

English proficiency to covered entities' health programs and activities. Clearly explaining the standards also promotes compliance and reduces enforcement costs. Options for addressing the prohibition of national origin discrimination as it affects individuals with limited English proficiency are discussed in the preamble to the proposed rule.

OCR considered a regulatory scheme requiring covered entities to provide meaningful access to each individual with limited English proficiency by providing effective language assistance services, at no cost, unless such action would result in an undue burden or fundamental alteration. OCR also considered requiring covered entities of a certain type or size to have enhanced obligations to provide language assistance services. Such enhanced obligations would include providing a predetermined range of language assistance services in certain non-English languages that met defined thresholds. A covered entity that was not of a certain type or size still would be required to provide meaningful access to each individual with limited English proficiency in its health programs and activities, but the covered entity would not have to provide a predetermined range of language assistance services in certain non-English languages. OCR also explored applying the threshold requirement to standardized vital documents on a national, State, or county level, as well as specific to a covered entity's geographic service area.

The strengths of these alternate regulatory schemes included limited obligations for small businesses providing health programs or activities and defined standards for larger entities. The costs of these approaches included the complexity of the regulatory scheme and the potential burden on the covered entities of a certain type or size that would have enhanced applications. OCR determined these costs outweigh the benefits.

OCR considered drafting new provisions addressing effective communication (apart from communication through electronic and information technology) with individuals with disabilities, but instead is incorporating provisions of the regulation implementing Title II of the ADA to ensure consistency for covered entities and potentially reduce burden by limiting resources spent on training and modification of policies and procedures.

Options regarding communication through electronic and information technology are discussed in the

preamble to the regulation. Regarding the accessibility requirements under the proposed regulation, OCR at first considered a narrower interpretation that the rule applied only to access to health programs and activities provided through covered entities' Web sites. However, we chose a broader interpretation, to include both Web sites and other means of electronic and information technology. While this could potentially increase the burden on recipients of Federal financial assistance and State-based Marketplaces, this would offer clarity to covered entities, increase the benefit of the rule, and help enhance access for individuals with disabilities.

In the area of compliance, OCR considered having one set of procedures for all compliance activities involving recipients of Federal financial assistance and State-based MarketplaceSM entities. Instead, OCR decided to adopt the unique Age Act procedures³⁸² for age-related compliance activities under Section 1557 because Age Act compliance activities and Section 1557 compliance activities regarding age discrimination are likely to substantially overlap.

With regard to other areas of compliance, OCR considered developing a separate set of procedures for Section 1557 compliance activities involving HHS health programs and activities, but decided to largely adopt the existing procedures for disability compliance activities involving HHS health programs and activities (with some enhancement) to improve efficiencies for OCR and the HHS health programs and activities covered by Section 1557.

V. Unfunded Mandates Reform Act of 1995

Section 202 of the Unfunded Mandates Reform Act of 1995 requires that agencies assess anticipated costs and benefits before issuing any rule that includes a Federal mandate that could result in expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of \$100 million in 1995 dollars, updated annually for inflation. In 2016, that threshold level is approximately \$146 million.

The Unfunded Mandates Reform Act does not address the total cost of a final rule. Rather, it focuses on certain categories of cost, mainly those "Federal mandate" costs resulting from: (1)

³⁸² The Age Act procedures, for example, require mediation of all age discrimination complaints, and exhaustion of administrative remedies prior to the filing of a civil lawsuit. 45 CFR 91.43, 91.50.

Imposing enforceable duties on State, local, or tribal governments, or on the private sector; or (2) increasing the stringency of conditions in, or decreasing the funding of, State, local, or tribal governments under entitlement programs.

Our impact analysis shows that burden associated with training staff working for covered entities will be spread widely across health care entities, State and local governmental entities, and a substantial number of health insurance issuers. The analysis estimates the unfunded burden will be about \$422 million in training and familiarization costs. We project that for the first few years following promulgation of the final rule, private sector costs for investigating discrimination complaints may amount to \$87 million per year. Within the first five years following the final rule's promulgation, we anticipate complaints will increase, and then eventually drop off as covered entities modify their policies and practices in response to the final rule.

As we explain in the RIA, we believe there will be benefits gained from the promulgation of this regulation in the form of reduction in discrimination based on race, color, national origin, sex, age, and disability, and the corresponding improvement in the quality of care to underserved communities. In response to comments concerning the costs to covered entities, we note that we have not included some changes that would have been beneficial to individuals because we recognize that they would be costly for covered entities.

VI. Executive Order 13132: Federalism

As required by Executive Order 13132³⁸³ on Federalism, OCR examined the effects of provisions in the regulation on the relationship between the Federal government and the States. OCR has concluded that the regulation does have Federalism implications but preempts State law only where the exercise of State authority directly conflicts with the exercise of Federal authority under the Federal statute.

The regulation attempts to balance State autonomy with the necessity of creating a Federal floor that will provide a uniform level of nondiscrimination protection across the country. The regulation restricts regulatory preemption of State law to the minimum level necessary to achieve the objectives of the underlying Federal statute, Section 1557 of the ACA.

³⁸³ Exec. Order No. 13132, 64 FR 43255 (1999).

It is recognized that the States generally have laws that relate to nondiscrimination against individuals on a variety of bases. State laws continue to be enforceable, unless they prevent application of the final rule. The final rule explicitly provides that it is not to be construed to supersede State or local laws that provide additional protections against discrimination on any basis articulated under the regulation. Provisions of State law relating to nondiscrimination that is “more stringent” than the proposed Federal regulatory requirements or implementation specifications will continue to be enforceable.

Section 3(b) of Executive Order 13132 recognizes that national action limiting the policymaking discretion of States will be imposed only where there is constitutional and statutory authority for the action and the national activity is appropriate in light of the presence of a problem of national significance. Discrimination issues in relation to health care are of national concern by virtue of the scope of interstate health commerce. The ACA’s provisions reflect this position.

Section 3(d)(2) of Executive Order 13132 requires that where possible, the Federal government defer to the States to establish standards. Title I of the ACA authorized the Secretary to promulgate regulations to implement Section 1557, and we have done so accordingly.

Section 4(a) of Executive Order 13132 expressly contemplates preemption when there is a conflict between exercising State and Federal authority under a Federal statute. Section 4(b) of the Executive Order authorizes preemption of State law in the Federal rulemaking context when “the exercise of State authority directly conflicts with the exercise of Federal authority under the Federal statute.” The approach in this regulation is consistent with these standards in the Executive Order in superseding State authority only when such authority is inconsistent with standards established pursuant to the grant of Federal authority under the statute.

Section 6(b) of Executive Order 13132 includes some qualitative discussion of substantial direct compliance costs that State and local governments could incur as a result of a proposed regulation. We have determined that the costs of the final rule will not impose substantial direct compliance costs on State or local governments. We have considered the cost burden that this rule will impose on State and local health care and benefit programs, and estimate State and local government costs will be in the order of \$17.8 million in the first two

years of implementation. The \$17.8 million represents the sum of the costs of training State workers and enforcement costs attributable to State agencies analyzed above.

VII. Regulatory Flexibility Act (RFA)

The RFA requires agencies that issue a regulation to analyze options for regulatory relief of small businesses if a rule will have a significant impact on a substantial number of small entities. The RFA generally defines a “small entity” as:

(1) A proprietary firm meeting the size standards of the Small Business Administration (SBA);

(2) A nonprofit organization that is not dominant in its field; or

(3) A small government jurisdiction with a population of less than 50,000 (States and individuals are not included in the definition of “small entity”).

HHS uses as its measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3% for 5% or more of affected small entities.

In instances where OCR judged that the final rule would have a significant impact on a substantial number of small entities, we considered alternatives to reduce the burden. To accomplish our task, we first identified all the small entities that may be impacted, and then evaluated whether the economic burden we determined in the RIA represents a significant economic impact.

A. Entities That Will Be Affected

HHS has traditionally classified most health care providers as small entities even though some nonprofit providers would not meet the definition of “small entity” were they proprietary firms. Nonprofit entities are small if they are independently owned and operated and are not dominant in their fields.

The CMS Provider of Service file has indicators for profit and nonprofit entities, but these have proven to be unreliable. The Census data identifies firms’ tax status by profit and non-profit status but only reports revenues and does not report them by the profit and non-profit status of the entity.

1. Physicians

One class of providers we do not automatically classify as small businesses is physician practices. Physician practices are businesses and therefore are “small” if they meet the SBA’s definition. The current size standard for physicians (excluding mental health specialists) (North American Industry Classification System code 62111) is annual receipts

of less than \$11 million.³⁸⁴ Using the Census data showing the number of firms, employees and payroll, we selected physicians that reported fewer than 20 employees as the top end for small physician offices. This equaled 17,835 entities or 9.6% of all physician offices defined as “large.” This left 167,814 offices or 90.4% as “small.”³⁸⁵

2. Pharmacies

Pharmacies also are businesses, and the size standard for them is annual receipts of less than \$27.5 million. According to Census Statistics of U.S. Businesses, there are 18,852 pharmacy and drug store firms (North American Industry Classification System code 44611). Because of the lack of revenue or receipt data for pharmacies, we are unable to estimate the number of small pharmacies based on the SBA size standard. However, using the number of employees taken from the Statistics of U.S. Businesses as a proxy for revenues, the data is divided by number of employees per firm and shows the number of employers with fewer than 20 employees and those with more than 20 employees.³⁸⁶ The number of firms with fewer than 20 employees is 16,520 and represents 88% of the total number of pharmacy firms. It seemed reasonable to assume that firms with fewer than 20 employees satisfy the SBA size standard and thus we accepted that the number of small pharmacy firms equaled 16,520. As with the number of small physician offices, our method can only identify the minimum number of “small” pharmacies that meet the SBA size standard. We cannot determine the actual number of “small” pharmacies.

3. Health Insurance Issuers

Another class of covered entities that are business enterprises is health insurance issuers. The SBA size standard for health insurance issuers is annual receipts of \$38.5 million. Although the Blue Cross/Blue Shield companies that operate in some markets are organized as nonprofit entities, they often are large enough so as to not meet the definition of “small entity.”

³⁸⁴ U.S. Small Business Administration, Table of Small Business Size Standards Matched to North American Industry Classification System Codes. Small Business Administration, (June, 2016), <https://www.sba.gov/sites/default/files/Size5FStandards5FTable.pdf>.

³⁸⁵ Physician practices may earn more than \$11 million per year and that would reduce the number of “large” practices to be excluded from the analysis. But as we will later show, large practices will have proportionally larger workforce staff that must be excluded from the analysis.

³⁸⁶ U.S. Census Bureau, Statistics of U.S. Businesses, *supra* note 314.

Unfortunately, we cannot use the Census revenue data for estimating the number of small health insurance issuers because the Census data combines life and health insurance. Substituting costs for revenues allows us to obtain a rough estimate of the number of large insurance issuers, realizing that cost will probably be less than revenues, thus giving us a lower count of large issuers. Using the National Health Expenditure for 2013, net cost of health insurance equaled

\$173.6 billion. However, the 2012 Census data report a total of 815 health insurance issuers. Dividing the \$174 billion in costs by the number of insurance issuers reported in the census tables yields average costs of over \$213 million, which means that average annual revenues per issuer exceeds \$213 million. We concluded, therefore, that there are almost no small insurance issuers. The above analysis comports with the conclusion CMS published in

the Health Insurance Web Portal Requirements.³⁸⁷

4. Local Government Entities

We also excluded local governmental entities from our count of small entities because we lack the data to classify them by populations of fewer than 50,000. The following table shows the number of small covered entities we estimated could be affected by the proposed rule.

TABLE 6—SMALL COVERED ENTITIES

NAIC	Entity type	Number of firms
62142	Outpatient mental health and substance abuse centers	4,987
62141	HMO medical centers	104
62142	Kidney dialysis centers	492
62143	Freestanding ambulatory surgical and emergency centers	4,121
621498	All other outpatient care centers	5,399
6215	Medical and diagnostic laboratories	7,958
6216	Home health care services	21,668
6219	All other ambulatory health care services	6,956
62321	Residential mental retardation facilities	6,225
62199	General medical and surgical hospitals	3,067
621991	Psychiatric and substance abuse hospitals	411
6221	Specialty (except psychiatric and substance abuse) hospitals	373
6231	Nursing care facilities (skilled nursing facilities)	8,623
44611	Pharmacies and drug stores	16,520
6211	Offices of physicians	167,814
	Navigator grantees	100
	Total small entities	254,998

B. Whether the Rule Will Have a Significant Economic Impact on Covered Small Entities

Total undiscounted costs associated with the final rule are an average of \$189 million per year over a five year period. If all of those costs are borne by small entities, this amounts to an average of \$739 each year over that five year period. As a result, we believe that fewer than 5% of all small entities will experience a burden of greater than 3% of their revenues. Ambulatory health care services facilities (North American Industry Classification System 621), for example, are small entities with an average of 13 employees and revenue of \$1.7 million based on 2012 reported data for employees of 6.4 million and total revenues of \$825.7 million for

485,235 firms.³⁸⁸ In addition, the majority of the costs associated with this final rule are proportional to the size of entities, meaning that even the smallest of the affected entities are unlikely to face a substantial impact. Thus, we would not consider this regulation a significant burden on a substantial number of small entities, and, therefore, the Secretary certifies that the final rule will not have a significant impact on a substantial number of small entities.

VIII. Conclusion

For the most part, because this regulation is consistent with existing standards applicable to the covered entities, the new burdens created by its issuance are minimal. The major impacts are in the areas of voluntary training, posting of notices, enforcement

(where increased caseloads pose incremental costs on covered entities), voluntary development of language access plans, and revisions or development of new policies and procedures. The final rule does not include broad expansions of existing civil rights requirements on covered entities, and therefore minimizes the imposition of new burdens. Nevertheless, it is still a major rule with economically significant costs. The annualized cost of this rule over the first five years following its publication is \$192.5 million using a discount rate of 3%, and \$197.8 million using a discount rate of 7%. This RIA was organized and designed to explain the origin of these cost impacts and to incorporate relevant public comments.

³⁸⁷ 75 CFR 24481, May 5, 2010.

³⁸⁸ U.S. Dep't of Labor, Bureau of Labor Statistics, Industries at a Glance, <http://www.bls.gov/iag/tgs/iag621.htm> (last visited Mar. 26, 2016).

TABLE 7—ACCOUNTING STATEMENT

Accounting statement				
Category	Primary estimate	Low estimate	High estimate	Source
BENEFITS				
Qualitative Benefits (02)	• Potential health improvements and longevity extensions as a result of reduced barriers to medical care for transgender individuals.			RIA
COSTS (millions)				
Annualized monetized	Covered entities train 40% of their employees on the new regulations	Covered entities train 60% of their employees on the new regulations		
3%	192.5	177.0	208.1	RIA
7%	197.8	181.4	214.2	RIA
Non-quantified costs (02)	Costs of increased provision of health care services as a result of reduced barriers to access for transgender individuals.			RIA
Transfers (02)	Health insurance premium reductions for affected women, with offsetting increases for other premium payers in affected plans.			RIA
Effects on State and Local Governments (02)	\$17.8 million costs in the first 2 years (training + enforcement)			RIA
Effects on Small Entities (02)	Average of less than \$1,000 per small entity per year			RFA

List of Subjects in 45 CFR Part 92

Administrative practice and procedure, Civil rights, Discrimination, Elderly, Health care, Health facilities, Health insurance, Health programs and activities, Individuals with disabilities, Nondiscrimination, Reporting and recordkeeping requirements, Sex discrimination.

For the reasons set forth in the preamble, the Department of Health and Human Services adds 45 CFR part 92 as follows:

PART 92—NONDISCRIMINATION ON THE BASIS OF RACE, COLOR, NATIONAL ORIGIN, SEX, AGE, OR DISABILITY IN HEALTH PROGRAMS OR ACTIVITIES RECEIVING FEDERAL FINANCIAL ASSISTANCE AND HEALTH PROGRAMS OR ACTIVITIES ADMINISTERED BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES OR ENTITIES ESTABLISHED UNDER TITLE I OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

Subpart A—General Provisions

- 92.1 Purpose and effective date.
- 92.2 Application.
- 92.3 Relationship to other laws.
- 92.4 Definitions.
- 92.5 Assurances required.
- 92.6 Remedial action and voluntary action.
- 92.7 Designation of responsible employee and adoption of grievance procedures.
- 92.8 Notice requirement.

Subpart B—Nondiscrimination Provisions

- 92.101 Discrimination prohibited.

Subpart C—Specific Applications to Health Programs and Activities

- 92.201 Meaningful access for individuals with limited English proficiency.
- 92.202 Effective communication for individuals with disabilities.
- 92.203 Accessibility standards for buildings and facilities.
- 92.204 Accessibility of electronic and information technology.
- 92.205 Requirement to make reasonable modifications.
- 92.206 Equal program access on the basis of sex.
- 92.207 Nondiscrimination in health-related insurance and other health-related coverage.
- 92.208 Employer liability for discrimination in employee health benefit programs.
- 92.209 Nondiscrimination on the basis of association.

Subpart D—Procedures

- 92.301 Enforcement mechanisms.
- 92.302 Procedures for health programs and activities conducted by recipients and State-based Marketplaces.
- 92.303 Procedures for health programs and activities administered by the Department.

Appendix A to Part 92—Sample Notice Informing Individuals About Nondiscrimination and Accessibility

Requirements and Sample
Nondiscrimination Statement
Appendix B to Part 92—Sample Tagline
Informing Individuals With Limited
English Proficiency of Language
Assistance Services
Appendix C to Part 92—Sample Section 1557
of the Affordable Care Act Grievance
Procedure

Authority: 42 U.S.C. 18116, 5 U.S.C. 301.

Subpart A—General Provisions

§ 92.1 Purpose and effective date.

The purpose of this part is to implement Section 1557 of the Patient Protection and Affordable Care Act (ACA) (42 U.S.C. 18116), which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. Section 1557 provides that, except as provided in Title I of the ACA, an individual shall not, on the grounds prohibited under Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, or Section 504 of the Rehabilitation Act of 1973, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance or under any program or activity that is administered by an Executive Agency or any entity established under Title I of the ACA. This part applies to health programs or activities administered by recipients of Federal financial assistance from the Department, Title I entities that administer health programs or activities, and Department-administered health programs or activities. The effective date of this part shall be July 18, 2016, except to the extent that provisions of this part require changes to health insurance or group health plan benefit design (including covered benefits, benefits limitations or restrictions, and cost-sharing mechanisms, such as coinsurance, copayments, and deductibles), such provisions, as they apply to health insurance or group health plan benefit design, have an applicability date of the first day of the first plan year (in the individual market, policy year) beginning on or after January 1, 2017.

§ 92.2 Application.

(a) Except as provided otherwise in this part, this part applies to every health program or activity, any part of which receives Federal financial assistance provided or made available by the Department; every health program or activity administered by the Department; and every health program

or activity administered by a Title I entity.

(b)(1) Exclusions to the application of the Age Discrimination Act of 1975, as set forth at 45 CFR 91.3(b)(1), apply to claims of discrimination based on age under Section 1557 or this part.

(2) Insofar as the application of any requirement under this part would violate applicable Federal statutory protections for religious freedom and conscience, such application shall not be required.

(c) Any provision of this part held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to continue to give maximum effect to the provision permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event the provision shall be severable from this part and shall not affect the remainder thereof or the application of the provision to other persons not similarly situated or to other, dissimilar circumstances.

§ 92.3 Relationship to other laws.

(a) *Rule of interpretation.* Neither Section 1557 nor this part shall be construed to apply a lesser standard for the protection of individuals from discrimination than the standards applied under Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, or the regulations issued pursuant to those laws.

(b) *Other laws.* Nothing in this part shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals under Title VI of the Civil Rights Act of 1964, Title VII of the Civil Rights Act of 1964, the Architectural Barriers Act of 1968, Title IX of the Education Amendments of 1972, Sections 504 or 508 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, as amended by the Americans with Disabilities Act Amendments Act of 2008, or other Federal laws or to supersede State or local laws that provide additional protections against discrimination on any basis described in § 92.1.

§ 92.4 Definitions.

As used in this part, the term—
1991 Standards means the 1991 ADA Standards for Accessible Design, published at Appendix A to 28 CFR part 36 on July 26, 1991, and republished as Appendix D to 28 CFR part 36 on September 15, 2010.

2010 Standards means the 2010 ADA Standards for Accessible Design, as defined at 28 CFR 35.104.

ACA means the Patient Protection and Affordable Care Act (Pub. L. 111–148, 124 Stat. 119 (2010) as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111–152, 124 Stat. 1029 (codified in scattered sections of U.S.C.)).

ADA means the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 *et seq.*), as amended.

Age means how old an individual is, or the number of elapsed years from the date of an individual's birth.

Age Act means the Age Discrimination Act of 1975 (42 U.S.C. 6101 *et seq.*), as amended.

Applicant means an individual who applies to participate in a health program or activity.

Auxiliary aids and services include:

(1) Qualified interpreters on-site or through video remote interpreting (VRI) services, as defined in 28 CFR 35.104 and 36.303(b); note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunication products and systems, text telephones (TTYs), videophones, and captioned telephones, or equally effective telecommunications devices; videotext displays; accessible electronic and information technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing;

(2) Qualified readers; taped texts; audio recordings; Braille materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs; large print materials; accessible electronic and information technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision;

(3) Acquisition or modification of equipment and devices; and

(4) Other similar services and actions.

Covered entity means:

(1) An entity that operates a health program or activity, any part of which receives Federal financial assistance;

(2) An entity established under Title I of the ACA that administers a health program or activity; and

(3) The Department.

Department means the U.S. Department of Health and Human Services.

Director means the Director of the Office for Civil Rights (OCR) of the Department.

Disability means, with respect to an individual, a physical or mental impairment that substantially limits one or more major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment, as defined and construed in the Rehabilitation Act, 29 U.S.C. 705(9)(B), which incorporates the definition of disability in the ADA, 42 U.S.C. 12102, as amended. Where this part cross-references regulatory provisions that use the term “handicap,” “handicap” means “disability” as defined in this section.

Electronic and information technology means the same as “electronic and information technology,” or any term that replaces “electronic and information technology,” as it is defined in 36 CFR 1194.4.

Employee health benefit program means:

(1) Health benefits coverage or health insurance coverage provided to employees and/or their dependents established, operated, sponsored or administered by, for, or on behalf of one or more employers, whether provided or administered by entities including but not limited to an employer, group health plan (as defined in the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1191b(a)(1)), third party administrator, or health insurance issuer.

(2) An employer-provided or employer-sponsored wellness program;

(3) An employer-provided health clinic; or

(4) Long term care coverage or insurance provided or administered by an employer, group health plan, third party administrator, or health insurance issuer for the benefit of an employer’s employees.

Federal financial assistance. (1) Federal financial assistance means any grant, loan, credit, subsidy, contract (other than a procurement contract but including a contract of insurance), or any other arrangement by which the Federal government provides or otherwise makes available assistance in the form of:

(i) Funds;

(ii) Services of Federal personnel; or

(iii) Real and personal property or any interest in or use of such property, including:

(A) Transfers or leases of such property for less than fair market value or for reduced consideration; and

(B) Proceeds from a subsequent transfer or lease of such property if the Federal share of its fair market value is not returned to the Federal government.

(2) Federal financial assistance the Department provides or otherwise makes available includes Federal financial assistance that the Department plays a role in providing or administering, including all tax credits under Title I of the ACA, as well as payments, subsidies, or other funds extended by the Department to any entity providing health-related insurance coverage for payment to or on behalf of an individual obtaining health-related insurance coverage from that entity or extended by the Department directly to such individual for payment to any entity providing health-related insurance coverage.

Federally-facilitated MarketplaceSM means the same as “Federally-facilitated Exchange” defined in 45 CFR 155.20.

Gender identity means an individual’s internal sense of gender, which may be male, female, neither, or a combination of male and female, and which may be different from an individual’s sex assigned at birth. The way an individual expresses gender identity is frequently called “gender expression,” and may or may not conform to social stereotypes associated with a particular gender. A transgender individual is an individual whose gender identity is different from the sex assigned to that person at birth.

Health Insurance MarketplaceSM means the same as “Exchange” defined in 45 CFR 155.20.

Health program or activity means the provision or administration of health-related services, health-related insurance coverage, or other health-related coverage, and the provision of assistance to individuals in obtaining health-related services or health-related insurance coverage. For an entity principally engaged in providing or administering health services or health insurance coverage or other health coverage, all of its operations are considered part of the health program or activity, except as specifically set forth otherwise in this part. Such entities include a hospital, health clinic, group health plan, health insurance issuer, physician’s practice, community health center, nursing facility, residential or community-based treatment facility, or other similar entity. A health program or activity also includes all of the operations of a State Medicaid program, a Children’s Health Insurance Program, and the Basic Health Program.

HHS means the U.S. Department of Health and Human Services.

Individual with a disability means any individual who has a disability as defined for the purpose of Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 705(20)(B)–(F), as amended.

Where this part cross-references regulatory provisions applicable to a “handicapped individual,” “handicapped individual” means “individual with a disability” as defined in this section.

Individual with limited English proficiency means an individual whose primary language for communication is not English and who has a limited ability to read, write, speak, or understand English.

Language assistance services may include, but are not limited to:

(1) Oral language assistance, including interpretation in non-English languages provided in-person or remotely by a qualified interpreter for an individual with limited English proficiency, and the use of qualified bilingual or multilingual staff to communicate directly with individuals with limited English proficiency;

(2) Written translation, performed by a qualified translator, of written content in paper or electronic form into languages other than English; and

(3) Taglines.

National origin includes, but is not limited to, an individual’s, or his or her ancestor’s, place of origin (such as country or world region) or an individual’s manifestation of the physical, cultural, or linguistic characteristics of a national origin group.

On the basis of sex includes, but is not limited to, discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity.

Qualified bilingual/multilingual staff means a member of a covered entity’s workforce who is designated by the covered entity to provide oral language assistance as part of the individual’s current, assigned job responsibilities and who has demonstrated to the covered entity that he or she:

(1) Is proficient in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology and phraseology, and

(2) Is able to effectively, accurately, and impartially communicate directly with individuals with limited English proficiency in their primary languages.

Qualified individual with a disability means, with respect to a health program or activity, an individual with a disability who, with or without reasonable modifications to policies, practices, or procedures, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of aids, benefits, or services offered or provided by the health program or activity.

Qualified interpreter for an individual with a disability. (1) A qualified interpreter for an individual with a disability means an interpreter who via a remote interpreting service or an on-site appearance:

(i) Adheres to generally accepted interpreter ethics principles, including client confidentiality; and

(ii) is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology and phraseology.

(2) For an individual with a disability, qualified interpreters can include, for example, sign language interpreters, oral transliterators (individuals who represent or spell in the characters of another alphabet), and cued language transliterators (individuals who represent or spell by using a small number of handshapes).

Qualified interpreter for an individual with limited English proficiency means an interpreter who via a remote interpreting service or an on-site appearance:

(1) Adheres to generally accepted interpreter ethics principles, including client confidentiality;

(2) has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language; and

(3) is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

Qualified translator means a translator who:

(1) Adheres to generally accepted translator ethics principles, including client confidentiality;

(2) has demonstrated proficiency in writing and understanding both written English and at least one other written non-English language; and

(3) is able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

Recipient means any State or its political subdivision, or any instrumentality of a State or its political subdivision, any public or private agency, institution, or organization, or other entity, or any individual, to whom Federal financial assistance is extended directly or through another recipient and which operates a health program or activity, including any subunit, successor, assignee, or transferee of a recipient.

Section 504 means Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112; 29 U.S.C. 794), as amended.

Section 1557 means Section 1557 of the ACA (42 U.S.C. 18116).

Sex stereotypes means stereotypical notions of masculinity or femininity, including expectations of how individuals represent or communicate their gender to others, such as behavior, clothing, hairstyles, activities, voice, mannerisms, or body characteristics. These stereotypes can include the expectation that individuals will consistently identify with only one gender and that they will act in conformity with the gender-related expressions stereotypically associated with that gender. Sex stereotypes also include gendered expectations related to the appropriate roles of a certain sex.

State-based MarketplaceSM means a Health Insurance MarketplaceSM established by a State pursuant to 45 CFR 155.100 and approved by the Department pursuant to 45 CFR 155.105.

Taglines mean short statements written in non-English languages that indicate the availability of language assistance services free of charge.

Title I entity means any entity established under Title I of the ACA, including State-based Marketplaces and Federally-facilitated Marketplaces.

Title VI means Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352; 42 U.S.C. 2000d *et seq.*), as amended.

Title IX means Title IX of the Education Amendments of 1972 (Pub. L. 92-318; 20 U.S.C. 1681 *et seq.*), as amended.

§ 92.5 Assurances required.

(a) *Assurances.* An entity applying for Federal financial assistance to which this part applies shall, as a condition of any application for Federal financial assistance, submit an assurance, on a form specified by the Director, that the entity's health programs and activities will be operated in compliance with Section 1557 and this part. A health insurance issuer seeking certification to participate in a Health Insurance MarketplaceSM or a State seeking approval to operate a State-based

MarketplaceSM to which Section 1557 or this part applies shall, as a condition of certification or approval, submit an assurance, on a form specified by the Director, that the health program or activity will be operated in compliance with Section 1557 and this part. An applicant or entity may incorporate this assurance by reference in subsequent applications to the Department for Federal financial assistance or requests for certification to participate in a Health Insurance MarketplaceSM or approval to operate a State-based MarketplaceSM.

(b) *Duration of obligation.* The duration of the assurances required by this subpart is the same as the duration of the assurances required in the Department's regulations implementing Section 504, 45 CFR 84.5(b).

(c) *Covenants.* When Federal financial assistance is provided in the form of real property or interest, the same conditions apply as those contained in the Department's regulations implementing Section 504, at 45 CFR 84.5(c), except that the nondiscrimination obligation applies to discrimination on all bases covered under Section 1557 and this part.

§ 92.6 Remedial action and voluntary action.

(a) *Remedial action.* (1) If the Director finds that a recipient or State-based MarketplaceSM has discriminated against an individual on the basis of race, color, national origin, sex, age, or disability, in violation of Section 1557 or this part, such recipient or State-based MarketplaceSM shall take such remedial action as the Director may require to overcome the effects of the discrimination.

(2) Where a recipient is found to have discriminated against an individual on the basis of race, color, national origin, sex, age, or disability, in violation of Section 1557 or this part, and where another recipient exercises control over the recipient that has discriminated, the Director, where appropriate, may require either or both entities to take remedial action.

(3) The Director may, where necessary to overcome the effects of discrimination in violation of Section 1557 or this part, require a recipient or State-based MarketplaceSM to take remedial action with respect to:

(i) Individuals who are no longer participants in the recipient's or State-based MarketplaceSM's health program or activity but who were participants in the health program or activity when such discrimination occurred; or

(ii) Individuals who would have been participants in the health program or

activity had the discrimination not occurred.

(b) *Voluntary action.* A covered entity may take steps, in addition to any action that is required by Section 1557 or this part, to overcome the effects of conditions that result or resulted in limited participation in the covered entity's health programs or activities by individuals on the basis of race, color, national origin, sex, age, or disability.

§ 92.7 Designation of responsible employee and adoption of grievance procedures.

(a) *Designation of responsible employee.* Each covered entity that employs 15 or more persons shall designate at least one employee to coordinate its efforts to comply with and carry out its responsibilities under Section 1557 and this part, including the investigation of any grievance communicated to it alleging noncompliance with Section 1557 or this part or alleging any action that would be prohibited by Section 1557 or this part. For the Department, including the Federally-facilitated Marketplaces, the Director will be deemed the responsible employee under this section.

(b) *Adoption of grievance procedures.* Each covered entity that employs 15 or more persons shall adopt grievance procedures that incorporate appropriate due process standards and that provide for the prompt and equitable resolution of grievances alleging any action that would be prohibited by Section 1557 or this part. For the Department, including the Federally-facilitated Marketplaces, the procedures for addressing complaints of discrimination on the grounds covered under Section 1557 or this part will be deemed grievance procedures under this section.

§ 92.8 Notice requirement.

(a) Each covered entity shall take appropriate initial and continuing steps to notify beneficiaries, enrollees, applicants, and members of the public of the following:

(1) The covered entity does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities;

(2) The covered entity provides appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner, when such aids and services are necessary to ensure an equal opportunity to participate to individuals with disabilities;

(3) The covered entity provides language assistance services, including translated documents and oral interpretation, free of charge and in a timely manner, when such services are necessary to provide meaningful access to individuals with limited English proficiency;

(4) How to obtain the aids and services in paragraphs (a)(2) and (3) of this section;

(5) An identification of, and contact information for, the responsible employee designated pursuant to § 92.7(a), if applicable;

(6) The availability of the grievance procedure and how to file a grievance, pursuant to § 92.7(b), if applicable; and

(7) How to file a discrimination complaint with OCR in the Department.

(b) Within 90 days of the effective date of this part, each covered entity shall:

(1) As described in paragraph (f)(1) of this section, post a notice that conveys the information in paragraphs (a)(1) through (7) of this section; and

(2) As described in paragraph (g)(1) of this section, if applicable, post a nondiscrimination statement that conveys the information in paragraph (a)(1) of this section.

