or whose claims the trade association is pursuing in a representative capacity, or state that there is no such member:
6. Does this case arise out of a bankruptcy proceeding?  YES  NO  
If yes, the debtor, the trustee, or the appellant (if neither the debtor nor the trustee is a party) must list (1) the members of any creditors' committee, (2) each debtor (if not in the caption), and (3) if a debtor is a corporation, the parent corporation and any publicly held corporation that owns 10% or more of the stock of the debtor.
7. Is this a criminal case in which there was an organizational victim?  YES  NO  
If yes, the United States, absent good cause shown, must list (1) each organizational victim of the criminal activity and (2) if an organizational victim is a corporation, the parent corporation and any publicly held corporation that owns 10% or more of the stock of victim, to the extent that information can be obtained through due diligence.

Signature: /s/ Sarah E. Miller

Date: 01/09/2026

Counsel for: Amici Curiae

**ATTACHMENT TO DISCLOSURE STATEMENT****Full List of *Amici Curiae***

The Public Justice Center

FreeState Justice

Equality California

Justice in Aging

Legal Aid at Work

National Employment Law Project

National LGBTQ+ Bar Association

Services and Advocacy for Gay, Lesbian, Bisexual, and Transgender Elders, Inc.

Silver Spring United Methodist Church

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## STATEMENT OF INTEREST

The **Public Justice Center** (“PJC”) is a non-profit civil rights and anti-poverty legal organization. The PJC’s Appellate Advocacy Project expands and improves representation for indigent and disadvantaged persons raising civil rights issues and challenging discriminatory laws before the Maryland and federal appellate courts. The PJC has a longstanding commitment to protecting and expanding the civil rights of LGBTQ+ individuals and to helping those who have been excluded from employment law protections. *See, e.g., Scott v. Baltimore County, Maryland*, 101 F.4th 336 (4th Cir. 2024) (amicus); *Doe v. Catholic Relief Services*, 484 Md. 640 (2023) (amicus); *Conaway v. Deane*, 401 Md. 219 (2007) (amicus).

*Amicus FreeState Justice* is a direct legal services program that provides free civil legal representation, advocacy, and resource services to low-income members of the LGBTQ+ (lesbian, gay, bisexual, transgender, queer/questioning, and all other non-conforming sexual orientations or gender identities) community in Maryland. From its experience in serving clients and advocating for health-related legislation, FreeState Justice believes that allowing religious-affiliated employers to deny health care benefits to LGBTQ+ employees would have disastrous consequences for LGBTQ+ people’s access to healthcare services, as well as public health.

*Amici* **Equality California; Justice in Aging; Legal Aid at Work; National Employment Law Project; National LGBTQ+ Bar Association; Services and Advocacy for Gay, Lesbian, Bisexual, and Transgender Elders, Inc.; and Silver Spring United Methodist Church**, all nonprofit entities, include civil rights organizations, legal advocacy organizations, a membership-based professional association, and a religious organization. In their varying roles, *Amici* protect, preserve, and advance the employment rights of individuals LGBTQ+ people; seek to ensure that all employees, and especially the most vulnerable ones, receive access to good jobs and the full protection of labor and employment laws, including access to employer-provided benefits; advocate for affordable, accessible, and culturally competent health care and economic security for older LGBTQ+ adults; promote equality for all people regardless of sexual orientation or gender identity or expression; prevent discrimination against LGBTQ+ people as legal advocates; or spiritually serve LGBTQ+ persons and their families, including those who have left the Roman Catholic Church because they did not feel that their families were welcome or would receive the full support and ministry of that church.<sup>1</sup>

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<sup>1</sup> No person or party other than *Amici* contributed money for or participated in the preparation or submission of this brief.

## INTRODUCTION

Health insurance occupies a uniquely vital place in everyday life. It is the safety net that cushions people from financial catastrophe, the quiet infrastructure that keeps families secure when health problems arise, accidents happen, or unexpected losses strike, and the framework that assists people in receiving needed services to maintain healthy lives. Yet despite its essential role, accessing adequate insurance remains a steep challenge for millions, a paradox that is further compounded for LGBTQ+<sup>2</sup> people. Alex Montero et al., *LGBT Adults' Experiences with Discrimination and Health Care Disparities: Findings from the KFF Survey of Racism, Discrimination, and Health*, Kaiser Fam. Found. (Apr. 2, 2024), <https://www.kff.org/racial-equity-and-health-policy/lgbt-adults-experiences-with-discrimination-and-health-care-disparities-findings-from-the-kff-survey-of-racism-discrimination-and-health/#58056b5a-162b-494b-a376-ca11faacc93c>; *see also* Hiba B. Al-Ramahi, *The Impact of Bostock v. Clayton County on Access to Health Care for LGBTQ Persons*, 15 St. Louis U. J. Health L. & Pol'y 485, 486 (2022).

Mr. Doe's case arises out of a growing trend wherein religious employers are seeking to evade anti-discrimination laws through efforts to expand the church

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<sup>2</sup> LGBTQ+ refers to people who identify as lesbian, gay, bisexual, transgender, queer, or gender nonconforming and other related groups. Throughout this brief there are different initialisms used when the various sources cited explored different subsets of the LGBTQ+ population.

autonomy doctrine. *Amici* urge this Court to affirm the lower court’s decision so that LGBTQ+ individuals’ access to health care—something that is already difficult to obtain and too often denied—does not deteriorate further, and to make clear that our legal system will not allow an already-marginalized community to be pushed into even greater danger by reduced access to essential medical services.

## ARGUMENT

### I. THE BARRIERS THAT LGBTQ+ PEOPLE ALREADY FACE IN THE HEALTH CARE SYSTEM LEAD TO POOR INDIVIDUAL AND PUBLIC HEALTH OUTCOMES.

