Appendix A: REPORT AND RECOMMENDATION ON DEFENDANTS' MOTION TO DISMISS

REPORT AND RECOMMENDATION

ON DEFENDANTS' MOTION TO DISMISS

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

JOHN J. DIERLAM, *Plaintiff,* v. DONALD TRUMP,[1] in his official capacity as President of the United States, *et al.*, *Defendants.*	§ § § § § § § § § § § §	CASE NO. 4:16-CV-307

REPORT AND RECOMMENDATION ON DEFENDANTS' MOTION TO DISMISS

Before the Court is Defendants' Motion to Dismiss Plaintiff's First Amended Complaint. ECF No. 37.[2] Plaintiff's suit challenges Defendants'

[1] On February 4, 2016, Plaintiff filed suit against Defendants Barack Hussein Obama, in his official capacity as the president of the United States; the United States Department of Health and Human Services ("HHS"); Sylvia Mathews Burwell, in her official capacity as Secretary of HHS; the United States Department of the Treasury ("the Treasury"); Jacob J. Lew, in his official capacity as Secretary of the Treasury; the United States Department of Labor ("Labor"); and Thomas E. Perez, in his official capacity as Secretary of Labor. On January 20, 2017, Donald Trump succeeded President Obama as President of the United States. Pursuant to Federal Rule of Civil Procedure 25(d), President Trump, Acting Secretary of HHS Eric D. Hargan, Secretary of the Treasury Steven Mnuchin, and Secretary of Labor Alexander Acosta have been substituted as named Defendants in this action.

[2] On May 26, 2016, Defendants filed a motion to dismiss Plaintiff's original complaint under Fed. R. Civ. P. 12(b)(1) and 12(b)(6), which Plaintiff opposed and sought leave to amend. ECF No. 18, *see* ECF Nos. 27, 28. The Court granted Plaintiff leave to amend. ECF No. 29. On July 18, 2016, Plaintiff filed his First Amended Complaint ("Complaint"). On October 3, 2017, this case was reassigned to Judge Ellison after Judge Hoyt recused himself. ECF Nos. 62, 63. On October 16, 2017, the Court referred the Defendants' pending motion to dismiss to this Court for a report and recommendation in accordance with 28 U.S.C. § 636(b)(1)(B).

implementation of minimum essential coverage provision of the Patient Protection and Affordable Care Act ("ACA"), as well as the constitutionality of the individual mandate and the contraceptive services mandate. Pl.'s Amend. Compl., ECF No. 32. Because Plaintiff's claims are now moot and he has failed to allege a substantial burden on his religious beliefs, the Court recommends that Plaintiff's claims be dismissed.

I. BACKGROUND

Plaintiff John J. Dierlam is a lifelong Roman Catholic.[3] Plaintiff opposes the use, funding, provision, and support of contraceptives. Plaintiff asserts that paying for or participating in a health insurance plan that provides coverage for contraceptives violates his sincerely-held religious beliefs. Plaintiff believes that life begins at conception, that the "practice of abortion, contraception, and sterilization [is] reprehensible and sinful," and that "supporting these activities even indirectly" is contrary to the teachings of the Catholic Church. *Id.* at 6.

In 2012, Plaintiff was employed by ZXP Technologies ("ZXP"). At that time, he was enrolled in his employer-provided medical, dental, and vision insurance plans. *Id.* at 3. During the open enrollment period in the fall of 2012, Plaintiff learned that the medical insurance plans ZXP offered had changed for the

[3] For the purposes of deciding this motion to dismiss, Plaintiff's factual allegations are taken as true. *Brown v. Bd. of Trustees Sealy Indep. Sch. Dist.*, 871 F. Supp. 2d 581, 590 (S.D. Tex. 2012) (citing *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (Ellison, J.).

upcoming year. In particular, Plaintiff asserts, "contraceptive coverage had been expanded and some abortion services probably would be covered within the next year." *Id.* at 3-4. Plaintiff "decided to follow the teachings of [his] faith, drop medical coverage, and thereby not support these services through payment of premiums and fees."[4] *Id.* at 4. Plaintiff apparently made this decision without first obtaining replacement insurance.

Plaintiff attempted to find insurance that would provide coverage consistent with his faith. *Id.* at 5. First, he contacted at least three health insurance providers, but their plans included coverage for contraceptives. *Id.* Next, Plaintiff contacted a Christian medical bill sharing organization. Although this group provided coverage consistent with his religious beliefs, Plaintiff did not join the organization because he found the required Protestant affirmation inconsistent with his beliefs. *Id.* Finally, Plaintiff contacted an insurance representative for the State of Texas, who "indicated [that] they could not help" Plaintiff find suitable health insurance coverage. *Id.* Plaintiff subsequently "ceased all efforts" to obtain health insurance. *Id.* In both April 2014 and April 2015, pursuant to the ACA, Plaintiff was required to pay a penalty, termed a "shared responsibility payment," because he did not have the required coverage. *Id.* at 10.

