DECLARATION OF DANA CARAWAY

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

MAXWELL KADEL, *et al.*,

Plaintiffs,

v.

DALE FOLWELL, in his official capacity as State Treasurer of North Carolina, *et al.*,

Defendants.

No. 1:19-cv-00272-LCB-LPA

DECLARATION OF DANA CARAWAY

Pursuant to 28 U.S.C.§ 1746, I hereby declare as follows:

1. I am a plaintiff in the above-captioned action. I have actual knowledge of the matters stated in this declaration.

2. I am a native of Morganton, North Carolina. I have worked for the State of North Carolina as a corrections officer for twenty-seven years.

3. I am transgender, and I am being denied equal access to healthcare coverage under the North Carolina State Health Plan for Teachers and State Employees ("NCSHP") because it contains an exclusion for coverage of gender-confirming care.

4. I have brought suit to end the State's discrimination and to seek compensation for the harm I have suffered. I submit this declaration in support of summary judgment.

Career

5. I have worked as a corrections officer since 1994. For that whole time, my employer has been the Department of Public Safety, although it was still called the Department of Corrections when I started. I was hired at the rank of correction officer, and I was promoted in 2006 to the rank of Sergeant.

6. I currently hold the position of supervisor in the Division of Adult Correction and Juvenile Justice at Foothills Correctional Institution in Morganton. I supervise up to fifteen corrections officers to ensure that they are following laws and policies regarding inmate custody, housing, programming, medical care, and discipline.

7. For the past two years, I have also worked part-time as a salesperson at Torrid, a women's clothing boutique in Hickory. This part-time job does not afford me access to health insurance.

My Gender Transition

8. I am a transgender woman. Although I was assigned the sex of male at birth based on external physical sex characteristics, I am female.

9. I have known I am female since even before I knew how to describe that feeling. By the time I was around four or five, I was already wearing my mother's and my girl friends' clothes, but I had to stop when I got caught and was punished multiple times for wearing clothes not consistent my sex assigned at birth. But I would still dream. As far back as I can remember dreaming, I would dream about having a female body, and about not being punished for wearing the "wrong" clothes.

10. As I grew older, my desperation deepened, knowing that I was born into the wrong body, not the body I should have, and that society would punish me for this feeling

this way, or for doing anything about it. So I mostly kept my feelings to myself. I would occasionally dress as a woman alone in my home. But I was ashamed and scared, and I for a long time I didn't even talk to my family about how I felt.

11. Knowing that I was in the wrong body caused me great distress and mental anguish. Not being able to do anything about it just made it worse. I was so uncomfortable with who I was physically that I became a recluse and wouldn't let other people in to my life. I gained a lot of weight, I had relationship problems and sleeplessness. I didn't see anyone outside my home other than wife and kids. Everything was centered around having to hide the fact that I was female and born in the wrong body.

12. Around 2014 I couldn't take being along with these feelings anymore. I started to talk about them with my wife, and I started to dress as a woman outside my home occasionally.

13. In 2017 I started reaching out over the internet to members of the LGBTQ community for support. We talked about gender dysphoria, and about organizations that supported LGBTQ people in Western North Carolina, and about seeking healthcare.

14. By mid-2018, I had decided to stop living as the wrong gender and in the wrong body, relieve my distress, and be more in line with my true self. I had decided I would begin the process of transition. I found a therapist who could help me figure out what was going on, and a medical practice that would be provide me proper treatment if it was deemed necessary. I wanted to be sure my health insurance would cover any medical care I needed. The 2018 NCSHP plan booklet hadn't come out yet, so I looked in

the 2017 plan booklet, and I was relieved to see that transgender healthcare was not excluded.

15. I also came out at work in 2018. My colleagues have been abusive. When I had to take a brief medical leave in early 2019 due to a kidney issue, I had a breakdown and was unable to return to work due to the situational anxiety caused by my coworkers' hostility—and because, as it turned out, NCSHP refused to cover the healthcare I needed. I was forced to stay out of work for several additional weeks until my condition stabilized. I have filed an EEOC charge, separately from this lawsuit, against the Department of Public Safety about my hostile work environment.

NCSHP

16. I am required by the Department of Public Safety to have health insurance and have been a member of NCSHP since I joined the Department of Corrections.

17. I am enrolled in NCSHP's 80/20 plan. I pay a $50 per month premium for it, which is deducted from my paychecks. As far as I know, this is the same as what other State employees pay. For example, my spouse, who is also a State employee, pays the same.

18. The NCSHP covers most of my healthcare. However, on January 1, 2018, the exclusion for transgender care was reinstated. This means that surgery for things like my kidney condition has been covered, but the gender-confirming surgeries I need are not.

Being Denied Healthcare Coverage

19. My therapist diagnosed me with gender dysphoria in mid-2018. I began

regular mental health therapy, and I still go regularly.

20. Also in mid-2018, I began hormone replacement therapy. At my first visit to Planned Parenthood, I discussed hormone replacement therapy options, but they did not prescribe hormone replacement therapy for me right away. They eased me into it gradually during subsequent visits over several months, adding and adjusting medications as appropriate to treat my gender dysphoria. I still need to take these medications now, in order to maintain alignment between my body and my gender, and also because my body no longer produces sex hormones, and so I still go to Planned Parenthood regularly for them to adjust my medications.

21. I had problems getting health insurance coverage for this care. Around October of 2018, I went back to the NCSHP plan booklet to confirm that my healthcare should be covered. But this time, I couldn't find anything comparable to what I had seen in the information from the year before. Instead of saying transgender health services were covered, the 2018 plan booklet said they were excluded.

22. So I googled things, and I saw the news that the exclusion had been reinstated. This was immensely upsetting, emotionally, physically, and mentally. I felt hated and treated as a second-class person, not as an equal, by the State.

23. I also discussed the possibility of gender confirming surgery with my therapist, and later also with a psychologist. My therapist recommended gender-confirming surgery because it would help alleviate gender dysphoria. So did my psychologist, who also sent a letter to my surgeon recommending surgery. I selected a surgeon for top and bottom surgery, met with her, discussed the risks and benefits of the

surgery, and set a surgery date for November of 2019.

24. However, by this time, I knew that the NCSHP had an exclusion in it, and I couldn't afford to pay for the surgery then. So I had to postpone it. This was devastating. But I wasn't going to let it stop me. I started withdrawing funds out of my retirement account. I began making payments to my surgeon. By the summer of 2020, I had fully paid for the surgery. At that point, my surgeon submitted another preauthorization request, even though we both expected it would be denied, because we both hoped I might recoup at least something. But the preauthorization request was denied completely. The denial letter from NCSHP states that only reason for the denial is the exclusion. A true and correct copy of the letter, with redactions applied, is attached as Exhibit A. On August 5, 2020, I was finally able to obtain top and bottom surgery.

25. Including the surgeon's fee, the hospital fee, the anesthesiologist fee, and the hair removal I was required to have for the surgery, has cost me over $27,000. I even had to pay for an Airbnb to stay near the hospital, because I couldn't afford the cost of staying in-hospital during my recovery.

26. I also have an appointment for vocal feminization surgery, on November 18, 2021. My surgeon for that procedure has recommended the surgery because it would alleviate my dysphoria with my voice. He has also recommended therapy to help change my voice, which I started doing earlier this year. Because NCSHP excludes coverage of vocal therapy or surgery for treatment of gender dysphoria, I have had to pay about $11,000 out of pocket for these items.

27. I would like to make an appointment for facial feminization surgery as well,

because it would alleviate my gender dysphoria by taking away or improve the masculine portions of my appearance and bring my face more in line with my gender identity. However, I cannot make the appointment because I have not yet saved up enough money to make an appointment for that. I believe this would be covered if BCBSNC eliminated its exclusion, because it is covered under Blue Cross Blue Shield of North Carolina's Corporate Medical Policy, and so if the exclusion were removed I could stop waiting and obtain the care I need.

28. I have even had trouble getting coverage for my hormone replacement therapy under the NCSHP. The NCSHP has sometimes covered my hormone medications and visits to Planned Parenthood, and sometimes it has not. I don't understand why. For example, when I first started my visits with Planned Parenthood, NCSHP did not cover them. After my first four visits, it began covering them, but sometimes in full and sometimes only partially. Also, the NCSHP has sometimes paid for my hormones, and sometimes hasn't. Currently, it is refusing to cover the estrogen pellets that I have to have inserted a few times a year. This is confusing me to me because I have male co-workers whose hormone pellets are covered under NCSHP.

29. The transgender care that I have been able to obtain thus far, mostly by paying for it myself, has helped, up to a point.

30. But I still feel a lot of distress, anxiety, stress and sleeplessness due to having to stay in a body that still feels in important ways like it isn't mine. I still need to take medications to manage anxiety and sleeplessness. I expect I will feel this way until my medical care is completed. My providers still notice this as well, and my providers

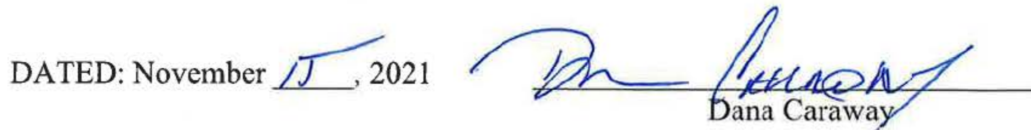
agree that feminizing my face and voice would be an improvement for me socially, mentally, physically. The reason I stayed in this body for longer than I needed to, and the reason I still haven't completed my surgical care, is that NCSHP has forced me to by denying coverage for my medically necessary care.

31. Also, without facial feminization surgery, and without feminizing my voice, I continue to suffer discrimination based on my appearance. People see me as transgender. I've been denied service in restaurants. I feel more vulnerable to hate crimes. On June 20, 2021, I was assaulted on duty at work by an inmate, who called me a transgender-related derogatory name and struck me.

32. I also still feel a lot of heartache and hurt because of the exclusion. It makes me feel like I'm being treated like a nobody. This contributes to my sleeplessness, anxiety, and distress.

33. I do believe that with the completion of the rest of my gender confirming surgeries, along with the ones that I have already undertaken, that I will be a complete person. I do believe that if the exclusion is removed that I will feel like a person who deserves equality and respect from co-workers and the community, and not the second-class citizen I have been treated as.

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



DATED: November 15, 2021

Dana Caraway

SUBSCRIBED AND SWORN TO BEFORE ME THIS

15 DAY OF November, 20 21

COURTLAND BUTTS, III
NOTARY PUBLIC
ALAMANCE COUNTY, NC
My Commission Expires: 1/30/2024

CERTIFICATE OF SERVICE

I certify that the foregoing document was filed electronically with the Clerk of Court using the CM/ECF system which will send notification of such filing to all registered users.

Dated: November 30, 2021

/s/ Amy E. Richardson
Amy E. Richardson
N.C. State Bar No. 28768
HARRIS, WILTSHIRE & GRANNIS LLP
1033 Wade Avenue, Suite 100
Raleigh, NC 27605-1155
Telephone: 919-429-7386
Facsimile: 202-730-1301
arichardson@hwglaw.com

Counsel for Plaintiffs

Exhibit A

North Carolina State Health Plan FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

BlueCross BlueShield of North Carolina
Healthcare Management and Operations
P.O. Box 2291
Durham, NC 27702

Telephone Number: 800-672-7897
Fax Number: 800-672-6587
Website: WWW.BCBSNC.COM

[redacted] CARAWAY
[redacted]
MORGANTON NC [redacted]

Date of Notice: June 19, 2020

This document contains important information that you should retain for your records.

This document serves as notice of an adverse benefit determination. We have declined to provide benefits, in whole or in part, for the requested treatment or service described below. If you think this determination was made in error, you have the right to appeal (see the enclosures to this letter for information about your appeal rights.)

Case Details:

Member/Patient Name: [redacted] CARAWAY
ID Number: [redacted]

Provider: [redacted], MD
Facility: [redacted]
Service: Surgical Stay
Date(s) of Service: 8/5/2020 - 8/6/2020
Service: INTERSEX SURGERY; MALE TO FEMALE
Date(s) of Service: 8/5/2020 - 8/6/2020
Service: MAMMAPLASTY, AUGMENTATION; WITH PROSTHETIC IMPLANT
Date(s) of Service: 8/5/2020 - 8/6/2020

Reference #: 114690052

Reason for Denial: The requested service is not a covered benefit per your benefit booklet or plan documents.

Explanation of Basis for Determination:

"The following is not a covered benefit " see page 53 of 2020 SHP BB: Treatment or studies leading to or in connection with sex changes or modifications and related care.

Sincerely,

Healthcare Management and Operations

cc: [redacted], MD
cc: [redacted]

I

Important Information about Your Appeal Rights

This notice is an "adverse benefit determination." This means that a request for a procedure or services made by you or your doctor has not been approved for coverage. Please read this information, and call our customer service department if you have any questions about this notice.

What if I don't agree with this decision? You may ask for an appeal. You must ask for an appeal within 180 days of the date of this letter. If you need help in filing an appeal, please call 1-888-234-2416.

What is an appeal? An appeal is another review of your case. A staff member who works in a separate department from the staff members who denied your first request will look at your appeal. The appeals staff members have not reviewed your case or information before. These reviews can take up to 30 calendar days. You will get a letter of the decision of your appeal by the end of the 30-day timeframe. The decision may be to agree with the first adverse benefit determination, or to disagree with the first adverse benefit determination and allow your request to be covered. If the decision is to agree with the first adverse benefit determination, you may have more appeal rights. The appeal decision letter will tell you about these rights.

Who can ask for an appeal? Only you have the right to ask for an appeal. You can also give permission for someone else to ask for the appeal for you. BCBSNC must have a signed release form from you on record so that person can act for you. You can get the release form by calling Customer Service or on the internet at www.shpnc.org and searching for "important forms."

How do I file an appeal? Appeals must be in writing. You can send a letter for an appeal request or fill out a member appeal form. You can get these forms by calling Customer Service or on the internet at www.shpnc.org and searching for "important forms." You have the right to give us any information or materials that support your request. You should fax or mail the letter, appeal form, and any other clinical information to:

Blue Cross and Blue Shield of North Carolina
Appeals Department Level I
PO Box 30055
Durham, NC 27702
Fax: 1-919-765-2322

What happens next for an appeal? When the BCBSNC Appeals Department has received your appeal request, they will mail you a letter within three business days. This letter will give your next steps for the appeals process.

How do I learn more about this decision? You may ask for information about your case at no cost to you. This could include:

- copies of all records about your case;
- copies of the rules, medical policies, or any other clinical guidelines used to make this decision. The specific rule, policy, or guideline used for your decision is included on the first page under "Explanation of Basis of Determination."

You can ask for this information by writing to us at the address below. Please include your medical policy ID number on your BCBSNC ID card with your request.

Blue Cross and Blue Shield of North Carolina
Care Management & Operations
PO Box 2291
Durham, NC 27702

What if I need more help? The Health Insurance Smart NC Program through the NCDOI is able to help you with questions about health insurance. Health Insurance Smart NC also gives consumer counseling on utilization review and appeals issues. You may contact Health Insurance Smart NC at:

By Mail:
North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
Toll Free Telephone: (855) 408-1212
http://www.ncdoi.com/smart

In Person:
For the physical address for Health Insurance Smart NC, please visit the web-page:
http://www.ncdoi.com/smart
Toll Free Telephone: (855) 408-1212

Non-Discrimination and Accessibility Notice

Discrimination is Against the Law

- Blue Cross and Blue Shield of North Carolina ("BCBSNC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
- BCBSNC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

  BCBSNC:
  - Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
  - Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages
- If you need these services, contact Customer Service **1-888-234-2416**, TTY and TDD, call **1-800-442-7028**.
- If you believe that BCBSNC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
  - BCBSNC, PO Box 2291, Durham, NC 27702, Attention: Civil Rights Coordinator- Privacy, Ethics & Corporate Policy Office, Telephone **919-765-1663**, Fax **919-287-5613**, TTY **1-888-291-1783** civilrightscoordinator@bcbsnc.com
- You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator - Privacy, Ethics & Corporate Policy Office is available to help you.
- You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 **1-800-368-1019, 800-537-7697** (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.
- This Notice and/or attachments may have important information about your application or coverage through BCBSNC. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call Customer Service **1-888-234-2416**.

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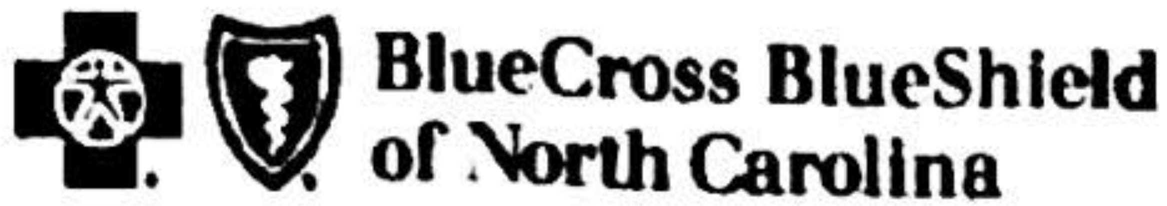
v. 10/16



ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-234-2416 (TTY: 1-800-442-7028).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-234-2416 (TTY: 1-800-442-7028).

注意：如果您講廣東話或普通話，您可以免費獲得語言援助服務。請致電 1-888-234-2416 (TTY：1-800-442-7028)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-234-2416 (TTY: 1-800-442-7028).

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LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-234-2416 (TTY: 1-800-442-7028).

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PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-234-2416 (TTY: 1-800-442-7028).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:સુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-234-2416 (TTY: 1-800-442-7028).

ចំណាំ៖ ប្រសិនបើលោកអ្នកនិយាយជាភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាមានផ្ដល់ជូនសម្រាប់លោកអ្នកដោយមិនគិតថ្លៃ។ សូមទំនាក់ទំនងតាមរយៈលេខ៖ 1-888-234-2416 (TTY: 1-800-442-7028)។

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-234-2416 (TTY: 1-800-442-7028).

ध्यान दें: यदि आप हिन्दी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-234-2416 (TTY: 1-800-442-7028) पर कॉल करें।

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-234-2416 (TTY: 1-800-442-7028).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-234-2416（TTY: 1-800-442-7028）まで、お電話にてご連絡ください。

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v. 10/16

**IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA**

MAXWELL KADEL, et al.,	)	
Plaintiffs,	)	
v.	)	No. 1:19-cv-272-LCB-LPA
DALE FOLWELL, et al.,	)	
Defendants.	)	

PLAN DEFENDANTS' RESPONSE IN OPPOSITION TO MOTION FOR LEAVE TO FILE BRIEF OF *AMICI CURIAE* BY AMERICAN MEDICAL ASSOCIATION AND SEVEN ADDITIONAL HEALTH CARE ORGANIZATIONS IN SUPPORT OF PLAINTIFFS

Pursuant to Local Rule 7.5(b), Defendants, the North Carolina State Health Plan for Teachers and State Employees, Dale Folwell, and Dee Jones (the "Plan Defendants"), by and through undersigned counsel, respond in opposition to the Motion for Leave to File Brief of *Amici Curiae* in Support of Plaintiffs submitted by eight medical associations.

INTRODUCTION

The Court should acknowledge the proposed *amicus* brief for what it is: an anonymous, unsworn expert report, and it should deny the motion for leave to file. The proposed *amicus* brief does not cite a single judicial decision, legal brief, or law review article. Instead, the *amici* seek to provide medical information, (Doc. No. 131 at p.7), much of which is nowhere else in the record.

Approximately 50% of the medical articles cited in the proposed *amicus* brief (24 of 46) are not in any of the reports by Plaintiffs' experts. Because of this, the proposed *amicus* creates the risk that the Court will reach conclusions using unsolicited "evidence" that none of the parties, nor the parties' experts, have identified as a legitimate basis for summary judgment.

Moreover, the proposed *amici* do not offer or meet any of the three possible justifications for their participation at the trial court. *See Bryant v. Better Business Bureau,* 923 F. Supp. 720, 727 (D. Md.1996). The proposed brief does not aid the court's legal analysis. The proposed brief is not needed to help struggling counsel. Finally, the stated interest of *amici*—a "commitment to improving the physical and mental health of all Americans"—does not qualify as the type of special interest required by the courts to justify *amicus* participation at the district court level. This Court should thus deny the request to file the proposed *amicus* brief.

I. Granting *Amici*'s Motion will Prejudice the Defendants.

Rule 26(a) requires that, during the discovery period, all parties must disclose all expert witnesses and submit a report with a "complete statement of all opinions ... and the reason and basis for them." Fed. R. Civ. P. 26(a)(2)(B)(i). Moreover, expert testimony must comply with this Court's case management orders. The Court required disclosure of Plaintiffs' experts by March 1, 2021, the Plan Defendants' experts by May 1, 2021, and Plaintiffs'

rebuttal experts by June 11, 2021. *See* Text Order adopting Parties' Rule 26(f) Report, (Doc. No. 61, August 13, 2020); Order granting Motion for Extension of Time, (Doc. No. 90, Mar. 25, 2021); Order granting Motion for Extension of Time, (Doc. No. 101, May 12, 2021). With two limited exceptions, all expert depositions needed to be complete by September 30, 2021. (Doc. No. 98, May 11, 2021).

The proposed *amicus* brief complies with none of these requirements, even though it directly addresses a factual disagreement between the parties. The Plaintiffs assert that the gender transition treatments they desire are medically necessary, and the Plan Defendants' experts have testified that the current peer-reviewed science indicates that these treatments remain experimental.

