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

THE RELIGIOUS SISTERS OF MERCY, *et al.*, *Plaintiffs,* v. ALEX M. AZAR, Secretary of the United States Department of Health and Human Service, *et al.*, *Defendants.*	No. 3:16-cv-386 **Plaintiffs' Motion for Partial Summary Judgment, or in the Alternative, Preliminary Injunction** **Oral Argument Requested**
CATHOLIC BENEFITS ASSOCIATION, *et al.* *Plaintiffs,* v. ALEX M AZAR, Secretary of the United States Department of Health and Human Service, *et al.*, *Defendants.*	No. 3:16-cv-432

Plaintiffs respectfully move this Court for summary judgment (on Counts I-V, XIII, and XV of their amended complaint (ECF No. 95)) and for permanent declaratory and injunctive relief pursuant to Federal Rule of Civil Procedure 56.

This lawsuit challenges the Department of Health and Human Services' ("HHS") interpretation of Section 1557 of the Affordable Care Act ("ACA"), 42 U.S.C. § 18116(a). Under HHS's interpretation of Section 1557, Plaintiffs are required to provide and insure gender-transition procedures and abortions or else face liability

for "sex" discrimination. As set forth in Plaintiffs' Memorandum in support of this motion, Plaintiffs are entitled to summary judgment because HHS's interpretation of Section 1557 forces the religious Plaintiffs to violate their religious beliefs without satisfying strict scrutiny in violation of the Religious Freedom Restoration Act. HHS's interpretation of Section 1557 also violates the Administrative Procedure Act by misinterpreting Section 1557 and failing to incorporate a statutorily mandated religious exemption from Title IX. And HHS's interpretation of Section 1557 violates the Spending Clause by imposing unauthorized and coercive conditions on Plaintiff North Dakota.

Furthermore, absent an injunction, HHS's interpretation of Section 1557 will impose irreparable harm on Plaintiffs, the balance of harms heavily favors Plaintiffs, and an injunction protecting Plaintiffs' statutory and constitutional rights is in the public interest. Therefore, Plaintiffs request that this Court permanently enjoin Defendants from interpreting and enforcing Section 1557 in a manner that would compel Plaintiffs to provide and insure gender-transition procedures and abortion. Alternatively, at a minimum, Plaintiffs request a preliminary injunction no later than January 20, 2021—the date on which the new Administration can begin punishing them under Section 1557—and for the pendency of this litigation. Plaintiffs at minimum are entitled to a preliminary injunction prohibiting HHS from enforcing its existing Section 1557 regulations against Plaintiffs in a manner that would require Plaintiffs to provide and insure gender-transition procedures and abortion.

Plaintiffs request oral argument pursuant to Local Rule 7.1(E). Plaintiffs believe that oral argument would assist the Court in assessing the merits of Plaintiffs' claims under the Religious Freedom Restoration Act, the Administrative Procedure Act, and the Spending Clause, as well as Plaintiffs' request for a permanent injunction and declaratory relief, or in the alternative, a preliminary injunction.

A memorandum in support of this Motion satisfying the requirements of Local

Rule 7.1(B) is filed contemporaneously with this Motion.

Respectfully submitted this the 23rd day of November, 2020.

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INTRODUCTION

Section 1557 of the Affordable Care Act (ACA) prohibits any federally funded health program from engaging in sex discrimination. This means federally funded health programs are prohibited from engaging in practices that would treat men better than women, or vice versa.

The Department of Health and Human Services (HHS), however, interprets Section 1557 more broadly. It interprets "sex" discrimination to include discrimination based on "gender identity" or "termination of pregnancy." And based on this interpretation, HHS says doctors and hospitals must perform and pay for controversial gender transition procedures and abortions on pain of massive financial penalties—even when doing so would violate their religious beliefs and medical judgment.

HHS's sweeping interpretation of Section 1557 is unlawful for several reasons. First, it violates the Religious Freedom Restoration Act by forcing the Plaintiffs—including several Catholic healthcare providers—to violate their religious beliefs, without serving any compelling governmental interest. Second, it violates the Administrative Procedure Act by misinterpreting Section 1557 and failing to incorporate a statutorily mandated religious exemption. Third, it violates the Spending Clause by imposing unauthorized and coercive conditions on Plaintiff North Dakota.

Another federal court has already ruled that HHS's interpretation of Section 1557 is unlawful. *Franciscan All., Inc. v. Azar*, 414 F. Supp. 3d 928 (N.D. Tex. 2019). HHS initially agreed with that decision, and it attempted to walk back its interpretation of Section 1557 by promulgating a new Rule in 2020. However, that Rule has now been preliminarily enjoined by two federal courts, which have reinstated HHS's unlawful interpretation of Section 1557. And in the wake of the Supreme Court's recent decision in *Bostock v. Clayton County*, 140 S. Ct. 1731 (2020), HHS itself has taken the position that Section 1557 forces doctors and hospitals like Plaintiffs to perform

and pay for potentially harmful gender transition procedures in violation of their religious beliefs and medical judgment. Indeed, the next Administration has already stated its intent to extend Section 1557 to "the LGBTQ+ community" and "reverse" "religious exemptions" for "medical providers."

Accordingly, Plaintiffs seek relief from this Court. Specifically, they request declaratory relief and a permanent injunction prohibiting HHS from interpreting and enforcing Section 1557 in a way that would force Plaintiffs to perform or pay for gender transition procedures and abortions. At a minimum, they request a preliminary injunction no later than January 20, 2021—which is the date on which a new Administration can begin imposing financial penalties.

STATEMENT OF FACTS

A. Plaintiffs

Plaintiffs are four private Catholic organizations and one State that are adversely affected by Defendants' ("HHS") interpretation of Section 1557. Plaintiff **Religious Sisters of Mercy** is a Catholic order of religious sisters devoted to works of mercy, including offering healthcare to the underserved. Ex.A ¶2. Each sister has chosen to follow Jesus Christ by taking a lifetime vow to serve the poor and sick by caring for the whole person—including physical, psychological, intellectual, and spiritual woundedness. *Id.* ¶4. As part of their mission, they seek "to bring about that profound and extensive healing which is a continuation of the work of redemption." Ex.A ¶4; *see, e.g.*, Ex.F-1. Consistent with this mission, some of the sisters serve as licensed healthcare professionals in healthcare facilities throughout the country. Ex.A ¶5-6.

The Religious Sisters of Mercy own and operate a clinic that is also a Plaintiff—**Sacred Heart Mercy Health Care Center** in Alma, Michigan. *Id.* ¶6. Sacred Heart is incorporated as a religious nonprofit. *Id.* The clinic furthers the sisters' mission to care for the elderly and the poor by serving Medicare and Medicaid patients and by providing low-cost or free care to the uninsured. *Id.* ¶8. Some of the sisters work in

the clinic as doctors, nurses, or other healthcare professionals. *Id.* ¶6. Sacred Heart shares the Religious Sisters of Mercy's beliefs and is run in accordance with the U.S. Conference of Catholic Bishops' Ethical and Religious Directives for Catholic Health Care Services. *Id.*

Plaintiff **SMP Health System** is a nonprofit Catholic health system headquartered in Valley City, North Dakota, and founded and sponsored by the Sisters of Mary of the Presentation. Ex.B ¶3. The sisters believe that Catholic healthcare services and programs are ecclesial in nature, mandated by the Church to carry on the healing ministry of Jesus. Ex.F-2. As part of that healing ministry, SMP Health provides a variety of healthcare services throughout North Dakota, including critical-access hospitals, clinics, long-term care facilities, and senior housing. Ex.B ¶3. It has a special emphasis on providing services to the poor and elderly, including many Medicare and Medicaid patients. Ex.B ¶4. SMP Health shares the beliefs of the sisters and also operates in accordance with the Ethical and Religious Directives for Catholic Health Care Services. Ex.B ¶5.

Plaintiff **University of Mary** is a Roman Catholic, Benedictine University with its main campus in Bismarck, North Dakota. The University infuses all its programs with Christian, Catholic, Benedictine values to prepare its students to be ethical leaders in their communities. Ex.C ¶6. The University welcomes students of all faiths and backgrounds, and, as is fundamental to its mission, upholds Catholic teaching in all its programs. *Id.* The University is subject to HHS's interpretations of Section 1557 because it offers a nursing program that receives funding administered by HHS. Ex.C ¶8. It also has a student health clinic. Ex.C ¶10.

Like the Catholic Church they serve, these Plaintiffs believe that every man and woman is created in the image of God and reflects God's image in unique—and uniquely dignified—ways. Ex.A ¶9; Ex.B ¶6; Ex.C ¶9. To the extent they provide

medical services, Plaintiffs serve everyone in need, including transgender individuals. Ex.A ¶7; Ex.E ¶4. They also believe that gender-transition procedures can be deeply harmful to their patients; thus, providing those procedures would violate their religious beliefs and medical judgment. Ex.D ¶¶9-11; Ex.B ¶8; Ex.E ¶5. They also have similar religious and medical objections to providing abortions or sterilizations. Ex.B ¶¶9-10; Ex.E ¶¶8-9.

Plaintiff **State of North Dakota** oversees and controls several agencies and a healthcare facility that receive federal funding administered by HHS. Ex.G ¶4. North Dakota also employs many healthcare professionals and provides health benefits to those employees and their families. HHS's construction of Section 1557 will require North Dakota to provide gender-transition procedures, even when its doctors believe such procedures are harmful. *Id.* ¶7. If North Dakota's doctors have a religious objection to performing those procedures, HHS's interpretation of Section 1557 would make it illegal for the State to accommodate those doctors' religious beliefs, even though Title VII would otherwise require it to do so. HHS's regulations will also require North Dakota to provide insurance coverage for transition procedures and abortions, as well as training, at significant financial cost. If North Dakota does not comply, it faces significant financial penalties, including loss of federal funding and private lawsuits for damages and attorneys' fees. *Id.*

B. The Affordable Care Act and Section 1557

In March 2010, Congress enacted the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029, collectively known as the "Affordable Care Act" or "ACA." The key provision at issue in this case is Section 1557 of the ACA, which forbids "discrimination" in healthcare

Specifically, Section 1557 prohibits "discrimination under[] any health program or activity, any part of which is receiving Federal financial assistance." 42 U.S.C.

§ 18116(a). But Section 1557 itself does not specify the grounds on which discrimination is prohibited. Instead, it incorporates the "ground[s] prohibited" under four other federal antidiscrimination statutes—(1) "title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d *et seq.*)" (*i.e.*, "race, color, or national origin"); (2) "title IX of the Education Amendments of 1972 (20 U.S.C. 1681 *et seq.*)" (*i.e.*, "sex"); (3) "the Age Discrimination Act of 1975 (42 U.S.C. 6101 *et seq.*)" (*i.e.*, "age"); and (4) "section 794 of Title 29" (*i.e.*, "disability"). Section 1557's sole basis for prohibiting sex discrimination, then, is its reference to Title IX.

Congress enacted Title IX in 1972, prohibiting discrimination in certain education programs on the basis of "sex." 20 U.S.C. § 1681(a). Title IX expressly exempts religious organizations from complying with the statute and precludes interpreting "sex" to mean abortion. 20 U.S.C. § 1681(a)(3); 20 U.S.C. § 1688.

At the time of Title IX's enactment, the term "sex" was commonly understood to refer to the physiological differences between men and women, particularly with respect to reproductive functions. *See, e.g.*, American Heritage Dictionary 1187 (1976) ("The property or quality by which organisms are classified according to their reproductive functions."). That understanding is reflected throughout the statute, which requires equal treatment with respect to two different "sexes"—male and female. 20 U.S.C. § 1681(a)(2); *see also id.* § 1681(a)(8) (requiring comparable activities between students of "one sex" and "the other sex"). The law has long been interpreted to prohibit federally funded education programs from treating men better than women, or vice versa. *See, e.g.*, *Cannon v. Univ. of Chicago*, 441 U.S. 677, 680 (1979); *Chalenor v. Univ. of N.D.*, 291 F.3d 1042, 1044 (8th Cir. 2002).

C. The 2016 Rule

On May 18, 2016, after notice and comment, HHS issued a rule interpreting Section 1557. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376 (May 18, 2016) (the "2016 Rule"). The 2016 Rule applies to any "entity that operates

a health program or activity, any part of which receives Federal financial assistance." 81 Fed. Reg. at 31,466 (definition of "Covered entity"). "Federal financial assistance" is defined broadly to include "any grant, loan, credit, subsidy, contract … or any other arrangement" by which the federal government makes available its property or funds. *Id.* at 31,467. Thus, by HHS's own estimate, the 2016 Rule applies to almost every healthcare provider in the country—including over 133,000 health care facilities (such as hospitals and health clinics) and "almost all licensed physicians"—because they all accept some form of federal funding, such as Medicare or Medicaid. *Id.* at 31,445-46.

The 2016 Rule prohibits discrimination "on the basis of … sex," defines "sex" to include "gender identity," and defines "gender identity" as an individual's "internal sense of gender, which may be male, female, neither, or a combination of male and female." *Id.* at 31,467. The 2016 Rule also defines "sex" to include discrimination based upon "termination of pregnancy." *Id.*

Medical Procedures. The 2016 Rule interprets Section 1557 to require covered entities to perform medical transition procedures (such as hysterectomies, mastectomies, hormone treatments, plastic surgery, and other treatments designed to alter a patient's body in response to gender dysphoria) or else be liable for "discrimination." As HHS explained: "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." 81 Fed. Reg. at 31,455. In other words, if a gynecologist performs a hysterectomy for a woman with uterine cancer, she must do the same for a woman who wants to remove a healthy uterus to transition to living as a man. Thus, according to HHS, declining to remove a healthy organ is "discrimination." HHS explains that this reasoning applies across the full "range of transition-related services." *Id.* at 31,435. This "is not limited to surgical

treatments and may include, but is not limited to, services such as hormone therapy and psychotherapy, which may occur over the lifetime of the individual." *Id.* at 31,435-36.

In addition, because the 2016 Rule interprets Section 1557 to prohibit discrimination on the basis of "termination of pregnancy," it pressures healthcare providers who perform procedures such as a dilation and curettage for a miscarriage to perform the same procedure for an abortion.

Insurance Coverage. The 2016 Rule also interprets Section 1557 to require covered entities to pay for medical transition procedures in their health-insurance plans. The 2016 Rule states: "A covered entity shall not, in providing or administering health-related insurance … [h]ave or implement a categorical coverage exclusion or limitation for all health services related to gender transition." *Id.* at 31,471-72. According to HHS, this means that a plan excluding "coverage for all health services related to gender transition is unlawful on its face." *Id.* at 31,429. In addition, if a doctor concludes that a hysterectomy "is medically necessary to treat gender dysphoria," the patient's employer would be required to cover that procedure on the same basis that it would cover a hysterectomy for other conditions (like cancer). *Id.* Also, because the 2016 Rule prohibits discrimination on the basis of "termination of pregnancy," it pressures employers who cover procedures such as a dilation and curettage for a miscarriage to cover the same procedure for an abortion.

Enforcement. If a covered entity violates Section 1557, it is subject to the same penalties that accompany a violation of Title IX. 42 U.S.C. § 18116(a). These include the loss of federal funding (Medicare and Medicaid alone can total many millions of dollars), debarment from doing business with the government, and false-claims liability. 81 Fed. Reg. at 31,472. Penalties also include enforcement proceedings brought by the Department of Justice, *id.* at 31,440, and private lawsuits for damages and attorneys' fees. *Id.* at 31,472.

HHS adopted this novel interpretation of Section 1557 despite "significant disagreement within the medical community" as to the "necessity and efficacy" of gender-transition procedures in the first place. *Gibson v. Collier*, 920 F.3d 212, 216, 224 (5th Cir. 2019); *Smith v. Rasmussen*, 249 F.3d 755, 760-61 (8th Cir. 2001) (recognizing "the lack of consensus in the medical community" regarding "sex reassignment surgery"). And HHS did this despite the fact that HHS's own medical experts recommended against mandating coverage of gender-reassignment surgery in Medicare—concluding after "a thorough review of the clinical evidence" that "there is not enough evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria," and some studies "reported harms." ECF No. 6-6; *see* ECF No. 6-7.

Despite this medical disagreement, and to say nothing of obvious implications for religious healthcare providers, HHS nonetheless declined to include a religious exemption or provide any mechanism by which a religious entity could determine if it was entitled to any existing religious protections under the law. 81 Fed. Reg. at 31,376. The 2016 Rule also failed to include an abortion exemption.

D. Lawsuits Challenging the 2016 Rule

After the 2016 Rule was finalized, multiple plaintiffs brought lawsuits challenging it. In August 2016, a coalition of States, religious hospitals, and religious healthcare professionals sued in the Northern District of Texas. *Franciscan All., Inc. v. Burwell*, No. 16-cv-108, ECF No. 1 (N.D. Tex. filed Aug. 23, 2016). On November 6, 2016, Plaintiffs filed this lawsuit challenging the 2016 Rule, ECF No. 1, and on December 28, 2016, another suit was filed in this District, *Catholic Benefits Assoc. v. Burwell*, No. 16-cv-432, ECF No. 1 (D.N.D. filed Dec. 28, 2016). These two District of North Dakota suits were eventually consolidated before this Court. ECF No. 37.

Franciscan proceeded first, and on December 31, 2016, the district court prelimi-

narily enjoined HHS from enforcing the 2016 Rule's prohibition against discrimination on the basis of "gender identity" and "termination of pregnancy." *Franciscan All., Inc. v. Burwell*, 227 F. Supp. 3d 660, 670 (N.D. Tex. 2016). The court concluded that HHS's "implement[ation] of Section 1557" had likely violated RFRA by "plac[ing] substantial pressure on [plaintiffs] to perform and cover transition and abortion procedures" without its action being narrowly tailored to a compelling government interest. *Id.* at 672, 691-93. The court also agreed that the 2016 Rule exceeded HHS's statutory authority by defining "sex" discrimination under Section 1557 to include discrimination on the basis of "gender identity" and by not incorporating Title IX's religious and abortion exemptions. *Id.* at 687-91.

Meanwhile, this Court issued orders staying enforcement of the 2016 Rule against Plaintiffs. ECF Nos. 23, 36. This Court noted that the *Franciscan* court had issued a nationwide preliminary injunction prohibiting HHS from enforcing the 2016 Rule and specifically found "the order issued in *Franciscan Alliance* to be thorough and well-reasoned." ECF No. 36 at 2.

Following these decisions, HHS filed motions for voluntary remand and to stay in these consolidated cases and in *Franciscan*. It requested "the opportunity to reconsider the regulation at issue … based in part on the Administration's desire to assess the reasonableness, necessity, and efficacy" of the 2016 Rule and "to address certain issues identified by [the *Franciscan*] court in granting a preliminary injunction against those aspects of the regulation." ECF No. 45 at 1. Both this Court and the *Franciscan* court granted HHS's motions to stay.

In December 2018, however, following 17 months of inaction, the *Franciscan* court lifted the stay of litigation. In May 2019, after the plaintiffs there had filed motions for summary judgment, HHS issued a Notice of Proposed Rulemaking proposing to amend the 2016 Rule. *Franciscan,* No. 16-cv-108, ECF No. 159 (N.D. Tex. May 31, 2019). The proposed rule noted that Section 1557 should "not be applied in a manner

that conflicts with or supersedes … statutes protecting conscience and religious freedom" and acknowledged the *Franciscan* court's conclusion that the prior rule violated RFRA. *Id.* at 10-11, 75. Additionally, upon "further consideration of this issue," HHS stated that "enforcement of Section 1557 … must be constrained by the statutory contours of Title IX, which include explicit abortion and religious exemptions." *Id.* at 76. Finally, the proposed rule noted that the 2016 Rule's definition of "sex" "exceeded [HHS's] authority under Section 1557." *Id.* at 15. The proposed rule sought to address this issue by repealing the 2016 Rule's definition of "sex" in its entirety, which would allegedly "allow the Federal courts, in particular, the U.S. Supreme Court to resolve any dispute about the proper legal interpretation of" "sex" in Section 1557. *Id.* at 112-13. As the proposed rule noted, the Supreme Court had recently granted certiorari to decide whether "sex" discrimination under Title VII included discrimination on the basis of "sexual orientation" and "gender identity," in three cases that would be decided together as *Bostock*. *Id.* at 40-41.

On October 15, 2019, the *Franciscan* court granted summary judgment for the plaintiffs. 414 F. Supp. 3d 928. The court found "no reason to depart from its" preliminary-injunction analysis on the merits, holding that the 2016 Rule violated both RFRA and the APA. *Id.* at 942. The court concluded, however, that the proper remedy was vacatur of "the unlawful portions of" the 2016 Rule, "not a permanent injunction." *Id.* at 944-45; *see Franciscan*, No. 16-cv-108, ECF No. 182 (N.D. Tex. Nov. 21, 2019) (clarifying that the 2016 Rule was vacated "insofar as [it] defines '*On the basis of sex*' to include gender identity and termination of pregnancy"). HHS did not appeal the court's ruling on the merits; the plaintiffs, however, appealed the denial of injunctive relief to the Fifth Circuit, where briefing on the appropriate form of relief is currently underway. *Franciscan All., Inc. v. Azar*, No. 20-10093 (5th Cir. filed Jan. 24, 2020).