#### A. Barriers LGBTQ+ People Face

LGBTQ+ individuals face significant barriers when trying to obtain and maintain access to health care: discrimination, both overt and subconscious, that pervades despite the laws intended to prevent it, and expensive costs. These barriers are exacerbated for transgender, nonbinary, and gender nonconforming people, and even further worsened for LGBTQ+ individuals with other marginalized identities, such as race. When LGBTQ+ individuals face these barriers, they are more likely to postpone or avoid both routine and situationally needed care. Postponing and avoiding health care is harmful to individual members of the LGBTQ+ community’s health as well as for public health.

##### *i. Discrimination is a barrier*

LGBT adults face higher rates of discrimination and unfair treatment in

health care settings compared to non-LGBT adults. Montero et al., *supra*. Despite the laws in place outlawing it, LGB people face varying forms of discrimination due to their sexual orientation, including: outright denials of health care services; physical abuse; verbal abuse; and medical professionals refusing to properly perform physical examinations out of fear or disgust of the individual. Lambda Legal, *When Health Care Isn't Caring*, 10–11 (Jul. 31, 2014), [https://legacy.lambdalegal.org/sites/default/files/publications/downloads/whcic-report\\_when-health-care-isnt-caring.pdf](https://legacy.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf). In a study performed by Lambda Legal, 56% of all respondents experienced at least one of those types of discrimination when seeking health care. *Id.* Additionally, in a study performed by the Kaiser Family Foundation, researchers found that LGBT adults are twice as likely as non-LGBT adults to report discriminatory experiences (like those previously mentioned) while receiving health care. Montero et al., *supra*. LGBT adults were treated unfairly or with disrespect 33% of the time, while non-LGBT adults only experienced that treatment 15% of the time. *Id.* Further, 61% of LGBT adults had at least one of several negative experiences with a provider, “including a provider assuming something about them without asking, suggesting they were personally to blame for a health problem, ignoring a direct request or question, or refusing to prescribe needed pain medication[,]” while non-LGBT adults only experienced this treatment 31% of the time. *Id.*

Data clearly demonstrates that these experiences are significantly more frequent for transgender, nonbinary, and gender nonconforming people. In the same study discussed above, Lambda Legal found that “70% of transgender and gender nonconforming respondents had one or more of [the aforementioned] experiences[.]” Lambda Legal, *supra*, at 10. Further, 26.7% of transgender respondents were denied health care outright, 15.4% experienced health care professionals refusing to touch them, 20.9% experienced harsh or abusive language, and 7.8% experienced physical abuse or roughness because of their gender identity. *Id.* at 10–11. In a 2022 study specific to transgender individuals, 47% of respondents experienced at least one negative interaction with a health care provider, 37% of respondents experienced their health care provider use the wrong name or pronouns, 18% of respondents had to teach their health care provider about transgender people to receive appropriate care, and 11% of respondents experienced their health care provider asking unnecessary or invasive questions about their trans status that were unrelated to the visit. Ankit Rastogi et al., *Health and Wellbeing: A Report of the 2022 U.S. Transgender Survey*, Advocs. for Transgender Equal., 7, 30 (Jun. 2025), [https://transequality.org/sites/default/files/2025-06/USTS\\_2022Health%26WellbeingReport\\_WEB.pdf/](https://transequality.org/sites/default/files/2025-06/USTS_2022Health%26WellbeingReport_WEB.pdf/).

One of the most common forms of discrimination experienced by

transgender, nonbinary, and gender nonconforming people is medical staff refusing to provide care. “When medical professionals refuse to provide care to patients, it can lead to delays that contribute to poorer health outcomes and exacerbate health disparities.” Caroline Medina & Lindsey Mahowald, *Discrimination and Barriers to Well-Being: The State of the LGBTQI+ Community in 2022*, Ctr. for Am.

Progress (Jan. 12, 2023), <https://www.americanprogress.org/article/discrimination-and-barriers-to-well-being-the-state-of-the-lgbtqi-community-in-2022/>. “[N]early 1 in 3 transgender or nonbinary respondents . . . reported encountering some kind of health care refusal by a doctor or other health care provider in the past year[.]” *Id.* These experiences included but were not limited to “providers refusing them reproductive or sexual health services because of their actual or perceived gender identity (21%) . . . and outright refusing to see the respondent because of their actual or perceived gender identity (10%).” *Id.*

Data concerning non-white LGBTQ+ individuals demonstrates that they fare even worse. Respondents of color experienced higher rates of discrimination and substandard care in “nearly every category.” *See* Lambda Legal, *supra*, at 6, 11; *see also* Montero et al., *supra*. In the above-referenced study performed by the Center for American Progress, “more than 4 in 10 transgender or nonbinary respondents of color” reported encountering some kind of health care refusal. Medina & Mahowald, *supra*.

Finally, although some individuals seek out LGBTQ+ community health centers to avoid such discrimination, they are not widely available across the United States, and many are unable to provide comprehensive services. Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for Am. Progress (Jan. 18, 2018), <https://www.americanprogress.org/article/discrimination-prevents-lgbtq-people-accessing-health-care/>.

*ii. Costs are barriers*

Another barrier that LGBTQ+ people face when trying to access health care is the cost. LGBT people are increasingly likely to sit in lower socioeconomic brackets, meaning that the expensive cost of health care strikes them disproportionately. Bianca, D. M. Wilson et al., *LGBT Poverty in the United States*, UCLA Williams Inst., 1–5 (2023), <https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Poverty-COVID-Feb-2023.pdf>.