(c) For use by covered entities, the Director shall make available, electronically and in any other manner that the Director determines appropriate, the content of a sample notice that conveys the information in paragraphs (a)(1) through (7) of this section, and the content of a sample nondiscrimination statement that conveys the information in paragraph (a)(1) of this section, in English and in the languages triggered by the obligation in paragraph (d)(1) of this section.

(d) Within 90 days of the effective date of this part, each covered entity shall:

(1) As described in paragraph (f)(1) of this section, post taglines in at least the top 15 languages spoken by individuals with limited English proficiency of the relevant State or States; and

(2) As described in paragraph (g)(2) of this section, if applicable, post taglines in at least the top two languages spoken by individuals with limited English proficiency of the relevant State or States.

(e) For use by covered entities, the Director shall make available, electronically and in any other manner that the Director determines appropriate, taglines in the languages triggered by the obligation in paragraph (d)(1) of this section.

(f)(1) Each covered entity shall post the notice required by paragraph (a) of this section and the taglines required by

paragraph (d)(1) of this section in a conspicuously-visible font size:

(i) In significant publications and significant communications targeted to beneficiaries, enrollees, applicants, and members of the public, except for significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures;

(ii) In conspicuous physical locations where the entity interacts with the public; and

(iii) In a conspicuous location on the covered entity's Web site accessible from the home page of the covered entity's Web site.

(2) A covered entity may also post the notice and taglines in additional publications and communications.

(g) Each covered entity shall post, in a conspicuously-visible font size, in significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures:

(1) The nondiscrimination statement required by paragraph (b)(2) of this section; and

(2) The taglines required by paragraph (d)(2) of this section.

(h) A covered entity may combine the content of the notice required in paragraph (a) of this section with the content of other notices if the combined notice clearly informs individuals of their civil rights under Section 1557 and this part.

Subpart B—Nondiscrimination Provisions

§ 92.101 Discrimination prohibited.

(a) *General.* (1) Except as provided in Title I of the ACA, an individual shall not, on the basis of race, color, national origin, sex, age, or disability, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any health program or activity to which this part applies.

(2) This part does not apply to employment, except as provided in § 92.208.

(b) *Specific discriminatory actions prohibited.* Under any health program or activity to which this part applies:

(1)(i) Each covered entity must comply with the regulation implementing Title VI, at § 80.3(b)(1) through (6) of this subchapter.

(ii) No covered entity shall, on the basis of race, color, or national origin, aid or perpetuate discrimination against any person by providing significant assistance to any entity or person that discriminates on the basis of race, color, or national origin in providing any aid, benefit, or service to beneficiaries of the covered entity's health program or activity.

(2)(i) Each recipient and State-based MarketplaceSM must comply with the regulation implementing Section 504, at §§ 84.4(b), 84.21 through 84.23(b), 84.31, 84.34, 84.37, 84.38, and 84.41 through 84.52(c) and 84.53 through 84.55 of this subchapter. Where this paragraph cross-references regulatory provisions that use the term “recipient,” the term “recipient or State-based MarketplaceSM” shall apply in its place.

(ii) The Department, including the Federally-facilitated Marketplaces, must comply with the regulation implementing Section 504, at §§ 85.21(b), 85.41 through 85.42, and 85.44 through 85.51 of this subchapter.

(3)(i) Each covered entity must comply with the regulation implementing Title IX, at § 86.31(b)(1) through (8) of this subchapter. Where this paragraph cross-references regulatory provisions that use the term “student,” “employee,” or “applicant,” these terms shall be replaced with “individual.”

(ii) A covered entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration that have the effect of subjecting individuals to discrimination on the basis of sex, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program with respect to individuals on the basis of sex.

(iii) In determining the site or location of a facility, a covered entity may not make selections that have the effect of excluding individuals from, denying them the benefits of, or subjecting them to discrimination under any programs to which this regulation applies, on the basis of sex; or with the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the program or activity on the basis of sex.

(iv) A covered entity may operate a sex-specific health program or activity (a health program or activity that is restricted to members of one sex) only if the covered entity can demonstrate an exceedingly persuasive justification, that is, that the sex-specific health program or activity is substantially related to the achievement of an important health-related or scientific objective.

(4)(i) Each covered entity must comply with the regulation implementing the Age Act, at § 91.11(b) of this subchapter.

(ii) No covered entity shall, on the basis of age, aid or perpetuate discrimination against any person by providing significant assistance to any agency, organization, or person that discriminates on the basis of age in

providing any aid, benefit, or service to beneficiaries of the covered entity’s health program or activity.

(5) The enumeration of specific forms of discrimination in this paragraph does not limit the generality of the prohibition in paragraph (a) of this section.

(c) The exceptions applicable to Title VI apply to discrimination on the basis of race, color, or national origin under this part. The exceptions applicable to Section 504 apply to discrimination on the basis of disability under this part. The exceptions applicable to the Age Act apply to discrimination on the basis of age under this part. These provisions are found at §§ 80.3(d), 84.4(c), 85.21(c), 91.12, 91.15, and 91.17–18 of this subchapter.

(d) Where the regulatory provisions referenced in paragraphs (b)(1), (b)(3), and (b)(4), and paragraph (c) of this section use the term “recipient,” the term “covered entity” shall apply in its place. Where the regulatory provisions referenced in paragraphs (b)(1), (b)(3), and (b)(4) and paragraph (c) of this section use the terms “program or activity” or “program” or “education program,” the term “health program or activity” shall apply in their place.

Subpart C—Specific Applications to Health Programs and Activities

§ 92.201 Meaningful access for individuals with limited English proficiency.

(a) *General requirement.* A covered entity shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities.

(b) *Evaluation of compliance.* In evaluating whether a covered entity has met its obligation under paragraph (a) of this section, the Director shall:

(1) Evaluate, and give substantial weight to, the nature and importance of the health program or activity and the particular communication at issue, to the individual with limited English proficiency; and

(2) Take into account other relevant factors, including whether a covered entity has developed and implemented an effective written language access plan, that is appropriate to its particular circumstances, to be prepared to meet its obligations in § 92.201(a).

(c) *Language assistance services requirements.* Language assistance services required under paragraph (a) of this section must be provided free of charge, be accurate and timely, and protect the privacy and independence of

the individual with limited English proficiency.

(d) *Specific requirements for interpreter and translation services.* Subject to paragraph (a) of this section:

(1) A covered entity shall offer a qualified interpreter to an individual with limited English proficiency when oral interpretation is a reasonable step to provide meaningful access for that individual with limited English proficiency; and

(2) A covered entity shall use a qualified translator when translating written content in paper or electronic form.

(e) *Restricted use of certain persons to interpret or facilitate communication.* A covered entity shall not:

(1) Require an individual with limited English proficiency to provide his or her own interpreter;

(2) Rely on an adult accompanying an individual with limited English proficiency to interpret or facilitate communication, except:

(i) In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available; or

(ii) Where the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances;

(3) Rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available; or

(4) Rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency.

(f) *Video remote interpreting services.* A covered entity that provides a qualified interpreter for an individual with limited English proficiency through video remote interpreting services in the covered entity’s health programs and activities shall provide:

(1) Real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication;

(2) A sharply delineated image that is large enough to display the interpreter’s

face and the participating individual's face regardless of the individual's body position;

(3) A clear, audible transmission of voices; and

(4) Adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the video remote interpreting.

(g) *Acceptance of language assistance services is not required.* Nothing in this section shall be construed to require an individual with limited English proficiency to accept language assistance services.

§ 92.202 Effective communication for individuals with disabilities.

(a) A covered entity shall take appropriate steps to ensure that communications with individuals with disabilities are as effective as communications with others in health programs and activities, in accordance with the standards found at 28 CFR 35.160 through 35.164. Where the regulatory provisions referenced in this section use the term "public entity," the term "covered entity" shall apply in its place.

(b) A recipient or State-based MarketplaceSM shall provide appropriate auxiliary aids and services to persons with impaired sensory, manual, or speaking skills, where necessary to afford such persons an equal opportunity to benefit from the service in question.

§ 92.203 Accessibility standards for buildings and facilities.

(a) Each facility or part of a facility in which health programs or activities are conducted that is constructed or altered by or on behalf of, or for the use of, a recipient or State-based MarketplaceSM shall comply with the 2010 Standards as defined in § 92.4, if the construction or alteration was commenced on or after July 18, 2016, except that if a facility or part of a facility in which health programs or activities are conducted that is constructed or altered by or on behalf of, or for the use of, a recipient or State-based MarketplaceSM, was not covered by the 2010 Standards prior to July 18, 2016, such facility or part of a facility shall comply with the 2010 Standards, as defined in § 92.4, if the construction was commenced after January 18, 2018. Departures from particular technical and scoping requirements by the use of other methods are permitted where substantially equivalent or greater access to and usability of the facility is provided. All newly constructed or altered buildings or facilities subject to

this section shall comply with the requirements for a "public building or facility" as defined in Section 106.5 of the 2010 Standards.

(b) Each facility or part of a facility in which health programs or activities are conducted that is constructed or altered by or on behalf of, or for the use of, a recipient or State-based MarketplaceSM in conformance with the 1991 Standards or the 2010 Standards as defined in § 92.4 shall be deemed to comply with the requirements of this section and with 45 CFR 84.23(a) and (b), cross-referenced in § 92.101(b)(2)(i) with respect to those facilities, if the construction or alteration was commenced on or before July 18, 2016. Each facility or part of a facility in which health programs or activities are conducted that is constructed or altered by or on behalf of, or for the use of, a recipient or State-based MarketplaceSM in conformance with the Uniform Federal Accessibility Standards as defined in § 92.4, shall be deemed to comply with the requirements of this section and with 45 CFR 84.23(a) and (b), cross-referenced in § 92.101(b)(2)(i) with respect to those facilities, if the construction was commenced before July 18, 2016 and such facility was not covered by the 1991 Standards or 2010 Standards.

§ 92.204 Accessibility of electronic and information technology.

(a) Covered entities shall ensure that their health programs or activities provided through electronic and information technology are accessible to individuals with disabilities, unless doing so would result in undue financial and administrative burdens or a fundamental alteration in the nature of the health programs or activities. When undue financial and administrative burdens or a fundamental alteration exist, the covered entity shall provide information in a format other than an electronic format that would not result in such undue financial and administrative burdens or a fundamental alteration but would ensure, to the maximum extent possible, that individuals with disabilities receive the benefits or services of the health program or activity that are provided through electronic and information technology.

(b) Recipients and State-based Marketplaces shall ensure that their health programs and activities provided through Web sites comply with the requirements of Title II of the ADA.

§ 92.205 Requirement to make reasonable modifications.

A covered entity shall make reasonable modifications to policies, practices, or procedures when such modifications are necessary to avoid discrimination on the basis of disability, unless the covered entity can demonstrate that making the modifications would fundamentally alter the nature of the health program or activity. For the purposes of this section, the term "reasonable modifications" shall be interpreted in a manner consistent with the term as set forth in the ADA Title II regulation at 28 CFR 35.130(b)(7).

§ 92.206 Equal program access on the basis of sex.

A covered entity shall provide individuals equal access to its health programs or activities without discrimination on the basis of sex; and a covered entity shall treat individuals consistent with their gender identity, except that a covered entity may not deny or limit health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that the individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available.

§ 92.207 Nondiscrimination in health-related insurance and other health-related coverage.

(a) *General.* A covered entity shall not, in providing or administering health-related insurance or other health-related coverage, discriminate on the basis of race, color, national origin, sex, age, or disability.

(b) *Discriminatory actions prohibited.* A covered entity shall not, in providing or administering health-related insurance or other health-related coverage:

(1) Deny, cancel, limit, or refuse to issue or renew a health-related insurance plan or policy or other health-related coverage, or deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, on the basis of race, color, national origin, sex, age, or disability;

(2) Have or implement marketing practices or benefit designs that discriminate on the basis of race, color, national origin, sex, age, or disability in a health-related insurance plan or policy, or other health-related coverage;

(3) Deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other

limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available;

(4) Have or implement a categorical coverage exclusion or limitation for all health services related to gender transition; or

(5) Otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual.

(c) The enumeration of specific forms of discrimination in paragraph (b) does not limit the general applicability of the prohibition in paragraph (a) of this section.

(d) Nothing in this section is intended to determine, or restrict a covered entity from determining, whether a particular health service is medically necessary or otherwise meets applicable coverage requirements in any individual case.

§ 92.208 Employer liability for discrimination in employee health benefit programs.

A covered entity that provides an employee health benefit program to its employees and/or their dependents shall be liable for violations of this part in that employee health benefit program only when:

(a) The entity is principally engaged in providing or administering health services, health insurance coverage, or other health coverage;

(b) The entity receives Federal financial assistance a primary objective of which is to fund the entity's employee health benefit program; or

(c) The entity is not principally engaged in providing or administering health services, health insurance coverage, or other health coverage, but operates a health program or activity, which is not an employee health benefit program, that receives Federal financial assistance; except that the entity is liable under this part with regard to the provision or administration of employee health benefits only with respect to the employees in that health program or activity.

§ 92.209 Nondiscrimination on the basis of association.

A covered entity shall not exclude from participation in, deny the benefits

of, or otherwise discriminate against an individual or entity in its health programs or activities on the basis of the race, color, national origin, sex, age, or disability of an individual with whom the individual or entity is known or believed to have a relationship or association.

Subpart D—Procedures

§ 92.301 Enforcement mechanisms.

(a) The enforcement mechanisms available for and provided under Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, or the Age Discrimination Act of 1975 shall apply for purposes of Section 1557 as implemented by this part.

(b) Compensatory damages for violations of Section 1557 are available in appropriate administrative and judicial actions brought under this rule.

§ 92.302 Procedures for health programs and activities conducted by recipients and State-based Marketplaces.

(a) The procedural provisions applicable to Title VI apply with respect to administrative enforcement actions concerning discrimination on the basis of race, color, national origin, sex, and disability discrimination under Section 1557 or this part. These procedures are found at §§ 80.6 through 80.11 of this subchapter and part 81 of this subchapter.

(b) The procedural provisions applicable to the Age Act apply with respect to enforcement actions concerning age discrimination under Section 1557 or this part. These procedures are found at §§ 91.41 through 91.50 of this subchapter.

(c) When a recipient fails to provide OCR with requested information in a timely, complete, and accurate manner, OCR may find noncompliance with Section 1557 and initiate appropriate enforcement procedures, including beginning the process for fund suspension or termination and taking other action authorized by law.

(d) An individual or entity may bring a civil action to challenge a violation of Section 1557 or this part in a United States District Court in which the recipient or State-based MarketplaceSM is found or transacts business.

§ 92.303 Procedures for health programs and activities administered by the Department.

(a) This section applies to discrimination on the basis of race, color, national origin, sex, age, or disability in health programs or activities administered by the

Department, including the Federally-facilitated Marketplaces.

(b) The procedural provisions applicable to Section 504 at §§ 85.61 through 85.62 of this subchapter shall apply with respect to enforcement actions against the Department concerning discrimination on the basis of race, color, national origin, sex, age, or disability under Section 1557 or this part. Where this section cross-references regulatory provisions that use the term "handicap," the term "race, color, national origin, sex, age, or disability" shall apply in its place.

(c) The Department shall permit access by OCR to its books, records, accounts, other sources of information, and facilities as may be pertinent to ascertain compliance with Section 1557 or this part. Where any information required of the Department is in the exclusive possession of any other agency, institution or individual, and the other agency, institution or individual shall fail or refuse to furnish this information, the Department shall so certify and shall set forth what efforts it has made to obtain the information. Asserted considerations of privacy or confidentiality may not operate to bar OCR from evaluating or seeking to enforce compliance with Section 1557 or this part. Information of a confidential nature obtained in connection with compliance evaluation or enforcement shall not be disclosed except where necessary under the law.

(d) The Department shall not intimidate, threaten, coerce, or discriminate against any individual for the purpose of interfering with any right or privilege secured by Section 1557 or this part, or because such individual has made a complaint, testified, assisted, or participated in any manner in an investigation, proceeding or hearing under Section 1557 or this part. The identity of complainants shall be kept confidential by OCR, except to the extent necessary to carry out the purposes of Section 1557 or this part.

Appendix A to Part 92—Sample Notice Informing Individuals About Nondiscrimination and Accessibility Requirements and Sample Nondiscrimination Statement: Discrimination is Against the Law

[Name of covered entity] complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. [Name of covered entity] does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

[Name of covered entity]:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language 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 [Name of Civil Rights Coordinator]

If you believe that [Name of covered entity] 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: [Name and Title of Civil Rights Coordinator], [Mailing Address], [Telephone number], [TTY number—if covered entity has one], [Fax], [Email]. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, [Name and Title of Civil Rights Coordinator] 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, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Nondiscrimination statement for significant publications and signification communications that are small-size:

[Name of covered entity] complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Appendix B to Part 92—Sample Tagline Informing Individuals With Limited English Proficiency of Language Assistance Services

ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

Appendix C to Part 92—Sample Section 1557 of the Affordable Care Act Grievance Procedure

It is the policy of [Name of Covered Entity] not to discriminate on the basis of race, color,

national origin, sex, age or disability. [Name of Covered Entity] has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of [Name and Title of Section 1557 Coordinator], [Mailing Address], [Telephone number], [TTY number—if covered entity has one], [Fax], [Email], who has been designated to coordinate the efforts of [Name of Covered Entity] to comply with Section 1557.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for [Name of Covered Entity] to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within (60 days) of the date the person filing the grievance becomes aware of the alleged discriminatory action.

- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.

- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of [Name of Covered Entity] relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.

- The Section 1557 Coordinator will issue a written decision on the grievance, based on

a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.

- The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the (Administrator/Chief Executive Officer/Board of Directors/etc.) within 15 days of receiving the Section 1557 Coordinator's decision. The (Administrator/Chief Executive Officer/Board of Directors/etc.) shall issue a written decision in response to the appeal no later than 30 days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is 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, DC 20201.

Complaint forms are available at: <http://www.hhs.gov/ocr/office/file/index.html>. Such complaints must be filed within 180 days of the date of the alleged discrimination.

[Name of covered entity] will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

Dated: May 11, 2016.

Sylvia M. Burwell,
Secretary.

[FR Doc. 2016-11458 Filed 5-13-16; 11:15 am]

BILLING CODE 4153-01-P



Administrative Bulletin 2015-5

Date: November 24, 2015

To: All insurance companies, fraternal benefit societies, hospital service corporations, non-ERISA employer group plans, managed care organizations, medical service corporations and health care centers that deliver or issue individual and group health insurance policies in Minnesota

Subject: Gender Identity Nondiscrimination Requirements

The purpose of this Bulletin is to advise entities delivering or issuing individual and group health insurance policies in Minnesota that discrimination against an individual because of the individual's gender identity or expression is prohibited. This prohibition extends to the availability of health insurance coverage and the provision of health insurance benefits.

Section 1557(a) under the Affordable Care Act (ACA) prohibits discrimination on the basis of gender identity and sex stereotyping in any health program receiving federal funds or by an entity established under the ACA, including exchanges. Proposed guidance on this topic has recently been released by the U.S. Department of Health and Human Services and the Centers for Medicare and Medicaid Services.

Minnesota Statutes sections 62A.02 and 62D.07 authorize the Commissioners of Commerce and Health to disapprove any policy of insurance or health maintenance organization contract if it contains a provision that is unjust, unfair, inequitable, misleading or deceptive. Minnesota Statutes section 363A.17 prohibits discrimination in any business practice, including insurance, if it allows discrimination based on certain protected classes, including sex and sexual orientation.

The Minnesota Departments of Commerce and Health are committed to ensuring that Minnesotans do not face discrimination in accessing medically necessary health care benefits, including those based on transsexualism, gender identity disorder, and gender dysphoria. Commerce and Health currently disapprove policy forms filed by insurers if there are exclusions on coverage for medically necessary treatment for gender dysphoria and related health conditions, including gender confirmation surgery (previously known as sex reassignment surgery). Commerce and Health will also continue to conduct independent

reviews for denials of coverage on the basis that services are not medically necessary via the Departments' external review programs. Determination of medical necessity and prior authorization protocols for gender dysphoria-related treatment must be based on the most recent, published medical standards set forth by nationally recognized medical experts in the transgender health field.

Questions

Questions on this bulletin may be directed to:

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Signed:



Mike Rothman
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DOMESTIC/FOREIGN INSURERS BULLETIN NO. 86

TO: All Insurers, Producers, Third Party Administrators, Medical Service Plans, and Hospital Service Plans Licensed To Do Business In Delaware; and Other Interested Persons

RE: The Gender Identity Nondiscrimination Act of 2013

DATED: March 23, 2016

The purpose of this Bulletin is to provide guidance regarding implementation of the Gender Identity Nondiscrimination Act of 2013 (S.B. 97; 79 Del. Laws Ch. 47) (the “Gender Identity Nondiscrimination Act”), which was enacted by the Delaware General Assembly and signed by Governor Markell on June 19, 2013.

The Gender Identity Nondiscrimination Act specifically applies to Title 18 of the Delaware Code, Insurance, amending Section 2304(22) of the Unfair Trade Practices Act to make it an unlawful practice for any insurance company licensed to do business in Delaware to discriminate in any way based on an individual’s gender identity. The Gender Identity Nondiscrimination Act defines “gender identity” to mean “a gender-related identity, appearance, expression or behavior of a person, regardless of the person’s assigned sex at birth.”

Section 2304(13)(b) of the Unfair Trade Practices Act further prohibits unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premiums, policy fees or rates charged for any policy or contract of health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

Section 1557 of the Affordable Care Act (the “ACA”) prohibits discrimination on the basis of sex in any health program receiving federal funds or by an entity established under the ACA, including health insurance exchanges. The U.S. Department of Health and Human Services has issued guidance and a subsequent proposed rule under Section 1557 of the ACA confirming that the sex nondiscrimination protections of such section encompass discrimination on the basis of gender identity.

The Department interprets the above provisions of the law to prohibit the denial, cancellation, termination, limitation, refusal to issue or renew, or restriction, of insurance coverage or benefits thereunder because of a person’s gender identity or transgender status, or because the

person is undergoing gender transition. This includes the availability of health insurance coverage and the provision of health insurance benefits.

Insurance companies also may not deny, exclude, or otherwise limit coverage for medically necessary services, as determined by a medical provider in consultation with the individual patient, based on the individual patient's gender identity if the service would be covered for another individual under such contract of insurance. The Department takes the position that any blanket policy exclusion for gender dysphoria, gender identity disorder, medically necessary surgeries or other treatments related to gender transition or related services is a violation of the Unfair Trade Practices Act because it is discrimination based on gender identity. It is also the Department's position that the imposition of different premiums or rates for insurance coverage based on an insured's gender identity is a violation of the Unfair Trade Practices Act. Benefits for conditions related to an insured's gender identity should be available on an equivalent basis as coverage provided for any other health condition by basing coverage decisions on medical necessity and not on the basis of a person's gender identity. This assures that insureds have equal access to benefits under a contract of insurance regardless of their gender identity.

The Department further expects that determinations of medical necessity, eligibility, and prior authorization requirements for diagnoses related to an insured's gender identity are based on current medical standards established by nationally recognized transgender health medical experts.

The requirements of this Bulletin shall also apply to qualified health plans offered through Delaware's Health Insurance Marketplace operated through the Federally-Facilitated Exchange State Partnership Option under the ACA, as well as to plans offering Essential Health Benefits in accordance with Delaware's Essential Health Benefits benchmark. The Department specifically notes that Delaware's Essential Health Benefits benchmark plan for plan year 2016 contains an exclusion for surgical benefits for "change of sex surgery," except to correct a congenital defect. Insurers should not consider that benchmark to supersede this Bulletin or State law and the Department reiterates, as stated elsewhere in this Bulletin, that such a blanket exclusion constitutes a violation of the Unfair Trade Practices Act and the ACA.

The Department will take administrative or legal action against any insurance company licensed to do business in Delaware that fails to comply with the Unfair Trade Practices Act, as amended by the Gender Identity Nondiscrimination Act, or other State law.

As of the effective date of this Bulletin, new insurance policy forms filed by insurers will be disapproved by the Department if they exclude or limit coverage based on an insured's gender identity. Provisions of other Delaware laws regarding procedures and processes for appeal and review of denials of coverage, benefits, or adverse determinations apply.

The Department will not be promulgating a regulation to implement the Gender Identity Nondiscrimination Act at this time. This Bulletin and the enacted statutory provisions shall provide adequate guidance for compliance.

Any questions, comments or requests for clarification about this bulletin should be emailed to [DOI Consumer Resource@state.de.us](mailto:DOI_Consumer_Resource@state.de.us).

This Bulletin shall be effective immediately and shall remain in effect unless withdrawn or superseded by subsequent law, regulation or bulletin.



Karen Weldin Stewart, CIR-ML
Delaware Insurance Commissioner

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Only the Westlaw citation is currently available.

United States District Court,
D. Minnesota.

Brittany R. Tovar, Plaintiff,

v.

Essentia Health, Innovis Health, LLC, d/b/a Essentia Health West, and HealthPartners, Inc., Defendants.

Civ. No. 16-100 (RHK/LIB)

|
Filed 05/11/2016

Attorneys and Law Firms

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MEMORANDUM OPINION AND ORDER

RICHARD H. KYLE United States District Judge

INTRODUCTION

*1 Plaintiff Brittany Tovar commenced this action after her son, a beneficiary under her employer-sponsored health insurance policy, was denied coverage for gender reassignment services and surgery. She alleges her employer, Defendants Essentia Health and Innovis Health, LLC, d/b/a Essentia Health West (collectively, “Essentia”),¹ violated Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e *et seq.* (“Title VII”), and the Minnesota Human Rights Act, Minn. Stat. § 363A.01 *et seq.* (“MHRA”), by excluding coverage for gender reassignment services or surgery in Essentia’s employee medical plan. She also alleges Defendant HealthPartners, Inc. (“HealthPartners”) violated Section 1557 of the Affordable Care Act, 42 U.S.C. § 18116 (“ACA”), by administering Essentia’s plan and enforcing the exclusion. Defendants move to dismiss Tovar’s claims; for the reasons that follow, their Motions will be granted.

BACKGROUND

Tovar is a nurse practitioner employed by Essentia since 2010. (Compl. ¶ 21.) As part of her employee benefits, she is provided health insurance through the Essentia Health Employee Medical Plan (the “Plan”), which is sponsored by Essentia and administered by HealthPartners.² (*Id.* ¶¶ 7, 22–24.) In late 2014, Tovar’s teenage son became a beneficiary under the Plan and was subsequently diagnosed with gender dysphoria.³ (*Id.* ¶¶ 26–27.)

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At issue in this case is the 2015 version of the Plan (the “2015 Plan”), which barred coverage for “services and/or [surgery for gender reassignment](#).” (*Id.* ¶ 25; *see also* Bunde Decl. Ex. A ⁴ at 51.) Due to this exclusion, Tovar’s son was denied coverage for certain medications and [gender reassignment surgery](#) that were deemed medically necessary by his doctors. (Compl. ¶¶ 30–31.) Tovar’s Complaint cites three specific incidents where her son was denied coverage:

1. In 2015, he was prescribed the drug [Lupron](#), which is recommended for treatment of symptoms associated with [dysmenorrhea](#) (painful menstruation) and can temporarily suspend menstruation; the latter being why Tovar’s son was prescribed the drug. (*Id.* ¶¶ 35–37.) But because the 2015 Plan excluded services for gender reassignment, the [Lupron](#) prescription was not covered and would have cost approximately \$9,000. (*Id.* ¶¶ 38, 40.) Tovar was unable to afford this and her son did not receive [Lupron](#). (*Id.* ¶ 40.)
- *2 2. Tovar’s son was also prescribed [Androderm](#), a form of [testosterone](#), to treat his gender [dysphoria](#). (*Id.* ¶ 42.) Coverage also was denied for this prescription because the medicine was “for use by males only” and was “not covered for patient gender.” (*Id.* ¶ 43.) However, Tovar did pay out-of-pocket for this prescription and “Essentia later agreed” to cover the medicine as a one-time exception. (*Id.* ¶¶ 44–45.)
3. In December 2015, Tovar contacted HealthPartners seeking pre-authorization for [gender reassignment surgery](#) for her son; she was notified it would not be authorized because of the exclusion in the 2015 Plan. (*Id.* ¶ 46.) Tovar alleges that, because her son was unable to obtain these necessary medical services, she suffered from stress, worry, anger, disappointment, and sleeplessness, experienced an increase in migraines, and ultimately reduced her hours at work. (*Id.* ¶¶ 41, 48.)

Effective January 1, 2016, the Plan was amended (the “2016 Plan”) and the exclusion for gender-reassignment services and surgery was removed. (Bunde Decl. Ex. E at Amendment.) The 2016 Plan remains self-insured and sponsored by Essentia. (*Id.* at 22–23.)

Tovar commenced this action on January 15, 2016, alleging sex discrimination against Essentia in violation of Title VII and the MHRA (Counts I and II, respectively) and against HealthPartners in violation of the ACA (Count III). For the economical and emotional harm she allegedly suffered due to this “discrimination,” she seeks compensatory damages, as well as declaratory and injunctive relief.

HealthPartners now moves to dismiss for lack of subject-matter jurisdiction and Essentia moves to dismiss for failure to state a claim. Defendants raise two issues with Tovar’s Complaint. HealthPartners argues Tovar does not have standing to assert her claims against it because a separate entity, HealthPartners Administrators, Inc. (“HPAI”), is actually the third-party administrator (“TPA”) of Essentia’s self-insured Plan. Essentia argues that Tovar lacks statutory standing and thus fails to state a claim upon which relief can be granted. The Motions have been fully briefed, the Court heard oral argument on April 14, 2016, and the Motions are ripe for disposition.

I. Subject-matter jurisdiction (Rule 12(b)(1))

a. Standard of decision

It is a plaintiff’s burden to establish that jurisdiction exists. [Osborn v. United States](#), 918 F.2d 724, 730 (8th Cir. 1990). In deciding a motion to dismiss for lack of subject-matter jurisdiction, the Court is “free to weigh the evidence and satisfy itself as to the existence of its power to hear the case.” *Id.* There are two methods of challenging whether subject-matter jurisdiction exists: a facial attack, which challenges the plaintiff’s allegations within the Complaint, [Stalley v. Catholic Health Initiatives](#), 509 F.3d 517, 520-21 (8th Cir. 2007), and a factual attack, which looks to matters beyond the pleadings to resolve facts and determine jurisdiction, [Osborn](#), 918 F.2d at 729 n.6. Here, HealthPartners has mounted a factual attack because its argument is based on matters outside the pleadings, namely, the 2015 Plan (Bunde Decl. Ex. A) and the 2016 Plan (*id.* Ex. E).

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b. Analysis

*3 HealthPartners argues Tovar does not have standing to sue it because her injuries are not “fairly traceable” to its conduct; the TPA of the 2015 Plan is actually HPAI. (HealthPartners Mem. at 2 n.1.) The 2015 Plan, which Tovar agrees is properly before the Court, explicitly lists HPAI as the TPA. (See Bunde Decl. Ex. A. at 22–23.) The 2016 Plan states the same. (*Id.* Ex. E at 22–23.)

This highlights why Tovar's third count against HealthPartners fails for lack of standing. She alleges that HealthPartners discriminated against her in violation of the ACA⁵ “by serving as the [TPA] for the Essentia Health Employee Medical Plan and enforcing the Plan's discriminatory exclusion of any ‘services and/or surgery for gender reassignment.’ ” (Compl. ¶ 63.) But, HealthPartners plainly was not the administrator of either the 2015 or 2016 Plan. The parties agree that to satisfy Article III's standing requirements, Tovar 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, and not merely speculative, that the injury will be redressed by a favorable decision. [McClain v. Am. Econ. Ins. Co.](#), 424 F.3d 728, 731 (8th Cir. 2005). Not only is Tovar's alleged injury not fairly traceable to HealthPartners, but HealthPartners is also unable to provide her redress.⁶ See [Sharpe Holdings, Inc. v. U.S. Dep't of Health & Human Servs.](#), 801 F.3d 927, 934 n.6 (8th Cir. 2015) (“A self-insured employer bears the financial risk of paying its employees' health-insurance claims.”).

Even if HealthPartners was involved in administering the Plan, Tovar's claims against it would still fail. First, regardless of whether the exclusion is itself discriminatory (as Tovar argues it is), HealthPartners would have fiduciary duties under ERISA to follow the terms of the Plan or be subject to legal action, 29 U.S.C. § 1104(a)(1)(D); and it was *Essentia* that decided on those terms (see Bunde Aff. Ex. A at 22–23). Second, HealthPartners points out that yet another way to impose liability on it would be to allege that it had some control over what coverage was provided. See [Williams v. Grimes Aerospace Co.](#), 988 F. Supp. 925, 935–36 (D.S.C. 1997) (“liability hinges on who is in control” and if both defendants exhibit control, each may be liable). But, HealthPartners continues, even this argument would fail because the 2015 Plan states *Essentia* retained “all powers and discretion to ... change the Plan.” (Bunde Aff. Ex. A at 23). Third, Tovar alleges that the 2015 Plan itself is discriminatory, yet has not sued the Plan. Instead, she sued HealthPartners, but alleged no discriminatory action it took in administering the Plan, which would have been sufficient to state an ACA claim. See [Callum v. CVS Health Corp.](#), --- F. Supp. 3d ---, 2015 WL 5782077, at *22–23 (D.S.C. 2015) (plaintiff stated ACA claim where CVS denied him the right to have his prescriptions filled at CVS pharmacies because of his race and disability); [Rumble v. Fairview Health Serv.](#), Civ. No. 14-2037, 2015 WL 1197415, at *15–16 (D. Minn. March 16, 2015) (Nelson, J.) (transgender plaintiff stated claim where emergency room doctor denied him medical care he was entitled to as a patient due to his gender identity). Finally, Tovar does not allege that HealthPartners gave her a different plan or fewer benefits *because* she had a transgender child, which would clearly be discrimination under the ACA. See [Se. Pa. Transp. Auth. v. Gilead Scis., Inc.](#), 102 F. Supp. 3d 688, 700 (E.D. Pa. 2015) (suggesting what facts might sufficiently allege discrimination under the ACA).

