UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

Brittany R. Tovar,

Plaintiff,

v.

Essentia Health,
Innovis Health, LLC,
dba Essentia Health West, and
HealthPartners, Inc.,

Defendants.

Court File No. 16-cv-00100 (RHK/LIB)

MEMORANDUM IN OPPOSITION TO DEFENDANT HEALTHPARTNERS, INC.'S MOTION TO DISMISS PLAINTIFF'S COMPLAINT

INTRODUCTION

Defendant HealthPartners, Inc. ["HealthPartners"] introduces its argument by stating that it "ha[s] long advocated in favor of expanding access to health care, particularly for underserved communities." This is admirable, if true.[1] But like other arguments HealthPartners submits to this Court, it misses the mark. Whether HealthPartners has advocated for expanding access to health care is not at issue in this lawsuit.

What is ultimately at issue for HealthPartners is whether the company violated the Affordable Care Act [or "ACA"] by serving as the third party administrator [or "TPA"] for a health care plan that categorically excludes coverage for "[s]ervices and/or surgery for gender reassignment." Plaintiff alleges that having this type of categorical exclusion makes a health care plan discriminatory on its face. Further, she alleges that the ACA prohibits

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[1] Technically speaking, it is not a fact in the record. See page 2 n.2 and pages 7-8 below regarding the facts properly before the Court on HealthPartners' Motion to Dismiss.

covered entities such as HealthPartners from administering such facially discriminatory plans, much as Title VII prohibits staffing firms from carrying out a client company's discriminatory hiring instructions.

HealthPartners' Motion to Dismiss presents this Court with two preliminary questions, prior to any merits analysis: first, whether this Court has subject matter jurisdiction to hear Plaintiff's ACA claim; and second, whether Plaintiff has stated an ACA claim upon which relief may be granted. As laid out in detail below, the answer to both questions is yes.

The Court has subject matter jurisdiction over Plaintiff's ACA claim because Plaintiff has Article III standing and her claim is neither unripe nor moot.

Plaintiff has stated a claim upon which relief may be granted because her ACA claim is independent of ERISA, it is a plausible reading of the statute, and it could lead to meaningful remedies.

The meaningful remedies Plaintiff seeks include compensation for the harms she has suffered – for example, for her inability to obtain a key drug, Lupron, during the window of time in which it would have greatly benefitted her son. And they include declaratory and injunctive relief that will prevent HealthPartners and similarly-situated TPAs from ever again administering a plan – whether for Essentia or for any client company – which discriminates on the basis of sex in violation of the ACA.

FACTUAL BACKGROUND[2]

Plaintiff Brittany Tovar has been employed by Defendant Essentia[3] since September 24, 2010. (Complaint at ¶ 21.) Tovar's employee benefits at Essentia include health insurance provided through the Essentia Health Employee Medical Plan ("the Plan"). (*Id.* at ¶ 22.) Essentia specifically selected the Plan at issue, which was designed and offered by HealthPartners as Policy No. G008HPC-03. (*Id.* at ¶ 23.) HealthPartners serves as the third party administrator [or "TPA"] of the Plan.[4] (*Id.* at ¶ 24.) The Plan contains a categorical exclusion barring any insurance coverage for "[s]ervices and/or surgery for gender reassignment," regardless of medical necessity. (*Id.* at ¶ 25.)

Tovar's beneficiaries include her teenage son, who has been a beneficiary of the Plan since October 1, 2014. (*Id.* at ¶ 26.) In November 2014, Tovar's son was diagnosed with

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[2] This factual background relies solely on the allegations in the Complaint, which must be taken as true on a motion to dismiss. HealthPartners submitted five exhibits and purports to rely on them in its summary of the facts. However, only the first of these, Exhibit A (a copy of the Summary Plan Description), is properly before the Court as material that is "necessarily embraced" by the Complaint. *See Minnesota Majority v.* Mansky, 708 F.3d 1051, 1056 (8th Cir. 2013). The other additional materials – Exhibits B-E – are not properly before the Court and should be disregarded.

[3] Plaintiff's Complaint names as her employer Defendants Essentia Health and Innovis Health, LLC, dba Essentia Health West. (Complaint at ¶ 6.) The Complaint refers to these defendants collectively as "Essentia." (*Id.*) Essentia does likewise. (Essentia Memo at 1.) Plaintiff expects that discovery will reveal whether, as HealthPartners asserts, "Innovis Health, LLC, is Plaintiff's actual employer" (HealthPartners Memo at 2 n.2).

[4] HealthPartners asserts that "[c]ontrary to Plaintiff's Complaint, HealthPartners Administrators, Inc., (rather than HealthPartners, Inc.) is the entity that serves as a third-party administrator for the Essentia Health health plan at issue in this case." (HealthPartners Memo at 2 n.1.) If discovery reveals that HealthPartners Administrators, Inc., should be added as a defendant or substituted for HealthPartners, Inc., Plaintiff will seek to amend her Complaint accordingly.

gender dysphoria, a condition recognized in the Diagnostic and Statistical Manual, fifth edition ["DSM-5"], as arising when individuals' gender identity differs from the gender they were assigned at birth.[5] (*Id.* at ¶ 27.) Such individuals may be referred to as "transgender," while individuals whose gender identity is aligned with the sex or gender they were assigned at birth may be referred to as "cisgender." (*Id.* at ¶ 28.) The DSM-5 includes among symptoms of gender dysphoria "clinically significant distress or impairment in social, occupational, or other important areas of functioning." (*Id.* at ¶ 29.) These and other symptoms have been shown to be relieved by, *inter alia*, medical treatments such as mental health counseling, hormone therapy, and gender reassignment surgery. (*Id.* at ¶ 30.)