E. The 2020 Rule

On June 12, 2020, HHS issued a new rule interpreting Section 1557, finalizing the

rule proposed in 2019. *See* Nondiscrimination in Health and Health Education Programs or Activities, 85 Fed. Reg. 37,160 (June 19, 2020) (the "2020 Rule"). HHS noted that the 2020 Rule was promulgated in part in response to the *Franciscan* court's orders and to address deficiencies identified in the 2016 Rule.

Most importantly, the 2020 Rule repealed the 2016 Rule's definition of "sex" discrimination, which included, among other things, discrimination based on "termination of pregnancy" and "gender identity," as well as "sex stereotyping." *Id.* at 37,167. HHS concluded that "the 2016 Rule's extension of sex-discrimination protections to encompass gender identity was contrary to the text of Title IX." *Id.* at 37,168.

HHS, however, declined to replace the 2016 Rule's definition of "sex" with a new definition, reasoning instead that the Supreme Court's then-forthcoming decision in *Bostock* would "likely have ramifications for the definition of 'on the basis of sex' under Title IX." *Id.*; *see also id.* ("[T]his rule … does not define sex[.]"); *id.* at 37,178 ("This final rule repeals the 2016 Rule's definition of 'on the basis of sex,' but declines to replace it with a new regulatory definition."). HHS clarified that simply repealing the 2016 Rule's prior definition would then permit "application of the [*Bostock*] Court's construction." *Id.* at 37,168.

The 2020 Rule also included provisions addressing abortion and religious organizations. First, on abortion, HHS explained that the Section 1557 regulations are to be implemented consistent with the abortion neutrality exemption in Title IX, which states that nothing in Title IX "shall be construed to 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; 85 Fed. Reg. at 37,192. HHS noted that its decision to incorporate Title IX's abortion-neutrality exemption into the 2020 Rule was also justified by the *Franciscan* court's decision "vacat[ing] the 'termination of pregnancy' language in the 2016 Rule because it failed to incorporate the abortion-neutrality language from" Title IX. *Id.* at 37,193.

Second, on religious organizations, HHS recognized that its Section 1557 regulations must be "consistent with Title IX and its implementing regulations," *id.* at 37,192, and that Title IX itself states that "this section shall not apply to an educational institution which is controlled by a religious organization if the application of this subsection would not be consistent with the religious tenets of such organization." 20 U.S.C. § 1681(a)(3); 20 U.S.C. § 1687(4) (Title IX covers defined "program[s] or activit[ies]" but "does not include any operation of an entity which is controlled by a religious organization if the application of section 1681 of this title to such operation would not be consistent with the religious tenets of such organization"). Nonetheless, HHS declined to include in the text of the 2020 Rule "a religious exemption, whether narrow or broad," 85 Fed. Reg. at 37,205, and instead purported to incorporate by reference Title IX's religious exemption for "[a]ny *educational operation* of an entity … control[led] by a religious organization." *Id.* at 37,207 (emphasis added). On HHS's view, then, this exemption would not protect the Religious Sisters of Mercy, Sacred Heart Mercy Health Care Center, or SMP Health.

Finally, as relevant here, the 2020 Rule "eliminat[ed] the [2016 Rule's] language specifying a right to sue," but took no position "on the issue of whether Section 1557 provides a private right of action." *Id.* at 37,203. Rather, HHS claimed that "the issue of whether a person has a right to sue in Federal court under Section 1557 is one determined by the courts themselves and not by [HHS's] regulations." *Id.* at 37,236. "To the extent that Section 1557 permits private rights of action, plaintiffs can assert claims under Section 1557 itself rather than under [HHS's] Section 1557 regulation." *Id.* at 37,203. Thus, the 2020 Rule does not bar a plaintiff from bringing a private action to enforce Section 1557.

F. *Bostock* and Recent Lawsuits Challenging the 2020 Rule

On June 15, 2020, three days after HHS issued the new 2020 Rule, the Supreme

Court decided *Bostock*. 140 S. Ct. 1731. The Court held that when "an employer … fires someone simply for being homosexual or transgender," the employer has "discriminated against that individual 'because of such individual's sex'" within the meaning of Title VII. *Id.* at 1753. The Court cautioned, however, that its opinion did not "prejudge" the proper interpretation of "other federal or state laws that prohibit sex discrimination," *id.*, including Section 1557 and Title IX, *see id.* at 1779-82 & n.57 (Alito, J., dissenting). And the *Bostock* Court explained it was "deeply concerned with preserving the promise of the free exercise of religion," stating that religious employers might not be liable under Title VII "in cases like ours" if complying would require them "to violate their religious convictions." *Id.* at 1753-54.

Following the Supreme Court's ruling, plaintiffs in at least five different lawsuits sued HHS, challenging the 2020 Rule based on *Bostock* and seeking restoration of the 2016 Rule, in whole or in part. *See Whitman-Walker Clinic, Inc. v. U.S. Dep't of Health & Human Servs.*, No. 20-cv-01630 (D.D.C. filed June 22, 2020); *Walker v. Azar*, No. 20-cv-02834 (E.D.N.Y. filed June 26, 2020); *Boston All. of Gay, Lesbian, Bisexual & Transgender Youth v. U.S. Dep't of Health & Human Servs.*, No. 20-cv-11297 (D. Mass. filed July 9, 2020); *Washington v. U.S. Dep't of Health & Human Servs.*, No. 20-cv-01105 (W.D. Wash. filed July 16, 2020); *New York v. U.S. Dep't of Health & Human Servs.*, No. 20-cv-05583 (S.D.N.Y. filed July 20, 2020).

In two lawsuits, plaintiffs alleged that "sex" discrimination included discrimination based on "termination of pregnancy" and "gender identity" and that HHS's incorporation of exemptions was contrary to Section 1557. *Boston All.*, No. 20-cv-11297, ECF No. 1 ¶¶228-56, 271-83 (D. Mass. July 9, 2020); *New York*, No. 20-cv-05583, ECF No. 1 ¶86(a)-(f) (S.D.N.Y. July 20, 2020).

In another case, brought by the State of Washington, the court dismissed for lack of standing. *Washington v. U.S. Dep't of Health & Human Servs.*, No. C20-1105-JLR,

2020 WL 5095467, at *8 (W.D. Wash. Aug. 28, 2020). The court concluded that Washington lacked Article III standing because, in light of *Bostock*, it was possible that "Title IX and Section 1557 … incorporate protection for gender identity and sexual orientation discrimination" such that "the 2020 Rule does, in fact, extend protection against discrimination to LGBTQ individuals via the Rule's incorporation of Title IX by reference." *Id.*

In the remaining two cases, the district courts entered "overlapping injunctions," *Whitman-Walker Clinic, Inc. v. U.S. Dep't of Health & Human Servs.*, No. 20-cv-01630, 2020 WL 5232076, at *41 (D.D.C. Sept. 2, 2020) (quotation marks omitted), preventing the 2020 Rule "from becoming operative" and reinstating portions of the 2016 Rule, *Walker v. Azar*, No. 20-cv-02834, 2020 WL 4749859, at *1 (E.D.N.Y. Aug. 17, 2020).

One of these courts acknowledged that it had "no power to revive a rule vacated by another district court," referring to *Franciscan*. *Id.* at *7. Nevertheless, the court "predict[ed] that either the district court or some higher authority w[ould] revisit the vacatur," and then specifically held that portions of the 2016 Rule vacated by the *Franciscan* court—including "the definitions of 'on the basis of sex,' 'gender identity,' and 'sex stereotyping'"—"remain in effect." *Id.* at *7, *10; *see also Walker v. Azar*, No. 20-cv-02834, 2020 WL 6363970, *4 (E.D.N.Y. Oct. 29, 2020) (also enjoining repeal of the former 45 C.F.R. § 92.206).

The other district court indicated that a portion of the 2016 Rule purportedly not vacated by the *Franciscan* court—namely, the provision defining "sex" to include "sex stereotyping"—independently prohibits "[d]iscrimination based on transgender status—*i.e.*, gender identity." *Whitman-Walker*, 2020 WL 5232076, at *23, *45. The court therefore enjoined the 2020 Rule's repeal of this portion of the 2016 Rule in light of *Bostock*, "le[aving] … the 2016 Rule's prohibition on discrimination based on sex stereotyping"—which, again, the court had just said would also prohibit gender-identity

discrimination—in effect. *Id.* at *14.

Finally, the *Whitman-Walker* court also enjoined the 2020 Rule's incorporation of the religious exemption from Title IX, even though the *Franciscan* court held that the 2016 Rule was arbitrary and capricious for *not* including Title IX's religious exemption. *Id.* at *27-29.

Recognizing that these new developments expose them to liability, Plaintiffs moved to lift the stay in these consolidated cases, which the Court granted. ECF No. 93. Plaintiffs now move for partial summary judgment (on Counts I-V, XIII, and XV of their amended complaint (ECF No. 95) and to permanently enjoin HHS from interpreting and enforcing Section 1557 to require them to provide or cover gender transition procedures and abortions. At a minimum, given that the incoming administration has pledged to enforce Section 1557 on behalf of "the LGBTQ+ community" and to "reverse" "religious exemptions" for "medical providers" (Ex.F-10.), Plaintiffs request a preliminary injunction no later than January 20, 2021—the date on which the new Administration can begin punishing them under Section 1557.

ARGUMENT

Plaintiffs are entitled to summary judgment on their RFRA, APA, and Spending Clause claims. And because Plaintiffs satisfy all four factors necessary for injunctive relief, this Court should also grant a permanent injunction.

"Summary judgment is proper if there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law." *Mahler v. First Dakota Title Ltd. P'ship*, 931 F.3d 799, 804 (8th Cir. 2019) (citing Fed. R. Civ. P. 56(a)).

"The standard for granting a permanent injunction is essentially the same as for a preliminary injunction, except that to obtain a permanent injunction the movant must attain success on the merits." *Bank One, Utah v. Guttau*, 190 F.3d 844, 847 (8th Cir. 1999). Thus, in addition to (1) actual success on the merits, courts also consider (2) the threat of irreparable harm to the movant, (3) the balance of harms between

the parties, and (4) the public interest. *Sharpe Holdings, Inc. v. U.S. Dep't of Health & Human Servs.*, 801 F.3d 927, 936-37 (8th Cir. 2015), *vacated on other grounds, Dept. of Health & Human Servs. v. CNS Int'l Ministries*, No. 15-775, 2016 WL 2842448 (U.S. May 16, 2016).

I. As interpreted by HHS, Section 1557 violates RFRA.

Section 1557—as interpreted by HHS and other courts to prohibit discrimination based on "gender identity" and "termination of pregnancy"—violates RFRA. RFRA provides "very broad protection for religious liberty." *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 683 (2014). Under RFRA, "Government may substantially burden a person's exercise of religion only if it demonstrates that application of the burden to the person … is the least restrictive means of furthering [a] compelling governmental interest." 42 U.S.C. § 2000bb-1(b)-(b)(2).

RFRA claims proceed in two steps. First, the Court must determine whether the government has imposed a "substantial burden" on the plaintiffs' religious exercise. Second, if so, the government must satisfy strict scrutiny—*i.e.*, it must "'demonstrate[] that application of the burden to the person' represents the least restrictive means of advancing a compelling interest." *Gonzales v. O Centro Espirita Beneficente Uniao do Vegetal*, 546 U.S. 418, 423 (2006) (quoting 42 U.S.C. § 2000bb-1(b)). Here, as interpreted by HHS, Section 1557 substantially burdens Plaintiffs' religious exercise by requiring Plaintiffs, on pain of massive financial liability, to perform and pay for controversial medical procedures in violation of their religious beliefs. And as applied to Plaintiffs, Section 1557 does not even come close to satisfying strict scrutiny.

A. HHS's interpretation of Section 1557 substantially burdens Plaintiffs' religious exercise.

The government substantially burdens religious exercise "when it 'conditions receipt of an important benefit upon conduct proscribed by a religious faith'" or "impos[es] … significant monetary penalties" on "adhere[nce] to [one's religious] beliefs."

Sharpe Holdings, 801 F.3d at 937 (quoting *Thomas v. Review Bd.*, 450 U.S. 707, 717-18 (1981)). That's just what HHS has done here. Because of their religious beliefs, Plaintiffs cannot perform or pay for gender transitions or abortions. Yet under Section 1557 as interpreted by HHS, if they decline to do so, they will forfeit "important benefit[s]"—millions of dollars in federal funding—and be subject to significant "penal[ties]"—*e.g.*, enforcement proceedings and treble damages. *Id.*

Plaintiffs' beliefs have never been in dispute. Plaintiffs are Catholic organizations that provide healthcare and health insurance consistent with their faith. Ex.A ¶¶3-5, 9-12, 15-18; Ex.B ¶¶3-11; Ex.C ¶¶4, 6, 9-13. Consistent with their beliefs, Plaintiffs care for transgender individuals with compassion and respect. Ex.A ¶7; Ex.B ¶7; Ex.D ¶5. And Plaintiffs believe medical transition procedures are not just contrary to God's plan for human sexuality but also experimental, potentially harmful, and thus not in their patients' best interests. Ex.A ¶¶11-12; Ex.B ¶8; Ex.D ¶¶9-13. They therefore cannot, in accordance with their religious beliefs and medical judgment, participate in transition procedures, although they provide health services that are routinely requested as part of a gender transition. Ex.D ¶¶9-11; Ex.B ¶8; Ex.E ¶5.

Plaintiffs similarly cannot participate in elective abortion or sterilization. Ex.B ¶¶9-10. Plaintiffs offer procedures for women who have miscarried a baby, such as dilation and curettage, that can also be used to perform an abortion. Ex.B ¶10. But because of their religious beliefs regarding the sanctity of human life, they cannot offer these services in furtherance of an abortion.

Nor can they provide health benefits coverage for any of these procedures without violating their religious beliefs. Ex.A ¶15; Ex.B ¶11; Ex.C ¶14. Plaintiffs believe that just as they cannot perform these procedures themselves, they cannot insure them either; to do so would be to harm their employees and violate their beliefs. Ex.A ¶¶15-18; Ex.B ¶11; Ex.C ¶14.

HHS's action substantially burdens Plaintiffs' religious exercise by "pressur[ing]"

them to abandon it on pain of "significant monetary penalties." *Sharpe Holdings*, 801 F.3d at 937. According to HHS's interpretation of Section 1557, it is illegal "sex" discrimination for Plaintiffs to decline to perform or insure gender transitions and abortions, at least if they would (as Plaintiffs do) perform or insure the same medical procedures for other purposes. 81 Fed. Reg. at 31,435-36; *see id.* at 31,429. If Plaintiffs adhere to their beliefs nonetheless, they face the loss of Medicare, Medicaid, and other federal funds, 81 Fed. Reg. at 31,472; debarment from federal contracting; enforcement proceedings brought by the Department of Justice; liability under the False Claims Act, including treble damages, *id.* at 31,440; and private lawsuits brought by patients or employees for damages and attorneys' fees, *id.* at 31,472.

Penalties like these are the quintessential substantial burden. In *Hobby Lobby*, for example, the Court said that because the Affordable Care Act provision there "force[d] [plaintiffs] to pay an enormous sum of money … if they insist on providing insurance coverage in accordance with their religious beliefs, [it] clearly impose[d] a substantial burden on those beliefs." 573 U.S. at 726. Similarly, in *Sharpe Holdings*, the Eighth Circuit held that when "the government imposes a direct monetary penalty to coerce conduct that violates religious belief"—there, as here and in *Hobby Lobby*, facilitating religiously objectionable health insurance—"there has never been a question" that that is a substantial burden. 801 F.3d at 938 (cleaned up).

This is an *a fortiori* case. HHS's interpretation of Section 1557 imposes the same sort of enormous financial penalties on religious exercise as in *Hobby Lobby* and *Sharpe Holdings*. Yet here, Plaintiffs are not only forced to "provid[e] insurance coverage," they are also forced to perform the procedures themselves. *Hobby Lobby*, 573 U.S. at 726. As the court held in *Franciscan*: "The [Section 1557] Rule places substantial pressure on Plaintiffs to perform and cover transition and abortion procedures … Accordingly, the Rule imposes a substantial burden." 227 F. Supp. 3d at 692.

B. HHS's interpretation of Section 1557 fails strict scrutiny.

Because Section 1557 as applied here imposes a substantial burden on Plaintiffs' religious exercise, the only question is whether HHS satisfies strict scrutiny. If not, Plaintiffs are "entitled to an exemption." *Hobby Lobby*, 573 U.S. at 694-95.

Strict scrutiny is "'exceptionally demanding.'" *Sharpe Holdings*, 801 F.3d at 943 (quoting *Hobby Lobby*, 573 U.S. at 728). HHS first must demonstrate that applying its interpretation of Section 1557 to Plaintiffs furthers an interest "of the highest order." *Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 546 (1993). Then it "bear[s] the burden of demonstrating that" its actions are "the least restrictive means of achieving" that interest." *Hamilton v. Schriro*, 74 F.3d 1545, 1552 (8th Cir. 1996) (citing 42 U.S.C. § 2000bb-1(b)). HHS can carry neither burden here.

1. HHS's interpretation furthers no compelling interest.

First, HHS can't show a compelling interest in forcing Plaintiffs to perform and insure gender transitions and abortions. Indeed, HHS has conceded as much, stating that in light of the lack of "medical consensus" as to proper gender-dysphoria treatment, it "sees no compelling interest in forcing the provision, or coverage, of these medically controversial services by covered entities." 85 Fed. Reg. at 37,188.

HHS's concession is correct. This Circuit has already recognized "the lack of consensus in the medical community" regarding procedures like "sex reassignment surgery." *Smith*, 249 F.3d at 760-61. And "sex reassignment surgery remains one of the most hotly debated topics within the medical community today." *Gibson v. Collier*, 920 F.3d 212, 216, 224 (5th Cir. 2019). HHS can't have a compelling interest in mandating as a matter of antidiscrimination law that every doctor in the country take one side in this debate.

In fact, HHS itself has expressed doubt about the efficacy and necessity of transition procedures. Even before promulgating the 2016 Rule, HHS's own experts recognized: "Based on a thorough review of the clinical evidence available," "there is not

enough evidence to determine whether gender reassignment surgery improves health outcomes for [patients] with gender dysphoria." ECF No. 6-6 (emphasis added). Instead, "[t]here were conflicting (inconsistent) study results—of the best designed studies, some reported benefits while *others reported harms*." *Id.* (emphasis added).

The harms are especially pronounced for children. As guidance documents HHS relied on in the 2016 Rule explain: "Gender dysphoria during childhood does not inevitably continue into adulthood"; rather, the desistence rate appears to be as high as 94%.[1] HHS cannot have a compelling interest in requiring Plaintiffs to provide children with cross-sex hormones and other irreversible transition procedures if gender dysphoria for the overwhelming majority of them will resolve on its own.

For adults, too, the risks are significant. The Institute of Medicine has noted that hormone therapy may result in "increased risk" of "breast, ovarian, uterine, or prostate cancer." Ex.F-4 at 264. WPATH likewise has explained that hormone therapy is associated with increased risk of cardiovascular disease, Type 2 diabetes, gallstones, venous thromboembolic disease, and hypertension. ECF No. 6-8 at 40. Risks like these are exactly why Plaintiffs view gender-transition procedures as "experimental" and potentially "harmful for patients." Ex.A ¶11; Ex.D ¶9.

Controversy over the efficacy of gender-transition procedures has only grown since publication of the 2016 Rule. In October 2019, for example, researchers from the Yale School of Public Health published in the American Journal of Psychiatry the "first total population study" analyzing the long-term effects of "gender-affirming hormone and surgical interventions" on mental health.[2] Although the study's authors initially claimed to find a benefit from surgery—a finding touted in the media—the journal

[1] ECF No. 6-8 at 11 (cited in 81 Fed. Reg. at 31,435 n.263)).

[2] Richard Bränström & John E. Pachankis, *Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study*, Am. J. Psychiatry 177:8, 727 (Aug. 2020).

later issued a correction, noting flaws in its "statistical methodology" and acknowledging that the data "demonstrated no advantage of surgery in relation to subsequent mood or anxiety disorder-related health care."[3] This correction aligned with the study's original finding that hormonal treatments, too, offered no advantage.[4]

Likewise, the UK's National Health Service recently shifted its guidance on puberty blockers for children, going from stating that their consequences are "fully reversible" to acknowledging "[l]ittle is known about the long-term side effects." Ex.F-6; Ex.F-7. And the Department of Defense in 2018 found there is "considerable scientific uncertainty and overall lack of high quality scientific evidence demonstrating the extent to which transition-related treatments, such as cross-sex hormone therapy and sex reassignment surgery[,] … remedy the multifaceted mental health problems associated with gender dysphoria." Ex.F-8.