As one example, Dr. Stephen Levine, M.D., wrote in his expert declaration for the Plan Defendants that "[w]ithin the last two years, detailed research reviews exposing multiple and serious methodological and ethical flaws in the research of … affirmation supporters have pinpointed fundamental methodological errors in their papers which claim to support affirmation treatment." Declaration of Stephen B. Levine at 10 (April 29. 2021). Dr. Levine will testify that the treatments Plaintiffs seek "remain experimental and have never been accepted by the relevant scientific community and have no known nor published error rate." *Id.* at 10-11.

Now, long after discovery has closed, the proposed *amici* seek to provide their views on the "best practices when treating transgender individuals for gender dysphoria and providing gender-confirming care." (Doc. 131 at p.6). The proposed *amicus* brief discusses the diagnosis of Gender Dysphoria, "What it means to be transgender," (Doc. 131-2, Proposed *amicus* brief at p.4), "Accepted treatment protocols for Gender Dysphoria," *id.* at p.11, and *amici*'s views on treatment outcomes for this illness, *id.* at p.17. The Motion for Leave asserts that the brief reflects "agreed upon best practices" in transgender health. (Doc. No. 131 at p.6).

The *amici* offer this information even though the *amicus* brief lacks the signature, or even the name, of a single individual with a medical degree who has reviewed or approved its contents. *See* Fed. R. Civ. P. 26(a)(2) (requirements for expert witnesses).

Were the proposed *amicus* brief offered by a party, its timing and contents would be the type of procedural unfairness that "unfairly inhibits" the other party's "ability to properly prepare" for trial. *Garey v. James S. Farrin, P.C.*, 514 F. Supp. 3d 784, 788 (M.D.N.C. 2021). "Conclusory expert reports, eleventh hour disclosures, and attempts to proffer expert testimony without compliance with Rule 26 violate both the rules and principles of discovery, and the obligations lawyers have to the court." *White v. City of Greensboro*, 532 F. Supp. 3d 277, 300 (M.D.N.C. 2021) (quoting *Tokai Corp. v. Easton Enters., Inc.*,

632 F.3d 1358, 1365-66 (Fed. Cir. 2011)). "Exclusion and forfeiture are appropriate consequences to avoid repeated occurrences of such manipulation of the litigation process." *Id.*[1]

There is no rule or other authority that allows an *amicus* to offer such expert testimony when the opposing party does not do so. Indeed, at least one court has made clear that "an *amicus* who argues facts should rarely be welcomed." *Strasser v. Doorley,* 432 F.2d 567, 569 (1st Cir.1970).

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[1] Were the Plaintiffs themselves to seek to introduce the information from the proposed *amicus* brief—something they arguably desire considering their citation to the *amicus* brief in their own motion for summary judgment—they would have to show their failure to disclose this information during discovery "was substantially justified or is harmless." *Id.* (quoting Fed. R. Civ. P. 37(c)(1)). *See* Doc No. 179 at p.21 (citing "the *amicus* brief filed by many of those organizations in this case" as evidence for this Court's consideration).

The Fourth Circuit analyzes out-of-time expert material under a five-part test. The Court must consider (1) the surprise to the party against whom the evidence would be offered; (2) the ability of that party to cure the surprise; (3) the extent to which allowing the evidence would disrupt the trial; (4) the importance of the evidence; and (5) the non-disclosing party's explanation for its failure to disclose the evidence. *S. States Rack & Fixture, Inc. v. Sherwin-Williams Co.*, 318 F.3d 592, 597 (4th Cir. 2003).

The first four factors relate primarily to the harmlessness exception, while the final factor tests whether the initial exclusion of information was substantially justified. *Id.* The information in the proposed *amicus* was presented to the Plan Defendants the same day properly filed summary judgment motions were due, November 30, 2021. (Doc. No. 131, 131-2). Moreover, the information cannot simultaneously "assist the Court in its deliberations," (Doc. No. 131 at p.7), and be harmless to the interests of the other parties in the litigation. The proper remedy would be to strike the proposed expert testimony, and that should be the Court's ruling here.

Beyond the procedural unfairness, the proposed *amicus* brief creates the potential for reversible error. When a Court reviews motions for summary judgment, the record includes only that information that could be considered at trial. *See* Fed. R. Civ. P. 56. A Court cannot rely upon "factual assertions supported only by a citation to an unsworn expert report" as such information is "hearsay and do[es] not qualify as admissible evidence." *Penobscot Nation v. Mills*, 151 F. Supp. 3d 181, 185 (D. Me. 2015).

The proposed *amicus* brief is precisely this—inadmissible "factual assertions supported only by a citation to an unsworn expert report." *Id.* The brief is not signed by a medical expert or anyone else qualified to provide expert testimony. The brief is not a sworn declaration. More than 50% of the citations in the proposed brief (24 of 46) are new; they do not appear in any reports submitted by either the Plaintiffs' initial or rebuttal experts. Nevertheless, the *amici* ask that this Court take "the information contained in their proposed brief" into "its deliberations" on summary judgment. (Doc. No. 131 at p.7).

The risk should be clear. If the Court does not intend to rely upon the information in the proposed *amicus* brief, then it should deny the Motion for Leave and exclude the information entirely. If the Court does rely on the information in the proposed brief, then its decision will include extra-record evidence that neither party put before the Court and that lacks the "[v]igorous cross-examination, presentation of contrary evidence, and careful instruction

on the burden of proof" that expert opinion requires. *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579, 596 (1993).

The Court should not risk poisoning the factual record with "unsworn expert testimony" on summary judgment. *See*, *e.g.*, *New York v. Microsoft*, No. CIV.A. 98-1233 CKK, 2002 WL 31628215 at *1 (D.D.C. Nov. 14, 2002). The Motion for Leave should be denied on this basis alone.

II. The Proposed *Amici* must justify their *amicus* participation and have wholly failed to do so.

In addition, the Motion for Leave ignores the requirements for *amicus* participation that are regularly applied by trial courts in the Fourth Circuit. No Federal Rule of Civil Procedure governs *amicus curiae* before a federal district court. *City of Columbus v. Trump*, 453 F. Supp. 3d 770, 785 (D. Md. 2020). The Middle District's local rules provide a process but no substantive standard. Local Rule 7.5. "Whether to permit a nonparty to submit a brief, as *amicus curiae*, is, with immaterial exceptions, a matter of judicial grace." *Nat'l Org. for Women v. Scheidler*, 223 F.3d 615, 616 (7th Cir. 2000).

Although the Court has discretion, Judge Davis—when serving as a U.S. District Court Judge before joining the Fourth Circuit—summarized the usual analysis for an *amicus* request as follows: *Amici* are "allowed at the trial level where [1] they provide helpful analysis of the law, [2] they have a special interest in the subject matter of the suit, or [3] existing counsel is in need of

assistance." *Bryant v. Better Business Bureau,* 923 F. Supp. 720, 727 (D. Md. 1996) (internal citations omitted). Even then, "[a] motion for leave to file an *amicus* curiae brief ... should not be granted unless the court 'deems the proffered information timely and useful.'" *Bryant,* 923 F. Supp. at 727–28 (citing *Yip v. Pagano,* 606 F. Supp. 1566, 1568 (D.N.J.1985)). *See also Am. Humanist Ass'n v. Maryland-Nat'l Cap. Park*, 147 F. Supp. 3d 373, 389 (D. Md. 2015) (same analysis).[2]

The proposed *amicus* brief does not fulfill any of the roles identified by Judge Davis. *Amici*'s brief does not "provide helpful analysis of the law" because it contains no legal reasoning whatsoever. Neither are Plaintiffs' fifteen "existing counsel in need of assistance."

While *amici* with a "special interest" in the case are sometimes allowed, courts often require that the proposed *amicus* also demonstrate at least one of the other two criteria. "[A] special interest in the outcome of the suit" alone is not sufficient to justify participation when *amici* does not provide "helpful legal analysis beyond the thorough job done by the parties' counsel." *Am. Humanist*

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[2] District courts elsewhere have suggested that the meaning of the phrase *amicus curiae*—"friend of the court"—implies that an *amicus* should not be "partial to a particular outcome in the case." *James v. Glob. Tel-Link Corp.*, No. 2:13-CV-04989-WJM-MF, 2020 WL 6194016 at *5 (D.N.J. Oct. 22, 2020). District Courts in this circuit have not always demanded neutrality, but this Motion for Leave makes no pretense to it, filed as a Motion "in Support of Plaintiffs." (Doc. 131 at p.1).

Ass'n, 147 F. Supp. 3d at 389. *See also Wheelabrator Baltimore, L.P. v. Mayor & City Council of Baltimore*, 449 F. Supp. 3d 549, 555 n.1 (D. Md. 2020) (While "the Local Government Coalition for Renewable Energy and the Energy Justice Network purport to have a special interest in this litigation," the *amici* "do not provide any legal analysis beyond the arguments raised in the parties' briefs and are not necessary for the Court's determination of the legal issues at hand" and are therefore denied leave to file.).

Even if a "special interest" was sufficient justification alone, the proposed *amici* fail to identify any such special interest. Instead, the proposed *amici* offer only one broad reason for their participation:

> All *amici* share a commitment to improving the physical and mental health of all Americans—regardless of gender identity—and to informing and educating lawmakers, the judiciary, and the public regarding the public-health impacts of laws and policies.

(Doc. No. 131 at p.6). A generic interest in "improving the physical and mental health of all Americans" does not qualify as a "special interest." "When evaluating a potential *amici*'s proffered interest in a case, the court looks to whether its 'interests which would be ultimately and directly affected by the court's ruling on the substantive matter before it." *Dwelling Place Network v. Murphy*, No. CV 20-6281 (RBK/AMD), 2020 WL 3056305 at *1 (D.N.J. June 9, 2020) (quoting *Granillo v. FCA US LLC*, 2018 WL 4676057 at *5 (D.N.J. Sept. 28, 2018)).

A special interest is more than "a trade association with a generalized interest in all cases" related to a specific subject matter. *Sciotto v. Marple Newtown Sch. Dist.*, 70 F. Supp. 2d 553, 555 (E.D. Pa. 1999). Rather, a special interest at the trial level exists when a party, "although short of a right to intervene[,]" has "a special interest that justifies his having a say." *Strasser,* 432 F.2d at 569.

The importance of a "special interest"—rather than a generalized one—has been aptly explained by the First Circuit. "[A] district court lacking joint consent of the parties should go slow in accepting, and even slower in inviting, an *amicus* brief unless, as a party, although short of a right to intervene, the *amicus* has a special interest that justifies his having a say, or unless the court feels that existing counsel may need supplementing assistance." *Id.* at 569. This is true even though, "if an *amicus* causes the district court to make an error of law—an *amicus* who argues facts should rarely be welcomed—the error can be corrected on appeal." *Id.*

This Court should reject and deny the proposed Motion for Leave, (Doc. No. 131), as insufficient to justify the participation of the *amici* at this stage of litigation. The *amici* organizations do not specialize in transgender health. *Id.* at p.1-4). The *amici*'s interest in "informing and educating" decisionmakers, *id.* at p.6, may justify their own decision to submit "*amicus* briefs in similar cases pending throughout the country," but this private interest is not one of

the "special interests that would weigh in favor of granting *amici* status." *Dwelling Place Network,* 2020 WL 3056305 at *1. *See also Havana Docks Corp. v. Royal Caribbean Cruises, Ltd.*, No. 19-CV-23590, 2021 WL 4819580 at *1 (S.D. Fla. Oct. 15, 2021) (trade association "failed to explain how its brief will benefit the Court by offering a new or unique perspective beyond that already presented by the parties"); *Granillo*, 2018 WL 4676057 (2018) (denying *amici* status to a consumer group that regularly filed *amicus* briefs, noting this indicates generalized concern not specific interest).

Lacking any legal analysis, the need to assist Plaintiffs' counsel, or any assertion of a special interest, the Motion for Leave by the proposed *amici* should be denied.

III. Conclusion

The Court should promptly deny the Motion for Leave to File the Proposed *Amicus* Brief, Doc. No. 131. The request is procedurally untimely, unsupported by evidence that can be considered under Rule 56, and prejudicial to the Plan Defendants. In the face of these concerns, the proposed *amici* have neither analyzed their request under the generally accepted test used by trial courts in the Fourth Circuit nor offered meaningful justification for their participation. Because of this failure, combined with the risk to the record presented by the proposed brief, the Court should promptly deny the Motion for Leave to File the Proposed *Amicus* Brief, Doc. No. 131.

Respectfully submitted this 20th day of December, 2021.

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CERTIFICATE OF WORD COUNT

Pursuant to L.R. 7.3(d)(1), the undersigned certifies that this Response in Opposition to Motion for Leave to File Brief of *Amici Curiae* complies with the Court's word limit, containing 2,689 words calculated with the word count feature of the word processing software in making this certification.

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CERTIFICATE OF SERVICE

I hereby certify that on 20th day of December, the foregoing Response in Opposition to Motion for Leave to File Brief of *Amici Curiae* was filed electronically with the Clerk of Court using the CM/ECF electronic filing system which will send notification of such filing to all registered users.

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

MAXWELL KADEL, et al., *Plaintiffs*, v. DALE FOLWELL, et al., *Defendants*.	No. 1:19-cv-00272-LCB-LPA

PLAINTIFFS' OPPOSITION TO STATE HEALTH PLAN DEFENDANTS' MOTION FOR PARTIAL SUMMARY JUDGMENT

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Plaintiffs respectfully oppose the Motion for Partial Summary Judgment ("MSJ") by Defendants Folwell, Jones, and North Carolina State Health Plan for Teachers and State Employees ("NCSHP"; collectively, "Defendants").[1] ECF Nos. 136-37.

STATEMENT OF THE CASE AND FACTS

This case seeks to vindicate the right of state employees and their dependents to receive health coverage free from sex discrimination. Although Defendants repeatedly argue that NCSHP need not cover all medical treatments or all medically necessary care, ECF No. 137 at 5, 8, that is not what Plaintiffs seek. Instead, Plaintiffs ask that Defendants comply with their obligations under federal law to provide coverage without invidious distinctions based on sex or transgender status.

ARGUMENT

I. The Exclusion Discriminates Based on Sex and Transgender Status.

Although Defendants move only on Plaintiffs' statutory claims, Defendants' MSJ begins with extraneous discussion of constitutional doctrine. ECF No. 137 at 1. But Defendants subsequently clarify that they seek "partial summary judgment" on "two of Plaintiffs' claims" under Title VII and the ACA. *See* ECF No. 137 at 1-2; *see also id.* at 2 ("Plaintiffs' equal protection claims remain for trial."). Defendants' discussion of constitutional law is thus irrelevant, but to eliminate all doubt, Plaintiffs briefly explain

[1] All references to "Ex." refer to exhibits to the Declaration of Amy Richardson at ECF Nos. 180-81. All references to "Supp. Richardson Decl." refer to the declaration filed with this brief. All defined terms have the meaning ascribed to them in Plaintiffs' Motion for Summary Judgement "Plaintiffs' MSJ".

why Defendants' cited authorities do not affect Plaintiffs' statutory or constitutional claims.[2]

Defendants cite *Geduldig v. Aiello*, 417 U.S. 484 (1974), in an effort to paint the Exclusion as facially neutral, but this argument fails. ECF No. 137 at 1, 3. First, *Geduldig* was decided before the Supreme Court recognized sex stereotyping claims in *Price Waterhouse v. Hopkins*, 490 U.S. 228, 250 (1989), and therefore says nothing about Plaintiffs' sex stereotyping claims. Second, *Geduldig* does not transform the sex discrimination on the face of the Exclusion into neutral "medical benefit" discrimination. ECF No. 137 at 3. In ruling on a disability insurance program's exclusion of pregnancy coverage, *Geduldig* did not hold that pregnancy-based classifications *never* violate the Equal Protection Clause, instead concluding more narrowly that not every pregnancy classification is an explicit sex-based classification "like those considered in" *Reed v. Reed*, 404 U.S. 71 (1971), and *Frontiero v. Richardson*, 411 U.S. 677 (1973). *Geduldig*, 417 U.S. at 496 n.20. Courts have had no trouble identifying the sex-based classification explicit in exclusions for gender-confirming care. *See, e.g.*, *Fletcher v. Alaska*, 443 F.Supp.3d 1024, 1030 (D. Alaska 2020); *Boyden v. Conlin*, 341 F.Supp.3d 979, 995 (W.D. Wis. 2018); *Flack v. Wis. Dep't of Health Servs.*, 328 F.Supp.3d 931, 948 (W.D. Wis. 2018).

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[2] Plaintiff Silvaine's Equal Protection claim is moot since he no longer works for the state, but contrary to Defendants' suggestion, ECF No. 137 at 4, Mr. Kadel retains a ripe Equal Protection claim since he has rejoined state employment and is covered through NCSHP. ECF No. 179-1 ¶ 2. All Plaintiffs have damages claims under the ACA. ECF No. 75, Count III.

Regardless, Defendants' reliance on *Geduldig* in a motion regarding Plaintiffs' statutory claims is particularly odd. After the Supreme Court applied *Geduldig* to Title VII in *General Elec. Co. v. Gilbert*, 429 U.S. 125 (1976), Congress expressly repudiated *Gilbert* (and its reliance on *Geduldig*) by amending Title VII to include pregnancy discrimination. *See Newport News Shipbuilding & Dry Dock Co. v. E.E.O.C.*, 462 U.S. 669, 678 (1983) (Congress "unambiguously expressed its disapproval of both the holding and the reasoning of the Court in the *Gilbert* decision"). "By concluding that pregnancy discrimination is not sex discrimination within the meaning of Title VII, the Supreme Court disregarded the intent of Congress … to protect all individuals from unjust employment discrimination, including pregnant women." *Discrimination on the Basis of Pregnancy, 1977: Hearing on S. 995 Before the Subcomm. on Labor of the Senate Comm. on Hum. Res.,* 95th Cong. 1 (1977), *available at* https://bit.ly/2meSlm9; *see also Newport News*, 462 U.S. at 679 ("Proponents of the bill repeatedly emphasized that the Supreme Court had erroneously interpreted Congressional intent …."). Accordingly, *Geduldig*'s reasoning has been expressly repudiated under Title VII.

Defendants also cite *Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263 (1993), but that case supports Plaintiffs, not Defendants. As *Bray* observed, "[s]ome activities may be such an irrational object of disfavor that, if they are targeted, and … happen to be engaged in exclusively or predominantly by a particular class of people, an intent to disfavor that class can readily be presumed." *Id.* at 270. Just as a "tax on wearing yarmulkes is a tax on Jews," *id.*, an exclusion of gender-affirming care is an

exclusion of transgender people since the need for medical transition applies exclusively to transgender people. *See Boyden*, 341 F.Supp.3d at 1000; *Toomey v. Arizona*, No. 19-cv-00035, 2019 WL 7172144, at *6 (D. Ariz. Dec. 23, 2019) ("[T]ransgender individuals are the only people who would ever seek gender reassignment surgery.").

Defendants misleadingly imply that four exclusions deny coverage to transgender people. ECF No. 137 at 8. Not so. Plaintiffs' Complaint challenged two facially discriminatory exclusions: one for "[p]sychological assessment and psychotherapy treatment in conjunction with proposed gender transformation," and one for "[t]reatment … in connection with sex changes or modifications" (the "Exclusion"). Exs. 8-9. NCSHP's corporate designee testified that NCSHP does not enforce the first exclusion, Ex. 12, 49:8-23, and Defendants now clarify that it has not been enforced for decades and will be removed in 2022. ECF No. 137 at 8 n.2. Accordingly, the Exclusion for "[t]reatment … in connection with sex changes or modifications" is the one at issue. ECF No. 137 at 8.

Defendants point to two other exclusions, including one for "[c]osmetic services … and surgery for psychological or emotional reasons," *id.*, and one for experimental medications and medications not approved by the U.S. Food and Drug Administration ("FDA"), *id.* at 9. Neither has any relevance to this case. They have not been invoked in Plaintiffs' denials of care. *See* ECF No. 179-3 ¶¶ 11-12 Exs. A-B; ECF No. 179-9 ¶ 24 Ex. A; ECF No. 179-4 ¶ 10 Ex. A; ECF No. 179-1 ¶ 10 Ex. A; ECF No. 179-8 ¶¶ 31-32 Exs. B-E. When NCSHP staff recommended that the Exclusion for gender-confirming

care be eliminated in 2017, they did not mention any other exclusion, Ex. 39, PLANDEF0006985, PLANDEF00069888; and those exclusions remained untouched in 2017 while NCSHP covered gender-confirming care. Supp. Richardson Decl. Exs. A-B. In 2017, NCSHP followed the Blue Cross Blue Shield of North Carolina ("BCBSNC") Corporate Medical Policy, which does not apply those exclusions. *See* Ex. 40, PLANDEF0012816; Ex. 12, 41:25-42:15; Ex. 43. Indeed, the very BCBSNC testimony that Defendants submitted with their MSJ states that BCBSNC "has never implemented the portion of the Plan's benefit booklets that excludes 'surgery for psychological or emotion[al] reasons.'" ECF No. 137-4 ¶ 27.