[4] Plaintiff maintained enrollment in his dental and vision insurance plans "as there were no moral implications to do[ing] so." ECF No. 32 at 4.

In his Complaint, Plaintiff challenges both the minimum essential coverage provision (the individual mandate) and the preventive services provision of the ACA that requires contraceptive coverage (the contraceptive mandate) based on his religious objection to participating in any health insurance plan that includes coverage for contraceptive services. Plaintiff seeks a declaration pursuant to 28 U.S.C. §§ 2201-2202 that the individual insurance mandate of the ACA is unconstitutional based on the Religious Freedom Restoration Act ("RFRA"), the Establishment Clause of the First Amendment, the Equal Protection Clause of the Fourteenth Amendment, the Free Exercise Clause of the First Amendment, the Taxing and Spending Clause,[5] the Due Process Clause of the Fifth Amendment, and the "right to privacy and association."[6] ECF No. 32. Based on these same constitutional challenges, Plaintiff also seeks injunctive relief against enforcement of the individual mandate and an order requiring the Internal Revenue Service

[5] The United States Supreme Court already determined that the ACA's individual mandate is constitutional under Congress' power to tax and spend. *Nat'l Fed'n of Indep. Bus. v. Sebelius* ("*NFIB*"), 567 U.S. 519, 574 (2012).

[6] To the extent that Plaintiff claims that the ACA forces him to enter into a contract, thus violating his "right to privacy and association," thus necessitating the refund of his shared responsibility payments, his claim fails to state a claim upon which relief can be granted and must be dismissed. ECF No. 32 at 17. The ACA does not require Plaintiff to enter into a contract, as he was never required to purchase health insurance. The Supreme Court has explained that if a person "chooses to pay [a shared responsibility payment] rather than obtain health insurance, they have fully complied with the law." *NFIB*, 132 S. Ct. at 2597. Here, Plaintiff was able to avoid entering into a contract by making shared responsibility payments, and therefore his rights of privacy and association were not infringed.

("IRS") to refund his shared responsibility payment. *Id.*[7]

II. STANDARD OF REVIEW

Defendants contend that all of the claims in Plaintiff's Complaint (other than the § 1502(c) claim) should be dismissed for failure to state a claim for relief. Defs.' Motion to Dismiss, ECF No. 37.

A court may dismiss a complaint for "failure to state a claim upon which relief can be granted." Fed. R. Civ. P. 12(b)(6). "Under Federal Rule of Civil Procedure 8(a)(2), a pleading must contain a 'short and plain statement of the claim showing that the pleader is entitled to relief.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 677-78 (2009). However, "[m]otions to dismiss under Rule 12(b)(6) are viewed with disfavor and are rarely granted." *Lormand v. U.S. Unwired, Inc.*, 565 F.3d 228, 232 (5th Cir. 2009) (citation omitted); *Duke Energy Intern., L.L.C. v. Napoli*, 748 F. Supp. 2d 656 (S.D. Tex. 2010) (Atlas, J.). "To survive a Rule 12(b)(6) motion to dismiss, a complaint 'does not need detailed factual allegations,' but must provide the plaintiff's grounds for entitlement to relief – including factual allegations that when assumed to be true 'raise a right to relief

[7] Plaintiff also asserts a claim under § 1502, alleging that Defendants failed to provide him with the required statutory notice of services available through the Texas state health insurance exchange. *See* 42 U.S.C. § 18092 (hereinafter "§ 1502(c)"). Defendants' motion seeks dismissal of this claim under Rule 12(b)(1) for lack of jurisdiction. ECF No. 37 at 11-15. Plaintiff concedes, however, that Congress did not create a private right of action to remedy lack of notice. ECF No. 32 at 9. Thus, this claim should be dismissed.

above the speculative level.'" *Culliver v. Taylor*, 503 F.3d 397, 401 (5th Cir. 2007) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007)). The complaint must include more than mere "labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do." *Twombly*, 550 U.S. at 555 (internal quotation marks and citations omitted). That is, a complaint must "contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Iqbal*, 556 U.S. at 678 (2009) (quoting *Twombly*, 550 U.S. at 570).

The ultimate question for the court to decide is whether the complaint states a valid claim when viewed in the light most favorable to the plaintiff. The court must accept well-pleaded facts as true, but legal conclusions are not entitled to the same assumption of truth. *Id.* at 678.