Given "the lack of consensus in the medical community," *Smith*, 249 F.3d at 760-61, and the well documented harms from gender transition procedures, HHS has no interest, much less an "interest[] of the highest order" (*Lukumi*, 508 U.S. at 546 (cleaned up)), in punishing as "discriminators" those who, like Plaintiffs, believe based on their medical judgment that such procedures can be harmful.

Nor do any of the other interests HHS originally offered (though has now abandoned) qualify as compelling under RFRA. First, HHS claimed in 2016 that it had "a compelling interest in ensuring that individuals have nondiscriminatory access to health care and health coverage." 81 Fed. Reg. at 31,380. But under RFRA, such "[b]roadly formulated, or sweeping governmental interests are inadequate." *Sharpe Holdings*, 801 F.3d at 943 (cleaned up). Rather, RFRA requires courts "to 'scrutiniz[e]

[3] Correction to Bränström and Pachankis, Am. J. Psychiatry (Aug. 1, 2020), https://perma.cc/6J2K-G69H (emphasis added); *see also* Ex.F-5.

[4] Bränström & Pachankis, *supra* n.2, at 731 ("Time since initiating gender-affirming hormone treatment was not associated with … mental health treatment outcomes.").

the asserted harm of granting specific exemptions to particular religious claimants'—in other words, to look to the marginal interest in enforcing" Section 1557 in this case. *Hobby Lobby*, 573 U.S. at 726-27 (quoting *O Centro*, 546 U.S. at 431)). Applying this test, HHS can't show that it has a compelling interest in ensuring access to gender transition procedures by requiring *Plaintiffs* to provide them, particularly when the "growing number of healthcare providers who … specialize in those services" can provide them instead. *Franciscan*, 227 F. Supp. 3d at 693.

Second, HHS previously asserted an interest in removing obstacles to access to healthcare for transgender individuals. 81 Fed. Reg. at 31,460. But the relevant question isn't whether Plaintiffs should offer healthcare services to transgender individuals. Plaintiffs already do—for everything from cancer to the common cold. Rather, the question is whether HHS has a compelling interest in forcing private doctors to violate their medical judgment and perform procedures that HHS's own experts admit are potentially harmful. As already explained, it does not.

As for abortions, Congress has long provided exemptions for medical professionals who cannot participate in abortion. *Franciscan*, 227 F. Supp. 3d at 682-83. Therefore, HHS has no compelling interest in forcing Plaintiffs to do so. *See Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania*, 140 S. Ct. 2367, 2392 (2020) (Alito, J., concurring) ("We can answer the compelling interest question simply by asking whether *Congress* has treated the [alleged interest] as … compelling[.]").

Nor does HHS have a compelling interest in forcing Plaintiffs to *insure* these procedures. "A law cannot be regarded as protecting an interest of the highest order … when it leaves appreciable damage to that supposedly vital interest unprohibited." *281 Care Comm. v. Arneson*, 766 F.3d 774, 785 (8th Cir. 2014) (cleaned up). Here, however, the government has exempted every employer in the country that does not receive certain federally administered funds. It has also exempted *its own health-*

insurance programs from covering gender-transition procedures. For example, TRICARE, the military's insurance program, excludes coverage for "surgical treatment for gender dysphoria," as well as cross-sex hormones for children under 16. Ex.F-9 at 4.1, 3.2.2. It also protects the religious beliefs of physicians who object to performing gender-transition procedures.[5] And the Veterans Health Administration's benefits package specifically excludes "gender alterations." 38 C.F.R. § 17.38(c)(4).

As the *Franciscan* court explained, the government cannot have a "compelling" interest in a policy that it is not even "willing to pursue itself." 227 F. Supp. 3d at 693-94. In short, HHS's interpretation of Section 1557 seeks to impose on Plaintiffs a rule that has massive exemptions for others, including the government itself. That is fatal to any purported compelling interest.

2. HHS has many less restrictive means of furthering its interests.

Even assuming Section 1557 as interpreted here furthered a compelling interest, HHS has ways of pursuing that interest without forcing religious objectors like Plaintiffs to violate their religious beliefs—so its actions still violate RFRA.

Under RFRA, HHS must produce evidence that compelling religious providers like Plaintiffs to perform and insure gender transition procedures and abortions is "the only feasible means to" accomplish its goal, such that "no alternative means would suffice." *Sharpe Holdings*, 801 F.3d at 943. But HHS has numerous alternatives here.

First, "[i]f the government wishes to expand access" to these procedures financially, "'[t]he most straightforward" way "would be for the government to assume the cost of providing the[m] to any … unable to obtain them under their health-insurance policies due to their employers' religious objections.'" *Franciscan*, 227 F. Supp. 3d at 693 (quoting *Hobby Lobby*, 573 U.S. at 728). "[T]he government could provide subsidies, reimbursements, tax credits, or tax deductions to employees." *Sharpe Holdings*,

[5] ECF No. 6-9 at 2-3("In no circumstance will a provider be required to deliver care that he or she feels unprepared to provide either by lack of clinical skill or due to ethical, moral, or religious beliefs.").

801 F.3d at 945. Or it "could pay for the distribution of [services] at community health centers, public clinics, and hospitals with income-based support." *Id.*

The government could also create an alternative system for provision of benefits. For example, it could (by act of Congress or statutorily-authorized regulation) require non-objecting insurance providers to offer plans with gender-transition coverage on an exchange. Or HHS could negotiate with providers to ensure that some or all plans on federally-facilitated exchanges offer coverage for these procedures. The government already offers credits to those who need help affording healthcare on the exchanges; those could be made available to individuals whose employer's plan doesn't cover these procedures. Or the government could set up an alternative coverage mechanism, as it has with the contraceptive mandate. *See Hobby Lobby*, 573 U.S. at 730-31. Before burdening Plaintiffs' exercise, HHS must "eliminate[]" these "as a viable option," *Sharpe Holdings*, 801 F.3d at 945—which it cannot do.

Second, there are also ways HHS could expand access to the procedures as a medical matter besides coercing objecting doctors to perform them. As the *Franciscan* court explained, "[t]he government could … assist transgender individuals in finding … the growing number of healthcare providers who offer and specialize in those services." 227 F. Supp. 3d at 693; c*f.* Ex.F-3 (listing "health clinics that specialize in trans health care"). Or it could train healthcare navigators to assist individuals in finding such services, just as it does with assisting individuals to find plans on ACA exchanges. These options wouldn't just increase access to transition procedures; they would also result in *better care* than conscripting unwilling doctors who often lack the necessary expertise. And if "less restrictive means" like these are available, HHS "must use" them. *Holt v. Hobbs*, 574 U.S. 352, 364-65 (2015).

HHS's interpretation of Section 1557 burdens Plaintiffs' religious exercise and, as applied to Plaintiffs, doesn't satisfy strict scrutiny. Plaintiffs prevail under RFRA.

II. HHS's interpretation of "sex" to include "gender identity" is contrary to Title IX and Section 1557.

RFRA aside, HHS's interpretation of Section 1557 to bar "gender identity" discrimination is also unlawful under the APA. As explained, the *Franciscan* court already vacated the 2016 Rule insofar as it defined "sex" discrimination to include "gender identity" and "termination of pregnancy" discrimination. In light of *Bostock*, however, two federal district courts have held that "gender identity" provisions of the 2016 Rule "remain in effect," and a third has suggested that the same result follows from the combination of the 2020 Rule and *Bostock* itself. *Supra* pp. 13-15.

Now as before, however, HHS's interpretation of Section 1557 to bar "gender identity" discrimination violates the APA. Agency regulations are unlawful if they conflict with the relevant statute. 5 U.S.C. § 706(2)(A), (2)(C). If the statute is "silent or ambiguous," courts defer to "reasonable" agency interpretations. *Hawkins v. Cmty. Bank of Raymore*, 761 F.3d 937, 940-41 (8th Cir. 2014) (cleaned up; citing *Chevron*). But if, "employing traditional tools of statutory construction," "Congress' intent is clear, that is the end of the matter"; a contrary rule must be set aside. *North Dakota v. EPA*, 730 F.3d 750, 763 (8th Cir. 2013) (quotation marks omitted); *see Kisor v. Wilkie*, 139 S. Ct. 2400, 2415 (2019) (deference applies only when the "legal toolkit is empty").

Here, Section 1557's prohibition on "sex" discrimination unambiguously means biological sex, not "gender identity"—and *Bostock* isn't to the contrary.

A. The text and history of Title IX and Section 1557 show that they do not prohibit "gender identity" discrimination.

Section 1557 forbids federally funded health programs from discriminating on "the grounds prohibited under" four other federal statutes: Title VI, 42 U.S.C. § 2000d ("race, color, or national origin"); Title IX, 20 U.S.C. § 1681 ("sex"); the Age Discrimination Act, 42 U.S.C. § 6101 ("age"); and the Rehabilitation Act, 29 U.S.C. § 794 ("disability"). Section 1557 does not itself use the term "sex"; instead, it simply incorporates the prohibition contained in Title IX.

Title IX's operative provision states that "[n]o person in the United States shall, on the basis of sex, … be subjected to discrimination under any education program or activity receiving Federal financial assistance[.]" 20 U.S.C. § 1681(a). Thus, the key question is whether "sex" in Title IX refers to physiological differences between males and females, or whether the term also means "gender identity."

The answer is the former. "[T]he meaning of sex in Title IX unambiguously refers to "the biological and anatomical differences between male[s] and female[s] … as determined at their birth." *Franciscan*, 227 F. Supp. 3d at 687; ECF No. 36 at 2.

First, "begin[ning]," "as always, with the statute's text," *United States v. Goad*, 788 F.3d 873, 875 (8th Cir. 2015), the word "sex" means biological sex, not "gender identity." Because Title IX doesn't define "sex," this Court must give the term its "ordinary, contemporary, common meaning." *Id.* (internal quotation marks omitted). And when Title IX passed, virtually every dictionary definition of "sex" referred to physiological distinctions between females and males, particularly with respect to reproduction. *See, e.g.*, American Heritage Dictionary 1187 (1976); Webster's Third New Int'l Dictionary 2081 (1971); 9 Oxford English Dictionary 578 (1961); *see also Thompson Truck & Trailer, Inc. v. United States*, 901 F.3d 951, 953 (8th Cir. 2018) ("Ordinarily, a word's usage accords with its dictionary definition." (cleaned up)).

The term "gender identity," by contrast, was hardly used at all. ECF No. 6 at 14-15 (collecting sources). And the handful of academics who *did* use it at the time of Title IX's passage *contrasted* it to "sex": "gender" referred to socially constructed roles; "sex" referred to biology. *Id.* The single word "sex" in Title IX can't encompass both.

This ordinary meaning of "sex" is reinforced by the "language and design of the statute as a whole." *Velasquez v. Barr*, No. 19-1148, 2020 WL 6290677, at *4 n.3 (8th Cir. Oct. 27, 2020). Other provisions of Title IX also use the word "sex"—and they plainly reflect the understanding of "sex" as referring to the physiological distinction between males and females. For example, Title IX states that if certain activities are

provided for students of "one sex," comparable activities must be provided for students of "the other sex." 20 U.S.C. § 1681(a)(8). And it provides that schools may transition from admitting students of "only one sex" to admitting students of "both sexes." *Id.* § 1681(a)(2); *see also* 34 C.F.R. § 106.33 (longstanding Title IX regulation permitting separate facilities for "students of one sex" and "the other sex").

These provisions are irreconcilable with a reading of "sex" to mean "gender identity," which rejects the concept of two "sexes." As HHS explained, the "gender identity spectrum includes an array of possible gender identities beyond male and female," 81 Fed. Reg. 31,392, including "neither" or a "combination" thereof, *id.* at 31,467. Thus, interpreting "sex" in Title IX to mean gender identity would render much of the statute "nonsensical and superfluous." *Corley v. United States*, 556 U.S. 303, 314 (2009); *see Union Pac. R.R. Co. v. Surface Transp. Bd.*, 863 F.3d 816, 826 (8th Cir. 2017) ("[A] term is presumed to have the same meaning throughout the same statute.")

This textual evidence "also comports with the purposes and policies underlying" Title IX and Section 1557. *Hawkins*, 761 F.3d at 942. Congress enacted Title IX after hearings on pervasive discrimination in education against women. 44 Fed. Reg. 71,413, 71,423 (Dec. 11, 1979); *N. Haven Bd. of Ed. v. Bell*, 456 U.S. 512, 523 n.13 (1982). Its sponsor said the purpose was to give "women of America … an equal chance to attend the schools of their choice." 118 Cong. Rec. 5808 (1972). There is no hint of any congressional purpose regarding "gender identity."

Likewise, the 2010 Congress's evident purpose in incorporating Title IX into Section 1557 was to prohibit "sex" discrimination in healthcare. And in the healthcare context, it makes no sense to coerce physicians to disregard biology and instead treat patients "consistent with their gender identity." *Cf.* 81 Fed. Reg. 31,471. "Physical differences between men and women … are enduring," and "[t]he two sexes are not fungible." *United States v. Virginia*, 518 U.S. 515, 533 (1996) (internal quotation marks omitted). And these differences are relevant to almost every aspect of

healthcare.[6] Men and women exhibit different heart-attack symptoms,[7] perceive pain differently,[8] and respond differently to everything from aspirin (higher risk of gastro-intestinal bleeding for women)[9] to beta-blockers ("may be an acute precipitant of heart failure in … women, but not men").[10] Ignoring these differences in favor of "gender identity"—like all bad medicine—can have tragic consequences.[11]

For all these reasons, Title IX's use of the term "sex," as incorporated into Section 1557, is not ambiguous. It refers to the biological differences between males and females—not to an "internal sense" of gender. *Cf.* 81 Fed. Reg. at 31,467.

B. "Gender identity" discrimination is not forbidden "sex stereotyping."

The *Walker* and *Whitman-Walker* courts have suggested that, independent of the ordinary meaning of "sex," "gender identity" discrimination may be forbidden under Section 1557 as a form of "sex stereotyping." *Walker*, 2020 WL 4749859, at *7, *9; *Whitman-Walker*, 2020 WL 5232076, at *23. These courts are incorrect; to the contrary, to the extent the 2016 Rule's separate prohibition on "sex stereotyping" purports to independently bar "gender identity" discrimination, it violates the APA, too.

The "sex stereotyping" theory derives from the Supreme Court's decision in *Price*

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[6] Janine Austin Clayton, *Applying the New SABV (Sex as a Biological Variable) Policy to Research and Clinical Care*, 187 Physiology & Behavior 2 (2018), https://perma.cc/JTJ9-PJ6E?type=image ("it has become increasingly clear that male/female differences extend well beyond reproductive and hormonal issues"; "[s]ex affects: cell physiology, metabolism, and many other biological functions; symptoms and manifestations of disease; and responses to treatment" and "has profound influences in neuroscience").

[7] 85 Fed. Reg. at 37,185.

[8] Clayton, *supra* n. 6, at 2.

[9] Edward S. Huang et al., *Long Term Use of Aspirin and the Risk of Gastrointestinal Bleeding*, U.S. Nat'l Library of Medicine (May 2012), https://perma.cc/VHX2-JBKY.

[10] Raffaele Bugiardini et al., *Prior Beta-Blocker Therapy for Hypertension and Sex-Based Differences in Heart Failure Among Patients with Incident Coronary Heart Disease*, Am. Heart Ass'n J. (July 13, 2020), https://perma.cc/4TJP-8Q8J.

[11] *E.g.*, Daphna Stroumsa et al., *The Power and Limits of Classification—A 32-Year-Old Man with Abdominal Pain*, New England J. Med. (May 16, 2019), https://perma.cc/Q73M-CPE5%20 (patient identifying as male treated for abdominal pain in accordance with gender identity, resulting in undiagnosed pregnancy, miscarriage, and stillbirth).

Waterhouse v. Hopkins, 490 U.S. 228, 251 (1989). There, a four-Justice plurality stated that Title VII prohibits "disparate treatment of men and women resulting from sex stereotypes." *Id.* at 251. Seizing on this language, some courts have reasoned that discrimination based on "gender identity" is "necessarily" a form of "sex stereotyping" (because transgender individuals don't conform to gender norms), and therefore discrimination based on "gender identity" is a form of "sex" discrimination. *E.g.*, *EEOC v. R.G. & G.R. Harris Funeral Homes, Inc.*, 884 F.3d 560, 576-77 (6th Cir. 2018); *but see Bostock*, 140 S. Ct. at 1738-43 (affirming *Harris* on other grounds).

But this syllogism falters at every step. First, it overreads *Price Waterhouse*. *Price Waterhouse* didn't hold that "sex stereotyping" as such is forbidden by Title VII. It held that sex stereotyping is forbidden *when it results in* "disparate treatment of men and women." 490 U.S. at 251. In *Price Waterhouse*, for instance, the "sex stereotype" was the employer's "belief" that women "must not be" "aggressive" in the workplace—a belief that "place[d] women in an … impermissible catch 22: out of a job if they behave aggressively and out of a job if they do not." 490 U.S. at 251.

A doctor's objection to performing a gender transition doesn't result in disparate treatment of men and women, and it isn't a sex stereotype. Indeed, it isn't sex-specific at all. The objection extends to involvement in transitions by both men and women—may be "gender identity" discrimination according to HHS's illegal 2016 Rule, but isn't "sex stereotyping" within the meaning of *Price Waterhouse*.

Second, the "sex stereotyping" argument is inconsistent with HHS's own regulations. The 2016 Rule prohibited both "gender identity" discrimination and—separately—"sex stereotyping." 81 Fed. Reg. at 31,467. It prohibited both because HHS correctly understood that "gender identity" discrimination *isn't* inherently a form of "sex stereotyping." *Cf. Solis v. Summit Contractors, Inc.*, 558 F.3d 815, 823 (8th Cir. 2009) ("We also should avoid a regulatory construction that would render another part of the same regulation superfluous." (cleaned up)).

Third, understanding "gender identity" discrimination as a subset of "sex stereotyping" produces absurd results. On that logic, it is "sex stereotyping" to say that only women (not men) may identify as women, and only men (not women) may identify as men. But if that is forbidden sex stereotyping, so are many other common practices—such as saying that only women (not men) may use women's bathrooms and changing rooms. That result would violate not only "common sense," *Adams v. Sch. Bd. of St. Johns Cty.*, 968 F.3d 1286, 1318 (11th Cir. 2020) (Pryor, C.J., dissenting), but also the decades-old agency understanding that Title IX specifically *permits* entities to "provide separate" (but "comparable") bathrooms and changing rooms "on the basis of sex." 34 C.F.R. § 106.33 (1980); *see also Barnhart v. Walton*, 535 U.S. 212, 219-20 (2002) ("longstanding" agency interpretations receive "particular deference"). Thus, HHS's strained theory of "sex stereotyping" likewise violates the APA.

C. *Bostock* does not justify HHS's interpretation.

Bostock isn't to the contrary. In *Bostock*, the Court held that when "an employer … fires someone simply for being homosexual or transgender," the employer has "discriminated against that individual 'because of such individual's sex'" within the meaning of Title VII. 140 S. Ct. at 1753. But *Bostock* explicitly did "not prejudge" laws other than Title VII. *Id.* And even if *Bostock*'s reasoning extended to the statutes at issue here, it wouldn't justify HHS's conclusion that declining to perform gender transitions—for males and females alike—is "sex" discrimination.

First, *Bostock* dealt only with Title VII—not Title IX or Section 1557. And the Supreme Court has said courts "must be careful not to apply rules applicable under one statute to a different statute without careful and critical examination." *Gross v. FBL Fin. Servs., Inc.*, 557 U.S. 167, 174 (2009) (quotation marks omitted) (declining to apply Title VII decision to identical language in the ADEA).

Here, Section 1557 and Title IX are "materially different" from Title VII, such that they don't forbid gender-identity discrimination even if Title VII does. *See id.* at 173.

For one thing, multiple provisions of Title IX refer to "one sex," "the other sex," or "both sexes." 20 U.S.C. § 1681(a)(2), (8). This language would be nonsensical if "sex" included the full "spectrum" of "non-binary" gender identities, 81 Fed. Reg. at 31,392—and it has no textual analogue in Title VII. Moreover, while *Bostock* noted that an individual's "transgender status is not relevant to employment decisions," 140 S. Ct. at 1741, the same simply isn't true in the healthcare context covered by Section 1557. In this context, the stubbornly real physiological differences between males and females mean that treating a patient consistent with gender identity (rather than biological sex) can risk the patient's life. *Supra* pp. 27-28.

