No. 16-3186

IN THE

United States Court of Appeals for the Eighth Circuit

BRITTANY TOVAR,

Plaintiff-Appellant,

—v.—

ESSENTIA HEALTH ET AL.

Defendant-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA

BRIEF *AMICI CURIAE* OF TRANSGENDER LEGAL DEFENSE AND EDUCATION FUND, WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH, AND WHITMAN WALKER HEALTH IN SUPPORT OF APPELLANT URGING REVERSAL

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Fed. R. App. P. 26.1, *amici* state that they are 501(c)(3) nonprofit organizations. None of the *amici* has a parent corporation. No publicly owned corporation holds ten percent or more of the stock of any *amici*, as none of the *amici* issues any stock.

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INTEREST OF *AMICI CURIAE*

The *amici curiae* joining this brief are as follows:

Transgender Legal Defense and Education Fund, Inc. ("TLDEF"), is a national civil rights organization committed to achieving full recognition of civil rights of transgender persons in the United States. Since its founding in 2003, TLDEF has represented transgender persons who have been denied medically necessary healthcare through advocacy, administrative appeals, administrative charges of discrimination, and federal impact litigation throughout the country.

World Professional Association for Transgender Health ("WPATH") is an interdisciplinary professional and educational organization devoted to the understanding and treatment of gender dysphoria. WPATH's mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health worldwide. As an international interdisciplinary, professional organization, WPATH aims to further the understanding and treatment of gender dysphoria by professionals in medicine, psychology, law, social work, counseling, psychotherapy, family studies, sociology, anthropology, sexology, speech and voice therapy, and other related

fields. Among other projects, WPATH publishes the leading clinical guidance on gender dysphoria treatment. E. Coleman et al., *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7*, 13 Int'l J. Transgenderism 165 (2012) [hereinafter *Standards of Care*]. Currently in its seventh edition, WPATH's *Standards of Care* is the most widespread peer reviewed treatment protocol for treating gender dysphoria and related conditions. Federal and state courts and administrative agencies regularly cite the *Standards of Care* in cases challenging access barriers to healthcare.

Whitman-Walker Health ("WWH" or "Whitman-Walker"), is a non-profit community health center in the Washington, D.C. metropolitan area with a special expertise in LGBT healthcare and HIV treatment and prevention. Founded in 1978, WWH was one of the first responders to the HIV/AIDS epidemic in Washington D.C., and is a nationally renowned leader in LGBT health issues, including the diagnosis and treatment of gender dysphoria. Whitman-Walker provides health services to more than 1200 individuals annually who identify as transgender or gender nonconforming. In addition to providing medical and mental healthcare services, WWH is home to one

of the nation's oldest medical-legal partnerships and offers legal services as part of its integrated health center. Whitman-Walker's attorneys are highly-regarded experts in transgender law, and provide legal assistance to approximately 500 transgender and gender-nonconforming persons annually, including many who are not WWH healthcare patients. Whitman-Walker aims to remove barriers to healthcare, and has specialized expertise on obstacles transgender persons face in obtaining coverage for medically necessary transgender healthcare through both public and private health plans.

This case is the first in the nation calling on a United States Court of Appeals to interpret Title VII and the Affordable Care Act's sex nondiscrimination provisions to reach transgender healthcare exclusions. Accordingly, *amici* offer the following analysis, which complements the parties' briefing, to assist the Court in determining the scope of the statutes' nondiscrimination provisions as informed by *amici*'s expertise on treatment of gender dysphoria and knowledge of the deleterious effects of transgender healthcare exclusions.

Plaintiff-Appellant Tovar consented to the filing of this brief. Defendant-Appellee Essentia has not indicated whether it opposes this

filing. Defendant-Appellee HealthPartners opposes the filing of this brief. *Amici* have therefore moved the Court for leave to file this brief *amici curiae*.[1]

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[1] No party's counsel authored this brief in whole or part. No party or its counsel contributed money that was intended to fund preparing or submitting this brief. No person—other than the *amici curiae*, their members or their counsel—contributed money that was intended to fund preparing or submitting this brief.