*4 Accordingly, Tovar's ACA claim fails because HealthPartners is an improper party to this action and her alleged injury is not traceable to it or redressable by it.⁷ See [Reid v. BCBSM, Inc.](#), 984 F. Supp. 2d 949, 955 n.6 (D. Minn. 2013) (Kyle, J.) (plaintiff failed to state a claim under the ADA because she did not allege facts to indicate that the *review* of the insurance plan was discriminatory, only that the *plan* was discriminatory); [Ark. ACORN Fair Hous., Inc. v. Greystone Dev., Ltd. Co.](#), 160 F.3d 433, 434–35 (8th Cir. 1998) (“[T]he injury must also be traceable to some act of the *defendant*.”) (emphasis added). As such, Count III will be dismissed without prejudice.⁸

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II. Failure to state a claim (Rule 12(b)(6))

a. Standard of decision

To avoid dismissal, a complaint must include “enough facts to state a claim to relief that is plausible on its face.” [Bell Atl. Corp. v. Twombly](#), 550 U.S. 544, 547 (2007). A “formulaic recitation of the elements of a cause of action” will not suffice. *Id.* at 555. “The plausibility standard is not akin to a ‘probability requirement,’ but it asks for more than a sheer possibility that a defendant has acted unlawfully.” [Ashcroft v. Iqbal](#), 556 U.S. 662, 678 (2009) (quoting [Twombly](#), 550 U.S. at 556).

When reviewing a motion to dismiss, the Court “must accept [the] plaintiff’s specific factual allegations as true but [need] not ... accept a plaintiff’s legal conclusions.” [Brown v. Medtronic, Inc.](#), 628 F.3d 451, 459 (8th Cir. 2010) (citing [Twombly](#), 550 U.S. at 556). The complaint must be construed liberally, and any allegations or reasonable inferences arising therefrom must be interpreted in the light most favorable to the plaintiff. [Twombly](#), 550 U.S. at 554-56. A complaint should not be dismissed simply because the Court is doubtful the plaintiff will be able to prove all of the necessary factual allegations. *Id.* at 556. Accordingly, a well-pleaded complaint will survive a motion to dismiss even if it appears that recovery is very remote and unlikely. *Id.* “Finally, the complaint should be read as a whole, not parsed piece by piece to determine whether each allegation, in isolation, is plausible.” [Braden v. Wal-Mart Stores, Inc.](#), 588 F.3d 585, 594 (8th Cir. 2009).

b. Analysis

Essentia argues Tovar has failed to state a claim upon which relief can be granted because she lacks statutory standing. Statutory standing is a doctrine employed by courts to avoid jurisdiction when Article III otherwise permits suit. In [Lexmark International, Inc. v. Static Control Components, Inc.](#), 134 S. Ct. 1377, 1388 (2014), the Supreme Court discouraged the use of such prudential standing theories, noting courts should not foreclose a cause of action created by Congress merely because “prudence dictates.” Instead, concepts of statutory interpretation should be used to determine whether a plaintiff falls within the individuals the statute intended to protect, otherwise known as the “zone of interests.” *Id.* Finding that a plaintiff does not fall within the zone of interests is effectively the same as failing to state a claim. [Leyse v. Bank of Am. Nat’l Ass’n](#), 804 F.3d 316, 320 (3d Cir. 2015) (“statutory standing is not jurisdictional”) (citing [Lexmark Int’l, Inc.](#), 134 S. Ct. at 1388 & n.4). As such, this Court will address whether Tovar falls within the zone of interests sought to be protected by Title VII and the MHRA and hence whether she has stated a claim to relief.

*5 Tovar alleges her emotional and economical harms were caused by Essentia’s incorporation of the exclusion in the 2015 Plan in violation of Title VII and the MHRA. Under Title VII, an employer is prohibited from discriminating “against any individual with respect to [her] compensation, terms, conditions, or privileges of employment, because of such individual’s ... sex.” 42 U.S.C. § 2000e-2(a). Title VII provides that “a civil action may be brought ... by the person claiming to be aggrieved.” 42 U.S.C. § 2000e-5(f)(1); [Thompson v. N. Am. Stainless, LP](#), 562 U.S. 170, 177 (2011) (stating the term “aggrieved” is construed more narrowly than Article III).

Similarly, the MHRA makes it unlawful for an employer, because of sex, to discriminate against a person with respect to terms, conditions, or privileges of employment. [Minn. Stat. § 363A.08, subd. 2\(3\)](#). The MHRA states that “[a]ny person aggrieved by a violation of this chapter may” sue. [Minn. Stat. § 363A.28, subd. 1](#). A party is “aggrieved” if “she has suffered the denial or infringement of a legal right.” [Krueger v. Zeman Constr. Co.](#), 781 N.W.2d 858, 862 (Minn. 2010). For purposes of this Motion, the Court will apply the same analysis to both the Title VII and MHRA claims. *See, e.g.*, [Torgerson v. City of Rochester](#), 643 F.3d 1031, 1043 (8th Cir. 2011) (*en banc*); [Johnson v. City of Blaine](#), 970 F. Supp. 2d 893, 914 (D. Minn. 2013) (Davis, C.J.).

Essentia contends, and Tovar agrees, that a person is “aggrieved” if she falls within the zone of interests; that is, “to protect employees from their employers’ unlawful actions” in the workplace. *See, e.g.*, [Pedroza v. Cintas Corp. No. 2](#), 397 F.3d 1063,

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1068 (8th Cir. 2005) (“Title VII prohibits an employer from discriminating against an employee based on the employee’s sex.”) (citing 42 U.S.C. § 2000e–2(a)(1)); [Gen. Tel. Co. of the Nw., Inc. v. EEOC](#), 446 U.S. 318, 323 (1980) (“Title VII protects all employees of and applicants for employment with a covered employer ... against discrimination based on ... sex.”). Essentia argues that only an *employee* is protected from discrimination and can bring a claim. There is no dispute that Tovar is an employee and her son is not. Accordingly, Tovar must be the individual to have suffered the discrimination—and this is where her claim falters. Essentia argues that Tovar is not an aggrieved person because she does not allege that she, as the employee, was discriminated against based on *her* sex or gender identity.

It is difficult to discern the precise contours of Tovar’s argument in response because she makes legal conclusions and cites case law distinguishable from her position, in which plaintiff-employees were directly discriminated against and brought successful claims. (See Mem. in Opp’n to Essentia at 11–13.) What is clear is her insistence that she is an aggrieved person because, as she concludes, she has suffered harm from discrimination based on (someone’s) sex simply by the exclusion being in her Plan. (See *id.* at 2 (“She was prevented from fully utilizing [her] benefits, and the basis on which Essentia denied her access was sex.”); see also *id.* at 9–10; Compl. ¶¶ 19, 53 (“Essentia violated Title VII’s bar on sex discrimination” by having the exclusion in the 2015 Plan).) But, this is simply insufficient to state a claim of discrimination.

Regardless of whether the exclusion discriminates against transgender individuals, Tovar’s allegation that this exclusion was “absolutely [] used against [her]” in violation of Title VII and the MHRA is unsupported by the facts alleged in the Complaint. (Mem. in Opp’n to Essentia at 10.) There are no allegations that Tovar herself is transgender or was denied health benefits by either Essentia or HealthPartners, let alone denied benefits because of her sex. Instead, she assumes the discrimination against her transgender son was also discrimination against her. This assumption confuses the true target because it was not Tovar who was discriminated against; it was her son (a non-employee and non-party) who was the sole object of the discrimination. This does not support a claim of discrimination. See, e.g., [Jackson v. Deen](#), 959 F. Supp. 2d 1346, 1355 (S.D. Ga. 2013) (plaintiff-employee’s claims fail because she did not allege *she* was the target of the discrimination); [Thompson](#), 562 U.S. at 178 (plaintiff-employee suffered discriminatory action based on *his* protected status as an employee and was not “an accidental victim of the retaliation”); [Krueger](#), 781 N.W.2d at 864 (plaintiff-employee may sue under MHRA only if the employer discriminated against *her*); [Niemeier v. Tri-State Fire Prot. Dist.](#), Civ. No. 99-7391, 2000 WL 1222207, at *4 (N.D. Ill. Aug. 24, 2000) (plaintiff-employee did not have standing to sue under ADA based on discrimination suffered by his non-employee wife who was a beneficiary under his insurance plan); [Newport News Shipbuilding & Dry Dock Co. v. E.E.O.C.](#), 462 U.S. 669, 672 (1983) (discrepancies between pregnancy-related hospitalization benefits offered to male and female employees discriminated against male employees because of *their sex*, not their wives’ sex).

*6 To show she has suffered discrimination, Tovar analogizes her situation to that in [Tetro v. Elliott Popham Pontiac, Oldsmobile, Buick, & GMC Trucks, Inc.](#), 173 F.3d 988 (6th Cir. 1999). In *Tetro*, a Caucasian man sued his former employer, alleging he was discriminated against because he had a biracial child. *Id.* at 994. The court found *Tetro* did state a claim of racial discrimination, “even though the root animus for the discrimination was prejudice against the biracial child,” because the employer targeted the plaintiff-employee with its discriminatory conduct, culminating in his discharge. *Id.*

Here, Tovar has alleged no similar discriminatory conduct or adverse action taken by Essentia against her. Instead, she argues “she is entitled to the full enjoyment of the privileges of her employment, including access to and use of her health care benefits equal to that of other employees.” (Mem. in Opp’n to Essentia at 13–14.) Yet, there are no facts in the Complaint to support that she was ever personally denied the benefits or privileges of her employment or personally experienced anything less than full coverage of the benefits provided. At oral argument, Tovar continued to make these same public policy arguments in support of how she has been injured: that a facially discriminatory health plan restricts people from freely choosing their employment and discriminatorily impacts employees’ conditions of employment. (See Doc. No. 21, Mot. Hr’g Tr. at 21–25.) The Court is unpersuaded—not only are policy arguments better addressed to the legislature, but the generalized grievance asserted here is insufficient to confer standing. See [Warth v. Seldin](#), 422 U.S. 490, 499 (1975) (“[W]hen the harm asserted is a ‘generalized

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grievance' shared in substantially equal measure by all or a large class of citizens, that harm alone normally does not warrant exercise of jurisdiction.").

While the Court must take as true the fact that Tovar has been injured emotionally and financially, these purported injuries are *effects* of the discrimination her *son* allegedly endured based on his sex. In [Glass v. Hillsboro School District 1J](#), 142 F. Supp. 2d 1286, 1288 (D. Or. 2001), the court granted the defendant's motion to dismiss the plaintiff-parents' Americans with Disabilities Act ("ADA") claim because the parents did not allege they suffered separate and independent injuries sufficient to state a claim of discrimination. The court drew a distinction between ancillary-economic/derivative injuries and direct-discriminatory injuries. [Glass](#), 142 F. Supp. 2d at 1289–90. The former injuries were expenditures incurred by the plaintiffs to secure services for their child, while the latter were injuries suffered by their disabled child for being denied medical services. *Id.* The court held that only the infliction of the latter injury was sufficient to state a discrimination claim under the ADA. *Id.*

The same failures in [Glass](#) also appear here and the same result is warranted. Tovar has not alleged that Essentia's actions discriminated against her and caused her direct injuries; like [Glass](#), she has suffered no discrimination or injury just because her son was the object of discriminatory conduct. *See id.* at 1290. Tovar sought no service under the 2015 Plan and was not denied any benefit to which she was entitled. *See id.* at 1291–92. And, applying [Glass](#)'s injury-distinction here, Tovar's emotional distress and economic difficulties are not separate and direct injuries sufficient to state a claim of discrimination. *See id.* at 1290–92; *see also* [Niemeier](#), 2000 WL 1222207, at *4 (husband's emotional injury resulting from alleged discrimination to wife was not a "separate and distinct injury caused by [defendant's] actions" and was insufficient to state claim under the ADA).

*7 Tovar further attempts to distinguish her situation from that in [Pierzynowski v. Police Dep't City of Detroit](#), 941 F. Supp. 633, 640 (E.D. Mich. 1996), claiming "[s]he is not merely a third-party bystander." (Mem. in Opp'n to HealthPartners at 26.) But, in the Court's view, this is another case that actually cuts against Tovar. In [Pierzynowski](#), the defendant's wife and two other family members sued the Police Department under § 1983, asserting injuries for mental anguish, humiliation, embarrassment, and personal injury requiring medical treatment, as a result of the defendant's acquittal following his arrest and prosecution. *Id.* at 640–41. The family members did not aver that any of their own constitutional rights had been violated and the court found the family members lacked standing and dismissed their claims. *Id.* (stating wife's injury "relate[d] to" the prosecution of her husband).

Tovar argues her situation is different; she was a covered party under the 2015 Plan and "the benefits she received *through her beneficiary son* were lacking because of the discrimination." (Mem. in Opp'n to HealthPartners at 26 (emphasis added).) However, the Court finds [Pierzynowski](#) analogous to the facts of the case at hand. The three family-member plaintiffs in [Pierzynowski](#) claimed indirect injuries suffered vicariously through the alleged constitutional violations committed against the defendant. 941 F. Supp. at 640. The court reasoned that "[i]f the constitutional rights of one family member are violated, this does not confer standing on other family members." *Id.* Here, Tovar also claims her injuries are "due to" her son being denied medical care. (Compl. ¶ 48.) The Court finds Tovar's alleged injuries are similarly vicarious in nature and do not make her an aggrieved person under the law. Therefore, Counts I and II will be dismissed for failure to state a claim.

CONCLUSION

Based on the foregoing, and all the files, records, and proceedings herein, **IT IS ORDERED** that Essentia's Motion to Dismiss (Doc. No. 10) and HealthPartners' Motion to Dismiss (Doc. No. 12) are **GRANTED**; Counts I and II of Tovar's Complaint (Doc. No. 1) are **DISMISSED WITH PREJUDICE**, and Count III is **DISMISSED WITHOUT PREJUDICE**.

LET JUDGMENT BE ENTERED ACCORDINGLY.

All Citations

Slip Copy, 2016 WL 2745816

Footnotes

- 1 Defendant HealthPartners, Inc. contends that Tovar actually is employed only by Innovis Health, LLC. (HealthPartners Mem. at 2 n.2.) Essentia does not join in this argument and the Court will not address it at this time.
- 2 HealthPartners contends it is incorrectly named as a defendant and, instead, asserts that HealthPartners Administrators, Inc. is the third-party administrator for the Plan. This issue is discussed below.
- 3 This condition occurs when an individual's gender identity differs from the gender assigned at birth, which is also known as being “transgender.” (Compl. ¶¶ 27–28.) It appears that Tovar's son was assigned the female gender at birth but now identifies as male.
- 4 The parties agree this exhibit—the 2015 Plan—is “necessarily embraced” by, and does not contradict, the Complaint; as such, the Court will consider it on this Motion to Dismiss. (Mem. in Opp'n to HealthPartners at 3 n.2 (citing [Minn. Majority v. Mansky](#), 708 F.3d 1051, 1056 (8th Cir. 2013)).)
- 5 Section 1557 of the ACA provides, in relevant part:

An 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 [section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794)], be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance.

42 U.S.C. § 18116(a).
- 6 It is important to note that HealthPartners and HPAI are separate legal entities. The Department of Health and Human Services (“HHS”) has promulgated proposed rules that shed light on the significance of this distinction. “Where an entity that acts as a [TPA] for an employer's employee health benefit plan is legally separate from an issuer that receives Federal financial assistance for its insurance plans, [HHS] will engage in a case-by-case inquiry to evaluate whether [the TPA] is appropriately subject to Section 1557.” See [Nondiscrimination in Health Programs and Activities](#), 80 Fed. Reg. 54,172, 54,189 n.73 (Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92). Tovar has alleged that HealthPartners receives federal financial assistance (Compl. ¶¶ 12–13), but she still cannot overcome the fact that Defendant HealthPartners is neither the TPA nor the plan sponsor, and as such, has no relation to this case.
- 7 HealthPartners also argues Tovar's ACA claim is moot because the exclusion at issue in the 2015 Plan was removed from the 2016 Plan *before* Tovar commenced this action. (Compare Bunde Decl. Ex. A at 51 with *id.* Ex. E at Amendment.) The Court agrees but dismisses this claim on other grounds.
- 8 Tovar asserts that “if discovery reveals that [HPAI] should be ... substituted for HealthPartners, Inc., [she] will seek to amend her Complaint accordingly.” (Mem. in Opp'n to HealthPartners at 3 n.4.) Tovar agrees that the 2015 Plan is properly before the Court, and it establishes that HPAI is the TPA. Tovar did not, and has not, amended her Complaint, even though she is free to seek leave to do so. See [Fed. R. Civ. P. 15\(a\)](#).

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Declined to Extend by [Southeastern Pennsylvania Transp. Authority v. Gilead Sciences, Inc.](#), E.D.Pa., May 4, 2015

2015 WL 1197415

Only the Westlaw citation is currently available.
United States District Court,
D. Minnesota.

Jakob Tiarnan RUMBLE, Plaintiff,

v.

FAIRVIEW HEALTH SERVICES d/b/a [Fairview Southdale
Hospital](#), and Emergency Physicians, P.A., Defendants.

No. 14-cv-2037 (SRN/FLN).

|
Signed March 16, 2015.

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MEMORANDUM OPINION AND ORDER

[SUSAN RICHARD NELSON](#), District Judge.

I. INTRODUCTION

*1 This matter is before the Court on (1) Defendant Emergency Physicians, P.A.'s Motion to Dismiss [Doc. No. 11]; and (2) Defendant Fairview Health Services' Motion to Dismiss [Doc. No. 18]. For the reasons set forth below, the Court denies both motions.

II. BACKGROUND

Plaintiff Jakob Tiarnan Rumble (“Rumble” or “Plaintiff”) filed suit against Defendant Fairview Health Services, d/b/a Fairview Southdale Hospital (“Fairview”), and Emergency Physicians, P.A. (“Emergency Physicians”), alleging that the treatment he received at Fairview from June 23 to June 28, 2013, constitutes discrimination in violation of Section 1557 of the Affordable Care Act (“ACA”), [42 U.S.C. § 18116](#), and the Minnesota Human Rights Act (“MHRA”), [Minn.Stat. § 363A.11](#). (*See generally* Compl. [Doc. No. 1].) Specifically, Rumble alleges that “he received worse care [from both Defendants] ... because of his status as a transgender man.” (*See id.* ¶ 3.)

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Rumble resides in Hennepin County, Minnesota. (*Id.* ¶ 4.) He was eighteen years old when he experienced the alleged discrimination by Defendants. (*See* Pl.'s Mem. at 10 [Doc. No. 25].)

Defendant Fairview is a “Minnesota-based health care organization receiving federal and state financial assistance such as credits, subsidies, or contracts of insurance.” (*Id.* ¶ 6.) At all times relevant, Fairview owned and operated Fairview Southdale Hospital, which is located at 6401 France Avenue South, Edina, Minnesota 55435. (*Id.* ¶ 5.) Plaintiff alleges that Fairview “employed the services of doctors, nurses, and other healthcare professional and non-professional health care providers, including the nurses and other health care providers who cared for Jakob Rumble in June 2013, and held itself out and warranted itself to the public as competent, careful, and experienced in the care and treatment of patients.” (*Id.* ¶ 7.)

Like Fairview, Defendant Emergency Physicians is also a “Minnesota-based healthcare organization receiving federal and state financial assistance such as credits, subsidies, or contracts of insurance.” (*Id.* ¶ 10.) Emergency Physicians employs the emergency room physicians who staff Fairview Southdale Hospital. (*Id.* ¶ 9.) Plaintiff alleges that Randall Steinman, M.D. is one such emergency room physician who is employed by Defendant Emergency Physicians. (*Id.* ¶ 12.)

A. Terminology Overview

Given the nature of this case, the Court provides an overview of the relevant terminology before detailing Plaintiff's claims. Rumble self-identifies as a “female-to-male transgender man.” (*Id.* ¶ 4.) Transgender is “[a]n umbrella term that may be used to describe people whose gender expression does not conform to cultural norms and/or whose gender identity is different from their sex assigned at birth. Transgender is a self-identity, and some gender nonconforming people do not identify with this term.” *See Trans Bodies, Trans Selves: A Resource for the Transgender Community* 620 (Laura Erickson–Schroth, ed.2014). Although Rumble was “labeled female at birth and given a female birth name,” he “identifies as male.” (Compl. ¶ 25 [Doc. No. 1].)

*2 Recently, courts have broadly characterized an individual's transgender status as part of that individual's “sex” or “gender” identity. *See, e.g., Smith v. City of Salem, Ohio*, 378 F.3d 566, 572–73 (6th Cir.2004) (holding that plaintiff with gender identity disorder sufficiently stated constitutional and Title VII sex discrimination claims based on his allegations that he was discriminated against because of his gender nonconforming behavior and appearance); *Radtke v. Miscellaneous Drivers & Helpers Union Local No. 638 Health, Welfare, Eye & Dental Fund*, 867 F.Supp.2d 1023, 1032 (D.Minn.2012) (explaining that “the ‘narrow view’ of the term ‘sex’ in Title VII” in *Sommers v. Budget Mktg., Inc.*, 667 F.2d 748, 750 (8th Cir.1982), “ ‘has been eviscerated by *Price Waterhouse.*’ ”) (quoting *Smith*, 378 F.3d at 573).

This recent development is a result of the United States Supreme Court's ruling in *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989), *superseded on other grounds by statute as stated in Burrage v. U.S.*, 134 S.Ct. 881 (2014). In *Price Waterhouse*, the Supreme Court held that Title VII's prohibition against discrimination because of sex includes discrimination based on gender stereotyping. *See* 490 U.S. at 250–52. Because the term “transgender” describes people whose gender expression differs from their assigned sex at birth, discrimination based on an individual's transgender status constitutes discrimination based on gender stereotyping. Therefore, Plaintiff's transgender status is necessarily part of his “sex” or “gender” identity.

However, an individual's transgender status in no way indicates that person's sexual orientation. *See* American Psychological Association, *Identification of Terms: Sex, Gender, Gender Identity, Sexual Orientation*, available online <http://www.apa.org/pi/lgbt/resources/sexuality-definitions.pdf>. Although this principle is factually correct, the State of Minnesota defines “sexual orientation” as including “having or being perceived as having a self-image or identity not traditionally associated with one's biological maleness or femaleness.” *See* Minn.Stat. § 363A.03, subd. 44. Therefore, solely for purposes of the Court's discussion of Plaintiff's Minnesota state law discrimination claim, the Court considers Plaintiff's gender identity as part of his “sexual orientation.”

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B. Plaintiff's Medical Condition Before Going to Fairview Hospital

Rumble alleges that “[d]uring the week of June 16 to June 22, 2013, [he] saw his primary care provider with a complaint that his reproductive organs were inflamed and causing him extreme pain.” (Compl. ¶ 26 [Doc. No. 1].) Plaintiff has a “uterus, vagina, cervix, and labia.”¹ (See *id.* ¶ 42.) Rumble's primary care physician prescribed a “7–day course of antibiotic treatment.” (*Id.* ¶ 26.) However, Rumble's pain allegedly increased during the course of his antibiotic treatment. (See *id.* ¶ 27.) In fact, Rumble alleges that he “could hardly walk because of the pain[, and] [w]hen he urinated, he had to grab something to brace himself or bit down on a towel to endure the pain .” (*Id.*)

*3 On June 23, 2013, when the pain had reached this severity, Plaintiff's mother, Jennifer Rumble, took Plaintiff's temperature and determined that he had a one hundred and four degree fever. (*Id.*) As a medical professional, Jennifer Rumble knew that “800 mg of **ibuprofen**” is the “highest safe dosage for an adult.” (*Id.* ¶¶ 37, 27.) To treat her son's pain, Jennifer gave Plaintiff 800 mg of **ibuprofen**. (*Id.* ¶ 27.) Plaintiff alleges that after he took the **ibuprofen**, he and his mother went to the emergency room at Fairview Southdale Hospital, which “was the hospital closest to their home.” (*Id.* ¶ 28.)

C. Treatment Plaintiff Received During Intake

Plaintiff arrived at Fairview at approximately 1 pm on June 23, 2013. (*Id.*) When checking-in at the front desk, Rumble handed the front desk clerk his driver's permit. (*Id.* ¶ 29.) At the time, Rumble's driver's permit “incorrectly identified [him] as female.” (*Id.*) The clerk allegedly told Rumble that he could not find Rumble in the computer system, and Rumble responded by telling the clerk his birth name. (See *id.*) The Fairview clerk told Rumble that Fairview has “female on file,” and subsequently gave Plaintiff a wristband labeled with an “F.” (See *id.* ¶ 30.)

Plaintiff claims that he was given this “F” wristband even though he told the clerk that he identifies as male. (See Pl.'s Mem. at 1 [Doc. No. 25].) Although Plaintiff's Complaint does not expressly state that Rumble told the clerk that he identifies as male, the Court reads Plaintiff's Complaint as alleging that Rumble communicated his gender identity when he answered the clerk's “preliminary questions.” (See Compl. ¶ 29 [Doc. No. 1].) Rumble further alleges that during this exchange with the Fairview clerk, the clerk “left the front desk to speak to [another] person and held a folder in front of his face while whispering to this person.” (See *id.* ¶ 31.) Rumble believes that these two individuals were “discussing his gender.” (*Id.*)

The clerk then took Rumble to an intake nurse in an examining room. (See *id.* ¶ 32.) Rumble allegedly registered a temperature of nearly one hundred degrees, “described the severity of his pain” to the intake nurse, and also told the intake nurse about his prior one hundred and four degree fever. (See *id.* ¶ 32–33.)

After Plaintiff's meeting with the intake nurse, Rumble and his mother were transferred to another room, where they waited to be seen by a doctor for hours. (See *id.* ¶ 35.) Rumble alleges that he remained in “severe pain” while he waited in this room. (See *id.*) Although Plaintiff and his mother both tried to call a nurse using the call button in the room, allegedly, no one responded to the call. (See *id.*) In order to gain the attention of a medical professional in the hospital, Plaintiff claims that his mother would “leave the room and search for emergency room staff.” (*Id.* ¶ 36.) Rumble's mother told staff members that her son was in severe pain and asked for him to receive pain medication. (See *id.* ¶ 35.) Emergency room staff allegedly responded by stating that “they would need to ask a doctor about [administering or obtaining pain medication for Rumble].” (See *id.*) Finally, “[a]fter several hours,” Fairview staff gave Plaintiff some pain medication. (*Id.* ¶ 36.) Plaintiff and his mother believe that “people with less urgent medical needs were treated much more quickly than [Rumble] was treated.” (*Id.* ¶ 37.)

D. Treatment Plaintiff Received by Emergency Room Doctor

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*4 Dr. Randall Steinman finally came to Rumble's room four and a half to five hours after Rumble initially arrived at the emergency room. (*See id.* ¶ 38.) Dr. Steinman is employed by Defendant Emergency Physicians. (*See* Compl. ¶ 12 [Doc. No. 1].) Dr. Steinman was accompanied by a female nursing assistant/emergency room technician, and Dr. Karee Lehrman, an obstetrician-gynecologist. (*Id.* ¶ 38.) Dr. Steinman allegedly asked Rumble in a “hostile and aggressive manner,” “[w]ho are you having sex with?” (*Id.* ¶ 39.) When Rumble asked Dr. Steinman “what he meant by that [question],” Dr. Steinman asked, “[m]en, women, or both?” (*See id.* ¶ 40.) Rumble alleges that “Dr. Steinman seemed angry, and held his face a few inches from [Rumble's] face when he asked questions.” (*Id.*) In fact, Rumble claims that “Dr. Steinman's manner was so hostile that [Rumble] felt as if the questions were an attempt to embarrass [Rumble] rather than to diagnose him.” (*Id.*) For instance, Dr. Steinman allegedly asked Plaintiff if he was “engaging in penetration,” and whether “he'd ever had sex with objects.” (*See id.*)

After questioning Rumble, Dr. Steinman proceeded with a physical examination of Plaintiff's genitalia. Plaintiff informed Dr. Steinman that “he was in extreme pain,” and asked Dr. Steinman “to please be gentle.” (*See id.* ¶ 41.) “Dr. Steinman took a strip of gauze and [allegedly] wiped [Rumble's] labia in a very rough manner.” (*Id.* ¶ 43.) In fact, Rumble alleges that he “felt like he was being stabbed,” because “[i]t seemed as if [Dr. Steinman] was pressing down as hard as he could.” (*Id.*) Dr. Steinman then allegedly “repeatedly jabbed at [Rumble's] genitals with his fingers.” (*Id.*) Rumble began to cry from the pain of this exam. (*See id.*)

When Dr. Steinman asked “[i]s this what this normally looks like?,” Plaintiff “responded that his labia were swollen to almost three times their normal size.” (*Id.* ¶ 44.) Dr. Steinman then allegedly stated that “he couldn't tell what was going on because of the male hormones.” (*See id.*) Rumble takes prescription hormone medication. (*Id.* ¶ 42.) Throughout the exam, Dr. Steinman “repeated several times that he didn't know what the male hormones [Rumble] was taking were doing to [Rumble's] body,” nor did Dr. Steinman know “how much swelling was due to the hormones.” (*Id.*)

Dr. Steinman proceeded by continuing to jab Plaintiff's genitals. (*Id.* ¶ 45.) Rumble cried out from the pain, and when he could not bear the pain any longer he asked Dr. Steinman to stop the exam, twice. (*See id.*) However, “Dr. Steinman [allegedly] ignored him and did not stop, but continued to forcefully jab at [Rumble's] genitals, causing [Rumble] more pain.” (*Id.*) Although Dr. Lehrman and the female nursing assistant/emergency room technician were in the exam room, they did not intervene or stop Dr. Steinman. (*See id.* ¶ 48.)