LGB+ individuals are more likely to be concerned about medical bills than their non LGB+ counterparts. Arielle Bosworth et al., Dep't of Health and Hum. Servs., Off. of Health Pol'y, *Health Insurance Coverage and Access to Care for LGBTQ+ Individuals: Current Trends and Key Challenges* 1 (Jun. 2021), <https://aspe.hhs.gov/sites/default/files/2021-07/lgbt-health-ib.pdf>. LGBT people are approximately 30% more likely to struggle paying a medical bill and

approximately 40% more likely to live without insurance because they cannot afford it, compared to non-LGBT people. Thomas Waldrop, *Equitable Insurance Coverage and Access Can Advance LGBT Health*, The Century Found. (Oct. 2, 2023), <https://tcf.org/content/commentary/equitable-insurance-coverage-and-access-can-advance-lgbt-health/>. “These numbers climb even higher for transgender and intersex adults[.]” Caleb Smith & Haley Norris, *The LGBTQI+ Community Reported High Rates of Discrimination in 2024*, Ctr. for Am. Progress (Mar. 12, 2025), <https://www.americanprogress.org/article/the-lgbtqi-community-reported-high-rates-of-discrimination-in-2024/>.

Just as with discrimination—wherein a barrier to LGBTQ+ people accessing health care was more severely felt by those who also belong to racial minorities—here too, “[c]ost was disproportionately a prohibitive factor” for racial minorities. Rastogi, *supra*. It was prohibitive for Middle Eastern/North African respondents 37% of the time, Bi/Multiracial respondents 34% of the time, American Indians/Alaska Native respondents 33% of the time, and Latine respondents 32% of the time, compared to 26% of the time for white people. *Id.*

**B. Discrimination + Expensive Costs = LGBTQ+ People Avoiding and Postponing Health Care and Less Likely to Have a Usual Source of Care**

What is more, data from varying studies consistently demonstrates that suffering from forms of discrimination, anticipating facing forms of discrimination,

and the cost of health care cause LGBTQ+ individuals to be less likely to seek care and more likely to postpone or avoid seeking care altogether. Mirza & Rooney, *supra*; Lambda Legal, *supra*, at 9, 12–13; Smith & Norris, *supra*; Medina & Mahowald, *supra*; Bosworth, *supra*, at 1 (“In the [National Health Interview Survey], LGB+ individuals report[ed] being more likely to delay care[.]”); Montero et al., *supra* (“Larger shares of LGBT adults compared to non-LGBT adults report having a negative health care experience . . . that . . . made them less likely to seek health care (39% v. 15%)[.]”). Facing forms of discrimination and the fear of facing discrimination while receiving health care from a provider have been known to cause LGB people to switch health providers frequently, leading to less continuity in care. *See* Montero et al., *supra*; *see also* Bosworth, *supra*, at 1. All of which frequently leads to general alienation from the health care system. Lambda Legal, *supra*, at 9.

In a 2017 study by the Center for American Progress, 8% of all LGBTQ “people—and 14% of those who had experienced discrimination on the basis of their sexual orientation or gender identity in the past year—avoided or postponed needed medical care because of disrespect or discrimination from health care staff. Among transgender people, 22% reported such avoidance.” Mirza & Rooney, *supra*. This number rose to 24% in a 2024 study, with respondents specifically citing the “fear of being mistreated as a trans person.” Rastogi, *supra*.

LGBTQ+ adults are more than twice as likely as non-LGBTQ+ adults to postpone or avoid needed medical care “when sick or injured because they could not afford it.” Medina & Mahowald, *supra*. LGBTQ+ adults are also more than thrice as likely as non-LGBTQ+ adults to postpone or not try to get preventive care because they cannot afford it, including preventative screenings for “sexually transmitted infections, HIV, high blood pressure, and cholesterol.” *Id.* LGBTQ+ people are more likely to delay counseling and therapy due to cost. Bosworth, *supra*, at 8. “Nearly half of LGBT adults (46%) say there was at time in the past three years when they needed mental health services but didn’t get them[.]” Montero et al., *supra*. Delaying mental health care is “particularly concerning” for LGBTQ+ individuals because they “face higher rates of multiple forms of violence, such as sexual assault, interpersonal violence, and harassment[.]” and thus, are more likely to need counseling and therapy. *Id.* “When broken down by insurance coverage, 23% with health insurance and 60% without health insurance did not see a provider in the past year due to cost.” Rastogi, *supra*.

Again, these numbers climb even higher for non-cisgender people: “45% of transgender adults postponed care due to affordability, as did 60% of intersex adults.” Smith & Norris, *supra*.

### **C. Avoiding and Postponing Health Care and a Lack of Continuity in Care Harms Individuals and Creates Adverse Public Health Consequences**

Society is healthier when people are under the care and advisement of trained medical professionals. See U.S. Dep't of Health and Hum. Servs., Off. of Disease Prevention and Health Promotion, *Access to Primary Care*, <https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-primary-care> (last visited Dec. 11, 2025); Leiyu Shi, *The Impact of Primary Care: A Focused Review*, *Scientifica* 1 (2012). Access to “comprehensive, quality healthcare services is important for promoting and maintaining” the best health outcomes, including but not limited to, “preventing and managing disease, reducing unnecessary disability and premature death, and achieving health equity[.]” Agency for Healthcare Rsch. and Quality, *National Healthcare Quality and Disparities Reports: Access to Healthcare and Disparities in Access* (Dec. 2021), <https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrd/2021qdr.pdf>.