Because of the Plan's categorical exclusion of "[s]ervices and/or surgery for gender reassignment," Tovar's son has been denied insurance coverage for health care that his providers have deemed medically necessary. (*Id.* at ¶ 31.) Beginning in March 2015, Tovar used the pre-authorization and appeal processes outlined under the Plan to seek clarification regarding the enforcement of the exclusion, repeatedly emphasizing to Defendants the serious repercussions if her son were denied medically necessary care. (*Id.* at ¶ 32.)

In a letter dated April 9, 2015, HealthPartners reaffirmed its intent to enforce the categorical exclusion. (*Id.* at ¶ 33.) The representative stated in the letter that HealthPartners was "not questioning whether these services are medically necessary or appropriate" but was nonetheless enforcing the Plan's categorical exclusion. (*Id.*) When HealthPartners denied

[5] Because our society links individuals' sex (as determined by their chromosomes, hormones, genitals, or other biological features) to particular gender roles, and vice versa, it is also accurate to say that gender dysphoria arises when individuals' gender identity differs from their sex assigned at birth.

coverage, Tovar was forced to pay out of pocket for services or medications. (*Id.* at ¶ 34.) When this was not possible, Tovar's son was forced to go without necessary care. (*Id.*)

One of the treatments denied Tovar by HealthPartners and Essentia was her son's prescription for the drug Lupron, which was medically indicated for the window of time in which it was appropriate to suspend menstruation, prior to any use of testosterone supplements. (*Id.* at ¶¶ 35-38, 42-44.) The cost of Lupron was approximately $9,000. (*Id.* at ¶ 40.) Because this otherwise covered drug (*id.* at ¶ 39) was being prescribed for Tovar's son as a "[s]ervice[] . . . for gender reassignment," coverage was categorically excluded under the Plan. (*Id.* at ¶ 38.) Tovar could not afford the high out-of-pocket cost of this drug, and her son had to forego its benefits. (*Id.* at ¶ 40.)

Providers also prescribed Androderm, a form of testosterone, to treat Tovar's son for gender dysphoria. (*Id.* at ¶ 42.) As with the Lupron, Androderm was initially denied under the Plan, even though it would have been covered unquestionably for use by cisgender males. (*Id.* at ¶ 43.) Tovar was forced to pay out of pocket for this drug. (*Id.* at ¶ 44.) Essentia later approved Androderm for Tovar as a one-time exception but kept the categorical exclusion in the Plan. (*Id.* at ¶ 45.)

In December 2015, when Tovar contacted HealthPartners Member Services regarding pre-authorization for gender reassignment surgery for her son, she was told that the surgery would not be authorized, due to the Plan's continuing exclusion of "[s]ervices and/or surgery for gender reassignment." (*Id.* at ¶ 46.) Had the surgery been recommended by a medical provider for a purpose other than gender reassignment necessitated by gender

dysphoria – for instance, a mastectomy for a woman with breast cancer – it would have been covered by the Plan. (*Id.* at ¶ 47.)

Tovar's worry for her son, anger, disappointment, and sleeplessness made it difficult for her to focus on her job and caused a sharp increase in migraines. (*Id.* at ¶ 41.) She frequently found herself in tears at work and was ultimately compelled to reduce her work hours because of the stress. (*Id.*)

Tovar filed this action against Essentia and HealthPartners, alleging that Essentia violated Title VII and the Minnesota Human Rights Act ["MHRA"] and that HealthPartners violated the ACA. (*Id.* at ¶¶ 6-7.) Tovar alleges that Defendants' violations have caused her economic harm and emotional distress, and she seeks declaratory and injunctive relief as well as damages. (*Id.* at pp. 12-13.)

As her final factual allegation, Plaintiff alleges that, as of January 15, 2016 (the date on which the Complaint was filed), "[she] and her family continue to suffer financial and emotional harm due to the Plan's discriminatory exclusion of coverage for medical care needed by [her] son." (*Id.* at ¶ 48.) Essentia asserts in a footnote that "[t]his exclusion was eliminated from the Plan as of January 1, 2016." (Essentia Memo at 2 n.2.) However, this fact is not in the record before the Court, nor is it relevant to the Court's analysis of Defendants' arguments.[6]

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[6] For clarity, Plaintiff notes that she expects discovery to demonstrate the basis of her belief that the exclusion was still in place as of the date she filed her Complaint, January 15, 2016. However, the analysis below demonstrates that Plaintiff's claims are not in any way reliant on the Plan being in place after January 1, 2016. Plaintiff's Complaint raises merits and damages issues against both Essentia and HealthPartners even assuming that Essentia's assertion is correct, and the discriminatory exclusion was removed as of January 1, 2016. At issue are Defendants' actions prior to January 2016.

ARGUMENT

HealthPartners' Motion to Dismiss must be denied because this Court has subject matter jurisdiction over Plaintiff's ACA claim and Plaintiff has stated a claim upon which relief may be granted.