*5 Rumble then asked his mother, “Mom, can you make him stop?” (*Id.* ¶ 46.) Jennifer Rumble responded by allegedly yelling “[s]top! He said that you needed to stop. Didn't you hear him?” (*Id.*) At this point, the female nursing assistant/emergency room technician left the room. (*See id.*) Dr. Steinman finally stopped jabbing Plaintiff's genitals and Rumble asked whether Dr. Steinman had determined the problem. Dr. Steinman allegedly stated in a tense and angry voice, “I can't tell you because your mom made me stop the exam.” (*See id.* ¶ 47.) Without further explanation, Dr. Steinman then allegedly left the room. (*See id.*)

Once both doctors had left Rumble's exam room, Rumble waited in the room for two additional hours. (*See id.* ¶ 49.) Jennifer Rumble asked emergency room staff if they often made people wait in the emergency room for nearly seven hours, and the staff allegedly responded they did not. (*See id.* ¶ 50.) Rumble's mother also asked whether she and her son could have something to eat. (*See id.*) Although the staff initially stated that they did not feed people who were in the emergency room, after acknowledging that the Rumbles had been waiting for nearly seven hours, the staff brought the Rumbles sandwiches. (*See id.*)

E. Treatment Plaintiff Received Once Admitted to Fairview

Finally, around 8 pm on June 23, 2014, Plaintiff was admitted to the hospital. (*Id.* ¶ 51.) Jennifer Rumble was later informed by a Fairview hospital doctor that her son “would have been septic within 12 to 24 hours [from] when [she] brought [her son] in[to the emergency room] and he could have died.” (*Id.* ¶ 59.) Because of the interaction with Dr. Steinman, Rumble was afraid of being left alone in the hospital. (*Id.* ¶ 51.) Rumble's mother shared his fear, as “[s]he did not know what might happen if

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she was not present.” (*Id.* ¶ 52.) Therefore, Rumble's mother stayed in the hospital with her son for his entire stay, and she spent nights sleeping on a chair. (*Id.*)

Rumble was in the hospital for six days. (*Id.* ¶ 62.) While he was a patient, he had his own private room. (*Id.* ¶ 54.) On a dry erase board on the wall across from the foot of Rumble's bed, Fairview staff tracked the names of Rumble's on-duty nursing staff, his reported pain levels, and the names and specialties of his treating physicians. (*See id.*) One of Rumble's treating physicians was Dr. Lehrman, the same doctor who was present during Rumble's interaction with Dr. Steinman. (*See id.*) The dry erase board indicated that Dr. Lehrman is an “OB/GYN.” (*See id.*) Rumble alleges that he was “upset and embarrassed by Defendant Fairview's disclosure on the dry erase board[,] that he was being treated by an ‘OB/GYN[,]’ to non-medical personnel such as dietary and housekeeping/environmental services and any personal guests to his room.” (*See id.* ¶ 55.) Accordingly, Rumble's mother erased the “OB/GYN” notation with her finger after observing her son's discomfort with the visible information. (*See id.*) Rumble alleges that this visible notation was unnecessary because “all medical professionals treating [Plaintiff] would have had access to the same information on his charts.” (*Id.*)

*6 In addition to Dr. Lehrman, Rumble was assigned an infectious disease doctor, Dr. Stephen Obaid. (*See id.* ¶ 56.) Dr. Obaid examined Rumble around 7 am on June 24, 2013. (*Id.*) Dr. Obaid examined Plaintiff's genital area while wearing gloves, then wiped his gloves on the blanket on Rumble's bed, and proceeded to examine Rumble's eyes and mouth using the same gloves. (*See id.*) Rumble “later developed sores on his face in the places that Dr. Obaid had touched.” (*Id.*)

In addition to the lack of sanitary or hygienic precautions taken by Dr. Obaid, Plaintiff alleges that he was mistreated by the nurses at Fairview. (*See id.* ¶¶ 57–58.) For instance, Rumble claims that “some of the nurses were hostile towards him because they seemed tense and avoided speaking to him when they came into his room.” (*Id.* ¶ 57.) Additionally, at the beginning of each nurse's shift, the nurse would examine his genitals. (*Id.*) Rumble asked one nurse why the nurses needed to conduct this exam, and the nurse responded that it was simply “completely necessary,” without elaborating further. (*Id.*) Rumble also asked this nurse if she knew what was wrong and she responded that “I don't know because I don't have any experience with this sort of thing.” (*Id.* ¶ 58.) Rumble believes that the nurse implied that she had no experience with transgender patients. (*Id.*)

Although Rumble was initially treated with antibiotics when he was admitted to the hospital, he “did not appear to be getting any better.” (*Id.* ¶ 53.) Therefore, Rumble's mother decided to complete her own research and she “searched the internet to get information about what might be wrong.” (*Id.* ¶ 60.) As a result of her research, she asked Dr. Obaid if her son may have a sexually-transmitted infection. (*Id.*) After this suggestion, Dr. Obaid swabbed Rumble's genitals for testing, and informed Rumble's mother that “it would be a week before they had the lab results.” (*Id.* ¶ 61.) Nonetheless, Fairview staff began to treat Rumble with a different medication and his medical condition began to improve. (*Id.*) After two days on the new medicine, Rumble asked to be discharged. (*Id.* ¶ 62.) Although Rumble believed that he could have improved more from staying longer in the hospital, “he did not feel safe at the hospital and preferred to leave.” (*Id.*) Rumble was released from the hospital on Friday, June 28, 2013. (*Id.*)

F. Aftermath from Plaintiff's Treatment at Fairview

A few weeks later, Rumble received a bill from Emergency Physicians, the group that employs Dr. Steinman. (*Id.* ¶ 63.) The bill was in regards to his emergency room visit at Fairview Southdale Hospital. (*Id.*) “The bill indicated [that] no insurance payments were pending and [Rumble] owed the full amount. In the billing description for the time he had spent at Fairview Southdale Hospital, it stated, ‘THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER.’” (*Id.*) In contrast to the statement on this bill, Plaintiff alleges that his ultimate diagnoses were conditions that can, and do, affect people of any sex or gender.² (*Id.*)

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*7 As a result of his experience with Defendants, Plaintiff fears doctors and “refuses to visit a hospital or doctor's office alone.” (*Id.* ¶ 64.) Additionally, Rumble claims that he will never go to Fairview Southdale Hospital again, “even in an emergency” although it is the nearest hospital to his home. (*Id.* ¶ 65.)

The Court also notes that on December 12, 2013, Plaintiff filed a complaint of discrimination with the Office for Civil Rights (“OCR”) in the Department of Health and Human Services alleging that Defendants violated his rights under Section 1557 of the ACA. (*Id.* ¶ 67.) “The OCR is responsible for ensuring compliance with Section 1557. Region V of [the] OCR is responsible for investigating and remedying violations of Section 1557 that occur in Minnesota, where Fairview Southdale Hospital is located.” (*Id.*) The OCR's investigation of this matter is allegedly ongoing.

G. Plaintiff's Claims

Plaintiff's Complaint states two counts against Defendants. In Count I, Plaintiff alleges that Defendants discriminated against him on the basis of sex, in violation of Section 1557 of the ACA.³ (*See id.* ¶¶ 69–76.) According to Section 1557:

Except as otherwise provided for in this title (or an amendment made by this title), an 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 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act shall apply for purposes of violations of this subsection.

See 42 U.S.C. § 18116 (emphasis added). Accordingly, Defendants, who both allegedly received federal financial assistance, may not discriminate against Plaintiff on the basis of “sex,” as Title IX prohibits discrimination on this “ground.” *See id.* When analyzing Title IX, courts have interpreted the term “sex” to include “individuals who are perceived as not conforming to gender stereotypes and expectations.” (*See* Compl. ¶ 72 (citing *Kastl v. Maricopa Cnty. Community College Dist., No. 02–cv–1531 (PHX/SRB), 2004 WL 2008954, at *2 (D. Ariz. June 3, 2004)* (stating that “[i]t is well settled that Title VII's prohibition on sex discrimination encompasses discrimination against an individual for failure to conform to sex stereotypes.”), and *Miles v. New York University, 979 F.Supp. 248, 250 n.4 (S.D.N.Y.1997)* (explaining that “the Title IX term ‘on the basis of sex’ is interpreted in the same manner as similar language in Title VII”)) [Doc. No.1].) Furthermore, Leon Rodriguez, the Director of the OCR, stated in an agency opinion letter that Section 1557 of the ACA “extends to claims of discrimination based on gender identity or failure to conform to stereotypical notions of masculinity or femininity.” (*See* Barrett Wiik Decl., Ex. C [Doc. No. 26–1].) Accordingly, Plaintiff alleges that, in direct violation of Section 1557, “Defendants perpetrated discrimination[, based upon Rumble's gender identity or transgender status,] with malice, deliberate disregard for, or deliberate reckless indifference to Plaintiff's rights.” (Compl. ¶ 75 [Doc. No. 1].)

*8 In Count II, Plaintiff alleges that Defendants' conduct violated the MHRA, Minn.Stat. § 363A.11. (*See id.* ¶¶ 77–82.) Pursuant to the MHRA, it is an “unfair discriminatory practice:”

to deny any person the full and equal enjoyment of the goods, services, facilities, privileges, advantages, and accommodations of a place of public accommodation because of race, color, creed, religion, disability, national origin, marital status, *sexual orientation*, or sex ...

See Minn.Stat. § 363A.11, subd. 1(a)(1) (emphasis added). As noted above, Minnesota law defines “sexual orientation” as “having or being perceived as having a self-image or identity not traditionally associated with one's biological maleness or

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femaleness.” See [Minn.Stat. § 363A.03, subd. 44](#). Plaintiff claims that, under the MHRA, he is protected from discrimination based on his gender identity and transgender status, “since those are subsumed under the statutory definition of ‘sexual orientation.’” (Compl. ¶ 79 [Doc. No. 1].)

Plaintiff seeks: (1) a permanent injunction requiring that “Defendants adopt practices in conformity with the requirements of [Section 1557] and [the MHRA]” and “prohibiting Defendants from engaging in the practices complained of [by Plaintiff];” (2) compensatory damages “for his physical pain, embarrassment, humiliation, emotional pain and anguish, violation of his dignity, and loss of enjoyment of life;” and (3) punitive damages, “to the extent allowed by state and federal anti-discrimination law.” (*See id.* at 16.)

H. Procedural Posture

Plaintiff filed his Complaint on June 20, 2014. (*See generally* Compl. [Doc. No. 1].) On July 18, 2014, Defendant Emergency Physicians filed a Motion to Dismiss [Doc. No. 11], with a supporting memorandum [Doc. No. 13]. Similarly, Defendant Fairview filed a Motion to Dismiss [Doc. No. 18] and a supporting memorandum [Doc. No. 20] on July 18, 2014. Plaintiff filed a single response brief in opposition to both Defendants' motions [Doc. No. 25], with a declaration and several supporting exhibits [Doc. No. 26]. Defendant Fairview then filed a reply brief on October 17, 2014 [Doc. No. 28], and Defendant Emergency Physicians did the same [Doc. No. 29]. The Court heard oral argument on both motions on November 14, 2014. (*See* Minute Entry [Doc. No. 30].)

III. DISCUSSION

A. Standard of Review

Defendants move to dismiss Plaintiff's Complaint, pursuant to [Rule 12\(b\)\(6\) of the Federal Rules of Civil Procedure](#), for failure to state a claim upon which relief can be granted. When evaluating a motion to dismiss, the Court assumes the facts in the Complaint to be true and construes all reasonable inferences from those facts in the light most favorable to Plaintiff. [Morton v. Becker](#), 793 F.2d 185, 187 (8th Cir.1986). However, the Court need not accept as true wholly conclusory allegations, [Hanten v. School District of Riverview Gardens](#), 183 F.3d 799, 805 (8th Cir.1999), or legal conclusions Plaintiff draws from the facts pled, [Westcott v. City of Omaha](#), 901 F.2d 1486, 1488 (8th Cir.1990). In addition, the Court ordinarily does not consider matters outside the pleadings on a motion to dismiss. *See* [Fed.R.Civ.P. 12\(d\)](#). The Court may, however, consider exhibits attached to the complaint and documents that are necessarily embraced by the pleadings, [Mattes v. ABC Plastics, Inc.](#), 323 F.3d 695, 697 n.4 (8th Cir.2003), and may also consider public records, [Levy v. Ohl](#), 477 F.3d 988, 991 (8th Cir.2007).⁴

*9 To survive a motion to dismiss, a complaint must contain “enough facts to state a claim to relief that is plausible on its face.” [Bell Atl. Corp. v. Twombly](#), 550 U.S. 544, 570 (2007). Although a complaint need not contain “detailed factual allegations,” it must contain facts with enough specificity “to raise a right to relief above the speculative level.” *Id.* at 555. “Threadbare recitals of the elements of a cause of action, supported by mere conclusory statements,” will not pass muster. [Ashcroft v. Iqbal](#), 556 U.S. 662, 678 (2009) (citing [Twombly](#), 550 U.S. at 555). In sum, this standard “calls for enough fact[s] to raise a reasonable expectation that discovery will reveal evidence of [the claim].” [Twombly](#), 550 U.S. at 556.

B. Defendant Emergency Physicians' Motion to Dismiss

Defendant Emergency Physicians argues that the Court should dismiss (1) Plaintiff's Count I because (a) Rumble failed to allege that he sought medical care from a health program or activity that receives federal funds, and (b) Plaintiff does not allege facts supporting either an adverse action or differential treatment on the basis of sex (*see* Def. Emergency Physicians' Mem. at 8, 9 [Doc. No. 13]); and (2) Plaintiff's Count II because (a) Plaintiff “does not assert facts to demonstrate that [Emergency

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Physicians] denied Plaintiff any service, facility, privilege, advantage, or accommodation of any public accommodation,” and (b) Plaintiff does “not assert facts to show that [Emergency Physicians] discriminated against Plaintiff because of Plaintiff’s sexual orientation and gender identity” (*see id.* at 13–14.) The Court disagrees.

1. Count I: Section 1557 Claim

To the Court’s knowledge, this is the first case that requires interpretation of Section 1557. As this is a matter of first impression, the canons of statutory interpretation guide the Court’s analysis. Statutory interpretation begins with the statute’s “plain language.” *See United States v. Cacioppo*, 460 F.3d 1012, 1016 (8th Cir.2006); *Lamie v. U.S. Trustee*, 540 U.S. 526, 534 (2004) (explaining that when a “statute’s language is plain,” courts must enforce it “according to its terms.”). “Where the language is plain, [the Court] need inquire no further.” *Cacioppo*, 460 F.3d at 1016 (citing *United States v. Ron Pair Enters., Inc.*, 489 U.S. 235, 241 (1989)). In other words, if the statutory text is unambiguous, then the Court need not look to an agency’s interpretation of the statute, nor look to the statute’s legislative history. *See Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 844 (1984); *Horras v. Leavitt*, 495 F.3d 894, 900 (8th Cir.2007); *Degnan v. Sebelius*, 658 F.Supp.2d 969, 970–71 (D.Minn.2009). However, “[i]f the language of the statute is ambiguous or silent, the issue for the court is whether the agency’s interpretation of the statute is a reasonable one.” *See Degnan*, 658 F.Supp.2d at 970–71 (citing *Smiley v. Citibank, N.A.*, 517 U.S. 735, 744–45 (1996)).

*10 Section 1557 references and incorporates four different civil rights statutes: Title VI, which prohibits discrimination on the basis of race, color, and national origin; Title IX, which prohibits discrimination on the basis of sex; the Age Discrimination Act, which prohibits discrimination on the basis of age; and section 504 of the Rehabilitation Act, which prohibits discrimination on the basis of disability. *See 42 U.S.C. § 18116*. The parties appear to disagree about the extent to which, or the manner in which, these four civil rights statutes are incorporated into Section 1557. The Court reads Section 1557 as referencing these four statutes to list “the ground[s]” on which discrimination is prohibited in a health care setting. *See id.* (stating that “an individual shall not, on the ground prohibited under [the four civil rights statutes] be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity”).

Although the four civil rights statutes provide the separate and distinct grounds or bases on which discrimination is prohibited, the Court finds that the language of Section 1557 is ambiguous, insofar as each of the four statutes utilize different standards for determining liability, causation, and a plaintiff’s burden of proof. *See 42 U.S.C. § 18116*. Therefore, the Court looks to agency interpretation for some guidance.

The Department for Health and Human Services (“HHS”) is responsible for promulgating regulations pursuant to Section 1557 and the OCR, a sub-agency of HHS, is responsible for enforcing compliance with Section 1557. Here, all parties agree that HHS and/or the OCR have yet to promulgate any rules or regulations interpreting Section 1557. (*See* Pl.’s Mem. at 9 [Doc. No. 25]; Def. Fairview’s Reply at 3 [Doc. No. 28].)

Although the OCR has yet to promulgate formal regulations interpreting Section 1557, Plaintiff emphasizes that in an opinion letter, Leon Rodriguez, the Director of the OCR, stated that Section 1557 of the ACA “extends to claims of discrimination based on gender identity or failure to conform to stereotypical notions of masculinity or femininity” and prohibits “discrimination regardless of the actual or perceived sexual orientation or gender identity of the individuals involved.” (*See* Barrett Wiik Decl., Ex. C [Doc. No. 26–1].) In *In re Union Pac. R.R. Employment Practices Litig.*, the Eighth Circuit held that “[a]n agency’s interpretation that is found in an opinion letter ... ‘lack[s] the force of law’ and is not entitled to deference under *Chevron*, 467 U.S. 837 (1984).” *See* 479 F.3d 936, 943 (8th Cir.2007). Thus, Defendant Fairview correctly states that Rodriguez’s opinion letter is not controlling on the Court. (*See* Def. Fairview’s Reply at 3 [Doc. No. 28].)

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Nonetheless, the Court may still determine that the OCR's interpretation is persuasive under *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944). The weight that the Court places on the OCR's interpretation in its opinion letter is based on “the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade.” *Skidmore*, 323 U.S. at 140. Here, the Court finds the OCR's interpretation of Section 1557 persuasively concludes that Section 1557 protects plaintiffs, like Rumble, who allege discrimination based on “gender identity.” (See Barrett Wiik Decl., Ex. C [Doc. No. 26–1].)⁵

*11 While the OCR expresses an opinion about whether Section 1557 prohibits discrimination based on gender identity, the agency currently provides no guidance about the evidentiary or causation standards to apply to Section 1557 cases. Defendants contend that different statutory standards should apply depending upon the Section 1557 plaintiff's class status. For instance, Defendants argue that Title IX standards should apply to Plaintiff because his claim is based on discrimination because of sex. (See Def. Emergency Physicians' Mem. at 7–9 [Doc. No. 13]; Def. Fairview's Mem. at 9–13 [Doc. No. 20].) Plaintiff disagrees, and claims that the courts should apply a singular, uniform standard, regardless of the plaintiff's protected class status. (See Pl.'s Mem. at 22–27 [Doc. No. 25].)

Although the Court interprets Section 1557 in order to include “every word and clause” in its interpretation, the Court “must not be guided by a single sentence or member of a sentence, but look to the provision of the whole law, and to its object and policy.” *Hennepin Cnty. Med. Ctr. v. Shalala*, 81 F.3d 743, 748 (8th Cir.1996) (quoting *U.S. National Bank of Oregon v. Independent Insurance Agents*, 508 U.S. 439, 455 (1993)). Here, looking at Section 1557 and the Affordable Care Act as a whole, it appears that Congress intended to create a new, health-specific, anti-discrimination cause of action⁶ that is subject to a singular standard, regardless of a plaintiff's protected class status.

Reading Section 1557 otherwise would lead to an illogical result, as different enforcement mechanisms and standards would apply to a Section 1557 plaintiff depending on whether the plaintiff's claim is based on her race, sex, age, or disability. For instance, a plaintiff bringing a Section 1557 race discrimination claim could allege only disparate treatment, but plaintiffs bringing Section 1557 age, disability, or sex discrimination claims could allege disparate treatment or disparate impact. See *Alexander v. Sandoval*, 532 U.S. 275, 293 (2001) (holding that no private right of action exists to enforce disparate impact regulations under Title VI); *Alexander v. Choate*, 469 U.S. 287, 299 (1985) (“assum[ing] without deciding that § 504 [of the Rehabilitation Act] reaches at least some conduct that has an unjustifiable disparate impact upon the handicapped”); see also *Sharif v. N.Y. State Educ. Dep't*, 709 F.Supp. 345, 361 (S.D.N.Y.1989) (holding that Title IX permits disparate impact suits).

Similarly, a plaintiff bringing a Section 1557 age discrimination claim would have to exhaust administrative remedies and would be barred from recovering damages, but plaintiffs bringing Section 1557 race, disability, or sex discrimination claims would not have to exhaust administrative remedies and would not be barred from recovering damages. Compare 42 U.S.C. § 2000d–1(1), 20 U.S.C. § 1682 (2006), and 29 U.S.C. § 794 (2006), with 42 U.S.C. § 6104(f); see *Gebser v. Lago Vista Indep. Sch. Dist.*, 524 U.S. 274, 285–90 (1998) (requiring actual knowledge of discrimination for monetary damages in a Title IX case); *Franklin v. Gwinnett Cnty. Pub. Sch.*, 503 U.S. 60, 71–72 (1992) (holding that compensatory damages are available in a Title IX action alleging intentional discrimination); *Guardians Ass'n v. Civil Serv. Comm'n of City of New York*, 463 U.S. 582, 595–96 (1983) (holding that compensatory relief in a Title VI action is only available upon a showing of intentional discrimination).

*12 Plaintiff recognizes the absurd inconsistency that could result if the Court interpreted Section 1557 as Defendants do. (See Pl.'s Mem. at 22–27 [Doc. No. 25].) Rumble also aptly notes that if different standards were applied based on the protected class status of the Section 1557 plaintiff, then courts would have no guidance about what standard to apply for a Section 1557 plaintiff bringing an intersectional discrimination claim.⁷ (See *id.* at 23.)

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However, the Court does not intend to imply that Congress meant to create a new anti-discrimination framework that is completely “unbound by the jurisprudence of the four referenced statutes.” (Cf. Def. Fairview's Reply at 4 [Doc. No. 28].) Nonetheless, given the inconsistency that would result if the Court interpreted Section 1557 as Defendants do, the Court holds that Congress likely referenced the four civil rights statutes mainly in order to identify the “ground[s]” on which discrimination is prohibited—i.e., race, sex, age, and disability. Congress also likely intended that the same standard and burden of proof to apply to a Section 1557 plaintiff, regardless of the plaintiff's protected class status. To hold otherwise would lead to “patently absurd consequences,” *United States v. Brown*, 333 U.S. 18, 27 (1948), that “Congress could not possibly have intended,” *F.B.I. v. Abramson*, 456 U.S. 615, 640 (1982) (O'Connor, J., dissenting). But, as the Court discusses in more detail below, at this stage of the proceedings, it need not determine the precise standard to apply to Plaintiff's Section 1557 claim.

a. Covered Health Program or Activity

Defendant Emergency Physicians claims that Rumble “never alleges facts to show he sought medical care from [Emergency Physicians] pursuant to a[f]ederally funded or administered ‘health program or activity.’” (See Def. Emergency Physicians' Mem. at 8 [Doc. No. 13].) Defendant misstates the relevant legal standard for determining which entities are covered by Section 1557. According to the ACA, entities that are subject to the anti-discrimination provisions in Section 1557 include “any health program or activity, *any part* of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance,” or “any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments).” See 42 U.S.C. § 18116 (emphasis added). Thus, as long as part of an organization or entity receives federal funding or subsidies of some sort, the entire organization is subject to the anti-discrimination requirements of Section 1557. A potential plaintiff need not seek medical care specifically from the part of the organization that receives federal funding. (Cf. Def. Emergency Physicians' Mem. at 8 [Doc. No. 13]); see Civil Rights Restoration Act, Pub.L. No. 100–259, § 382, 102 Stat. 28, 28–29 (1988) (overturning the United States Supreme Court's decision in *Grove City Coll. v. Bell*, 465 U.S. 555, 556 (1984), to clarify that the civil rights laws reached an institution, as a whole, even if only part of the institution received federal funding). Rather, the organization is only required to have a health program or activity that receives federal financial assistance.

*13 Here, Plaintiff alleges that Emergency Physicians is a “Minnesota-based healthcare organization [that] receiv[es] federal and state financial assistance such as credits, subsidies, or contracts of insurance.” (Compl. ¶ 10 [Doc. No. 1].) In his brief, Plaintiff argues that because Emergency Physicians allegedly receives Medicare and Medicaid funds, it is “a covered entity” for purposes of Title VI and the Rehabilitation Act, which are referenced by Section 1557. (Pl.'s Mem. at 18 [Doc. No. 25].) “The parties have not cited, and the Court has not found, any cases from the Eighth Circuit dealing with the issue of whether Medicare/Medicaid payments to a hospital are sufficient to create Title VI liability.” *Bissada v. Arkansas Children's Hosp., No. 4:08CV00362 (JLH)*, 2009 WL 1010869, at *11 (E.D.Ark. Apr. 14, 2009) *aff'd*, 639 F.3d 825 (8th Cir.2011); see also *Bowen v. Am. Hosp. Ass'n*, 476 U.S. 610, 624 n.9 (1986) (declining “to review the [Second Circuit] Court of Appeals' assumption that the provision of health care to infants in hospitals receiving Medicare or Medicaid payments is a part of a ‘program or activity receiving Federal financial assistance.’ ”).

Nonetheless, courts outside the Eighth Circuit have resoundingly held that Medicare and Medicaid payments constitute federal financial assistance for, at least, the purposes of section 504 and Title VI.⁸ See, e.g., *United States v. Baylor Univ. Med. Ctr.*, 736 F.2d 1039, 1042 (5th Cir.1984) (holding that “Medicare and Medicaid are federal financial assistance for the purpose of Section 504 [of the Rehabilitation Act], and that the district court did not err in defining inpatient and emergency room services as the ‘program or activity’ that would be the appropriate target of HHS's investigation as the result of the alleged violation of Section 504.”); *NAACP v. Medical Center, Inc.*, 599 F.2d 1247, 1248 n.4 (3d Cir.1979), *aff'd in relevant part*, 453 F.Supp. 280, *later proceeding*, 453 F.Supp. 330 (D.Del.1978), (affirming district court's determination that hospital's receipt of Medicare, Medicaid, and unspecified “other” assistance triggered Section 504 and Title VI); *United States v. University Hosp. of State Univ. of N.Y. at Stony Brook*, 575 F.Supp. 607, 612–13 (E.D.N.Y.1983), *aff'd on other grounds*, 729 F.2d 144, 151 (2d Cir.1984) (holding that legislative history reveals Medicare and Medicaid are “federal financial assistance” for purposes of § 504); *United*

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States v. Cabrini Medical Center, 639 F.2d 908, 910 (2d Cir.1981) (holding that, under the Rehabilitation Act, Medicare and Medicaid payments constitute “federal financial assistance” if the payments are used for employment purposes); *Bob Jones University v. Johnson*, 396 F.Supp. 597, 603 n.21 (D.S.C.1974), aff’d without opinion, 529 F.2d 514 (4th Cir.1975) (holding that Medicare and Medicaid constitute federal financial assistance for Title VI purposes). Because Section 1557 relies on and incorporates section 504 and Title VI, the Court finds that Medicare and Medicaid payments received by Emergency Physicians constitute federal financial assistance for the purpose of Section 1557 as well.

*14 In order for the Medicare and Medicaid funds to qualify as “federal financial assistance” relevant for section 504 and Title VI, a civil rights plaintiff is regularly required to demonstrate that the Medicare and Medicaid funds were used for a particular purpose. Specifically, “[a] number of cases have held ... that a Title VI plaintiff must show that the received funds were used for employment.” *Bissada*, 2009 WL 1010869, at *11; see *Valentine v. Smith*, 654 F.2d 503, 512 (8th Cir.1981) (dismissing the plaintiff’s Title VI claim because she failed to show that the university defendant used its federal assistance for the purpose of providing faculty employment); see also *Mass v. Martin Marietta Corp.*, 805 F.Supp. 1530, 1542 (D.Colo.1992) (explaining that a Title VI plaintiff must also demonstrate that the federal government received no goods or services in return for the Medicare or Medicaid payments). Similarly, a section 504 plaintiff must also demonstrate that “a primary objective for the federal funds” must be “to provide for the employment” of staff. See *Simon v. St. Louis Cnty., Mo.*, 656 F.2d 316, 319 (8th Cir.1981) (holding that because the record demonstrated that “a primary objective for the federal funds going to the St. Louis County Police Department is to provide for the employment of commissioned police officers,” the “district court properly concluded that Simon had standing to bring a suit under section 504.”).

However, a civil rights plaintiff is not required to substantively prove how the funds were used until summary judgment or trial. See *Muller v. Hotsy Corp.*, 917 F.Supp. 1389, 1418 (N.D.Iowa 1996) (granting summary judgment for the defendant on the plaintiff’s section 504 claim because the plaintiff failed to show that the government’s intention was to subsidize the defendant, as opposed to compensate the defendant for its goods and services); *Bissada*, 2009 WL 1010869, at *12 (granting summary judgment for the defendant on the plaintiff’s Title VI claim because the plaintiff failed to show that the federal assistance received by the defendant was used directly to provide employment for its physicians); *Simon*, 656 F.2d at 319 (affirming the district court’s ruling that the section 504 plaintiff met his burden of proof during trial that the federal funds were used for employment purposes). Rather, Rumble must only allege facts that “raise a reasonable expectation that discovery will reveal evidence” that substantiates his claim that Emergency Physicians received federal funds, which were used for employment purposes. See *Twombly*, 550 U.S. at 556.

In sum, Plaintiff is not required to demonstrate that he sought medical care from Emergency Physicians through one of Defendant’s federally funded or administered health programs or activities. Because Plaintiff alleges that Emergency Physicians receives federal funds and is subject to Section 1557, the Court plausibly assumes that the federal funds were used for employment purposes. As explained above, Rumble could only substantiate his claim further with the benefit of discovery. Accordingly, the Court finds that Defendant Emergency Physicians is subject to the anti-discrimination provisions in Section 1557.⁹

b. Adverse Action or Differential Treatment on the Basis of Sex

*15 In addition to arguing that Plaintiff failed to show that he sought medical care from a federally funded health program, Defendant Emergency Physicians argues that Plaintiff’s Count I should be dismissed because he failed to show that Emergency Physicians took an adverse action against him or treated him differently because of his transgender status. (See Def. Emergency Physicians’ Mem. at 8–9 [Doc. No. 13].) Specifically, Defendant argues that Rumble must establish that Emergency Physicians, through its employee, Dr. Steinman, had “discriminatory intent.” (See *id.* at 10.) Defendant’s basis for their argument is an Eighth Circuit case interpreting the intent standard required for a Title IX sex discrimination claim. (See *id.* at 9.)

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In contrast, Plaintiff argues that the Court need not determine whether the Title IX standard should apply to Plaintiff's Section 1557 claim. (*See* Pl.'s Mem. at 34 [Doc. No. 25].) Alternatively, Plaintiff argues that even if the Court were to apply the Title IX standard, Rumble's Complaint meets the intent standard. (*See id.*) The Court agrees with Plaintiff that it need not decide whether the Title IX standard applies to Rumble's Section 1557 claim at this stage in the litigation. Rather, the Court holds that even if the Title IX standard applies, Plaintiff alleges a plausible Section 1557 claim.

i. Adverse Action or Differential Treatment

Defendant Emergency Physicians contends that Rumble failed to plead that Dr. Steinman's actions amount to an “adverse action” or “differential treatment” that is prohibited by Section 1557. (*See* Def. Emergency Physicians' Mem. at 9 [Doc. No. 13].) The Court disagrees. According to Section 1557, a covered entity, such as Emergency Physicians, may not exclude an individual from being a patient in the hospital, deny the individual the benefits of being a patient, or subject the individual to discrimination, on the basis of sex. *See* 42 U.S.C. § 18116. Therefore, in order for Dr. Steinman's action to rise to an actionable level, he must have either excluded Rumble from receiving medical care at the hospital, denied Rumble the benefits of medical care at the hospital, or otherwise discriminated against him. *See id.* The Court finds that Plaintiff alleges facts sufficiently demonstrating that Dr. Steinman discriminated against Rumble, and denied Rumble the benefits of medical care that he was entitled to as a patient in the emergency room at Fairview Southdale Hospital.

Dr. Steinman allegedly treated Rumble with hostility and aggression while asking him pointed questions that were allegedly meant to embarrass Rumble. (*See* Compl. ¶¶ 39–40 [Doc. No. 1] .) These questions included asking Plaintiff whether he was having sex with men or women, engaging in penetration, and whether he had ever had sex with objects. (*See id.*) Dr. Steinman also allegedly made disparaging comments about Rumble's use of hormones, and Dr. Steinman aggressively communicated that he was unsure whether Rumble's genital inflammation was caused by the hormones. (*Id.* ¶ 44.) Therefore, although Dr. Steinman did not expressly “mock[] or criticize[]” Rumble's transgender status (*cf.* Def. Emergency Physicians' Mem. at 11 [Doc. No. 13]; Def. Emergency Physicians' Reply at 3 [Doc. No. 29]), Plaintiff plausibly alleges that Dr. Steinman's comments were made as indirect, offensive references about Plaintiff's gender identity.

*16 Plaintiff also alleges facts that demonstrate Dr. Steinman conducted an “assaultive exam.” (*See* Pl.'s Mem. at 32 [Doc. No. 25].) Specifically, Rumble alleges that although he was crying and demanded Dr. Steinman to stop the painful exam, *twice*, Dr. Steinman continued to forcefully jab at Rumble's genitals causing Rumble to continue to cry and scream in pain. (*See* Compl. ¶¶ 43–45 [Doc. No. 1].) In fact, it was not until Rumble's mother demanded and yelled for Dr. Steinman to stop jabbing at her son's genitals that Dr. Steinman's allegedly assaultive exam ended. (*Id.* ¶ 46.) At the conclusion of the physical exam, Dr. Steinman then allegedly left the room without explaining to Rumble and his mother what the next steps entailed, such as whether or not Rumble would be admitted to the hospital. (*Id.* ¶ 47.) Plaintiff's allegations about the exam are not “subjective impressions of Dr. Steinman's manner.” (*Cf.* Def. Emergency Physicians' Mem. at 11 n.2 [Doc. No. 13].) Rather, these allegations describe an objective series of events, in which Dr. Steinman ignored Plaintiff's pleas for Dr. Steinman to stop the exam.

Read as a whole, these facts demonstrate that the alleged mistreatment rises to the level of the denial of benefits of appropriate medical care. (*See* Pl.'s Mem. at 24 [Doc. No. 25].) “Whether gender-oriented conduct rises to the level of actionable ‘harassment’ ... ‘depends on a constellation of surrounding circumstances, expectations, and relationships.’” *Davis Next Friend LaShonda D. v. Monroe Cnty. Bd. of Educ.*, 526 U.S. 629, 651 (1999) (citing *Oncale v. Sundowner Offshore Services, Inc.*, 523 U.S. 75, 82 (1998)). Generally, the two parties in a doctor-patient relationship are not on equal footing, as a doctor normally has significantly more experience and expertise in his position of authority. The specific circumstances surrounding Rumble's interaction with Dr. Steinman also supports the Court's finding. When any individual permits a doctor to conduct a genital exam, the patient is in a physically vulnerable position, which the doctor controls. Here, Rumble had a reasonable expectation that his treating doctor at the emergency room would not physically “assault” him, or at the very least would stop an intrusive and painful genital exam when asked to stop.

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Defendant Emergency Physicians contends that because Rumble was eventually admitted to the hospital and received subsequent medical care, then Dr. Steinman must not have denied Rumble the benefits of medical care. (*See* Def. Emergency Physicians' Reply at 3 [Doc. No. 29].) The Court disagrees. Section 1557 does not require the plaintiff to demonstrate that he received no medical care or attention. (*Cf. id.*) Rather, the statute simply requires that the plaintiff demonstrate that he was denied the benefits of a health program or activity, or discriminated against. Here, Plaintiff meets this burden.