Delay or avoidance of both regular and situational health care leads to unmet health needs and contributes to poorer health outcomes for LGBTQ+ people. Medina & Mahowald, *supra*. “Inability to access medical care in a timely manner can lead to higher risks for worsened illnesses, greater odds of depression, and

more[.]” Smith & Norris, *supra*. For instance, LGBTQ+ individuals “may be at higher risk for certain medical conditions, such as cancer, due to compounding challenges[.]” *Id.*

When LGBTQ+ people avoid regular, preventative, and emergency care, there are negative outcomes: they frequently miss early detection for serious diseases and conditions such as cancer, diabetes, and high blood pressure; they have a higher risk for worsening conditions and subsequently long-term complications of those conditions; they experience increased severity of an illness, disease, or condition; and delayed care often means more complex surgeries, longer hospital stays, and more expensive medical bills. *See* Medina & Mahowald, *supra*; Smith & Norris, *supra*; *see also* Nat’l Women’s L. Ctr., *Health Care Refusals Harm Patients: The Threat to LGBT People and Individuals Living with HIV* (Jan. 2013), [https://nwlc.org/wp-content/uploads/2015/08/refusals\\_harm\\_patients\\_lgbt\\_hiv\\_1-24-2013.pdf](https://nwlc.org/wp-content/uploads/2015/08/refusals_harm_patients_lgbt_hiv_1-24-2013.pdf). As intervenor United States Department of Justice points out, it happened in this case: Mr. Doe’s husband delayed needed dental work which resulted in an additional surgery that would not have been necessary had he been able to receive the needed dental work in a timely fashion and had he been covered by Catholic Relief Service’s health insurance at the time.

When transgender people avoid health care, they have greater odds of

having depression, suicidal ideations, and suicide attempts. Kristi L. Seelman et al., *Transgender Noninclusive Healthcare and Delaying Care Because of Fear: Connections to General Health and Mental Health Among Transgender Adults*, 2.1 *Transgender Health* 17, 26 (2017).

As this data illustrates, avoiding or delaying health care, along with a lack of continuity in services, has significant negative consequences for LGBTQ+ peoples' individual health. These consequences place added strain on the health care system creating negative outcomes for public health by increasing reliance on emergency rooms, overburdening providers, lengthening wait times, and increasing medication non-adherence. Joel S. Weissman et al., *Delayed Access to Health Care: Risk Factors, Reasons, and Consequences*, 114 *Annals of Internal Med.* 325, 325 (1991) (“[D]elays are associated with longer hospital stays and potentially poorer health outcomes.”); Kendra L Ratnapradipa et al., *Factors Associated with Delaying Medical Care: Cross-Sectional Study of Nebraska Adults*, *Nat’l Libr. of Med.* (2023) (“Delaying medical care can negatively affect health outcomes, inpatient stays, and the frequency of emergency department visits.”); Jennifer Ranz, *Delayed health care has clinical and financial impacts*, *Mass. Mun. Ass’n*, <https://www.mma.org/delayed-health-care-has-clinical-and-financial-impacts/> (last visited Dec. 13, 2025) (“Medication non-adherence can . . . exacerbate a patient’s medical condition . . . leading to more intense treatment and longer

hospitalizations in the future[.]”); see Denis J. Pereira Gray et al., *Continuity of care with doctors—a matter of life and death? A systematic review of continuity of care and mortality*, *BMJ Open* (2018), <https://bmjopen.bmj.com/content/bmjopen/8/6/e021161.full.pdf> (discussing the importance of continuity in care and that it is associated with improved health outcomes, like increased adherence to medication and reduced hospital use). These consequences drive up costs, as individuals increasingly require emergency treatment for conditions that could have been managed more effectively and affordably through timely, routine care. Weissman, *supra*, at 325 (“[D]elays may result in the patient being more severely ill at admission and with a worse prognosis, and possibly a longer hospital stay and higher costs than if [they] had received care earlier.”); Julia C. Prentice & Steven D. Pizer, *Delayed Access to Health Care and Mortality*, *Health Rsch. and Educ. Tr.* 644, 644 (2007) (“Delayed access has been found to increase the use of emergency rooms for nonurgent conditions . . . and to decrease patient satisfaction.”); Ranz, *supra* (“Medication non-adherence . . . also increases the financial toll on the U.S. health care system by more than \$5 billion annually[.]”).

As demonstrated, LGBTQ+ people already confront significant and often dangerous barriers in accessing health care. This Court should affirm to ensure that no new obstacles are imposed on LGBTQ+ people that would further jeopardize

their health and safety and place further strain on public health.

## **II. U.S. SOCIETY IS DEPENDENT ON EMPLOYER-SPONSORED HEALTH CARE; WITHOUT IT, MILLIONS OF LGBTQ+ PEOPLE WOULD GO UNINSURED.**

### **A. Reliance on Employer-Sponsored Health Care**

Reliance on employer-sponsored insurance (“ESI”) is baked into our society. As of 2023, ESI represented “the single largest source of health coverage in the U.S., providing health benefits to more than 160 million” people (with some estimates as high as 164.7 million), which is approximately half of the U.S. population. U.S. Chamber of Com., *Prioritizing Workforce Health, Employers Remain Committed to Employer-Sponsored Insurance* (“Prioritizing Workforce Health”) (May 12, 2023), <https://www.uschamber.com/health-care/prioritizing-workforce-health-employers-remain-committed-to-employer-sponsored-insurance>; see also Maanasa Kona & Sabrina Corlette, *The Erosion of Employer-Sponsored Health Insurance and Potential Policy Responses*, Georgetown Univ. Ctr. of Health Ins. Reforms (Dec. 5, 2022), <https://chir.georgetown.edu/erosion-employer-sponsored-health-insurance-potential-policy-responses/>; Gary Claxton et al., *Employer-Sponsored Health Insurance 101*, Kaiser Fam. Found. (Oct. 8, 2025), <https://www.kff.org/health-costs/health-policy-101-employer-sponsored-health-insurance/?entry=table-of-contents-introduction>. In fact, “America is the only developed nation that relies so heavily on employers for health insurance

coverage[.]” Kona & Corlette, *supra*. Today, ESI covers more than 70% of workers, 53% of children, and 36% of nonworking adults. Jake Spiegel & Paul Fronstin, The Commonwealth Fund, Achieving Universal Coverage, *What Employers Say About the Future of Employer-Sponsored Health Insurance* (Jan. 26, 2023), <https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/what-employers-say-future-employer-health-insurance>. “Through decades of policy and political change, and even a pandemic, ESI has remained the backbone of American health care; employers have not wavered in their belief that it is the best system to ensure a healthy workforce and keep costs down.” *Prioritizing Workforce Health, supra*.