A. Standard of Review for A Motion to Dismiss Alleging A Lack of Subject Matter Jurisdiction Under Rule 12(b)(1)

On a Rule 12(b)(1) facial challenge, "the court merely [needs] to look and see if plaintiff has sufficiently alleged a basis of subject matter jurisdiction." *Branson Label, Inc. v. City of Branson*, 793 F.3d 910, 914 (8th Cir. 2015) (quoting *Menchaca v. Chrysler Credit Corp.*, 613 F.2d 507, 511 (5th Cir. 1980)). Accordingly, "the court restricts itself to the face of the pleadings and the non-moving party receives the same protections as it would defending against a motion brought under Rule 12(b)(6)." *Id.* (quoting *Osborn v. United States*, 918 F.2d 724, 729 n.6 (8th Cir. 1990)). The court must take the facts alleged in the Complaint as true and construe all reasonable inferences from those facts most favorably to the complainant. *See Ashcroft v. Iqbal*, 56 U.S. 662, 680 (2009).

The court must generally disregard materials outside the pleadings. *Thunander v. Uponor, Inc.*, 887 F. Supp. 2d 850, 859 n.1 (D. Minn. 2012) (citation omitted). Defendant HealthPartners has nonetheless filed five exhibits with its memorandum. (Decl. of Julie Bunde, Exhibits A-E.) It argues that the Court "may consider the Bunde Declaration and its Exhibits because those materials do not contradict the Complaint and are necessarily embraced by the pleadings." (HealthPartners Memo at 3 n.3, citing *Minnesota Majority v.* Mansky, 708 F.3d 1051, 1056 (8th Cir. 2013).)

Plaintiff disagrees with this sweeping statement. She does not object to the Court's consideration of Exhibit A, which HealthPartners asserts is a copy of the Summary Plan Description for the health plan provided to Tovar by Essentia Health, effective January 2015. (Decl. of Julie Bunde, ¶ 2.) The Summary Plan Description of the plan at issue is necessarily embraced by the Complaint.

This is not the case for Exhibits B-E, however. Plaintiff does not rely on these Exhibits (redacted letters from HealthPartners and a subsequent Plan Description), and she objects to their consideration, as they are by definition one-sided and potentially misleading. *Cf. Minnesota Majority*, 708 F.3d at 1056 (permitting consideration of materials outside the pleadings where both parties rely on the materials and no party objects).

B. The Court Has Subject Matter Jurisdiction Over Plaintiff's ACA Claim

The Court has subject matter jurisdiction over Plaintiff's ACA claim against HealthPartners because Plaintiff has Article III standing to bring the claim and the claim is neither unripe nor moot.

1. Plaintiff Has Standing to Sue HealthPartners[7]

HealthPartners argues that Plaintiff lacks standing to pursue her ACA claims, that is, it argues that she is not entitled to ask this Court to decide the merits of the dispute. *Warth v. Seldin*, 422 U.S. 490, 498 (1975). The basic elements of the standing doctrine are derived

[7] Essentia's argument, or at least a portion of its argument, might be interpreted as an Article III standing argument, rather than a separate "statutory standing" argument. (*See* Essentia Memo at 5-7.) If Essentia's argument is so intended, it collapses for the same reasons as HealthPartners' Article III standing argument: Plaintiff has been injured by Essentia's discriminatory plan, that injury is fairly traceable to Essentia (as well as to HealthPartners), and that injury is likely to be redressed by the relief she seeks. *See Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992).

from Article III of the Constitution, which limits the federal judicial power to justiciable "cases" and "controversies." *Reid v. BCBSM, Inc.*, 984 F. Supp. 2d 949, 953 (D.Minn. 2013). The leading case, *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992), identifies three such elements:

> A plaintiff must allege she suffered a "personal injury" that is "fairly traceable to the defendant's allegedly unlawful conduct" and "likely to be redressed by the requested relief."

Reid, 984 F. Supp. 2d at 953, citing *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992) (internal citations omitted).

As HealthPartners notes, the Eighth Circuit has laid out a more detailed version of the three *Lujan* elements:

> To satisfy Article III's standing requirements, a plaintiff must show (1) [she] has suffered an injury-in-fact that is (a) concrete and particularized and (b) actual or imminent, not conjectural or hypothetical; (2) the injury is fairly traceable to the challenged action of the defendant; and (3) it is likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision.

(HealthPartners Memo at 7-8, quoting *McClain v. Am. Economy Ins. Co.*, 424 F.3d 728, 731(8th Cir. 2005).)

But this detailed variation of the *Lujan* elements should not distract from the essential nature of the standing doctrine. "Standing is not a technical rule intended to keep aggrieved parties out of court . . . Rather it is a practical concept designed to ensure that courts and parties are not vexed by suits brought to vindicate nonjusticiable interest." *Maloney v. Pac*, 439 A.2d 349, 353-54, (Conn. 1981). The goal is merely to ensure "that judicial decisions which may affect the rights of others are forged in hot controversy, with each view fairly and vigorously represented." *Id.*

A plaintiff with standing is one who "has the requisite 'personal stake in the outcome' of his suit." *Barlow v. Collins*, 397 U.S. 159, 172-73 (1970) "[A] person so harmed will, as best he can, frame the relevant questions with specificity, contest the issues with the necessary adverseness, and pursue the litigation vigorously." *Id.* " Recognition of his standing to litigate is then consistent with the Constitution, and no further inquiry is pertinent to its existence." *Id.*

a. Plaintiff Has Been Injured

Plaintiff alleges that HealthPartners violated her rights under Section 1557 of the ACA, which provides:

> [A]n individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 794 of title 29, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity.

42 U.S.C. § 18116(a).

This statutory language is notoriously hard to parse. Stated more simply, Plaintiff's ACA claim against HealthPartners alleges that she was "denied the benefits of, or [was] subjected to discrimination under" a health program (the plan administered by HealthPartners) "on the ground prohibited under title IX," namely sex or gender.