*17 Defendant erroneously argues that in order for Plaintiff's claim to survive dismissal, the Court must "invent facts not alleged by Plaintiff." (*Cf. id.* at 4–5.) In support of this proposition Defendant cites this Court's order in *Pittman v. Jesson*, No. 12–cv–1410 (SRN/TNL), 2014 WL 4954286, at *11 (D.Minn. Sept. 30, 2014). In *Pittman*, this Court held that the patient-plaintiff's race discrimination claim failed against one of the defendants because the plaintiff did not allege that this defendant treated white and black patients differently. *See id.* In fact, the plaintiff did not allege that this defendant treated him adversely in any way, or treated other black patients unfavorably. *See id.* In contrast, here, Rumble sufficiently alleges detailed examples of Dr. Steinman's discriminatory or unfavorable conduct as evidenced by his allegedly rude remarks, and failure to heed Plaintiff's requests to stop the painful exam. *Cf. Folger v. City of Minneapolis*, F.Supp.3d, No. 13–cv–3489 (SRN/JJK), 2014 WL 4187504, at *6, 10 (D.Minn. Aug. 22, 2014) (dismissing the plaintiffs' Fair Housing Act and Equal Protection Clause discrimination claims because the plaintiffs failed to allege "any factual basis" for the defendant's alleged "animus").

Moreover, the Court notes that Plaintiff need not allege facts demonstrating that Dr. Steinman "treated other patients who presented with similar symptoms and medical conditions differently." (*Cf.* Def. Emergency Physicians' Mem. at 11 [Doc. No. 13].) At this stage in the proceeding, without the benefit of discovery, Plaintiff does not have knowledge of how Dr. Steinman treated other patients in the emergency room with similar conditions. Thus, it would be unreasonable for the Court to require Plaintiff to plead comparative evidence in his Complaint. Accordingly, Plaintiff sufficiently alleges that Emergency Physicians, through Dr. Steinman, took an "adverse action" against him.

ii. Dr. Steinman Discriminated On the Basis of Sex

Defendant Emergency Physicians also argues that Rumble failed to allege facts showing that Dr. Steinman discriminated against Rumble *on the basis of* Rumble's sex. (*See* Def. Emergency Physicians' Mem. at 10 [Doc. No. 13].) Defendant relies on the Eighth Circuit's holding in *Wolfe v. Fayetteville, Arkansas Sch. Dist.*, 648 F.3d 860, 865 (8th Cir.2011) to support its contention that Plaintiff must prove that Dr. Steinman intended to discriminate against Rumble. (*See* Def. Emergency Physicians' Mem. at 9 [Doc. No. 13].) Likely, Defendant relies on *Wolfe* because Plaintiff alleges discrimination on the basis of sex, and *Wolfe* involves the Eighth Circuit's analysis of Title IX, a civil rights statute that prohibits discrimination on the basis of sex. *See* 20 U.S.C. § 1681(a).

According to *Wolfe*, a Title IX plaintiff is "legally required to show" that the defendant "intended to discriminate against him 'on the basis of sex,' meaning the harassment was motivated by either [the plaintiff's] gender or failure to conform with gender stereotypes." *See* 648 F.3d at 867.

*18 Even if Plaintiff was required to prove that Dr. Steinman intended to harass Rumble because of Rumble's transgender status, or Rumble's failure to conform with gender stereotypes, Plaintiff plausibly alleges facts demonstrating Dr. Steinman's requisite intent. As one district court explained, "[a] record of disparate treatment and unprofessional behavior directed at a plaintiff may constitute evidence of discriminatory intent." *See Pierce v. President and Fellows of Harvard College*, 994 F.Supp.2d 157, 163 (D.Mass.2014) (denying summary judgment because a jury could infer discriminatory intent from the defendants' unprofessional behavior and the defendants' inconsistent explanations for the treatment plaintiff received). Here, the alleged manner in which Dr. Steinman treated Plaintiff, at a minimum, constitutes "unprofessional behavior," from which a factfinder could infer discriminatory intent.

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The Court finds that (1) the alleged questions that Dr. Steinman asked and the comments he made about Rumble's hormone use, (2) Dr. Steinman's alleged tone during questioning, (3) the alleged “assaultive behavior” Dr. Steinman subjected Rumble to during the physical exam, and (4) the medical bill Rumble received after his hospital visit, sufficiently “nudge[]” Rumble's Section 1557 claim “across the line from conceivable to plausible,” and plausibly demonstrate Dr. Steinman's discriminatory intent. *See Twombly*, 550 U.S. at 547.

As the Court noted above, Plaintiff alleges that Emergency Physicians sent Rumble a medical bill after his visit to the hospital that stated, “THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER.” (*Id.* ¶ 63.) Plaintiff argues that this “insulting bill” further demonstrates how Dr. Steinman's alleged maltreatment of Rumble was based on Rumble's gender. (*See* Pl.'s Mem. at 12 [Doc. No. 25].) Emergency Physicians contends that this bill was likely sent to Plaintiff as a result of confusion on the part of Rumble's insurer. (*See* Def. Emergency Physicians' Mem. at 12 [Doc. No. 13].) Defendant additionally notes that “[a]ny temporary confusion reflected in Plaintiff's allegation about [Emergency Physicians'] bill is not a material adverse action upon which Plaintiff can base a valid claim of sex discrimination.” (*See id.*) The Court agrees, but the Court does not read Plaintiff's Complaint as alleging that the bill forms a separate and distinct factual basis for Rumble's discrimination claim. Rather, the Court reads Rumble's Complaint as alleging that the bill merely bolsters Plaintiff's claim that he was treated adversely because of his gender identity.¹⁰

Reading the facts alleged in the Complaint as a whole, the Court holds that it is plausible that Dr. Steinman mistreated Plaintiff *because* of Rumble's gender identity, and the mistreatment was not “random[] poor treatment that anyone might have received.” (*See* Pl.'s Mem. at 44 [Doc. No. 25].)

However, the Court notes that it need not determine whether the *Wolfe* intent standard applies to Plaintiff's Section 1557 claim at this stage in the litigation. As the Court explained in more detail above, Section 1557 references Title VI, Title IX, the Age Discrimination Act, and section 504 of the Rehabilitation Act when listing the grounds for which discrimination is prohibited (e.g., race, color, national origin, sex, age, and disability). *See* 42 U.S.C. § 18116. Therefore, Defendant Emergency Physicians' insistence that *Wolfe's* Title IX standard applies because Plaintiff's claim is “on the basis of sex” is not necessarily correct. Likely, Congress intended for the same discriminatory intent standard, and overall burden of proof, to apply to a Section 1557 plaintiff's claim, regardless of the basis for the alleged discrimination.¹¹ Accordingly, the Court declines to rule on the intent standard required for a Section 1557 claim at this time, but holds that even if Plaintiff is required to show that Dr. Steinman, or Defendant Emergency Physicians, intended to discriminate against Plaintiff because of his transgender status, then Plaintiff has sufficiently alleged plausible facts satisfying this standard.

2. Count II: MHRA Claim

*19 “The MHRA requires the plaintiff to show: (1) membership in a protected class; (2) denial of services or accommodations; and (3) that the denial occurred because of the plaintiff's membership in the protected class.” *Childs v. Extended Stay of Am. Hotels*, No. 10–cv–3781 (SRN/JJK), 2012 WL 2126845, at *5 (D. Minn. June 12, 2012) (citing *Monson v. Rochester Athletic Club v. Rochester Athletic Club*, 759 N.W.2d 60, 63 (Minn.Ct.App.2009)); *see* Minn.Stat. § 363A.11, subd. 1(a)(1). Emergency Physicians argues that Rumble failed to show the second and third elements required to state an actionable MHRA claim.

Specifically, Emergency Physicians contends that the Court should dismiss Plaintiff's Count II because (a) Plaintiff “does not assert facts to demonstrate that [Emergency Physicians] denied Plaintiff any service, facility, privilege, advantage, or accommodation of any public accommodation,” and (b) Plaintiff does “not asserts facts to show that [Emergency Physicians] discriminated against Plaintiff because of Plaintiff's sexual orientation and gender identity.” (*See* Def. Emergency Physicians' Mem. at 13–14 [Doc. No. 13].) The Court addresses both of these arguments below.

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a. Denied Service or Accommodation

Defendant asserts that Plaintiff failed to allege that he was denied access to any place of public accommodation. (*See* Def. Emergency Physicians' Mem. at 14 [Doc. No. 13].) Emergency Physicians notes that because Dr. Steinman evaluated Plaintiff in the emergency room, Plaintiff was ultimately admitted to the hospital, and Plaintiff remained hospitalized for seven days, it is clear that Rumble was not "prevented from receiving medical care or otherwise from accessing a public hospital or other facility." (*See id.*) The Court disagrees.

The MHRA prohibits the "full and equal enjoyment" of a public accommodation. *See* Minn.Stat. § 363A.11, subd. 1(a)(1). According to the Minnesota Supreme Court, an actionable MHRA claim must include "some tangible change in ... conditions," or some "material ... disadvantage." *See Bahr v. Capella Univ.*, 788 N.W.2d 76, 83 (Minn.2010) (citing *Burchett v. Target Corp.*, 340 F.3d 510, 518 (8th Cir.2003); *Brannum v. Mo. Dep't of Corr.*, 518 F.3d 542, 549 (8th Cir.2008); and *Jones v. Fitzgerald*, 285 F.3d 705, 714 (8th Cir.2002)).

Reading the facts that Rumble alleges as true, Plaintiff was denied the "full and equal enjoyment of humane and dignified care that other patients would have received." (*See* Pl.'s Mem. at 38 [Doc. No. 25].) Dr. Steinman allegedly treated Plaintiff inhumanely, not only by allegedly asking Rumble hostile questions meant to embarrass Plaintiff, but also by allegedly continuing with a painful physical examination of Plaintiff's genitals, even after Plaintiff twice cried out for Dr. Steinman to stop the examination. (*See* Compl. ¶¶ 39–47 [Doc. No. 1].) If true, this type of "assaultive exam" demonstrates that Plaintiff likely experienced a material disadvantage compared to others who were seen by emergency room doctors at Fairview.¹² Therefore, Plaintiff plausibly states a claim that, pursuant to the MHRA, he was denied the full and equal enjoyment of an individual seeking professional and humane medical care from an emergency room physician.

b. Dr. Steinman Discriminated Because of Rumble's Gender Identity/Sexual Orientation

*20 Defendant Emergency Physicians also contends that Rumble failed to allege that Dr. Steinman's denied him full and equal benefits of emergency room care *because of* Rumble's sexual orientation and gender identity. (*See* Def. Emergency Physicians' Mem. at 14 [Doc. No. 13].) Again, the Court disagrees.

As noted above, the MHRA prohibits discrimination "because of ... sexual orientation." *See* Minn.Stat. § 363A.11, subd. 1(a)(1). Minnesota law further defines "sexual orientation" as "having or being perceived as having a self-image or identity not traditionally associated with one's biological maleness or femaleness." *See* Minn.Stat. § 363A.03, subd. 44. Thus, solely for the purposes of Plaintiff's MHRA claim, Rumble alleges that he was discriminated against by Dr. Steinman because of Rumble's "sexual orientation."

As with Plaintiff's Section 1557 claim against Emergency Physicians, the facts alleged in Plaintiff's Complaint plausibly demonstrate that Dr. Steinman discriminated against Plaintiff because of his gender identity or transgender status. Dr. Steinman's comments and hostile questioning about Plaintiff's sexual activities, coupled with his disregard for Rumble's repeated request for Dr. Steinman to stop the painful physical examination demonstrate that the alleged mistreatment Plaintiff endured was because of Rumble's gender identity. (*See* Pl.'s Mem. at 44 [Doc. No. 25].)

As noted earlier, Rumble need not allege in his Complaint that Dr. Steinman "treated other patients with similar clinical presentations more favorably because of their sexual orientation and gender identity." (*Cf.* Def. Emergency Physicians' Mem. at 14–15 [Doc. No. 13].) Rather, Plaintiff need only allege facts that make it plausible that he was treated differently because of his gender identity. Rumble correctly states in his brief that "comparator evidence is only one of several ways that a plaintiff may prove a claim of discrimination at trial." (*See* Pl.'s Mem. at 45 [Doc. No. 25].) For instance, Plaintiff may attempt to prove sexual

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orientation discrimination through “direct evidence in the form of actions or remarks by [Defendant] that reflect discriminatory intent .” See *Rodgers v. U.S. Bank, N.A.*, 417 F.3d 845, 859 n.9 (8th Cir.2005) (Colloton, J., concurring) *abrogated on other grounds by Torgerson v. City of Rochester*, 643 F.3d 1031 (8th Cir.2011). Accordingly, Rumble sufficiently alleges “enough fact[s] to raise a reasonable expectation that discovery will reveal evidence of [his MHRA claim].” *Twombly*, 550 U.S. at 556.

Emergency Physicians contends that Plaintiff impermissibly “relies on reports and surveys about general adverse treatment of the transgender population” to substantiate his discrimination claim against Dr. Steinman. (See Def. Emergency Physicians' Reply at 8 [Doc. No. 29].) The Court disagrees. Plaintiff does in fact cite to two reports in his Complaint that document discrimination that transgender people experience in health care settings. (See Compl. ¶¶ 18–23 (citing Lambda Legal, *When Health Care Isn't Caring*, (2009), [http:// www.lambdalegal.org/sites/default/files/publications/downloads /whcic-report-when-health-care-isnt-caring.pdf](http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report-when-health-care-isnt-caring.pdf); and Jaime M. Grant et al., *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey* (2011), http://transequality.org/sites/default/files/docs/resources/NTDS_Report.pdf) [Doc. No. 1].) While the Court does not read the reference to these reports as the substantive basis or proof of Dr. Steinman's alleged discrimination in this case, these public documents do bolster the plausibility of Plaintiff's claims.

C. Defendant Fairview's Motion to Dismiss

*21 Defendant Fairview also filed a Motion to Dismiss Plaintiff's two counts. (See Def. Fairview's Mot. to Dismiss [Doc. No. 11].) Plaintiff alleges that “Defendant Fairview is vicariously and/or contractually liable for the actions of its principals, agents, employees, shareholders and/or partners.” (Compl. ¶ 8 [Doc. No. 1].) Fairview claims that: (1) Fairview cannot be held vicariously liable under either federal or state law for the alleged acts of Dr. Steinman; and (2) Rumble failed to state a viable discrimination claim because he did not allege that any material adverse actions were taken against him. (See Def. Fairview's Mem. at 1 [Doc. No. 20].) The Court addresses both of these issues below.

1. Liability for Dr. Steinman's Actions

Defendant Fairview claims that “only the facts alleged against *Fairview* are relevant to the instant [m]otion because Fairview is not vicariously liable for the acts Rumble alleges were done by Emergency Physicians [via Dr. Steinman].” (See Def. Fairview's Mem. at 7 (emphasis original) [Doc. No. 20].) Fairview suggests that the Court should not consider Dr. Steinman's actions when determining the plausibility of either Plaintiff's Section 1557 claim or his MHRA claim. The Court holds that it need not determine the vicarious liability standard to apply to Plaintiff's Section 1557 claim because Plaintiff sufficiently alleges that Defendant Fairview is directly liable for Dr. Steinman's actions. The Court additionally finds that, under the MHRA, Fairview may likely be held indirectly liable for Dr. Steinman's actions. (See Compl. ¶ 8 [Doc. No. 1].)

a. Liability Pursuant to Section 1557 Claim

As it applies to Plaintiff's Section 1557 claim, Fairview contends that it is not vicariously liable for Dr. Steinman's acts because Title IX “does not recognize the concept of vicarious liability,” Plaintiff's Section 1557 sex discrimination claim is based on Title IX principles, and therefore, Plaintiff's Section 1557 claim also cannot rely on the concept of vicarious liability. (See *id.*) In opposition, Plaintiff argues that Defendant misstates the relevant Title IX standard, and “even if the Court assumes, as Fairview does, that the Title IX standard controls,” then Plaintiff satisfies this standard. (See Pl.'s Mem. at 21–22 [Doc. No. 25].) The Court agrees that Fairview does not cite the relevant Title IX standard that may potentially apply to this case. Moreover, the Court holds that it need not determine the appropriate vicarious liability standard to apply to Plaintiff's Section 1557 claim because Plaintiff sufficiently alleges that Defendant Fairview is directly liable for Dr. Steinman's actions.

The Supreme Court announced the standard for determining a school district's direct liability for an employee's discriminatory acts under Title IX in *Gebser v. Lago Vista Independent School District*, 524 U.S. 274, 285–91 (1998). Fairview asserts that

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the *Gebser* Court held that “a plaintiff may not use Title IX to hold a [school] district liable for an employee's harassment of a student based on the principles of *respondeat superior* or vicarious liability.” (See Def. Fairview's Mem. at 8 [Doc. No. 20].) Fairview mischaracterizes and misapplies the relevant holding of *Gebser*. Rather, in *Gebser*, the Supreme Court held that a plaintiff *may* use Title IX to hold a district liable for an employee's harassment of a student based on principles of *direct* liability, if an “appropriate person,” or “an official who at a minimum has authority to address the alleged discrimination and to institute correctives measures on the recipient's behalf[,] has actual knowledge of discrimination in the recipient's programs[,] and fails adequately to respond.” *Gebser*, 524 U.S. at 290. The official's response must “amount to deliberate indifference to discrimination,” in order for direct liability to attach. See *id.*

*22 Here, Dr. Steinman is not an employee of Fairview. Rather, as Plaintiff alleges, Dr. Steinman is an employee of Emergency Physicians. (See Compl. ¶ 12 [Doc. No. 1].) Therefore, *Gebser's* direct liability standard for employees is not relevant to this case. Instead, even assuming that the Court should apply case law interpreting Title IX, the Court must analyze the relevant direct liability standard for a third party's actions, as opposed to the actions of an employee.

In *Davis*, the Supreme Court discussed the standard for determining a school district's direct liability for a third party's discriminatory actions. See 526 U.S. at 633. The *Davis* Court held that “a [Title IX] private damages action may lie against the school board in cases of student-on-student harassment ... only where the funding recipient acts with deliberate indifference to known acts of harassment in its programs or activities ... [and] only for harassment that is so severe, pervasive, and objectively offensive that it effectively bars the victim's access to an educational opportunity or benefit.” See *id.* The Court also held that a school district would only be liable for a third-party's actions when the school “exercises substantial control over both the harasser and the context in which the known harassment occurs.” *Id.* at 630.

The Court finds that even if the *Davis* Court's Title IX standard applies to this case, Defendant Fairview may be held liable for Dr. Steinman's actions if Plaintiff sufficiently alleges the following four elements: (1) Dr. Steinman's actions effectively barred Rumble's access to reasonable, non-harassing medical care; (2) an appropriate person at Fairview knew of Dr. Steinman's discriminatory acts; (3) that Fairview official acted with deliberate indifference to the discrimination; and (4) Fairview has substantial control over Dr. Steinman and the emergency room. See *id.* at 630, 633.

At this stage in the litigation, the Court finds that Plaintiff plausibly alleges the four elements outlined above. First, as discussed in more detail in Part III(B)(1)(b), Dr. Steinman's alleged treatment of Rumble was “objectively offensive,” particularly when Dr. Steinman refused to stop a painful genital exam, despite Plaintiff's repeated pleas. By allegedly ignoring Plaintiff's requests, Dr. Steinman effectively barred Plaintiff from an opportunity to have “humane and dignified [medical] care.” (See Pl.'s Mem. at 34 [Doc. No. 25].) A reasonable person, seeking treatment from an emergency room doctor at a hospital, would expect that the doctor would respect the patient's wishes to stop a painful exam.

Plaintiff also sufficiently alleges that an “appropriate person” knew of Dr. Steinman's behavior and actions. Specifically, Rumble alleges that Dr. Lehrman, an OB/GYN employed by Fairview, and a female nursing assistant/emergency room technician, also presumably employed by Fairview, were in the exam room, saw Dr. Steinman complete the exam, and did not intervene or stop Dr. Steinman from proceeding with the exam. (See Compl. ¶ 48 [Doc. No. 1].) The Eighth Circuit has noted that it cannot “pretend to fashion a bright-line rule as to what job titles and positions automatically mark an individual as having sufficient authority or control for the purposes of Title IX liability.” See *Plamp v. Mitchell Sch. Dist. No. 17–2*, 565 F.3d 450, 457 (8th Cir.2009) (citing *Murrell v. Sch. Dist. No. 1, Denver, Colo.*, 186 F.3d 1238, 1247 (10th Cir.1999) (explaining that “[b]ecause officials' roles vary among school districts, deciding who exercises substantial control for the purposes of Title IX liability is necessarily a fact-based inquiry.”)).

*23 Here, although Plaintiff does not detail whether either Dr. Lehrman or the female nursing assistant have “authority to address the alleged discrimination and to institute correctives measures,” *Gebser*, 524 U.S. at 290, the Court does not expect

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that Plaintiff would be able to do so without further discovery, *see Plamp*, 565 F.3d at 457. Therefore, for the purposes of Defendants' Motions to Dismiss, the Court finds that Plaintiff plausibly alleges that at least one “appropriate person” knew of Dr. Steinman's “assaultive” exam.

The Court also concludes that Plaintiff plausibly alleges that either Dr. Lehrman or the nursing assistant acted with deliberate indifference to Dr. Steinman's discriminatory behavior by not intervening or stopping Dr. Steinman from continuing with the genital exam. Finally, the Court finds that Rumble plausibly alleges that Fairview has substantial control over the Fairview emergency room and over Dr. Steinman, a doctor who works in Fairview's emergency room. (*See* Compl. ¶ 7 [Doc. No. 1].) Additional facts about the control Fairview exercises will only become evident after discovery.

Therefore, even assuming that the Title IX standard for direct liability for a third-party's actions applies to this case, Plaintiff satisfies his burden. Accordingly, the Court considers Dr. Steinman's alleged actions when evaluating the plausibility of Plaintiff's Section 1557 claim against Defendant Fairview. The Court emphasizes, however, that it is not entirely clear whether Plaintiff must satisfy the four elements outlined above. Because Section 1557 incorporates and references four civil rights statutes, only one of which is Title IX, the Court may conclude that Plaintiff is not required to satisfy the Title IX liability standard. Rather, Plaintiff may be subject to an entirely different burden of proof under the unique cause of action created by Section 1557.

b. Liability Pursuant to the MHRA

In addition to arguing that Fairview is not liable for Dr. Steinman's actions for Plaintiff's Section 1557 claim, Defendant also claims that Fairview is not vicariously liable for Dr. Steinman's actions for Plaintiff's MHRA claim. (*See* Def. Fairview's Mem. at 8 [Doc. No. 20].) Similar to the Court's finding with respect to Plaintiff's Section 1557 claim, the Court holds that Plaintiff plausibly alleges that Fairview is liable for Dr. Steinman's actions for the MHRA claim as well.

The Court's analysis is guided by Title VII case law because Title VII and the MHRA are often interpreted similarly. *See Torgerson v. City of Rochester*, 643 F.3d 1031, 1043 (8th Cir.2011) (finding that “the same analysis applies to both MHRA and Title VII claims”); *see also Kasper v. Federated Mut. Ins. Co.*, 425 F.3d 496, 502 (8th Cir.2005); *Bahr v. Capella Univ.*, 788 N.W.2d 76, 83 (Minn.2010).¹³ As this Court has done previously, it assumes, without deciding, “that standards for employer liability in federal hostile environment case law apply to [Rumble's] public-services [discrimination] claim under the MHRA.” *See Hudson*, 2006 WL 752935, at *11.

*24 Title VII and the MHRA first require a plaintiff to show that the defendant was the third party's de facto employer. A plaintiff may demonstrate this de facto employee-employer relationship either by liberally interpreting the term “employer,” *see Baker v. Stuart Broad. Co.*, 560 F.2d 389, 391 (8th Cir.1977) (citing *Sibley Memorial Hospital v. Wilson*, 488 F.2d 1338 (D.C.Cir.1973)), or by showing how the relationship between the defendant and the third party satisfies a twelve factor test as set out in *Schweiger v. Farm Bureau Ins. Co. of Neb.*, 207 F.3d 480, 484 (8th Cir.2000)¹⁴. *See also Stoner v. Ark. Dep't of Corr.*, 983 F.Supp.2d 1074, 1087–88 (E.D.Ark.2013) (finding that the defendant was the third party's de facto employer under Title VII, either under the twelve factor test or under a liberal construction of the term “employer,” because the facts showed that the defendant's policies applied to the third party, and the defendant controlled whether the third party was banned from the defendant's complex, which would “effectively terminat[e] [the third party's] employment”).

Similarly, Title VII and the MHRA also require a plaintiff to show that the defendant controlled the plaintiff's environment and could alter the conditions of the environment, knew or should have known of the discrimination, and failed to take prompt remedial action. *See Crist v. Focus Homes, Inc.*, 122 F.3d 1107, 1111–12 (8th Cir.1997) (holding that defendant residential program operator could be held liable for sexual harassment under the MHRA and Title VII for the acts of its employees because

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the defendant “clearly controlled” the plaintiff’s environment and “had the ability to alter those conditions to a substantial degree”).

Here, Plaintiff alleges that Fairview was Dr. Steinman’s “employer,” liberally construed, because Fairview exercised control over the physicians who work in the emergency room. (*See* Pl.’s Mem. at 23 [Doc. No. 25].) Rumble further alleges that Fairview could have stopped or prevented Dr. Steinman from discriminating against Plaintiff; Fairview knew of the discrimination because Dr. Lehrman and the nursing assistant witnessed it; and Fairview failed to take prompt remedial action. (*See* Compl. ¶¶ 48, 81 [Doc. No. 1].) Defendant contends, in contrast, that it had no opportunity to control or prevent Dr. Steinman’s actions. (*See* Def. Fairview’s Mem. at 9 [Doc. No. 20] .) As the Court noted above with respect to Plaintiff’s Section 1557 claim, the Court cannot conclude without discovery whether Fairview, in fact, had the opportunity to control Dr. Steinman. Nonetheless, at this stage in the litigation, the Court construes all reasonable inferences in the light most favorable to Plaintiff, *Morton v. Becker*, 793 F.2d 185, 187 (8th Cir.1986), and concludes that Fairview plausibly may have been able to control Dr. Steinman; and thus, may be held indirectly liable for Dr. Steinman’s actions. Accordingly, the Court considers Dr. Steinman’s alleged actions when evaluating the plausibility of Plaintiff’s MHRA claim against Defendant Fairview.

2. Plausibility of Section 1557 Claim

*25 Fairview contends that Rumble failed to state a claim under Section 1557. (*See* Def. Fairview’s Mem. at 9 [Doc. No. 20].) Specifically, Fairview argues that although the “alleged differential treatment must be *material* to be actionable,” here, Rumble failed to allege facts that constitute plausible, actionable discrimination. (*See* Def. Fairview’s Mem. at 12 (emphasis original) [Doc. No. 20].) Defendant claims that “Rumble’s allegations of snubs and delays are only the proverbial ‘perceived slights’ that the Eighth Circuit has held are *not* sufficient to give rise to a discrimination claim.” (*See id.* at 12–13 (emphasis original).)

Because Fairview contends that it is not liable for Dr. Steinman’s actions, Fairview does not discuss how Dr. Steinman’s treatment of Plaintiff affects the plausibility of Plaintiff’s Section 1557 claim. Thus, Fairview focuses solely on the alleged actions of hospital staff and asserts that the following treatment was not discriminatory: (1) Plaintiff received a hospital bracelet identifying his sex as “female;” (2) Rumble waited for several hours before he received treatment in the emergency room; the “OB/GYN” notation was written on the dry erase board in Rumble’s hospital room; (4) Fairview nurses examined Rumble’s genitals while he was a patient at the hospital; (5) a Fairview nurse told Rumble that she does not know what was wrong with Rumble “because [she didn’t] have any experience with this sort of thing;” and (6) hospital staff whispered about Plaintiff, and hospital nurses behaved unfriendly toward Rumble. (*See* Def. Fairview’s Mem. at 13 [Doc. No. 20].)

Defendant correctly states that “mere name-calling” is not enough to arise to the level of an actionable discrimination claim. *See Scusa v. Nestle U.S.A. Co.*, 181 F.3d 958, 969–70 (8th Cir.1999) (holding that “general allegations of co-worker ostracism are not sufficient to rise to the level of an adverse employment action for purposes of Title VII.”); *Oncale*, 523 U.S. at 80–81 (explaining that Title VII does not prohibit all verbal or physical harassment, rather, a plaintiff must prove that the conduct at issue constituted discrimination because of sex and was not just “merely tinged with offensive sexual connotations”); *Davis*, 526 U.S. at 651–52 (holding that for a plaintiff to have an actionable Title IX claim the harassment must amount to more than “simple acts of teasing and name-calling among school children”); *see also Wolfe*, 648 F.3d at 866–67 (holding that the plaintiff must prove that the harassment complained of amounted to more than mere name-calling, in order to state an actionable Title IX claim); *Shaver v. Indep. Stave Co.*, 350 F.3d 716, 721 (8th Cir.2003) (finding that “[c]onduct that is merely rude, abrasive, unkind, or insensitive does not come within the scope of the [Americans with Disabilities Act]”).¹⁵

However, the Court disagrees with Fairview insofar as it contends that the hospital staff’s alleged conduct amounts to only “perceived slights.” (*See* Def. Fairview’s Mem. at 12 [Doc. No. 20].) Much of the conduct that Plaintiff alleges amounted to more than “mere name-calling,” and constituted objectively offensive behavior.

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*26 For instance, Plaintiff contends that Fairview purposefully “misgender [ed]” Plaintiff, by giving Rumble a hospital bracelet that identified his sex as “female.” (See Pl.’s Mem. at 33–34 [Doc. No. 25].) Plaintiff explains that the “deliberate misgendering” of transgender people is a prime example of “trans-exclusion.” (See *id.* (citing Julia Serano, *Whipping Girl: A Transsexual Woman on Sexism and the Scapegoating of Femininity* (2007).) Plaintiff alleges that the intake clerk purposefully and deliberately gave him a hospital bracelet that incorrectly identified his gender even after he explained that he had transitioned to identifying as male. (See Compl. ¶ 29 [Doc. No. 1].) Given Plaintiff’s transgender status and the fact that the clerk was aware of Plaintiff’s preferred gender, Fairview’s misgendering of Rumble could be considered objectively offensive behavior.

The fact that Rumble was forced to wait for several hours in the emergency room before being provided pain medication or being seen by an emergency room doctor also amounts to more than a “perceived slight.” (See *id.* ¶¶ 35–37.) Rumble’s health and well-being was at stake while he waited in severe pain for someone at Fairview to treat him. (See *id.* ¶ 35–36.) Fairview’s alleged delay in treating Plaintiff is even more appalling given Plaintiff’s allegation that “people with less urgent medical needs were treated much more quickly than [Rumble] was treated.” (*Id.* ¶ 37.) The urgent severity of Plaintiff’s condition when he entered Fairview is evident by the fact that a Fairview doctor allegedly told Rumble’s mother that her son “would have been septic within 12 to 24 hours” from being brought to the hospital. (*Id.* ¶ 59.)

Moreover, in addition to the fact that Plaintiff had to wait for Dr. Steinman, Plaintiff then also waited for several more hours before being admitted to the hospital and treated with any sort of antibiotic. (*Id.* ¶¶ 49–50.) As Plaintiff explains, “several times during his time at Fairview, Rumble was refused care, and at other times, he was refused humane and dignified care.” (See Pl.’s Mem. at 34 [Doc. No. 25].) Forcing Plaintiff to wait hours on end, while he was in unbearable pain and could have entered septic shock, is clearly actionable discriminatory conduct, if Fairview staff were motivated by the fact that Plaintiff is transgender.

Additionally, the fact that Dr. Obaid conducted a genital exam of Plaintiff’s inflamed genitals, wiped his gloves on Plaintiff’s hospital bed, and then examined Plaintiff’s eyes and mouth using the same gloves also amounts to more than a “perceived slight.” (See Compl. ¶ 56 [Doc. No. 1].) If this alleged conduct was because of Plaintiff’s transgender status, then this incident also serves as a basis for Plaintiff’s Section 1557 claim. This behavior amounts to conduct that is more than simply insensitive. Rather, if true, it constitutes unacceptable medical care, in which a medical professional misused his authority to harass a patient. (See Pl.’s Mem. at 38 [Doc. No. 25].) As the Supreme Court noted in *Davis*, “[t]he relationship between the harasser and the victim necessarily affects the extent to which the misconduct can be said to breach Title IX’s guarantee of equal access to educational benefits.” *Davis*, 526 U.S. at 653. Here, the Court finds that the relationship between the harasser and the victim necessarily affects the extent to which the misconduct breaches Section 1557’s guarantee of equal access to medical benefits and care. Just as “teacher-student harassment” is more likely to satisfy the requirements for a Title IX claim than “peer harassment,” so too is medical professional-patient harassment more likely to satisfy the requirements for a Section 1557 claim than patient-patient harassment.

*27 Finally, Plaintiff also alleges that it was objectively offensive that: a hospital staff person had written the “OB/GYN” notation on the dry erase board in his hospital room; and that hospital staff whispered about him; and that hospital nurses behaved unfriendly toward him. (See Compl. ¶¶ 31, 55, 57 [Doc. No. 1].) Although, on its own, this behavior may be insufficient to constitute discrimination under Section 1557, the Court reads these allegations in tandem with the other allegations in Plaintiff’s Complaint and concludes that, as a whole, Plaintiff states a plausible Section 1557 claim against Fairview. See *Braden v. Wal-Mart Stores, Inc.*, 588 F.3d 585, 594 (8th Cir.2009) (holding that a court must read a complaint as a whole “to determine whether each allegation, in isolation, is plausible”).