SUMMARY OF ARGUMENT

Ensuring that transgender Americans have meaningful, unencumbered access to medically necessary healthcare is of paramount importance to *amici*. Decades of research and clinical experience evidence that transgender healthcare is safe, effective, and medically necessary treatment for persons with gender dysphoria ("GD"). Unfortunately, many employers and health plan administrators maintain health plans with transgender healthcare exclusions. These exclusions are harmful to transgender people and have negative consequences for public health.

Transgender healthcare exclusions are also patently discriminatory. These exclusions curtail transgender enrollees' access to medically necessary care that is otherwise available to nontransgender enrollees on the same plan because the enrollee is transgender. As pled below, Plaintiff-Appellant's son was denied coverage of hormone blockers, exogenous hormones, and chest reconstruction surgery because of such an exclusion. If Plaintiff-Appellant's son were not transgender and otherwise had a medical need for these same treatments, they would have been covered.

Defendant-Appellees will urge this Court to hold that a health services employer and the third-party administrator of its health plan should both escape liability for facially discriminatory transgender healthcare exclusions. In support of this position, Defendant-Appellees will argue that Title VII, the Minnesota Human Rights Act, and Section 1557 cannot reach health benefits discrimination that is in plain contravention of the spirit and intent of these broad, remedial civil rights laws. Their arguments should be rejected.

It is well settled that Title VII and the Minnesota Human Rights Act prohibit discrimination in the provision of fringe benefits. Since transgender healthcare exclusions deny transgender enrollees on the same employer plan coverage of services that are available to other enrollees, these exclusions are forbidden and liability should attach to all entities that play an instrumental role in carrying out the discriminatory scheme. Similarly, Section 1557 of the Affordable Care Act prohibits sex discrimination, and therefore, transgender healthcare exclusions also violate Section 1557. Liability should attach to both covered employers and plan administrators since both entities' conduct effectuate the discriminatory scheme.

ARGUMENT

I. BARRIERS TO HEALTHCARE SHOULD BE REMOVED

A. Transgender Healthcare is Healthcare

Gender Dysphoria ("GD") is a widely recognized medical condition. Transgender Americans with GD are entitled to medically necessary healthcare on equal terms with nontransgender people.

1. Hormone therapy and surgery are effective and safe treatments for Gender Dysphoria.

Persons with GD experience a profound disconnect between their internal sense of gender (gender identity) and the sex that they are assigned at birth. Am. Psychol. Ass'n, The Diagnostic and Statistical Manual of Mental Disorders: DSM-V § 302.85 (2013). Because a person's gender identity cannot be changed, GD treatments such as hormone therapy and surgery are administered to align the patient's secondary sex characteristics with their gender identity. These treatments are colloquially termed transgender healthcare.

Hormone blockers are pharmaceuticals that suppress the production of internally produced sex hormones such as estrogen, progesterone, and testosterone. For adult patients, hormone blockers

serve many clinical purposes, including suspending post-pubertal maturation of secondary sex characteristics and suppressing internal sex hormone production that interferes with exogenous sex hormone therapy. Wylie Hembree et al., *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, 94 J. Clin. Endocrinological Metabolism 3132, 3143 (2009). In transgender youth, administration of hormone blockers suspends puberty (*id.* at 3139–42), which prevents the development of identity-discordant secondary sex characteristics and has been shown to decrease depressive symptoms and significantly improve general functioning. Annelou L.C. de Vries et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 Pediatrics 696 (2014) [hereinafter de Vries et al., Pediatrics *Outcome*] (finding transgender youth treated with hormone blockers and exogenous hormones had similar or better psychological functioning than same-age youth in the general population).

Exogenous sex hormones induce the development of secondary sex characteristics that match the patient's gender identity. For transgender adults, testosterone therapy triggers deepening of the

voice, development of male-typical facial hair and body hair, fat redistribution into male-typical patterns, and cessation of menses. Louis J. Gooren, *Care of Transsexual Persons*, 364 New Eng. J. Med. 1251, 1253 (2011). Similarly, estrogen and progesterone therapies trigger female-typical breast development, reduce male-typical pattern hair growth, and induce body fat redistribution into female-typical patterns. *Id.* For transgender youth who have received hormone blockers, exogenous sex hormones induce identity-congruent puberty; a growing body of research shows that transgender youth treated with exogenous hormones lead happy, healthy lives and have similar or better psychological functioning than their non-transgender peers. *See, e.g.*, de Vries et al., Pediatrics *Outcome*.