Contrary to HealthPartners' argument (HealthPartners Memo at 8-9), nothing in this statutory language requires that Plaintiff was herself denied medical care (*e.g.,* a prescription for Androderm), in order for her to have Article III standing to challenge the legality of HealthPartners' actions under Section 1557.

In *Luhan* terms, Plaintiff has a "personal injury" because the discriminatory plan at issue resulted in her son not obtaining necessary medical care. Any parent would agree: it is hard to imagine a more personal injury. As noted in the Complaint, this violation of the ACA caused her a number of personal harms, both financial (paying for, or attempting to pay for, her son's care out-of-pocket) and psychological (feeling worry, anger, disappointment, and sleeplessness).

Similarly, in *McClain* terms, Plaintiff has suffered an "injury-in-fact" that is quite concrete and particularized and very much actual, not conjectural or hypothetical. Being so personally harmed, she can be counted on to, "as best [she] can, frame the relevant questions with specificity, contest the issues with the necessary adverseness, and pursue the litigation vigorously."

And contrary to HealthPartners' back-up argument (*see* HealthPartners Memo at 9), Plaintiff need not argue that she is bringing this action on behalf of her son. She is not bringing the case as "an interested onlooker"; rather, she is bringing the case to redress the harms done to her.

b. Plaintiff's Injuries Are Traceable To HealthPartners

HealthPartners argues that Plaintiff's injuries are not traceable to HealthPartners because it had no discretion to do anything other than enforce the plan that Essentia had selected, and that the only thing HealthPartners did was accurately report the exclusion. (HealthPartners Memo at 9-10.) This argument ignores the decision HealthPartners made to agree to administer a discriminatory plan in the first place. This action of HealthPartners, in contracting to administer a plan for Essentia that on its face illegally discriminated on the

basis of sex, directly led to the injuries Tovar experienced in receiving discriminatory health care coverage.

HealthPartners argues that Tovar can't trace the injuries she experienced to its conduct, citing a case where a non-profit housing organization sued a housing provider for discriminatory advertising. *Arkansas ACORN Fair Hous. v. Greystone Dev.*, 160 F.3d 433 (8th Cir. 1998). The non-profit provided evidence of staff hours spent investigating and responding to discriminatory advertising, but could not quantify the portion of the injury that was attributable to this particular developer's advertising. *Id.* at 434. The Eighth Circuit held that the plaintiff organization could not trace its injury to the particular defendant and therefore lacked standing. *Id.* at 434-35. The analogy to HealthPartners and Essentia fails. Here, Tovar's injuries are traceable to the joint actions of Defendants HealthPartners and Essentia. HealthPartners and Essentia contracted to provide illegally discriminatory health care coverage. It took the actions of both parties: Essentia requesting the discriminatory plan and HealthPartners agreeing to administer the discriminatory plan,[8] to cause Tovar's injuries.

The situation is analogous to a staffing agency and its customer jointly agreeing to violate Title VII by, for example, the customer requesting and the staffing agency agreeing to provide only male employees for warehouse work. Title VII holds both the staffing agency and the customer responsible for the discrimination. The staffing agency, like HealthPartners

[8] Plaintiff's characterization of the negotiations between HealthPartners and Essentia as Essentia "requesting" and HealthPartners "agreeing to" the discriminatory plan is used here without benefit of evidence that could be available in discovery. The exact nature of the negotiation between HealthPartners and Essentia to provide Tovar's plan is not part of Tovar's Complaint and unknown prior to discovery. If both Essentia and HealthPartners are responsible for their agreement, as Plaintiff argues here, it ultimately does not matter which of them initiated or proposed the plan.

as third party administrator here, is not permitted to escape liability by arguing that it was only doing what the customer wanted. *See* EEOC Enforcement Guidance: Application of EEO Laws to Contingent Workers Placed by Temporary Employment Agencies and Other Staffing Firms, Number 915.002 (Dec. 3, 1997) (available at http://www.eeoc.gov/policy/docs/conting.html). As the EEOC Guidance makes clear, "both staffing firms and their clients share EEO responsibilities." *Id.* at 3; *see also Williams v. Grimes Aerospace Co.*, 988 F. Supp. 925, 934 (D.S.C. 1997) (discussing standard for joint liability under Title VII). By analogy, here both HealthPartners and Essentia share the responsibility for agreeing to violate §1557.

c. HealthPartners Is Responsible For Redressing Plaintiff's Claim

HealthPartners argues that it cannot redress Plaintiff's injuries, even assuming Plaintiff had unredressed injuries. It argues that Essentia bore the risk of loss under the plan. Tovar agrees that the nature of a self-insured plan such as the one at issue here is that the employer bears the risk of loss and the third-party administrator is hired to administer the plan. But it does not follow, and HealthPartners can point to no principle and no case law that would permit HealthPartners to escape responsibility for Plaintiffs' damages simply because it is not the party that bears the risk of paying insurance claims under the contract. Plaintiff's damages are more than merely the cost of insurance claims that were denied. She has alleged economic and emotional distress damages that will be explored further in discovery. (Compl. at ¶64.) She argues that HealthPartners and Essentia are jointly responsible, through their agreement to provide and administer a discriminatory plan, for these damages.

Plaintiff also seeks injunctive relief against both Essentia and HealthPartners, forbidding them from participating as employer or third-party administrator, respectively, in plans containing this discriminatory exclusion in the future. HealthPartners claims that Essentia has removed this exclusion from its 2016 plan, but it does not identify whether it has agreed to administer other plans for other employers that contain this exclusion.