Consistent with the Court’s findings above, it is plausible that Fairview staff treated Plaintiff in the manner that they did because of his protected class status. The emergency room clerk was plausibly aware of Plaintiff’s transgender status as a result of the conversation he had with Rumble about the difference between Rumble’s assigned gender at birth and his current gender. The hospital staff members who made Plaintiff wait before and after seeing Dr. Steinman were also plausibly aware that Rumble is

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transgender because they could have found out this information from the intake clerk or Dr. Steinman. Additionally, the nurses and physicians who treated Plaintiff during his several day stay at the hospital were also plausibly aware that Plaintiff was transgender because they knew from examining Rumble that Rumble identifies as male, but has female genitalia. Moreover, the Court notes that if Defendant Fairview is later determined to be liable for Dr. Steinman's actions, then additional facts pertaining to the genital exam Dr. Steinman completed further bolster the plausibility that Fairview violated Section 1557.

3. Plausibility of MHRA Claim

Defendant Fairview argues that Rumble failed to state a plausible MHRA claim because Rumble did not allege that: (1) Fairview took any “tangible” or “material” adverse action against him that resulted in a denial of services (*see* Def. Fairview's Mem. at 14 [Doc. No. 20]); and (2) the actions that Fairview did take were driven by “discriminatory animus” (*see* Def. Fairview's Reply at 9 [Doc. No. 28]).¹⁶ The Court addresses both of these arguments below.

a. Adverse Action

Defendant claims that Plaintiff merely alleges facts substantiating “hurt feelings,” and not a denial of services or accommodations or discrimination to substantiate his MHRA claim. (*See* Def. Fairview's Mem. at 14–15 [Doc. No. 20].) The Court disagrees. Although generally an MHRA claimant alleges an outright “denial” of services or accommodations, *Childs*, 2012 WL 2126845, at *5, a plaintiff may also allege a denial of the “full and equal enjoyment” of services, *see Minn.Stat. § 363A.11*. In other words, a plaintiff may allege that he received materially inferior services because of his protected class status. *See id.*; *Bahr v. Capella Univ.*, 788 N.W.2d 76, 83 (Minn.2010) (citing *Burchett*, 340 F.3d at 518; *Brannum*, 518 F.3d at 549; and *Jones*, 285 F.3d at 714). Therefore, the MHRA does not require Plaintiff to allege that he was denied services. Rather, pursuant to the MHRA, Rumble appropriately alleges that he received inferior medical services from Fairview. (*See generally* Compl. [Doc. No. 1].)

*28 As the Court discussed in detail above, Plaintiff alleges facts about the harassment he experienced from the intake clerk, Dr. Obaid, the hospital staff, and the hospital nurses that, read as a whole, amount to an allegation that he received inferior medical care and treatment. *See supra* Part III(C)(1)(b)(2). The hospital staff's conduct and behavior amounts to more than mere “perceived slights” or “hurt feelings.” Additionally, if the Court ultimately determines that Fairview is liable for Dr. Steinman's actions, then Plaintiff's MHRA claim against Fairview is further bolstered by facts demonstrating that Dr. Steinman treated Rumble poorly or adversely.

Rumble's case is clearly distinguishable from *Porter v. Children's Health–Care Minneapolis*, No. C5–98–1342, 1999 WL 71470 (Minn.Ct.App. Feb. 16, 1999). (*See* Def. Fairview's Mem. at 16 [Doc. No. 20].) In *Porter*, the Minnesota Court of Appeals upheld the district court's grant of summary judgment for the defendant on the plaintiff's MHRA discrimination claim. *See* 1999 WL 71470, *6. The *Porter* Court held that the plaintiff's MHRA claim failed because the plaintiff did not provide sufficient direct and circumstantial evidence that “he was treated differently from anyone else using [the defendant's] services at that time and under those circumstances.” *Id.*

In contrast, here, Plaintiff provides the requisite direct and circumstantial evidence. Based on observing the individuals who came into the emergency room, Rumble alleges that “people with less urgent medical needs were treated much more quickly than [he was].” (*See* Compl. ¶ 37 [Doc. No. 1].) Therefore, Plaintiff alleges that he was treated differently from others seeking Fairview's services at the exact same time that he was seeking medical services from Fairview. *Cf. Porter*, 1999 WL 71470, at *6. Moreover, Plaintiff alleges that a Fairview staff person admitted to his mother that although Rumble was forced to wait for nearly seven hours in the emergency room before being admitted to the hospital or receiving treatment, Fairview did not usually keep patients waiting for this long. (*See* Compl. ¶ 50 [Doc. No. 1].) If the Court accepts this allegation as true, then the facts show that even one of Defendant's employees admitted that Plaintiff received disparate treatment. Accordingly, Rumble

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plausibly alleges that Fairview denied him the “full and equal enjoyment” of medical services, and the disparate treatment amounts to an actionable adverse action under [Minn.Stat. § 363A.11](#).

b. Discriminatory Animus

Fairview also contends that Plaintiff's allegations do not demonstrate that he was denied medical treatment “because of” his sexual orientation or gender identity. (See Def. Fairview's Reply at 8–9 [Doc. No. 28].) Fairview claims that Plaintiff's allegations are based only on his “subjective belief” that he received disparate treatment “because of” his transgender status. (See *id.* at 9.) The Court disagrees.

*29 To prove a claim of disparate treatment under the MHRA, “proof of discriminatory motive is critical, although it can in some situations be inferred from the mere fact of differences in treatment.” See [Hubbard v. United Press Intern., Inc.](#), 330 N.W.2d 428, 441 n. 12 (Minn.1983) (quoting [International Brotherhood of Teamsters v. United States](#), 431 U.S. 324, 335–36 n.15 (1977)). Rumble alleges several facts demonstrating that he was treated poorly or differently from other patients at the hospital. See *supra* Part III(C)(1)(b)(2). In fact, as the Court noted above, a Fairview staff person even admitted to Plaintiff that Fairview did not usually make people wait in the emergency room for nearly seven hours. (See Compl. ¶ 50 [Doc. No. 1].) And as with Plaintiff's Section 1557 claim, the Court also notes that if Defendant Fairview is determined to be liable for Dr. Steinman's actions, then additional facts pertaining to the genital exam Dr. Steinman completed may be used to show how Rumble received disparate treatment from Fairview in violation of the MHRA. Accordingly, at this stage of the proceedings, the Court finds that a discriminatory motive may be plausibly inferred from the fact that Rumble received disparate treatment.

The Court notes that, generally, merely pleading “on information and belief, without more, is insufficient to survive a motion to dismiss for failure to state a claim.” [Kampschroer v. Anoka Cnty.](#), No. 13–cv–2512 (SRN/TNL), 2014 WL 5530590, at *14 (D.Minn. Nov. 3, 2014) (citing [Solis v. City of Fresno](#), No. 1:11–cv–00053, 2012 WL 868681, at *8 (E.D.Cal. Mar. 13, 2012)). And Defendant correctly notes that Plaintiff alleges that he: (1) “believed” that the intake clerk was discussing his gender with another person (Compl. ¶ 31 (emphasis added) [Doc. No. 1]); (2) “believed that people with less urgent medical needs were treated much more quickly than [he] was treated” (*id.* ¶ 37) (emphasis added); and (3) “had the *impression* that some of the nurses were hostile towards him” (*id.* ¶ 57) (emphasis added).

Here, however, Plaintiff's allegations are not based solely upon information and belief. Rather, Plaintiff's allegations of discriminatory animus are based on the totality of the circumstances surrounding each interaction he had with Fairview employees.

For instance, the Court finds it plausible that the intake clerk was in fact whispering about Plaintiff's gender with another person, based on the fact that Plaintiff alleges that the whispering took place right after the clerk had a conversation with Plaintiff about his gender on file. (See Compl. ¶¶ 29–31 [Doc. No. 1].) Therefore, Plaintiff plausibly “believed” the whispering was motivated by discriminatory animus. (See *id.* ¶ 31.) It is also plausible that Rumble and his mother “believed” that other patients with less urgent medical needs were treated more quickly than Rumble was, because Plaintiff and his mother may have seen patients entering and exiting the emergency room waiting room and approaching the intake desk. (See *id.* ¶ 37.) In addition, Rumble may have had the “impression” that some of the nurses were hostile towards him because of his gender identity, based on a reasonable expectation that nurses would usually not avoid speaking to patients when caring for them. (See *id.* 57.) Thus, in sum, Plaintiff's allegations of discriminatory animus are based on more than pure speculation.

*30 Defendant cites the following cases to bolster its claim that Plaintiff failed to plausibly allege that Fairview had discriminatory animus: (1) [Bilal v. Northwest Airlines, Inc.](#), 537 N.W.2d 614 (Minn.1995); (2) [Nash v. JBPM, Inc.](#), No. 09–cv–1437 (RHK/RLE), 2010 WL 2346605 (D. Minn. June 9, 2010); (3) [Phillips v. Speedway SuperAmerica LLC](#), No. 09–cv–2447 (RHK/FLN), 2010 WL 4323069 (D.Minn. Oct. 22, 2010); and (4) [Willenbring v. City of Breezy Point](#), No. 08–cv–4760 (MJD/

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RLE), 2010 WL 3724361 (D .Minn. Sept. 16, 2010). However, each of these cases is distinguishable. First, the Court notes that all of these cases were decided after a full evidentiary trial was held, or upon a motion for summary judgment, after discovery had taken place. Here, Plaintiff has not yet had the benefit of the discovery process and is left with only the information that was readily available to him while he was a patient at Fairview. Second, these cases are clearly distinguishable insofar as the plaintiffs in these cases failed to substantiate their claims of discriminatory animus with any circumstantial or direct evidence.

For instance, in *Bilal*, the Minnesota Supreme Court held that the trial court judgment was properly reversed because the plaintiff had “not established a discriminatory motive on the part of [the defendant] or its employees.” See 537 N.W.2d at 619. The plaintiff alleged that one of the defendant's employees had discriminated against her, because although the plaintiff was Muslim, the employee had told the plaintiff that she should “dress as if she were going to church.” *Id.* at 617. The Minnesota Supreme Court explained that because the employee “did not even know of which religion, if any, [the plaintiff] was a member,” then the employee could not have “intentionally discriminated against [the plaintiff].” *Id.* at 619. Here, however, Plaintiff alleges that the Fairview employees either affirmatively knew or were likely aware that Rumble is transgender, and thus could have intentionally discriminated against him.

Nash is similarly distinguishable from Rumble's case. In Nash, the pro se plaintiff had not even filed a response brief to the defendant's motion for summary judgment. See 2010 WL 2346605, at *2. Therefore, the court held that there was no basis for a reasonable jury to conclude that the defendant's actions were taken because of the plaintiff's protected class status since the plaintiff had “proffered no evidence at all in response to [the defendant's] Motion.” See *id.* The Nash Court explained that without any evidence to the contrary, it was forced to conclude that the defendant might act similarly to all customers, regardless of the customer's race. See *id.* Here, Rumble sufficiently alleges facts demonstrating that Fairview's actions were plausibly taken because of Rumble's protected class status. Moreover, Plaintiff alleges that other patients were likely treated differently and better than he was, because they were not transgender. While Rumble cannot yet proffer more specific evidence of comparative treatment at this stage in the litigation, after discovery Plaintiff will have the opportunity to present this evidence.

*31 Phillips is also distinguishable from Rumble's case. In Phillips, the court granted the defendant's motion for summary judgment on the plaintiff's MHRA claim because the plaintiff failed to present evidence that permitted the inference that the conduct complained of was motivated by the plaintiff's race. See 2010 WL 4323069, at *3. The court specifically noted that “[t]here is no dispute that other black customers patronized [the defendant's] store on the night in question, and they were neither detained nor accused of shoplifting,” the plaintiff “proffered no evidence indicating that the store ha[d] a history of accusing blacks of theft or that [the defendant's employees] singled out black customers for disparate treatment,” and an employee's lone comment about race was “insufficient to establish that [the defendant's employees] acted out of racial animosity.” See *id.* However, as Rumble argues, “the [Phillips Court] does not state or even imply that if the plaintiff had provided sufficient evidence that he was accused of shoplifting and physically grabbed *because of* his race, that those actions would not have constituted discrimination.” (See Pl.'s Mem. at 41 (emphasis added) [Doc. No. 25].)

Here, Rumble alleges facts that permit the inference that the conduct of Fairview staff was motivated by Plaintiff's transgender status. Specifically, Plaintiff alleges that based on the totality of the circumstances Fairview staff likely knew, or were affirmatively aware, that Plaintiff was transgender. Thus, Plaintiff plausibly alleges that he received disparate treatment because of his gender identity. The Court does not expect Plaintiff to bolster his MHRA claim with more substantive evidence at this stage in the litigation. Rather, Plaintiff must only allege “enough fact[s] to raise a reasonable expectation that discovery will reveal evidence of [the claim].” *Twombly*, 550 U.S. at 556. Accordingly, Plaintiff meets this burden.

Finally, Plaintiff's case is also distinguishable from *Willenbring*. See 2010 WL 3724361. In *Willenbring*, the court granted the defendant's motion for summary judgment on the plaintiff's MHRA claim because the plaintiff provided no evidence suggesting that the defendant's employee's conduct was “motivated by [the plaintiff's] status as a woman.” *Id.* at *12. Here, as earlier described in great detail, Plaintiff sufficiently alleges facts demonstrating that Fairview's conduct was motivated by Rumble's

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transgender status. Since “[a] record of disparate treatment and unprofessional behavior directed at a plaintiff may constitute evidence of discriminatory intent,” *Pierce*, 994 F.Supp.2d at 163, Plaintiff’s Complaint meets the requisite threshold to survive dismissal.

THEREFORE, IT IS HEREBY ORDERED THAT:

1. Defendant Emergency Physicians’ Motion to Dismiss [Doc. No. 11] is **DENIED**.
2. Defendant Fairview’s Motion to Dismiss [Doc. No. 18] is **DENIED**.

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Footnotes

- 1 Generally, it is offensive and inappropriate to ask anyone, including a transgender individual, whether their genitals correspond with their self-proclaimed gender identity. *See* Erickson–Schroth, *supra*, at 265. However, as this case pertains to the medical care that Plaintiff received to treat his genital pain, the Court engages in a discussion about Plaintiff’s genitalia.
- 2 Plaintiff does not allege that he incurred expenses because of the insurance company’s initial denial of coverage. (*See generally* Compl. [Doc. No. 1]; Def. Emergency Physicians’ Reply at 2 [Doc. No. 29].) Rather, Plaintiff only argues that the language further substantiates his federal and state law discrimination claims.
- 3 Section 1557 provides Plaintiff with a private right of action to sue Defendants. The Court reaches this conclusion because the four civil rights statutes that are referenced and incorporated into Section 1557 permit private rights of action. *See Gonzaga Univ. v. Doe*, 536 U.S. 273, 283–84 (2002) (holding that “Title VI ... and Title IX ... create individual rights because those statutes are phrased ‘with an unmistakable focus on the benefited class’”) (emphasis added); *Barnes v. Gorman*, 536 U.S. 181, 185 (2002) (finding that section 504 of the Rehabilitation Act is “enforceable through private causes of action” because the statutory language of section 504 mirrors Title VI); 42 U.S.C. § 6104(e)(1) (the Age Discrimination Act of 1975 states that “any interested person [may] bring [an action] in any United States district court for the district in which the defendant is found or transacts business to enjoin a violation of this Act ... [and] such interested person may elect, by a demand for such relief in his complaint, to recover reasonable attorney’s fees, in which case the court shall award the costs of suit, including a reasonable attorney’s fee, to the prevailing plaintiff.”). Because Section 1557 states that the enforcement mechanisms available under those four statutes apply to violations of Section 1557, Section 1557 necessarily also permits private causes of action.
- 4 In his Complaint, Rumble references two publicly-available documents that contain data and statistics about the discrimination transgender and gender nonconforming individuals face in health care settings, and a third document that constitutes federal agency correspondence relating to Section 1557. (*See* Compl. ¶¶ 19, 73 [Doc. No. 1].) The Court references these documents as needed throughout the Order.
- 5 As further evidence that Section 1557 applies to plaintiffs alleging discrimination based on gender identity, Plaintiff points to an OCR Bulletin that details two investigations involving alleged sex discrimination. (*See* Pl.’s Mem. at 9 [Doc. No. 25].) Defendant Fairview argues that the persuasive effect of the two investigations detailed in the bulletin is minimal because the investigations did not develop into administrative or judicial adjudications. (*See* Def. Fairview’s Reply at 3 [Doc. No. 28].) The Court disagrees. Rather, it concludes that the OCR’s investigation of these two cases is consistent with the OCR’s opinion letter insofar as the letter stated that Section 1557 “extends to claims of discrimination based on ... failure to conform to stereotypical notions of masculinity or femininity.” (*See* Barrett Wiik Decl., Ex. C [Doc. No. 26–1].)
- 6 Commentators have noted that Section 1557 “does not merely extend Title VI to additional health programs; [rather,] it creates a new civil right and remedy while leaving in place Title VI and other existing civil rights laws.” *See* Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race and Equity*, 55 How. L.J. 855, 870 (2012); Sarah G. Steege, *Finding a Cure in the Courts: A Private Right of Action for Disparate Impact in Health Care*, 16 Mich. J. Race & L. 439, 456–59 (2011). The Court agrees with this observation. In fact, Section 1557 expressly states that “[n]othing in this title ... shall be construed to invalidate

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or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under [any of the four existing civil rights statutes].” See 42 U.S.C. § 18116(b). Thus, Congress likely intended to create a new right and remedy in a new context without altering existing laws.

7 Intersectional discrimination claims are based on the intersectionality of at least two of a plaintiff’s protected class statuses. Professor Cheryl I. Harris explains that:

The particular experience of black women in the dominant cultural ideology of American society can be conceptualized as intersectional. Intersectionality captures the way in which the particular location of black women in dominant American social relations is unique and in some senses unassimilable into the discursive paradigms of gender and race domination.

See Cheryl I. Harris, *Whiteness As Property*, 106 Harv. L.Rev. 1709, 1791 (1993) (internal quotation and citation omitted).

8 Moreover, courts must generally “accord great weight to the longstanding interpretation placed on a statute by an agency charged with its administration.” *NLRB v. Bell Aerospace Co. Div. of Textron Inc.*, 416 U.S. 267, 275 (1974). “The Department of Health, Education and Welfare (the predecessor to the Department of Health and Human Services) expressly included Medicare and Medicaid as programs covered by Title VI, see 38 Fed.Reg. 17982 (1973); 40 Fed.Reg. 18173 (1975), and HHS’s regulations continue to list these programs among those covered by Title VI.” *United States v. Baylor Univ. Med. Ctr.*, 736 F.2d 1039, 1047 (5th Cir.1984) (citing 45 C.F.R. Part 80, Appendix A at Part 1, # 121 and Part 2, # 30). Additionally, “[t]he Department’s regulations implementing Section 504 expressly state that service providers whose only source of federal financial assistance is Medicaid ‘should be regarded as recipients under the statute and the regulation and should be held individually responsible for administering services in a non-discriminatory fashion.’” *Baylor*, 736 F.2d at 1047 (citing 45 C.F.R. Part 84, App. A, Subpart A(1)).

9 Moreover, the Court notes that the fact that the OCR initiated an investigation of an emergency department in New Orleans, Louisiana, as part of its enforcement of Section 1557, demonstrates that at least one emergency room facility, which likely received Medicare and Medicaid payments from the federal government, qualified as an entity that was subject to the anti-discrimination mandate of Section 1557. (See Pl.’s Mem. at 10 n.3 [Doc. No. 25] .)

10 The Court notes that neither party clearly describes the billing process, nor explains whether, nor how, Emergency Physicians selects the language to include on the bill. Nonetheless, at this stage in the proceedings the Court finds that the facts alleged about the medical bill are sufficient to bolster Plaintiff’s discrimination claims, and push Plaintiff’s claims “across the line from conceivable to plausible.” See *Twombly*, 550 U.S. at 547.

11 Different intent standards apply to Title IX and the Rehabilitation Act, for example. Although Title IX requires that the defendant intended to discriminate, a Rehabilitation Act plaintiff need only demonstrate that the defendant “fail[ed] to abide by a legally imposed duty,” and need not prove what motivated the defendant’s action. See *Peebles v. Potter*, 354 F.3d 761, 767 (8th Cir.2004) (explaining that “it is not the employer’s discriminatory intent in taking adverse employment action against a disabled individual that matters. Rather, discrimination occurs when the employer fails to abide by a legally imposed duty.”).

12 Emergency Physicians claims that Plaintiff’s allegations “do not rise to the level of the material adverse events necessary to establish a valid claim of discrimination under the MHRA” because Plaintiff only alleges that (1) he perceived Dr. Steinman to be angry, and (2) he received an erroneous bill for services. (See Def. Emergency Physicians’ Mem. at 15 [Doc. No. 13].) The Court disagrees. Plaintiff painstakingly accounts how Dr. Steinman allegedly “jabbed” at Rumble’s genitals and did not stop jabbing until Rumble’s mother demanded Dr. Steinman to stop. (See Compl. ¶¶ 43–47 [Doc. No. 1].)

13 The Court notes that although the statutes are often interpreted similarly, it is unclear whether a distinction exists under the MHRA between the standard for vicarious liability for sexual harassment in an employment setting and the standard for vicarious liability in the public accommodation setting. See *Hudson v. City of Minneapolis*, No. 04–cv–3313 (JNE/FLN), 2006 WL 752935, at *11 (D.Minn. Mar. 23, 2006). Nonetheless, as other courts have done, see *id.*, the Court proceeds by applying the standard that courts have used for vicarious liability for sexual harassment in an employment setting, under the MHRA.

14 The Eighth Circuit explained in *Schwieger* that in order to determine whether an employer-employee relationship exists “[a] primary consideration is the hiring party’s right to control the manner and means by which a task is accomplished.” *Schwieger*, 207 F.3d at 484. The Eighth Circuit also noted the following twelve factors that a court could take into account when determining whether an employer-employee relationship exists:

the skill required; the source of the instrumentalities and tools; the location of the work; the duration of the relationship between the parties; whether the hiring party has the right to assign additional projects to the hired party; the extent of the hired party’s discretion over when and how long to work; the method of payment; the hired party’s role in hiring and paying assistants; whether the work is part of the regular business of the hiring party; whether the hiring party is in business; the provision of employee benefits; and the tax treatment of the hired party.

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Id. (quoting *Nationwide Mut. Ins. Co. v. Darden*, 503 U.S. 318, 323–24 (1992)).

- 15 The Court notes that while Defendant ardently argues that only Title IX case law applies for determining whether Fairview is liable for Dr. Steinman's actions, Fairview references case law analyzing Title VII and the Americans with Disabilities Act when discussing whether Fairview's conduct amounts to an actionable Section 1557 claim. (See Def. Fairview's Mem. at 12–13 [Doc. No. 12].) The fact that even Defendant Fairview is inconsistent about which standards to apply, bolsters the Court's understanding that Section 1557 is likely not bounded by the existing interpretation of only one civil rights statute. Rather, Section 1557 creates a new cause of action that may require courts or the OCR to determine new standards.
- 16 Fairview also argues that the Court should dismiss Plaintiff's MHRA claim because the Court may decline to exercise supplemental jurisdiction over the state-law claim if the “court has dismissed all claims over which it has original jurisdiction.” (See Def. Fairview's Mem. at 14 n.11 (citing 28 U.S.C. § 1367(c)(3)) [Doc. No. 20].) As the Court did not dismiss Plaintiff's Section 1557 claim against either Defendant, the Court finds that Fairview's argument is inapposite.

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UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

EQUAL EMPLOYMENT OPPORTUNITY
COMMISSION,

Case No. 0:15-cv-2646 (ADM/SER)

Plaintiff,

and,

BRITNEY AUSTIN,

Plaintiff/Intervenor,

CONSENT DECREE

v.

DELUXE FINANCIAL SERVICES, INC.,

Defendant.

I. RECITALS

1. This matter was instituted by Plaintiff, Equal Employment Opportunity Commission (“Commission” or “EEOC”), an agency of the United States government, alleging that Defendant Deluxe Financial Services, Inc. (“Deluxe”) violated Title VII of the Civil Rights Act of 1964 by subjecting Plaintiff/Intervenor Britney Austin (“Ms. Austin”) to a hostile work environment and disparate treatment because of her sex, including because Ms. Austin is a woman who is transgender; because of Ms. Austin’s transition from male to female during her employment with Deluxe; because Ms. Austin did not conform to Defendant’s sex or gender-based preferences, expectations, or stereotypes of women; and/or because of Defendant’s sex or gender-based expectations

or stereotypes related to individuals assigned the male sex at birth. In addition, Ms. Britney Austin alleges disparate treatment, disparate impact, and hostile work environment based on sex under Title VII, unlawful retaliation under Title VII, and disparate treatment, impact, unlawful medical inquiries, and retaliation under the Americans with Disabilities Act (ADA).

2. Defendant Deluxe denies that it violated Title VII or the ADA and further denies that it treated Ms. Austin unlawfully. Deluxe states it is fully committed to fostering an inclusive, respectful workplace.

3. The Parties to this Decree are the Plaintiff EEOC, Plaintiff/Intervenor Britney Austin, and the Defendant Deluxe Financial Services, Inc. (collectively referred to as the “Parties”).

4. The Parties, desiring to settle this action by an appropriate Consent Decree (“Decree”), agree to the jurisdiction of this Court over the Parties and the subject matter of this action, and agree to the power of this Court to enter a Consent Decree enforceable against Defendant.

5. As to the issues resolved, this Decree is final and binding upon the Parties and their successors and assigns.

6. In the interest of resolving this matter, to avoid further cost of litigation, and as a result of having engaged in comprehensive settlement negotiations, the Parties have agreed that this action should be resolved by entry of this Decree. For the purpose of amicably resolving disputed claims, the Parties jointly request this Court to adjudge as follows:

IT IS ORDERED, ADJUDGED, AND DECREED AS FOLLOWS:

II. JURISDICTION

7. The Parties stipulate to the jurisdiction of the Court over the Parties and subject matter of this action and have waived the entry of findings of fact and conclusions of law.

III. TERM AND SCOPE

8. **Term:** The duration of this Decree shall be three years from the date of signing by the Court.

9. **Scope:** The terms of this Decree shall apply to all of Defendant's facilities and operations. The terms of the Decree will also apply to any additional facilities which Defendant opens during the three year term of the Decree.

IV. ISSUES RESOLVED

10. This Decree resolves the claims alleged in the above-captioned lawsuit, and constitutes a complete resolution of all of the EEOC's and Ms. Austin's claims of unlawful employment practices under Title VII and the ADA filed in this action, and in the underlying Charge of Discrimination No. Charge No. 540-2011-02711, filed by Ms. Austin.

11. Nothing in this Decree shall be construed to preclude EEOC from bringing suit to enforce this Decree. Neither does this Decree preclude EEOC from filing lawsuits based on charges not resolved in this Decree. Any individual charges of discrimination filed with EEOC after the effective date of this Decree will be processed by EEOC in accordance with its standard procedures.

12. Defendant and its officers, agents, employees, successors, and all other persons in active concert or participation with any of them will not interfere with the relief herein ordered, but shall cooperate in the implementation of this Decree.

V. MONETARY RELIEF

13. Defendants will not condition the receipt of individual relief upon Ms. Austin's agreement to: (a) maintain as confidential the terms of this Decree or the facts of the case; (b) waive her statutory right to file a charge with any federal or state anti-discrimination agency; or (c) promise not to reapply for a position at any of Defendant's facilities.

14. Within five (5) calendar days following the Court's approval of this Decree, Deluxe shall pay a total of One Hundred Fifteen Thousand dollars (\$115,000.00) in the form of three checks as follows:

- a. By check made payable to "Britney Austin" in the amount of Two thousand two hundred fifty-four and 40/100 dollars (\$2,254.40) representing backpay, including the value of lost benefits of employment and interest, less only the employee's share of required federal, state and local tax withholdings. Defendant shall timely issue an I.R.S. Form W-2 for Britney Austin for this amount; and
- b. By check made payable to "Britney Austin" in the amount of Seventy-two thousand seven hundred eighty-three and 49/100 dollars (\$72,783.49) representing other damages, including but not limited to, damages for compensatory damages. Defendant shall designate the compensatory

damage payment as “other income” (Box 3) on an I.R.S. Form 1099-MISC.

- c. By check made payable to the “Law Offices of Jillian T. Weiss, P.C.,” in the amount of Thirty-nine thousand nine hundred sixty-two and 11/100 dollars (\$39,962.11), representing payment for attorneys’ fees and expenses. Deluxe shall issue an IRS Form 1099-Misc. (Box 3) to Austin in connection with this payment, and an IRS Form 1099-Misc. (Box 14) to the Law Offices of Jillian T. Weiss, P.C., in connection with this payment.

15. The payment(s) set forth in Paragraph 14 above, shall be delivered to: Britney Austin c/o Jillian T. Weiss, Esq., Law Office of Jillian T. Weiss, P.C., P.O. Box 642, Tuxedo Park, New York 10987.

16. Copies of the payment(s) set forth in Paragraphs 14 and 15 above and related documents (including copies of I.R.S. Form W-2 and I.R.S. Form 1099) shall be sent contemporaneously to Iris Halpern, Senior Trial Attorney, EEOC, Denver Field Office, 303 E. 17th Avenue, Suite 410, Denver, CO, 80203.

17. If Deluxe fails to timely meet its payment obligations as described in Paragraphs 14, 15 and 16 above, then Deluxe shall pay interest on the defaulted payments at a rate calculated pursuant to 26 U.S.C. §6621(b) until effective payments are mailed, and bear any additional costs incurred by Austin and/or the EEOC caused by the non-compliance or delay. And, in the event Deluxe fails to meet its payment obligations

under Paragraph 14 above, then Deluxe agrees that Judgment may be entered in favor of Ms. Austin in the amount of \$115,000.00.

VI. OTHER INDIVIDUAL RELIEF

18. **Expungement of Personnel Files.** Defendant shall expunge from Ms. Austin's personnel file (a) any poor evaluations, discipline, or discharge documents after September 1, 2010 and destroy these; (b) any and all references to any charge of discrimination filed against Defendant; (c) any and all references to the allegations of discrimination filed against Defendant that formed the basis of this action; and (d) any and all references to Ms. Austin's participation in this action.

19. **Reference:** Defendant agrees that whenever a prospective employer requests a reference relating to Britney Austin, Defendant shall provide the dates of Ms. Austin's employment. No mention of the charge of discrimination this lawsuit, or Ms. Austin's prior legal name shall be made as part of any reference. In addition, Deluxe will provide a neutral reference in the form attached as Exhibit A, which will make clear that Ms. Austin is eligible for rehire.

20. **Assure Personnel Records Are Correct.** Defendant shall ensure that all of Defendant's records reflect that Britney Austin was laid-off as part of an office-wide reduction in force when the Phoenix, Arizona office ceased operations.

21. **Letter of Apology.** Within ten (10) business days after entry of this Decree, Defendant shall provide a letter of apology to Britney Austin on company letterhead in the form attached as Exhibit B.

VII. EQUITABLE RELIEF

A. *Injunctive Relief*

22. Defendant, its officers, agents, successors, and other persons in active concert or participation with it, is permanently enjoined from engaging in any employment practice which discriminates on the basis of sex, including sex-stereotyping, gender identity, and transgender status.

23. Defendant, its officers, agents, successors, and other persons in active concert or participation with it, is permanently enjoined from engaging in reprisal or retaliation of any kind against any person because of such person's opposition to any practice made unlawful under Title VII of the Civil Rights Act of 1964, as amended, or the Americans with Disabilities Act, as amended. Defendant shall not retaliate against a person because such person refuses to engage in or participate in discriminatory practices; brings an internal complaint of discrimination with the Defendant; files or causes to be filed a charge of discrimination with the Commission or any other agency charged with the investigation of employment discrimination complaints, or whose statements serve as the basis of a charge; or because such person testifies or participates in the investigation or prosecution of an alleged violation of Title VII and ADA.

24. Defendant, its officers, agents, successors, and other persons in active concert or participation with it, is permanently enjoined from engaging in any employment practice which discriminates under the Americans with Disabilities Act.