Reconstructive surgeries, sometimes referred to as sex reassignment surgeries, are surgical procedures that either alter secondary sex characteristics or reconstruct sex organs to align these features with the patient's gender identity. There are a variety of procedures that fall under this umbrella, including but not limited to chest reconstruction surgery (i.e., removing or reconstructing breasts), hysterectomy, orchiectomy, phalloplasty (creation of a phallus),

vaginoplasty (creation of a vagina), hysterectomy (removal of the uterus and related structures), and orchiectomy (removal of the testes). *See Standards of Care* at 200–05 (discussing surgical treatments). Decades of research evidence that these procedures are a safe and effective means of treating GD. *See, e.g.*, Esther Gómez-Gil et al., *Hormone-Treated Transsexuals Report Less Social Distress, Anxiety and Depression*, 37 Psychoneuroendocrinology 662 (2012); Griet De Cuypere et al., *Sexual and Physical Health After Sex Reassignment Surgery*, 34 Archives Sexual Behavior 679 (2005) (noting high levels of satisfaction with treatment).

The efficacy of transgender healthcare is undisputed by experts in the field. In addition to the authorities submitting this *amicus* brief, the American Medical Association, the Minnesota Medical Association, the American College of Obstetricians and Gynecologists, the American Psychological Association, the Endocrine Society, the World Medical Association and myriad number of other national and international professional associations recognize the efficacy of transgender

healthcare.[2] Leading health plan administrators throughout the country, including Defendant-Appellee HealthPartners, also recognize the efficacy of transgender healthcare and have promulgated broad and inclusive coverage guidelines. *See, e.g.*, HealthPartners, *Gender*

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[2] *See, e.g.*, Am. Med. Ass'n, *H-185.950 Removing Financial Barriers to Care for Transgender Patients*, *available at* http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glbt-advisory-committee/ama-policy-regarding-sexual-orientation.page (last visited Oct. 11, 2016) ("Our AMA supports public and private health insurance coverage for treatment of gender identity disorder as recommended by the patient's physician."); Am. Med. Ass'n, *H-180.980 Sexual Orientation and/or Gender Identity as Health Insurance Criteria*, *available at* http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glbt-advisory-committee/ama-policy-regarding-sexual-orientation.page (last visited Oct. 11, 2016) ("The AMA opposes the denial of health insurance on the basis of sexual orientation or gender identity."); Minn. Med. Ass'n, *20.15 Transgender Health Access (HD-R307-2012)*, *reprinted at* http://www.mnmed.org/getattachment/advocacy/Key-Issues/MNsure/PolicyComp2013-3.pdf.aspx?lang=en-US (Apr. 30, 2015) (expressing support for and incorporating text of AMA Policy H-185.950 *Removing Financial Barriers to Care for Transgender Patients*); Am. Psychol. Ass'n, *Policy Statement: Transgender, Gender Identity, & Gender Expression Non-Discrimination* (Aug. 2008); Am. Coll. Obstetricians & Gynecologists, *Committee Opinion, Care for Transgender Individuals 1* (Dec. 2011), *reprinted at* http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Health%20Care%20for%20Underserved%20Women/co512.pdf?dmc=1&ts=20140826T1734594637; Wylie Hembree et al., *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, 94 J. Clin. Endocrinological Metabolism 3132 (2009); World Med. Ass'n, *Statement on Transgender People* (Oct. 2015), *reprinted at* http://www.wma.net/en/30publications/10policies/t13/).

Reassignment Surgery, Policy G008-05 (Feb. 1, 2016), *reprinted at* https://www.healthpartners.com/public/coverage-criteria/gender-reassign-surg.htm (last visited Oct. 11, 2016); Cigna, *Gender Reassignment Surgery*, Policy No. 0266 (Mar. 15, 2016), *available at* http://tinyurl.com/pyyarly (last visited Oct. 11, 2016); Aetna, Gender Reassignment Surgery, Policy No. 0615 (Oct. 2015), *reprinted at* http://www.aetna.com/cpb/medical/data/600_699/0615.html (last visited Oct. 11, 2016); UnitedHealthcare, *Gender Dysphoria (Gender Identity Disorder) Treatment,* Guideline Number: CDG.011.07 (Oct. 1, 2016), *reprinted at* http://tinyurl.com/7oncnju (last visited Oct. 11, 2016).