Defendants also note that several medications prescribed to transgender people are not approved by the FDA to treat gender dysphoria. ECF No. 137 at 13; ECF No. 137-10. But they ignore the evidence in the record that off-label usage is common and has been covered by NCSHP previously.[3] Regardless, Defendants fail to explain how this could serve as a defense to Plaintiffs' claims. As explained in Plaintiffs' MSJ, exclusions for gender-confirming care are facially discriminatory. ECF No. 179 at 17-18; *Fletcher*, 443 F.Supp.3d at 1030-31. Facial discrimination can be justified *only* by a bona

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[3] Not only is it "common for medications to be used 'off label' across all domains of medicine," Ex. 26(a) ¶ 96, the lack of FDA approval did not prevent NCSHP from covering care during plan year 2017, and NCSHP's Rule 30(b)(6) designee admitted NCSHP has covered other non-approved applications of medications. *See* Ex. 12, 107:17-19 (NCSHP covered COVID care, which was not FDA-approved until many months after). The FDA has provided for at least three decades that physicians may prescribe drugs on an off-label basis. *See, e.g.*, Ex. 28, 223:14-232:6; *see also Buckman Co. v. Plaintiffs' Legal Comm.*, 531 U.S. 341, 351 (2001) ("off-label use is generally accepted").

fide occupational qualification, which does not apply to fringe benefits plans. *Ariz. Governing Comm. for Tax Deferred Annuity & Deferred Comp. Plans v. Norris*, 463 U.S. 1073, 1084 n.13 (1983). Defendants' claims about FDA approval are both misleading and irrelevant to the statutory analysis.

With little to say about the Exclusion actually at issue, Defendants focus instead on the billing practices of BCBSNC and CVS. ECF No. 137 at 9-12. But BCBSNC and CVS are not the problem. Both administered inclusive coverage in 2017, it was BCBSNC's Corporate Medical Policy that was used to determine coverage parameters, and BCBSNC advised NCSHP that it would need to be indemnified once NCSHP reinstated the Exclusion. *See* Exs. 45, 47.

Defendants nonetheless recount at length the codes used to process claims for care, ECF No. 137 at 10-12, arguing that the Exclusion "is based on diagnosis and medical coding and not transgender identity"—as if the codes employed by third party administrators *to implement NCSHP's discriminatory Exclusion* are somehow the culprit. The way the Exclusion operates is simple: NCSHP inserts it into the plans (against the advice of their consultants, and over BCBSNC's objection that it needs to be indemnified); and BCBSNC and CVS have no choice but to implement it. *See, e.g.*, ECF No. 137-4 ¶ 11 (testimony from BCBSNC that NCSHP "creates a benefits booklet" and BCBSNC "is responsible for implementation" of it); *see also* ECF No. 137 at 5 (acknowledging that the booklet "describes the covered and non-covered services," which BCBSNC "implements"). Defendants also emphasize that BCBSNC and CVS do

not track whether a participant is transgender, ECF No. 137 at 9-10, 12, but that does not change the analysis. Defendants ensure that the care is not covered when transgender people need it for gender transition, and BCBSNC and CVS implement the discriminatory Exclusion. *See* ECF No. 137-4 ¶ 19 (BCBSNC "will not approve a claim … not covered by the Plan").

This structure is apparent even when one considers the codes themselves: Treatment is not covered when "performed to treat one of two diagnosis codes: F64.0 (*Transsexualism*) or Z87.890 (Personal history of *sex reassignment*)"—i.e., when the codes indicate the care is required by transgender people for gender transition. ECF No. 137 at 10 (emphasis added); *see also* ECF No. 137 at 9-10, 12 (procedures are not covered when used for "treatment of gender dysphoria," but if care is coded for other purposes, "the Plan would pay it").

Defendants' attempt to disguise the Exclusion as mere "diagnosis and medical coding" discrimination—instead of sex and transgender status discrimination—repeats an error the Supreme Court has rejected definitively. It is "irrelevant" what a defendant "might call its discriminatory practice, how others might label it, or what else might motivate it." *Bostock v. Clayton Cnty., Georgia*, 140 S. Ct. 1731, 1744 (2020). For this reason, the defendant in *Manhart v. City of Los Angeles, Dep't of Water & Power*, 435 U.S. 702 (1978), could not have justified requiring larger pension contributions from women as "life expectancy" discrimination instead of sex discrimination. *Bostock*, 140 S. Ct. at 1744. Nor could the defendant in *Phillips v. Martin Marietta Corp.*, 400 U.S.

542 (1971) (per curiam), have recast its prohibition on pre-school age children for female applicants as "motherhood" discrimination instead of sex discrimination. *Bostock*, 140 S. Ct. at 1744. Defendants thus cannot pretend that the facially discriminatory Exclusion is mere "diagnosis and medical coding" discrimination. "[J]ust as labels and additional intentions or motivations didn't make a difference in *Manhart* or *Phillips*, they cannot make a difference here." *Id.* Accordingly, the Exclusion is sex discrimination for all the reasons described in Plaintiffs' MSJ. ECF No. 179 at 17-20.

Defendants offer some tangential assertions about the nature of gender dysphoria, but without explaining how they relate to the legal analysis. ECF No. 137 at 7-8. "Critically," Defendants claim, "not all transgender individuals suffer from gender dysphoria." *Id.* at 7. While Defendants never explain why that is purportedly "critical," the fact that symptoms of gender dysphoria abate after treatment is not remarkable—it is the purpose of providing care. *See* Supp. Richardson Decl. Ex. C, 20:12-22; Ex. 25(a) ¶ 56 (the "overarching goal … is to eliminate clinically significant distress by aligning an individual patient's body and presentation with their internal sense of self"). Defendants also claim Plaintiffs have not provided evidence of the "proportion of transgender individuals suffer[ing] from gender dysphoria." ECF No. 137 at 7-8. But this makes no difference. The Exclusion is not concerned with how many transgender participants experience untreated gender dysphoria—it simply denies care to them all. Nor is this relevant to the legal analysis. There is no numerosity threshold that a targeted group must reach before it is entitled to equal protection of the law.

Defendants feign confusion about whether the Exclusion targets transgender people, or whether cisgender people might also be affected. ECF No. 137 at 2 ("Plaintiffs cannot prevail only with assertions that gender dysphoria disproportionately affects members of a protected class."). But the Exclusion makes clear who is targeted: those seeking "[t]reatment … in connection with sex changes or modifications"—i.e., transgender people. Exs. 8-9. In fact, this Court has previously rejected Defendants' "attempt to frame the Exclusion as one focused on 'medical diagnoses, not ... gender.'" *Kadel v. Folwell*, 446 F.Supp.3d 1, 18 (M.D.N.C. 2020); *id.* ("[S]ex and gender are directly implicated; it is impossible to refer to the Exclusion without referring to them."). The Exclusion's singling out of transgender people for differential treatment thus is unmistakable. *See also Toomey*, 2019 WL 7172144, at *6 ("No cisgender person would seek, or medically require, gender reassignment. Therefore, as a practical matter, the exclusion singles out transgender individuals for different treatment."); *Kadel*, 446 F.Supp.3d at 18 (an "employer cannot be permitted to use a technically neutral classification as a proxy to evade the prohibition of intentional discrimination") (quote omitted).[4]

Defendants' argument also is belied by a record replete with admissions that Defendants knew the Exclusion treats transgender people differently, lifted it for one year

[4] For these reasons, the motion to dismiss-stage holding in *Lange v. Houston County, Georgia*, 499 F.Supp.3d 1258, 1275 (M.D. Ga. 2020), that a similar exclusion was facially neutral, fails to persuade. ECF No. 137 at 2-3. This Court has already rejected that analysis, and *Lange*'s reliance on *Geduldig* renders it particularly unpersuasive for Plaintiffs' statutory claims, where Congress has directly renounced *Geduldig*'s reasoning.

to afford equal treatment, and provided for reinstatement after concluding (wrongly) that the law no longer required equal treatment. *See, e.g.*, Ex. 39 (slides presented to the Board as it considered lifting the Exclusion for 2017, which include the term "transgender" 10 times); *see also id.* PLANDEF0006980 (explaining that ACA regulation "makes clear … that blanket exclusions of transgender services" are outmoded); Ex. 36 ("Transgender Cost Estimate" memorandum from Segal Consulting); Ex. 48 (Defendant Folwell's statement that he would not provide coverage for "sex change operations" until "the court system … tells us that we 'have to'"); Supp. Richardson Decl. Ex. D, 107:17-108:6 (Defendant Folwell uses "sex change operation" to refer to "folks who want to transition, transition their gender"—i.e., transgender people).

In re Union Pacific R.R. Emp. Pracs. Litig., 479 F.3d 936 (8th Cir. 2007), does not change the analysis. Defendants cite this case for the proposition that the proper comparator is the medical benefit in question, ECF No. 137 at 3, but *Union Pacific* merely clarified that in a challenge alleging that men were treated more favorably than women for contraception coverage, one must compare women's contraception coverage with men's contraception coverage—not women's contraception coverage with men's coverage for male-pattern baldness or tetanus shots. 479 F.3d at 944. Here, the comparison between the care covered for cisgender people and excluded for transgender people is direct: the Exclusion bars the same treatments for transgender people that are covered when medically necessary for cisgender participants, including hormone therapy,

Ex. 2 Admis. 1, Ex. 5 Admis. 2; puberty-delaying hormone treatment, Ex. 5 Admis. 2; mammoplasty and breast reconstruction, Ex. 2 Admis. 2, Ex. 5 Admis. 3; vaginoplasty, Ex. 2 Admis. 3; and hysterectomy, Ex. 2 Admis. 4.

Because of the Exclusion's facial discrimination, showing discriminatory intent is not necessary—let alone "animus." ECF No. 137 at 3. *See, e.g.*, *Gerdom v. Cont'l Airlines*, 692 F.2d 602, 608 (9th Cir. 1982) (where a policy "on its face applies less favorably" to a group, the complainant "need not otherwise establish … discriminatory intent"); *Lusardi v. Dep't of the Army*, EEOC Appeal No. 0120133395, 2015 WL 1607756, at *6 (Apr. 1, 2015). And as this Court already has observed, "[s]ometimes … the government's chosen classification will be clear from the text of the law or policy itself. Plaintiffs argue that that is the case here … and the Court agrees." *Kadel*, 446 F.Supp.3d at 18.

Defendants inaccurately claim that Plaintiffs allege that "discriminatory animus" motivated the reinstatement of the Exclusion, but that term appears nowhere in Plaintiffs' Complaint, ECF No. 75, and animus has never been required for statutory or constitutional claims. It does not matter whether discriminatory treatment is rooted in an undisputed truth, innocent misunderstanding, or active bias—sex and transgender discrimination are no more tolerable in any of these circumstances. *See, e.g.*, *Manhart*, 435 U.S. at 707 (pension plan violated Title VII even though "the parties accept as unquestionably true [that]: Women, as a class, do live longer than men."); *Erie Cnty. Retirees Ass'n v. Cnty. of Erie, Pa.*, 220 F.3d 193, 212 (3d Cir. 2000) (an employer's

"beneficence … does not undermine the conclusion that an explicit gender-based policy is sex discrimination") (quoting *Int'l Union, United Auto., Aerospace & Agric. Implement Workers of Am., UAW v. Johnson Controls, Inc.*, 499 U.S. 187, 200 (1991)); *cf. Parker v. Sony Pictures Ent., Inc.*, 260 F.3d 100, 112 (2d Cir. 2001) (it is no defense "to hold a good-faith, but erroneous, belief that the law permits taking an adverse job action on the basis of a prohibited factor").[5]

For these reasons, the argument that Defendants merely maintain the Exclusion based on their (mistaken) conclusion that the ACA no longer requires equal treatment is both incorrect on the law, and inadequate. Defendants invoke *Franciscan All., Inc. v. Burwell*, 227 F.Supp.3d 660 (N.D. Tex. 2016), but that only enjoined the U.S. Department of Health and Human Services ("HHS") from enforcing an ACA regulation; it did not alter the statutory guarantee of freedom from sex discrimination, or enjoin the ability to bring private suits. Separately, deliberately reinstating and maintaining the Exclusion because of a mistaken belief about the status of the ACA's regulations provides Defendants no shelter. The question is not whether Defendants intended to be meanspirited, but simply whether they intended to do it. On that point, there is no dispute: the Exclusion was not accidental or inadvertent, but intentional and deliberate. Ex. 40, PLANDEF0012816-17.

[5] Defendants cite *Williams v. Hansen*, 326 F.3d 569 (4th Cir. 2003) to suggest that animus is required, but cite the *dissenting* opinion in this constitutional case, which says nothing about Plaintiffs' statutory claims. ECF No. 137 at 3.

II. NCSHP is Liable as an Agent and Joint Employer Under Title VII.

A. NCSHP is Liable as an Agent.

Title VII defines "employer" to include the "agent" as well, and prohibits sex discrimination by both. 42 U.S.C. § 2000e(b). Defendants argue that inclusion of an employer's "agent" in the statute does not establish liability for the agent, but simply expands the employer's liability for an agent's conduct. ECF No. 137 at 20-21. But this Court previously rejected that argument when Plaintiffs sought to amend their Complaint with Sgt. Caraway's Title VII claim against NCSHP. ECF No. 74. Defendants nonetheless press the argument again, claiming that *Birkbeck v. Marvel Lighting Corp.*, 30 F.3d 507 (4th Cir. 1994), and *Lissau v. S. Food Serv., Inc.*, 159 F.3d 177 (4th Cir. 1998), establish that only employers may bear liability and not their agents. ECF No. 137 at 21. This Court flatly rejected that characterization:

> [I]n context *Birkbeck* merely concluded that no liability could attach to an *individual* employee …, *see Birkbeck*, 30 F.3d at 509-11, … consistent with the many courts that have rejected employment discrimination claims against individuals, *see Lissau*, 159 F.3d at 181 …. *Birkbeck* neither foreclosed nor endorsed an agency theory under which more than one *entity* may bear Title VII liability. … Here, the issue of individual Title VII liability (and *Birkbeck*'s holding to that effect) remains irrelevant because the Amended Complaint does not lodge a Title VII claim against anyone in an individual capacity.

ECF No. 74 at 22-23. Then as now, "Defendants have identified no authority demonstrating that such theory … fails." *Id.* at 23-24, and case law instead shows that

NCSHP is liable on the merits.[6] *See* ECF No. 179 at 31-33 (discussion in Plaintiffs' MSJ of NCSHP's liability as an agent of Sgt. Caraway's employer).

The Supreme Court itself held in *Manhart* that an administrative board implementing a discriminatory fringe benefit may be sued as the "agent" of the employing government agency. 435 U.S. at 718 n.33; *id.* ("Title VII applies to 'any agent' of a covered employer."). Other courts examining this question in a similar context have reached the same conclusion. *See, e.g.*, *Boyden v. Conlin*, No. 17-cv-264, 2017 WL 5592688, at *2-3 (W.D. Wis. Nov. 20, 2017) (collecting authorities demonstrating that to be liable as an agent under Title VII, an entity must be "empowered" with respect to an employment practice such as "provid[ing] benefits"); *id.* at *3 (W.D. Wis. May 11, 2018) (finding plaintiff's university employers had delegated responsibility for health coverage to state entities administering that coverage).

This Court also considered a similar argument in *Crowder v. Fieldcrest Mills, Inc.*, 569 F.Supp. 825 (M.D.N.C. 1983), involving claims against an employer and its health plan administrator as the employer's agent under Title VII.[7] The plaintiff challenged the

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[6] Defendants also misconstrue *Butler v. Drive Auto. Indus. of Am., Inc.*, 793 F.3d 404 (4th Cir. 2015), claiming that it held only an "employer" can be liable under Title VII. ECF No 137 at 20. But the paragraph Defendants quote observes that Title VII expressly defines an employer to include an "agent." 793 F.3d at 408. *Butler* does not otherwise discuss agent liability, and certainly does not contain the holding Defendants suggest. Instead, *Butler*'s adoption of the joint employer doctrine expressly recognizes that more than one entity can be liable as an employer.

[7] Defendants attempt to distinguish *Crowder* because it was decided before *Butler* adopted the current standards for the joint employment doctrine. ECF No. 137 at 22 n.5. But Plaintiffs rely on *Crowder*'s analysis of whether an entity is liable as an "agent." 569 F.Supp. at 828.

health plan's more favorable coverage for spouses of male employees than female employees. *Id.* at 826. Because the administrator served in merely an "advisory capacity" with no "significant control" over the plan terms, no agent relationship existed; but where an employer delegates responsibility, that "functionally result[s]" in the administrator "having control of an aspect of the terms and conditions of employment," rendering the administrator an "employer" by virtue of serving as an agent. *Id.* at 827-28. That describes NCSHP precisely. *See* N.C. Gen. Stat. § 135-48.2(a); Ex. 5 Admis. 12-14; ECF No. 96 ¶ 179. For these reasons, the Court should find that NCSHP has violated Title VII as an agent of DPS.

B. NCSHP is Liable as a Joint Employer.

NCSHP admits that the "'joint employment doctrine is the law of [the Fourth] Circuit.'" ECF No. 137 at 22 (quoting *Butler*, 793 F.3d at 409). Defendants try to undercut *Butler*'s application by focusing rigidly on the factors it identifies to help determine whether two entities share control over a key aspect of employment. ECF No. 137 at 23-27. But the underlying purpose of *Butler*'s "hybrid test" is to allow for "the broadest possible set of considerations in making a determination of which entity is an employer." 793 F.3d at 414. *Butler* instructs that "courts can modify the factors to the specific industry context." *Id.* Importantly, "the consideration of factors must relate to the particular relationship under consideration." *Id.* at 415 (quote omitted). Above all else, the guide star remains the common law element of control. *Id.* The Court should heed *Butler*'s call to adapt the analysis to this context, and set aside Defendants' urging to

focus on everything but the term of employment actually at issue—health coverage. ECF No. 137 at 24-27. NCSHP's mechanistic arguments about irrelevant factors such as control of Sgt. Caraway's work uniform thus should not persuade this Court. ECF No. 137 at 23-24. Nothing about the *Butler* test requires the Court to apply a host of factors with no bearing on the term of employment at issue, and the Court should instead examine *Butler*'s guidepost, i.e., "control" over the health coverage relevant to this case. *Id.* at 414.

On this core issue, NCSHP is largely silent. But there is no dispute that state law delegates control over employee health coverage to NCSHP, which exists solely to permit that delegation. N.C. Gen. Stat. § 135-48.2(a); *see also* ECF No. 96 ¶ 179; Ex. 14, 13:3-14:6. NCSHP implicitly concedes the point. *See* ECF No. 137 at 17 (conceding that "DPS does not determine the health risks that the Plan will protect against or the benefits available to those who elected to participate"—because that is NCSHP's role). Where an entity "exhibit[s] a high degree of control over the terms of [] employment," it must be held liable as a joint employer. *Butler*, 793 F.3d at 415. The undisputed facts here make clear that NCSHP functions as a joint employer for purposes of health coverage, and is liable under Title VII for all the reasons explained in Plaintiffs' MSJ. ECF No. 179 at 33-34.

III. Defendants' Reliance on HHS's Redefinition of "Health Program or Activity" in 2020 is Misplaced.

Defendants argue NCSHP is entitled to summary judgment on Plaintiffs' ACA claim because in 2020, HHS, under the Trump administration, issued a rule redefining

"health program or activity" to exclude health insurance and that such redefinition is entitled to deference under *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837 (1984). Defendants' argument lacks merit. The text of Section 1557 is unambiguous in this regard and the redefinition is contrary to law, arbitrary, and capricious.

"*Chevron* deference is not a given." *People for the Ethical Treatment of Animals v. United States Dep't of Agric.*, 861 F.3d 502, 506–07 (4th Cir. 2017). "*Chevron* deference is not warranted where … the agency errs by failing to follow the correct procedures in issuing the regulation." *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 220 (2016). Among those requirements is that a rule not be "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706.

A. The Statutory Text is Clear and Unambiguous Such That the Health Insurance is Covered.

Resolving the dispute over the meaning of "health program or activity" "begins where all such inquiries must begin: with the language of the statute itself." *United States v. Ron Pair Enters., Inc.*, 489 U.S. 235, 241 (1989); *see also King v. Burwell*, 759 F.3d 358, 367 (4th Cir. 2014) ("At *Chevron*'s first step, a court looks to the 'plain meaning' of the statute."), *aff'd*, 576 U.S. 473 (2015). "[W]hen conducting [this] statutory analysis, a reviewing court should not confine itself to examining a particular statutory provision in isolation." *King*, 759 F.3d at 368 (quote omitted).

The redefinition of "health program or activity" is contrary to the ACA's statutory text, as well as common sense. Section 1557 plainly covers health insurance as a "health program or activity." Indeed, health insurance is what enables most Americans to access

health care. It defies logic to argue that *health* insurance is not a *health* program or activity. Moreover, Section 1557 applies to "*any health program or activity*, any part of which is receiving Federal financial assistance, including … *contracts of insurance*." 42 U.S.C. § 18116(a) (emphasis added). "It is unclear to whom this clause would apply if not health insurance issuers like The Health Plan." *Fain v. Crouch*, No. CV 3:20-0740, 2021 WL 2657274, at *3 (S.D.W. Va. June 28, 2021).

This Court should not review the meaning of "health program or activity" in isolation; it should seek to ascertain the statutory term's meaning from its context. *King*, 759 F.3d at 368. The Court "must … interpret the statute as a symmetrical and coherent regulatory scheme, and fit, if possible, all parts into a harmonious whole." *Food and Drug Admin. v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 132-33 (2000) (cleaned up). In that sense, that "health program or activity" includes health insurance is evident from definitions of "health program" and "health care" contained within the ACA, which refers to "health programs" and "health care entities" as including insurers and insurance plans in other provisions. *See Fain*, 2021 WL 2657274, at *3 (noting "[o]ther sections of the ACA provide further support"). For example, Section 1331 permits states flexibility to provide a "basic *health program*" by offering "1 or more standard *health plans* providing at least the essential health benefits described in section 1302(b) to eligible individuals." 42 U.S.C. § 18051 (emphasis added). Similarly, Section 1553 defines "health care entity" to include "*a health maintenance organization*, *a health*

insurance plan, or any other kind of health care facility, organization, or *plan*." 42 U.S.C. § 18113 (emphasis added).

