IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
EASTERN DIVISION

The Religious Sisters of Mercy, et al., Plaintiffs, vs. Alex M. Azar II, Secretary of the United States Department of Health and Human Services, et al., Defendants.	)	**MEMORANDUM AND ORDER** Case No. 3:16-cv-00386

Catholic Benefits Association, et al., Plaintiffs, vs. Alex M. Azar II, Secretary of the United States Department of Health and Human Services, et al., Defendants.	)	Case No. 3:16-cv-00432

In these consolidated cases, a coalition of entities affiliated with the Catholic Church and the State of North Dakota challenge the implementation of Section 1557 of the Patient Protection and Affordable Care Act ("ACA"), a statute that prohibits certain forms of discrimination in healthcare. The Plaintiffs contend that the Department of Health and Human Services ("HHS") and, derivatively, the Equal Employment Opportunity Commission ("EEOC") interpret Section 1557 and related antidiscrimination laws in a way that compels them to perform and provide insurance coverage for gender transitions and abortions.

The Catholic Plaintiffs move for summary judgment and injunctive relief under the Religious Freedom Restoration Act of 1993 ("RFRA"). North Dakota joins some of them in an

Administrative Procedure Act ("APA") challenge and separately seeks reprieve under the Spending Clause of the Constitution. For the reasons below, the Court concludes that the RFRA entitles the Catholic Plaintiffs to permanent injunctive relief from the provision or coverage of gender-transition procedures. The other claims either run afoul of jurisdictional limitations or do not warrant summary judgment.

I. BACKGROUND

The Court begins with the statutory framework of Section 1557. Next is an overview of the implementing regulations and resulting litigation. An introduction of the parties follows. Last is a summary of these cases' recent procedural developments.

A. Statutory Framework

Enacted in March 2010, the ACA is "a comprehensive national plan to provide universal health insurance coverage." Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 583 (2012). Fundamentally, the ACA is designed to broaden access to healthcare and insurance coverage. King v. Burwell, 576 U.S. 473, 478-79 (2015). Part and parcel with that objective is the ACA's ban on discrimination in healthcare.

Codified at 42 U.S.C. § 18116, Section 1557 of the ACA prohibits any federally funded or administered health program or activity from engaging in discrimination. Rather than specifically listing the prohibited grounds for discrimination, Section 1557 coopts four preexisting civil rights statutes: (1) Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.) (race, color, or national origin); (2) Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.) (sex); (3) the Age Discrimination Act of 1975 (42 U.S.C. § 6101 et seq.) (age); and (4) the Rehabilitation Act of 1973 (29 U.S.C. § 794) (disability). In kind, Section 1557 adopts the enforcement mechanisms available under each incorporated statute. 42 U.S.C. § 18116(a). The

Secretary of HHS holds discretionary authority to promulgate implementing regulations. Id. § 18116(c).

The lone prohibited ground relevant for these cases stems from Title IX, which forbids discrimination "on the basis of sex." 20 U.S.C. § 1681(a). Two exceptions merit mention up front. First, Title IX is inapplicable "to an educational institution which is controlled by a religious organization" if application "would not be consistent with the religious tenets of such organization." Id. § 1681(a)(3); see also 20 U.S.C. § 1687. Second, Title IX cannot "require or prohibit any person, or public or private entity, to provide or pay for any benefit or service, including the use of facilities, related to an abortion." 20 U.S.C. § 1688.

For enforcement, Section 1557 (by way of Title IX) greenlights administrative agencies to revoke federal funding for an offending health program or activity. 20 U.S.C. § 1682. Agencies may also pursue "any other means authorized by law," including civil enforcement proceedings, debarment from doing business with the federal government, lawsuits under the False Claims Act, and even criminal penalties.[1] See id. In addition, Section 1557 supports a private right of action for damages and attorney's fees. See Rumble v. Fairview Health Servs., No. 14-cv-2037 (SRN/FLN), 2015 WL 1197415, at *7 n.3 (D. Minn. Mar. 16, 2015) (concluding that Section 1557 provides a private right of action because each incorporated statute does so).