2. Transgender healthcare should be treated like equivalent care.

The clinic doors should not be shut in the face of transgender Americans simply because they are transgender. But that is exactly what transgender healthcare exclusions do. Such disparate treatment is medically unsupported and discriminatory.

The treatments that health plans label as "transgender healthcare" are routinely administered to nontransgender people. For example, nontransgender adults are regularly prescribed hormone blockers to treat prostate cancer and certain forms of ovarian cancer;

nontransgender children diagnosed with precocious puberty are also routinely prescribed hormone blockers. Gooren, *Care of Transsexual Persons* at 1253 (noting similarity between cancer treatment and GD); *id.* at 1255 (noting similarity between precocious puberty treatment and GD). Exogenous sex hormones testosterone and estrogen are commonly administered to nontransgender persons with hypogonadism. Eva Moore et al., *Endocrine Treatment of Transsexual People: A Review of Treatment Regimens, Outcomes, and Adverse Effects*, 88 J. Clinical Endocrinology & Metabolism 3467, 3470 (2003) (describing similarities in testosterone regimens for transgender men and nontransgender men with hypogonadism); *id.* at 3472 (comparing estrogen regimens for transgender women and nontransgender women with hypogonadism). Double mastectomies are frequently performed to treat breast cancer in nontransgender women. Phalloplasty is a go-to treatment for many nontransgender men who have experienced severe genito-urinary injuries. *See* Jessica Firger, *Penile Reconstruction Surgery Has High Success Rate and Outcomes*, Newsweek (May 7, 2016), http://www.newsweek.com/penile-reconstruction-outcomes-transgender-phalloplasty-456931. Vaginoplasty is performed on nontransgender

women with Mayer-Rokitansky-Kuster-Hauser (MRKH) syndrome. Liron Eldor & Jeffrey Friedman, *Reconstruction of Congenital Defects of the Vagina*, 25 Seminars Plastic Surgery 142 (2011) (discussing vaginoplasty techniques for MRKH syndrome patients). Hysterectomies are quite common; between 2011 and 2013 an estimated 10.4 percent of American women between the ages of 40 and 44 had had a hysterectomy. Ctrs. Disease Control & Prevention, *Key Statistics from the National Survey of Family Growth*, http://www.cdc.gov/nchs/nsfg/key_statistics/h.htm#hysterectomy (last visited Oct. 11, 2016).

Transgender healthcare exclusions are driven by anti-transgender animus, not sound medical evidence. "Negative attitudes towards [this care] largely do not originate with health care providers treating transgender patients; rather, they result from discrimination and public mis-understanding of the medical necessity and effectiveness of such treatments." Nick Gorton, *Transgender Health Benefits: Collateral Damage in the Resolution of the National Health Care Financing Dilemma*, 4 Sexuality Res. & Soc. Pol'y 81, 81 (2007). It is medically specious to deem transgender healthcare to be categorically different

than other healthcare. The identity of the recipient of care does not transform the treatment into something any less evidence-based or medically efficacious. *See* Kari E. Hong, *Categorical Exclusions: Exploring Legal Responses to Health Care Discrimination Against Transsexuals*, 11 Colum. J. Gender & L. 88, 96 (2002) ("The lack of medical or fiscal justifications suggests that the insurance policies' [transgender] exclusion clauses operate as a pretext for other purposes."). Where plans cover a set of treatments for nontransgender people, transgender people should receive coverage on equal terms. *See* Sam Winter et al., *Synergies in Health and Human Rights: A Call to Action to Improve Transgender Health*, 388 Lancet 318, 318 (2016) (calling for equal coverage).