III. DISCUSSION

In 2010, Congress passed the ACA. Pub.L. No. 111-148, 124 Stat. 119 (2010). The ACA was intended to "increase the number of Americans covered by health insurance and decrease the cost of health care." *NFIB*, 567 U.S. at 538. ACA requires non-grandfathered *group health plans* and *insurance providers* to cover four categories of preventative health services, without cost-sharing. One of these four categories is "preventative care and screenings" for women, requiring every *group health plan* and *insurance provider* to cover "all Food and Drug

Administration approved contraceptive methods and sterilization procedures," a requirement known as the "contraceptive mandate."[8] *See* 42 U.S.C. § 300gg-13(a)(4); 77 Fed. Reg. 8725, 8726 (Feb. 15, 2012). It does not require anything from the employee or insured. *Real Alternatives, Inc. v. Secretary Department of Health and Human Services*, 867 F.3d 338, 344 (3d. Cir. 2017).

The ACA individual mandate requires an "applicable individual" to maintain minimum essential coverage, receive an exemption from the coverage requirement, or make a shared responsibility payment. 26 U.S.C. § 5000A; *see NFIB*, 567 U.S. at 539. An "applicable individual" is any individual except one who qualifies for a religious exemption, is not lawfully present, or is incarcerated. 26 U.S.C. § 5000A(d).

Here, Plaintiff challenges the individual mandate and the preventive services coverage provision. Plaintiff's claims stem from his religious objection to contraceptive services, and his refusal to participate in any health insurance plan that conforms to the requirements of the contraceptive mandate.

A. The Department of Health and Human Services' Recent Rule Renders Plaintiff's Claims for Injunctive and Declaratory Relief Moot.

The Constitution of the United States limits the jurisdiction of the federal courts to "[c]ases" and "[c]ontroversies." U.S. Const., art. III, § 2. The "case or

[8] This requirement does not apply to "grandfathered" group health plans.

controversy" requirement demands that a cause of action before a federal court present a justiciable controversy. "No justiciable controversy is presented . . . when the question sought to be adjudicated has been mooted by subsequent developments." *Flast v. Cohen*, 392 U.S. 83, 95 (1968). The Fifth Circuit has held that the promulgation of new regulations may render moot "what was once a viable case." *Sannon v. U.S.*, 631 F.2d 1247, 1250-51 (5th Cir. 1980). A federal court has an obligation to raise the issue of mootness, *sua sponte*, "if the facts suggest mootness notwithstanding the silence of the parties with respect to the issue." *Dailey v. Vought Aircraft Co.*, 141 F. 3d 224, 227 (5th Cir. 1998).

In considering Plaintiff's claims, the Court is mindful of the premise that *pro se* litigants' allegations must be liberally construed so as to ensure that their claims are not unfairly dismissed. *See Erickson v. Pardus*, 551 U.S. 89, 94 (2007). However, a *pro se* litigant is not "exempt . . . from compliance with the relevant rules of procedural and substantive law." *Birl v. Estelle*, 660 F.2d 592, 593 (5th Cir. 1981).

In this case, even the most liberal construction cannot prevent dismissal, as the new rule moots Plaintiff's claims. On May 4, 2017, more than a year after Plaintiff filed his Complaint and Defendants filed their motion to dismiss, President Trump issued an executive order, instructing the Secretary of Health and Human Services ("HHS") to consider enacting amended regulations to address

conscience-based objections to the contraceptive mandate. "Executive Order Promoting Free Speech and Religious Liberty," Exec. Order No. 13798, 82 Fed. Reg. 21675 (May 4, 2017). Within months, HHS issued an interim final rule, effective October 6, 2017, providing an exemption for (1) individuals who have sincerely held religious objections to contraceptives (2) whose employers or health insurance issuers "are willing to offer a policy accommodating the objecting individual." 45 C.F.R. Part 147(II)(C)(2).

The adoption of this rule rendered Plaintiff's claims for injunctive and declaratory relief moot, as Plaintiff can satisfy both prongs of this exemption. The sincerity of Plaintiff's religious objection to contraception is not in dispute. ECF No. 37 at 17. Under the interim rule, individuals who object on religious grounds are exempt from purchasing health insurance plans that offer coverage for contraceptive services, and instead can purchase health insurance that does not cover contraceptive services.

The sole issue is whether Plaintiff can obtain such coverage. Plaintiff alleged that he searched for such coverage in 2014, but was unable to locate any coverage options that conformed to his religious beliefs. He did find a Christian bill sharing ministry, but did not believe that the required affirmation was consistent with his Catholic faith. However, Plaintiff apparently overlooked a Catholic health care sharing ministry that offers—and has offered since at least October 2014—a

"health care option . . . [c]onsistent with Catholic teaching."[9] Thus, Plaintiff may join the Catholic sharing ministry without violating his religious beliefs. In addition, because of this new exemption under the interim rule, the health care marketplace will adapt, if it has not done so to date, to provide insurance plans that do not cover contraceptive services. *See, e.g., Real Alternatives*, 867 F.3d at 346 (employer represented that its insurer would be willing to provide a plan that omits contraceptive coverage); *March for Life v. Burwell*, 128 F.Supp.3d 116, 132 (D.D.C. 2015) (representing that the employer would offer such insurance to its employees). The adoption of the interim final rule, and the immediate availability of a Catholic health care sharing ministry, has rendered Plaintiff's claims for injunctive and declaratory relief moot.