Second, at the time of Title VII's passage, no court had considered whether "sex" discrimination included discrimination on the basis of "gender identity." But by the time Congress enacted Section 1557, decades of uniform Circuit caselaw under Title VII had rejected precisely that argument.[12] "When judicial interpretations have settled the meaning of an existing statutory provision," incorporating it "in a new statute" generally indicates "the intent to incorporate its … judicial interpretations as well." *Jerman v. Carlisle, McNellie, Rini, Kramer & Ulrich LPA*, 559 U.S. 573, 589-90 (2010). This pre-Section 1557 consensus thus indicates—consistent with Title IX's text and the healthcare context—that in enacting Section 1557, Congress forbade healthcare discrimination based on biological sex, not "gender identity." And that's true regardless whether *Bostock* rejected the consensus as to Title VII. *See* 140 S. Ct. at 1750 ("[W]e must be sensitive to the possibility a statutory term that means one thing today … might have meant something else at the time of its adoption.").

Third, even if *Bostock*'s reasoning were extended to Title IX and Section 1557,

[12] *See Etsitty v. Utah Transit Auth.*, 502 F.3d 1215, 1221 (10th Cir. 2007) ("discrimination against a transsexual based on the person's status as a transsexual is not discrimination because of sex"); *Ulane v. E. Airlines, Inc.*, 742 F.2d 1081, 1085 (7th Cir. 1984) (same); *Sommers v. Budget Mktg., Inc.*, 667 F.2d 748, 750 (8th Cir. 1982) (same); *Holloway v. Arthur Anderson & Co.*, 566 F.2d 659, 661 (9th Cir. 1977) (same); *see also, e.g., Johnston v. Univ. of Pittsburgh*, 97 F. Supp. 3d 657, 674 (W.D. Pa. 2015) (consensus of "nearly every federal court that has considered the question").

HHS's interpretation of "sex" discrimination as requiring doctors to perform gender transitions would *still* be contrary to law. *Bostock* held that an employer's firing an employee "simply for being … transgender" is "sex" discrimination because the firing is based on "actions or attributes it would tolerate in an individual of another sex." *Id.* at 1737, 1740. In other words, sex is a but-for cause of such a firing, because "changing the employee's sex would have yielded a different choice." *Id.* at 1741.

But this reasoning doesn't apply to refusals to perform gender-transition procedures. If a doctor declines to perform (for example) a hysterectomy on a woman to facilitate her transition to living as a man, the doctor isn't discriminating based on "sex" within the meaning of *Bostock*. For "changing the [patient]'s sex" wouldn't "yield a different choice," as the Plaintiff wouldn't perform a hysterectomy on a man, either. So even under *Bostock*, HHS's interpretation of Section 1557 violates the APA.

III. HHS's failure to incorporate Title IX's religious exemption is contrary to Title IX and Section 1557.

Separately, HHS's interpretation of Section 1557 is also "not in accordance with law" and "in excess of statutory jurisdiction" because it fails to include in full the religious exemption mandated by the controlling statutes. 5 U.S.C. § 706(2)(A), (2)(C). Title IX exempts religious institutions from its ban on "sex" discrimination. Section 1557, in turn, incorporates both the ban and the exemption. Yet in the 2016 Rule, HHS refused to incorporate any religious exemption at all. 81 Fed. Reg. at 31,380. Then, in the 2020 Rule, HHS acknowledged the exemption's applicability, but interpreted it more narrowly than Congress mandated. 45 C.F.R. § 92.6(b); 85 Fed. Reg. at 37,207. HHS's actions thus violate the APA.

Section 1557 bars discrimination "on the ground prohibited under … title IX of the Education Amendments of 1972." 42 U.S.C. § 18116(a). Title IX prohibits "sex" discrimination in "education," but then—in the same sentence—exempts educational institutions that are religious:

> this section shall not apply to an educational institution which is controlled by a religious organization if the application of this subsection would not be consistent with the religious tenets of such organization.

20 U.S.C. § 1681(a)(3). Thus, when Congress incorporated "title IX of the Education Amendments of 1972" into Section 1557, it also incorporated Title IX's religious exemption. Yet despite many requests to include this exemption in the 2016 Rule, HHS refused. *See* 81 Fed. Reg. at 31,379-80.

HHS's refusal was unlawful. Had Congress wanted to ban sex discrimination without incorporating a religious exemption, it could have easily done so. Instead, it banned sex discrimination by incorporating "20 U.S.C. 1681 *et seq.*," 42 U.S.C. § 18116(a)—which "can only mean Congress intended to incorporate the entire statutory structure, including the … religious exemption[]." *Franciscan*, 227 F. Supp. 3d at 690. Permitting HHS to omit an exemption for religious institutions would "nullif[y] Congress's specific direction to prohibit only the ground proscribed by Title IX," *id.* at 690-91—violating the APA.

HHS purported to address this failing in the 2020 Rule, but its efforts (which in any event have been enjoined) violate the APA, too, and for similar reasons. In the 2020 Rule, HHS acknowledged that the *Franciscan* court vacated the 2016 Rule in part because of its "failure to incorporate … the Title IX religious exemption," and thus purported to "explicitly incorporate" the exemption this time around. 85 Fed. Reg. at 37,162; *see* 45 C.F.R. § 92.6(b). But HHS stated that although Section 1557 had transposed Title IX's ban on "sex" discrimination in education to the healthcare context, the incorporated religious exemption nonetheless would be limited to "[a]ny educational operation of an entity … control[led] by a religious organization," 85 Fed. Reg. at 37,207, rather than protecting religious healthcare providers generally.

That exemption is narrower than the one Congress mandated. Title IX's religious exemption matches the scope of its prohibition: Title IX prohibits "sex" discrimination "under any education program or activity receiving Federal financial assistance," 20

U.S.C. § 1681(a), but then exempts otherwise-covered recipients—"educational institutions"—that meet the relevant religious requirements (*i.e.*, are "controlled by a religious organization" and have "religious tenets" inconsistent with Title IX's prohibition, *id.* § 1681(a)(3)). Thus, when Congress incorporated Title IX into Section 1557, it incorporated a religious exemption that matches *Section 1557's* scope. That is, Congress applied Title IX's prohibition on "sex" discrimination to "any *health* program or activity … receiving Federal financial assistance," 42 U.S.C. § 18116(a) (emphasis added), but exempted otherwise-covered recipients—now, healthcare providers—if they meet Title IX's religious requirements (again, "controlled by a religious organization" and "religious tenets" inconsistent with the prohibition).

Put differently, Section 1557 incorporates Title IX "*mutatis mutandis*"—just as Title IX put strings on education funding, but exempted religious educational institutions, so Section 1557 puts strings on healthcare funding, but exempts religious healthcare institutions. *See Bowen v. Mich. Acad. of Family Phys.*, 476 U.S. 667, 680 (1986); *United States v. Nature*, 898 F.3d 1022, 1024 (9th Cir. 2018). Indeed, there's no other sensible way to read Section 1557. If the incorporated religious exemption retains its education hook, then the incorporated prohibition would as well—triggering the strange result that Section 1557 would prohibit "sex" discrimination only in health *education*. Likewise, HHS has articulated no rationale—and there is none—for why Congress would require religious healthcare providers generally to violate their religious tenets while exempting only those that happen to also be educators.

HHS's halfway incorporation of the Title IX exemption in the 2020 Rule thus violates the APA. *See Franciscan*, 227 F. Supp. 3d at 690-91.

IV. As interpreted by HHS, Section 1557 violates the Spending Clause.

Under HHS's interpretation of Section 1557, that statute also violates the Spending Clause by imposing unauthorized and coercive conditions on the States. Congress is permitted to use its Spending Clause power to induce States to voluntarily accept

federal conditions in exchange for federal funds. But such conditions must be both (a) unambiguous and (b) non-coercive. *South Dakota v. Dole*, 483 U.S. 203, 207-08, 211 (1987). As applied here, Section 1557 fails both tests.

First, the condition on healthcare funding HHS has attached to Section 1557—that recipients must perform and insure gender transitions and abortions—was hardly "unambiguous[]." "The legitimacy of Congress' power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.'" *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). Of course, States cannot voluntarily and knowingly accept conditions they do not know about. "Accordingly, if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously." *Id.*

Many courts have struck down or refused to impose ambiguous conditions on federal funds. For example, in *Gross v. Weber*, the Eighth Circuit refused to impose retroactive Title IX liability on a school district on the grounds that "[t]itle IX provides no notice that educational institutions will be subject to liability for prior events. It would be unfair to impose a greater duty than that which the educational institutions agreed to assume." 186 F.3d 1089, 1092 (8th Cir. 1999). Likewise, in *Pennhurst*, the Supreme Court found that Congress had not unambiguously required participating States to satisfy the statute's "bill of rights" provisions in a program for the developmentally disabled, and thus that the States could not be forced to comply. As the Court explained, "where Congress has intended the States to fund certain entitlements as a condition of receiving federal funds, it has proved capable of saying so explicitly." *Pennhurst,* 451 U.S. at 17-18, 20.

Here, there is no plausible argument that Congress unambiguously told the States that their receipt of Medicare and Medicaid funds was conditioned on embracing HHS's expansive definition of "sex." To understand the terms North Dakota accepted,

"the focus must be on the law when [the relevant statute] was enacted." *Premachandra v. Mitts*, 753 F.2d 635, 638 (8th Cir. 1985) (en banc). Both Medicaid and Medicare were adopted in 1965. Social Security Amendments of 1965, Pub. L. No. 89–97, 79 Stat. 286 (1965). But there is nothing in either statute to suggest that States accepting federal funds to care for the poor and elderly through these programs were "unambiguously" informed—or informed *at all*—that their participation in helping those in need also included an agreement to interpret "sex" to require performing and covering gender-transition procedures.

And indeed, the Eighth Circuit in *Smith v. Rasmussen* already held they were not, in a decision that should be dispositive here. 249 F.3d at 760-61. In *Smith*, the plaintiff argued that an Iowa regulation categorically prohibiting sex-reassignment surgeries for Medicaid recipients violated the Medicaid Act. The Eighth Circuit rejected this argument and ruled for the State, concluding that given "the disagreement regarding the efficacy of sex reassignment surgery," "the State's prohibition on funding of sex reassignment surgery is both reasonable and consistent with the Medicaid Act." *Id.* at 761. In other words, it is settled law in this Circuit that the States did not agree to fund sex-reassignment surgeries by accepting Medicaid funds (indeed, as of the time *Smith* was decided, at least 36 States *didn't*, *id.* It necessarily follows that any reading of Section 1557 imposing such a condition violates the Spending Clause.

Section 1557 also violates the Spending Clause as applied here because it is unconstitutionally coercive. "Congress may use its spending power to create incentives for States to act in accordance with federal policies. But when pressure turns into compulsion, the legislation runs contrary to our system of federalism." *NFIB v. Sebelius*, 567 U.S. 519, 577-78 (2012) (quotation marks omitted). In *NFIB*, the Court held that a threat to eliminate all federal Medicaid funding, which constituted "10 percent of a State's overall budget," was unconstitutionally coercive. *Id.* at 582. Here, North Dakota faces even more coercion than was rejected in *NFIB*, because it stands to lose

not only all its Medicare funding, but all other HHS funding, and to face private lawsuits for damages and attorneys' fees. Thus, this is an *a fortiori* case.

V. Injunctive relief is required.

As shown, Plaintiffs have satisfied the most important injunctive-relief factor: success on the merits. And as demonstrated below, they also satisfy the remaining three: threat of irreparable harm, balance of harms, and the public interest. *Sharpe Holdings*, 801 F.3d at 936-37. The Court should therefore permanently enjoin HHS from interpreting and enforcing Section 1557 to require Plaintiffs to perform or insure gender-transition procedures and abortions.

The Court may grant a permanent (rather than preliminary) injunction when "nothing remains … to resolve regarding the underlying facts" and the parties "disagree only on questions of law." *Guttau*, 190 F.3d at 847. And a permanent injunction is especially necessary here, where after four years of litigation and a whole new rulemaking, Plaintiffs still face crippling liability for abiding by their beliefs and medical judgment. *See Christian Emps. All. v. Azar*, No. 3:16-cv-309, 2019 WL 2130142, at *6 (D.N.D. May 15, 2019) (similar permanent relief against contraceptive mandate).

At a minimum, should the Court not be in a position to grant permanent relief at this stage, the Court should issue a preliminary injunction before January 20, 2021. Since 2017, HHS under the current Administration has been content to abide by the Court's December 2016 stay of enforcement, although that stay originally was set to last only until "a determination on … recusal" and a hearing on Plaintiffs' initial preliminary-injunction motion (which never occurred). ECF No. 23. But the next Administration has made its intent clear to "[g]uarantee the Affordable Care Act's" supposed "nondiscrimination protections for the LGBTQ+ community" and "reverse" "religious exemptions" for (*inter alia*) "medical providers." Ex.F-10. Beginning on January 20, then, Plaintiffs face crippling penalties jeopardizing their ability to continue serving the needy consistent with their beliefs and (for the State) its sovereign interests.

Success on the Merits. As already shown, Plaintiffs succeed on the merits of all their claims. This factor is paramount, *Sharpe Holdings*, 801 F.3d at 937, and in cases like this one, where plaintiffs have established violations of their religious-liberty and constitutional rights, the analysis begins and ends here. *See Telescope Media Grp. v. Lucero*, 936 F.3d 740, 762 (8th Cir. 2019); *see also Hobby Lobby Stores, Inc. v. Sebelius*, 723 F.3d 1114, 1146 (10th Cir. 2013) ("[O]ur case law analogizes RFRA to a constitutional right."), *aff'd*, 573 U.S. 682; *Archdiocese of St. Louis v. Burwell*, 28 F. Supp. 3d 944, 958 (E.D. Mo. 2014) ("a likely RFRA violation satisfies … irreparable harm.").

Irreparable Harm. Even if Plaintiffs had to make a separate showing of irreparable harm, they have done so here. Absent an injunction, HHS's interpretation of Section 1557 means Plaintiffs must either comply with invalid regulations and violate their faith or violate those regulations and face massive financial penalties. That "loss of" religious freedom "unquestionably constitutes irreparable injury," *Elrod v. Burns*, 427 U.S. 347, 373 (1976), which is why an injunction is the typical relief under RFRA. *E.g.*, *O Centro*, 546 U.S. at 427; *Sharpe Holdings*, 801 F.3d at 945-46.

HHS's interpretation also threatens irreparable harm to North Dakota by upending its laws and policies governing its healthcare facilities and insurance plans. A State suffers irreparable harm when its laws or policies are enjoined. *Maryland v. King*, 567 U.S. 1301 (2012) (Roberts, C.J., in chambers). Here, HHS's interpretation of Section 1557 strips North Dakota of its right to enforce its own laws in its healthcare programs, requires State facilities to offer transition and abortion procedures, and requires the State to train employees about their new obligations. North Dakota did not agree to these requirements when it chose to participate in Medicare and Medicaid decades ago. This is irreparable harm to its sovereign interest. *See Kansas v. United States*, 249 F.3d 1213, 1227 (10th Cir. 2001).

If HHS contends that Plaintiffs face no risk of enforcement and therefore irreparable harm is unlikely, it is mistaken. *Cf. Winter v. Nat. Res. Def. Council, Inc.*, 555

U.S. 7, 22 (2008). Plaintiffs face ongoing, irreparable harm from HHS's actions and divergent decisions from across the country.

First, while the *Franciscan* court properly vacated the portions of the 2016 Rule that required parties like Plaintiffs to perform and cover transition procedures and abortions, two district courts have now expressly purported to reinstate provisions of the 2016 Rule having just that effect. *Walker*, 2020 WL 4749859, at *10; *Whitman-Walker*, 2020 WL 5232076, at *14, *23. And a third has held that, in light of *Bostock*, the 2020 Rule itself may, "in fact, extend protection against discrimination to LGBTQ individuals via the Rule's incorporation of Title IX by reference." *Washington*, 2020 WL 5095467, at *8.

Moreover, even aside from these decisions, the *Franciscan* court's vacatur wouldn't prohibit HHS from imposing the same requirement by other means, such as by initiating an enforcement action directly under Section 1557 or promulgating a new rule imposing the same burden. *Cf.* 42 U.S.C. § 18116(c) (HHS "*may* promulgate regulations to implement this section." (emphasis added)). And again, the incoming Administration has already signaled its resolve to do just that. *See* Ex.F-10.

Finally, even apart from the specifics of any interpretive rule, some courts have interpreted Section 1557 itself to cover "gender identity" discrimination and therefore require provision or coverage of gender-transition procedures. *See, e.g., Tovar v. Essentia Health*, 342 F. Supp. 3d 947, 952-53 (D. Minn. 2018); *Prescott v. Rady Children's Hosp.-San Diego*, 265 F. Supp. 3d 1090, 1098-1100 (S.D. Cal. 2017). These decisions were "not based on" the 2016 or 2020 Rule but were "grounded in the language of the statute itself." *Prescott*, 265 F. Supp. 3d at 1098. Plaintiffs believe these decisions wrongly interpret the statute, as explained above. But what is clear is that regardless of which specific Section 1557 regulation governs, "irreparable injury is likely in the absence of an injunction." *Winter*, 555 U.S. at 22 (emphasis omitted).

In short, Plaintiffs face the very real threat of enforcement and liability such that

a permanent injunction is both timely and necessary. *See, e.g.*, *Archdiocese of St. Louis*, 28 F. Supp. 3d at 958 ("[I]n light of the current legal uncertainty regarding the enforceability of the contraceptive mandate as to nonprofit organizations with religious objections, the Court finds it in the public interest to … enjoin enforcement of the mandate[.]" (citations omitted)).

Balance of Harms. "[T]he balance-of-harm and public-interest factors need not be taken into account" here, since "the public interest will perforce be served by enjoining the enforcement of" an invalid law. *Guttau*, 190 F.3d at 847-48. Nonetheless, the balance tips for Plaintiffs. The harms faced by Plaintiffs are severe. *Supra* pp. 16-18, 34-37. And the harms to HHS are minimal. As HHS itself agrees, its interests are served when "providers [are] generally free to use their best medical judgment, consistent with their understanding of medical ethics, in providing healthcare to Americans." 85 Fed. Reg. at 37,187. That's precisely what an injunction would achieve.

Public Interest. "[I]t is always in the public interest to protect constitutional rights," *Carson v. Simon*, 978 F.3d 1051 (8th Cir. 2020) (quotation marks omitted), and "[t]his principle applies equally to" the Spending Clause as to RFRA, since RFRA "enforces the First Amendment," *Opulent Life Church v. City of Holly Springs*, 697 F.3d 279, 298 (5th Cir. 2012). "The public interest in the vindication of religious freedom" thus "favors the entry of an injunction." *Christian Emps. All.*, 2019 WL 2130142, at *6. Moreover, stripping Plaintiffs of Medicare and Medicaid funding hurts the vulnerable people that depend on Plaintiffs' services—the poor, the elderly, and those in underserved rural areas. The public interest favors an injunction.

CONCLUSION

The motion should be granted.

Respectfully submitted this the 23rd day of November, 2020.

/s/ Luke W. Goodrich Luke W. Goodrich Mark L. Rienzi The Becket Fund for Religious Liberty 1200 New Hampshire Ave. NW Suite 700 Washington, DC 20036 Telephone: (202) 349-7216 Facsimile: (202) 955-0090 lgoodrich@becketlaw.org *Counsel for Plaintiffs Religious Sisters of Mercy; Sacred Heart Mercy Health Care Center (Alma, MI); SMP Health System, and University of Mary*	/s/ Wayne Stenehjem Wayne Stenehjem Attorney General of North Dakota 600 E. Boulevard Avenue Bismarck, ND 58505-0040 Telephone: (701) 328-2210 Facsimile: (701) 328-2226 Douglas A. Bahr Solicitor General N.D. Office of Attorney General 500 N. 9th Street Bismarck, ND 58501 Telephone: (701) 328-3640 Facsimile: (701) 328-4300 *Counsel for Plaintiff North Dakota*

CERTIFICATE OF SERVICE

I hereby certify that on November 23, 2020, the foregoing was served on all parties via ECF.

/s/ Luke W. Goodrich
Luke W. Goodrich

EXHIBIT A

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

THE RELIGIOUS SISTERS OF MERCY, *et al.*, *Plaintiffs,* v. ALEX M. AZAR, Secretary of the United States Department of Health and Human Service, *et al.*, *Defendants.*	No. 3:16-cv-386 **Declaration of Sister Mary Judith O'Brien, R.S.M., J.C.D**
CATHOLIC BENEFITS ASSOCIATION, *et al.* *Plaintiffs,* v. ALEX M AZAR, Secretary of the United States Department of Health and Human Service, *et al.*, *Defendants.*	No. 3:16-cv-432

1. My name is Sister Mary Judith O'Brien. I am over the age of 21 and am capable of making this declaration pursuant to 28 U.S.C. § 1746. I have not been convicted of a felony or crime involving dishonesty. The facts contained herein are within my personal knowledge. If I were called upon to testify to these facts, I could and would competently do so.