B. Transgender Healthcare Exclusions Are Harmful

The transgender community faces significantly depressed health outcomes and staggering rates of discrimination and stigma. *See generally* Jamie Grant et al., Nat'l Ctr. for Transgender Equality & Nat'l Gay & Lesbian Task Force, Injustice at Every Turn: A Report of the National Transgender Discrimination Survey (2011) [hereinafter Injustice at Every Turn]. Transgender healthcare exclusions are a

primary cause. A robust body of research and decades of clinical experience teach that transgender healthcare exclusions play an outsized role in depressing health outcomes in the transgender community, with clear, measurable effects that imperil public health.

Where transgender people cannot access healthcare, the distress of living with untreated GD taxes the body and mind. GD patients report that the experience of living in a body that does not match their gender identity is immensely distressing, and for some it is akin to torture. *See, e.g.*, Sarah Karlan, *We Asked People to Illustrate Their Gender Dysphoria*, BuzzFeed (Mar. 10, 2016), https://www.buzzfeed.com/skarlan/we-asked-people-to-illustrate-what-their-gender-dysphoria-fe?utm_term=.xcMvq3qlv#.agbJKmKgJ. Unsurprisingly, the profound distress caused by untreated GD leads many to engage in self-harm. *See, e.g.*, Sam Winter et al., *Transgender People: Health at the Margins of Society*, 388 Lancet 390, 394 (2016). Additional consequences of inadequate GD treatment include heightened incidence of risky behavior, underutilization of primary care and preventative treatments, high rates of self-medication, and heightened suicidality. *See generally* Nelson F. Sanchez, *Health Care*

Utilization, Barriers to Care, and Hormone Use Among Male-to-Female Transgender Persons, 99 Am. J. Pub. Health 713 (2009); Amaya Perez-Brumer et al., *Individual- and Structural-Level Risk Factors for Suicide Attempts Among Transgender Adults*, 41 Behavioral Med. 164 (2015).

Transgender healthcare exclusions directly contribute to stigma and reinforce discriminatory attitudes towards this already vulnerable population. *See generally* Jaclyn White Hughto et al., *Transgender Stigma and Health: A Critical Review of Stigma Determinants, Mechanisms, and Interventions*, 147 Soc. Sci. & Med. 222 (2015). Transgender healthcare exclusions single out transgender persons for disparate treatment and signal to broader society that the healthcare needs of transgender people are unimportant. Joe Davidson, *State Department Ends Transgender Exclusion from Health Plan*, Wash. Post (Oct. 13, 2014), https://www.washingtonpost.com/news/federal-eye/wp/2014/10/13/state-department-ends-transgender-exclusion-from-health-plan/ (Secretary of State John Kerry provided the following rationale for removing exclusions from the Department's health plan: "It's tough to tell other countries to provide equal opportunity if we're not living that out ourselves. . . . I've met transgender colleagues at the

Department and in addition to being brave and strong, they're just good officers. Why should they have it any different when it comes to health care?"). Transgender people widely report that healthcare exclusions are offensive. As one patient notes, "When I got that denial back because my policy has an exclusion, I was—I literally—I was very shocked by that. . . . What if I as a nurse, a patient came in and I was prejudiced against an individual and I said, I'm not going to treat them? We just don't do that." Nat'l Pub. Radio, *Denied Coverage For Surgery, Transgender Man Sues His Insurance Provider* (Aug. 1, 2016), http://www.npr.org/2016/08/01/488191810/denied-coverage-for-surgery-transgender-man-sues-his-insurance-provider. A growing body of research also evidences that these exclusions increase distress. *See, e.g.*, White Hughto et al., *Transgender Stigma and Health*. Indeed, public health studies investigating the consequences of laws and policies that single out minority populations for disparate treatment reveal that institutional discrimination of this ilk measurably increases incidence of psychiatric disorders. *See, e.g.*, Mark Hatzenbuehler et al., *The Impact of Institutional Discrimination on Psychiatric Disorders in*

Lesbian, Gay, and Bisexual Populations: A Prospective Study, 100 Am. J. Pub. Health 452 (2010).