2. Plaintiff's Claims Are Ripe And Are Not Moot

Plaintiff experienced harm as a result of Defendants' mutual agreement to provide a discriminatory plan, so her claims are not moot. HealthPartners argues that Tovar "never purchased Lupron," so she has no economic harm from its denial. (HealthPartners Memo at 12.) This argument ignores the harm and damages that Tovar has alleged in her complaint. Plaintiff argues that her son, who is a beneficiary of the plan that the Defendants provided to Tovar, did not receive necessary medical treatment because of Defendants' discrimination. The fact that she didn't pay $9,000 out of pocket for her son's Lupron prescription is not the point. The point is that her son did not receive the proper treatment at a time when he needed it. (Compl. at ¶40.) He endured medical symptoms that the treatment could have alleviated. Tovar had to experience the pain of watching her son experience harmful symptoms for which medical care was available but unaffordable to her.

In her Complaint, Tovar alleges that she experienced economic damages and emotional distress. (*Id.* at ¶64.) She was unable to focus on her work and her migraines increased. (*Id.* at ¶41.) She cried in between providing care to her patients. (*Id.*) She was unable to work as many hours as she had previously because of her distress. (*Id.*) Damages for emotional distress are available under §1557 through the incorporation of remedies

available under Title IX. 42 U.S.C. § 18116(a); *see Franklin v. Gwinnett County Pub. Sch.*, 503 U.S. 60, 76 (1992). Defendants claim that Plaintiff's economic damages were ultimately all repaid, but in the absence of discovery and record evidence, they cannot support this.

Defendant HealthPartners argues that Tovar's claim for benefits is moot, citing *Engelhardt v. Paul Revere Life Ins. Co.*, which held that a plaintiff in an ERISA claim could not sustain a claim for past benefits once all past benefits were paid. 77 F.Supp.2d 1226, 1234 (M.D. Ala 1999). However, the damages available under an ERISA claim are not the same as the damages under a Title IX or § 1557 claim, which can include emotional distress damages. *See Franklin*, 503 U.S. at 76. The harm that Tovar experienced must be redressed through emotional distress damages because HealthPartners cannot rewind time and provide Tovar's son with the treatment he was denied at the time when he needed it. In addition, in the absence of discovery and record evidence, HealthPartners cannot show that Tovar's economic losses have all been repaid. Therefore the logic of *Engelhardt* does not apply to this claim.

Plaintiff's claims are ripe because she is not challenging coverage available under the 2016 plan. Plaintiff's Complaint contains no references to the 2016 plan. Tovar was injured by the exclusion in the prior plan. The plan provided by Essentia and administered by HealthPartners in 2016 is not relevant to Tovar's claim of past harm that caused damages.

C. Standard of Review for Motion to Dismiss Alleging A Failure to State a Claim Under Rule 12(b)(6)

Courts evaluate a motion to dismiss under Rule 12(b)(6) by first accepting all of the plaintiff's factual allegations, but not bare legal conclusions, as true. *Ashcroft v. Iqbal*, 56 U.S. 662, 680 (2009). A complaint must include enough facts to state a plausible claim for relief.

Id. at 678. The complaint must be viewed as a whole to examine its plausibility, rather than determining whether any individual allegation, standing alone, meets that standard. *Braden v. Wal-Mart Stores, Inc.*, 588 F.3d 585, 594 (8th Cir. 2009). Plausibility requires more than a slight possibility of success on the merits, but it is not a probability standard. *Id.* (citing *Bell Atl. Corp. v. Twombly*, 440 U.S. 544, 556 (2007). A plaintiff does not need to plead specific facts showing exactly how the defendant's behavior was illegal. *Id.* (citing *Erickson v. Pardus*, 551 U.S. 89, 93 (2007)). Instead, the facts must "allow the court to draw the reasonable inference that the plaintiff is entitled to relief." *Id.* (quoting *Iqbal*, 556 U.S. at 678) (internal quotations omitted).

A complaint should not be dismissed simply because the Court is doubtful that the plaintiff will be able to prove all of the necessary factual allegations. *Twombly*, 550 U.S. at 556. Accordingly, a well pleaded complaint will survive a motion to dismiss even if recovery appears unlikely. *Id.*

D. Plaintiff Has Stated a Claim Upon Which Relief May Be Granted

HealthPartners argues that Plaintiff's ACA claim fails the Rule 12(b)(6) standard on three grounds: first, that her claim is incompatible with ERISA; second, that she cannot allege a viable Section 1557 claim because only Essentia, not HealthPartners, can be held liable for the harm caused to her by the discriminatory plan; and third, that she has no recoverable damages. All three arguments miss the mark.

1. Plaintiff's Section 1557 Claim Does Not Require Her To Exhaust ERISA Administrative Remedies.

Plaintiff's claim against Defendant HealthPartners is a §1557 claim. The statute prohibits discrimination by a covered entity on the basis of sex. 42 U.S.C. §18166.

Defendant HealthPartners argues that Plaintiff's claim against HealthPartners should fail because she "failed to exhaust her administrative remedies as required by ERISA." (HealthPartners Memo at 16.) But Tovar's §1557 claim is outside the scope of an ERISA claim and is not governed by its rules or procedure.

ERISA's preemption provision in § 514(a) indicates that it "supersede[s] any and all *State* laws" that relate to benefit plans. 29 U.S.C. §1144(a) (emphasis added). Separately, ERISA provides that "[n]othing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States . . . or any rule or regulation issued under any such law." 29 U.S.C. §1144(d). There are exceptions enumerated in the law, but these exceptions relate to pre-existing law and are not relevant here. *Id.* In other words, ERISA explicitly does not preempt other federal statutes such as §1557.