Defendants invite the Court to ignore the statute's plain language and rewrite the law, but courts "are not permitted to ignore the statute's plain language." *United States v. Stitt*, 552 F.3d 345, 353 (4th Cir. 2008). And an agency "may not make its own administrative amendments," as HHS sought to do here. *Bracamontes v. Holder*, 675 F.3d 380, 387 (4th Cir. 2012). Instead, courts "are obliged to give effect to the statutes as they are written and enacted." *Id.* (cleaned up); *see also Louisiana Pub. Serv. Comm'n v. FCC*, 476 U.S. 355, 376 (1986) ("[O]nly Congress can rewrite [a] statute.").

Moreover, courts "must reject administrative constructions which are contrary to clear congressional intent." *Chevron*, 467 U.S. at 843 n.9. Here, the inclusion of health insurance within "health program or activity" is apparent from Congress's intent. Senator Patrick Leahy explained that Section 1557's prohibition on discrimination was "necessary to remedy the shameful history of invidious discrimination and the stark disparities in outcomes in our health care system" and to "ensure that all Americans are able to reap the benefits of *health insurance* reform equally *without discrimination*." Health Care and Education Reconciliation Act of 2010, 156 Cong. Rec. S. 1821, 1842 (daily ed. Mar. 23, 2010) (emphasis added). Moreover, "when looking at the ACA as a whole, the Act clearly aims to increase the number of Americans covered by health insurance by transforming the health insurance industry." *Fain*, 2021 WL 2657274, at *3 (quote omitted). "Given this context, … 'health program or activity' under Section 1557

necessarily includes health insurance issuers such as The Health Plan." *Fain*, 2021 WL 2657274, at *3.

Defendants' argument that this Court holding that "health program or activity" unambiguously includes health insurance would mean that HHS can never interpret that phrase, ECF No. 137 at 31 n.6, is without merit. It just means that HHS cannot adopt a definition excluding health insurance, in accordance with the statutory text and context.

The Court should therefore "conclude that The Health Plan is unambiguously a 'health program or activity' under the plain text of Section 1557." *Fain*, 2021 WL 2657274, at *5; *see also T.S. v. Heart of CarDon, LLC*, No. 1:20-cv-01699, 2021 WL 981337, at *9 (S.D. Ind. Mar. 16, 2021), *reconsideration denied, motion to certify appeal granted*, No. 1:20-cv-01699, 2021 WL 2946447 (S.D. Ind. July 14, 2021).[8]

B. The 2020 Redefinition of "Health Program or Activity" is Not Entitled to Deference.

Even assuming "health program or activity" is ambiguous with regard to inclusion of health insurance (it is not), the Court, under *Chevron* Step Two, must assess whether the redefinition of "health program or activity" is permissible or reasonable. *See PETA v. United States Dep't of Agric.*, 861 F.3d 502, 510 (4th Cir. 2017). It is not, as the

[8] Defendants claim that *Callum v. CVS Health Corp.*, 137 F.Supp.3d 817, 849-50 (D.S.C. 2015) found the term "health program or activity" to be ambiguous. ECF No. 137 at 30. Not so. *Callum* simply noted that it was undefined and "the parties disagree as to whether a retail pharmacy outlet … qualifies as one." *Callum*, 137 F.Supp.3d at 850. *Callum* "did not consider whether an insurance issuer could be held liable under Section 1557 and instead applied the law to pharmacies." *Fain*, 2021 WL 2657274, at *2 n.2.

redefinition is inconsistent with the ACA's text and Congress's intent, as well as arbitrary and capricious.

In 2016, HHS issued a regulation interpreting "health program or activity" to include all operations of an entity "principally engaged" in "the provision or administration of … health-related coverage." 81 Fed. Reg. 31,467. Notably, courts applied Section 1557 to health insurance *prior to* the 2016 rule. *See East v. Blue Cross & Blue Shield of Louisiana*, No. 3:14-cv-00115, 2014 WL 8332136 (M.D. La. Feb. 24, 2014).

When it issued its 2020 rule, HHS did not explain or provide rational explanation for its redefinition. Rather, it sought to justify the redefinition through its *ipse dixit* that providing "health insurance" is different than providing "healthcare." 85 Fed. Reg. at 37,172-73. But Section 1557 plainly covers "*any* health program or activity," not just direct health care. The argument that the Civil Rights Restoration Act ("CRRA") applies "to all health programs or activities receiving Federal financial assistance, but not to all providers of health insurance" has no support. 85 Fed. Reg. at 37,171. Indeed, the CRRA does not define "health care" or suggest that "being principally engaged in the business of providing healthcare" excludes health insurance companies.

Furthermore, the redefinition violates Section 1554 of the ACA and undermines the ACA's purpose, which was designed to expand access to health insurance and create new nondiscrimination protections in health insurance. *See, e.g.*, *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 519 (2012). Section 1554 explicitly prohibits HHS from

promulgating any regulation that "creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care" or "impedes timely access to health care services." 42 U.S.C. § 18114. The redefinition of "health program or activity" frees health insurance providers from the ACA's nondiscrimination mandate and violates Section 1554 by creating unreasonable barriers to individuals seeking care.

In addition, the administration "entirely failed to consider an important aspect of the problem"—the harm caused by its new interpretation. *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). Commenters expressed concern that the exclusion of "many of the plans, products, and operations of most health insurance issuers, such as self-funded group health plans," would allow health insurers to conduct their activities "in a discriminatory manner." 85 Fed. Reg. at 37,173. The Trump administration arbitrarily and capriciously ignored these concerns, responding only that HHS "will robustly enforce the nondiscrimination requirements for [qualified health plans] under Title I of the ACA, for Exchange plans established by the ACA, and for any other insurance plans that Section 1557 covers." *Id.*

Finally, multiple challenges to the redefinition are pending and stayed in courts across country. *See, e.g.*, *Whitman-Walker Clinic v. U.S. Dep't of Health & Hum. Servs.*, 485 F.Supp.3d 1 (D.C. Cir. 2020);[9] *Boston All. of Gay, Lesbian, Bisexual & Transgender*

[9] Defendants misrepresent *Whitman-Walker Clinic*. There the court found plaintiffs had not sufficiently showed standing at the preliminary injunction stage but noted "the potential for Plaintiffs to better support their standing argument in the future with revamped allegations," such as through "representational standing." 485 F.Supp.3d at 32.

Youth v. U.S. Dep't of Health & Hum. Servs., No. 20-cv-11297, 2021 WL 3667760 (D. Mass.); *New York v. U.S. Dep't of Health & Hum. Servs.*, No.1:20-cv-05583 (S.D.N.Y.). These cases are stayed based on the Biden administration's reporting "that its ongoing reassessment had raised substantial and legitimate policy concerns with the challenged Rule that HHS intends to address in a Section 1557 rulemaking proceeding … in early 2022." Defs.' Mem. in Opposition to Mot. to Lift Stay at 11, *Whitman-Walker Clinic*, 485 F.Supp.3d 1 (D.D.C. filed Aug. 13, 2021) (ECF No. 75). Given the above, the Court should refuse to afford the 2020 redefinition *Chevron* deference.

Health insurance is a "health program or activity" covered by Section 1557 of the ACA. This Court should join the multitude of courts that have applied Section 1557 to health insurance plans. *See, e.g.*, *Schmitt v. Kaiser Found. Health Plan of Washington*, 965 F.3d 945, 951 (9th Cir. 2020); *Tovar v. Essentia Health*, 857 F.3d 771, 779 (8th Cir. 2017); *Fain*, 2021 WL 2657274; *C.P. v. Blue Cross Blue Shield of Illinois*, 536 F.Supp.3d 791 (W.D. Wash. 2021); *T.S.*, 2021 WL 981337; *Boyden*, 341 F.Supp.3d 979; *Ferrer v. CareFirst, Inc.*, 265 F.Supp.3d 50 (D.D.C. 2017); *East*, 2014 WL 8332136.

CONCLUSION

For all the reasons above, the Court should deny Defendants' MSJ on Sgt. Caraway's Title VII claim, and all Plaintiffs' ACA claims, against NCSHP.

Dated: December 30, 2021

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing brief is in compliance with Local Rule 7.3(d)(1) because the body of this brief, including headings and footnotes, does not exceed 6,250 words as indicated by Microsoft Word, the program used to prepare this document.

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CERTIFICATE OF SERVICE

I certify that the foregoing document was filed electronically with the Clerk of Court using the CM/ECF system which will send notification of such filing to all registered users.

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

MAXWELL KADEL, et al., *Plaintiffs*, v. DALE FOLWELL, et al., *Defendants*.	No. 1:19-cv-00272-LCB-LPA

SUPPLEMENTAL DECLARATION OF AMY RICHARDSON

I, Amy Richardson, do hereby declare as follows:

1. I am more than 18 years of age, have personal knowledge of the facts set forth herein, and am otherwise competent to testify to the matters set forth herein.

2. I am a partner with Harris, Wiltshire & Grannis LLP, and counsel for Plaintiffs in this matter. I submit this declaration in support of Plaintiffs' Opposition to State Health Plan Defendants' Motion for Partial Summary Judgment.

3. Attached to this declaration are true and correct copies of the documents listed in the table below. Entries in the table indicate where documents have been excerpted, or have had highlighting applied to indicate the relevant portions of the document.

Exhibit	Description
A	Excerpt from 70/30 PPO Plan Benefits Booklet for 2017, with yellow highlighting applied to relevant portions
B	Excerpt from 80/20 PPO Plan Benefits Booklet for 2017, with yellow highlighting applied to relevant portions
C	Excerpt of Dep. Tr. of Dan H. Karasic, M.D.
D	Excerpt of Dep. Tr. of Dale Folwell

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: December 30, 2021

/s/ Amy Richardson
Amy Richardson

CERTIFICATE OF SERVICE

I certify that the foregoing document was filed electronically with the Clerk of Court using the CM/ECF system which will send notification of such filing to all registered users.

Dated: December 30, 2021

/s/ Amy E. Richardson
Amy E. Richardson
N.C. State Bar No. 28768
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Exhibit A

State Health Plan for Teachers and State Employees

TRADITIONAL 70/30 PPO PLAN BENEFITS BOOKLET

January 1 – December 31, 2017

October 1, 2016

What is not Covered?

B

- **Body** piercing
- Collection and storage of **blood** and stem cells taken from the umbilical cord and placenta for future use in fighting a disease
- **Bone** density wrist or heel radiology testing
- **Blood** pressure machines, cuffs or other blood pressure monitoring device

C

- **Childbirth** preparation classes, including but not limited to Lamaze classes, childbirth refresher classes, cesarean birth classes, vaginal birth after cesarean classes, and infant safety classes including CPR by a non-physician *provider*
    - Human breast milk processing, storage and distribution
- **Claims** not submitted to the *Plan* within 18 months of the date the charge was *incurred*, except in the absence of legal capacity of the *member*
- Side effects and **complications** of non-*covered services*, except for *emergency services* in the case of an *emergency*
- **Convenience** items such as, but not limited to, devices and equipment used for environmental control, urinary incontinence devices (including bed wetting devices) and equipment, heating pads, hot water bottles, ice packs and personal hygiene items
- ***Cosmetic*** **services**, which include the removal of excess skin from the abdomen, arms or thighs, skin tag excisions, cryotherapy or chemical exfoliation for active acne scarring, superficial dermabrasion, injection of dermal fillers, services for hair *transplants*, electrolysis and *surgery* for psychological or emotional reasons, except as specifically covered by the *Plan* including:
- Services received either before or after the **coverage period** of the *Plan*, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination
- ***Custodial care*** designed essentially to assist an individual with activities of daily living, with or without routine nursing care and the supervisory care of a *doctor*. While some skilled nursing services may be provided, the patient does not require continuing skill services 24 hours daily. The individual is not under specific medical, surgical, or psychiatric treatment to reduce a physical or mental disability to the extent necessary to enable the patient to live outside either the institution or the home setting with substantial assistance and supervision, nor is there reasonable likelihood that the disability will be reduced to that level even with treatment. *Custodial care* includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over medications that could otherwise be self-administered. Such services and supplies are custodial as determined by the *Plan* without regard to the place of service or the *provider* prescribing or providing the services.
- **Camisoles**, or other clothing, post-mastectomy
- **Communication** boards or alternative communication devices

D

- **Dental care**, dentures, dental implants, oral orthotic devices, palatel expanders and orthodontics except as specifically covered by the *Plan*.
- **Dental services** provided in a *hospital*, except as specifically covered by the *Plan*.
- Evaluation and treatment of ***developmental dysfunction*** and/or learning disability.
- The following medications:
    - o Injections by a health care professional of injectable *prescription medications*

which can be self-administered, unless medical supervision is required

- Medications associated with conception by artificial means.
- For prescribed *sexual dysfunction* medications
- Take home medications furnished by a *hospital* or *nonhospital facility*
- *Experimental* medication or any medication or device not approved by the Food and Drug Administration (FDA) for the applicable diagnosis or treatment. However, this exclusion does not apply to *prescription medications* used in covered phases I, II, III and IV clinical trials, or medications approved by the FDA for treatment of cancer, if prescribed for the treatment of any type of cancer for which the medication has been approved as effective and accepted in any one of the following nationally recognized medication reference guides:
  - The American Medical Association Drug Evaluations
  - The American *Hospital Formulary* Service Drug Information
  - The United States Pharmacopoeia Drug Information
  - The National Comprehensive Cancer Network Drugs & Biologics Compendium
  - The Thomson Micromedex DrugDex
  - The Elsevier Gold Standard's Clinical Pharmacology
  - Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

E

- Services primarily for ***educational*** *treatment* an/or purposes including, but not limited to, evaluation, books, tapes, pamphlets, seminars, classroom, Web or computer programs, individual or group instruction, counseling, and vocational counseling, educational supplies such as books, tapes, and pamphlets for the patient's education at cost to physician or other qualified health care professional, educational services rendered to patients in a group setting by physician or other qualified health care professional, except as specifically covered by the *Plan*
- For **educational** or achievement testing for the sole purpose of resolving educational performance questions
- The following **equipment:**
  - Air conditioners, furnaces, humidifiers, vacuum cleaners, electronic air filters and similar equipment
  - Devices and equipment used for environmental accommodation requiring vehicle and/or building modifications such as, but not limited to, positioning seats, chair lifts, stair lifts, home elevators, and ramps
  - Physical fitness equipment, hot tubs, Jacuzzis, heated spas, whirlpools, pools or membership to health clubs
  - Personal computers
  - Pacemaker monitors and external defibrillators with integrated electrocardiogram analysis
  - Postural drainage boards and similar equipment
  - Standing frames.

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Exhibit B

State Health Plan for Teachers and State Employees

ENHANCED 80/20 PPO PLAN BENEFITS BOOKLET

January 1 – December 31, 2017

Revised: September 3, 2016

WHAT IS NOT COVERED?

Exclusions that are specific to a type of service are stated along with the benefit description in "*Covered Services*." Exclusions that apply to many services are listed in this section. To understand all of the exclusions that apply, read "*Covered Services*," "Summary of Benefits" and "What Is Not Covered?" In addition, your health benefit plan does not cover services, supplies, drugs or charges that are:

- Not *medically necessary*
- Anything specifically listed in this benefits booklet as not covered or excluded, regardless of *medical necessity*.
- *Investigational* in nature or obsolete, including any service, medications, procedure or treatment directly related to an *investigational* treatment, except as specifically covered by the plan.
- Any *experimental* medication or any medication or device not approved by the Food and Drug Administration (FDA) for the applicable diagnosis or treatment. However, this exclusion does not apply to *prescription drugs* used in covered phases I, II, III and IV clinical trials, or drugs approved by the FDA for treatment of cancer, if prescribed for the treatment of any type of cancer for which the drug has been approved as effective and accepted in any one of the following:
  - The National Comprehensive Cancer Network Drugs & Biologics Compendium
  - The Thomson Micromedex DrugDex
  - The Elsevier Gold Standard's Clinical Pharmacology
  - Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services
- Side effects and complications of non-*covered services,* except as specifically covered by your health benefit plan or except for *emergency services* in the case of an *emergency*
- Not prescribed or performed by or upon the direction of a doctor or *other provider*
- For any condition, disease, illness or injury that occurs in the course of employment, if the *employee*, employer or carrier is liable or responsible for the specific medical charge (1) according to a final adjudication of the claim under a state's workers' compensation laws, or (2) by an order of a State Industrial Commission or other applicable regulatory agency approving a settlement agreement
- For basic life or work-related or medical disability examinations
- For a health care professional to administer injectable *prescription drugs* which can be self-administered, unless medical supervision is required
- For *inpatient* admissions primarily for the purpose of receiving diagnostic services or a physical examination. *Inpatient* admissions primarily for the purpose of receiving therapy services are excluded except when the admission is a continuation of treatment following care at an *inpatient* facility for an illness or accident requiring therapy
- For care in a self-care unit, apartment or similar facility operated by or connected with a *hospital*
- For *custodial care*, domiciliary care or rest cures, care provided and billed for by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility, home for the aged, infirmary, school infirmary, institution providing education in special environments, in residential treatment facilities, except for *chemical dependency* treatment, or any similar facility or institution
- For respite care of any kind except as specifically covered by your health benefit plan
- For services provided at request of patient in a location other than physician's office which are normally provided in the physician's office
- For day care services, chore services, attendant care services, homemaker services, companion care services, foster care services
- Received prior to the *member's effective date*
- Received after the coverage termination date, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination
- For telephone consultations or web-based, online or other electronic evaluations, charges for failure to keep a scheduled visit, charges for completion of a claim form, charges for obtaining medical records, and late payment charges
- *Incurred* more than 18 months prior to the *member's* submission of a claim

What is not Covered?

- For *cosmetic* purposes for any reason, including but not limited to excess skin from the abdomen, arms or thighs, and *surgery* for psychological or emotional reasons except as specifically covered by this health benefit plan.
- For camisoles, or other clothing, post-mastectomy
- For any services that would not be necessary if a non-*covered service* had not been received, except for *emergency services* in the case of an *emergency*
- For benefits that are provided by any governmental unit except as required by law
- For services that are ordered by a court that are otherwise excluded from benefits under this health benefit plan
- For care that the *provider* cannot legally provide or legally charge or is outside the scope of license or *certification*
- Provided and billed by a licensed health care professional who is in training
- Available to a *member* without charge and/or for care given to a *member* by a *provider* who is in a *member's* immediate family
- For any condition suffered as a result of any act of war or while on active or reserve military duty
- In excess of the *allowed amount* for services usually provided by one doctor, when those services are provided by multiple doctors
- For palliative, *cosmetic* or *routine foot care*
- For dental care, dentures, dental implants, oral orthotic devices, palatal expanders and orthodontics except as specifically covered by the Plan
- Considered to be dental services provided in a *hospital*, except when a hazardous condition exists at the same time or covered oral *surgery* services are required at the same time as a result of a bodily injury
- For any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the weight of a *member* or for treatment of obesity, except for nutritional visits or surgical treatment of morbid obesity, or as specifically covered by your health benefit plan
- Bariatric *surgery*, except when provided at a Blue Distinction Center (BDC).
- Wigs, hair pieces and services for hair implants and electrolysis for any reason
- Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group
- For prescribed *sexual dysfunction* medications
- Music therapy, remedial reading, recreational or activity therapy, alternative therapy services, all forms of special education and supplies or equipment used similarly
- Hypnosis except when used for control of acute or chronic pain
- Acupuncture and acupressure
- Travel, whether or not recommended or prescribed by a doctor or other licensed health care professional, except as specifically covered by your health benefit plan
- For heating pads, hot water bottles, ice packs and personal hygiene and convenience items such as, but not limited to, devices and equipment used for environmental control, incontinence products (including briefs, diapers, underwear, underpads), and urinary incontinence devices (including bed wetting devices) and equipment
- For devices and equipment used for environmental accommodation requiring vehicle and/or building modifications such as, but not limited to, positioning seats, chair lifts, stair lifts, home elevators, and ramps
- Communication boards or alternative communication devices
- For safety equipment, devices or accessories, including but not limited to helmets with face guards and soft interfaces and any type of restraints
- For air conditioners, furnaces, humidifiers, dehumidifiers, vacuum cleaners, electronic air filters and similar equipment
- Physical fitness equipment, hot tubs, Jacuzzis, heated spas, whirlpools, pool or memberships to health clubs
- Athletic training evaluations or re-evaluations
- The following vision services:

Exhibit C

1 IN THE UNITED STATES DISTRICT COURT
2 FOR THE MIDDLE DISTRICT OF NORTH CAROLINA
3 Civil Action No. 1:19-cv-00272
4
MAXWELL KADEL, et al.,)
5)
Plaintiffs,)
6)
vs.)
7)
DALE FOLWELL, in his official)
8 capacity as State Treasurer of)
North Carolina, et al.,)
9)
Defendants,)
10 ___________________________________)
11
12 DEPOSITION OF DAN H. KARASIC, M.D.
13 Remote
September 20, 2021
14 9:00 a.m. Pacific Time
15
16
17
18
19 Prepared by:
Vicki L. O'Ceallaigh Champion, CR
20 Certificate No. 50534
21
22
23 Prepared for:
24
25 (Certified copy)