These exclusions also impair healthcare providers' ability to appropriately treat GD patients. Providers routinely identify exclusions as a key impediment to providing patients adequate care. *See, e.g.*, Stanley Vance et al., *Health Care Providers' Comfort With Barriers to Care for Transgender Youth*, 56 J. Adolescent Health 251 (2015) (observing that one of the chief barriers to providing care to transgender youth is insurance reimbursement). Indeed, the ubiquity of exclusions has stymied institutional investment in provider training and artificially constricted capacity for treatment for decades. *See, e.g.*, Sumathi Reddy, *With Insurers on Board, More Hospitals Offer Transgender Surgery*, Wall St. J. (Sept. 26, 2016), *reprinted at* http://www.wsj.com/articles/with-insurers-on-board-more-hospitals-offer-transgender-surgery-1474907475 (noting that coverage levels are directly linked to institutional investments in building capacity for care).

Transgender healthcare exclusions in employer provided health plans are also costly and needlessly exacerbate the rising cost of

healthcare in the United States. A critical mass of transgender Americans depend upon employer provided health plans to meet their healthcare needs. *Injustice at Every Turn* at 77 (noting that 51% of the persons surveyed said they were dependent on employer-provided health benefits). While one-third of Fortune 500 companies and many local and state government employers provide their employees with health plans without transgender healthcare exclusions, exclusionary plans continue to burden employers and beneficiaries alike. Claire Zillman, *Changing Genders at Work: Inside the Fortune 500's Quiet Transgender Revolution*, Fortune (July 13, 2015), *reprinted at* http://fortune.com/2015/07/13/transgender-fortune-500/. For transgender patients and their families, the astronomical cost of paying for healthcare out of pocket is prohibitive for many and financially ruinous for others. *See, e.g.*, Erin Siegal, *Doing the Transgender Math: The Costs of Transition*, Reuters (Oct. 29, 2015), http://www.reuters.com/article/us-transgender-costs-idUSKCN0SN1UA20151029 (referencing the financial burden of out of pocket care, one patient noted: "I emptied all my accounts . . . And I consider myself one of the lucky ones."); Maddie Deutsch, *Medical*

Transition, *in* Trans Bodies, Trans Selves: A Resource for the Transgender Community 244 (Laura Erickson-Schroth ed., Oxford Univ. Press 2014) ("When I first started using hormone replacement therapy, [insurance] did not pay for my prescriptions or for the blood work related to them. I was paying entirely out of pocket, and cut down on my food expenses by dumpster diving and stealing food in order to afford transition-related expenses."). There are also negative consequences for employers and nontransgender enrollees—a growing body of research shows that transgender exclusions *increase* plan costs since foregoing care exacerbates other health conditions. *See, e.g.*, W. Padula et al., *Societal Implications for Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis*, 31 J. Gen. Intern. Med. 394, 398 (2016) (finding it is more cost effective for insurers to cover transgender healthcare because provision of care reduces incidence of HIV, depression, suicidality, and drug abuse resulting in a effective cost savings). *See also* Jody L. Herman et al., Williams Inst., *Costs and Benefits of Providing Transition-Related Health Care Coverage in Employee Health Benefits Plans* 3 (2013) (finding that "there was no

relationship between scope of the coverage provided and reported costs of adding the coverage, meaning providing broader coverage did not result in higher costs for surveyed employers").

C. Transgender Healthcare Exclusions Are Unconscionable

Amici's call to remove transgender healthcare exclusions is in line with a growing body of decisions from a diverse array of tribunals finding that barriers to care are discriminatory and contrary to evidence-based medicine.

This Court and other federal and state tribunals within the Eighth Circuit have deemed transgender healthcare exclusions unlawful in an array of contexts. In striking down Iowa's Medicaid transgender exclusion, this Court observed that the exclusion "reflects inadequate solicitude for the applicant's diagnosed condition, the treatment prescribed by the applicant's physicians, and the accumulated knowledge of the medical community." *Pinneke v. Preisser*, 623 F.2d 546, 549 (8th Cir. 1980). The Supreme Court of Minnesota has deemed categorical denials of GD treatment to be arbitrary and capricious. *Doe v. State, Dep't of Public Welfare*, 257 N.W.2d 816, 821 (Minn. 1977). Most tellingly, in a Title VII and ADA