B. EEO Policy and Practice Review

25. Within sixty (60) days of the entry of this Decree, Defendant shall, in consultation with an outside consultant experienced in the area of employment discrimination law (“Consultant”), review its existing EEO policies and practices to conform to the law and revise, if necessary. The written EEO policies must include at a minimum:

- a. A strong and clear commitment to preventing unlawful sex discrimination, including, but not limited to, prohibiting discrimination based on disability (including gender dysphoria), sex-stereotyping, gender identity, and transgender status;
- b. A strong and clear commitment to preventing unlawful harassment including, but not limited to, harassment based on sex, sex-stereotyping, gender identity, and transgender status (including the intentional misgendering of transgender employees);
- c. A strong and clear commitment to preventing retaliation;
- d. A statement that discrimination based on sex, disability, and retaliation is prohibited and will not be tolerated;
- e. An explanation that prohibited behavior will not be tolerated from its employees, customers, agents, contractors, sub-contractors, clients and any other persons present at any of the Deluxe’s facilities and locations;
- f. A clear and strong encouragement of persons who believe they have been discriminated or retaliated against to report such concerns;

- g. An explanation that employee concerns about discrimination may be raised with any manager, any HR representative, any Deluxe executive or through an employee hotline (including phone number 1-800-231-1751);
- h. An explanation that employees will not be required to complain of discrimination directly to the individual that is engaged in the discriminatory behavior;
- i. A clear explanation of the steps an employee must take to report discrimination or retaliation, which must include the options of either an oral or written complaint;
- j. An assurance that Defendant will investigate allegations of any activity that might be construed as unlawful discrimination and that such investigation will be prompt, fair, and reasonable, and conducted by a neutral investigator specifically trained in receiving, processing, and investigating allegations of discrimination;
- k. An assurance that appropriate corrective action will be taken by Defendant to eradicate any unlawful conduct within its workforce;
- l. A description of the consequences, up to and including termination, that will be imposed upon violators of Defendant's anti-discrimination policies;
- m. An assurance of non-retaliation for persons who report unlawful discrimination, harassment, and/or retaliation, and for witnesses who

provide testimony or assistance in the investigation(s) of such unlawful discrimination, harassment, and/or retaliation.

- n. A requirement that supervisors and managers report any complaints about harassment, discrimination or retaliation to Deluxe Employee Relations.

26. Defendant will ensure not to discriminate based on sex and/or disability against anyone for requesting changes to their biographical information (including name and sex-designation) in Defendant's internal records, computers or communication systems and will not require medical documentation or medical records, or conduct any other inquiry into the requesting individual's medical history, in relation to any such requests. .

27. Defendant will ensure that employee requests to change sex-designation or name information in Defendant's internal records, computer and communication systems are fully and promptly complied with.

28. Defendant and/or its related companies currently have transgender employees who are allowed use of restrooms commensurate with their gender identity and who, to the best of Defendant's knowledge, do not claim to have been treated unlawfully. Defendant will ensure that access for these employees to restrooms commensurate with their gender identity will remain unhindered.

29. Within sixty (60) days of the entry of this Decree and in consultation with the Consultant, Defendant will review and modify its written guidelines for supervisors and managers to make clear that transgender employees are permitted to use restrooms commensurate with their gender identity. Defendant will prohibit any inquiry into an

employee's medical history, including, but not limited to, requests for information about, or requiring medical records or documentation of, sex reassignment surgery or other medical treatment before an employee may use a restroom commensurate with his or her gender identity.

30. As of January 1, 2016, Defendant's national health benefits plan does not and will not include partial or categorical exclusions for otherwise medically necessary care solely on the basis of sex (including transgender status) and gender dysphoria. For example, if the health benefits plan covers exogenous hormone therapy for non-transgender enrollees who demonstrate medical necessity for treatment, the plan cannot exclude exogenous hormone therapy for transgender enrollees or persons diagnosed with gender dysphoria where medical necessity for treatment is also demonstrated. This plan was available to all Deluxe's United States-based employees during open enrollment for 2016 and will be available for all open enrollment periods during the term of this Decree. In addition, Defendant will notify its national plan third party administrator contracted to provide benefits to covered beneficiaries of these non-discrimination requirements. Defendant will also take steps to ensure that employees can meaningfully report health benefits related discrimination on the basis of sex (including transgender status) and gender dysphoria directly to Defendant in the same manner other complaints of sex and disability discrimination are reported.

31. Within seventy five (75) days after completion of the policy reviews and changes required under this Decree, the written EEO policies shall be made part of the

employee handbook and posted on Deluxe's "Inside Deluxe" intranet. Notice of these changes shall be conspicuously highlighted on the "Inside Deluxe" intranet homepage.

32. Defendants shall review and revise any policies or procedures they have for receiving and responding to complaints of sex or disability discrimination, including complaints about unlawful treatment that raise a concern of discrimination without using the exact phrases disability discrimination or sex discrimination. To the extent that no policies or procedures exist, they must be created. Defendants shall assure that all supervisors, managers, human resources personnel, as well as any persons responsible for receiving and addressing employee complaints, do the following:

- a. Document in writing, without bias, any complaint of discrimination, harassment, and/or retaliation, even if the complaint is oral or the complainant does not want to provide a written statement, and the complainant does not use these technical terms.
- b. Document in writing, without bias, any interview by the person(s) investigating the complaint.
- c. Document in writing, without bias, all steps taken to investigate a complaint of discrimination, harassment, and/or retaliation.
- d. Have in place a system of preservation, for all original records of complaints and subsequent investigations that ensures preservation of all documents for no less than 5 years.

C. Training

33. At least annually, Defendant shall provide EEO training for all its personnel.

34. **Employees:** Under this provision, all United States-based Deluxe employees, including employees, supervisors, managers, and Human Resources personnel, will be trained annually at a minimum in the following areas: (a) the Defendant's policy and procedures for reporting alleged discrimination; (b) understanding the kind of conduct which may constitute unlawful sex and disability discrimination, including discrimination based on sex-stereotyping, gender-identity, transgender status, and gender dysphoria; (c) the penalties of engaging in discriminatory behavior; and (d) Defendant's non-retaliation policy. All training under this Paragraph shall be at Defendant's selection and expense. This training shall be incorporated into Defendant's existing mandatory training program, which includes penalties for employees who fail to complete the training each year.

35. **Supervisors and Managers:** In addition to the annual training required in paragraph 34, all of Defendant's United States-based supervisors and managers will also receive additional annual training in the following areas: (a) supervisor and manager responsibilities under Defendant's EEO policies and practices; (b) Defendant's prohibition against retaliation for complaints or reports of harassment, including harassment based upon sex-stereotyping, gender-identity, transgender status, and gender dysphoria; (c) the role and responsibilities of supervisors and managers when an employee complains about or reports harassment or suspected harassment. All training

under this Paragraph shall be at Defendant's selection and expense. This training shall be made mandatory.

36. **Human Resource Employees:** In addition to the annual training required in paragraphs 34 and 35, during calendar year 2016, Defendant will require all individuals in the United States who work in a human resource capacity and who provide human resources support to receive additional training regarding Title VII, the ADA, and other federal anti-discrimination laws as described in this paragraph.

- a. The training must directly address sex discrimination, including sex-stereotyping, gender-identity discrimination, and discrimination based on transgender status.
- b. The training must directly address disability discrimination, including discrimination against individuals who have been diagnosed with gender dysphoria.
- c. The training must include instruction in the proper methods of identifying, receiving, communicating, investigating (where applicable), and ameliorating discrimination, including the proper procedures for documenting and preserving evidence of discrimination, archiving the corporation's investigation of complaints, as well as detailing the consequences and result of the investigation where discrimination is found.

37. Defendant will require employees who are newly hired or promoted into a human resource position to receive this training within thirty (30) days of being hired or promoted into a human resource position.

38. **Training on Investigative Techniques:** All employees with direct responsibility for responding to or investigating complaints of discrimination, shall be provided annual training on accepted professional standards for identifying possible discrimination or retaliation, receiving and investigating complaints of discrimination, including such matters as witness interview techniques, other evidence-gathering techniques, maintaining investigative notes and records, legal analysis of the evidence, and methods for eliminating and ameliorating violations of anti-discrimination law.

39. Defendant agrees that the training will take place during 2016. Defendant agrees to document all personnel who complete trainings under this paragraph.

D. Posting of Notice

40. Within ten (10) calendar days from the Court's execution of this Decree, Deluxe shall post an eight and one-half (8.5) inches by eleven (11) inches laminated copy of the Notice attached as Exhibit C to this Decree at all of Deluxe's facilities in a conspicuous location or locations, easily accessible to and commonly frequented by Deluxe's employees (*i.e.* employee bulletin board or lunch room). The Notice shall remain posted for the duration of this Decree. Deluxe shall take all reasonable steps to ensure that the posting is not altered, defaced or covered by any other material. Within fifteen (15) calendar days from the Court's execution of this Decree, Deluxe shall certify

to the EEOC in writing that the Notice has been properly posted as described in this paragraph.

E. EEO Compliance as a Component of Management Evaluation

41. Defendant shall, beginning in 2016, and at least continuously for the duration of this Decree, modify its management evaluation and compensation system to include EEO compliance and, compliance with policies and laws prohibiting retaliation as factors which shall be used to evaluate all managerial employees, including all managers and supervisors.

VIII. RECORD KEEPING AND REPORTING PROVISIONS

42. For the duration of this Consent Decree, Defendant shall maintain all records concerning implementation of this Consent Decree, including, but not limited to, all of the following:

- a. Complaints of discrimination based on sex stereotyping, gender identity or transgender status received by Deluxe Employee Relations and/or the Deluxe Employee Hotline and records documenting investigation of such complaints, including witness statements, documents compiled, conclusions and findings, and any corrective and remedial actions taken;
- b. All documents related to the employee training described above, including but not limited to training materials;
- c. Copies of all written policies and/or guidelines that result from complying with this Decree, including, but not limited, Defendant's revised EEO polices and guidelines; and,

d. Documents related to compliance with this Decree.

43. **Reporting Requirements:** Defendant shall provide annual reports following the entry of this Decree. The first such report shall be due six months following the entry of this Decree and the final report shall be submitted to the Commission six weeks prior to the date on which the Consent Decree is to expire.

44. Each report shall provide the following information:

a. **Reports of Discrimination**

1. For purposes of this Paragraph the term “report of discrimination” will include any written or verbal complaint received by Deluxe Employee Relations and/or Deluxe Employee Hotline that might allege discrimination, or the witnessing of discrimination, based on sex-stereotyping, gender identity discrimination, or transgender status.

2. The report will include:

- The name, address and telephone number of each person making a complaint of such discrimination to Defendant or any federal, state, or local government agency;
- The name, address and telephone number of each person identified as a potential witness to the incident of discrimination;
- A brief summary of each complaint, including the date of the complaint, the name of the individual(s) who allegedly engaged in the discriminatory conduct, the Defendant’s investigation and response to the complaint, the name of the person who investigated

or responded to the complaint, and what, if any resolution was reached; and,

- Copies of all non-privileged documents memorializing or referring to the complaint, investigation, and/or resolution thereof.

- b. **Posting of Notice.** Defendant shall recertify to the Commission that the Notice required under this Consent Decree was posted in accordance with the requirements of this Decree.
- c. **EEO Policies and Guidelines.** Defendant's first report under this provision shall include copies of Defendant's revised EEO policy and guidelines. If changes are made to the EEO policy and guidelines, these changes must be included in the next report.
- d. **Letter of Reference and Letter of Apology.** Defendant's first report under this provision shall include copies of the Letter of Reference and Letter of Apology sent to Britney Austin as required by this Decree.

IX. RETENTION OF JURISDICTION AND ENFORCEMENT OF DECREE

45. This Court shall retain jurisdiction of this cause for purposes of compliance with this Decree and entry of such further orders or modifications as may be necessary or appropriate to effectuate equal employment opportunities for employees.

X. COMPLIANCE

46. In the event that the Commission believes that Defendant has failed to comply with any provision(s) of this Consent Decree, it shall:

- a. Notify Defendant in writing of the alleged non-compliance; and,

- b. Afford Defendant forty-five (45) business days after service of such notification to remedy the non-compliance.
- c. If Defendant has not remedied the alleged non-compliance within forty-five (45) business days, the EEOC may petition the Court to enforce the terms of this Consent Decree at any time during which this Court maintains jurisdiction over this action.
- d. In the event the Court finds Defendant violated this Consent Decree, the Court may order appropriate relief to remedy the non-compliance, including attorneys' fees and appropriate injunctive relief.

X. EEOC AUTHORITY

47. With respect to matters or charges outside the scope of this Decree, this Decree shall in no way limit the powers of the Commission to seek to eliminate employment practices or acts made unlawful by any of the statutes over which the EEOC has enforcement authority, and do not arise out of the claims asserted in this lawsuit.

XI. COSTS AND ATTORNEY'S FEES

48. Defendant shall be responsible for and shall pay Plaintiff Intervenor's attorney fees, as specified above.

XII. NOTICE

49. Unless otherwise indicated, any notice, report, or communication required under the provisions of this Decree shall be sent by certified mail, postage prepaid, as follows:

For Plaintiff:

Iris Halpern
Senior Trial Attorney
EEOC Denver Field Office
303 East 17th Avenue Suite 410
Denver, Co. 80203
(303) 866-1374

For Defendant:

Mary Budge
Senior Counsel
Deluxe Corporation
3680 Victoria Street North
Shoreview, MN 55126
(651) 787-1318

XIII. SIGNATURES

50. The parties agree to the entry of this Decree subject to final approval by the Court.

SO ORDERED this 20th day of January, 2016.

BY THE COURT:

s/Ann D. Montgomery
Ann D. Montgomery
United States District Judge

BY CONSENT AND APPROVED AS TO FORM:

EQUAL EMPLOYMENT
OPPORTUNITY COMMISSION

DELUXE FINANCIAL SERVICES, INC.

By: s/ Mary Jo O'Neill
Mary Jo O'Neill
Regional Attorney

By: s/ Anthony Scarfone
Anthony C. Scarfone
Director/Manager

Date: 1/15/2016

Date: 1/15/2016

s/ Iris Halpern
Iris Halpern (NY #4681607)
Senior Trial Attorney
Michael Imdieke (Colo. #43940)
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303 East 17th Avenue, Ste. 410
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PLAINTIFF INTERVENOR COUNSEL

s/ Jillian T. Weiss
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845-709-3237
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eyoung@jtweisslaw.com

EXHIBIT A (Letter of Reference)

[On Company Letterhead]

To Whom It May Concern:

Britney Austin worked for Deluxe Financial Services from October 8, 2007 to July 29, 2011. Ms. Austin worked at Deluxe's call center in Phoenix, Arizona until the call center was closed. Ms. Austin is eligible for rehire with our company.

Sincerely,

Deluxe Financial Services, LLC

EXHIBIT B (Letter of Apology)

[On Company Letterhead]

RE: *EEOC v. Deluxe Financial Services, Inc.*, Civil Action No. 0:15-cv-02646
(D. Minn.)

Dear Ms. Austin:

On behalf of Deluxe Financial Services, I wish to express my sincere regret at how you were treated in the last year of your employment with Deluxe. We want to ensure you that we have made changes to our internal policies, including how we treat transgender employees' requests to change biographical information or use a restroom commensurate with their gender identity. The company has changed its policies to ensure that transgender employees may use a restroom commensurate with their gender identity, that the company will promptly correct that employee's sex designation and name in our internal records and systems, and that we will take hostile comments based on sex-stereotyping seriously, investigate them, and take prompt corrective and remedial action.

Sincerely,

Julie Loosbrock
Senior Vice President Human Resources
Deluxe Financial Services

EXHIBIT C

[On company letterhead]

NOTICE

The following notice is being circulated pursuant to the terms of a Consent Decree reached between the Parties in *EEOC v. Deluxe Financial Services, Inc.*, filed in the United States District Court for the District of Minnesota, Civil Action No. 0:15-cv-02646.

Federal law, including Title VII of the Civil Rights Act of 1964, makes it unlawful for an employer to discriminate based upon sex including treating differently or harassing an employee because of stereotypes about how a person of his or her sex should look or act, or because of his or her gender identity or transgender status. Discrimination against transgender status includes the intentional misuse of gender pronouns when referring to an employee, and refusing to let a transgender employee use a restroom commensurate with his or her gender identity. The Americans with Disabilities Act also prohibits discrimination against individuals with gender dysphoria. Federal laws generally protect against discrimination because of race, color, sex (including sexual harassment and pregnancy discrimination), religion, disability, and age.

If you believe you have been subjected to discrimination or retaliation because of your disability, sex, or because you are transgender, employees are encouraged to contact [Insert name of appropriate authority(s) and if applicable contact numbers].

Any employee who believes that he/she has suffered discrimination on the basis of age, race, color, religion, sex, pregnancy, national origin, genetic information, or disability, has the right to contact the EEOC directly at [phone number; address of local office], or the Minnesota Department of Human Rights at [phone number/ local address]. It is unlawful for any employer to retaliate against an employee because the employee complains about a discriminatory practice, sought legal advice with respect to possible discriminatory treatment, or because the employee filed a charge of discrimination with any municipal, state, or federal equal employment opportunity agency, or because the employee has participated in an investigation of a charge of discrimination. In compliance with federal law, no official at Deluxe Financial Services will retaliate against an employee who makes an internal complaint of discrimination or who contacts the EEOC or its state counterpart.

By: _____

Date: _____

Julie Loosbrock
Senior Vice President Human Resources

Cruz v. Zucker, 116 F.Supp.3d 334 (2015)

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116 F.Supp.3d 334
United States District Court,
S.D. New York.

Angie CRUZ, I.H., Ar'es Kpaka, and Riya Christie, on behalf
of themselves and all others similarly situated, Plaintiffs,

v.

Howard ZUCKER, as Commissioner of the Department of Health [of the State of New York], Defendant.

No. 14-cv-4456 (JSR).

|
Signed July 29, 2015.

Synopsis

Background: Medicaid recipients, who had been diagnosed with Gender Dysphoria (GD), brought putative class action against Commissioner of Department of Health of State of New York, alleging that exclusion in New York's Medicaid program that barred payment for gender reassignment treatment violated their rights under federal Medicaid Act. Commissioner moved to dismiss for failure to state claim.

Holdings: The District Court, [Jed S. Rakoff, J.](#), held that:

- [1] Medicaid Act's Availability Requirement conferred individual right redressable under § 1983;
- [2] Comparability Requirement conferred individual right redressable under § 1983;
- [3] recipients could not privately enforce Reasonable Standards Requirement;
- [4] recipients failed to state claim for sex discrimination under Affordable Care Act (ACA);
- [5] recipients stated claim under Comparability Requirement; and
- [6] recipients were not required to seek coverage for "cosmetic" services in order for their challenge to New York's exclusion for such services to be ripe for adjudication.

Motion granted in part and denied in part.

West Headnotes (13)

- [1] **Health** 🔑 Medicaid and similar programs in general
- Health** 🔑 State participation in federal programs

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Medicaid is a cooperative state and federal benefit program designed to provide necessary medical services to needy persons of modest income; states need not participate in the program, but if they choose to do so, they must implement and operate Medicaid programs that comply with detailed federally mandated standards. Medicaid Act, §§ 1901, 1902, 42 U.S.C.A. §§ 1396, 1396a.

[Cases that cite this headnote](#)

[2] **Civil Rights** 🔑 Rights Protected

In order to seek redress through § 1983, a plaintiff must assert the violation of a federal right, not merely a violation of federal law. 42 U.S.C.A. § 1983.

[Cases that cite this headnote](#)

[3] **Civil Rights** 🔑 Rights Protected

In determining whether a particular statutory provision gives rise to a federal right, as required for a plaintiff to seek redress under § 1983, courts apply a three-pronged test: (1) Congress must have intended that the provision in question benefit the plaintiff; (2) the plaintiff must demonstrate that the right assertedly protected by the statute is not so vague and amorphous that its enforcement would strain judicial competence; and (3) the statute must unambiguously impose a binding obligation on the states, meaning it must be couched in mandatory, rather than precatory, terms. 42 U.S.C.A. § 1983.

[Cases that cite this headnote](#)

[4] **Civil Rights** 🔑 Rights Protected

Civil Rights 🔑 Availability, Adequacy, Exclusivity, and Exhaustion of Other Remedies

If the plaintiff demonstrates that the federal statute creates an individual right, the defendant may nonetheless rebut the presumption that such right is enforceable via a § 1983 action by showing that Congress specifically foreclosed a remedy under § 1983, either expressly or impliedly, by creating a comprehensive enforcement scheme that is incompatible with individual enforcement under § 1983. 42 U.S.C.A. § 1983.

[Cases that cite this headnote](#)

[5] **Civil Rights** 🔑 Public Services, Programs, and Benefits

Provision of federal Medicaid Act that required state Medicaid plans to provide for making medical assistance available to all categorically needy individuals, including at least certain enumerated types of care and services, conferred individual right to medical services described in the provision, as required for New York's alleged violation of provision as to Medicaid recipients with Gender Dysphoria (GD) to be redressable under § 1983; language of provision expressly addressed needs of individual Medicaid beneficiaries, provision supplied concrete and objective, rather than vague, standards for enforcement, and provision was framed in mandatory terms, including using word "must." Medicaid Act, §§ 1902(a)(10)(A), 1905(a), 42 U.S.C.A. §§ 1396a(a)(10)(A), 1396d(a).

[1 Cases that cite this headnote](#)

[6] **Civil Rights** 🔑 Public Services, Programs, and Benefits

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Provision of federal Medicaid Act that required that medical assistance made available to any categorically needy individual under state Medicaid plans to be not less in amount, duration, or scope than medical assistance made available to any other such individual, conferred individual right to medical services described in the provision, as required for New York's alleged violation of provision as to Medicaid recipients with Gender Dysphoria (GD) to be redressable under § 1983; provision focused on particular services that individual beneficiaries were entitled to receive, provision used mandatory language, and provision was not vague or amorphous. Medicaid Act, § 1902(a)(1)(B)(i), 42 U.S.C.A. § 1396a(a)(1)(B)(i).

[1 Cases that cite this headnote](#)

[7] **Action** 🔑 Statutory rights of action

Health 🔑 Judicial Review; Actions

Provision of federal Medicaid Act that required state Medicaid plans to include reasonable standards for determining eligibility was subject to administrative enforcement mechanism, i.e., defunding by Secretary of Health and Human Services, and thus Medicaid recipients with Gender Dysphoria could not privately enforce provision against state of New York. Medicaid Act, § 1902(a)(17), 42 U.S.C.A. § 1396a(a)(17).

[1 Cases that cite this headnote](#)

[8] **Civil Rights** 🔑 Public Services, Programs, and Benefits

Medicaid recipients with Gender Dysphoria (GD) failed to allege that treatments barred by exclusion in New York's Medicaid program, i.e., hormone therapy or gender reassignment therapy for individuals under 18 and gender reassignment surgery for individuals under 21, were available to non-transgender individuals, as required to state claim for sex discrimination under Affordable Care Act (ACA). Patient Protection and Affordable Care Act, § 1557, 42 U.S.C.A. § 18116.

[Cases that cite this headnote](#)

[9] **Civil Rights** 🔑 Complaint in general

Complaints alleging civil rights violations must be construed especially liberally.

[Cases that cite this headnote](#)

[10] **Health** 🔑 Sex change; gender disorders

Medicaid recipients with Gender Dysphoria (GD) stated claim under provision of federal Medicaid Act, which required that medical assistance made available to any categorically needy individual under state Medicaid plans to be not less in amount, duration, or scope than medical assistance made available to any other such individual, by alleging that New York denied recipients medically necessary surgical procedures but provided medically necessary procedures to individuals with conditions other than GD. Medicaid Act, § 1902(a)(1)(B)(i), 42 U.S.C.A. § 1396a(a)(1)(B)(i).

[Cases that cite this headnote](#)

[11] **Federal Courts** 🔑 Nature of dispute; concreteness

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A claim is not ripe for adjudication if it rests upon contingent future events that may not occur as anticipated, or indeed may not occur at all.

[Cases that cite this headnote](#)

[12] Federal Courts 🔑 Ripeness; Prematurity

Courts do not require a futile gesture as a prerequisite for a claim to be ripe for adjudication in federal court.

[Cases that cite this headnote](#)

[13] Health 🔑 Judicial Review; Actions

Any attempt for Medicaid recipients with Gender Dysphoria (GD) to seek coverage for procedures deemed “cosmetic” by New York’s Medicaid program would have been futile gesture, and thus recipients were not required to seek such coverage in order for their challenge to New York’s exclusion of coverage for “cosmetic” procedures to be ripe for adjudication; exclusion made clear that “payment will not be made for” services deemed “cosmetic.”

[Cases that cite this headnote](#)

Attorneys and Law Firms

*336 [Adriene L. Holder](#), [Belkys Raquel Garcia](#), [Judith A. Goldiner](#), [Kimberly Forte](#), [Rebecca Antar Novick](#), [Scott Alan Rosenberg](#), [Legal Aid Society](#), [Mary Jane Eaton](#), [Megan Yolanda Hogan](#), [Christopher James McNamara](#), [Lee Larson Hulsebus](#), [Norman Paul Ostrove](#), [Wesley Railey Powell](#), [Willkie Farr & Gallagher LLP](#), [Pooja Sunder Gehi](#), [Elana Carroll Redfield](#), [Sylvia Rivera Law Project](#), [Sumani Vani Lanka](#), [Virginia & Ambinder, LLP](#), New York, NY, for Plaintiffs.

[John Peter Gasior](#), [Peter W. Beauchamp](#), [Zoey Chenitz](#), [Office Of The Attorney General](#), New York, NY, for Defendant.

OPINION

[JED S. RAKOFF](#), District Judge.

The intersection of our cognition with our emotions is both the essence of our humanity and the source of our anxiety. According to the plaintiffs in this class action, someone who is born with the physical equipment of one sex but emotionally identifies as someone of the opposite sex suffers severe anxiety and emotional distress that may, however, be materially alleviated by available medical procedures. Plaintiffs further contend that New York wrongly denies Medicaid coverage for many such procedures, regarding them as merely “cosmetic” or the like. The immediate question before the Court is whether the plaintiffs here can sue for redress of this alleged wrong. The Court concludes that they can.

*337 Plaintiff [Angie Cruz](#), now fifty years old, alleges that she was assigned male at birth but has identified as female since she was ten years old. *See* Amended Class Action Complaint dated March 27, 2015, ECF No. 27 (“Am. Compl.”) ¶¶ 91, 93. She began taking hormones as a teenager in an effort to bring her physical appearance into alignment with her gender identity and has undergone hormone therapy for much of her adult life, purchasing her hormones sometimes from doctors and pharmacies and sometimes on the street. *Id.* ¶¶ 94–95. Although this therapy has given her body a more feminine appearance, she still experiences intense distress and interference with her capacity for normal activity as a result of the mismatch between her body

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and her identity. *Id.* ¶¶ 96, 99, 104–05. Cruz is a “categorically needy” Medicaid recipient, meaning that she meets one of nine eligibility categories set forth in the federal Medicaid Act, 42 U.S.C. § 1396a(a)(10)(A)(i). *Id.* ¶¶ 29, 91.

Plaintiff Ar'es Kpaka, also a categorically needy Medicaid recipient, alleges that, although born with a male body, she has identified as female since she was three years old. *Id.* ¶ 136. As an adolescent, she hid her gender identity from her mother and brothers until, at age twenty-one, she was forced to move out of her mother's home and became homeless for several months. *Id.* ¶ 137. Now twenty-three, she is undergoing hormone therapy but still struggles with depression relating to her gender identity. *Id.* ¶¶ 136, 138, 140.

Plaintiff Riya Christie alleges that, growing up in Jamaica, she faced violence because of her gender expression and suffered from severe depression and suicidal thoughts. *Id.* ¶¶ 149–50. At the age of twenty-one, she moved to the United States and was granted asylum on the ground that her gender identity made it unsafe for her to return home. *Id.* ¶ 152. Now twenty-three, she continues to experience pain and anxiety as a result of the incongruence between her body and her gender identity. *Id.* ¶ 159. She, like Cruz and Kpaka, is a categorically needy Medicaid recipient. *Id.* ¶ 136.

Each of the three named plaintiffs in this class action has been diagnosed with Gender **Dysphoria** (“GD”) (formerly known as Gender Identity Disorder).¹ *Id.* ¶¶ 95, 138, 155. They allege that GD is recognized by the medical community as “ ‘an identifiable, severe and incapacitating disease.’ ” *Id.* ¶ 80 (quoting D. Harish & B. Sharma, *Medical Advances in Transsexualism and the Legal Implications*, 24 Am. J. Forensic Med. & Pathology 100, 101 (2003)). It is defined in the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (“DSM–V”) as a “marked incongruence between one's experienced/expressed gender and assigned gender,” as manifested by at least two of the following: (i) a “marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics...”; (ii) a “strong desire to be rid of one's primary and/or secondary sex characteristics...”; (iii) “a strong desire for the primary and/or secondary sex characteristics of the other gender”; (iv) a “strong desire to be of the other gender...”; (v) a “strong desire to be treated as the other gender...”; and (vi) a “strong conviction that one has the typical feelings and reactions of the other gender...” *Id.* ¶ 82 (quoting DSM–V §§ 302.06, 302.85). The DSM–V further specifies that GD is “associated with clinically *338 significant distress or impairment in social, occupational, or other important areas of functioning.” *Id.*

Plaintiffs allege that, in order to alleviate the profound psychological suffering and **social and occupational impairment** that they experience as a result of their GD, they need certain treatments to facilitate their **transitions** to the gender with which they identify. The treatments they seek include **breast augmentation**, facial feminizing surgery, chondrolarngoplasty (commonly referred to as “tracheal shave”), body sculpting procedures, and **electrolysis**. *Id.* ¶¶ 101, 141, 157. Plaintiffs allege that these treatments are safe, effective, and medically necessary. *Id.* ¶¶ 83–88. However, plaintiffs allege, they have been denied access to the needed treatments because such treatments are excluded from coverage under New York State's Medicaid program. *Id.* ¶¶ 103, 143, 158.

Prior to 1998, medical coverage was available under New York's Medicaid program for the treatment of GD, including hormone treatment and sex reassignment surgery. *Id.* ¶ 2. However, in 1998, the New York State Department of Health (“DOH”), which is responsible for administering the state's Medicaid program, promulgated 18 N.Y.C.R.R. § 505.2(l), which barred payment for all “care, services, drugs or supplies rendered for the purposes of gender reassignment” treatment or for “promoting” such treatment (“Section 505.2(l)”). *Id.*

On June 19, 2014, plaintiffs filed a class action complaint on behalf of themselves and all similarly situated individuals against Dr. Howard Zucker, acting in his official capacity as Commissioner of DOH, alleging that Section 505.2(l) violates various provisions of state and federal law. ECF No. 1. On August 21, 2014, the parties agreed to a Provisional Stipulation and Order of Class Certification, pursuant to which the Court certified a class consisting of:

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All New York State Medicaid recipients who have been diagnosed with Gender Identity Disorder or Gender **Dysphoria**, and whose expenses associated with medically necessary Gender Identity Disorder- or Gender Dysphoria-related treatment are not reimbursable by Medicaid pursuant to [18 N.Y.C.R.R. § 505.2\(l\)](#).

ECF No. 23. Subsequently, on December 17, 2014, DOH published a Notice of Proposed Rule Making that proposed amendments to [Section 505.2\(l\)](#) (“Amended [Section 505.2\(l\)](#)”).

The proposed Amended [Section 505.2\(l\)](#) lifted the blanket ban on coverage for treatment of GD, making hormone therapy and [gender reassignment surgery](#) available to certain Medicaid recipients. Am. Compl. ¶ 5; Declaration of John Gasior dated April 17, 2015, ECF No. 31 (“Gasior Decl.”) Ex. 1. However, it preserved two important coverage exclusions. First, it excluded coverage for “cosmetic surgery, services, and procedures,” which it defined as “anything solely directed at improving an individual’s appearance,” including but not limited to certain enumerated procedures such as [breast augmentation](#), [electrolysis](#), thyroid [chondroplasty](#), and facial [bone reconstruction](#), reduction, or sculpturing (the “Cosmetic Procedures Exclusion”). Gasior Decl. Ex. 1. Second, it did not provide coverage for hormone therapy or [gender reassignment surgery](#) for individuals under the age of eighteen, or for [gender reassignment surgery](#) for individuals under the age of twenty-one where such surgery would result in sterilization (the “Youth Exclusion”). *Id.*

The Amended [Section 505.2\(l\)](#) came into effect on March 11, 2015. On March 27, 2015, plaintiffs filed their Amended Complaint. *339 In it, plaintiffs allege that the Amended [Section 505.2\(l\)](#) violates various provisions of Title XIX of the Social Security Act (the “Medicaid Act”), the Patient Protection and Affordable Care Act (“ACA”), and the New York State Constitution. Specifically, plaintiffs assert six causes of action: (I) violation of [42 U.S.C. § 1396a\(a\)\(10\)\(A\)](#) and its implementing regulation, [42 C.F.R. § 440.210](#) (the “Availability Requirement” of the Medicaid Act); (II) violation of [42 U.S.C. § 1396a\(a\)\(10\)\(B\)](#) and its implementing regulation, [42 C.F.R. § 440.240\(b\)](#) (the “Comparability Requirement” of the Medicaid Act); (III) violation of [42 U.S.C. §§ 1396a\(a\)\(17\)](#), [1396a\(a\)\(10\)\(B\)\(i\)](#) and their implementing regulation, [42 C.F.R. § 440.230\(c\)](#) (the “Reasonable Standards Requirement” of the Medicaid Act); (IV) violation of [Article I, Section 11 of the New York State Constitution](#), which guarantees equal protection of the laws; (V) Section 1557 of the ACA, [42 U.S.C. § 18116](#), which prohibits sex discrimination in the provision of healthcare; and (VI) violation of [42 U.S.C. § 1396a\(a\)\(43\)](#), which requires states to provide “early and periodic screening, diagnostic, and treatment services” for eligible persons under the age of twenty-one (the “EPSDT Requirement” of the Medicaid Act).²

Defendant moved to dismiss the Amended Complaint. By “bottom line” Order dated June 26, 2015, the Court granted in part and denied in part defendant’s motion. ECF No. 46. This Opinion explains the reasons for those rulings.