1 I N D E X

2

3 WITNESS:

4 DAN H. KARASIC, M.D. PAGE

5 Examination by Mr. Knepper 5

6 Examination by Mr. Haskel................ Xx

7

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20 9 Short-Term Outcomes Of Pubertal Suppression 80
In A Selected Cohort Of 12 To 15 Year Old

21 Young People With Persistent Gender Dysphoria
In The UK

22
10 Puberty Blockers and Suicidality in 91

23 Adolescents Suffering from Gender Dysphoria

24

25

1 DEPOSITION OF DAN H. KARASIC, M.D.
2 commenced at 9:00 a.m. on September 20, 2021, via
3 Zoom, before VICKI L. O'CEALLAIGH CHAMPION, a
4 Certified Reporter, CR No. 50534, for the State of
5 Arizona.
6
7 * * *
8 A P P E A R A N C E S
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23
24 Also Present:
25 Mr. Braden Bates, Legal Videographer

1 when we are referring to people with gender
2 dysphoria, little-G-little-D, we are also maybe
3 referring people -- to people who might meet a
4 criteria -- might meet the criteria for the DSM
5 diagnosis, but the DSM diagnosis is, you know -- has
6 a specific set of criteria.
7 And the gender dysphoria, small letters,
8 existed before those seven criteria were laid out,
9 because that -- those criteria did not, you know,
10 exist until 2013.
11 BY MR. KNEPPER:
12 Q. Do all transgender people suffer from the
13 diagnosis of gender dysphoria?
14 MR. HASKEL: Objection to form, foundation.
15 A. So in the DSM, they put in a post-transition
16 specifier, and specifically -- so the people --
17 people can get ongoing care post-transition, so --
18 so I think that that was put in specifically so that
19 if people are being, you know, treated under that
20 diagnosis and their -- their symptoms have
21 alleviated because of treatment, they can continue
22 getting treatment under that diagnosis.
23 BY MR. KNEPPER:
24 Q. Are there individuals -- does that mean that
25 all individuals -- are there any other individuals

Exhibit D

Deposition of:

Dale Folwell

August 12, 2021

In the Matter of:

Kadel, et al vs. Folwell

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1 IN THE UNITED STATES DISTRICT COURT FOR
2 THE MIDDLE DISTRICT OF NORTH CAROLINA
3
4
5 MAXWELL KADEL, et al.,)
)
6 Plaintiffs,)
) No. 1:19-cv-272-LCB-LPA
7 v.)
)
8 DALE FOLWELL, et al.,)
)
9 Defendants.)
__________________________)
10
11
12
DEPOSITION
13 OF
DALE FOLWELL
14
15 AUGUST 12, 2021
16
17 THIS TRANSCRIPT IS NOT COMPLETE
PORTIONS OF THIS TRANSCRIPT AND/OR EXHIBITS
18 MAY BE DESIGNATED CONFIDENTIAL/ATTORNEYS EYES ONLY
AFTER REVIEW OF TRANSCRIPT BY ATTORNEYS WITHIN 30
19 DAYS OF DATE OF DEPOSITION PER PROTECTIVE ORDER
20
21
22 NORTH CAROLINA STATE HEALTH PLAN
3200 Atlantic Avenue, First Floor
23 Raleigh, North Carolina
24
25 Reported by: Michelle Maar, RDR, RMR, FCRR

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On behalf of Defendants Dale Folwell, Dee Jones, and the NC
13 State Health Plan for Teachers and State Employees:
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1 On behalf of Defendant State of North Carolina
Department of Public Safety:

2

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3 By: Alan McInnes (via teleconference)

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1 Ms. Fitzgerald.
2 A. What generated me saying that?
3 Q. Yes.
4 A. I got a call.
5 Q. Okay. And it says that you, your statement was
6 that the State Health Plan's 32 billion dollar debt --
7 again, are you referencing the unfunded liability there?
8 A. Yes. And the reason I use terms like that is
9 it's important, if you're trying to fix a problem, that you
10 describe it in terms that people are more accustomed to.
11 Unfunded liability and OPEB are not something
12 people are accustomed to.
13 Q. Do you know what the unfunded liability is today?
14 A. I do.
15 Q. And what is it?
16 A. 27.8 billion.
17 Q. And the last sentence there, it says the
18 provisions to pay for sex change operations does none of
19 these three things.
20 What did you mean by sex change operations?
21 A. The topic for which we've been discussing, that
22 you refer to as gender dysphoria.
23 Q. Okay. So if -- so what is your understanding of
24 a sex change operation I guess I'm trying to get at?
25 MR. WILLIAMS: Objection to the form.

1 You can answer.
2 THE WITNESS: My definition of -- I don't have a
3 medical definition of a sex change operation.
4 It's the things that are commonly known, commonly
5 think of, which I've already described as things associated
6 with folks who want to transition, transition their gender.
7 BY MR. WEAVER:
8 Q. Is it your understanding that there's other
9 healthcare benefits provided by the Plan that don't achieve
10 those three goals, reducing the debt, providing a more
11 affordable family premium, and provide transparency to
12 taxpayers?
13 A. I'm sure there are, but I cannot articulate them.
14 Q. Okay. Now, my understanding, you were sworn in
15 officially in your duties on January 1, 2017.
16 A. Correct.
17 Q. Okay. I'll show you Exhibit 6.
18 (Exhibit 6 is marked for identification.)
19 BY MR. WEAVER:
20 Q. It's another e-mail chain. This is PLAN
21 DEF0021691.
22 A. Do I go to the back again?
23 Q. Yes, please, sir.
24 A. Last time it was in the front.
25 Okay.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

MAXWELL KADEL, *et al.*, *Plaintiffs*, v. DALE FOLWELL, in his official capacity as State Treasurer of North Carolina, *et al.*, *Defendants*.	1:19-cv-00272-LCB-LPA

REPLY BRIEF OF *AMICI CURIAE* THE AMERICAN MEDICAL ASSOCIATION AND SEVEN ADDITIONAL HEALTH CARE ORGANIZATIONS IN SUPPORT OF THEIR MOTION FOR LEAVE TO FILE AN AMICUS BRIEF

Pursuant to L.R. 7.5, the American Medical Association ("AMA"), the American Academy of Pediatrics, American College of Obstetricians and Gynecologists, the American Psychiatric Association, the Endocrine Society, the North American Society for Pediatric and Adolescent Gynecology, National Association of Nurse Practitioners in Women's Health, and the Society of OB/GYN Hospitalists (together, "*Amici*") respectfully submit this Reply in support of their motion for leave to submit a brief as *amici curiae* (the "Motion"). As set forth below, Defendants' arguments for opposing leave to file *Amici's* brief are meritless,

particularly in view of the fact that several of these *Amici* already have served exactly this role on the same issues in a recent case before the Fourth Circuit.

I. *Amici* Are Experts in their Fields, Not Expert Witnesses.

Proposed *Amici* are eight leading medical, mental health, and other health care organizations. Collectively, *Amici* represent hundreds of thousands of physicians, nurses and mental-health professionals, including specialists in family medicine, mental health, internal medicine, endocrinology, obstetrics and gynecology. As leading healthcare providers both within the State of North Carolina and beyond, *Amici* are in a unique position to inform the Court about the proper treatments for people experiencing gender dysphoria, the negative health outcomes when gender dysphoria is left untreated, and other health concerns that could arise from lack of coverage by State health care plans, which will directly impact the *Amici's* ability to care for their patients. *Amici's* expertise in a particular field, however, does not mean that they are expert *witnesses*.

Defendants spend over half their brief arguing that *Amici* are seeking to serve as expert witnesses in this case and are not complying with Fed. R. Civ. P. 26. (Doc. 186, at 2–7). That argument is completely inapt: *Amici* have not been retained as expert witnesses by any party to this case and are not receiving any compensation whatsoever for submitting their brief. *See* L.R. 7.5(d). *Amici*, unlike the parties' expert witnesses, do not opine on the care owed to the individual plaintiffs in this

case, the evidence at issue, or the wrongdoing or liability of the specific defendants in this case. *Amici* are not witnesses of any sort.

Moreover, unlike a typical expert witness, *Amici* have a direct interest and stake in the outcome of this litigation, because of the patients they serve. *Amici's* ability to serve those patients, including their ability to provide necessary treatments to those patients, will be affected by the decision in the present case. *Amici*'s brief therefore seeks to inform the Court of the medical consensus regarding what it means for their patients to be transgender; the protocols for the treatment of gender dysphoria, which include living in accordance with one's gender identity in all aspects of life; and the predictable harms to the health and well-being of transgender individuals who are denied access to necessary medical treatments.

As *amicus curiae*, and *not* as expert witnesses, prior *amicus* briefs submitted by the proposed *Amici* have been accepted – and cited extensively – by federal and state courts throughout the country, including the Fourth Circuit and the U.S. Supreme Court. Proposed *Amicus* AMA, for example, has been granted leave to file hundreds of *amicus* briefs over the years. Those briefs have been cited favorably in judicial decisions at the district court level, *see, e.g.*, *United States v. Jefferson*, No. CRIM. 97-276 04 MJD, 2015 WL 501968 at *3 n. 1 (D. Minn. Feb. 5, 2015), *aff'd*, 816 F.3d 1016 (8th Cir. 2016) ("[T]he Court found the Amici Curiae brief of the American Medical Association . . . to be excellent resources . . ."); before courts of

appeals (including the Fourth Circuit), *see, e.g.*, *Peters v. Aetna Inc.,* 2 F.4th 199, 234 (4th Cir. 2021), *petition for cert. filed*, No. 21-761 (U.S. Nov. 22, 2021) ("This interpretation is bolstered by the brief of *amici*, the American Medical Association . . . ."); *Kohl by Kohl v. Woodhaven Learning Ctr.,* 865 F.2d 930, 933 n. 2 (8th Cir. 1989) ("We are indebted to the American Medical Association for its excellent amicus curiae brief, which is the source of much of our information . . . ."); and before the Supreme Court of the United States (*see, e.g.*, *Roman Cath. Diocese of Brooklyn v. Cuomo*, 141 S.Ct. 63, 78, 208 L. Ed. 2d 206 (2020) (Breyer, J. dissenting) (citing AMA *amicus curiae* brief); *Sch. Bd. of Nassau Cty., Fla. v. Arline*, 480 U.S. 273, 288 (1987) ("[W]e agree with *amicus* American Medical Association . . . ."). The other proposed *Amici* have also filed *amicus* briefs that have likewise garnered citations and appreciation from the reviewing court. *See, e.g.*, *Stenberg* v. *Carhart*, 530 U.S. 914, 932–936 (2000) (quoting American College of Obstetricians and Gynecologists ("ACOG") brief extensively and referring to ACOG as a "significant medical authority"); *Jefferson*, 2015 WL 501968, at *3 n. 1 ("the Court found the Amici Curiae brief of the . . American Psychiatric Association . . . to be excellent resources in preparing for this resentencing, and would recommend that a court that is resentencing a defendant in light of Miller consult these references.").

Particularly notable is that the Fourth Circuit recently relied on and quoted extensively from a substantially similar *amicus* brief filed by some of the same

Amici—the American Academy of Pediatrics, the AMA, and the American Psychiatric Association—on the very same subject matter presented here. *See Grimm v. Gloucester Cty. Sch. Bd.,* 972 F.3d 586 (4th Cir. 2020). *Grimm* involved a transgender student's lawsuit against a school district, alleging that its policy requiring students to use bathrooms based on their birth-assigned sex and its refusal to amend the plaintiff's school records to reflect his gender identity violated the Equal Protection Clause and Title IX. *Id.* at 593. The relevant portions of the *amicus* brief accepted by the court in *Grimm* are substantially identical to the brief submitted in this case (and written by one of the same law firms as on the brief here, Jenner & Block LLP) and addressed the same pertinent background as presented here: namely, what it means to be transgender and the medical and mental health issues that transgender individuals face. Recognizing the value of the information and insights presented by the *Amici Curiae*, the Fourth Circuit devoted three pages of its opinion to a recitation of the information provided in the *Amici's* brief, with extensive quotations from the brief. *Id.* at 594–96. As the court put it, "[w]ith that essential grounding, we turn to the facts of this case." *Id.* at 597.

Amici believe that the information contained in their proposed brief will assist the Court in its deliberations by presenting a complete and accurate description of the medical conditions and treatments at issue in the pending case, from the unique perspective that the *Amici* can offer as healthcare providers. As the Fourth Circuit

described it in *Grimm*, the information provided by *Amici* on these topics is the "essential grounding" to inform the Court as it turns to the facts of the case. 972 F.3d at 597.

Finally, Defendants' argument, taken to its logical conclusion, would prohibit *any amicus* from ever submitting a brief. If the Court should not consider the information submitted by an *amicus* in its deliberations, as urged by Defendants (Doc. 186, at 6–7), then no *amicus* could ever be helpful to the Court, and LR 7.5 would serve no purpose. Defendants' argument should be summarily rejected.

II. *Amici* Have Particular Expertise Not Possessed by Any Party.

As courts around the country have recognized, *amicus* briefs are appropriate and useful when, as here, the proposed *Amici* have "particular expertise not possessed by any party." *Neonatology Assocs., P.A. v. Comm'r*, 293 F.3d 128, 132 (3d Cir. 2002) (Alito, J.). As in *Grimm* and in this case, the proposed *Amici* often file *amicus* briefs when the issue before the court is uniquely within their knowledge or expertise and when they believe that they may be able to assist the Court in understanding relevant medical and scientific information. *Amici* have rigorous approval processes for *amicus* briefs, the touchstone of which is an assessment of whether a case is one in which there is sufficient medical and scientific research, data, and literature relevant to one or more questions before the court so that they

can usefully contribute to the court's understanding of that question. *Amici* regard this case as presenting such questions.

As Defendants acknowledge, *amici* are "allowed at the trial level where . . . they have a special interest in the subject matter of the suit." (*Id.* at 7) (citation omitted). As explained above, *Amici's* concern for and knowledge about the effect this Court's decision will have on their constituents' patients and their own ability to care for their patients amply vests *Amici* with the special interest that qualifies them to submit a brief. Defendants' footnote about "neutrality" is confounding. (Doc. 186, at 8 n. 2). Throughout this case, Defendants have demanded strict compliance with the Middle District of North Carolina's Local Rules. Local Rule 7.5(b) requires *Amici* to "identify the party or parties supported." Now that *Amici* have done so, Defendants seek to exclude their proposed brief. Indeed, *Amici* support the Plaintiffs in this case, as patients of their constituents seeking medical care. As such, *Amici* have the special interest required.

Conspicuously, several of the cases cited by Defendants in their opposition (Opp. at 7–8) *granted* motions for leave to file *amicus* briefs for similar reasons. *See City of Columbus v. Trump,* 453 F. Supp. 3d 770, 786 (D. Md. 2020) (granting leave where *amici* "demonstrated a special interest in the outcome of the suit and provided helpful information to the court"); *Bryant v. Better Bus. Bureau of Greater Md, Inc.,* 923 F. Supp. 720, 728 (D. Md. 1996) (granting leave to the National Association for

the Deaf to appear as *amicus* in an individual's discrimination lawsuit because the organization "represent[s] large constituencies of individuals which have a vested interest in how the provisions of the ADA are construed and applied" and observing that permitting *amici* "may be advisable where third parties can contribute to the court's understanding") (citation omitted).

Defendants argue that *Amici* will not offer a "new or unique perspective beyond that already presented by the parties" (Doc. 186, at 11 (citation omitted)), but that argument was rejected by the Fourth Circuit in *Grimm.* The Fourth Circuit relied heavily on the substantially similar *amicus* brief presented by some of the same *Amici* to provide the "essential grounding" that assisted the court in its analysis of the facts. 972 F.3d at 597. For example, the Fourth Circuit relied on *Amici's* similar brief for an understanding of gender identity and what it means to be transgender. *Id.* at 594. The court went on to quote *Amici* and their resources extensively regarding health disparities experienced by transgender people, the diagnosis and treatment of gender dysphoria, and the widely accepted standards of care utilized by medical and health professionals in treating transgender people, including young people. *Id.* at 595-96. Notably, Defendants themselves acknowledge that *Amici* will present the Court with fresh information and perspectives that are not presented by the other parties to this case. (Doc. 186, at 2)

("Approximately 50% of the medical articles cited in the proposed *amicus* brief (24 of 46) are not in any of the reports by Plaintiffs' experts").

That is exactly the appropriate role that *Amici* request the opportunity to serve here. The Fourth Circuit welcomed *Amici's* participation and input to inform its analysis, and *Amici* respectfully request that this Court do so as well.

CONCLUSION

For the foregoing reasons, proposed *Amici*'s motion for leave to submit a brief as *amici curiae* should be granted.

Respectfully submitted, this the 3rd day of January, 2022.

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CERTIFICATE OF WORD COUNT

Pursuant to L.R. 7.3(d)(1) the undersigned counsel hereby certifies that the brief, in support of a motion, which is prepared using a proportionally spaced font, is less than 3,125 words (excluding cover, captions, indexes, tables of authorities, certificates of service, and this certificate of word count, counsel's signature block, and appendixes) as reported by word-processing software used to prepare this brief.

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I hereby certify that, on this date, the foregoing was filed electronically. Notice of this filing will be sent by operation of the Court's Electronic Filing System to all parties indicated on the electronic filing receipt. Parties may access this filing through the Court's system.

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

MAXWELL KADEL, *et al.*, *Plaintiffs*, v. DALE FOLWELL, *et al.*, *Defendants*.	No. 1:19-cv-00272-LCB-LPA

REPLY IN SUPPORT OF STATE HEALTH PLAN DEFENDANTS' MOTION FOR PARTIAL SUMMARY JUDGMENT

I. Plaintiff Caraway's Title VII claim does not lie against the State Health Plan, either as an agent of her actual employer, the North Carolina Department of Public Safety, or as a joint employer.

Caraway seeks to expand the reach of Title VII, arguing that the State Health Plan (the "Plan") is her "joint employer for purposes of health coverage," ECF No. 188 at 18, or that an "agent" of an employer can have liability under Title VII, *id.* at 13-14.

The Plan is not Caraway's employer because, like most health benefit programs, it does not employ prison guards. Common sense dictates this result, and the Fourth Circuit's rules for Title VII liability align with common sense. An agent can *create* Title VII liability, but the liability belongs to the employer, not the agent. Moreover, "joint employers" must "share or co-determine … the essential terms and conditions of employment." *Butler v. Drive Auto. Indus. of*

Am., Inc., 793 F.3d 404, 408 (4th Cir. 2015). Caraway cannot satisfy *Butler*'s nine-factor analysis and makes no attempt to do so. The Plan is not her "joint employer," and her Title VII claim against the Plan should be dismissed.

A. Under Title VII, only employers incur liability for agents' actions.

Caraway argues that the Plan is an "agent" of her employer, the North Carolina Department of Public Safety ("DPS"). But the reference to "agent" in the Title VII definition of "employer" is "an unremarkable expression of *respondeat superior*—that discriminatory personnel actions taken by an employer's agent may create liability for the employer." *Birkbeck v. Marvel Lighting Corp.*, 30 F.3d 507, 510 (4th Cir. 1994); *Lissau v. S. Food Serv., Inc.*, 159 F.3d 177, 180 (4th Cir. 1998) (definition of employer in Title VII "must be read in the same fashion" as *Birkbeck*'s interpretation of "employer" in Age Discrimination in Employment Act).

Caraway provides two unpersuasive responses. First, Caraway attempts to distinguish between cases where the "agent" is an individual and where the "agent" is an entity. ECF No. 188 at 15. Such a distinction cannot be squared with *Lissau,* which held that Title VII does not allow claims against an agent of an employer. 159 F.3d at 181. *Lissau* does not distinguish between 'types' of agents, and it would be novel if it did. The rule of law does not allow the interpretation of a statutory term—in this case "agent of the employer"—to

vary based on the defendant's identity. It is Caraway's obligation, not the Plan's, to identify some basis for her distinction in the statutory text, and she fails to do so.[1]

Second, Caraway asks this Court to adopt forty-year-old dicta from *Crowder v. Fieldcrest Mills, Inc.*, 569 F.Supp. 825 (M.D.N.C. 1983). *Crowder* speculated that "control of **an aspect** of the terms and conditions of employment" might make an entity an "employer," even though this reasoning played no role in its decision. *Id.* at 828 (emphasis added).

Butler overruled such analysis. *Butler* held that "[a]n entity can be held liable in a Title VII action **only if it is an 'employer' of the complainant**" and provides the framework to determine who, precisely, qualifies as such. 793 F.3d at 408 (emphasis added). Title VII's definition of "employer" may include "any agent" of an employer, but **liability** does not extend to a defendant unless it has "joint employer liability." *Id.*

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[1] While Judge Auld allowed Plaintiffs to amend their Complaint, adding Caraway and her Title VII claim, he held only that, before discovery, Caraway's Title VII claim "does not suffer from futility." ECF No. 74 at 23-24. Judge Auld did not rule that Title VII permits Caraway's claim against the Plan.

B. Control over the benefits available under the Plan fails to satisfy the Fourth Circuit's nine-factor analysis of joint employment.

As Plaintiffs note in their motion for summary judgment, "[h]ealth insurance constitutes an important part of one's compensation for employment." ECF No. 179 at 32 (citing *Newport News Shipbuilding & Dry Dock Co. v. EEOC*, 462 U.S. 669, 682 (1983)). However, "joint employer" status requires more than supplying one part of compensation, no matter how "important." There first must be an employer-employee relationship. It is this "contractual relationship of employment" that "triggers the provision of Title VII governing 'terms, conditions, or privileges of employment.'" *Hishon v. King & Spalding*, 467 U.S. 69, 74 (1984).