B. Plaintiff Is Not Entitled to a Refund Of His Shared Responsibility Payment Because the Individual Mandate Did Not Impose a Substantial Burden On His Exercise of Religion.

Having determined that Plaintiff's claims for injunctive and declaratory relief are moot, the Court turns next to Plaintiff's request for a refund of his shared

[9] In ruling on a Rule 12(b)(6) motion to dismiss, courts may "ordinarily examine . . . matters of which a court may take judicial notice." *Tellabs, Inc. v. Makor Issues & Rights, Ltd.*, 551 U.S. 308, 322 (2007). Under Federal Rule of Evidence 201(b), a judicially noticed fact "must be one not subject to reasonable dispute in that it is either (1) generally known within the territorial jurisdiction of the trial court or (2) capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." Fed. R. Evid. 201(b). In this case, the Court takes judicial notice of the existence of Christus Medical Foundation Curo, a Catholic health care sharing ministry that is exempt from ACA's individual mandate and offers financial protection to its members for health care costs on a basis that is consistent with the Catholic faith. *About CMF Curo*, CHRIST MEDICUS FOUNDATION, https://cmfcuro.com/about-cmf-curo (last visited Nov. 17, 2017).

responsibility payments for 2014 and 2015. Plaintiff has paid in full the shared responsibility payment he owed under the ACA. Therefore, this Court has jurisdiction. *Flora v. United States*, 362 U.S. 145, 146 (1960) (concluding that full payment of a tax assessment is a jurisdictional prerequisite to suit in federal district court). Invoking RFRA, Plaintiff claims that the shared responsibility payment constitutes a substantial burden on his exercise of religion.

1. RFRA requires a substantial burden on religious exercise.

Congress enacted RFRA "to provide very broad protection for religious liberty." *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2760-61 (2014). In enacting RFRA, Congress determined that "laws [that are] 'neutral' toward religion may burden religious exercise as surely as laws intended to interfere with religious exercise."[10] 42 U.S.C. § 2000bb(a)(2). "[T]o ensure broad protection for religious liberty, RFRA provides that the 'Government shall not substantially burden a person's exercise of religion even if the burden results from a rule of general applicability." *Id.* at 2761 (citing 42 U.S.C. § 2000bb-1(a)). Under RFRA,

[10] A brief historical detour is helpful in understanding the origins of RFRA. In cases including *Sherbert v. Verner*, 374 U.S. 398 (1963), and *Wisconsin v. Yoder*, 406 U.S. 205 (1972), the Supreme Court used a balancing test to determine whether government actions violated the Free Exercise Clause of the First Amendment. The balancing test considered whether the challenged action imposed a substantial burden on the exercise of religion and, if so, whether it was necessary to serve a compelling government interest. In *Employment Div., Dept. of Human Resources of Ore. V. Smith*, 494 U.S. 872 (1990), however, the Court abandoned the balancing test, holding that religiously neutral laws of general applicability could be applied to religious practices even absent a compelling government interest. In response to the Court's decision in *Smith*, Congress enacted RFRA.

a plaintiff makes a *prima facie* case by "showing that the government substantially burdens a sincere religious exercise." *Hobby Lobby Stores, Inc. v. Sebelius*, 723 F.3d 1114, 1126 (10th Cir. 2013). "If the Government substantially burdens a person's exercise of religion, under the Act, that person is entitled to an exemption from the rule unless the Government 'demonstrates that application of the burden to the person—(1) is in furtherance of a compelling government interest; and (2) is the least restrictive means of furthering that compelling government interest.'" *Hobby Lobby*, 134 S. Ct. at 2760-61 (citing 42 U.S.C. § 2000bb-1(b)).

According to the Supreme Court, religious exercise is substantially burdened "when government action compels an individual 'to perform acts *undeniably* at odds with fundamental tenets of [his] religious beliefs.'" *Real Alternatives*, 867 F.3d at 356 (quoting *Wisconsin v. Yoder*, 406 U.S. 205, 218 (1972)).

> Where the state conditions receipt of an important benefit upon conduct proscribed by a religious faith, or where it denies such a benefit because of conduct mandated by religious belief, thereby putting *substantial* pressure on an adherent to modify his behavior and to violate his beliefs, a burden upon religion exists.

Id. (quoting *Thomas v. Review Bd.*, 450 U.S. 707, 717-18 (1981)).