2. I am a Religious Sister within the Religious Sisters of Mercy, a Catholic order of religious sisters devoted to works of mercy, including offering healthcare to the underserved. I received my licentiate and doctorate, *magna cum laude*, at the Pontifical Gregorian University in Rome in 1994. I am also a civil lawyer. For over a decade, I have worked for the Diocese of Saginaw, first as Vice-Chancellor and now as Chancellor. Before my assignment in Saginaw, I worked in the Archdiocese of Denver, helping to establish St. John Vianney Seminary and serving as chair of the Department of Pastoral Theology. In Denver, I collaborated with the Archbishop's office in a variety of canonical and civil law projects. I have previously served on the board for the Sacred Heart Mercy Health Care Center clinic, which is owned and operated by the Religious Sisters of Mercy.

3. Located in Alma, Michigan, the Religious Sisters of Mercy is a nonprofit corporation incorporated in 1973. The Religious Sisters of Mercy are an international institute of pontifical right—that is, officially approved by the Vatican—which traces its roots back to Venerable Catherine McAuley in Dublin, Ireland in 1831.

4. As Religious Sisters of Mercy, we have chosen to follow Jesus Christ by taking a lifetime vow to serve the poor and sick by offering care for the whole person, and working to heal those who are suffering from physical, psychological, intellectual, and spiritual woundedness. The Religious Sisters of Mercy offer a variety of apostolic services. One aspect of our mission is fulfilled through "comprehensive health care" services, which we understand as "the complete care of the total human person" which

"seeks to bring about that profound and extensive healing which is a continuation of the work of redemption."

5. Consistent with this mission, some of the Religious Sisters of Mercy serve in healthcare facilities, such as hospitals, throughout the country. These Sisters include licensed doctors, including a surgeon, and other healthcare professionals. In accordance with their vows, the Religious Sisters of Mercy offer healthcare services in accordance with the Ethical and Religious Directives of the United States Conference of Catholic Bishops and our Catholic faith. For decades, the religious beliefs of the Religious Sisters of Mercy have been respected by health institutions where they work.

I. The Sacred Heart Clinic

6. The Religious Sisters of Mercy own and operate a clinic, Sacred Heart Mercy Health Care Center, in Alma, Michigan. In the past, the Religious Sisters of Mercy also operated Sacred Heart Mercy Health Care Center in Jackson, Minnesota. The clinic is a nonprofit incorporated in Michigan. The Religious Sisters of Mercy also run the clinic in accordance with the Ethical and Religious Directives of the United States Conference of Catholic Bishops. The clinic has a religious chapel and prominently displays religious iconography. Some of the Religious Sisters of Mercy serve as licensed doctors, nurses, or other healthcare professionals who perform medical services in this clinic.

7. The Religious Sisters of Mercy at the Sacred Heart clinic strive to provide top-quality care to all their patients. They serve and respect individuals of all faiths and walks of life, including patients who identify as gay, lesbian, and transgender. They seek to ensure that patients and their families can exercise their own faith traditions and beliefs in order to assist them in the healing and recovery process, and to make critical decisions about matters such as end-of-life care and clinical ethics.

8. The clinic furthers the Sisters' mission to care for the elderly and the poor by serving Medicare and Medicaid patients and also provide low-cost or free care to the uninsured. A significant portion of the patients served by the Sacred Heart clinic are poor, disabled, and elderly Medicare and Medicaid patients. If the Sacred Heart clinic lost this HHS funding, the clinic would suffer a crippling blow to its capacity to carry out its religious mission to serve the poor, disabled, and elderly.

9. The Religious Sisters of Mercy hold religious beliefs about the nature and purposes of human sexuality. Like the Catholic Church they serve, the Religious Sisters of Mercy believe that every man and woman is created in the image and likeness of God, and that they reflect God's image in unique—and uniquely dignified—ways.

10. Further, in their professional medical judgment, the Religious Sisters of Mercy who work in health care believe that optimal patient care—including patient

education, diagnosis, and treatment—requires taking account of the biological differences between men and women.

11. In the Sisters' best medical judgment, providing or assisting with gender transition services is not in keeping with the best interests of their patients, and in fact is experimental and could be harmful for patients.

12. Providing services that are contrary to their understanding of God's plan for human sexuality would also violate the religious exercise of the Religious Sisters of Mercy.

13. I am aware that our Sacred Heart Clinics have received requests for gender transition services.

14. For example, one physician sister has been asked to provide cross-hormone therapy services to a patient for a gender transition purpose. She declined to provide those services on the basis of her medical judgment that providing or assisting with gender transition services is never in the best interest of patients, and in fact is experimental and could be harmful for patients. She also declined to provide those services based on her religious beliefs regarding God's plan for human sexuality. This sister prescribes hormone therapy, including estrogen, in other situations not involving gender transition when she believes it is medically necessary for her patients.

II. Insurance Coverage

15. As part of their religious beliefs, the Sacred Heart clinic also offers health benefits to eligible employees who work for the clinic. It would violate the religious beliefs of the Sacred Heart clinic and the Sisters who own and operate it if they were forced to offer a health plan that included benefits for abortions, sterilizations, or any drugs or procedures related to gender transition. The Sacred Heart clinic and the Sisters who own and operate it sincerely believe that such coverage would constitute impermissible material cooperation with evil.

16. Therefore, in accordance with Catholic doctrine and our religious beliefs, the health plans offered by our Sacred Heart Clinic excludes coverage for gender transition services.

17. For example, one of our health plans excludes "any issues related to sexual/gender identity" with regard to mental health and counseling; "Gender reassignment surgery, reversal of prior gender reassignment surgery or any other surgical procedure related to gender identity disorder;" and "All gender reassignment services including hospital admissions, facility and professional services including hormonal therapy drugs, the injection of the drug or other services to administer the drug." We anticipate, and have requested, that our health plans will continue to contain this exclusion.

18. It would violate our religious beliefs if we were forced to remove those exclusions and provide coverage for gender transition services.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on November 19, 2020.

Sister Mary Judith O'Brien, R.S.M., J.C.D.

EXHIBIT B

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

THE RELIGIOUS SISTERS OF MERCY, *et al.*, *Plaintiffs,* v. ALEX M. AZAR, Secretary of the United States Department of Health and Human Service, *et al.*, *Defendants.*	No. 3:16-cv-386 **Declaration of Sister Suzanne Stahl**
CATHOLIC BENEFITS ASSOCIATION, *et al.* *Plaintiffs,* v. ALEX M AZAR, Secretary of the United States Department of Health and Human Service, *et al.*, *Defendants.*	No. 3:16-cv-432

1. My name is Sister Suzanne Stahl. I am over the age of 21 and am capable of making this declaration pursuant to 28 U.S.C. § 1746. I have not been convicted of a felony or crime involving dishonesty. The facts contained herein are within my personal knowledge. If I were called upon to testify to these facts, I could and would competently do so.

2. I am a Sister of Mary of the Presentation from Valley City, North Dakota. I presently serve as Regional Superior/President of the Sisters of Mary of the Presentation, and I have done so since 2014. Prior to that, I was the Provincial Assistant for nine years. I work at Maryvale, the Regional Home of the Sisters of Mary of the Presentation. I previously lived and worked at some of our Religious Congregation's missions in the United States and Africa.

3. The Sisters of Mary of the Presentation were founded in France in 1828 for the purpose of teaching children and serving the sick, disabled, and elderly. In 1903, fleeing religious persecution in France, the Sisters arrived in the United States and began a school in Wild Rice, North Dakota and a hospital in Spring Valley, Illinois. The Sisters of Mary of the Presentation now have Regional headquarters in Valley City, North Dakota, and operate three critical access hospitals in North Dakota, in addition to the original hospital in Spring Valley, IL. The Sisters also operate five nursing homes to serve the elderly in North Dakota and a home health care agency in Spring Valley, IL. Together, these ministries constitute SMP Health System.

4. SMP Health System is operated according to the religious beliefs of its sponsor, the Sisters of Mary of the Presentation. The mission of SMP Health System is to "provide leadership to its Catholic health care ministries as they work to fulfill the healing mission of Jesus." SMP Health System's vision statement explains that "Our concern is for all people, but the poor and elderly have a special claim on us.

From our limited resources we provide services characterized by excellence, compassion, and personalized concern. Because we care, we focus on the needs of the whole person, which includes their physical, spiritual, psychological, and social well-being." *See* SMP Health System, *Mission, Values, Vision and Philosophy*, http://smphs.org/mission-values-vision-philosophy.html (last visited Nov. 17, 2020). Thus, SMP Health System has a special emphasis on providing services to the poor and elderly, including many Medicare and Medicaid patients. If SMP Health System lost HHS funding, it would suffer a serious blow to its capacity to carry out that mission.

5. In accordance with this vision and mission, the Sisters of Mary of the Presentation operate SMP Health System in a manner that abides by *The Ethical and Religious Directives for Catholic Healthcare Services*, as issued by the United States Conference of Catholic Bishops and interpreted by the local Bishop. The Sisters of Mary of the Presentation strive to "provide quality patient care in an environment that contributes to the healing of the whole person."

6. Like the Catholic Church it serves, SMP Health System believes that every man and woman is created in the image and likeness of God and reflects God's image in unique—and uniquely dignified—ways. Being forced to provide or facilitate gender transition services would violate the religious beliefs of SMP Health System.

7. SMP Health System provides all of its standard medical services with dignity and compassion to every individual who needs and qualifies for its care,

including to individuals who identify as transgender. Thus, for instance, if a transgender individual comes in with high blood pressure or a diabetes diagnosis, SMP Health System would provide the same full spectrum of compassionate care for that individual as they provide for every other patient. And, just as we do for every other patient, SMP Health System would appropriately tailor that care to the biologically sex-specific health needs of the patient.

8. The SMP Health System physicians and facilities offer services such as hysterectomies, mastectomies, endocrinology services, and psychiatric support. In certain contexts, SMP Health System physicians also offer endocrinology services to pediatric patients, including children. It would violate SMP Health System's religious beliefs if we were forced to require physicians to offer these services for a gender transition.

9. Some of the procedures required under the Section 1557 regulations, including elective hysterectomies, can result in the sterilization of the patient. It would violate SMP Health System's religious beliefs if it were required to offer elective medical services that resulted in a sterilization.

10. In certain contexts, SMP Health System performs surgical procedures for women who have miscarried a baby, such as dilation and curettage. It would violate SMP Health System's religious beliefs if it were required to offer this procedure to terminate a pregnancy.

11. As part of its religious beliefs, SMP Health System offers health benefits to its full-time employees. It would violate the religious beliefs of SMP Health System if it were forced to offer a health plan that included benefits for abortions, sterilizations, or any drugs or procedures related to gender transition. SMP Health System and the Sisters of Mary of the Presentation sincerely believe that offering such coverage would constitute impermissible material cooperation with evil.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on November 19, 2020.

/s Sister Suzanne Stahl, SMP

Sister Suzanne Stahl

EXHIBIT C

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

THE RELIGIOUS SISTERS OF MERCY, *et al.*, *Plaintiffs,* v. ALEX M. AZAR, Secretary of the United States Department of Health and Human Service, *et al.*, *Defendants.*	No. 3:16-cv-386 **Declaration of Monsignor James Patrick Shea**
CATHOLIC BENEFITS ASSOCIATION, *et al.* *Plaintiffs,* v. ALEX M AZAR, Secretary of the United States Department of Health and Human Service, *et al.*, *Defendants.*	No. 3:16-cv-432

1. My name is Monsignor James Patrick Shea. I am over the age of 21 and am capable of making this declaration pursuant to 28 U.S.C. § 1746. I have not been convicted of a felony or crime involving dishonesty. The facts contained herein are within my personal knowledge. If I were called upon to testify to these facts, I could and would competently do so.

2. In 2009, I was inaugurated as the sixth President of the University of Mary—a position I still hold. I began my undergraduate work at Jamestown College, majoring in English and history. I then entered the seminary for the Diocese of Bismarck, earning a bachelor's degree and a pontifical master's degree (licentiate) in philosophy at the Catholic University of America in Washington, D.C. I studied classical Greek at the University of Texas at Austin and continued at the Vatican's North American College, studying theology at the Gregorian and Lateran universities in Rome. I have studied management at the University of Chicago's Graduate School of Business and I am also an alumnus of the Institutes for Higher Education at the Graduate School of Education, Harvard University.

3. I am a Knight Commander of the Holy Sepulchre of Jerusalem, and I serve on the Board of Directors for FOCUS, the Fellowship of Catholic University Students. I have served on the National Advisory Council to the United States Conference of Catholic Bishops and the Governor's Commission on Education Improvement for the State of North Dakota. I am also a Trustee of Saint John Vianney Seminary in Denver and a member of the Executive Committee of the Board for the Association of Benedictine Colleges and Universities.

4. The University of Mary has a long tradition of carrying out the mission of Jesus Christ through education. In 1878, a brave group of Benedictine Sisters arrived in Dakota Territory to bring ministries of healing and learning, founding schools and hospitals to serve the community.

5. In 1959, the Benedictine Sisters of the Annunciation founded Mary College, offering degrees in education and nursing. Over time, the college expanded and added additional programs. In the 1980s, it added its first graduate program, in nursing, and became the University of Mary.

6. The University strives to infuse all of its programs with Christian, Catholic, Benedictine values to prepare its students to be ethical leaders in their careers and their communities. The University welcomes students of all faiths and backgrounds and, as is fundamental to its mission, upholds Catholic teaching in all of its programs and services.

7. The University has a long history of offering medical education inspired by its Catholic faith. For example, the University is one of only a few in the United States to offer a master's degree in bioethics, designed to help professionals make morally sound decisions about responsible use of biomedical advances. The program is offered in partnership with the National Catholic Bioethics Center.

8. As it has since its founding, the University offers a nursing program. It provides several nursing degrees at the undergraduate, graduate and doctoral level. In June 2016, the University's nursing program received a three-year grant for over $1 million from the Department of Health and Human Services. That grant is intended to aid in training nurses to improve rural healthcare in North Dakota. The University expects to continue partnering with the Department of Health and Human Services in the future.

9. The University holds religious beliefs that sexual identity is an objective fact rooted in nature as male or female persons. The University believes that every man and woman is created in the image and likeness of God and that they reflect God's image in unique—and uniquely dignified—ways.

10. The University also has a student health clinic that operates in accordance with the Ethical and Religious Directives of the United States Conference of Catholic Bishops. This health clinic receives HHS funds from Medicaid. It would violate the University of Mary's religious beliefs if it were forced to use this health clinic to provide or facilitate services for a gender transition or abortion.

11. As part of its religious beliefs, the University offers health benefits to its employees. The University has 396 employees who are eligible for health insurance benefits from the University.

12. The University operates a self-funded health plan which provides coverage for its employees through a third-party administrator. The same plan provides coverage for all employees, whether in the nursing program or outside the nursing program.

13. It would violate the religious beliefs of the University if it were forced to offer a health plan that included benefits for abortions, sterilizations, or any drugs or procedures related to gender transition. The University sincerely believes that offering such coverage would constitute impermissible material cooperation with evil.

14. The Section 1557 regulations would make it more expensive for the University to work with its third-party administrator. The regulations subject the third-party administrator to potential liability for administering the University's religious health plan, and we expect that the third-party administrator will require us to indemnify it for this potential liability.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on November 18, 2020.

Monsignor James Patrick Shea

EXHIBIT D

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

THE RELIGIOUS SISTERS OF MERCY, *et al.*, *Plaintiffs,* v. ALEX M. AZAR, Secretary of the United States Department of Health and Human Service, *et al.*, *Defendants.*	No. 3:16-cv-386 **Declaration of Sister Edith Mary Hart, R.S.M., D.O.**
CATHOLIC BENEFITS ASSOCIATION, *et al.* *Plaintiffs,* v. ALEX M AZAR, Secretary of the United States Department of Health and Human Service, *et al.*, *Defendants.*	No. 3:16-cv-432

1. My name is Sister Edith Mary Hart. I am over the age of 21 and am capable of making this declaration pursuant to 28 U.S.C. § 1746. I have not been convicted of a felony or crime involving dishonesty. The facts contained herein are within my personal knowledge and medical judgment. If I were called upon to testify to these facts, I could and would competently do so.

2. I am both a licensed physician and a Religious Sister within the Religious Sisters of Mercy, a Catholic order of religious sisters devoted to works of mercy, including offering healthcare to the underserved. I graduated from Oklahoma State University College of Osteopathic Medicine in 2006. I completed my residency in Family Medicine at Sparrow Health System/Michigan State University in 2010 and my fellowship in Geriatric Medicine from Michigan State University in 2011, and I am board certified in both specialties.

3. I have worked in the Emergency Department at Sanford Jackson Medical Center in Jackson, Minnesota, and have served as the Director of the ED and Trauma Services. As long as I have offered medical services as a physician, my medical judgment and religious beliefs have been respected by health institutions where I work.

4. As a Sister of Mercy, I have chosen to follow Jesus Christ by taking a lifetime vow to serve the poor and sick by offering care for the whole person, and working to heal those who are suffering from physical, psychological, intellectual, and spiritual woundedness. One aspect of our mission is fulfilled through "comprehensive health care" services, which we understand as "the complete care of the total human person" which "seeks to bring about that profound and extensive healing which is a continuation of the work of redemption." I work to fulfill this mission, in part, by seeking to understand the root causes of issues affecting my patients, and to address

underlying causes directly rather than masking issues through offering ineffective treatments.

5. In every healthcare setting where I serve, I strive to provide top-quality and compassionate care to all of my patients. I also ensure that I provide medical services and advice in accordance with the Ethical and Religious Directives of the United States Conference of Catholic Bishops and my own Catholic faith.

6. Through my work as a physician at the Sacred Heart clinic, I have the opportunity to serve and respect individuals of all faiths and walks of life, including multiple patients of mine who identify as gay or lesbian. I offer medical services to both adults and children, including infants. A significant portion of the patients I have served at the Sacred Heart clinic were also poor, disabled, and elderly Medicare and Medicaid patients. The clinics further the Sisters' mission to care for the elderly and the poor by serving Medicare and Medicaid patients and also provide low-cost or free care to the uninsured. If the Sacred Heart clinic lost this HHS funding, we would suffer a crippling blow in our capacity to carry out our religious mission to serve the poor, disabled, and elderly.

7. I hold religious beliefs about the nature and purposes of human sexuality. I believe that every man and woman is created in the image and likeness of God, and that they reflect God's image in unique—and uniquely dignified—ways.

8. Further, in my professional medical judgment, I believe that optimal patient care—including patient education, diagnosis, and treatment—requires taking account of the biological differences between men and women.

9. In my best medical judgment, providing or assisting with gender transition services is not in keeping with the best interests of patients, and in fact is experimental and could be harmful for patients.

10. As part of my normal medical practice, I sometimes prescribe hormones to patients with medical issues, such as a woman going through menopause with insufficient estrogen. If I were asked to prescribe hormones to individuals for a gender transition purpose, such as prescribing estrogen to a male, I would not be able to do so in light of my medical judgment and religious beliefs.

11. As part of my normal medical practice, I sometimes counsel patients with mental health issues, including children or youth who suffer from anxiety or depression. I explore with these patients alternatives to alleviate their mental distress, and sometimes I prescribe medication to address issues such as anxiety. If I were asked to explore the possibility of a gender transition with a patient as a viable alternative to alleviate mental distress, or to affirm a non-binary view of gender, I would not be able to do so in light of my medical judgment and religious beliefs.

12. I would also not be able to refer to patients with transgender pronouns or names if they requested that I do so. I believe that using transgender pronouns would simply aggravate an issue of identity and self-perception, and further mask a

deeper underlying issue. In my medical judgment, this would not be doing a service to my patients. Being forced to use transgender pronouns and names would also violate my religious beliefs.

13. Providing services that are contrary to my understanding of God's plan for human sexuality would also violate my religious beliefs.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on November 20, 2020.

/s Sister Edith Mary Hart
Sister Edith Mary Hart, R.S.M., D.O.

EXHIBIT E

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

THE RELIGIOUS SISTERS OF MERCY, *et al.*, *Plaintiffs,* v. ALEX M. AZAR, Secretary of the United States Department of Health and Human Service, *et al.*, *Defendants.*	No. 3:16-cv-386 **Declaration of Dr. Richard Twanow, M.D.**
CATHOLIC BENEFITS ASSOCIATION, *et al.* *Plaintiffs,* v. ALEX M AZAR, Secretary of the United States Department of Health and Human Service, *et al.*, *Defendants.*	No. 3:16-cv-432

1. My name is Dr. Richard Twanow. I am over the age of 21 and am capable of making this declaration pursuant to 28 U.S.C. § 1746. I have not been convicted of a felony or crime involving dishonesty. The facts contained herein are within my personal knowledge and medical judgment. If I were called upon to testify to these facts, I could and would competently do so.