This “longstanding bond between employers and health insurance dates back to World War II[.]” Spiegel & Fronstin, *supra*. “The implementation of wage controls prompted companies to seek out ways to differentiate themselves from their competitors in a bid to attract workers[.]” *see* Spiegel & Fronstin, *supra*; many began to do so by providing health insurance benefits to their employees. U.S. Chamber of Com., *The Origins and Growth of Employer-Provided Insurance* (“Origins of ESI”) (Nov. 14, 2024), <https://www.uschamber.com/health-care/origins-and-growth-of-employer-provided-insurance>.

In 1954, Congress added section 106 to the Internal Revenue Code, *see* 26 U.S.C.A. § 106, which permitted employers to exclude the value of employer-

provided health insurance coverage from their taxable income. Origins of ESI, *supra*. “[A]mounts paid by an employer to cover health insurance premiums for its employees” have since then become tax deductible as “ordinary and necessary business expenses,” immensely reducing the cost of providing health insurance to workers and their families. *Id.* Employers are thus provided with substantial state and federal subsidies towards the cost of ESI. Claxton et al., *supra*. “In turn, this has encouraged employers to offer health insurance as a competitive benefit and played a key role in establishing the widespread employer-based system that defines American health care today.” Origins of ESI, *supra*.

“[R]ules exempting employer spending on health benefits from taxation, as well as several failed attempts to implement a universal coverage system, have cemented the role of employers in providing health benefits.” Spiegel & Fronstin, *supra*. This has created an interdependent relationship between employment and health care coverage. *See id.* This interdependence is further fostered by employees’ preference and desire to have ESI as their form of health insurance, a fact that is clearly illustrated by data. *Prioritizing Workforce Health, supra.*

In a 2022 study conducted by the U.S. Chamber of Commerce, health insurance was “the most important benefit” an employer could offer an employee, even when compared directly to other specific benefits. U.S. Chamber of Com., *New Poll of American Workers Reveals Tremendous Value Placed on Workplace*

*Health Benefits* (Dec. 15, 2022), <https://www.uschamber.com/health-care/new-poll-of-american-workers-reveals-tremendous-value-placed-on-workplace-health-benefits>. “Workers report[ed] that they overwhelmingly prefer[red] to receive health insurance directly from an employer rather than through other means.” *Id.* Ninety-six percent of respondents believed it “important [for] a job to offer health insurance[,]” and “97% of respondents agreed that ‘quality health coverage [was] an important way for companies to retain their valued employees.’” *Id.* Eighty-nine percent of respondents “expressed a preference for obtaining their health coverage through an employer [rather] than through other means.” *Id.* When compared with plans available on the marketplace, 83% of respondents said that ESI plans were more affordable and 95% said that ESI plans were more convenient than an open market plan. *Id.* Finally, “[o]ver 75% of respondents said they believed [ESI] plans were higher quality [than] open market plans.” *Id.*

In a study performed by Protecting America’s Coverage Together, a campaign put on by the Chamber of Commerce, “93% of respondents [were] satisfied with their current ESI plans[,]” and 98% “agreed that ‘a good company to work for provides quality health coverage to their employees.’” *Prioritizing Workforce Health, supra.* A study performed by the Employee Research Benefit Institute “found that the open market could leave some employees confused or even overwhelmed with the number of insurance plans to choose from.” Spiegel &

Fronstin, *supra*.

A different study, performed by the Kaiser Family Foundation, discovered that among workers eligible for ESI at their jobs in March of 2023, “74.4% were ESI policyholders. Of those who did not have ESI from their own job, 14.6% were covered by ESI as a dependent, 4.6% had Medicaid or other public coverage, 2.0% had non-group coverage, 1.1% had some other coverage, and 3.7% were uninsured.” Claxton et al., *supra*.

Thus, the history of ESI combined with this data proves that health insurance and employment have become interdependent, each reinforcing the other in ways that shape the broader health insurance landscape. *See Spiegel & Fronstin, supra; see also Origins of ESI, supra*. Employers rely on health benefits as a primary tool for attracting and retaining talent, while employees depend on those same benefits for affordable, stable access to health care. *See Spiegel & Fronstin, supra; see also Origins of ESI, supra*. This mutual reliance forms a self-perpetuating cycle, which underscores the enduring influence of ESI here.

Given this interdependence, allowing employers to discriminate, thereby selectively providing ESI to only cisgender and straight employees, means that LGBTQ+ people will face one of two consequences: they will either become uninsured, or they will have to seek coverage under the Affordable Care Act (“ACA”). Although the ACA has been successful at decreasing the uninsured

population in the U.S., see Jennifer Tolbert et al., *The Uninsured Population and Health Coverage*, Kaiser Fam. Found. (Oct. 8, 2025), <https://www.kff.org/uninsured/health-policy-101-the-uninsured-population-and-health-coverage/?entry=table-of-contents-introduction>, forcing LGBTQ+ people to obtain health insurance through the ACA will undermine that progress by putting an unnecessary and unforeseen burden on the marketplace.

### **B. The “Affordable” Part of the ACA is Under Attack; Millions Will Become Uninsured**

The cost of health insurance under the ACA is predicted to massively increase in two ways in 2026. Together these increases will create a situation in which many people insured through the ACA will no longer be able to afford health insurance and will become uninsured.