[1] Applicants for federal financial assistance from HHS must complete Form 690, which certifies that the applicant will comply with antidiscrimination laws like Section 1557 and Title IX. See 45 C.F.R. §§ 86.4, 92.4. Subsequent failure to comply with those laws may trigger the False Claims Act, exposing an offender to civil penalties of up to $11,000 per false claim "plus 3 times the amount of damages which the Government sustains because of" any false claim. 31 U.S.C. § 3729(a)(1). Further, an individual who makes a materially false statement in connection with the delivery of or payment for healthcare benefits or services is subject to criminal monetary penalties, up to five years' imprisonment, or both. 18 U.S.C. § 1035.

B. Regulations and Litigation

1. The 2016 Rule

More than six years after the ACA became law, HHS promulgated a rule interpreting Section 1557. See Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376 (May 18, 2016) ("2016 Rule"). The 2016 Rule applied broadly. HHS defined "covered entity" to encompass any "entity that operates a health program or activity, any part of which receives Federal financial assistance." Id. at 31,466 (formerly codified at 45 C.F.R. § 92.4). And a "health program or activity" meant "the provision of health-related services, health-related insurance coverage, or other health-related coverage." Id. at 31,467. For entities "principally engaged" in those endeavors, the regulation extended to "all of [their] operations." Id. Due to near-ubiquitous participation in Medicaid and Medicare, HHS estimated that the 2016 Rule would apply to "almost all practicing physicians in the United States" and to over 133,000 hospitals, clinics, and other healthcare facilities. Id. at 31,445-46. The agency also predicted that the regulation would apply to the approximately 180 insurers that offered health plans through ACA or state-based marketplaces. Id. at 31,445.

Making the incorporation of Title IX plain, the 2016 Rule prohibited discrimination "on the basis of . . . sex." Id. at 31,469 (formerly codified at 45 C.F.R. § 92.101(a)). HHS then defined that phrase to include "discrimination on the basis of . . . termination of pregnancy, . . . sex stereotyping, and gender identity." Id. at 31,467 (formerly codified at 45 C.F.R. § 92.4). Drilling down further, the 2016 Rule defined "gender identity" as "an individual's internal sense of gender, which may be male, female, neither, or a combination of male and female, and which may be different from an individual's sex assigned at birth." Id. And "sex stereotypes" in part meant "the expectation that individuals will consistently identify with only one gender and that they will act

in conformity with the gender-related expressions stereotypically associated with that gender." Id. at 31,468. The regulation left "termination of pregnancy" undefined.

HHS contextualized those definitions with specific examples of discriminatory conduct. To start, the 2016 Rule prohibited a covered healthcare provider from refusing to offer medical services for gender transitions[2] if that provider offered comparable services to others. Id. at 31,471 (formerly codified at 45 C.F.R. § 92.206). HHS used this example: "A provider specializing in gynecological services that previously declined to provide a medically necessary hysterectomy for a transgender man would have to revise its policy to provide the procedure for transgender individuals in the same manner it provides the procedure for other individuals." Id. at 31,455. The same concept theoretically applied for abortions. So if an obstetrician performed dilation and curettage procedures for miscarriages, then the 2016 Rule barred a later refusal to perform those procedures for abortions. See Doc. No. 95, ¶ 134. As for covered entities' health plans, HHS declared that any "categorical . . . exclusion or limitation on coverage for all health services related to gender transition is unlawful on its face." 81 Fed. Reg. at 31,429; see also id. at 31,471-72 (formerly codified at 45 C.F.R. § 92.207(b)(4)-(5)). Put differently, the 2016 Rule prohibited covered insurers and third-party administrators[3] ("TPAs") from offering or administering health plans with gender-transition exclusions. Doc. No. 97, ¶ 133. The regulation likewise banned healthcare providers from issuing such exclusions in their employee health plans. Id. ¶ 135.

[2] HHS noted that "[t]he range of transition-related services, which includes treatment for gender dysphoria, is not limited to surgical treatments and may include . . . hormone therapy and psychotherapy, which may occur over the lifetime of the individual." 81 Fed. Reg. at 31,435-36.
[3] Self-insured entities often contract with TPAs to administer their group health plans. TPAs "are generally not responsible for the benefit design of the self-insured plans they administer." 81 Fed. Reg. at 31,432.

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