The threshold question, therefore, is whether the contraceptive mandate imposes a substantial burden on Plaintiff's sincere exercise of religion. Plaintiff asserts that his sincerely held religious beliefs prohibit him from supporting the provision of certain contraceptive services, including "abortion, contraception, and

sterilization." ECF No. 32 at 6-7. His religious beliefs lead him to fear possible "excommunication from the [Catholic] Church" should he "[support] these activities even indirectly." *Id.* at 6. Defendants do not dispute the sincerity of Plaintiff's religious beliefs. ECF No. 37 at 17. Defendants do, however, dispute the assertion that the contraceptive mandate imposes a substantial burden on Plaintiff's exercise of religion. *Id.*

It is not the Court's role to "determine what religious observance [a plaintiff's] faith commands." *Priests for Life v. U.S. Department of Health and Human Services*, 772 F.3d 229, 247 (D.D.C. 2014). While the Court may not make this factual inquiry, however, it remains the obligation of the Court to undertake a legal inquiry into the substantiality of the burden imposed on an individual's exercise of religion. *See Hernandez v. Commissioner*, 490 U.S. 680, 699 (1989) (distinguishing between factual inquiries into the validity of a plaintiff's belief, on the one hand, and legal inquiries into whether an alleged burden is substantial, on the other hand); *see also Bowen v. Roy*, 476 U.S. 693, 700-701 (1986) (explaining that the appropriate "frame of reference" for considering constitutional claims is "the Constitution, rather than an individual's religion"). "Whether a burden is 'substantial' under RFRA is a question of law, not a question of fact." *Geneva College v. Secretary U.S. Dept. of Health and Human Services*, 778 F.3d 422, 442 (3rd Cir. 2015).

The Court, therefore, is required to objectively assess whether the contraceptive mandate does, in fact, impose a substantial burden on Plaintiff's exercise of religion. The Fifth Circuit has yet to address the issue of whether an individual suffers a substantial burden on his religious exercise when the Government regulates group health care plans and health insurance providers, requiring them to offer coverage that includes contraceptive services the individual finds objectionable based on his religious beliefs. This claim is distinct from those RFRA claims found to be meritorious by the Supreme Court in *Hobby Lobby*, in which an employer objects to the contraceptive mandate. *Real Alternatives*, 867 F.3d at 355. To make this determination, the Court must examine the role that an insured plays in acquiring ACA-mandated coverage, as distinguished from the employer's role in providing and funding health insurance coverage under the ACA.

2. An employer who provides an ACA insurance plan and finds contraceptive services objectionable to religious beliefs is substantially burdened.

In *Hobby Lobby*, the Supreme Court narrowly held that the contraceptive mandate imposed a substantial burden on the ability of a for-profit closely held corporation to conduct business in accordance with its religious beliefs. *Hobby Lobby*, 134 S. Ct. at 2778-79. In reaching this conclusion, the Court considered that, to comply with the contraceptive mandate, the employer plaintiffs were

required to *provide* coverage for and *fund* contraceptive services that violated their religious beliefs. *Id.* at 2754-55, 2781. If the employer plaintiffs refused to do so, and instead "provid[ed] insurance coverage in accordance with their religious beliefs," they would be "force[d] . . . to pay an enormous sum of money—as much as $475 million per year in the case of Hobby Lobby." *Id.* at 2779.

The Court did not elaborate on the role that the employer plays in the provision and funding of health care coverage to its employees, but this role is significant. Prior to the ACA, there was no requirement that an employer provide its employees with a healthcare plan.[11] However, over 60% of the Americans who have health coverage obtain it through an employer-sponsored plan.[12] In 1974, in recognition of the important role employers play in providing healthcare benefits to employees, Congress enacted the Employee Retirement Income Security Act ("ERISA"). ERISA mandated that once an employer decides to offer a health insurance plan to its employees, the plan must be run in accordance with certain

[11] *See ERISA and Healthcare Plan Enforcement*, FINDLAW, http://employment.findlaw.com/wages-and-benefits/erisa-and-healthcare-plan-enforcement.html (last visited Nov. 17, 2017); *Health Insurance Is the Foundation of a Comprehensive Benefits Package*, THE BALANCE, https://www.thebalance.com/health-insurance-benefits-foundation-1918146 (last visited Nov. 17, 2017).