First, the amount health insurers charge for coverage under the ACA marketplace will rise “by approximately 26% on average in 2026.” Cynthia Cox, *ACA Insurers Are Raising Premiums by an Estimated 26%, but Most Enrollees Could See Sharper Increase in What They Pay*, Kaiser Fam. Found. (Oct. 28, 2025), <https://www.kff.org/quick-take/aca-insurers-are-raising-premiums-by-an-estimated-26-but-most-enrollees-could-see-sharper-increases-in-what-they-pay/>. For instance, on December 18, 2025, Mary Jo Armstrong and her ex-husband William remarried (the divorce having been finalized in 2014) because Mary Jo’s health care premium was set to drastically increase from \$350 per month to \$1400

per month. That amount is almost 50% of Mary Jo’s monthly income, and remarrying “was the best solution they could muster.” Roberta Burkhart, *Skyrocketing ACA premiums are pushing some to extreme measures*, Pittsburgh Post-Gazette (Dec. 28, 2025), <https://www.post-gazette.com/news/health/2025/12/28/aca-health-insurance-premiums/stories/202512280050>. This increase in premiums is the largest increase since 2018 and solely concerns “the amount insurers are charging[.]” Cox, *supra*.

In addition to the increase in premiums, the cost of ACA coverage is predicted to skyrocket due to the possible expiration of Enhanced Premium Tax Credits. Premium Tax Credits (“PTCs”) are tax credits that enrollees of the ACA marketplace may apply for. Julie Carter, *Affordable Care Act Marketplace Premiums Expected to Skyrocket*, Medicare Rights Ctr. (Aug. 7, 2025), <https://www.medicarerights.org/medicare-watch/2025/08/07/affordable-care-act-marketplace-premiums-expected-to-skyrocket>. PTCs are a core part of the ACA and were established by Congress in 2010 with the initial passing of the ACA; requesting, claiming, and receiving PTCs first became available for tax year 2014. Jared Ortaliza et al., *The Affordable Care Act 101*, Kaiser Fam. Found. (Oct. 8, 2025), <https://www.kff.org/affordable-care-act/health-policy-101-the-affordable-care-act/?entry=table-of-contents-what-is-the-affordable-care-act>. PTCs help people with low or middle incomes pay their marketplace premiums. Carter, *supra*.

Enrollees who are granted PTCs receive subsidies based on a “sliding-scale of their household income” subject to a formula set by Congress. *Cox, supra*.

In 2021, in the American Rescue Plan Act, Congress created Enhanced PTCs (“EPTCs”) as a way to decrease the number of uninsured people who had been priced out of the market because their incomes did not previously qualify them for a subsidy. *See* American Rescue Plan Act of 2021, Pub. L. No. 117-2, 135 Stat. 4 (codified as 15 U.S.C. § 9001 note); *see also* Matthew Rae et al., *How the American Rescue Plan Act Affects Subsidies for Marketplace Shoppers and People Who Are Uninsured*, Kaiser Fam. Found. (Mar. 25, 2021), <https://www.kff.org/affordable-care-act/how-the-american-rescue-plan-act-affects-subsidies-for-marketplace-shoppers-and-people-who-are-uninsured>. EPTCs led to “huge gains” in reducing the number of uninsured people, *see Cox, supra*, more than doubling enrollment in the marketplace from 11.4 million people in 2020 to 24.3 million people in 2025. Kaiser Fam. Found., *Marketplace Enrollment, 2014–2025*, <https://www.kff.org/affordable-care-act/state-indicator/marketplace-enrollment/?activeTab=graph&currentTimeframe=0&startTimeframe=11&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Dec. 9, 2025). Currently, 22 “out of 24 million marketplace enrollees” receive some form of PTC. *Cox, supra*.

Although EPTCs expired on December 31, 2025, the U.S. House of Representatives passed a bill on January 8, 2026, that would revive and extend EPTCs for another three years. Sahil Kapur et al., *House votes to revive Obamacare funds as senators plot a scaled-back bill*, NBC News (Jan. 8, 2026), <https://www.nbcnews.com/politics/congress/house-votes-revive-obamacare-funds-senators-plot-scaled-back-bill-rcna252889>. However, as the bill heads to the Senate, its fate remains uncertain, as many senators have already publicly expressed that they will vote against it. *See id.* Without EPTCs, “currently subsidized enrollees will see their monthly premium payments more than double, increasing by about 114%, on average.” *Id.* The Congressional Budget Office (“CBO”) estimates that the loss of EPTCs “would increase the number of uninsured people by millions.” Letter from Phillip L. Swagel, Director of the CBO, to Ron Wyden, Chairman of the U.S. Senate Committee on Finance and Richard Neal, Ranking Member of the U.S. House of Representatives Committee on Ways and Means (Dec. 5, 2024), <https://www.cbo.gov/system/files/2024-12/59230-ARPA.pdf>. More specifically, the CBO further estimates that without EPTCs, “the number of uninsured people will rise by 2.2 million in 2026, 3.7 million in 2027, and by 3.8 million, on average, in each year over the 2026–2034 period.” *Id.* “In their 2026 filings to state regulators describing their requested premium increases, ACA [m]arketplace insurers said they would charge about 4 percentage points

more, on average, than they otherwise would have because they expected healthier people to drop [m]arketplace coverage if [EPTCs] expire.” Cox, *supra*.

LGBTQ+ individuals denied ESI who seek health insurance under the ACA are thus currently facing a reality where access to reliable, affordable health care is increasingly precarious. Without the renewal of EPTCs, countless LGBTQ+ people, like others, will see their health care costs surge by hundreds of dollars each month, unraveling recent gains in enrollment and affordability, and driving them into the ranks of the uninsured. In this environment of mounting instability, reversing the lower court’s decision would thus sanction the denial of ESI to LGBTQ+ people and leave many with no access to health care. Accordingly, this Court should affirm.