[1] As discussed above, in their Amended Complaint, plaintiffs allege violations of various provisions of the federal Medicaid Act. Medicaid is a cooperative state and federal benefit program designed to provide necessary medical services to “needy persons of modest income.” *Cnty. Health Ctr. v. Wilson–Coker*, 311 F.3d 132, 134 (2d Cir.2002). “States need not participate in the program, but if they choose to do so, they must implement and operate Medicaid programs that comply with detailed federally mandated standards.” *Cnty. Health Care Ass’n of N.Y. v. Shah*, 770 F.3d 129, 135 (2d Cir.2014) (quoting *Three Lower Cnties. Cnty. Health Servs., Inc. v. Maryland*, 498 F.3d 294, 297 (4th Cir.2007) (internal quotation marks omitted)). States that elect to receive federal Medicaid funds must submit a plan detailing how they will spend such funds to the Centers for Medicare and Medicaid Services, a federal agency within the Department of Health and Human Services. *Wilson–Coker*, 311 F.3d at 134 (citing [42 U.S.C. §§ 1396, 1396a](#)). State Medicaid plans are subject to extensive requirements, four of which are relevant here.

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Availability. The Availability Requirement provides that a state plan for medical assistance “must provide ... for making medical assistance available [to all categorically needy individuals], including at least” certain enumerated types of care and services, including inpatient and outpatient hospital services, laboratory and x-ray services, *340 nursing facility services, and physicians' services. 42 U.S.C. § 1396a(a)(10)(A), 42 U.S.C. § 1396d(a). Categorically needy individuals are those meeting one of nine eligibility criteria, which include, for example, receipt of supplemental security income benefits and having an income that does not exceed 133 percent of the poverty line. 42 U.S.C. § 1396a(a)(10)(A)(i)(I)-(IX).

The implementing regulation, 42 C.F.R. § 440.210, requires the State plan to provide categorically needy individuals with the “services defined in § 440.10 through 440.50[and] 440.70.” Those provisions, in turn, further define the types of services that must be provided. For example, “inpatient hospital services” are defined as services that “(1) are ordinarily furnished in a hospital for the care and treatment of inpatients; (2) are furnished under the direction of a physician or dentist; and (3) are furnished in an [appropriate and approved] institution...” 42 C.F.R. § 440.10(a). Similarly, “physicians' services” are defined as “services furnished by a physician ... [w]ithin the scope of practice of medicine or osteopathy as defined by State law; and ... [b]y or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.” 42 C.F.R. § 440.50(a).

The implementing regulations further provide, in relevant part:

- (b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.
- (c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or condition.
- (d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

42 C.F.R. § 440.230.

Comparability. The Medicaid Act's Comparability Requirement provides that “the medical assistance made available to any [categorically needy individual] ... shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual.” 42 U.S.C. § 1396a(a)(1)(B)(i). Its implementing regulation provides that the state's “plan must provide that the services available to any [categorically needy] individual ... are equal in amount, duration, and scope for all beneficiaries within the [categorically needy] group.” 42 C.F.R. § 440.240(b). The purpose of the Comparability Requirement is to make clear that “states may not provide benefits to some categorically needy individuals but not to others.” *Rodriguez v. City of New York*, 197 F.3d 611, 615 (2d Cir.1999).

EPSDT. The Medicaid Act further requires a state plan for medical assistance to provide “early and periodic screening, diagnostic, and treatment services,” including regular screening for physical and mental illnesses and conditions, to eligible individuals under the age of twenty-one. 42 U.S.C. §§ 1396a(a)(43), 1396d(r). In addition, the state plan must provide “[s]uch other necessary health care, diagnostic services, treatment, and other measures ... to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.” 42 U.S.C. § 1396d(r)(5).

Reasonable Standards. Finally, the Medicaid Act requires that the state plan must “include reasonable standards ... for determining eligibility for and the extent *341 of medical assistance under the plan which [] are consistent with the objectives of [the Medicaid Act].” 42 U.S.C. § 1396a(a)(17). This subsection further sets forth certain requirements for the “reasonable standards” that the state must adopt, such as the types of income and resources that the state may take into account in determining eligibility. *Id.*

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Plaintiffs' claims alleging violations of the Availability Requirement (Count I), the Comparability Requirement (Count II), and the EPSDT Requirement (Count VI) of the federal Medicaid Act are brought pursuant to 42 U.S.C. § 1983 ("Section 1983"), which provides:

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress...

42 U.S.C. § 1983. In his motion to dismiss, defendant argued that Section 1983 does not create a private right of action to enforce these provisions, and therefore that plaintiffs' Counts I, II, and VI must be dismissed for failure to state a claim.

[2] [3] [4] In *Maine v. Thiboutot*, the Supreme Court held that the Section 1983 remedy encompasses rights conferred by federal statutes. 448 U.S. 1, 4, 100 S.Ct. 2502, 65 L.Ed.2d 555 (1980). Nonetheless, "[i]n order to seek redress through § 1983, ... a plaintiff must assert the violation of a federal right, not merely a violation of federal law." *Blessing v. Freestone*, 520 U.S. 329, 340, 117 S.Ct. 1353, 137 L.Ed.2d 569 (1997). In determining whether a particular statutory provision gives rise to a federal right, courts apply a three-pronged test: (1) "Congress must have intended that the provision in question benefit the plaintiff"; (2) "the plaintiff must demonstrate that the right assertedly protected by the statute is not so 'vague and amorphous' that its enforcement would strain judicial competence"; and (3) "the statute must unambiguously impose a binding obligation on the States," meaning it "must be couched in mandatory, rather than precatory, terms." *Id.* at 340–41, 117 S.Ct. 1353. If the plaintiff demonstrates that the federal statute creates an individual right, the defendant may nonetheless rebut the presumption that such right is enforceable via a Section 1983 action by showing that Congress "specifically foreclosed a remedy under § 1983," either expressly or "impliedly, by creating a comprehensive enforcement scheme that is incompatible with individual enforcement under § 1983." *Id.* at 341, 117 S.Ct. 1353 (internal quotation marks and citations omitted). This test is known as the "*Blessing*" test.

In *Gonzaga University v. Doe*, the Supreme Court clarified that, with respect to the first prong of the *Blessing* test, it "reject[ed] the notion that our cases permit anything short of an unambiguously conferred right to support a cause of action brought under § 1983." 536 U.S. 273, 283, 122 S.Ct. 2268, 153 L.Ed.2d 309 (2002). It was insufficient, the Court held, that the "plaintiff falls within the general zone of interest that the statute is intended to protect." *Id.* at 283, 122 S.Ct. 2268. The Court reaffirmed that "unless Congress 'speak[s] with a clear voice,' and manifests an 'unambiguous' intent to confer individual rights, federal funding provisions provide no basis for private enforcement by § 1983." *Id.* at 280, 122 S.Ct. 2268 (quoting *342 *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 17, 28 and n. 21, 101 S.Ct. 1531, 67 L.Ed.2d 694 (1981)).

In arguing that provisions of the Medicaid Act cited by plaintiffs do not create private rights of action under Section 1983, defendant relies heavily on *Casillas v. Daines*, 580 F.Supp.2d 235, 242 (S.D.N.Y.2008). The plaintiff in that case, Terri Casillas, was a New York State Medicaid recipient who had been diagnosed with GD, and whose physicians had recommended that she undergo hormone therapy, orchiectomy (removal of the testes), and vaginoplasty (removal of the penis and creation of a vagina). *Id.* at 237–38. She brought an action under Section 1983 challenging the original Section 505.2(l) under the Availability and Comparability Requirements of the Medicaid Act.³ *Id.* at 241–44. The court granted defendant's motion for judgment on the pleadings, holding that neither provision created a right enforceable under Section 1983.

With respect to the Availability Requirement, *Casillas* held that neither the first nor the second prong of the *Blessing* test was met. As to the first prong, it held that, although the Availability Requirement may confer certain rights on certain classes of persons, it did not unambiguously confer the right that plaintiff asserted, namely the right to receive the specific treatments

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for GD that had been deemed medically necessary by her physicians. *Id.* at 241–43. The court reasoned that the Availability Requirement requires states to provide coverage for certain broad categories of medical services, but does not “mandate that a particular level or type of care must be provided.” *Id.* at 242. In so finding, it relied on Supreme Court's decision in *Beal v. Doe*, 432 U.S. 438, 97 S.Ct. 2366, 53 L.Ed.2d 464 (1977), for the proposition that “nothing in the statute suggests that participating states are required to fund every medical procedure that falls within the delineated categories of medical care.” *Id.* (quoting *Beal*, 432 U.S. at 444, 97 S.Ct. 2366) (alteration omitted).

The *Casillas* court further reasoned that the right that plaintiff asserted was inconsistent with the Availability Requirement's implementing regulation, which allows states to “ ‘place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.’ ” *Id.* (quoting 42 C.F.R. § 440.230(d)). These criteria, the court held, particularly the reference to “utilization control procedures,” “capture [] concepts that do not relate to the care of any one particular patient but looks to actual or expected utilization over a broader population,” and thus indicate that the Availability Requirement is intended to prescribe standards with which the state plan must comply rather than to create individual rights. *Id.*

As to the second prong of the *Blessing* test, *Casillas* further held that the phrase “utilization control procedures” was “so ‘vague and amorphous’ that its enforcement would strain judicial competence.” *Id.* at 243 (quoting *Blessing*, 520 U.S. at 340–41, 117 S.Ct. 1353). This term, the court noted, is “susceptible to multiple plausible interpretations and lacks a fixed meaning.” *Id.* Moreover, it noted, the regulation permits a state to rely on other unspecified criteria in crafting “appropriate limits” on medical services, thereby compounding the vagueness problem. *Id.*

*343 [5] Although in no way binding on this Court, *Casillas* is entitled to this Court's respectful attention. But in the end, the Court finds itself in disagreement with that decision's reasoning and conclusions. In particular, the Court concludes that the Availability Requirement unambiguously confers on categorically needy individuals an individual right to the medical services described in the statute and its implementing regulations. *Gonzaga*, 536 U.S. at 280, 122 S.Ct. 2268.

As an initial matter, *Casillas's* reliance on *Beal* is misplaced. That case concerned a Pennsylvania regulation that limited Medicaid coverage for abortions to those that had been certified by the recipient's physicians as medically necessary. *Beal*, 432 U.S. at 441–42, 97 S.Ct. 2366. In holding that the challenged regulation did not violate the Medicaid Act, the Supreme Court focused on the fact that the excluded procedures were not medically necessary. *Id.* at 440, 97 S.Ct. 2366 (describing the question presented as whether the Medicaid Act requires states to “fund the cost of *nontherapeutic abortions*” (emphasis added)). It expressly noted that denial of medically necessary treatment would pose a very different question: “Although serious statutory questions might be presented *if a state Medicaid plan excluded necessary medical treatment from its coverage*, it is hardly inconsistent with the objectives of the Act for a State to refuse to fund unnecessary though perhaps desirable medical services.” *Id.* at 444–45, 97 S.Ct. 2366 (emphasis added).⁴ Here, by contrast, plaintiffs allege that the treatments they seek are medically necessary, and on a motion to dismiss, the Court must accept that allegation as true.

Regarding the first prong of the *Blessing* test, the language of the Availability Requirement is expressly addressed to the needs of individual Medicaid beneficiaries: “[a] State plan ... must provide for making medical assistance available ... *to all individuals* ” who meet certain eligibility requirements. 42 U.S.C. § 1396a(a)(10)(A). This is precisely the “unmistakable focus on the benefited class” that the Supreme Court, in *Gonzaga*, held would evince Congress's intent to create an individual right. 536 U.S. at 284, 122 S.Ct. 2268 (citation and internal quotation marks omitted). Indeed, the Third Circuit has found that “the ‘individual focus’ of [the Availability Requirement] is unmistakable.” *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 190 (3d Cir.2004).

Although the Second Circuit has not had occasion to consider this question, it has held that a similarly worded provision of the Medicaid Act created a privately enforceable right. See *Rabin v. Wilson–Coker*, 362 F.3d 190 (2004). The provision at

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issue in *Rabin* granted a six-month extension of eligibility for medical assistance, provided the recipient complied with certain reporting requirements:

“[E]ach State plan approved under this subchapter must provide that each family which was receiving aid pursuant to a plan of the State ... in at least 3 of the 6 months immediately preceding the month in which such family becomes ineligible for such aid ... shall ... remain eligible for assistance under the *344 plan ... during the immediately succeeding 6-month period.”

Id. at 194 (quoting 42 U.S.C. § 1396r-6(b)). The Second Circuit found that, by focusing on individual (or family) entitlements rather than high-level programmatic requirements, Congress intended to create an enforceable right. *Id.* at 201–02. Given the grammatical similarity between this provision and the Availability Requirement, it follows that the Availability Requirement also evinces congressional intent to create an enforceable right.

Contrary to *Casillas*, nothing about the existence of this right is inconsistent with the “appropriate limits” clause of the implementing regulations. 42 C.F.R. § 440.230(d). That clause simply provides that, like most rights, the right to the medical services described in the Availability Requirement is not absolute. Rather, it is subject to limits that the state may enact, consistent with the discretion vested in the state by the statute. That discretion is not boundless. The state may enact only “appropriate” limits, must provide services that are “sufficient in amount, duration, and scope to reasonably achieve [their] purpose,” and “may not arbitrarily deny or reduce the amount, duration, or scope of a required service ... to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or condition.” 42 C.F.R. § 440.230(b)-(d). These provisions define the contours of the right; they do not negate its existence.

Nor is this right so “vague and amorphous” as to be judicially unmanageable under the second prong of the *Blessing* test. The Availability Requirement and its implementing regulations set forth in detail the services that states must provide to their needy residents, and states' compliance with these requirements is objectively measureable. See *Watson v. Weeks*, 436 F.3d 1152, 1161 (9th Cir.2006) (“[Sections 1396a(a)(10) and 1396d(a) supply concrete and objective standards for enforcement; they are hardly vague and amorphous.”).

Casillas found that the term “utilization control procedures,” as used in the implementing regulations, was not judicially manageable. *Casillas*, 580 F.Supp.2d at 243. But courts have had no trouble adjudicating whether a particular regulation is a valid utilization control procedure. For example, in *DeLuca v. Hammons*, 927 F.Supp. 132 (S.D.N.Y.1996), plaintiffs challenged a regulation, which the state defended as a utilization control procedure, that limited home-care services for new Medicaid recipients to twenty-eight hours per week. *Id.* at 134. The court found that this arbitrary cap was “not appropriate in that it discriminates among applicants and intentionally fails to take into account the amount of services that have been determined ... to be necessary for the health and safety of the patient.” *Id.* at 136. See also, e.g., *Davis v. Shah*, No. 12–CV–6134 CJS, 2013 WL 6451176, at *12 (W.D.N.Y. Dec. 9, 2013) (holding that regulation limiting access to medically necessary orthopedic shoes and compression stockings based on diagnosis was not valid utilization control procedure); *Ladd v. Thomas*, 962 F.Supp. 284, 294 (D.Conn.1997) (holding that requirement that Medicaid recipients submit requests for prior authorization of durable medical equipment to vendor was a valid utilization control procedure).

Casillas further expressed concern that the implementing regulation permits a state agency to place “appropriate limits” on services based on unspecified other criteria. To be sure, this provision grants the state a considerable measure of discretion. It does not, however, render the asserted right entirely standardless. For example, a limitation based on genuine *345 health and safety concerns would most likely be an “appropriate limit,” whereas one based solely on animus towards a disfavored class most certainly would not. Nothing about this determination stretches the bounds of judicial competence.

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Finally, regarding the third prong of the *Blessing* test, the Availability Requirement is framed in mandatory terms. It provides that state plans “must” make available the services described. Provision of these services is not optional. Accordingly, the Court finds that all three *Blessing* factors are met and the Availability Requirement creates an individual right enforceable under [Section 1983](#).⁵

[6] With respect to the Comparability Requirement, the Court also finds that all three *Blessing* factors are met. First, the statutory language is squarely directed toward individual rights: “the medical assistance made available to any [categorically needy individual] ... shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual.” [42 U.S.C. § 1396a\(a\)\(1\)\(B\)\(i\)](#). The implementing regulations further provide that a state Medicaid “plan must provide that the services available to any individual in the following groups are equal in amount, duration, and scope for all beneficiaries within the group: (1) The categorically needy. (2) A covered medically needy group.” [42 C.F.R. § 440.240\(b\)](#). These provisions, like those of the Availability Requirement, focus on the particular services that individual beneficiaries are entitled to receive, not on the broader structure of the Medicaid program as a whole, and thus evince congressional intent to create individual rights.

In holding otherwise, the *Casillas* court relied on [Rodriguez v. City of New York, 197 F.3d 611 \(2d Cir.1999\)](#). In *Rodriguez*, New York had elected to provide certain types of personal care services to individuals with disabilities, which were not among the services it was required to provide under the Availability Requirement. *Id.* at 613. Plaintiffs contended that, under the Comparability Requirement, the state was required to provide “safety monitoring,” a different service that plaintiffs alleged was comparable to the personal care services that the state had chosen to cover. *Id.* at 616. The Second Circuit rejected plaintiffs’ argument, noting that “[a] holding to the contrary would ... create a disincentive for states to provide services optional under federal law lest a court deem other services ‘comparable’ to those provided ... thereby increasing the costs of the optional services.” *Id.*

***346** The right asserted in *Rodriguez* is very different from the right asserted here. The *Rodriguez* plaintiffs sought access to a specific service that the state was not required to provide and that it had not chosen to provide to anyone. Here, by contrast, plaintiffs allege that the specific treatments they seek are already provided to other Medicaid recipients but have been denied to them on the basis of their GD diagnoses alone. This, they allege, demonstrates that the services they receive under New York’s Medicaid program are not “equal in amount, duration, and scope” to those received by other categorically needy individuals. [42 C.F.R. § 440.240\(b\)](#).

In *Casillas*, the court found that the right asserted by plaintiff would, as in *Rodriguez*, create a disincentive for states to provide specific treatments: “the state would have to consider other possible diagnoses for which the treatment might be prescribed before deciding whether to make it available for any single condition.” *Id.* at 244. While that may be the case, requiring the state to undertake such considerations is entirely consistent with the purpose of an anti-discrimination provision. In enacting the Comparability Requirement, Congress made clear that the states may not blithely provide services to some of their needy residents while denying the same services to others who are equally needy. Thus, this is not a reason to find that the Comparability Requirement does not give rise to an individual right.

The Comparability Requirement also satisfies the second and third prongs of the *Blessing* test. The standard set forth in the statute—that services provided to some categorically needy individuals may not be “less in amount, duration, or scope” than those provided to others—is neither vague nor amorphous. [42 U.S.C. § 1396a\(a\)\(1\)\(B\)\(i\)](#). And by directing that services “shall” be comparable, Congress made clear that this requirement was mandatory and binding on the states. Accordingly, the Court finds that the Comparability Requirement creates an enforceable individual right.⁶

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Finally, although defendant makes no argument regarding the EPSDT Requirement, *see supra* note 2, the Court finds that the EPSDT Requirement is also privately enforceable under [Section 1983](#). As numerous courts have held, the EPSDT Requirement (1) is unmistakably focused on the rights of Medicaid-eligible youth to receive the enumerated services, (2) provides detailed, objective, and manageable standards, including specific services that must be provided, and (3) is binding on states. *See, e.g., DaJour B. v. City of New York*, No. 00 Civ. 2044, 2001 WL 830674, at *8–*10 (S.D.N.Y. July 23, 2001); *see also Salazar v. District of Columbia*, 729 F.Supp.2d 257, 269 (D.D.C.2010).

Because the Court found that the Availability, Comparability, and EPSDT Requirements create private rights enforceable via [Section 1983](#), the Court denied the portion of defendant's motion seeking to dismiss Counts I, II, and VI.

With respect to certain of plaintiffs' other claims, however, the Court found that defendant's motion had merit, at least in part. Regarding plaintiffs' claim that Amended [Section 505.2\(I\)](#) violates the Reasonable Standards Requirement *347 (Count III), this claim is brought pursuant to the Supremacy Clause of the United States Constitution. *See* U.S. Const. art. VI.⁷ In his motion, defendant argued that the Supreme Court's recent opinion in *Armstrong v. Exceptional Child Center, Inc.*, —U.S.—, 135 S.Ct. 1378, 191 L.Ed.2d 471 (2015), establishes that plaintiffs have no cause of action under the Supremacy Clause to enforce the Reasonable Standards Requirement.

In *Armstrong*, the Court held that the Supremacy Clause does not confer a private right of action. *Id.* at 1384. Furthermore, although federal courts have inherent authority to enjoin unconstitutional actions by state and federal officials, that authority “is subject to express and implied statutory limitations.” *Id.* at 1385. Specifically, where a statute “implicitly precludes private enforcement,” a plaintiff “cannot, by invoking our equitable powers, circumvent Congress's exclusion of private enforcement.” *Id.*

At issue in that case was Section 30(A) of the Medicaid Act, which requires state plans to:

provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan ... as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area ...

[42 U.S.C. § 1396a\(a\)\(30\)\(A\)](#). The Court held that Section 30(A) is not privately enforceable because, first, the statute provides an express method of enforcement, namely withholding of Medicaid funds by the Secretary of Health and Human Services. *Id.* at 1385 (citing [42 U.S.C. § 1396c](#)). The creation of an administrative remedy, the Court held, evinced Congress's intent to preclude private enforcement. Second, the Court found that Section 30(A) was not amenable to private enforcement because its mandate was so “judgment-laden,” “broad[],” and “complex[]” as to be “judicially unadministrable.” *Id.*

[7] Like Section 30(A), the Reasonable Standards Requirement is subject to an express administrative enforcement mechanism, *viz.*, defunding by the Secretary of Health and Human Services. [42 U.S.C. § 1396c](#). Furthermore, this provision consists of a broad grant of discretion to the states to implement “reasonable standards ... for determining eligibility for and the extent of medical assistance under the plan” that are “consistent with the objectives of [the Medicaid Act].” [42 U.S.C. § 1396a\(a\)\(17\)](#). *Cf. Watson*, 436 F.3d at 1162 (“[Section 1396a\(a\)\(17\)](#) is a general discretion-granting requirement that a state adopt reasonable standards.”). Like Section 30(A), it focuses on programmatic aspects of the state plan as a whole, rather than on the specific benefits that must be accorded to individuals. Therefore, the Court concluded that the Reasonable Standards Requirement is not privately enforceable under *Armstrong*. Accordingly, the Court granted defendant's motion to dismiss Count III.

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Turning to Count V, defendant argued in his motion that plaintiffs failed to state a claim for violation of Section 1557 of the *348 ACA with respect to the Youth Exclusion. Section 1557 provides that “an individual shall not ... be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity” that receives federal funding on the basis of certain criteria, including sex. 42 U.S.C. § 18116. On a motion to dismiss under Rule 12(b)(6), a court must assess whether the complaint “contain[s] sufficient factual matter, accepted as true, to ‘state a claim to relief that is plausible on its face.’” *Ashcroft v. Iqbal*, 556 U.S. 662, 678, 129 S.Ct. 1937, 173 L.Ed.2d 868 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570, 127 S.Ct. 1955, 167 L.Ed.2d 929 (2007)). Defendant argues that the Youth Exclusion draws distinctions on the basis of age, not sex, and therefore does not violate this provision.

[8] Plaintiffs respond that the Youth Exclusion discriminates on the basis of sex in two ways: “(1) that certain services are available to non-transgender people but denied to transgender people where medically necessary; or (2) that regardless of the availability of these treatments to people generally, these coverage exclusions have a disparate impact on transgender people for whom these services are medically necessary.” Plaintiffs' Opposition to Defendant's Motion to Dismiss dated May 8, 2015, ECF No. 34, at 19.⁸

[9] However, plaintiffs fail to allege any facts in support of either theory.⁹ Most notably, plaintiffs fail to allege that the treatments barred by the Youth Exclusion are available to non-transgender youth. In the absence of such an allegation, defendant's failure to make such services available to transgender youth cannot constitute sex discrimination. Thus, although the Court is cognizant of the principle that “[c]omplaints alleging civil rights violations must be construed especially liberally,” *United States v. City of New York*, 359 F.3d 83, 91 (2d Cir.2004), here there is nothing to construe. Accordingly, the Court granted defendant's motion to dismiss Claim V of the Amended Complaint with respect to the Youth Exclusion for failure to state a claim.

[10] Defendant also argued in his motion that plaintiffs failed to state a claim for violation of the Comparability Requirement because they failed to plead sufficient factual support for their contention that they have not received comparable services. However, plaintiffs clearly allege that defendant provides sex medical coverage to similarly situated Medicaid recipients suffering from conditions other than GD for the surgical procedures and other treatments that are denied to them under Amended Section 505.2(l), and cite a provision of the DOH regulations supporting that contention. Am. Compl. ¶¶ 107, 146, 160 (citing 18 N.Y.C.R.R. § 533.5). These paragraphs adequately plead violations of the Comparability Requirement, as they allege that defendant has provided medically necessary procedures to some individuals but not to others. See *Providence Pediatric Med. Daycare, Inc. v. Alaigh*, 799 F.Supp.2d 364, 374 (D.N.J.2011) (denying motion to dismiss where plaintiffs alleged that certain “children are not receiving *349 those services that their physicians have designated as medically necessary”).

[11] [12] [13] Defendant further argued that plaintiffs' claims with respect to the Cosmetic Procedures Exclusion are not yet ripe for adjudication because plaintiffs failed to plead that they have requested and been denied any of the procedures barred by Amended Section 505.2(l). “A claim is not ripe for adjudication if it rests upon contingent future events that may not occur as anticipated, or indeed may not occur at all.” *Texas v. United States*, 523 U.S. 296, 300, 118 S.Ct. 1257, 140 L.Ed.2d 406 (1998) (internal quotation marks omitted). However, courts within this circuit do not require “a futile gesture as a prerequisite for adjudication in federal court.” *Desiderio v. Nat'l Ass'n of Sec. Dealers, Inc.*, 191 F.3d 198, 202 (2d Cir.1999) (quoting *Williams v. Lambert*, 46 F.3d 1275, 1280 (2d Cir.1995)). Amended Section 505.2(l), by its plain terms, excludes coverage for the procedures deemed “cosmetic.” See Amended Section 505.2(l)(4) (stating that “[p]ayment will not be made” for “cosmetic surgery, services, and procedures including but not limited to” the enumerated procedures). Furthermore, the Department of Health's Medicaid Update makes clear that “payment will not be made for” the services deemed “cosmetic.” Declaration of Arthur Biller dated May 8, 2015, Ex. 2, at 16. Therefore, the Court finds that any attempt to seek coverage for the so-called “cosmetic” services would have been a “futile gesture” and was not required to render plaintiffs' claims ripe for adjudication.

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Accordingly, the Court denied defendant's motion to dismiss plaintiffs' claims regarding the Cosmetic Procedures Exclusion as unripe.

Finally, defendant argued in his motion that plaintiffs' Claim IV, for violation of the equal protection provisions of the New York State Constitution, is barred by the Eleventh Amendment to the United States Constitution because it asserts a purely state law claim against a state official. *See Concourse Rehab. & Nursing Ctr., Inc. v. DeBuono*, 179 F.3d 38, 44 (2d Cir.1999); *Morningside Supermarket Corp. v. New York State Dep't of Health*, 432 F.Supp.2d 334, 339 (S.D.N.Y.2006) (dismissing state law claims against DOH official as barred by the Eleventh Amendment). Plaintiffs conceded this point at oral argument. *See* Transcript dated May 22, 2015, ECF No. 41, at 6:18. Accordingly, the Court granted defendant's motion to dismiss Count IV of the Amended Complaint.¹⁰

For the foregoing reasons, the Court, by Order dated June 26, 2015, dismissed Claims III and IV, and also dismissed Claim V with respect to the Youth Exclusion, but otherwise denied defendant's motion to dismiss the Amended Complaint.

All Citations

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Footnotes

- 1 One of the original named plaintiffs, I.H., subsequently withdrew as class representative. ECF No. 28.
- 2 Plaintiffs' sixth cause of action cites the Availability and Comparability Requirements, 42 U.S.C. § 1396a(a)(10). *See* Am. Compl. ¶ 177. However, plaintiffs represented in their opposition to defendant's motion that they intended to cite the EPSDT Requirement, 42 U.S.C. § 1396a(a)(43), which is referenced in other paragraphs of the Amended Complaint. Reading the Amended Complaint as a whole and drawing all inferences in plaintiffs' favor, it is clear that the citation to Section 1396a(a)(10) was merely a scrivener's error, and the Court will treat it as such. Because of this error, defendant does not make any argument with respect to the EPSDT Requirement. Defendant has not been prejudiced by plaintiffs' error, however, as the Court finds that the EPSDT Requirement gives rise to a private right of action. *See infra*.
- 3 Casillas also brought a Section 1983 claim alleging that Section 505.2(l) violated the Reasonable Standards Requirement. *Casillas*, 580 F.Supp.2d at 245–46. Because plaintiffs in this case bring their claim relating to the Reasonable Standards Requirement under the Supremacy Clause rather than Section 1983, this portion of the *Casillas* decision is not directly relevant.
- 4 Justice Brennan, joined by Justice Marshall and Justice Blackmun in dissent, interpreted the Medicaid Act to require coverage even for elective abortions. *Id.* at 449, 97 S.Ct. 2366 (Brennan, J., dissenting). As relevant here, Justice Brennan interpreted the Medicaid Act to leave decisions regarding medical treatment to the doctor and patient, not the state: “the very heart of the congressional scheme is that the physician and patient should have complete freedom to choose those medical procedures for a given condition which are best suited to the needs of the patient.” *Id.* at 450, 97 S.Ct. 2366 (Brennan, J., dissenting).
- 5 In so holding, the Court joins the overwhelming majority of courts, both before and after *Gonzaga*, that have considered this question. *See Watson v. Weeks*, 436 F.3d 1152, 1159–60 (9th Cir.2006) (“No circuit court has held that section 1396a(a)(10) does not create a section 1983 right.”); *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180 (3d Cir.2004); *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 603 (5th Cir.2004); *Pediatric Specialty Care, Inc. v. Arkansas Dep't of Human Servs.*, 293 F.3d 472, 478–79 (8th Cir.2002); *Westside Mothers v. Haveman*, 289 F.3d 852, 862–63 (6th Cir.2002); *Miller by Miller v. Whitburn*, 10 F.3d 1315, 1319 (7th Cir.1993); *Crawley v. Ahmed*, No. 08–14040, 2009 WL 1384147, at *19 (E.D.Mich. May 14, 2009); *Michelle P. ex rel. Deisenroth v. Holsinger*, 356 F.Supp.2d 763, 767 (E.D.Ky.2005); *Health Care For All, Inc. v. Romney*, No. CIV.A. 00–10833–RWZ, 2004 WL 3088654, at *2 (D.Mass. Oct. 1, 2004); *Memisovski ex rel. Memisovski v. Maram*, No. 92 C 1982, 2004 WL 1878332, at *11 (N.D.Ill. Aug. 23, 2004); *Kenny A. ex rel. Winn v. Perdue*, 218 F.R.D. 277, 294 (N.D.Ga.2003); *DaJour B. v. City of New York*, No. 00 CIV. 2044, 2001 WL 830674, at *8 (S.D.N.Y. July 23, 2001); *cf. Bryson v. Shumway*, 308 F.3d 79, 88–89 (1st Cir.2002) (holding that similarly worded provision of Medicaid Act creates privately enforceable right); *Doe I–13 By & Through Doe, Sr. I–13 v. Chiles*, 136 F.3d 709, 719 (11th Cir.1998) (same).

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- 6 Numerous other courts have so held. *See, e.g., Davis v. Shah*, No. 12–CV–6134 CJS, 2013 WL 6451176, at *12 (W.D.N.Y. Dec. 9, 2013); *Michelle P. ex rel. Deisenroth v. Holsinger*, 356 F.Supp.2d 763, 767 (E.D.Ky.2005); *Health Care For All, Inc. v. Romney*, No. CIV.A. 00–10833–RWZ, 2004 WL 3088654, at *2 (D.Mass. Oct. 1, 2004); *Antrican v. Buell*, 158 F.Supp.2d 663, 672 (E.D.N.C.2001) *aff’d sub nom. Antrican v. Odom*, 290 F.3d 178 (4th Cir.2002).
- 7 Plaintiffs also allege that the Availability and Comparability Requirements (Counts I and II) are preempted by the Supremacy Clause. Because the Court finds that plaintiffs have a private right of action to enforce these provisions under [Section 1983](#), it does not address whether they may also bring their claims pursuant to the Supremacy Clause.
- 8 It is not settled whether a disparate impact claim is cognizable under Section 1557 of the ACA. *See Rumble v. Fairview Health Servs.*, No. 14–CV–2037 SRN/FLN, 2015 WL 1197415, at *12 (D.Minn. Mar. 16, 2015).
- 9 The only factual allegation in the Amended Complaint relating to treatment of transgender youth is that “numerous respected clinics around the United States provide medical services for people diagnosed with GD/GID who are under the age of eighteen.” Am. Compl. ¶ 89. This allegation cannot support plaintiffs’ claim of discrimination.
- 10 Defendant raised several other arguments for the first time in his reply papers. Because these arguments were not raised in his opening brief, they were waived, and the Court does not address them. *See Knipe v. Skinner*, 999 F.2d 708, 711 (2d Cir.1993) (“Arguments may not be made for the first time in a reply brief.”).

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