[12] Michelle Long et al., *Trends in Employer-Sponsored Insurance Offer and Coverage Rates, 1999-2014*, THE HENRY J. KAISER FAMILY FOUNDATION, https://www.kff.org/private-insurance/issue-brief/trends-in-employer-sponsored-insurance-offer-and-coverage-rates-1999-2014/ (last visited Nov. 20, 2017).

minimum standards. 29 U.S.C. § 1001.[13] In addition, under the fiduciary responsibilities specified in the law, individuals who manage and control plans must meet certain standards of conduct.[14]

An employer has choices with regard to both the design and funding of the plan.[15] With regard to funding, the employer can choose either a fully-insured or a self-funded plan. Under a fully-insured plan, the employer contracts with an insurance company to cover employees and their dependents.[16] Under a self-funded plan, the employer provides health or disability benefits to employees with its own funds and assumes direct risk for payment of the claims for benefits.[17] Under either type of plan, the employer designs the plan and determines what services will be covered.[18] The employer can decide to pay the entire cost of coverage on behalf of its employees, but typically shares the cost with them.[19] In

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[13] *Health Plans & Benefits*, UNITED STATES DEPT. OF LABOR, https://www.dol.gov/general/topic/health-plans/erisa (last visited Nov. 17, 2017).

[14] *Id.*

[15] *What is the Difference Between Self-Funded and Fully-Insured Insurance Plans?*, BUSINESS BENEFITS GROUP, https://www.bbgbroker.com/difference-between-self-funded-and-fully-insured-plans/ (last visited Nov. 17, 2017).

[16] *Understanding Employer Self-Funding of Employee Health Benefits*, TEXAS DEPARTMENT OF INSURANCE, https://www.tdi.texas.gov/pubs/consumer/cb108.html (last visited Nov. 17, 2017).

[17] *See id.*

[18] *See id.*

[19] *Health Insurance Is the Foundation of a Comprehensive Benefits Package*, THE BALANCE, https://www.thebalance.com/health-insurance-benefits-foundation-1918146 (last visited Nov. 17,

addition, the employer can determine the rate of reimbursement for covered services under the plan. The terms of eligibility and covered benefits are set forth in a plan document, which tells plan participants what the plan provides and how it operates.[20]

In addition to providing and funding health insurance coverage, employers are required to administer the employee healthcare benefit plan, including enrolling employees and making changes as necessary, deducting premiums from the employee's wages and remitting them to the insurance company, acting as a liaison between employees and the insurer, and, in some cases, terminating benefits and extending Consolidated Omnibus Budget Reconciliation Act ("COBRA") coverage.[21] Employers are also responsible for ensuring compliance with reporting and disclosure requirements.[22] It is clear, therefore, that an employer plays a significant role in the provision of insurance to its employees.

2017); *What is the Difference Between Self-Funded and Fully-Insured Insurance Plans?*, BUSINESS BENEFITS GROUP, https://www.bbgbroker.com/difference-between-self-funded-and-fully-insured-plans/ (last visited Nov. 17, 2017).

[20] *Health Plans & Benefits: Plan Information*, UNITED STATES DEPT. OF LABOR, https://www.dol.gov/general/topic/health-plans/planinformation (last visited Nov. 20, 2017).

[21] *Administering Your Employee Health Care Benefit Plan*, BIZFILINGS, https://www.bizfilings.com/toolkit/research-topics/office-hr/administering-your-employee-health-care-benefit-plan (last visited Nov. 17, 2017).

[22] *Id.*

3. An employee is merely a consumer of healthcare coverage.

In contrast to the active role that an employer plays in making health insurance coverage available to employees, an employee's role is that of a passive recipient of health insurance coverage.

The term "participant," when used to describe employee recipients of employer-provided health insurance coverage, is a creation of ERISA. Under ERISA, a plan participant is "any employee or former employee . . . who is or may become eligible to receive a benefit of any type from an employee benefit plan." 29 U.S.C. § 1002(7); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 107 (1989). The term "participant," therefore, has limited meaning. It connotes nothing more than a person who may be entitled to a benefit—in this case, the benefit of health insurance coverage. *Cf. Firestone Tire & Rubber Co.*, 489 U.S. at 107.

ERISA confers several rights upon employee participants in health insurance plans. These rights include the right to notification, including the right to disclosure of important plan information, the right to a timely and fair process for benefit claims, the right to elect to temporarily continue group health coverage after losing coverage, the right to a certificate evidencing health coverage under a plan, and the right to recover benefits due under the plan.[23] Essentially, these rights ensure that consumers of health insurance coverage are treated fairly.

[23] *Health Plans & Benefits: Plan Information*, UNITED STATES DEPT. OF LABOR, https://www.dol.gov/general/topic/health-plans/planinformation (last visited Nov. 20, 2017).