ERISA also contains a cause of action in §502A to enforce rights provided by §510. This includes an anti-discrimination provision, but crucially and unlike §1557, the anti-discrimination provision only pertains to rights granted by the benefit plan itself or the particular statutes cited, prohibiting discrimination against an individual "for exercising any right to which he is entitled *under the provisions of an employee benefit plan* . . ." as well as enumerated statutes. 29 U.S.C. § 1140 (emphasis added). §1557 simply provides rights distinct from ERISA, with a separate cause of action to enforce those rights.

HealthPartners quotes *McClendon* for its argument that a claimant under §1557 must follow ERISA procedure. (HealthPartners Memo at 17.) But *McClendon* discusses the scope of ERISA's preemptive effect on *state* law, not federal law. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 135 (1990). When *McClendon* discusses ERISA as an "exclusive remedy," it is

reading the statute to look for evidence of congressional intent of broad preemption of state law. *Id.* at 143-44. None of these arguments are applicable to federal law such as §1557. HealthPartners discusses ERISA's goal, raised in *McClendon*, to ensure nationally uniform administration of benefit plans, but a broadly applicable federal law does not disturb that uniformity. *See id.* at 142. *McClendon* provides no guidance on how ERISA interacts with other federal laws.

For example, ERISA has not been interpreted to preempt Title VII anti-discrimination law. *See Burds v. Union Pac. Corp.*, 223 F.3d 814, 817 (8th Cir. 2000). In *Burds*, the plaintiffs brought separate claims under ERISA and Title VII. *Id.* at 816. Both claims were dismissed for failure to exhaust administrative remedies. *Id.* at 818. However, the Title VII claim was not dismissed for a failure to exhaust ERISA remedies, but for a failure to exhaust Title VII remedies because the plaintiffs had not timely filed their claims with the EEOC. *Id. Burds* is wholly consistent with Tovar's approach here. If Tovar were making a claim that implicated ERISA, for example if the plan at issue had provided coverage for transition services but in practice such claims were always denied, she would be permitted to bring both an ERISA claim and a §1557 claim, and each statutory claim would be governed by its own rules. Since Tovar's claim here raises a §1557 issue about a facially discriminatory plan that was administered according to its discriminatory terms, she does not have an ERISA claim and exhaustion of remedies under ERISA is simply not relevant.

This Court's rationale in a previous case is persuasive here. *See Reid v. BCBSM, Inc.*, 984 F.Supp.2d 949 (D.Minn. 2013). In *Reid*, the plaintiff brought a similar argument concerning a plan that the plaintiff argued was discriminatory on its face because of an

exclusion that affected a particular type of disability. *Id.* at 954. This Court dismissed the plaintiff's ERISA claim and kept the plaintiff's ADA and MHRA claims. *Id.* at 957. The same reasoning applies here: "ERISA permits a plan participant, such as [Tovar], to sue to recover benefits due to her under the terms of her plan. However, [Tovar's] claim is not that [transition-related services *are*] covered by her plan, her claim is that [they] *should be*. *Id.* at 955 (emphasis in original) (citations omitted). Had Tovar brought an ERISA claim, therefore, that claim would be subject to dismissal. *See id.* at 956. Instead, she properly brings a claim under the relevant anti-discrimination statute, here §1557, which forbids covered entities from discriminating on the basis of sex. *See* i*d.* ERISA exhaustion requirements are irrelevant to this claim.

HealthPartners urges this Court not to rule that §1557 eliminated ERISA exhaustion. (HealthPartners Memo at 18.) The Court here may rule in Plaintiff's favor without fear of that outcome because the §1557 claim at issue here simply does not change or alter ERISA exhaustion requirements. Similarly, the Department's Proposed Rules on §1557 say nothing about eliminating ERISA exclusivity because this is outside the Proposed Rules' scope of interpreting §1557.

Even if there were a plan administration exhaustion requirement within §1557, as HealthPartners repeatedly points out it would have been futile for Tovar to pursue. (HealthPartners Memo at 20.) We expect discovery to show that at every stage of the process once the plan was in place, HealthPartners insisted its hands were tied by the discriminatory terms of Tovar's plan. Tovar's Complaint itself does not allege facts showing a failure to exhaust administrative remedies, and we expect discovery to show that Tovar's

attempts to appeal the denial of coverage for Lupron were more comprehensive than relayed by HealthPartners in its brief. Exhaustion arguments under ERISA are typically addressed as an affirmative defense, at the summary judgment stage, perhaps for the reason that discovery is often necessary to fully explore these arguments. *See, e.g., Honeysett v. Allstate Ins. Co.*, 570 F.Supp.2d 994, 1004 (N.D.Ill. 2008).

Plaintiff's claims are not subject to dismissal for a failure to exhaust ERISA administrative remedies. Tovar has brought a claim under §1557, alleging that the plan for which HealthPartners agreed to act as third party administrator is discriminatory in its terms. ERISA does not preempt federal anti-discrimination law such as §1557, and Tovar is not bringing an ERISA claim alleging that HealthPartners failed to follow the terms of the plan. ERISA exhaustion requirements are outside the scope and do not apply to Plaintiff's claim.