2. I obtained my medical degree from the University of Saskatchewan. I performed a family medicine residency at the Plains Health Center in Regina, Saskatchewan. I am certified by the Canadian College of Family Physicians, and I am also certified by the American Board of Family Practice. I am licensed to practice in the State of Illinois. I currently serve as the Chairman of the Board of Directors for St. Margaret's Hospital in SMP Health System and have held that position since 2014. I have served on the Board of Directors for St. Margaret's Hospital since 2005. I have also served previously as Chairman of the Medicine/Family Medicine Committee, and I previously served as President of the medical staff for St. Margaret's Hospital. I am also a Clinical Assistant Professor at the University of Illinois, College of Medicine at Rockford. In addition, I am the Medical Director of a long term care facility called Aperion Care in Spring Valley, Illinois.

3. I have practiced family medicine for over 40 years, over 20 years of which have been at SMP Health System. My practice has included the full spectrum of family medicine, including in-patient care and emergency room work. My current practice of family medicine includes children, adults, and long-term care.

4. SMP Health System provides all of its standard medical services with dignity and compassion to every individual who needs and qualifies for its care, including to individuals who identify as transgender. Thus, for instance, if a transgender individual comes in with high blood pressure or a diabetes diagnosis, SMP Health System would provide the same full spectrum of compassionate care for

that individual as they provide for every other patient. And, just as we do for every other patient, SMP Health System would appropriately tailor that care to the biologically sex-specific health needs of the patient.

5. The SMP Health System physicians and facilities offer services such as hysterectomies, mastectomies, endocrinology services, and psychiatric support when medically indicated and in the patient's best interest. In certain contexts, SMP Health System physicians also offer endocrinology services to pediatric patients, including children, when medically appropriate. It would be a violation of SMP Health System's commitment to quality care for all patients if it were forced to offer these services for gender transition purposes, and thus it would violate SMP Health System's medical judgment if it were forced to offer these services for a gender transition purpose.

6. Such a requirement would interfere with the very important doctor-patient relationship, a relationship that is paramount to optimal patient care. SMP Health System also does not offer the full spectrum of care and expertise necessary to safely and effectively provide gender transition services to patients. SMP Health System would also object to forcing physicians to provide services that the physicians do not believe are in the best interest of their patients. In my medical judgment, it would not be safe or good medical care to force doctors to provide gender transition services when they do not have skills, knowledge, or facilities to do them correctly and safely for the patient.

7. SMP Health System physicians are encouraged to candidly discuss their medical opinions with their patients and offer medical advice freely about the risks of any procedure with patients. A requirement that inhibited a physician's ability to engage in candid discussions with patients about the risks of gender transition procedures would be detrimental to optimal patient care.

8. Some of the procedures required under the Section 1557 regulations, including elective hysterectomies, can result in the sterilization of the patient, which SMP Health System also medically objects to providing.

9. In certain contexts, SMP Health System performs surgical procedures for women who have miscarried a baby, such as dilation and curettage, when medically indicated and in the patient's best interest. However, SMP Health System would be unwilling to offer the same service if the goal of the procedure was to terminate a pregnancy.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on November 21, 2020.

/s/ Dr. Richard Twanow__
Dr. Richard Twanow, M.D.

EXHIBIT G

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

THE RELIGIOUS SISTERS OF MERCY, *et al.*, *Plaintiffs,* v. ALEX M. AZAR, Secretary of the United States Department of Health and Human Service, *et al.*, *Defendants.*	No. 3:16-cv-386 **Declaration of Caprice Knapp**
CATHOLIC BENEFITS ASSOCIATION, *et al.* *Plaintiffs,* v. ALEX M AZAR, Secretary of the United States Department of Health and Human Service, *et al.*, *Defendants.*	No. 3:16-cv-432

1. My name is Caprice Knapp. I am over the age of 21 and am capable of making this declaration pursuant to 28 U.S.C. § 1746. I have not been convicted of a felony or crime involving dishonesty. The facts contained herein are within my personal knowledge. If I were called upon to testify to these facts, I could and would competently do so.

2. I am the Medicaid Director for the North Dakota Department of Human

Services.

3. North Dakota Department of Human Services currently provides Medicaid services to approximately 100,000 North Dakotans.

4. North Dakota Department of Human Services received approximately $891,763,955 in federal funding in State fiscal year ending June 30, 2020 through Medicaid.

5. North Dakota Department of Human Services does not provide gender transition surgeries.

6. I am aware that the United States Department of Health and Human Services has promulgated regulations interpreting Section 1557 of the Affordable Care Act that define "on the basis of sex" to include "gender identity" and "termination of pregnancy."

7. If the Section 1557 regulations require healthcare providers to perform gender transition surgeries and abortions, the State of North Dakota risks losing federal funding.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on November 23, 2020.

Caprice Knapp

Caprice Knapp, Medicaid Director

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

THE RELIGIOUS SISTERS OF MERCY, *et al.*, *Plaintiffs,* v. ALEX M. AZAR, Secretary of the United States Department of Health and Human Service, *et al.*, *Defendants.*	No. 3:16-cv-386 **[Proposed] Order Granting Plaintiffs' Motion for Partial Summary Judgment and Request for Permanent Injunction**
CATHOLIC BENEFITS ASSOCIATION, *et al.* *Plaintiffs,* v. ALEX M AZAR, Secretary of the United States Department of Health and Human Service, *et al.*, *Defendants.*	No. 3:16-cv-432

Before the Court is Plaintiffs' motion for summary judgment on Counts I-V, XIII, and XV of their amended complaint (ECF No. 95). Plaintiffs request that the Court grant summary judgment in their favor on their claims under the Religious Freedom Act ("RFRA"), the Administrative Procedure Act ("APA"), and the Spending Clause. Plaintiffs also ask this Court for declaratory relief and to permanently enjoin Defendants Alex M. Azar II, in his official capacity as Secretary of the U.S. Department of Health and Human Services, and the U.S. Department of Health and

Human Services (collectively, "HHS"), from interpreting and enforcing Section 1557 of the Affordable Care Act ("ACA") against them in a manner that would require them to perform or provide insurance coverage for gender-transition procedures and abortions.

Having considered the parties' submissions and applicable law, the Court **GRANTS** Plaintiffs' motion for summary judgment. The Court hereby **DECLARES** that HHS's interpretation of Section 1557 violates RFRA by forcing the private Plaintiffs to violate their religious beliefs without satisfying strict scrutiny. HHS's interpretation of Section 1557 violates the APA by misinterpreting Section 1557 and failing to incorporate a statutorily mandated religious exemption from Title IX. And HHS's interpretation of Section 1557 violates the Spending Clause by imposing unauthorized and coercive conditions on Plaintiff North Dakota.

Furthermore, Plaintiffs have established that they satisfy all four factors necessary for obtaining a permanent injunction. *Bank One, Utah v. Guttau*, 190 F.3d 844, 847 (8th Cir. 1999). First as explained above, Plaintiffs are entitled to judgment on the merits of their RFRA, APA, and Spending Clause claims. Second, Plaintiffs will suffer irreparable harm for violations of their statutory and constitutional rights unless Defendants are permanently enjoined from enforcing Section 1557 to compel Plaintiffs to perform or cover gender-transition procedures and abortions. Third, the threatened injury to Plaintiffs outweighs any injury to Defendants resulting from this injunction. Fourth, the public interest in the vindication of Plaintiffs' statutory and constitutional rights favors the entry of an injunction.

The Court therefore **GRANTS** Plaintiffs' request for a permanent injunction. The Court **PERMANENTLY ENJOINS AND RESTRAINS** Defendants, their divisions, bureaus, agents, officers, commissioners, employees, and anyone acting in concert or participation with them, including their successors in office, from interpreting or enforcing Section 1557 of the ACA, 42 U.S.C. § 18116(a), against Plaintiffs, their

current and future members, and those acting in concert with them, in a manner that would require them to perform or provide insurance coverage for gender-transition procedures (including any surgery, counseling, provision of pharmaceuticals, or other treatments sought in furtherance of a gender transition) or abortions, including by denying Federal financial assistance to Plaintiffs because of their failure to perform or provide insurance coverage for such procedures or by otherwise pursuing, charging, or assessing any penalties, fines, assessments, investigations, or other enforcement actions. The Court also **PERMANENTLY ENJOINS AND RESTRAINS** Defendants, their divisions, bureaus, agents, officers, commissioners, employees, and anyone acting in concert or participation with them, including their successors in office, from enforcing any existing Section 1557 regulations against Plaintiffs, their current and future members, and those acting in concert with them, in a manner that would require them to perform or provide insurance coverage for gender-transition procedures or abortions, including by any of the means set out above.

For the reasons set forth herein, Plaintiffs' motion for summary judgment and request for a permanent injunction are GRANTED. The Court further orders that any motion by Plaintiffs for attorney's fees or costs shall be submitted within 30 days from the date of this Order. The Court shall retain jurisdiction as necessary to enforce this Order.

IT IS SO ORDERED.

Peter D. Welte, Chief Judge
United States District Court

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

THE RELIGIOUS SISTERS OF MERCY, *et al.*, *Plaintiffs,* v. ALEX M. AZAR, Secretary of the United States Department of Health and Human Service, *et al.*, *Defendants.*	No. 3:16-cv-386
THE CATHOLIC BENEFITS ASSOCIATION; DIOCESE OF FARGO; CATHOLIC CHARITIES NORTH DAKOTA; and CATHOLIC MEDICAL ASSOCIATION, *Plaintiffs,* v. ALEX M AZAR, Secretary of the United States Department of Health and Human Service, *et al.*, *Defendants.*	No. 3:16-cv-432

MEMORANDUM IN SUPPORT OF CBA PLAINTIFFS' MOTION FOR PARTIAL SUMMARY JUDGMENT AND FOR PERMANENT INJUNCTIVE AND DECLARATORY RELIEF [ORAL ARGUMENT REQUESTED]

The Catholic Benefits Association, Diocese of Fargo, Catholic Charities North Dakota, and Catholic Medical Association – Plaintiffs in Case No. 3:16-cv-432 – submit this memorandum in support of their Motion for Partial Summary Judgment and for Permanent Injunctive and Declaratory Relief ("Motion"), which is being filed contemporaneously herewith. Plaintiffs

request summary judgment on their claims under the Religious Freedom Restoration Act, 42 U.S.C. §§ 2000bb to 2000bb-4 ("RFRA"), and request permanent injunctive and declaratory relief against Defendants, as more fully described herein and in their accompanying Motion.

I. INTRODUCTION

In 2016, the Department of Health and Human Services ("HHS"), in coordination with the Equal Employment Opportunity Commission ("EEOC"), promulgated a rule interpreting Section 1557 of the Affordable Care Act. The gist of Section 1557 is that federally funded health programs and activities cannot discriminate on the basis of sex. HHS's rule, the "2016 Rule," radically expands that prohibition into a mandate that requires healthcare providers and other entities to perform and provide coverage for gender-transition and abortion services – even when these services violate their good-faith medical judgments and sincerely held religious beliefs. *See* 81 Fed. Reg. 31,376 (May 18, 2016). The EEOC committed to work with HHS to expand this mandate beyond the healthcare context by requiring any employer subject to Title VII of the Civil Rights Act of 1964 to cover gender-transition services in its health plan. *See id.* at 31,432. And even though the text of Section 1557 (by incorporating Title IX) contains both a religious-organization exemption and an abortion exemption, HHS refused to incorporate such exemptions into its rule, thereby forcing a needless confrontation between its novel (and medically controversial) healthcare mandate and the longstanding federal protections for rights of conscience and religious exercise. CBA Pls.' Verified Second Am. Comp. ("SAC") ¶¶ 70-90.

To violate Defendants' mandate means the loss of federal funding, civil and criminal penalties, agency enforcement actions, and exposure to private lawsuits. To comply means forsaking conscience and religious faith. Either choice is devastating for Catholic organizations like Plaintiffs and their members. *See* SAC ¶¶ 162-174, 220-241.

In recognition of the severe burden the 2016 Rule places on religious organizations, a federal district court in Texas preliminary enjoined then later vacated portions of the rule, telling HHS to reconsider. *See Franciscan Alliance, Inc. v. Burwell*, 227 F. Supp. 3d 660 (N.D. Tex. 2016) (preliminary injunction); *Franciscan Alliance, Inc. v. Azar*, 414 F. Supp. 3d 928 (N.D. Tex. 2019) (vacatur and remand to agency). Similarly, this Court entered a temporary stay of enforcement prohibiting HHS from enforcing portions of the 2016 Rule against Plaintiffs in this case. ECF No. 36.

Years passed and HHS kept promising a new rule. It finally announced one in June 2020. The new rule, the "2020 Rule," would have repealed the prior mandate, leaving organizations free to decide, based on their medical and religious judgment, whether to perform or cover gender-transition and abortion services. *See* Nondiscrimination in Health and Health Education Programs or Activities, 85 Fed. Reg. 37,160, 37,187-88 (June 19, 2020). The new rule also would have recognized that organizations cannot be forced to violate their consciences and religious beliefs in the provision or coverage of health services. *See id.* at 37,193, 37,207.

Had it taken effect, the 2020 Rule may have resolved some of the substantive issues in this case. (It did not, however, address the EEOC's imposition of a transgender services coverage mandate under Title VII.) But the new rule never became operative.

A few days after it was announced, the Supreme Court decided *Bostock v. Clayton County*, holding that an employer violates Title VII's ban on sex discrimination if it fires someone "simply for being . . . transgender." 140 S. Ct. 1731, 1753 (2020). Even though the Court was careful to say it was not "prejudg[ing]" how its logic might apply in other contexts like healthcare, and even though it expressed "dee[p] concer[n] with preserving the promise of the free exercise of religion,"

several states and private plaintiffs quickly brought legal challenges to the 2020 Rule, invoking *Bostock* and asking that the 2020 Rule be enjoined and the 2016 Rule be reinstated.

Two district courts obliged. In *Walker v. Azar*, the district court, finding that the 2020 Rule was "contrary to *Bostock*," "stay[ed] the repeal of the 2016 definition of discrimination on the basis of sex"; ordered that the 2016 Rule's "definitions of 'on the basis of sex,' 'gender identity,' and 'sex stereotyping' . . . will remain in effect"; and preliminarily enjoined HHS "from enforcing the repeal." 2020 WL 4749859, at *1, *10 (E.D.N.Y. 2020). In *Whitman-Walker Clinic, Inc. v. U.S. Dep't of Health & Human Servs.*, the district court issued a nationwide preliminary injunction enjoining the 2020 Rule to the extent it "eliminated 'sex stereotyping' from the [2016] Rule's definition of 'discrimination on the basis of sex,'" and barring HHS "from enforcing its incorporation of [a] religious exemption" into the new rule. 2020 WL 5232076, at *1, *45 (D.D.C. 2020).

Together, these "overlapping injunctions," *see id.* at *41 (quotation omitted), stay implementation of the 2020 Rule and resurrect those portions of the 2016 Rule vacated in *Franciscan Alliance*. The effect of these injunctions is to reinstate the same state of affairs, and reimpose upon Plaintiffs the same severe burdens, that they faced when they brought this lawsuit in 2016. If Plaintiffs' request for relief was critical then, it is even more critical now. Plaintiffs request that the Court enter summary judgment on their claims under the Religious Freedom Restoration Act ("RFRA"), 42 U.S.C. §§ 2000bb to 2000bb-4 (Counts XI and XII of their Second Amended Complaint), together with permanent injunctive and declaratory relief.

There are, to be sure, strong reasons to invalidate the 2016 Rule on its own terms under the Administrative Procedure Act ("APA"). Section 1557 bans sex discrimination by incorporating Title IX, stating that "an individual shall not, on the ground prohibited under . . . [T]itle IX," be

subject to discrimination in federally funded healthcare programs. 42 U.S.C. § 18116(a). Title IX, in turn, prohibits sex discrimination, but states that it "shall not apply" to religious organizations, 20 U.S.C. § 1681(a)(3), and "shall [not] be construed to require . . . any person . . . to provide or pay for any benefit or service . . . related to an abortion," *id.* § 1688. For HHS to refuse to incorporate these religious and abortion exemptions into its 2016 Rule was contrary to law at the outset. *See Franciscan Alliance*, 227 F. Supp. 3d at 691. Yet when HHS sought to correct its error in the 2020 Rule, the district court in *Whitman-Walker Clinic* enjoined it, finding that HHS's "incorporation of the religious exemption contained in Title IX" was itself contrary to law under the APA. 2020 WL 5232076, at *45. And in several other legal challenges to the 2020 Rule, plaintiffs likewise seek to preclude HHS from respecting religious freedom in its rulemaking, dimming the prospects for any regulatory religious exemption.[1]

There is no reason for Plaintiffs (or this Court) to continue to ride this administrative-judicial seesaw, nor should Plaintiffs have to wait yet another four years for an uncertain regulatory process to play out. This is because, regardless of how Section 1557, Title VII, and related federal laws are interpreted, RFRA protects Plaintiffs' religious exercise. "RFRA operates as a kind of super statute" and "supersedes [the] commands" of federal law when it burdens religious practices. *Bostock*, 140 S. Ct. at 1754. Thus, even if present and future interpretations of federal law require healthcare providers to perform, and employers to cover, gender-transition and abortion services, RFRA entitles Plaintiffs and their members to an exemption permitting them to perform and cover only those services that are consistent with their religious convictions.

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[1] *See BAGLY v. U.S. Dep't of Health & Human Servs.*, No. 20-cv-11297, Compl., ECF No. 1 (D. Mass. July 9, 2020); *New York v. U.S. Dep't of Health & Human Servs.*, No. 20-cv-05583, Compl., ECF No. 1 (S.D.N.Y. July 20, 2020); *Washington v. U.S. Dep't of Health & Human Servs.*, Compl., No. 20-cv-01105, Compl., ECF No. 1 (W.D. Wash. July 16, 2020).

Accordingly, Plaintiffs ask the Court to enter summary judgment on their RFRA claims, to declare unlawful any interpretation of Section 1557 and related federal laws (including Title IX and Title VII) that would require Plaintiffs and their members to perform or cover gender-transition and abortion services in violation of their sincerely held religious beliefs, and to permanently enjoin HHS and the EEOC from enforcing any such interpretation against Plaintiffs, their members, and their respective insurers or third party administrators ("TPAs").

II. STATEMENT OF UNCONTESTED MATERIAL FACTS

Plaintiff The Catholic Benefits Association ("CBA") exists to help its members, all Catholic institutions, carry out their callings and operate in a manner that complies with their Catholic convictions. SAC ¶ 44. Plaintiffs Diocese of Fargo, Catholic Charities North Dakota, and Catholic Medical Association are members of the CBA. *Id.* ¶¶ 12, 25, 32. All Plaintiffs and all CBA members are Catholic institutions that adhere to the teachings of the Catholic Church on issues such as abortion, sterilization, and the nature of the human person. *Id.* ¶ 70. Some operate health care programs or activities as part of their ministry. *Id.* ¶ 55-57. All seek to offer their employees generous health benefits. *Id.* ¶ 44. The CBA brings this action on behalf of itself and its members. *Id.* ¶ 60-64.

As Catholic institutions, CBA members believe that all persons should be treated with dignity. Because their Catholic faith teaches that gender transitions and abortions are immoral and harmful, CBA members cannot facilitate these services, either by performing them directly or by covering them in their health plans. *Id.* ¶¶ 70-90. Yet pursuant to Section 1557 and related federal laws, including Title VII, Defendants have promulgated a series of rules and policies (the "Mandate") that force CBA members to do just that. *Id.* ¶¶ 220-241. If CBA members refuse to comply with the Mandate, they face financial ruin: health care institutions will be cut off from

Medicare and Medicaid funding, and employers are threatened with federal enforcement actions and damages liability. *Id.* ¶¶ 162-174.

A. Pursuant to Section 1557 and Title VII, Defendants require healthcare providers and employers to perform and provide coverage for gender-transition and abortion services.

The Mandate has its genesis in a final rule promulgated in 2016 by HHS with support and input from the EEOC. The memorandum brief filed today by Plaintiffs Religious Sisters of Mercy et al. in Case No. 16-cv-00386 (ECF No. 96-1) well describes the Mandate and its key provisions requiring organizations to provide health services related to gender transition and abortion, and to cover these services as part of their employee health plans. Plaintiffs hereby incorporate the description of and arguments regarding the Mandate set forth in the contemporaneous briefing of the Religious Sisters of Mercy. Plaintiffs write separately to describe the EEOC's role in promulgation and enforcement of the Mandate and the effects of the Mandate on CBA members.