enforcement action defended by Defendant-Appellee Essentia's legal counsel in this matter (there representing a different client), the District of Minnesota entered a consent decree that ordered the employer to remove all transgender exclusions in its employee health plan, implicitly finding that such exclusions violate both Title VII and the ADA. *EEOC and Britney Austin v. Deluxe Fin. Servs., Inc.*, 0:15-cv-02646, ECF doc. 37 ¶ 30 (D.Minn. entered Jan. 20, 2016) (requiring Deluxe to maintain health plan without "partial or categorical exclusions for otherwise medically necessary care solely on the basis of sex (including transgender status) and gender dysphoria"). *See also EEOC v. Product Fabricators, Inc.*, 666 F.3d 1170, 1172–73 (8th Cir. 2012) (recognizing that a district court will not enter consent decree without implicitly finding it has jurisdiction over the injuries redressed therein).

A number of state and federal fora outside this Circuit have reached similar conclusions. The Seventh Circuit struck down a Wisconsin statute that barred comprehensive transgender healthcare to prisoners as violative of the 8th Amendment, observing that there was no evidence that there are adequate alternative treatments for GD that

"reduces dysphoria and can prevent the severe emotional and physical harms associated with it." *Fields v. Smith*, 653 F.3d 550, 556 (7th Cir. 2011). The Fifth Circuit observed that a categorical denial of healthcare simply "because it was transsexual surgery" violates Medicaid laws. *Rush v. Parham*, 625 F.2d 1150, 1157 n.12 (5th Cir. 1980). A Massachusetts court deemed denial of breast reconstruction surgery to a transgender woman "arbitrary and . . . not supported by substantial evidence" further finding that "Ms. Beger's right to breast reconstruction, which is a substantial right, has been unlawfully withheld and unreasonably delayed." *Beger v. Acting Cmm'r, Div. of Med. Assistance*, 11 Mass.L.Rptr. 745, 2000 WL 576335 at *4 (Mass. Sup. Ct. 2000). A New York court ordered a health plan to cover genital reconstruction surgery, observing that "[f]or this court to suggest alternative remedies or treatment for this procedure would interfere with the professional judgment of medical experts, and would be beyond the scope of this court's expertise or jurisdiction." *Davidson v. Aetna Life & Cas. Ins. Co.*, 101 Misc.2d 1, 5 (N.Y. Sup.Ct. 1979). A California appellate court observed that transgender healthcare is medically necessary, adding "[w]e do not believe by the wildest stretch of the

imagination, that such surgery can reasonably and logically be characterized as cosmetic." *J.D. v. Lackner*, 80 Cal.App.3d 90, 95 (Cal. Ct. App. 1978). Additionally, the Western District of Oklahoma declined to dismiss a hostile work environment claim predicated in part on the employer's admission that it maintained a fringe benefit health plan with a transgender healthcare exclusion. *U.S. and Rachel Tudor v. Se. Okla. State Univ. and Reg'l Univ. System of Okla.*, civ-15-324, 2015 WL 4606079 (W.D.Okla. July 10, 2015).

Administrative agencies throughout the nation have reached similar conclusions. In January 2016, the Medicare Appeals Council ordered a plan administrator to cover genital reconstruction. *In the Case of Claim for UnitedHealthcare/AARP Medicare Complete*, M-15-1069, 2016 WL 1470038 (HHS 2016). A tax court ruled that transgender healthcare should be treated the same as all other healthcare for tax purposes. *O'Donnabhain v. Comm'r of Internal Revenue*, 134 T.C. 34 (U.S. Tax Ct. 2010). In *M.K. v. Div. Med. Assistance & Health Servs.*, a New Jersey administrative court ordered coverage of genital reconstruction surgery, observing that genital reconstruction is medically necessary. 92 NJAR2d (DMA) 28, 1992 WL 280789 at *9 (N.J.

Admin. 1992). Regulators in Minnesota have ruled that transgender exclusions violate state and federal laws. Mike Rothman, Comm'r of Minn. Dep't Comm., *Re: Gender Identity Nondiscrimination Requirements*, 2015 WL 10533279 (Bulletin 2015-5, Nov. 24, 2015).

II. TRANSGENDER HEALTHCARE EXCLUSIONS VIOLATE TITLE VII AND THE MHRA

A. Transgender healthcare exclusions are impermissible fringe benefits discrimination.

Title VII and the MHRA employ different statutory language, but the result is the same: Employers are forbidden from engaging in transgender discrimination in all aspects of the employment relationship including fringe benefits.