### **III. THE DANGERS OF REVERSING THE LOWER COURT GIVEN THE INCREASE IN RELIGIOUS INVOLVEMENT IN HEALTH CARE AND THE DEFICIT OF CRUCIAL HEALTH CARE WORKERS.**

#### **A. Increase in Religious Involvement in Health Care**

This Court should not permit religiously affiliated employers to discriminate against employees who are not clergy members, faith leaders, religious educators, or others who have no role in the employer’s religious mission. Otherwise, LGBTQ+ workers lose critical civil rights protections guaranteed by the Constitution and the delicate statutory balance provided by current law. And they are left defenseless against revocations and outright denials of employment

benefits, like ESI, solely because of who they are. The result would be a regime in which LGBTQ+ people employed in hospitals, a myriad of other types of health care facilities, and social service agencies, like Catholic Relief Services, could be stripped of basic workplace rights, deepening the systemic inequities they already face. If this Court were to reverse, LGBTQ+ people employed by religious health care systems are likely to be most at risk.

Data as early as 2001 demonstrates that “Catholic health systems have aggressively acquired secular hospitals in much of the country.” Rachana Pradhan & Hannah Recht, *The Powerful Constraints on Medical Care in Catholic Hospitals Across America*, Kaiser Fam. Found. (Feb. 17, 2024), <https://kffhealthnews.org/news/article/catholic-hospitals-affiliates-ethical-religious-directives-reproductive-care/>; Loris Uttley & Christine Khaikin, *Growth of Catholic Hospitals and Health Systems: 2016 Update of the Miscarriage of Medicine Report*, MergerWatch 1 (2016), <http://static1.1.sqspcdn.com/static/f/816571/27061007/1465224862580/M> (demonstrating that in 2001 Catholic health systems controlled 259 hospitals, in 2011 that number increased to 330 hospitals, and in 2016 it increased again to 384 hospitals). The three largest for-profit systems (HCA Healthcare, Tenet Healthcare

and Community Health Systems) “operate 348 short-term acute care hospitals,”<sup>3</sup> which is an increase of 29% since 2001. Tess Solomon et al., Cmty. Catalyst, *Bigger and Bigger, The Growth of Catholic Health Systems*, 6 (2020), <https://www.communitycatalyst.org/wp-content/uploads/2022/11/2020-Cath-Hosp-Report-2020-31.pdf>. “By comparison, the four largest Catholic systems (CommonSpirit Health, Ascension Health, Trinity Health[,], and Providence St. Joseph Health) operate 282 short-term hospitals,” which is an increase of 83% since 2001. *Id.*

As of 2020, four of the United States’s ten largest hospital systems were Catholic, and at least one in six of America’s hospital beds were in Catholic hospitals. *Id.*; Pradhan & Recht, *supra* (citing data from the Agency for Healthcare Research and Quality); Uttley & Khaikin, *supra*, at 1, 4. Also as of 2020, the ten largest Catholic health systems “own[ed] or control[led] 394 short-term acute care hospitals,” which is a 50% increase since 2001. Solomon, *supra*, at 3. Plus, there are roughly 100 hospitals that are managed by Catholic chains. Pradhan & Recht, *supra*.

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<sup>3</sup> According to the Centers for Disease Control and Prevention, short-term acute care hospitals include “general hospitals, critical access hospitals, oncology hospitals, [and] military/VA hospitals.” Ctrs. for Disease Control and Prevention, Nat’l Healthcare Safety Network, Acute Care / Critical Access Hospitals, <https://www.cdc.gov/nhsn/acute-care-hospital/index.html> (last visited Dec. 13, 2025).

Additionally, “Catholic health systems are expanding outside the hospital setting.” *Id.* at 4. Catholic health systems are now extending “into all categories of inpatient facilities such as rehabilitation hospitals, substance abuse treatment centers[,] and other inpatient specialty care programs.” *Id.* at 3. For example, the ten largest Catholic health systems “operate 864 urgent care centers, 385 ambulatory surgery centers and 274 physician groups, along with other operations, such as clinics in retail pharmacies, imaging centers[,] and home health services.” *Id.* at 4.

As a result, Catholic health care providers have grown their market power. Bailey Sanders et al., *Growing Market Power Among Catholic Hospitals Restrains Access to Reproductive Health Care*, Ctr. for Am. Progress (Sep. 29, 2025), <https://www.americanprogress.org/article/growing-market-power-among-catholic-hospitals-restrains-access-to-reproductive-health-care/>. From 2001 to 2020, the growth rate of Catholic health care providers was 28.5%, yet non-Catholic health care providers declined by nearly 14% during that same period. *Id.* Thus, by 2020, Catholic facilities accounted for 15.6% “of all short-term acute care hospitals.” Solomon, *supra*, at 13.

Many religious employers “are well aware of the potential immunity” the religious freedom exceptions afford them “and have attempted to bring more types of employees, employers, and claims within the exception’s scope.” Allison R.

Ferraris, *The Expansive Scope of the Ministerial Exception After Our Lady of Guadalupe School v. Morrissey-Berru*, 62 B.C. L. Rev. E-Supplement II. 280, 295–96 (2021). “Some organizations have even gone so far as to explicitly provide religious employers with guidance for avoiding civil rights lawsuits by using the ministerial exception.” *Id.* at 296 (citing All. Defending Freedom & The Lutheran Church, *Protecting Your Ministry from Sexual Orientation Gender Identity Lawsuits* (Aug. 2016), <https://nidlcms.org/wp-content/uploads/2017/02/Protecting-Your-Ministry-PDF-from-LCFS.pdf> (a specific guide designed to help congregations, schools, and ministries prepare for civil rights lawsuits by taking advantage of the church autonomy doctrine)).