By its terms, Section 1557 bars sex discrimination only in the context of health programs and activities that receive federal funds. So HHS defined a "covered entity" subject to its Mandate as "any entity that has a health program or activity, any part of which receives Federal financial assistance from [HHS]." 81 Fed. Reg. at 31,445. As a practical matter, this includes most healthcare providers, such as physicians, hospitals, and clinics, as well as most health insurers and TPAs. *See* SAC ¶ 125. But HHS also recognized that its Mandate had wider implications because Section 1557 is not the only federal law that bans sex discrimination. Title IX (which Section 1557 expressly incorporates, *see* 42 U.S.C. § 18116(a)) prohibits sex discrimination in federally funded educational programs and activities. *See* 20 U.S.C. § 1681(a). And critically here, Title VII prohibits sex discrimination by any employer with 15 or more employees – regardless of whether it receives federal funds. *See* 42 U.S.C. §§ 2000e-2(a), 2000e(b).

The EEOC is the federal agency principally responsible for interpreting and enforcing Title VII. *See EEOC v. Commercial Office Prods. Co.*, 486 U.S. 107, 115 (1988). When HHS promulgated the Mandate, it coordinated with the EEOC to broaden the Mandate to all Title VII employers, even those that do not operate federally funded health programs. HHS achieved this result in three steps.

First, the Mandate declares that health plan exclusions for transition-related health services are discriminatory. *See* 81 Fed. Reg. at 31,429, 31,472 (making it unlawful for covered entities to categorically exclude or limit coverage "for all health services related to gender transition" and to deny or limit coverage for "specific health services related to gender transition" when doing so "results in discrimination against a transgender individual"). Second, the Mandate defines health insurers and TPAs to be covered entities, which means that when these entities provide insurance coverage or administer benefits for employer-sponsored plans, they must ensure that transition-related services are covered – even when the employer is not itself a covered entity. *See id.* at 31,432 (requiring compliance with the Mandate by "an entity that receives Federal financial assistance [and] is principally engaged in providing or administering health services, health insurance coverage, or other health coverage"). Finally, for non-covered entities that are outside HHS's "jurisdiction" and that refuse to cover transition-related services in their health plans, HHS said it would coordinate with the EEOC to address the matter:

> As part of its enforcement authority, [HHS] may refer matters to other Federal agencies with jurisdiction over the entity. Where, for example, [HHS] lacks jurisdiction over an employer responsible for benefit design, [HHS] typically will refer or transfer the matter to the EEOC and allow that agency to address the matter. The EEOC has informed [HHS] that, provided the filing meets the requirements for an EEOC charge, the date a complaint was filed with [HHS] will be deemed the date it was filed with the EEOC . . . .

Id.

The EEOC had already begun enforcing this aspect of the Mandate pursuant to its Title VII authority. When the Mandate was promulgated in 2016, official EEOC guidance interpreted Title VII's ban on sex discrimination to prohibit discrimination based on "transgender status." *See* SAC ¶ 156. And between 2016 and today, the EEOC has specifically enforced this interpretation to require employers to pay for gender-transition services as part of employee health coverage:

- The EEOC sued an employer and later entered into a three-year consent decree which provided that, "as of January 1, 2016, [employer's] national health benefits plan will not include any partial or categorical exclusion for otherwise medically necessary care based on transgender status." EEOC, Deluxe Financial to Settle Sex Discrimination Suit on Behalf of Transgender Employee, 2016 WL 246967 (Jan. 21, 2016).

- In 2016, the EEOC submitted an amicus brief in *Josef Robinson v. Dignity Health*, No. 3:16-cv-03035 (N.D. Cal. 2016), arguing that a hospital's categorical exclusion of coverage for gender transition services in its employee health plan violated Title VII. *See* SAC ¶ 158.

- The EEOC has taken enforcement action against other employers on the same grounds. *See* Soc'y for Human Res. Mgmt., Wal-Mart Loses Perfect LGBTQ Rating Because of Transgender Harassment, Nov. 30, 2017 (highlighting EEOC enforcement action against Wal-Mart for "categorical exclusion" from its health plans of "services related to transgender treatment/sex therapy").[2]

The EEOC still maintains this interpretation of Title VII. Even while HHS tried (unsuccessfully) to repeal the Mandate in its 2020 Rule, the EEOC has never backed off its view that Title VII requires employers to cover gender-transition services in their health plans. SAC ¶¶ 160-161. In this regard, the scope of the Mandate is breathtakingly broad. It is not just physicians, hospitals, clinics, insurers, TPAs, and other healthcare providers (i.e., covered entities) that are subject to the gender-transition coverage requirement. Rather, according to Defendants' interpretation of federal law, every employer in the United States subject to Title VII – whether or

[2] Available at https://www.shrm.org/resourcesandtools/legal-and-compliance/employment-law/pages/wal-mart-lgbtq-rating.aspx.

not it operates a health program, and whether or not it receives federal funds – must cover gender-transition services in its health plan.[3]

This aspect of Defendants' Mandate has concretely harmed CBA members. In 2016, two Catholic dioceses, both members of the CBA, received involuntary notices from their insurers that their health plans had begun covering gender-transition services, including cross-sex hormone therapy, male-to-female surgeries, and female-to-male surgeries.[4] When these members, who are not "covered entities," called their insurers to demand removal of this coverage, the insurers stated that coverage was required by Defendants' Mandate. SAC ¶¶ 136-140. In addition, CBA members with self-insured plans have taken steps to ensure their plans reflect their religious convictions and exclude gender-transition and abortion coverage. But the TPAs that administer these plans have demanded that CBA members indemnify the TPA or otherwise accept the TPA's liability, thereby forcing members to take on expanded legal obligations in the event Defendants or a private party seeks to enforce the Mandate against TPAs. *Id.* ¶¶ 21-22, 240, 244.

B. Defendants' Mandate substantially burdens the religious practices of CBA members.

CBA members' exercise of religion is substantially burdened by the Mandate because it coerces them, under the threat of severe economic losses and penalties, to provide and cover gender-transition services and abortions contrary to their Catholic faith. SAC ¶¶ 220-241.

CBA members that qualify as covered entities must perform gender transition and abortion

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[3] Title VII applies to any employer with 15 or more employees. According to the U.S. Census Bureau, there are over 875,000 such employers in the United States. *See* SAC ¶ 111.

[4] Covered male-to-female surgeries include orchiectomy and penectomy (removal of testicles and penis) and clitoroplasty, labiaplasty, and vaginoplasty (creation of a clitoris, labia, and vagina). Covered female-to-male surgeries include mastectomy, hysterectomy, vulvectomy and vaginectomy (removal of vulva and vagina), and metoidioplasty and phalloplasty (creation of penis). *See* SAC ¶ 136-140, SAC Exs. E and F.

services and must support efforts to transition in their counseling and mental health programs. *Id.* ¶¶ 127-129. Covered entities must alter their speech and advice to conform with HHS's conclusions about proper care, including agreeing to use a patient's preferred pronouns. *Id.* ¶¶ 130-131. Covered entities also must cover gender transition and abortion services in their employee health plans. *Id.* ¶¶ 132-136. Failure to comply risks the loss of federal funding, civil and criminal penalties, and other forms of liability. *Id.* ¶¶ 162-174.

As explained, CBA members that are not covered entities must comply with the Mandate by covering gender transition and abortion services in their health plans, either because their insurer or TPA (a covered entity) requires it or because these members are subject to Title VII. As a result of coordination between HHS and the EEOC, every CBA member with at least 15 employees is subject to civil enforcement actions and other penalties if it fails to comply with the Mandate's coverage requirements. *Id.* ¶¶ 161, 165-167, 171-174.

The CBA's own religious practices are burdened by the Mandate. The CBA is a membership organization whose mission is to help its members—Catholic organizations located in North Dakota and elsewhere[5]—exercise their right to practice their faith in their professions and workplaces, including their right to offer health care services and to provide employee health benefits consistent with Catholic values. *Id.* ¶ 44. Defendants' Mandate makes these aspects of the CBA's religious exercise virtually impossible.

[5] CBA members include over 1,000 Catholic employers across the United States, including over 60 Catholic dioceses and archdioceses, as well as Catholic hospitals, Catholic Charities, Catholic schools, and other Catholic ministries and businesses. *See* SAC ¶¶ 52-57 (describing CBA members).

C. Due to the injunctions against the 2020 Rule, the Mandate remains in effect and continues to burden Plaintiffs' religious practices.

HHS's 2020 Rule sought to "substantially repea[l] much of the 2016 Rule," 85 Fed. Reg. at 37,161, including the former rule's definition of "on the basis of sex," *id.* at 37,178. The 2020 Rule would have ensured that providers are "free to use their best medical judgment, consistent with their understanding of medical ethics," in providing health care, *id.* at 37,187; would have "explicitly incorporate[d] relevant statutory exemptions from Title IX, including abortion neutrality and the religious exemption," *id.* at 37,162; and would have clarified that Section 1557 must be interpreted consistent with RFRA and other federal laws protecting conscience and religious exercise, *id.* at 37,204-05.

But shortly before and shortly after the 2020 Rule's effective date of August 18, 2020, it was enjoined by two district courts. The first was the Eastern District of New York, which on August 17, 2020 found that plaintiffs were likely to succeed on the merits of their APA claim and entered a preliminary injunction against the 2020 Rule. *See Walker*, 2020 WL 4749859, at *1, *9. The court acknowledged that the 2016 Rule had been vacated in *Franciscan Alliance* and "agree[d] that it has no power to revive a rule vacated by another district court." *Id.* at *7. Yet the court "stay[ed] the repeal of the 2016 definition of discrimination on the basis of sex," ordered that this definition (along with the 2016 definitions of "gender identity" and "sex stereotyping") "will remain in effect"; and preliminarily enjoined HHS "from enforcing the repeal." *Id.* at *10.

On its heels was a decision by the federal district court in the District of Columbia, which on September 2, 2020 issued a nationwide preliminary injunction against key portions of the 2020 Rule. *Whitman-Walker Clinic*, 2020 WL 5232076, at *45. This court also acknowledged that it had "no authority . . . to disregard the final order of a district court vacating part of a regulation." *Id.* at *13. But it purported to distinguish between what it called the "'gender identity' portion" of

the 2016 Rule, which had been vacated, and the rule's "prohibition on discrimination based on sex stereotyping," which supposedly had not. *Id.* at *14. So the court enjoined the 2020 Rule to the extent it "eliminated 'sex stereotyping' from the [2016] Rule's definition of 'discrimination on the basis of sex.'" *Id.* at *1, *45. The court also faulted HHS for respecting religious freedom in the 2020 Rule, suggesting that "a blanket religious exemption" might "allow for discrimination on the bases prohibited by Section 1557 or for the denial of health services to women." *Id.* at *28 (quoting 81 Fed. Reg. at 31,379) (internal quotation marks omitted). The court thus enjoined HHS "from enforcing its incorporation of [a] religious exemption" in the new rule. *Id.* at *45.[6]

Together, the injunctions in *Walker* and *Whitman-Walker Clinic* stay implementation of the 2020 Rule, prevent repeal of the 2016 Rule, and reinstate Defendants' Mandate. The Mandate is grounded in HHS's interpretation of the prohibition of discrimination "on the basis of sex" in Section 1557, a phrase HHS defined to encompass both "gender identity" and "termination of pregnancy." *See* 81 Fed. Reg. 31,376 (summary of 2016 Rule). The court in *Walker* "stay[ed] the repeal" of that definition, ordered that definition (along with the 2016 definitions of "gender identity" and "sex stereotyping") to "remain in effect," and "preclude[d] the [2020 Rule] from

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[6] Other legal challenges to the 2020 Rule are pending. In *BAGLY v. U.S. Department of Health and Human Services*, for example, the plaintiffs seek to invalidate the 2020 Rule's elimination of "gender identity" and "termination of pregnancy" from the definition of sex discrimination, saying it will "embolden discrimination . . . on the basis of gender identity" and "embolden refusals of reproductive healthcare." No. 20-cv-11297, Compl., ECF No. 1, ¶¶ 231-32 (D. Mass. July 9, 2020); *see also New York v. U.S. Dep't of Health & Human Servs.*, No. 20-cv-05583, Compl., ECF No. 1, ¶¶ 96, 234 (S.D.N.Y. July 20, 2020) (challenging "[t]he 2020 Rule's removal of the mandate that covered entities treat transgender people consistent with their gender identity" and removal of the abortion mandate because it will "further stigmatize abortion" and "embolden providers to deny abortion care"); *Washington v. U.S. Dep't of Health & Human Servs.*, Compl., No. 20-cv-01105, Compl., ECF No. 1, ¶ 1(W.D. Wash. July 16, 2020) (challenging the 2020 Rule's elimination of "sex stereotyping and gender identity from the definition of prohibited 'sex' discrimination").

becoming operative." 2020 WL 4749859 at *1, *10. The *Whitman-Walker Clinic* court purported to distinguish between a "gender identity" portion and a "sex stereotyping" portion of the 2016 Rule, and then "enjoined . . . the repeal" of the latter portion. But even that court acknowledged that these two "portions" could not be "meaningfully separated" because "the belief that an individual should identify with only their birth-assigned sex is such a sex-based stereotype." 2020 WL 5232076, *23. Thus, however denominated, the requirement of the 2016 Rule that healthcare providers and employers like Plaintiffs provide and cover gender-transition services remains in effect and continues to burden their religious exercise.

The nationwide injunction in *Whitman-Walker Clinic* also prohibits "incorporation of the religious exemption contained in Title IX." *Id.* at *45. Although the court noted that "[n]othing in [its] decision" implicated the ACA's protections for conscience (including objections to abortion) and RFRA's protections for religious exercise, the court's invalidation of a "blanket religious exemption" essentially requires religious claimants to file lawsuits invoking these protections and to seek religious exemptions on case-by-case basis. This is itself a burden on religious exercise because it forces religious claimants into an expensive and time-consuming litigation process, often beset by delays and uncertainty – as this case demonstrates. Regardless, even while these two injunctions keep the Mandate alive, they preserve the right to seek judicially crafted, RFRA-based exemptions. *See id.* at *29. That is the relief Plaintiffs are requesting here.

III. ARGUMENT

"Summary judgment is required 'if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law.'" *Rodenburg LLP v. Certain Underwriters at Lloyd's, London*, 2020 WL 3455716, at *4 (D.N.D. 2020) (quoting Fed. R. Civ. P. 56(a)). Plaintiffs are entitled to summary judgment on their RFRA claims and to permanent injunctive and declaratory relief against Defendants. Any interpretation of federal law

that requires CBA members to perform and cover gender-transition and abortion services unlawfully burdens their religious exercise. Defendants promulgated such an interpretation in 2016 – HHS under Section 1557 (and by extension, Title IX) and the EEOC under Title VII – and their Mandate remains in effect now. HHS's effort to repeal the Mandate has been enjoined by two district courts, and the EEOC has never changed its official position that Title VII requires employers to cover gender transitions. But the Mandate, as applied to CBA members, cannot survive the rigorous scrutiny that RFRA demands. Defendants do not have a compelling interest in forcing CBA members to facilitate gender transitions and abortions, nor have they pursued that interest by the least restrictive means. Thus, even if the Mandate is a proper interpretation of federal law, it cannot be applied to CBA members.

A. *Bostock* does not support the Mandate and, in any event, expressly preserves RFRA-based exemptions.

The district courts in *Walker* and *Whitman-Walker Clinic* reasoned that *Bostock* requires reinstatement of the 2016 Rule. Although Plaintiffs are entitled to a RFRA-based exemption regardless, it is worth pausing to explain why these courts are wrong, why *Bostock* does not support this interpretation of federal law.

Bostock held that terminating an employee "simply for being . . . transgender" is a violation of Title VII's ban on discrimination "because of . . . sex." 140 S. Ct. at 1753. Thus, an employer transgressed Title VII when it fired a biological male employee who wished to "live and work . . . as a woman." *Id.* at 1738 (quotation omitted). Because the employer did not fire biological female employees who wished to live and work as women, the Court explained, the biological male employee had been treated differently "because of . . . sex." *See id.* at 1741 (explaining that an employer violates Title VII if it "fires a transgender person who was identified as a male at birth but who now identifies as a female," but "retains an otherwise identical employee who was

identified as female at birth").

Importantly, *Bostock* does *not* hold that the term "sex" in Title VII means "gender identity" or "transgender status," as if one simply swaps out one term for the other in the statute and then asks, for example, whether discrimination "because of . . . gender identity" has occurred. Rather, *Bostock* "assum[es]" that "sex" refers to biological sex, *i.e.*, to the "biological distinctions between male and female," *id.* at 1739, and the Court's logic is built upon a simple but-for test:

> If the employer intentionally relies in part on an individual employee's sex when deciding to discharge the employee – put differently, if changing the employee's sex would have yielded a different choice by the employer – a statutory violation has occurred.

Id. at 1741; *see also id.* at 1739 ("[A] but-for test directs us to change one thing at a time and see if the outcome changes.").

The Court in *Bostock* was careful to cabin its logic to the context of employment terminations, noting that this was the "only question" before it. *Id.* at 1753. While the dissent warned that the Court's decision would have implications for other areas of law, including Title IX and Section 1557, *see id.* at 1781 (Alito, J., dissenting), the Court's majority declined to "prejudge" those questions, *id.* at 1753 (maj. op.). And the dissent's concerns notwithstanding, *Bostock* cannot be read to require healthcare providers and employers to perform or cover gender-transition services (much less abortion).

In the first place, sex-based distinctions in healthcare are not only routine, but often required by the standard of care. Objective, biological differences between men and women necessitate different medical services and interventions. See 85 Fed. Reg. at 37,184 ("The biological differences between men and women . . . are in many ways even more relevant in the health setting."). It is not "discrimination" to tailor healthcare to men or to women specifically. Indeed, the opposite is true: to fail to take into account these biological differences could cause

harm to patients. *See id.*

Second, a healthcare provider that refuses to perform a service in aid of a patient's gender transition does not discriminate on the basis of sex under *Bostock*. To see why, imagine two biologically female patients: one requests a hysterectomy due to uterine cancer, and the other requests a hysterectomy so she can transition to living as a man. A hospital that performs the hysterectomy for the first patient but not the second has not engaged in discrimination on the basis of sex within the meaning of *Bostock*. In distinguishing between the two cases, the hospital has not "intentionally relie[d] in part on an individual [patient's] sex." 140 S. Ct. at 1741. Indeed, both patients are biologically female, so sex is irrelevant to the hospital's decision. Rather, the hospital differentiates between the two cases based on the medical reasons for the procedure (to treat cancer vs. gender dysphoria). Whether this hospital must perform the same procedure for two biologically female patients with two different medical conditions is simply not a question that *Bostock* answers. Nor does *Bostock*'s other formulation of the but-for test – whether hypothetically "changing the [patient's] sex would have yielded a different choice by the [hospital]" – alter the conclusion. If a biological male patient were to request a hysterectomy, he too would be denied the treatment.

In any event, the *Bostock* Court took pains to note that, even if its logic extended beyond the context of employment terminations, it was "deeply concerned with preserving the promise of the free exercise of religion enshrined in our Constitution," a guarantee that "lies at the heart of our pluralistic society." 140 S. Ct. at 1754. The Court specifically emphasized RFRA: "Because RFRA operates as a kind of super statute, displacing the normal operation of other federal laws, it might supersede Title VII's commands in appropriate cases." *Id.* This is such a case.

B. The Mandate substantially burdens CBA members' religious exercise.

The Mandate already has resulted in concrete burdens on CBA members' religious exercise. As noted, several CBA members have been forced either to cover gender-transition services in their health plans or to take on liability for excluding gender-transition and abortion coverage. And because the Mandate's central provisions "remain in effect," *Walker*, 2020 WL 4749859, CBA members continue to face serious economic repercussions, including the loss of federal funding, civil and criminal penalties, agency enforcement actions, private lawsuits, and damages liability, if they adhere to their religious convictions and refuse to comply with the Mandate.

As a result, the Mandate imposes a substantial burden on CBA members' religious exercise. The district court correctly so held in *Franciscan Alliance*. *See* 227 F. Supp. 3d at 692. For its part, HHS has conceded the merits of Plaintiffs' RFRA claim, stating in its 2020 Rule that "[t]he Department agrees with the court in *Franciscan Alliance* that particular provisions in the 2016 Rule violated RFRA as applied to private plaintiffs." 85 Fed. Reg. at 37,206.