Caraway inverts the Title VII analysis, asserting that "control over employee health coverage," a single employee benefit, necessarily constitutes "a high degree of control over the terms of employment." ECF No. 188 at 18. This is clear error; Title VII liability rests on whether the Plan "actually exercise[s] control over an **employee**," not an employee benefit. *Butler*, 793 F.3d at 409. The "provisions of Title VII attach and govern certain aspects of that relationship" only after "a contractual relationship of employment is established." *Hishon*, 467 U.S. at 74.

Butler's "joint employment doctrine" instructs this Court how to identify an employment relationship. "[C]ontrol remains the principal guidepost for determining whether multiple entities can be a plaintiff's joint employers." 793 F.3d at 415. For the Plan and DPS to jointly employ Caraway, both must "exercise significant control" over her work. *Id.* at 408.

As outlined in Plan Defendants' Motion for Partial Summary Judgment, every *Butler* factor shows that the Plan is not Caraway's "joint employer." ECF No. 137 at 21-27. DPS possesses exclusive authority to hire, fire, supervise, discipline, and train Caraway. DPS provides her equipment and place of employment. Caraway works exclusively for the benefit of DPS. Caraway has provided no indicia of an employment relationship with the Plan. Therefore, even if the Plan has "control over employee health coverage," ECF No. 188 at 18, Caraway has not, and cannot, establish that the Plan "exercises **control over an employee** to the extent necessary to be held liable under Title VII," *Butler*, 793 F.3d at 410 (emphasis added). Without an employment relationship, there is no Title VII liability.

C. Arguments regarding DPS's liability cannot expand Title VII beyond its statutory scheme.

Caraway asserts that if this Court "credits both Defendants' arguments, no one bears any liability at all" under Title VII for her alleged discrimination.

ECF No. 179 at 33. Without elaboration, Caraway argues that this renders "Defendants' positions … untenable." *Id.* It is unsurprising that DPS and the Plan have different perspectives about Title VII. DPS's arguments do not, however, overcome the Fourth Circuit's repeated holdings that Title VII liability for "employers" extends only within the doctrine of *respondeat superior*. *See* ECF No. 133 at 11-21. Even if this Court allows Caraway's Title VII claim to proceed, any such liability would attach only to DPS, not the Plan.[2]

II. Plaintiffs' Affordable Care Act claims fail as a matter of law.

A. This Court should defer to HHS's interpretation of "health care program or activity."

Plaintiffs fail to establish that the Plan has liability under § 1557 of the Affordable Care Act ("ACA"), 42 U.S.C. § 18116. The U.S. Department of Health and Human Services ("HHS") has interpreted § 1557 to not encompass employer health benefit plans; because the statute is ambiguous, and because

[2] DPS disclaims Title VII liability on the basis that it cannot offer health benefits that compete with those offered by the State Health Plan. ECF No. 133 at 6-7 (citing ECF No. 134-5 at 30-37). The North Carolina Attorney General's opinion, however, explicitly permit health benefits that are "over and above rather [than] duplicat[ing]" Plan coverage. ECF No. 134-5 at 30-31. Such is the case for the benefits at issue here.

the agency's regulation is consistent with the text of the statute, this Court must defer to HHS's rule.

As outlined in the Plan Defendants' Motion for Partial Summary Judgment, ECF No. 137 at 28-32, HHS defines "health program or activity" to exclude "an entity principally or otherwise engaged in the business of providing insurance," 85 Fed. Reg. 37160 (June 19, 2020); 45 C.F.R. §92.3(b),(c)(2021). Although this interpretation has been challenged in the courts, it has not been overruled or enjoined, and it remains in full effect. *See Boston All. of Gay, Lesbian, Bisexual & Transgender Youth v. U.S. Dep't of Health & Hum. Servs.*, 2021 WL 3667760 at *9 (D. Mass. Aug. 18, 2021); *New York v. U.S. Dep't of Health & Hum. Servs.*, No. 1:20-cv-05583 (Doc. No. 145) (Aug. 23, 2021).

HHS's interpretation of "health program or activity" is entitled to *Chevron* deference. Congress has explicitly authorized HHS to "promulgate regulations to implement" § 1557. 42 U.S.C. § 18116(c). This "delegated legislative power" allows HHS to issue legislative rules, *Guedes v. ATF*, 920 F.3d 1, 17-18 (D.C. Cir. 2019), which "have the force and effect of law," *Guilford Coll. v. Wolf*, 2020 WL 586672, at *4 (M.D.N.C. Feb. 6, 2020) (Biggs, J.).[3]

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[3] Beyond their statutory arguments, Plaintiffs argue the 2020 HHS regulation is not a "permissible or reasonable" interpretation of the phrase "health

B. Congress has not "directly spoken to the precise question" of whether employee health benefits plans are "health programs or activities" under § 1557.

Under *Chevron*, the threshold question is whether a statutory provision is "ambiguous," such that Congress has not "directly spoken to the precise question at issue." *Othi*, 734 F. 3d at 265 n.4. Plaintiffs urge this Court to hold that, as a matter of law, the phrase "health program or activity" includes employer health benefit programs such as the Plan. Plaintiffs discern this clear meaning from "common sense" and by reference to other provisions of the Affordable Care Act. ECF No. 188 at 19-20. Neither "common sense" nor these other, scattered terms, however, provides what *Chevron* requires: evidence that "Congress has directly spoken to the precise question at issue." *Othi v. Holder*, 734 F. 3d 259, 265 n.4 (4th Cir. 2013) (quoting *Chevron v. Nat'l Res. Def. Coun.*, 467 U.S. 837, 842 (1984)).

Federal courts have widely agreed that "health program or activity" is ambiguous in the context of the ACA, *Callum v. CVS Health Corp.*, 137 F.Supp.3d 817, 849-50 (D.S.C. 2015), and in other statutory contexts

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program or activity" because HHS did not provide a "rational explanation" for its interpretation or consider the "harm caused by its new explanation" to individuals such as Plaintiffs. ECF No. 188 at 22, 24. HHS considered and rejected these arguments, as have other courts considering challenges to the 2020 rule.

featuring identical language, *see Nat'l Collegiate Athletic Ass'n v. Smith*, 525 U.S. 459, 467-68 (1999); *Currie v. Grp. Ins. Comm'n*, 290 F.3d 1, 6-7 (1st Cir. 2002); *Victim Rts. L. Ctr. v. Cardona*, 2021 WL 3185743 at *12 (D. Mass. July 28, 2021). This precedent significantly outweighs Plaintiffs' citation to a single district court holding. ECF No. 188 at 17-18 (citing *Fain v. Crouch*, 2021 WL 2657274 at *2-4 (S.D.W.Va. June 28, 2021)). If anything, the disagreement among the federal courts over the meaning of "health program or activity" should be dispositive proof that ambiguity exists and that Congress has not provided direct guidance. *See Othi*, 734 F.3d at 265 n.4.

In response, Plaintiffs argue that it "defies logic" to conclude that a "health program or activity" does not include health insurance. ECF No. 188 at 19-20. But the State Health Plan is not an insurance plan. Rather, like other arrangements in which an employer pays for employee health care costs, the Plan is an "employee health benefit program." Even the 2016 version of the HHS rule exempted **some** employee health benefit plans from its scope. 81 Fed. Reg. 31376, 31472 (May 18, 2016) (creating 45 CFR § 92.208, which holds an "employee health benefit plan" is covered by § 1557 *only* if the entity is "principally engaged in providing or administering health services" and "receives Federal financial assistance a primary objective of which is to fund the entity's employee health benefit program"). It is therefore incorrect to say

that HHS previously concluded that the phrase "health program or activity" in § 1557 unambiguously extends to all employee health benefit programs. It never has.

Plaintiffs' next argument is that Congress has "spoken directly to the precise question" of whether § 1557 extends to health benefit plans, *Chevron*, 467 U.S. at 842, because it uses similar phrases elsewhere in the Affordable Care Act that appear to refer to insurance products. ECF No. 188 at 18. As an initial matter, the Court should disregard this argument as inconsistent with the Plaintiffs' representations to the U.S. Supreme Court, where they urged that Court to conclude that § 1557 "is itself a federal statute" that can be considered apart from the "omnibus" Affordable Care Act. Brief in Opp., *NCSHP v. Kadel*, No. 21-674 at 14-15 (Dec. 27, 2021).

Moreover, while *Chevron* analysis acknowledges "that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme," *Nat'l Ass'n of Home Builders v. Defs. of Wildlife*, 551 U.S. 644, 666 (2007), *Chevron* does not allow a court to jumble similar phrases into a pastiche. The relevant canon of statutory construction states there is a "natural presumption that **identical** words used in different parts of the same act are intended to have the same meaning," *Atl. Cleaners & Dyers v. U.S.*, 286 U.S. 427, 433 (1932) (emphasis added). None of the phrases

collected by Plaintiffs, or by the *Fain* court, are identical, and their context varies widely. *See Fain* 2021 WL 2657274 at *3; *compare* 42 U.S.C. § 18116 ("health program or activity") *with*, *e.g.*, Patient Protection and Affordable Care Act, 124 Stat. 119, 580 (data collection for "federally conducted or supported health care or public health program or activity"); 124 Stat. 199-201 ("basic health programs" under which States can offer "standard health plans"); 124 Stat. 331 (requiring panel members with expertise in "Federal safety net health programs" and, separately listed, "health plans and integrated delivery systems"); 124 Stat. 333 (referring to "Health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations"); 124 Stat 382 (data measurement for quality improvement in "Federal health programs").[4]

[4] Plaintiffs argue § 1557's reference to "contracts of insurance" demonstrates Congress intended to include health benefits plans. ECF No. 188 at 19-20; *Fain*, 2021 WL 2657274 at *3 n.3. This misunderstands health care law. Title VI of the Civil Rights Act of 1964 expressly excludes its application to "a contract of insurance or guaranty." 42 U.S.C. § 2000d-1; 42 U.S.C. § 2000d-4. In 1967, the Department of Health, Education and Welfare issued a regulation concluding that physicians treat patients under Medicare Part B pursuant to a "contract of insurance" and are therefore not subject to Title VI. Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 HOW. L.J. 855, 865-66 (2012). § 1557's reference to "contracts of insurance" therefore addresses a separate participant in the health care system: physicians. This is reinforced by the fact that "contract of insurance" in § 1557 is listed with other forms of "federal financial assistance," not as part of a clause modifying "health program or activity." 42 U.S.C. §18116(a).

One cannot infer that these phrases all mean the same thing. Indeed, Plaintiffs identify another antidiscrimination provision in the ACA, § 1553, that applies to every "health care entity" and is defined to specifically include providers *and* health insurance plans. ECF No. 188 at 20-21 (quoting 42 U.S.C. § 18113(b)). That Congress explicitly defined "health care entity" broadly in § 1553 is, contrary to Plaintiffs' assertion, and strong evidence that the phrase "health program or activity" in § 1557 has a different, narrower meaning that does not include a 'health insurance plan' or its like.

Plaintiffs attempt to bolster their textual argument with a floor statement Senator Leahy made *months after* the Senate debated the Affordable Care Act and *after* the ACA had become law. ECF No. 188 at 21-22. The Affordable Care Act, H.R. 3590, passed the Senate on December 24, 2009. 155 Cong. Rec. S13891 (daily ed.). The House of Representatives concurred in the Senate bill on March 21, 2010, clearing it for the President's signature. *See* 156 Cong. Rec. H2153 (daily ed.). The President signed the ACA on March 23, 2010, at a ceremony that began at 12:39 p.m. Remarks on the Patient Protection and Affordable Care Act, 2010 Daily Comp. Pres. Doc. 197. The Senate did not convene until later that day, at 3:13 p.m., when Senator Leahy spoke during debate on a separate piece of legislation, H.R. 4872. 156 Cong. Rec. S1821&1841-44 (daily ed. March 23, 2010). "[W]hatever interpretive force

one attaches to legislative history, the Court normally gives little weight to statements, such as those of the individual legislators, made *after* the bill in question has become law." *Barber v. Thomas*, 560 U.S. 474, 486 (2010).

Ultimately, without the identical phrases required by this interpretive canon, the Court is left with the impermissible "parsing of general terms in the text of the statute" in the hope this "will reveal an actual intent of Congress." *Chevron*, 467 U.S. at 861. As in *Chevron*, "overlapping" terms and "language [that] is not precisely directed to the question" does not provide clear Congressional intent. *Id.* Plaintiffs are left asking this Court to interpret "health program or activity" by "looking at the ACA as a whole." *Fain*, 2021 WL 2657274 at *3. *Chevron* deference exists, however, because sweeping conclusions about the policy goals of the ACA are left to administrative agencies, not courts.

C. **Chevron** ***requires this Court to defer to HHS's reasonable interpretation of § 1557, which forecloses its application to the Plan.***

Pursuant to the second step of *Chevron*, this Court must defer to HHS's interpretation if it is "based on a permissible construction of the statute." *Schafer v. Astrue*, 641 F.3d 49, 54 (4th Cir. 2011) HHS's analysis of the distinction between "health insurance" and "healthcare" is compatible with the text. *See* 85 Fed. Reg. 37172-74. In particular, as the rule's preamble points

out, when Congress enacted the Civil Rights Restoration Act of 1990, it redefined "program or activity" in the context of other civil rights laws, defining the term 'program' to be, *inter alia*, the "entire … private organization … which is principally engaged in the business of providing … health care." 20 U.S.C. § 1687(3)(A)&3(A)(ii). The agency could certainly make a "reasonable policy choice," *Chevron*, 467 U.S. at 845, to reject Plaintiffs' interpretation and adopt the distinction advanced by a commenter that "paying for healthcare is not providing healthcare," 85 Fed. Reg. 37,172.

Employee health benefit plans are specifically exempted from the term "health program or activity" in § 1557, so the Plan cannot be liable under the Affordable Care Act as a matter of law. Plaintiffs' § 1557 claim should be dismissed.

Respectfully submitted, this the 13th day of January, 2022.

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I hereby certify that I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system, which will provide electronic notification to all counsel of record in this matter.

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

MAXWELL KADEL; JASON FLECK; CONNOR THONEN-FLECK; JULIA MCKEOWN; MICHAEL D. BUNTING, JR.; C.B., *by his next friends and parents*, MICHAEL D. BUNTING, JR. and SHELLEY K. BUNTING; SAM SILVAINE, and DANA CARAWAY.	)	
Plaintiffs,	)	
v.	)	No. 1:19-cv-272
DALE FOLWELL, *in his official capacity as State Treasurer of North Carolina*; DEE JONES, *in her official capacity as Executive Administrator of the North Carolina State Health Plan for Teachers and State Employees*; NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES; NORTH CAROLINA DEPARTMENT OF PUBLIC SAFETY.	)	
Defendants.	)	

STATE HEALTH PLAN DEFENDANTS' RESPONSE IN OPPOSITION TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

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STATEMENT OF THE CASE

The Court should deny Plaintiffs' motion for summary judgment against the Plan Defendants because their claims are inextricably tied to contested facts.

At the outset of their Memorandum in Support of Plaintiffs' Motion for Summary Judgment, Plaintiffs assert that "health coverage" is part of their employee compensation, and thus the Plan's "sweeping exclusion" for "gender-affirming care" means Plaintiffs receive "less compensation than others" for the same work. ECF No. 179 at 4. Plaintiffs further assert that because the Plan provides certain drugs and surgeries "for other reasons," it should pay for "the same kinds of treatments" for their psychiatric diagnosis of gender dysphoria.

Each of these assertions is incorrect. The General Assembly and courts of North Carolina are clear that state employees do not receive "health coverage" as a part of compensation. Rather, the State "undertakes to make available a State Health Plan," N.C. Gen. Stat. Ann. § 135-48.2, and state employees, such as Plaintiffs, are "given the opportunity to enroll or decline enrollment" in a group plan at the time they are hired (but only if they meet other eligibility criteria, such as working full-time), N.C. Gen. Stat. Ann. § 135-48.42(a). In return for payment of a premium, the Plan pays money to health

care providers to offset the member's cost of treatment for various diagnoses and procedures. Plaintiffs pay the same premiums as other members do, and they receive the same coverage for the same illnesses. ECF No. 137 at 9-10.

Second, "gender affirming care" has no accepted medical definition and does not correspond to the actual delivery of healthcare services, and Plaintiffs offer no definition in their motion for summary judgment. Plaintiffs have invented this artificial category for litigation purposes to distinguish it from "treatments for cisgender employees," but no such distinction exists in the world. ECF No. 179 at 4. Like the rest of the healthcare industry, the Plan uses the medical coding system to determine whether to pay for specific medical procedures to treat a specific diagnosis. ECF No. 137 at 10-11. When one reviews the specific procedures that Plaintiffs do identify, they are offered to *everyone*, including the Plaintiffs themselves, for treatment of the same diagnoses. The Plan's coding and payment practices make this clear. *See* ECF No. 137 at 13-18.

The ambiguity of the category "gender-affirming care" also distracts the Court from understanding that some of the treatments that Plaintiffs seek are not covered for *anyone* on the State Health Plan. Plaintiffs' equal protection claim—that they are denied the "kinds of treatments" offered to "cisgender employees" for "other reasons," ECF No. 179 at 4—cannot justify the

expansion of Plan coverage to services that are offered to *no one else* for any diagnosis.

The Plan's decision not to provide more generous health benefits is not a violation of the equal protection clause, § 1557 of the Affordable Care Act, or Title VII of the Civil Rights Act. The Plan has legitimate, non-discriminatory reasons to deny coverage for hormonal and surgical treatment for gender dysphoria. The Plan's leadership has a fiduciary duty to all Plan members. Consistent with this statutory duty, the Board has chosen to "focus on costs" and limit spending to protect the long-term health and availability of the Plan. The Plan's "fiduciary responsibility to cover basic health" needs for Plan participants, with limited dollars, requires that it focus on coverage for illnesses that affect many Plan members (diabetes, rheumatoid arthritis, and cancer) and is inconsistent with adding additional benefits for small "niche groups" (including not only gender dysphoria, but also adult hearing aids, special infant formula, and acupuncture) Ex. 1 (Jones. Dep.) at 104:20-105:24. This is especially true when, as here, there is considerable uncertainty about whether medical science supports these desired hormonal and surgical interventions.

ARGUMENT

I. Plaintiffs' motion for summary judgment rests on disputed material facts.

Summary judgment is appropriate when "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." Fed. R. Civ. P. 56(a). "A dispute is genuine if a reasonable jury could return a verdict for the nonmoving party." *Jacobs v. N.C. Admin. Off. of the Cts.*, 780 F.3d 562, 568 (4th Cir. 2015) (internal quotations omitted). "[I]n deciding a motion for summary judgment, a district court is required to view the evidence in the light most favorable to the nonmovant… and to draw all reasonable inferences in his favor." *Harris v. Pittman*, 927 F.3d 266, 272 (4th Cir. 2019). A court "cannot weigh the evidence or make credibility determinations," and thus must "usually" adopt "the nonmovant's version of the facts," even if it seems unlikely that the moving party would prevail at trial. *Walls v. Ford Motor Co.*, 2021 WL 5206388, at *1 (M.D.N.C. Nov. 9, 2021) (Biggs, J.) (quoting *Jacobs*, 780 F.3d at 569 and *Witt v. W. Va. State Police, Troop 2*, 633 F.3d 272, 276 (4th Cir. 2011)).

The parties fundamentally disagree on critical facts underlying Plaintiffs' claims, so the Plan Defendants respectfully submit that this Court may not resolve their claims at summary judgment.

A. The efficacy of Plaintiffs' desired medical treatments presents a crucial dispute of material fact.

First, Plaintiffs have not established the efficacy of the medical treatments that they demand. Plaintiffs assert that undefined "gender affirming care" procedures are medically necessary treatments for gender dysphoria, and they have offered several experts who will testify about the need for hormonal therapy and surgical procedures. Plaintiffs also ask this Court to defer to the WPATH Guidelines as "authoritative standards of care" for transgender individuals, and proof that these treatments are "medically necessary and effective." ECF No. 179 at 17, 20. In doing so, Plaintiffs ask this Court to make a judgment about a significant medical controversy without any review of the current scientific evidence.[1]

"[G]ender dysphoria was, until just a few years ago, a very rare condition." Ex. 3 (Hruz Rep.) at 41. Recent data, however, shows "the number of people seeking care for gender dysphoria is rapidly increasing," *id.* at 42,

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1 Evidence before this Court shows that the WPATH Guidelines are far from a trustworthy resource. Dr. Stephen B. Levine, a licensed psychiatrist and Professor at Case Western Reserve University School of Medicine was a member of WPATH for almost 20 years. Ex. 2 (Levine Rep.) at 1. Dr. Levine explains that WPATH has become "a voluntary membership, activist advocacy organization" that accepts members who are not licensed medical professionals and "can no longer be considered a purely professional or scientific organization." Id. at 36.

and there has been a drastic "transformation of the patient population from early onset males to rapid onset adolescent girls," *id* at 67. For example, "[t]he number of adolescent girls seeking sex transitioning" in the United Kingdom increased "4,000% in the last decade." *Id.* For many decades, the typical patient with gender dysphoria was a biological male with a long, stable history of dysphoria since early childhood. But in the past 10 years, this has changed abruptly, and the typical patient is now an adolescent female with no documented long-term history of gender dysphoria. *Id.* at 67-68. Scientists have not explained this surprising shift, but such a quick change in a patient population suggests that theories of the cause or causes of gender dysphoria that are based on static features like "brain structures" or "genetics" are incorrect. *Id.* at 69.