“While religious freedom is a positive and key tenet of the Constitution, it cannot be extended so far as to impinge entirely on more recent—but also key—principles and rights, such as freedom from discrimination.” Rachel Barrick, *The Ministerial Exception: Seeking Clarity and Precision Amid Inconsistent Application of the Hosana-Tabor Framework*, 70 Emory L. J. 465, 470 (2020). Reversing the lower court could expand the types, and consequently the mass, of employers who could discriminate against LGBTQ+ people under the guise of religious freedom under the First Amendment. *See id.* at 469–70; *see also* Ferraris, *supra*, at 295 (explaining that the religious freedom exceptions “should apply to as few employees as possible, because a broad application has the potential to

undermine the statutory employment antidiscrimination protections of millions of American workers.”). If the Court were to permit discrimination against LGBTQ+ people, given this increase in the number of religiously-affiliated hospitals, many LGBTQ+ people employed in the health care field will lose their access to ESI.

### **B. Deficit of Health Care Workers**

In addition to the increase in religious employers in the health care sector, health care workers today are facing unprecedented levels of strain, turnover, and burnout. Travel Nurse Across Am., *The State of Healthcare Workforce Shortages: Challenges, Causes, and Solutions*, <https://tnaa.com/blog/the-state-of-healthcare-workforce-shortages-challenges-causes-and-solutions> (last visited Dec. 18, 2025). “While “[b]urnout and turnover peaked during the pandemic, [both] never fully went away.” *Id.* Further, experts have said that “while burnout and staffing shortages [are] not new, the scale of the current crisis was unprecedented.” Mrinalika Roy, *Over half of US healthcare workers plan to switch jobs by next year, survey finds*, Reuters (Sep. 16, 2025), <https://www.reuters.com/business/healthcare-pharmaceuticals/over-half-us-healthcare-workers-plan-switch-jobs-by-next-year-survey-finds-2025-09-15>. The strain and burnout are causing providers in all types of positions to leave the health care profession; their departure is creating a national shortage of health care professionals, a shortage that is predicted to continue for the foreseeable future.

See, e.g., Makinzi Hoover et al., *Data Deep Dive: A National Nursing Crisis*, U.S. Chamber of Com. (Jan. 29, 2024), <https://www.uschamber.com/workforce/nursing-workforce-data-center-a-national-nursing-crisis> (strain and burnout affecting a nursing shortage); Nat'l Inst. for Health Care Mgmt., *Addressing Health Care Workforce Shortages* (“Workforce Shortages”) (Jul. 16, 2025), <https://nihcm.org/publications/addressing-health-care-workforce-shortages> (“Shortages strain health care access and . . . contribute to burnout among [providers].”); Elizabeth Heinonen, *We must grow the health care workforce*, Kaiser Permanente (Jun. 17, 2025), <https://about.kaiserpermanente.org/news/must-grow-health-care-workforce>. Allowing religious health care employers to discriminate against LGBTQ+ people, including by denying them ESI, would have detrimental ripple effects, as it could encourage LGBTQ+ health care workers to leave the health care profession at a time when instead, the U.S. needs more providers.

“The U.S. forecasts a shortage of nearly 700,000 physicians, registered nurses[,] and licensed practical nurses by 2037, according to the Health Resources and Services Administration.” Roy, *supra*. In 2024, the American Association of Medical Colleges predicted that by 2036, there will be a “total projected physician shortfall” of between 13,500 and 86,000 physicians. Am. Ass’n of Med. Colls., *The Complexities of Physician Supply and Demand: Projections from 2021 to 2036*, 6

(Mar. 2024), <https://www.aamc.org/media/75236/download?attachment>. Within that range, there will be a shortage of 20,000 to 40,000 primary care physicians, and of 10,100 to 19,900 surgeons. *Id.* at 9, 11. Thirty-one out of thirty-five physician specialties, including obstetricians/gynecologists and geriatrics, are also facing ongoing shortages. Workforce Shortages, *supra*. The National Institute for Health Care Management predicts that forty-seven states are projected to have a shortage of primary care physicians by 2037. *Id.*

For every year from now until 2032, there are on average 193,100 projected job openings for registered nurses. Makinzi Hoover et al., *supra*. “However, for the decade between 2022–2032, the United States expects only an additional 177,400 nurses to enter the workforce, which is less than what is needed to fill one year of projected openings.” *Id.* Moreover, by 2037 there will also be a shortage of over 87,000 mental health counselors. Heinonen, *supra*.

Amidst these current and growing crisis-level shortages across the health care workforce, the Court should not sanction broader discrimination that would exacerbate them.

## CONCLUSION

For all these reasons, *Amici curiae* respectfully urge this Court to rule in favor of Appellee.

Respectfully Submitted,

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January 20, 2026

### **CERTIFICATE OF COMPLIANCE**

Pursuant to Fed. R. App. P. 32(g), I hereby certify that this brief complies with the type-volume limitation of Fed. R. App. P. 29(a)(5) because this brief contains 6468 words, excluding the parts of the brief exempted from the word count by Fed. R. App. P. 32(f).

I further certify that this brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word in Times New Roman 14-point font.

January 20, 2026

/s/ Sarah Miller

Sarah Miller

### **CERTIFICATE OF SERVICE**

I hereby certify that on January 20, 2026, the foregoing Brief of *Amici Curiae* in Support of Plaintiff-Appellee was filed through the CM/ECF system and thereby electronically served via ECF on all counsel of record in this matter.

January 20, 2026

/s/ Sarah Miller  
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