A plan participant may decide whether he wants to be covered under the plan offered. If he does want coverage, then he is required to pay a premium, which is deducted from his pay check.[24] Once enrolled in the plan, the employee may decide which health care services he requires. After obtaining those health care services, he submits a claim for reimbursement. While an employer may underwrite all or part of the cost of an employee's health insurance coverage, the employee does not subsidize anyone else's coverage. This is particularly true in regard to contraceptive services, as the ACA requires contraceptive services to be provided at no cost to the employee. The employer bears the entire cost of the contraceptive mandate.[25]

4. The Third Circuit has found that the ACA does not impose a substantial burden on individuals.

Since *Hobby Lobby*, those courts that have considered whether the contraceptive mandate may also impose a substantial burden on individuals have split.[26] In a well-reasoned opinion, the Third Circuit – the only circuit court to

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[24] *What is the Difference Between Self-Funded and Fully-Insured Insurance Plans?*, Business Benefits Group, https://www.bbgbroker.com/difference-between-self-funded-and-fully-funded-plans (last visited Nov. 17, 2017); *Administering Your Employee Health Care Benefit Plan*, BIZFILINGS, https://www.bizfilings.com/toolkit/research-topics/office-hr/administering-your-employee-health-care-benefit-plan (last visited Nov. 17, 2017).

[25] Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).

[26] *Compare Real Alternatives*, 867 F.3d at 360 (finding that although an individual employee was a consumer of coverage and availed himself of the ability to be reimbursed for services, he did not play an active role in his health insurance plan and his connection to other plan members' use of contraceptive services was too attenuated to impose a substantial burden on his exercise of

address this issue – concluded that the contraceptive mandate did not impose a substantial burden on an individual plaintiff's exercise of religion. *Real Alternatives*, 867 F.3d at 360. Examining the role of an individual employee in a health insurance plan, the Third Circuit concluded that the employee was essentially a consumer of healthcare coverage. Unlike employers, the Third Circuit explained, individual employees are not "'participa[nts]' [in the health insurance marketplace] in the real sense of the word." *Id.* "Subscribing to an insurance plan involves no real 'participation,' just as there is no active 'participation' when subscribing to a magazine or joining AARP or enrolling in a credit card that has membership benefits. These are all packages that involve a one-time enrollment, followed by essentially passive eligibility for certain services that the member opts in or out of." *Id.* at 359. The relationship between an employee's "decision to sign up for health insurance on the one hand and the provision of contraceptives to a particular individual on the other is 'far too attenuated to rank as substantial.'" *Id.* at 360 (citing *Hobby Lobby*, 134 S. Ct. at 2798-99 (Ginsburg, J. dissenting)). The Third Circuit added that there "is a material difference between employers arranging or providing an insurance plan that includes contraceptive coverage – so that employees can avail themselves of that benefit – and becoming eligible to

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religion) *with Wieland v. United States Department of Health and Human Services*, 196 F.Supp.3d 1010, 1017 (E.D. Mo. 2016) *and March for Life v. Burwell*, 128 F.Supp.3d 116, 129 (D.D.C. 2015) (finding in both cases that the contraceptive mandate put "'substantial pressure on an adherent to modify his behavior and to violate his beliefs.'").

apply for reimbursement for a service of one's choosing." *Id.* at 361.

This Court agrees with the Third Circuit's reasoning. Employers and employees play substantially different roles in the health insurance marketplace. In holding that the contraceptive mandate imposed a substantial burden on employers in *Hobby Lobby*, the Supreme Court focused on the active role that employers play in the health insurance marketplace. Employers actually *provide* healthcare coverage to their employees and *subsidize* employees' premiums (and, in particular, employees' contraceptive coverage, which is generally provided at no cost to the employee). *See Hobby Lobby*, 134 S. Ct. at 2779. Employers must seek out health insurance companies, evaluate and customize available coverage options, design a plan, negotiate rates, choose how much to pay toward employees' premiums, and administer group health plans. Employers act as intermediaries between health insurance companies, which sell health insurance products to employers, and employees, who receive reimbursement for health services. Employees, on the other hand, play a passive role in accepting – or choosing not to accept – the benefit of health care coverage.

In this case, therefore, the contraceptive mandate did not impose a substantial burden on Plaintiff's exercise of religion. To follow the teachings of his faith, Plaintiff freely made a series of choices. First, he chose to discontinue his membership in his employer's health insurance plan. Next, he declined to join a

Christian medical bill sharing organization, although membership in the organization would have reduced Plaintiff's health care costs without compromising his religious beliefs regarding contraceptives. Finally, Plaintiff chose not to conduct a thorough search for alternative health insurance plans. Instead, he chose to radically alter his diet to reduce his risk of future disease. ECF No. 32 at 10.

For Plaintiff, the cost of these choices—choices Plaintiff made of his own accord—was a shared responsibility payment. Plaintiff was not required, as were the employer plaintiffs in *Hobby Lobby*, to actually provide coverage for and "[fund] . . . specific contraceptive methods." 134 S. Ct. at 2779. At no time was Plaintiff forced to "engage in conduct that seriously violate[d] [his] religious beliefs." *Id.* at 2775. Plaintiff was not required to use any of the contraceptive methods in question. *See id.* at 2799 (Ginsburg, J., dissenting). He was not required to "pay an enormous sum of money" to adhere to his faith; he was simply required to pay a small penalty. Had Plaintiff maintained coverage through his former employer, he would have been a passive recipient of benefits, not an active provider of contraceptive services. Any connection between Plaintiff's membership in an employer-provided health care plan and the provision of contraceptives to another plan member is too attenuated to amount to a substantial burden. *See Real Alternatives*, 867 F.3d at 360.