2. Plaintiff Has Alleged a Plausible Section 1557 Claim

HealthPartners begins its Rule 12(b)(6) argument against Plaintiff's Section 1557 claim by once again pointing toward its co-defendant, Essentia, as the only party that could possibly be held liable: "HealthPartners did not discriminate against Plaintiff's son (or Plaintiff) because Essentia – not HealthPartners – is responsible for the exclusions in Essentia's Plan." (HealthPartners Memo at 19.) But this argument is wishful thinking, incompatible with many well-known doctrines in American law – see, for example, the civil and criminal doctrines applying to co-conspirators. Nothing in the law requires courts to select one and only one responsible party for any particular legal wrong.

HealthPartners also argues as a preliminary matter that the correct standard of liability under Section 1557 for a TPA's administration of a health plan alleged to discriminate on the

basis of sex must be the standard set out in a leading Title IX case, *Gebser v. Lago Vista Indep. Sch. Dist.*, 524 U.S. 274 (1998). (HealthPartners Memo at 19-20.) This argument is superficially appealing but ultimately wrong, on several levels.

First, it would be incorrect for the Court to treat Section 1557 as if it were simply intended as the independent extension of each the four statutes referenced (Title VI, the ADA, the Rehabilitation Act, and Title IX). Such a reading of Section 1557 fails to comport with Congress's intent and would lead to absurd results. *See Rumble v. Fairview Health Servs.*, No. 14-cv-2037 (SRN/FLN), 2015 U.S. Dist. LEXIS 31591, *30-*32 (D. Minn. March 16, 2015). Instead, "it appears that Congress intended to create a new, health-specific, anti-discrimination cause of action that is subject to a singular [doctrinal] standard," regardless of which protected class status is implicated. *Id.* at *30.

Second, it may be inappropriate for the Court to look to the *Gebser* standard of liability, which was designed to determine when schools should be liable for concealed sexual harassment. HealthPartners is not in the position of a school which is being asked to detect and correct a third party's discrimination. Rather, Plaintiff's Section 1557 claim asks the Court to hold HealthPartners liable for its own actions in choosing to administer (and profit from) a facially discriminatory plan.

a. Plaintiff's Claim Does Not Fail for Any Lack of Notification

In arguing that Plaintiff's claim must fail because she failed to notify HealthPartners of "any allegedly discriminatory conduct," HealthPartners relies on additional materials it submitted to the Court: Exhibits B, C, and E. (HealthPartners Memo at 20-21.) The Court

must set aside those arguments, because as noted above, those materials are not properly before the Court on a Motion to Dismiss.[9]

On a more general level, HealthPartners' notification argument must fail because its liability under Section 1557 cannot depend on Plaintiff "notifying" it about a plan it was already perfectly familiar with, having designed the plan, sold the plan, and then administered the plan. (*Compare* HealthPartners Memo at 21-22 *with* Complaint at ¶ 23.)

b. Plaintiff Has Plausibly Alleged Discrimination by HealthPartners

HealthPartners can argue at length that it "did not discriminate" because it repeatedly fails to grapple with the actual nature of Plaintiff's allegations under Section 1557. (See HealthPartners Memo at 22-27.)

Plaintiff's claim under Section 1557 does not require that Plaintiff or anybody else notify HealthPartners of the discriminatory nature of the plan it designed, sold, and administered. (*Id.* at 22.)

Nor must Plaintiff prove that "gender reassignment services or surgery would have been covered and paid for by Essentia but for some action or decision by HealthPartners." (*Id.*) Her claims against Essentia and HealthPartners are independent: if her allegations are upheld, Essentia will be liable for its own actions under Title VII, and HealthPartners will be liable for its own actions under Section 1557. Neither claim, to be successful, requires Plaintiff to prove that one of the Defendants could have or should have forced the other to change its behavior. In that sense, the laws at issue are again analogous to the separate provisions of Title VII that regulate employers and staffing agencies. Where an employer

[9] HealthPartners' argument regarding Exhibit E is also designated as a standing argument; as such, it is already addressed above in Part B.1.

and a staffing agency work together to implement a discriminatory policy, they are each independently liable, regardless of whether the facts would demonstrate that either had the ability to control the other. On a systemic level, of course, such regulations do operate to control the behavior of both employers and staffing agencies. But that systemic effect is achieved by applying the laws to each regulated entity, one by one.

HealthPartners also misconstrues the relationship of Plaintiff's Section 1557 claim to ERISA. First, Plaintiff is not bringing an ERISA claim, so HealthPartners' arguments regarding the operation of liability under ERISA are irrelevant. (HealthPartners Memo at 23.) Secondly, the Court need not be concerned about placing TPAs like HealthPartners in a "catch-22," "requir[ing] them to violate ERISA to avoid Section 1557 liability." (*Id.*). ERISA does not conflict with other federal laws like Title VII or Section 1557, because it only preempts state laws, not federal laws. *See* Section 514(d) of ERISA, 29 U.S.C. § 1144(d) (ERISA does not preempt other federal laws like Title VII); *see also Shaw v. Delta Air Lines*, 463 U.S. 85, 97 (1983) (holding that state laws like the MHRA are preempted by ERISA only to the extent that they go beyond separate, non-preempted federal law like Title VII).

Plaintiff need not make arguments regarding HealthPartners' treatment of "similarly situated persons," (HealthPartners at 24-25), because Plaintiff need not compile evidence designed to flush out discriminatory motives. Plaintiff is challenging the plan at issue as a facially discriminatory plan, no different in essence than a plan that covered only women, but not men, or only people of certain races or religions.