While the patient population has changed and increased, the physical interventions for gender dysphoria remain experimental. As Dr. Paul McHugh noted in his expert report, "this controversial field has faced increasing scrutiny" in recent years, with "national research reviews in England, Sweden, and Finland" and other studies finding that "the evidentiary base for these experimental treatments is weak;" hormonal and surgical treatments demonstrate "few benefits" and may actually "cause more harm than good." Ex. 4 (McHugh Rep.) at 10.

There are no long-term, peer-reviewed, reliable research studies that allow physicians to know "the percentage of patients receiving gender transition procedures who *are helped* by such procedures, using objective criteria" or the "percentage of patients receiving gender transition procedures who *are harmed* by such procedures, measured with objective criteria." Ex. 2 (Levine Rep.) at 87 (emphasis added).

While patients may say, when interviewed, that they have benefited from hormone and surgical treatment, the current peer-reviewed scientific literature has not found evidence to support these subjective claims. As Plaintiffs note, a diagnosis of gender dysphoria requires more than a feeling of "dissonance" between one's perceived gender and one's biological sex; the patient must also suffer "clinically significant distress or significant impairment of functioning." ECF No. 179 at 17-18. Patients identify depression or anxiety as debilitating symptoms of gender dysphoria, and they assert anecdotally, after hormone therapy or surgery, that they feel less anxious or depressed. But when follow-up studies track *objective* measurements, like use of antidepressants and anti-anxiety medication, there

is no measurable difference between patients who receive hormone therapy or surgery and those who do not.[2]

In particular, the "affirmation" model of care—the basis for the WPATH Guidelines—is not supported by existing medical science. "The available data does not support the contention that 'affirmation' of transgender identity reduces suicide or results in better physical or mental health outcomes generally." Ex. 2 (Levine Rep.) at 45, 45-69. Finland, Sweden, and United Kingdom have retreated from prior medical policies on cross-sex hormones and surgical treatments. Medical providers in these countries now restrict the use of hormones and surgery in minors based on identified gaps in the medical science. *Id.* at 51-55. "The current status of the field of gender affirmation treatments has been labelled 'low quality' science by multiple reviews." *Id.* at 56. Studies have concluded that the field of affirmation treatments is "still at the experimental stage lacking in general acceptance within the relevant

[2] The lack of valid, reliable scientific data about the effect of gender dysphoria treatments has ethical consequences, especially when a patient seeks surgery. "Since the abandonment of frontal lobotomies in 1967, there has been no other psychological condition for which surgery is performed, and there is no other area of surgical care where the diagnostician is the patient themselves, and the surgeon has no means of confirming or rejecting the diagnosis." Ex. 5 (Lappert Rep.) at 23-24. Valid surgical consent requires that a surgeon be able to ensure that a diagnosis is correct. *Id.* at 24. The surgical procedures involved in gender transition can have very high complication rates, with one procedure having a rate of complication over 50%, making it even more important to have confidence in treatment benefits. *Id.* at 29-39.

scientific communities and without known error rates for the efficacy of the treatment." *Id.*

Striking scientific evidence was made public in 2020. The American Journal of Psychiatry published a study of individuals in Sweden with gender dysphoria. *Id.* at 57-58. Researchers used national health system data to research individuals with gender dysphoria in 2005 and again in 2015. The study sought to determine whether individuals who used cross-sex hormones or underwent surgery had, ten years later, lower use of anti-anxiety medication or anti-depressants, fewer mental health visits, or fewer hospitalizations connected to unsuccessful suicide attempts (*i.e.* improved mental health) when compared to individuals who did not receive these treatments. Ex. 6 (Branstrom & Pachankis; Follow-up Letters). After review of the study's data, outside experts and the authors agreed that the evidence did not show that hormone treatment or surgery improves the mental health of patients with gender dysphoria. Ex. 2 (Levine Rep.) at 57-63. Indeed, patients who received surgery "were more likely to be treated for anxiety disorders" than those who did not. *Id.* at 63.[3]

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3 This conclusion—that hormone treatment for gender dysphoria does not reduce mental healthcare needs—is supported by a 2021 study in the peer-reviewed Journal of Sexual Medicine. Looking over time at adolescents who received cross-sex hormones, researchers found the patients' "mental health

Dr. Paul W. Hruz, M.D., Ph.D. is a pediatric endocrinologist and a Professor of Medicine at the Washington University School of Medicine in St. Louis. Ex. 3 (Hruz Rep.) at 2. He is also the *only endocrinologist*—*i.e.*, a physician with specific expertise in the endocrine system (hormones)—to provide an expert opinion in this case. Dr. Hruz's opinion is that hormone therapy and surgery are "experimental, highly intrusive, and potentially harmful medical procedures" that lack "credible, reliable, and valid scientific support." *Id.* at 7-8. As one example, scientists understand that sex hormones affect brain development, but this knowledge "is in its rudimentary stages right now." Ex. 7 (Hruz Dep.) at 285:1-286:11. Testosterone appears to have some effect on brain development for biological males, and this finding creates "many reasons to be concerned and question" what the effect of puberty suppressing medications or testosterone has on the brain of a biological female. *Id.* at 285:1-287:2. At this time, any effect is completely unknown. Plaintiffs respond to these concerns by citing to guidelines from the Endocrine Society regarding hormone therapy, but the guidelines explicitly state that "the strength of recommendations and the quality of evidence was low or very low"

utilization remained elevated" even after hormone treatment, and the "use of psychotropic medications increased." Ex. 7 (Hruz Dep.) at 269:8-271:6. *See also* Ex.8 (Hisle-Gorman).

in support of these treatments. Ex. 3 (Hruz Rep.) at 53. "Low" and "very low" are terms of art. A "low recommendation" means that "[f]urther research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate." Very low recommendations mean that "any estimate of effect is very uncertain." *Id.*

Plaintiffs' experts do not inform the Court about this current, raging scientific controversy. Instead, Plaintiffs shift the argument to assertions that the Plan has changed its mind about the efficacy of Plaintiffs' desired treatments, or that, in any event, any concerns are misplaced. ECF No. 179 at 27-30. In doing so, Plaintiffs improperly shift the burden of proof.

The Plan need not demonstrate that Plan officials are experts on medical care. It is the Plaintiffs who must demonstrate that the medical evidence supporting their proposed treatments is so strong that it would be "irrational" to "disfavor" coverage for such procedures. *Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263, 270 (1993). They cannot. Not a single drug has been FDA-approved for treatment of gender dysphoria. ECF No. 137 at 18.

Plaintiffs assert that these treatments have reduced their symptoms, ECF No. 137 at 5-9, but anecdotal evidence cannot establish that it is *unconstitutional* to reach a different conclusion about medical science. The existing scientific ambiguity demonstrates it would be profoundly

inappropriate for this Court enter an injunction at summary judgment, as Plaintiffs ask, and order the Plan to pay for Plaintiffs' desired medical treatment.

B. Plaintiffs' purported expert evidence is not appropriate for resolution without consideration by the factfinder.

To avoid the ongoing scientific controversy, Plaintiffs place extensive reliance upon guidelines issued by the World Professional Association for Transgender Health and the Endocrine Society. But this Court cannot summarily resolve this case by adopting such opinions as its own. *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579, 584 (1993). Prior to *Daubert*, courts asked whether a scientific opinion is based on a scientific technique that is "'generally accepted' as reliable in the relevant scientific community." *Daubert,* 509 U.S. at 584. Adoption of the Federal Rules of Evidence eliminated this standard. Instead, Plaintiffs must provide more.

Daubert held that to be admissible, expert testimony must be "not only relevant, but reliable"—*i.e.*, it must impart "'scientific knowledge'" "*derived by [a] scientific method*" and "*supported by appropriate validation*." 509 U.S. at 589-590 (emphasis added). Federal Rule of Evidence 702 requires courts to determine not only that expert testimony is "the product of reliable principles

and methods," but also that the expert has "reliably applied" those principles and methods to the facts of the case before admitting testimony.

Reference to the holdings of a professional association can be relevant under *Daubert*, but the WPATH Guidelines do not accurately reflect medical science, having been developed by a "private, activist, non-science organization" that "takes a very narrow and politically-ideologically driven view on increasingly controversial issues as to which there is a wide range of opinion among professionals." Ex. 2 (Levine Rep.) at 36, 35-40. "When policy is made by voting in the face of low quality science, claims that treatments are evidence-based should be considered misleading and deceptive." *Id.* at 89.

C. Plaintiffs' characterization of the Plan's coverage decisions is contradicted by the facts.

Another factual dispute arises, in part, from disagreement over medical efficacy. Because Plaintiffs are certain about the effect of their desired treatments, they assert that no possible motive other than sex stereotyping or discriminatory animus could justify the Plan's coverage decisions. This is not supported by the evidence. The Plan's decision has no animus associated with it. Rather, the timeline is transparent. The Plan received federal funding from the Retiree Drug Subsidy program. When the federal government attached new requirements to this funding—requiring that the Plan cover the Plaintiffs'

desired benefits—the Plan complied, but the Board of Trustees' approval in 2016 was temporary due to their uncertainty regarding the benefits. When this funding condition was enjoined, later to be rescinded, the Plan allowed the benefits to expire when the initial approval sunset. Ex. 1 (Jones Dep.) at 69:9-19; 56:12-57:25. As the courts have repeatedly recognized, health plans are permitted to cover some illnesses and not others. In this case, the Board of Trustees focused on reducing the overall cost of treatment under the Plan and covering illnesses that affect large numbers of members.

D. Plaintiffs have failed to provide any evidence for crucial questions of fact.

Several remaining factual disputes arise from Plaintiffs' failure to develop evidence to carry their burden of proof. Plaintiffs repeatedly refer to "gender-confirming care," but they have never defined or otherwise provided a concrete list of the procedures that comprise such care. Plaintiffs seek injunctive relief for the alleged violation of the Equal Protection clause, ECF No. 75 at 37, but this Court cannot grant summary judgment and order such relief without clarity about exactly how the Plan is to comply. The Plan can no more be ordered to provide undefined "gender-confirming care" than a prison can be ordered to accommodate religious "dietary requirements." *Raymond Lee X v. Johnson*, 888 F.2d 1387 (4th Cir. 1989) (holding "Muslim dietary

requirements" insufficiently clear requirement to impose as an injunction under Fed. R. Civ. P. 65(d)).

Moreover, under both § 1557 of the Affordable Care Act, 42 U.S.C. § 18116, and Title VII, Plaintiffs seek damages. But they have not presented any evidence for these damages. Plaintiffs seek damages for "financial harm," ECF No. 75 at 42, 44-45, but present no calculations or medical bills. Without such evidence, the Court cannot award summary judgment. Plaintiffs allege emotional damages, *id.*, but they have neither identified nor attempted to quantify the "independent compensable harm" that resulted from the alleged violation. *Price v. City of Charlotte, N.C.*, 93 F.3d 1241, 1248 (4th Cir. 1996).

Indeed, Plaintiffs have not submitted any medical records to this Court that prove they suffer from gender dysphoria. As noted in the Plan Defendants' response to the Plaintiffs' Motion to Seal, ECF No. 190 at 6-7, Plaintiffs submitted an expert report from George Brown, M.D., which includes statements about Plaintiffs' medical histories. Dr. Brown's report, however, does not specifically cite any of Plaintiffs' medical records, and he expressly disavowed that he himself was engaged in the practice of medicine (which is required to provide a medical diagnosis). *Id.*

II. Plaintiffs have not provided sufficient evidence to receive summary judgment on their claim pursuant to the Equal Protection Clause of the 14th Amendment.

A. Plaintiffs have not identified a group of individuals, with whom they are similarly situated, who are treated differently.

The Equal Protection Clause of the 14th Amendment is "essentially a direction that all persons *similarly situated* should be treated alike." *Grimm v. Gloucester Cty. Sch. Bd.*, 972 F.3d 586, 635 (4th Cir. 2020) (quoting *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 439 (1985) (emphasis in original)). Plaintiffs must therefore produce evidence that the Plan is "treating differently persons *who are in all relevant respects alike*." *Id.* (emphasis in original).[4]

This is a sequential analysis. First, Plaintiffs must make an "initial showing" they have been "intentionally treated differently" from others who are "similarly situated." *Sandlands C & D LLC v. Cty. of Horry*, 737 F.3d 45, 55 (4th Cir. 2013). The court does not apply constitutional scrutiny—whether rational-basis or heightened—until *after* a plaintiff has made this showing of

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4 The Defendants note that Plaintiffs can still demonstrate an Equal Protection violation if they can prove that a discriminatory animus motivated the adoption of a facially neutral policy that is neutrally applied. *Williams v. Hansen*, 326 F.3d 569, 584 (4th Cir.2003). Plaintiffs must proceed to trial, however, and allow the jury to weigh competing evidence of the Plan's intent.

similarity. *Id.* Without proof that two groups are "similarly situated," the Court has no basis to proceed with an equal protection analysis. "The Constitution does not require things which are different in fact … to be treated in law as though they were the same." *Roller v. Gunn*, 107 F.3d 227, 234 (4th Cir. 1997) (quoting *Tigner v. Texas,* 310 U.S. 141, 147 (1940)).

To satisfy the "similarly situated" standard, Plaintiffs must identify a comparative group of persons who are (1) materially identical to them but who (2) have received different treatment. "[A]pples should be compared to apples." *Barrington Cove Ltd. P'ship v. R.I. Hous. & Mortg. Fin. Corp.,* 246 F.3d 1, 8 (1st Cir. 2001). Two compared groups must be "identical or directly comparable in all material respects," *LaBella Winnetka, Inc. v. Village of Winnetka,* 628 F.3d 937, 942 (7th Cir. 2010), or "prima facie identical," *Grider v. City of Auburn, Ala.,* 618 F.3d 1240, 1264 (11th Cir. 2010). The Fourth Circuit requires that the "evidence must show an extremely high degree of similarity." *Willis v. Town of Marshall, N.C.,* 275 Fed. App'x. 227, 233 (4th Cir. 2008); *see also LaBella,* 628 F.3d at 942 ("The similarly situated analysis is not a precise formula, but … what is clear is that similarly situated individuals must be very similar indeed.").

Providing different medical treatments for different medical diagnoses does not violate equal protection. "[A] function of medical diagnosis is to

determine in what ways individuals are not similarly situated so that they can be treated accordingly." *Gann v. Schramm*, 606 F. Supp. 1442, 1447 (D. Del. 1985). This remains true even when different diagnoses have the same treatment. *Flaming v. Univ. of Texas Med. Branch*, 2016 WL 727941, at *9 (S.D. Tex. Feb. 24, 2016). An individual with testicular cancer may need testosterone injections, but that person is not 'similarly situated' to someone with gender dysphoria. *McMain v. Peters*, 2018 WL 3732660, at *3-4 (D.Or. Aug. 2, 2018).

This failure to define who is "similarly situated" to the Plaintiffs is exacerbated by the WPATH Guidelines on which Plaintiffs rely. Plaintiffs repeatedly cite the WPATH Guidelines as a "consensus" approach to the medical care they need, ECF No. 179 at 17-19, but when asked about that care, emphasize that the Guidelines are expressly "meant to be flexible standards," Ex. 13 (Brown. Dep.) at 160:8-18, that "individual health professionals and programs may modify themselves." Eli Coleman, et al., STANDARDS OF CARE FOR THE HEALTH OF TRANSSEXUAL, TRANSGENDER, AND GENDER-NONCONFORMING PEOPLE, v.7 at 2 (2012) (WPATH Guidelines). The term "gender affirming care" thus means anything the Plaintiffs, or an individual physician, believes could be helpful to a child or adult with gender dysphoria. This vague concept, which Plaintiffs advance despite the encyclopedic coding

system adopted by the federal government for medical diagnoses and procedures, is not sufficient information to permit the determination whether one Plan participant is "similarly situated" to another.[5]

Plaintiffs, and the two out-of-circuit district court cases they cite, do not acknowledge or even consider this initial requirement of an equal protection analysis. *See, e.g.*, *Fletcher v. Alaska*, 443 F.Supp.3d 1024, 1030-31 (D. Alaska 2020). This failure is most clear in *Boyden v. Conlin*. 341 F.Supp.3d 979, 995 (W.D. Wis. 2018). In that case, the district court assumed, without medical evidence, that a person with an unidentified genetic birth defect ("born without a vagina") is similarly situated to an individual with gender dysphoria, but then held that "no reasonable factfinder" could conclude without additional medical evidence that "a cisgender woman's depression because of small breast size" (which was not covered) "is medically comparable to gender dysphoria." *Id.*

If Plaintiffs want this Court to make similar findings, then at a minimum they need to show "medically comparable" diagnoses. *Id.* Plaintiffs do not. They argue only that if the Plan provides "the same kinds of treatments" for "other

[5] This vagueness also prevents the Court from simply relying on the WPATH Guidelines to define the healthcare procedures at issue. An injunction must "describe in reasonable detail—and not by referring to the complaint or other document—the act or acts restrained or required." Fed. R. Civ. P. 65(d).

reasons," then it must also cover their desired treatment for gender dysphoria. ECF No. 179 at 4. In doing so, Plaintiffs claim that hormones, puberty-delaying hormones, mammoplasty and breast reduction, vaginoplasty, and hysterectomies are available only for "cisgender participants" but not for "transgender people." ECF No. 179 at 12.

This is false. The Plan does not identify or track or record whether any participant is transgender, cisgender, non-binary or otherwise. ECF No. 137 at 14. The Plan evaluates whether the billed medical procedure corresponds to a covered diagnosis. For prescription medicines that are neither costly nor subject to abuse, neither the Plan nor CVS/Caremark (the Plan's Pharmacy Benefit Manager) *ever know* the reason for the prescription (*i.e.* the patient's diagnosis). *Id.* at 17-18. Those claims are paid.

Some prescription drugs are subject to special restrictions because they are expensive or subject to abuse. Each of these drugs must be prescribed for an FDA-approved diagnosis or for cancer treatment. *Id.* When these drugs are prescribed "off-label" for any other use, including treatment of gender dysphoria, they are denied. For example, the Plan requires prior authorization for some testosterone prescriptions. *See* Ex. 9 (CVS/Caremark, Prior Authorization Criteria). The authorization criteria identify the covered diagnoses: primary hypogonadism, hypogonadotropic hypogonadism, and

metastatic mammary cancer. *Id.* No individual ever receives a testosterone prescription to "reaffirm an individual's natal sex" or to "diverge[ ] from an individual's natal sex." ECF No. 179 at 21. Nothing in the authorization document refers to transgender individuals; prescriptions are authorized for both men and women.

The Plan applies the same restrictions—that the prescription is used to treat an FDA-approved diagnosis or to treat cancer—to hormone suppressing drugs that are covered by Specialty Guideline Management: Supprelin (central precocious puberty in all children), Eligard (prostate cancer and certain salivary gland tumors); Vantas (prostate cancer); Zoladex (prostate cancer, endometriosis, breast cancer); Triptodur (central precocious puberty in all children); and Trelstar (prostate cancer). *See* Ex. 10. Plaintiffs qualify for these prescriptions on the exact same basis as every other Plan participant.

For surgeries, again, the Plan authorizes payment based on diagnosis and procedure code. The Plan provides mastectomies for breast cancer, gynecomastia, breast reduction for macromastia (when breast size causes neck, back, and shoulder pain), and for individuals with a high risk of breast cancer. Ex. 11 (Blue Cross Blue Shield of North Carolina, Corporate Medical Policy, Breast Surgeries, August 2020. These patients can also, if they desire, receive breast reconstruction, but this is not the result of a Plan design or "sex

stereotypes." Federal law requires it. Every group health plan that provides "medical and surgical benefits with respect to a mastectomy" must provide "all stages of reconstruction of the breast on which the mastectomy has been performed" and "surgery and reconstruction of the other breast to produce a symmetrical appearance." 29 U.S.C. § 1185b(a).[6]

Payment for a specific procedure is not based on the sex or transgender identity of the patient; rather, the denial of coverage arises from the diagnosis. At deposition, at least some of the Plaintiffs conceded this point. *See*, *e.g.,* Ex. 12 (M. Bunting. Dep.) at 108:11-20 (Plaintiff does not assert that the "Plan does not pay for any of [C.B.'s] medical treatment," but rather that the Plan does not "cover treatment connected to [C.B.'s] gender dysphoria."). *See Saks v. Franklin Covey Co.*, 316 F.3d 337, 342 (2d Cir. 2003) (applying similar analysis to infertility); *In re Union Pac. R.R. Employment Practices Litig.*, 479 F.3d 936, 942, 944 (8th Cir. 2007) (contraceptive coverage).

"Generally, in determining whether persons are similarly situated for equal protection purposes, a court must examine *all* relevant factors." *United States v. Olvis,* 97 F.3d 739, 744 (4th Cir. 1996) (emphasis added). *Sandlands*

[6] The Plaintiffs claim there is a discrepancy in coverage of hysterectomies, ECF No. 179 at 12, but the Plan has no procedure codes that limit hysterectomies in connection with a diagnosis of gender dysphoria, ECF No. 137 at 15-17.

C & D LLC, 737 F.3d at 55. Plaintiffs' motion for summary judgment fails at this threshold inquiry because they have not produced any evidence to establish that an individual with gender dysphoria is "identical or directly comparable in all material respects," *LaBella Winnetka,* 628 F.3d at 942, or "prima facie identical," *Grider,* 618 F.3d at 1264, to an individual with a different medical diagnosis, such as breast or prostate cancer.