To accept the premise of Plaintiff's argument as true would mean that a Jehovah's Witness could mount a constitutional challenge to a health insurance plan that provides coverage for blood transfusions. Individuals who are Jewish or Muslim could challenge a health care plan that provides coverage for medications derived from pigs. Christian Scientists could challenge a plan that provides coverage for vaccinations. *See Hobby Lobby*, 134 S. Ct. at 2805 (Ginsburg, J., dissenting); *Real Alternatives*, 867 F.3d at 364 (listing a wide variety of medical treatments that some might find objectionable on religious grounds).

Health care plans provide coverage for a smorgasbord of medical services. In turn, individuals who are covered under the plan are free to choose from among these services based on myriad factors, including their religious beliefs. *See Hobby Lobby*, 134 S. Ct. at 2805 (Ginsburg, J., dissenting); *Real Alternatives*, 867 F.3d at 360 (the coverage offers a package of health benefits, but does not assure the availability of those services; it is for the individual employee to seek out and use or not). To suggest that Plaintiff's health care coverage somehow facilitates another person's decision to obtain contraceptive services, however, is to fundamentally misunderstand how the ACA works, the health insurance marketplace functions—and how individuals make personal decisions regarding their health.

C. Plaintiff Should Not Be Granted Leave To Amend Again.

"When a plaintiff's complaint fails to state a claim, the court should generally give the plaintiff a chance to amend the complaint under Rule 15(a) before dismissing the action with prejudice, unless it is clear that to do so would be futile." *Donnelly*, 2014 WL 429246, at *2 (citing *Great Plains Trust Co. v. Morgan Stanley Dean Witter & Co.*, 313 F.3d 305, 329 (5th Cir. 2002) ("[D]istrict courts often afford plaintiffs at least one opportunity to cure pleading deficiencies before dismissing a case, unless it is clear that the defects are incurable or the plaintiffs advise the court that they are unwilling or unable to amend in a manner that will avoid dismissal.")). While it is within the discretion of the court to grant leave to amend, "a plaintiff should be denied leave to amend a complaint if the court determines that 'the proposed change clearly is frivolous or advances a claim or defense that is legally insufficient on its face.'" *Id.* (citing 6 Charles A. Wright, Arthur R. Miller & Mary Kay Kane, FEDERAL PRACTICE & PROCEDURE § 1487 (2d ed. 1990); *Ayers v. Johnson*, 247 F.Appx. 534, 535 (5th Cir. 2007) ("[A] district court acts within its discretion when dismissing a motion to amend that is frivolous or futile.")).

Here, Plaintiff has already been granted leave to amend. His amended pleading fails to allege facts sufficient to show he is entitled to relief. It would be futile to allow him to amend because a subsequent regulation has rendered his

claims moot. His statutory claim under RFRA fails, moreover, because he cannot show a substantial burden on his exercise of religion. The Court, therefore, should not grant Plaintiff a third bite at the apple.

IV. CONCLUSION

The Court recommends that Plaintiff's First Amended Complaint be **DISMISSED WITH PREJUDICE**.

Signed on November 21, 2017, at Houston, Texas.

Dena Palermo

Dena Hanovice Palermo
United States Magistrate Judge

Appendix B: 6/14/2018 Final Judgment

Final Judgment

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

JOHN J. DIERLAM,	§	
	§	
Plaintiff,	§	
	§	
v.	§	
	§	**CIVIL ACTION NO. 4:16-cv-307**
DONALD JOHN TRUMP, *et al.*,	§	
	§	
	§	
Defendants.	§	

FINAL JUDGMENT

In this action against various officials and departments of the federal government, Plaintiff John Dierlam alleges that provisions of the Patient Protection and Affordable Care Act violate his rights under the U.S. Constitution and federal law, most notably the Religious Freedom Restoration Act. (Doc. No. 32.) Defendants moved to dismiss. (Doc. No. 37.) The Court referred this motion to U.S. Magistrate Judge Dena Palermo, who recommended dismissal of Plaintiff's claims. (Doc. No. 67.) All parties filed responses to Judge Palermo's report. (Doc. No. 73, 75.) At a hearing on June 14, 2018, the Court dismissed Plaintiff's claims, stating its reasons on the record.

Pursuant to Federal Rule of Civil Procedure 58(a), and for the reasons set forth at the hearing, final judgment is hereby **ENTERED** for Defendants.

IT IS SO ORDERED.

SIGNED at Houston, Texas on this the 14th day of June, 2018.

KEITH P. ELLISON
UNITED STATES DISTRICT JUDGE