Plaintiff alleges that HealthPartners is liable for its violation of Section 1557 because the statute has, from its passage, forbidden TPAs from administering facially discriminatory

plans. Given this, the timing of the HHS-OCR rules is irrelevant. *See* HHS, Nondiscrimination in Health Programs and Activities, 78 Fed. Reg. 54172 (Sept. 8, 2015) (to be codified at 45 CFR 92). Plaintiff agrees with HealthPartners that "the proposed rules are largely irrelevant to this motion" (HealthPartners Memo at 27), but that is because it is not the rules that make HealthPartners liable to Plaintiff; it is the statute itself, which has been in effect for more than six years.

c. Plaintiff's Claim Does Not Fail for Any Lack of Control by HealthPartners

HealthPartners' final Rule 12(b)(6) argument, that it "lacked control over the alleged discrimination" (HealthPartners Memo at 27-28), is just a rehash of the previous arguments, and fails for reasons already laid out.

It cites again to the *Gebser* rule, which applies to schools confronting (or failing to confront) concealed sexual harassment. But that is not the applicable model here, so it is irrelevant whether there is an "individual at a third-party administrator to whom a plaintiff could give the notice required by *Gebser*." (HealthPartners Memo at 28.) HealthPartners did not need Brittany Tovar to put it on notice that the plan it designed, it sold, and it administered was discriminatory on its face. Who knew better than HealthPartners that the plan it called Policy No. G008HPC-03 had an exclusion for "[s]ervices and/or surgery for gender reassignment"? No one, of course. (Complaint at ¶¶ 23, 25.)

And contrary to HealthPartners' final, helpless-sounding, dinosaur-arms plea that it "lacked authority to address the alleged discrimination" or "to institute corrective measures" (HealthPartners Memo at 28), HealthPartners *did* have the ability to take action to avoid liability. Like the staffing agencies that refuse to carry out discriminatory hiring requests,

HealthPartners could simply refuse to serve as a TPA for any plan that violates Section 1557 on its face. And requiring that it – and all the covered TPAs – take this action is how the statute accomplishes Congress's intent. The Section 1557 mandate on TPAs, like Title VII's mandate on staffing agencies, is entirely practicable for the entities being regulated and eminently sensible for the community as a whole.

3. Plaintiff Suffered Damages For Which She May Recover

Plaintiff has alleged economic and emotional distress damages due to Defendants' failure to provide necessary medical treatment to a beneficiary of her insurance policy, her son. (Compl. at ¶64.) Defendant HealthPartners claims without citing evidence that Tovar's economic losses were all ultimately repaid. In the absence of discovery it is too early to draw that conclusion.

Defendant HealthPartners also claims that emotional distress damages are unavailable to Plaintiff. But §1557 provides for emotional distress damages by incorporating damages available under Title IX. 42 U.S.C. § 18116(a); *see Franklin v. Gwinnett County Pub. Sch.*, 503 U.S. 60, 76 (1992). These damages are available to Plaintiff because it is her rights that were violated. Under §1557, covered entities are required to provide insurance coverage that does not discriminate on the basis of sex. Tovar was the insured party and her son was the beneficiary of her insurance coverage. The coverage was discriminatory, and Tovar suffered injury as a result.

Defendant cites to cases discussing §1983 claims. In *Pierzynowski v. Police Dep't City of Detroit*, four plaintiff family members filed a §1983 claim alleging that one family member was falsely arrested due to racial discrimination, and that other family members experienced

emotional distress because of the false arrest. 941 F.Supp. 633, 640 (E.D.Mich. 1996). This is not analogous to the claim at issue here. In the §1983 claim, the family members' connection to the alleged discrimination was solely as observers. In Plaintiff's §1557 claim, she is the covered party for the discriminatory health care plan. Tovar was provided with a plan that discriminated on the basis of sex, and the benefits she received through her beneficiary son were lacking because of the discrimination. As the insured party, the damages that Plaintiff experienced, including emotional distress she experienced due to her son not receiving necessary medical care, are recoverable. She is not merely a third-party bystander.

CONCLUSION

For all of the reasons stated above, this Court should deny HealthPartners' Motion to Dismiss this lawsuit.

Dated: March 24, 2016

Respectfully submitted,

GENDER JUSTICE

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UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

Brittany R. Tovar,

Plaintiff,

v.

Essentia Health,
Innovis Health, LLC,
dba Essentia Health West, and
HealthPartners, Inc.,

Defendants.

Court File No. 16-cv-00100 (RHK/LIB)

LR 7.1(F) CERTIFICATE OF COMPLIANCE REGARDING MEMORANDUM IN OPPOSITION TO DEFENDANT HEALTHPARTNERS, INC.'S MOTION TO DISMISS PLAINTIFF'S COMPLAINT

I, Jill R. Gaulding, certify that Plaintiff's Memorandum in Opposition to Defendant HealthPartners, Inc.'s Motion to Dismiss Plaintiff's Complaint complies with Local Rule 7.1(f).

I further certify that, in preparation of this memorandum, I used Microsoft Word, Version 2010, and that this word processing program has been applied specifically to include all text, including headings, footnotes, and quotations in the following word count. I further certify that the above-referenced memorandum contains 7352 words, in compliance with Local Rule 7.1(f)(1)(C).

I further certify that this memorandum complies with the type size requirements of Local Rule 7.1(h), because it is (a) typewritten in size 13 font,
(b) double spaced (except for headings, footnotes, and quotations that exceed two lines), and (c) submitted on 8½" by 11" paper with at least 1" margins on all four sides.

Dated: March 24, 2016

Respectfully submitted,

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