RFRA defines "exercise of religion" to include "any exercise of religion, whether or not compelled by, or central to, a system of religious belief." 42 U.S.C. §§ 2000bb-2(4), 2000cc-5(7)(A) "[A] religious exercise need not be mandatory for it to be protected under RFRA." *Kikumura v. Hurley*, 242 F.3d 950, 960 (10th Cir. 2001). Under RFRA, the government substantially burdens the exercise of religion when it "put[s] substantial pressure on an adherent to modify his behavior and to violate his beliefs" either by "condition[ing] receipt of an important benefit upon conduct proscribed by a religious faith" or by "den[ying] such a benefit because of conduct mandated by religious belief." *Sharpe Holdings, Inc. v. U.S. Dep't of Health & Human Servs.*, 801 F.3d 927, 937 (8th Cir. 2015) (quoting *Thomas v. Review Bd.*, 450 U.S. 707, 717-18 (1981)) (internal quotation marks omitted), *vacated on other grounds*, 2016 WL 2842448 (U.S.

May 16, 2016); *see Christian Employers Alliance v. Azar*, 2019 WL 2130142, at *1 (D.N.D. 2019) (noting that "the Court remain[s] bound by" *Sharpe Holdings*).

CBA members exercise religion when they choose both to provide generous health coverage benefits and to obey their consciences and refrain from performing, encouraging, funding, covering in their health plans, or otherwise participating in gender-transition and abortion services. Catholic teaching on the nature of the human person and on abortion is familiar and well-documented, and CBA members, including Plaintiffs, adhere to those teachings. See SAC ¶¶ 70-90. Their conscientious decision to refuse to participate in gender transition and abortion, and their efforts to exclude coverage of these services from their health plans, unquestionably qualify as the exercise of religion under RFRA. *See Sharpe Holdings*, 801 F.3d at 937 (refusal to comply with HHS's contraceptive mandate was exercise of religion).

It is likewise unquestionable that the Mandate substantially burdens the religious exercise of the CBA and its members. "When the government imposes a direct monetary penalty to coerce conduct that violates religious belief, there has never been a question that the government imposes a substantial burden on the exercise of religion." *Id.* at 938 (alteration and quotation omitted). The Mandate forces CBA members to choose between their faith and substantial financial consequences.

Covered entities. By virtue of their religious convictions, CBA members that provide healthcare services, such as Catholic physicians and Catholic hospitals, cannot participate in gender transitions or abortion procedures. SAC ¶¶ 79-83, 86-87. Catholic Charities and other CBA members offering counseling services cannot support their patients' efforts to transition away from their biological sex. *Id.* ¶¶ 75-78. Nor can any of these members provide employee health coverage for gender transitions and abortions. *Id.* ¶¶ 229-232. Yet by adhering to their religious convictions,

CBA members who are covered entities risk financial penalties, agency enforcement actions, private lawsuits, and more. *Id.* ¶¶ 162-174.

Non-covered entities. CBA members that are not covered entities are nevertheless affected by the Mandate's requirement that their health plans cover gender-transition and abortion services. For some members' health plans, gender-transition coverage has already, involuntarily, been imposed by their insurance carrier. *Id.* ¶¶ 136-140. And even if these members could find an insurer willing to exclude such coverage, they still risk enforcement actions and litigation by the EEOC, which has maintained its view (reflected in the Mandate) that Title VII requires such coverage. *Id.* ¶ 160-161. Even CBA members that self-insure and contract with TPAs for administration of employee health benefits have been forced to indemnify their TPAs, or accept their TPAs' liability, against the risk that the health plan will be found out of compliance with the Mandate. *Id.* ¶¶ 21-22, 240, 244. This, too, is a substantial burden on religious exercise because it negatively affects members' ability to "earn income, borrow, and plan for their financial future." *Cf. Jones v. Gale*, 470 F.3d 1261, 1267 (8th Cir. 2006).

C. The Mandate does not satisfy strict scrutiny.

Because the Mandate imposes a substantial burden on Plaintiffs' religious exercise, it is invalid unless Defendants carry their burden of demonstrating that it passes strict scrutiny. Strict scrutiny under RFRA is "exceptionally demanding." *Sharpe Holdings*, 801 F.3d at 943 (quoting *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 728 (2014)) (internal quotation marks omitted). Under that test, the government must demonstrate that the Mandate furthers an interest "of the highest order." *Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 546 (1993). And it "bear[s] the burden of demonstrating that the regulation is the least restrictive means of achieving a compelling interest." *Hamilton v. Schriro*, 74 F.3d 1545, 1552 (8th Cir. 1996) (citing 42 U.S.C. § 2000bb-1(b)). Defendants cannot carry either end of their burden.

1. The Mandate furthers no compelling interest.

Under strict scrutiny, "[o]nly the gravest abuses, endangering paramount interest, give occasion for permissible limitation." *Sherbert v. Verner*, 374 U.S. 398, 406 (1963). The government's asserted interests fail for several reasons.

First, the Mandate asserts "a compelling interest in ensuring that individuals have nondiscriminatory access to health care and health coverage." 81 Fed. Reg. at 31,380. But under RFRA, such "'[b]roadly formulated,' or 'sweeping' governmental interests are inadequate." *Sharpe Holdings*, 801 F.3d at 943 (citations omitted). Rather, RFRA requires courts "to 'scrutiniz[e] the asserted harm of granting specific exemptions to particular religious claimants'—in other words, to look to the marginal interest in enforcing the [Mandate] in [this case]." *Hobby Lobby*, 573 U.S. at 726-27. HHS now agrees that that it has "no compelling interest in forcing the provision, or coverage," of gender-transition procedures. 85 Fed. Reg. at 37,188; *see also id.* at 37,193 (declining to reimpose the "termination of pregnancy" provisions of the 2016 Rule because of longstanding federal protections for conscience and religious exercise).

Not only is the government's interest too broadly formulated, it is not at issue here. Although the Mandate expresses concern with transgender individuals "being refused medical treatment based on bias against them," 81 Fed. Reg. at 31,460, it acknowledges that "[n]one of the commenters supporting a religious exemption asserted that there would be a religious basis for generally refusing to treat LGBT individuals for a medical condition, for example, refusing to treat a broken bone or cancer." *Id.* at 31,379. As the Chairman of the U.S. Conference of Catholic Bishops has stated, "[t]he Catholic Church consistently affirms the inherent dignity of each and every human person and advocates for the wellbeing of all people, particularly the most vulnerable." SAC ¶ 72. The Catholic Church in general, and CBA member healthcare providers in particular, are committed to treating people with gender dysphoria with "compassion, sensitivity,

and respect." *Id*. ¶¶ 71-74.

Nor does the government have a compelling interest in forcing Plaintiffs to cover these services in their health plans. "A law cannot be regarded as protecting an interest of the highest order . . . when it leaves appreciable damage to that supposedly vital interest unprohibited." *281 Care Comm. v. Arneson*, 766 F.3d 774, 785 (8th Cir. 2014). The government has exempted its own health insurance programs from gender-transition coverage. For example, TRICARE, the military's insurance program, does not cover "surgery for gender dysphoria," and it protects the religious beliefs of physicians who object to performing gender-transition procedures. SAC ¶ 152. Further, Medicare and Medicaid do not require coverage for gender reassignment surgery, but allow states and local administrators to make coverage determinations on a case-by-case basis.[7] This coverage determination was based on the conclusions of HHS's own experts that "there is not enough evidence to determine whether gender reassignment surgery improves health outcomes" because while some studies "reported benefits," "*others reported harms*."[8] Under RFRA, the government cannot have a "compelling" interest in a policy that it is not even "willing to pursue itself." *Franciscan Alliance*, 227 F. Supp. 3d at 692-93.

Finally, because the compelling interest test is so demanding, even "important interests" usually fail. *Hobby Lobby*, 573 U.S. at 726 (acknowledging public health and gender equality as "important interests"). The Supreme Court has cautioned that "many laws will not meet the test." *City of Boerne v. Flores*, 521 U.S. 507, 534 (1997). Notably, RFRA requires a compelling

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[7] Ctrs. for Medicare & Medicaid Servs., Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (Aug. 30, 2016), https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=282.

[8] Ctrs. for Medicare & Medicaid Servs., Proposed Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (June 2, 2016) https://www.cms.gov/medicare-coverage-database/de-tails/nca-proposed-decision-memo.aspx?NCAId=282 (emphasis added).

"*governmental*" interest. 42 U.S.C. § 2000bb-1(b) (emphasis added). The Mandate, however, is entirely a species of administrative rulemaking by the two federal agency-defendants here. Congress has never mandated that health providers perform, or that employers cover, gender-transition services, and even *Bostock*'s interpretation of Title VII does not go that far. The lack of a governmental interest (much less a compelling one) is even more clear with respect to abortion: Congress has made clear that it does not want Title VII, Title IX, the ACA, or the receipt of federal funds to coerce anyone into paying for or performing an abortion. *See* SAC ¶¶ 114-120.

2. Defendants have numerous less restrictive means of furthering their interests.

Even assuming the Mandate furthered a compelling governmental interest—and it does not—it fails strict scrutiny because there are numerous less restrictive alternatives. Under RFRA, the government must "come forward with evidence" that "it lacks other means of achieving its desired goal without imposing a substantial burden on the exercise of religion." *Sharpe Holdings*, 801 F.3d at 943 (quoting *Hobby Lobby*, 573 U.S. at 728) (internal quotation marks omitted). But numerous alternatives are available here.

If the government wishes to increase access to gender transition services and insurance coverage for those services, "[t]he most straightforward way of doing this would be for the Government to assume the cost of providing the [procedures] at issue to any [individuals] who are unable to obtain them under their health-insurance policies due to their employers' religious objections." *Hobby Lobby*, 573 U.S. at 728. For example, "the government could provide subsidies, reimbursements, tax credits, or tax deductions to employees" or "the government could pay for the distribution of [services] at community health centers, public clinics, and hospitals with income-based support." *Sharpe Holdings*, 801 F.3d at 945. Here, as in *Hobby Lobby* and *Sharpe Holdings*, "the government has not shown that these alternatives are infeasible." *Id.*

The government could also set up an alternative system for provision of benefits. Indeed, HHS did so when it required insurance plans on its own exchanges to offer gender-transition coverage. 81 Fed. Reg. at 31,428. The government need not coerce religious charities when it can use its own marketplaces to ensure this type of care to those who wish to obtain it. *See Sharpe Holdings*, 801 F.3d at 945 (government could not satisfy strict scrutiny because healthcare exchanges remained "viable" alternative for ensuring contraceptive coverage).

"The government could also assist transgender individuals in finding and paying for transition procedures available from the growing number of healthcare providers who offer and specialize in those services." *Franciscan Alliance*, 227 F. Supp. 3d at 693. Many doctors and hospitals provide medical transition services; in fact, many hospitals have established centers specializing in transgender procedures. *See, e.g.*, Trans Health, *Trans Health Clinics*, http://www.trans-health.com/clinics/ (last updated Feb. 14, 2018) (listing "health clinics that specialize in trans health care"). If the government wants to increase access to gender transition services—and get better care for people who want them—the government could partner with willing professionals to increase access. It could train health care navigators to assist individuals in finding such services, just as it does with assisting individuals to find plans on the exchanges. Such options not only would increase access to health care for transgender individuals; they also would focus on doctors that specialize in transgender issues rather than conscripting unwilling doctors without necessary expertise.

"If a less restrictive means is available for the Government to achieve its goals, the Government must use it." *Holt v. Hobbs*, 574 U.S. 352, 365 (2015) (alteration and quotation omitted). Exempting the CBA and its members from the Mandate would not frustrate Defendants' interests or prevent them from pursuing the numerous, less restrictive avenues for achieving their

interests. For all these reasons, CBA members are entitled to an exemption, grounded in RFRA, from the Mandate and from any interpretation of federal law, now or in the future, that requires members to provide or cover gender-transition and abortion services in violation of their sincerely held religious beliefs.

D. Declaratory and injunctive relief are warranted.

Having established their entitlement to a RFRA-based exemption, and with HHS having conceded the merits of Plaintiffs' RFRA claims, Plaintiffs are entitled to summary judgment on those claims. In addition, Plaintiffs request declaratory relief and permanent injunctive relief from the present Mandate and any future iterations thereof. RFRA authorizes a court to enter "appropriate relief against a government." 42 U.S.C. § 2000bb-1(c). Declaratory and injunctive relief are the ordinary remedies for violations of RFRA, and both forms of relief are necessary here. *See Christian Employers Alliance*, 2019 WL 2130142, at *5 ("Upon careful consideration of the entire record and particularly the Defendants' concession on the merits of Plaintiffs' RFRA claim, the Court finds that a permanent injunction under Rule 65(d) and declaratory relief under 28 U.S.C. § 2201 are warranted.").

Declaratory relief may be issued in order to "clarify the relations between the parties and eliminate the legal uncertainties that gave rise to this litigation." *Levin v. Harleston*, 966 F.2d 85, 90 (2d Cir. 1992); *see also* 13C Wright, Miller & Cooper, *Federal Prac. & Proc. Juris.* § 3533.5 (3d ed.). A request for a permanent injunction is measured against a four-part test, and Plaintiffs must show (1) they have succeeded on the merits; (2) they will suffer irreparable injury; (3) the threatened injury outweighs any harm Defendants will suffer; and (4) the requested relief is in the public interest. *See Bank One, Utah v. Guttau*, 190 F.3d 844, 847 (8th Cir. 1999) ("The standard for granting a permanent injunction is essentially the same as for a preliminary injunction, except

that to obtain a permanent injunction the movant must attain success on the merits." (citing *Dataphase Sys., Inc. v. C.L. Sys., Inc.*, 640 F.2d 109 (8th Cir. 1981) (en banc))).

In 2019, this Court granted permanent declaratory and injunctive relief to religious plaintiffs in a similar RFRA challenge. In *Christian Employers Alliance*, a member organization of religious employers requested such relief against HHS's abortifacient mandate. 2019 WL 2130142, at *1. The legal circumstances there were remarkably similar: **(1)** HHS (along with two other federal agencies) had imposed a burdensome healthcare mandate on religious employers, resulting in a raft of RFRA litigation. *See id.* (citing *Sharpe Holdings*, 801 F.3d 927). **(2)** HHS later issued a Final Rule revising its mandate to fully exempt religious employers. *See id.* **(3)** Although the Final Rule should have relieved the burden and resolved the RFRA litigation, before it became operative, two district courts enjoined it as contrary to the APA and ordered HHS to "maintai[n] the status quo that preceded the Final Rul[e]." *California v. U.S. Dep't of Health & Human Servs.*, 351 F. Supp. 3d 1267, 1298 (N.D. Cal. 2019); *see also Pennsylvania v. Trump*, 351 F. Supp. 3d 791, 829 (E.D. Pa. 2019). **(4)** In this Court, the Christian Employers Alliance sought a RFRA-based exemption to the abortifacient mandate and requested permanent declaratory and injunctive relief for its present and future members; the government conceded the merits of the RFRA claim; and this Court granted such relief. *See Christian Employers Alliance*, 2019 WL 2130142, at *2, *5-6.

CBA members have the same need for relief from the Mandate at issue in this case, a Mandate that, pursuant to recent injunctions, remains in effect and continues to burden the religious practices of the CBA and its members.

1. The CBA and its members are entitled to a permanent injunction.

The CBA and its members are entitled to a permanent injunction because they have established the merits of their RFRA claim. Regardless of how Section 1557, Title IX, and Title

VII are ultimately interpreted by Defendants, RFRA entitles CBA members to adhere to their religious convictions in providing health services and covering health benefits. HHS concedes this. In regard to the other factors, it is well-established that "a likely RFRA violation satisfies the irreparable harm factor." *Archdiocese of St. Louis v. Burwell*, 28 F. Supp. 3d 944, 958 (E.D. Mo. 2014) (quoting *Hobby Lobby Stores, Inc. v. Sebelius*, 723 F.3d 1114, 1146 (10th Cir. 2013)). The balance of harms also clearly favors Plaintiffs, given the Mandate's significant financial consequences. *See id*. (citing *Hobby Lobby*, 723 F.3d at 1147). Finally, "it is always in the public interest to prevent the violation of a party's constitutional rights." *Smith v. South Dakota*, 781 F. Supp. 2d 879, 888 (D.S.D. 2011) (quoting *G & V Lounge, Inc. v. Mich. Liquor Control Comm'n*, 23 F.3d 1071, 1079 (6th Cir. 1994)); *see also Hobby Lobby*, 723 F.3d at 1147 (same).

2. The CBA and its members need protection from the Mandate.

Although HHS may have hoped that its 2020 Rule would resolve this case and other pending litigation against the Mandate, things have not worked out that way. Several states and allied groups have filed at least four lawsuits seeking to overturn the 2020 Rule and specifically attacking HHS's attempt to accommodate religious exercise. Two district courts have issued injunctions against the 2020 Rule, prohibiting HHS from repealing the 2016 Rule and ordering the Mandate to "remain in effect." And the EEOC has never backed off its own religiously burdensome interpretation of Title VII. This is essentially the same legal state of affairs that persuaded this Court, in the *Christian Employers Alliance* case, to grant declaratory relief and a permanent injunction.

Such relief should extend to both present and future members of the CBA. Although the government has previously opposed extending relief to future members in cases like this, this Court in *Christian Employers Alliance* found "little rational for limiting the injunction to current members" since it would "result in an endless cycle of litigation as new members and the Alliance

seek to protect their rights." 2019 WL 2130142, at *4. The Court's injunction in that case thus applied to current and future members, so long as (1) the member was not yet protected from the mandate by any other judicial order; (2) the member met the Alliance's strict membership criteria, (3) those membership criteria had not changed, and (4) the member was not subject to an adverse ruling on the merits in another case involving the mandate. *See id.* at *6-7; *see also Catholic Benefits Ass'n v. Hargan*, No. CIV-14-240-R, ECF No. 184, at 2 (W.D. Okla. March 7, 2018) (permanent injunction against contraceptive mandate based on same criteria for present and future CBA members); *Reaching Souls Int'l, Inc. v. Azar*, 2018 WL 1352186, at *2 (W.D. Okla. Mar. 15, 2018) (permanent injunction against abortifacient mandate for "all current and future participating employers in the GuideStone Plan"). The same reasoning applies here, and Plaintiffs' accompanying Motion requests injunctive relief based on these same criteria.

Relief also should extend to CBA members' health plans and to insurers and TPAs that insure or offer services in connection with CBA members' health plans. Such relief will ensure that members' insurers and TPAs may lawfully offer coverage and services in connection with health plans that exclude coverage of gender-transition and abortion services. *See Christian Employers Alliance*, 2019 WL 2130142, at *6 (enjoining government from enforcing abortifacient mandate "against the Alliance and its members, their health plans, and their insurers and third-party administrators in connection with Alliance member health plans").

As more fully set out in the accompanying Motion, Plaintiffs generally request two forms of relief. First, Plaintiffs request, on behalf of all present and future CBA members, a permanent injunction barring Defendants from enforcing the Mandate or any interpretation of federal law, whether arising under Section 1557, Title IX, Title VII, or otherwise, that coerces CBA members to provide, perform, or cover health services related to gender transitions and abortions in violation

of their sincerely held religious beliefs. Plaintiffs also request that Defendants be prohibited from interfering with the CBA members' efforts to contract with insurers and TPAs for morally compliant health coverage and benefits administration. Second, Plaintiffs request a declaratory judgment that the Mandate and any similar interpretation of federal law, now or in the future, may not lawfully be applied to the CBA and its present and future members, and that such members have a right, pursuant to RFRA, to refuse to provide, perform, or cover health services related to gender transitions and abortions.[9]

IV. CONCLUSION

For the foregoing reasons, Plaintiffs, and the CBA on behalf of its members, respectfully request that the Court enter summary judgment on their RFRA claims (Counts XI and XII) and issue a permanent injunction and declaratory relief against the Mandate. Plaintiffs also respectfully request oral argument on their Motion.

[9] Plaintiffs Religious Sisters of Mercy et al. in Case No. 16-cv-00386 request a permanent injunction against the Mandate and, in the alternative, a preliminary injunction no later than January 20, 2021, the date on which a new presidential administration can begin imposing financial penalties. Plaintiffs here, on behalf of all CBA members, make the same request in the alternative. Although Plaintiffs are entitled to summary judgment and although a permanent injunction is appropriate where, as here, "nothing remains for the district court to resolve regarding the underlying facts" and the parties "disagree only on questions of law," *Bank One*, 190 F.3d at 847; *see Christian Employers Alliance*, 2019 WL 2130142, at *5 (denying as moot motion for preliminary injunction and entering declaratory and permanent injunctive relief), nevertheless, should the Court not be in a position to grant a permanent injunction at this stage, the Court should issue a preliminary injunction before January 20, 2021, enjoining HHS and the EEOC from enforcing the Mandate (whether under Section 1557, Title IX, Title VII, or otherwise) against CBA members for the pendency of this litigation.

Respectfully submitted November 23, 2020,

s/ *Ian Speir*

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CERTIFICATE OF SERVICE

I hereby certify that on November 23, 2020, I electronically filed a copy of the foregoing. Notice of this filing will be sent via email to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's CM/ECF System.

s/ *Ian Speir*
Ian Speir