At the summary judgment stage, these relevant factors must be resolved against the Plaintiffs. The Court must assume that the differences between the diagnosis of gender dysphoria and other diagnoses are significant, and that the medical efficacy of the treatments differs, creating a "genuine dispute" of "material fact." Fed. R. Civ. P. 56(a).

B. Plaintiffs have not established that the State Health Plan imposes facial classifications on its beneficiaries

"Whether an employment practice involves disparate treatment through explicit facial discrimination does not depend on why the employer discriminates but rather on the explicit terms of the discrimination." *Int'l Union, United Auto., Aerospace & Agr. Implement Workers of Am., UAW v. Johnson Controls, Inc.*, 499 U.S. 187, 199 (1991). The Plaintiffs argue that the Plan discriminates, on its face, against the Plaintiffs. They do so based on the

Plan's benefit booklet, which states that the Plan does not cover, among other medical treatments, the following services:

> Treatment or studies leading to or in connection with sex changes or modifications and related care.

The text of this exclusion, however, does not distinguish between individuals on the basis of sex, gender, or transgender status. To be facial discrimination, the provision must distinguish between men and women. It does not. To discriminate against transgender individuals, it must separate the health care available to transgender individuals from the health care available to others. The provision does not.

Plaintiffs attempt to establish facial discrimination under two broad lines of reasoning. First, and primarily, Plaintiffs assert that the State Health Plan improperly denies coverage for certain "medically necessary care … based on an employee's birth-assigned sex." ECF No. 153 at 17. But by focusing on their individual desires for specific medical treatments, Plaintiffs miss the broader context of how those treatments are prescribed, administered, and paid for across the healthcare industry.

Plaintiffs are mistaken in their assertion that the Plan's exclusion of certain coverage is "discriminating against a person for being transgender," "based on gender transition," or "based on an employee's birth-assigned sex."[7] ECF No. 153 at 16-18. The Plan excludes coverage for specific procedures if they are prescribed for treatment of the psychiatric diagnosis of gender dysphoria. Ex. 1 (Jones Dep.) at 15:1-16:23, 117:10-18:5.

Payment hinges solely on the medical condition and the procedure performed to treat it, which is determined independently of the Plan by the patient's chosen healthcare provider. Unlike in *Bostock v. Clayton County*, 140 S. Ct. 1731 (2020), where the employer both evaluated the Plaintiff's biological sex and terminated the employee after considering that information, a patient's biological sex and/or expressed gender play no role in Plan coverage. For example, the Plan covers breast reduction surgery for a transgender man with a family history of breast cancer, a hysterectomy for a transgender man suffering from endometriosis, testosterone treatment for a transgender woman

7 Plaintiffs improperly conflate these three distinct equal protection claims into a single element of "discrimination." Discrimination based on gender identity and discrimination based on biological sex operate in different ways. Furthermore, Plaintiffs make no effort to clarify whether they allege discriminatory animus, disparate impact, or both. In sum, the breadth and vagueness of Plaintiffs' assertions highlight their misunderstanding of the specific policy grounds for the State Health Plan's coverage policies.

based on specific hormonal needs, or genital constructive surgery for any transgender (or cisgender) person with relevant injuries from a workplace or automobile accident. Ex. 14 (BCBS Decl.) at ¶ 28.

As the Plan has shown, ECF No. 137 at 14, none of its coverage decisions for gender dysphoria consider a patient's sex. It is unclear whether Plaintiffs' claim of discrimination is that *any* coverage decision is subject to heightened scrutiny if *the healthcare provider* considered the patient's biological sex as part of the diagnostic process. Healthcare providers must know a patient's sex for *every* medical diagnosis. While hormones or surgical procedures can alter the visual appearance of a patient, "the biology of the person remains as defined by genetic makeup, normatively by his (XY) or her (XX) chromosomes, including cellular, anatomic, and physiologic characteristics and the particular disease vulnerabilities associated with that chromosomally-defined sex." Ex. 3 (Hruz Rep.) at 66. As but one example how this is so: under the clinical guidelines for cardiovascular health, male biological sex is, by itself, a risk factor indicating preventive intervention. Ex. 15 (Robie. Dep.) at 70:13-71:25. Competent medical care requires *every diagnosing physician* to know and to consider the patient's biological sex. *Id.* This does not, however, make the

physician an agent of the Plan or mean that the Plan itself has looked beyond the diagnosis that this independent actor has supplied.[8]

Gender dysphoria is a mental illness that affects some people who are transgender and some who are not, Ex. 16 (Ettner Dep.) at 28:11-13, Ex. 17 (Levine Dep.) at 241:24-243:20, and the proportion of transgender individuals who suffer from this condition is entirely unknown. Ex. 13 (Brown Dep.) at 92:17-25. Many transgender people do not suffer from gender dysphoria at all. Ex. 16 (Ettner Dep.) at 28:11-13; Ex. 17 (Levine Dep.) at 241:24-243:20. Furthermore, "there may be people who have symptoms of gender dysphoria, but they personally don't identify as transgender." Ex. 18 (Karasic Dep.) at 27:25-28:17; Ex. 17 (Levine Dep.) at 241:24-243:20. As a result, Plaintiffs' assertion that "transgender individuals are the only people who would ever seek" treatments for gender dysphoria is flatly contradicted by the testimony

[8] In contrast to the information before a treating physician, the Plan sees only the information on the standard reimbursement form for health insurance, adopted by BCBSNC and the entire healthcare industry. This form does require each healthcare provider to report the patient's sex, but this can be biological sex or expressed gender; the information is irrelevant because the coverage decisions here do not consider this information at all. ECF No. 137 at 10-11. The Plan also receives bills that use the diagnostic codes developed by the World Health Organization and required by HHS, as is the case for every other participant in the healthcare industry. While some diagnostic or procedure codes are sex-specific, *see*, *e.g.*, ECF No. 137 at 10, this does not mean that the Plan has made any decision other than to use coding required by the healthcare industry.

of their own medical experts submitted to this Court. ECF No. 139 at 16 (citing *Toomey v. Arizona*, 2019 WL 7172144 at *6 (D. Ariz. Dec. 23, 2019)).[9]

The Plan's benefits, and limits on coverage, apply equally, and they are implemented *without any knowledge of the beneficiary's sex or gender*. Ex. 14 (BCBS Decl.) at ¶¶ 22,28. The Plan's benefit scheme therefore cannot be shown to discriminate facially on the basis of sex. This remains true even if one assumes, incorrectly, that only transgender individuals suffer from gender dysphoria. Ex. 16 (Ettner Dep.) at 28:11-13; Ex. 17 (Levine Dep.) at 241:24-243:20.

In *Geduldig v. Aiello*, the Supreme Court held that the exclusion of pregnancy from an insurance program was not facially "sex-based" even though only (biological) females become pregnant. 417 U.S. 484, 496 n.20 (1974). There is "no risk from which men are protected and women are not. Likewise, there is no risk from which women are protected and men are not." *Id.* at 496. "The lack of identity between the excluded disability and gender as

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9 Plaintiffs rely on the denial of a motion to dismiss in *Toomey v. Arizona*, 2019 WL 7172144 (D.Ariz. 2019) to support their motion for summary judgment. *Toomey* decided only that a particular plaintiff had stated a claim "that is plausible on its face," accepting all allegations and reasonable inferences as true, *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). This standard is in sharp contrast to Plaintiffs' motion here for summary judgment, under which the Plaintiffs themselves must produce evidence there is "no genuine dispute as to any material fact."

such under this insurance program becomes clear upon the most cursory analysis." *Id.*

> The program divides potential recipients into two groups—pregnant women and nonpregnant persons. While the first group is exclusively female, the second includes members of both sexes. The fiscal and actuarial benefits of the program thus accrue to members of both sexes.

Id. at 496 n.20. This case is the same. Not all transgender individuals suffer from gender dysphoria. Ex. 16 (Ettner Dep.) at 28:11-13; Ex. 17 (Levine Dep.) at 241:24-243:20; Ex. 13 (Brown Dep.) at 92:17-25. The Supreme Court's reasoning in *Aiello* controls the analysis here:

> The program divides potential recipients into two groups—[individuals who suffer from gender dysphoria and individuals who do not. Even if] the first group is exclusively [transgender (and the evidence shows it is not)], the second group includes [both transgender and non-transgender individuals]. The fiscal and actuarial benefits of the program thus accrue to members of both [groups]

Aiello, 417 U.S. at 496. Under the Plan, transgender females have the same coverage as a transgender males, and both transgender males and females have the same coverage as cisgender males and females.

Plaintiffs may feel that the Plan burdens them unfairly as transgender people, but this does not establish discrimination. *Aiello* holds that an insurance exclusion that disparately impacts members of a particular class is

not discrimination without evidence of discriminatory intent.[10] 417 U.S. at 496 n.20. Plaintiffs have made no effort to establish discriminatory intent beyond vague references to "impermissible stereotyping." This is precisely the type of contested fact that must proceed to trial. The Plan's exclusion of certain treatments for the psychiatric condition of gender dysphoria does not stem from any view about what healthcare Plaintiffs should receive; it stems from judgment about how to best provide medical care for all members in light of existing regulations, the health care needs for all patients covered by the Plan, and limited financial resources. Ex. 1 (Jones Dep.) at 73:4-75:8.

Plaintiffs must proceed to trial and provide more: evidence of discriminatory intent. They cannot prevail only with assertions that gender dysphoria disproportionately affects members of a protected class. *See Lange*

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10 Plaintiffs argue that *Aiello* has been overruled, ECF No. 188 at 5-6, but this is flatly incorrect. The Pregnancy Discrimination Act and cases cited by Plaintiffs "cast[ ] no doubt on the continuing vitality" of *Aiello*. *Bray*, 506 U.S. at 273 n.3. Nor does *Bostock* permit this Court to depart from *Aiello*'s reasoning and analysis. *Bostock* involved statutory interpretation. 140 S.Ct. at 1738. The Court did not consider whether the same analysis should apply in cases involving the Equal Protection Clause. When a Supreme Court precedent "has direct application in a case, yet appears to rest on reasons rejected in some other line of decisions," the lower court must "follow the case which directly controls, leaving to [the Supreme Court] the prerogative of overruling its own decisions." *Agostini v. Felton*, 521 U.S. 203, 237 (1997).

v. Houston Cty., 499 F. Supp. 3d 1258, 1275-77 (M.D. Ga. 2020) (insurance exclusion for gender dysphoria not facially discriminatory).

C. Plaintiffs have not established any legal authority for their claims that the Plan has an obligation to provide any member with specific medical care or that the refusal to do so is improper.

Plaintiffs' motion for summary judgment devotes significant time and attention to assertions that "medical treatment for gender dysphoria is medically necessary and effective." ECF No. 179 at 17-20. The claim that denial of medically necessary care inherently constitutes discrimination is mistaken, because *the Plan has no obligation to cover medically necessary care for participants*.

Plaintiffs assert that health benefits are "compensation" to employees. ECF No. 179 at 4. This is false. The General Assembly of North Carolina has explicitly provided that "employer-provided fringe benefits," which include "health, life or disability plans," are *not* "compensation." N.C. Stat. § 135-1(7a)(b). "A State employee receives the benefits of the State Health Plan only when needed," so the agency's payment to the Plan to offset the cost of these health benefits is not part of the employee's wages. *Kirk v. State*, 465 S.E.2d 301, 306 (N.C. Ct. App. 1995). "The State endeavors to 'make available a State Health Plan.' But "[m]aking available and providing access

does not create any specific contractual financial obligation." *Lake v. State Health Plan for Tchrs. & State Emps.*, 825 S.E.2d 645, 656 (N.C. Ct. App. 2019).

Plaintiffs' participation or "subscription" to the Plan does not guarantee any particular health benefits. "The value of this benefit [participation in the health plan] cannot be quantified." *Kirk*, 465 S.E.2d at 306. Moreover, the facts clearly indicate that the medical necessity of a given treatment is irrelevant to the State Health Plan's policies. The Plan declines to cover any number of "medically necessary" treatments and procedures, and it is well within its rights to do so. Ex. 1 (Jones Dep.) at 58:12-15; 72:4-6. The Plan is not a doctor. Its duty is not to guarantee maximalist treatment for every member; rather, its duty is to maximize value for the whole of its members. The Plan's "package of services has the general aim of assuring that individuals will receive necessary medical care, but the benefit provided remains the individual services offered—not 'adequate health care.'" *Alexander v. Choate*, 469 U.S. 287, 303 (1985).

Accordingly, any differences in the "individual services offered" by the Plan stems from its discretionary analysis of the applicable regulations, the relative priority of different treatments, and the available resources—not "because of … its adverse effects" upon Plaintiffs or any other group. *Pers. Adm'r of Mass. v. Feeney*, 442 U.S. 256, 279 (1979).

The federal courts have endorsed insurers' rights to make these decisions. Even when a patient has a fundamental right to a medical procedure and cannot afford to pay for it, the Constitution does not require that the Plan cover it; if anything, this barrier to care (refusal to pay for a procedure) represents a wealth classification based on individuals' ability to pay for certain treatment, not an actionable form of discrimination under the ACA or on equal protection grounds. *See Maher v. Roe*, 432 U.S. 464, 471 (1977). The Plan's policies discriminate against Plaintiffs "only in the same sense that [they] discriminate[ ] against those who might need penile prosthetic implants (which may be medically necessary to cure impotence), Kerato-refractive eye surgery (which may be medically necessary to cure vision defects), hearing aids (which may be medically necessary to overcome deafness), or those who suffer from eating or sleep disorders: they must pay for those procedures or devices themselves." *Saks v. Franklin Covey Co.*, 117 F.Supp.2d 318, 329 (S.D.N.Y. Oct. 2, 2000). All Plan members, including Plaintiffs, receive the actuarial benefit of this—and every other—coverage limit. Just as not all women are pregnant, not all transgender individuals require treatment for gender dysphoria.

Finally, it is a "legitimate purpose" to "limit[] health care costs." *Saah v. Contel Corp.*, 978 F.2d 1256 (4th Cir.1992) (per curiam). *See also Boyd v.*

Bulala, 877 F.2d 1191, 1197 (4th Cir.1989) ("[C]ap on [malpractice] liability bears a reasonable relation to a valid legislative purpose—the maintenance of adequate health care services."). "[S]o long as the line drawn by the State is rationally supportable, the courts will not interpose their judgment as to the appropriate stopping point" even if members of a protected class are disproportionately affected by the lack of coverage. *Aiello*, 417 U.S. at 495.

As one member of the Board of Trustees stated, his goal is "not to limit increases in cost" but to actually "cut the cost of healthcare for our state workers" because some individuals "are paying 20, 25 percent of their monthly income on healthcare on the State Health Plan." Robie.Dep.73:3-11. Once the Plan starts adding niche benefits, "then I have to keep going" for "[e]verybody who comes in and wants a benefit … because I can't discriminate." Jones.Dep.104:25-105:24. Plaintiffs suggest that this rationale weakens when the marginal cost of additional coverage is low, but there is no *de minimus* exception permitting Court intrusion when only "moderate alterations" to premium "variables" are needed. *Aiello*, 417 U.S. at 495-96. "The State has a legitimate interest in maintaining the self-supporting nature of its insurance program" and nothing in the Constitution requires a "more comprehensive" one. *Id.* at 496.

III. The Plaintiffs' remaining claims are not supported by the evidence.

A. Plaintiffs have not provided sufficient evidence to support a grant of summary judgment under § 1557 of the Affordable Care Act.

Plaintiffs seek summary judgment for injunctive relief and damages under § 1557 of the Affordable Care Act, alleging that the failure to cover hormone treatment and surgery for gender dysphoria is "discrimination based on sex in healthcare." ECF No. 179 at 30-32.[11]

To the extent Plaintiffs claim the Plan's decision not to cover each and every possible treatment for gender dysphoria reflects discrimination "on the basis of sex," this argument has been addressed above. Also relevant to the § 1557 claim, however, is the fact that the U.S. Department of Health and Human Services ("HHS") has now expressly disavowed the factual analysis and conclusions reached in its earlier 2016 rule interpreting the scope of § 1557. In 2016, HHS stated that transition-related treatment could no longer be considered "cosmetic or experimental;" refusal to cover hormone treatment

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[11] Plaintiffs cite another district court ruling on a motion to dismiss as support for a grant of summary judgment. ECF No. 179 at 28 (citing *C.P. by & through Pritchard v. Blue Cross Blue Shield of Illinois*, 536 F. Supp.3d 791 (W.D. Wash. 2021). *CP* held only that "[p]laintiffs provide enough [unspecified] factual support" to make an allegation of discrimination "plausible." The case is irrelevant on summary judgment, especially as the court did not identify the "factual support" it found persuasive. *Id.*

or surgery on such a basis "is now recognized as outdated and not based on current standards of care." 81 Fed. Reg. 31429 (May 18, 2019).

The revised 2020 Rule studied this factual question, received extensive comment, and the agency concluded after a "review of the most recent evidence" that the 2016 statement "was an erroneous assertion." 85 Fed. Reg. 37187 (June 19, 2020). The current Rule found that "there is, at a minimum, a lack of scientific and medical consensus to support this assertion," and the "lack of scientific and medical consensus—and the lack of high-quality scientific evidence supporting such treatments—is borne out by other evidence." *Id.*

With their claim under § 1557, Plaintiffs ask this Court to do what HHS has refused: impose a view about appropriate care for gender dysphoria in a way that "inappropriately interfere[s] with the ethical and medical judgment of health professionals." 85 Fed. Reg. 37187. "A medical provider may rightly judge a hysterectomy due to the presence of malignant tumors to be different in kind from the removal of properly functioning and healthy reproductive tissue for psychological reasons, even if the instruments used are identical." *Id.*[12]

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[12] Plaintiffs have provided no alternative theories or evidence in support their § 1557 claim other than the claim of facial discrimination rejected above.

Plaintiffs have also provided no evidence of damages. Under both § 1557 of the Affordable Care Act, 42 U.S.C. § 18116, and Title VII, Plaintiffs seek damages, but have presented no evidence for this Court to consider. Although Plaintiffs allege "financial harm," ECF No. 75 at 42, 44-45, they present no calculations or medical bills. Similarly, Plaintiffs allege emotional damages, *id.*, but have not identified or quantified the "independent compensable harm" that resulted from the alleged statutory violation. *Price v. City of Charlotte, N.C.*, 93 F.3d 1241, 1248 (4th Cir. 1996). Without such evidence, the Court cannot award summary judgment to Plaintiffs on either the § 1557 claim or the Title VII claim.

B. Plaintiff Caraway has not produced sufficient evidence to support her Title VII claim.

The Court should deny Caraway's motion for summary judgment and dismiss her Title VII claim. ECF No. 137 at 25-33; ECF No. 193 at 1-6. Caraway misunderstands the application of Title VII to fringe benefits, asserting that her health benefits are "compensation." ECF No. 179 at 4. This is false. As discussed earlier, "employer-provided fringe benefits" which include

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Because § 1557 adopts the "enforcement mechanisms provided for and available under" the referenced civil rights statutes, 42 U.S.C. § 18116(a), and because Title IX does not permit a claim based on "disparate impact," *Doe v. Fairfax Cty. Sch. Bd.*, 403 F.Supp.3d 508, 515 (E.D. Va. 2019), Plaintiffs cannot assert a disparate impact claim in this case either.

"health, life or disability plans" are *not* "compensation." N.C. Stat. § 135-1(7a)(b).

Manhart, the case Caraway relies upon, makes this analysis clear. In *Manhart*, the Supreme Court considered whether a pension plan could "require[ ] female employees to make monthly contributions to the fund which were…higher than the contributions required of comparable male employees." *City of Los Angeles, Dep't of Water & Power v. Manhart*, 435 U.S. 702, 705 (1978). The Court rejected such a distinction, because Title VII's "focus on the individual is unambiguous" and "precludes treatment of individuals as simply components of a racial, religious, sexual, or national class." *Id.* at 708. Therefore, even if "[w]omen, as a class, do live longer than men," *id.* at 707, the employer could not charge different amounts based on sex.

In response, the employer made an argument very similar to Caraway's. Just as Caraway argues that it is unfair that the Plan does not pay for all of her treatments, Manhart's employer argued that a *failure* to charge different contributions "would itself violate Title VII because of its disproportionately heavy impact on male employees." *Id.* at 710 n.20. The Court rejected this analysis. "This suggestion has no force in the sex discrimination context because each retiree's total pension benefits are ultimately determined by his *actual life span*; any differential in benefits paid to men and women in the

aggregate is thus "based on [a] factor other than sex." *Id.* The same logic applies here. Caraway's health care payments "are ultimately determined by" her *actual medical needs*; "any differential in benefits paid … in the aggregate is thus based on a factor other than sex." *Id.*

CONCLUSION

Plaintiffs ask this Court to conceptualize their case as involving an by the Plan on the autonomy of transgender individuals, but this profoundly misstates the facts, the law, and the procedural posture. The State Health Plan does not restrict Plaintiffs' medical care. The Plan does not classify Plan members based on whether they identify as transgender, cisgender, non-binary, non-gendered, or otherwise. The Plan does not provide different health coverage to Plaintiffs. The discrimination alleged by Plaintiffs is that the Plan cannot cover a medication or treatment for one diagnosis—for example, a mastectomy for a man or woman with breast cancer—without also paying for medical treatment for *a different diagnosis*. This is not the law.

Respectfully submitted, this the 19th day of January, 2022.

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CERTIFICATE OF WORD COUNT

Pursuant to L.R. 7.3(d)(1), the undersigned certifies that this Brief complies with the Court's expanded word limit using the word count feature of the word processing software in making this certification.

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