Title VII prohibits sex discrimination, including sex stereotype discrimination. *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989). Transgender discrimination is a form of sex stereotype discrimination since distaste for transgender persons is at its core animated by stereotypical assumptions that all persons will live as and identify with the gender they are assigned at birth. *Hunter v. United Parcel Serv., Inc.*, 697 F.3d 697, 702–03 (8th Cir. 2012) (observing that if appellant had proven his non-conformity to gender stereotypes or his being

perceived as transgender a *prima facie* case would be met). *See also Radtke v. Misc. 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 v. City of Salem, Ohio*, 378 F.3d 566, 572–73 (6th Cir. 2004)).

The MHRA prohibits sexual orientation discrimination, a statutory term of art that proscribes sex stereotype discrimination against transgender persons. *Goins v. West Grp.*, 635 N.W.2d 717, 722 (Minn. 2001). *See also Rumble v. Fairview Health Servs.*, 2015 WL 1197415 at *2 (D.Minn. Mar. 16, 2015) (explaining that although "an individual's transgender status in no way indicates that person's sexual orientation. . . . 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'.").

While neither Title VII nor the MHRA mandate that employers provide specific terms of coverage, where health benefits are provided, both statutes demand that benefits be equal. *Newport News Shipbuilding & Dry Dock Co. v. EEOC*, 462 U.S. 669 (1983); *Minn. Min. and Mfg. Co. v. State*, 289 N.W.2d 396, 398 (Minn. 1979). *See also Law Enforcement Labor Servs., Inc. v. Cnty. of Mower*, 483 N.W.2d 696, 701 (Minn. 1992) (observing that employer provided health benefits which cover the employee and his dependents are the "fruit" of the employee's labor). Thus, if a health plan covers specific treatments, all enrollees on the plan must receive the same scope of coverage. *EEOC v. United Parcel Serv., Inc.*, 141 F.Supp.2d 1216 (D.Minn. 2001) (citations omitted) ("Employee's fringe benefits include those received from the coverage of a dependent spouse. . . . Therefore, in determining if discrimination exists in the insurance plan, the Court should consider both the benefits provided to the employee as well as the benefits provided to the employee's dependents."). *Accord* 29 C.F.R. § 1630.8 (recognizing discrimination against dependents as associational fringe

benefits discrimination under the ADA). If an employer's plan is structured in such a way that one set of enrollees receives the benefit of coverage but another set does not receive coverage, fringe benefit discrimination has occurred. *See, e.g.*, *United Parcel Serv.*, 141 F.Supp.2d at 1219 (finding that plan's exclusion of "oral contraceptives for any reason, including treatment for female hormonal disorders, while medically necessary treatments for male hormonal disorders are not excluded" sufficiently alleges disparate treatment).

Title VII and the MHRA necessarily prohibit transgender health exclusions in employer-provided health plans. A transgender healthcare exclusion is "discriminatory on its face" because it singles out for exclusion services sought by transgender people because they are transgender. *Saks v. Franklin Convey Co.*, 316 F.3d 337, 343 (2d Cir. 2003) (quotations omitted) (finding that an otherwise inclusive plan that singles out pregnancy-related benefits for exclusion is "discriminatory on its face"). The conduct Plaintiff-Appellant complains of is illustrative. As pled below, Plaintiff-Appellant's health plan afforded a broader scope of coverage to nontransgender enrollees than transgender enrollees. Under the plan, all nontransgender enrollees

could receive coverage for hormone blockers (J.A. 1 ¶ 39), exogenous hormones (*id.* ¶ 43), and reconstructive chest surgery (*id.* ¶ 47) so long as medical necessity was demonstrated. Yet, because of the transgender healthcare exclusion, Plaintiff-Appellant's son was denied coverage of these exact same treatments. The fact that the health plan expressly excludes a set of treatments sought by transgender persons that it otherwise covers for nontransgender persons is evidence of the exclusion's illicitness. *Cf. Henderson v. Bodine Aluminum, Inc.*, 70 F.3d 958, 960 (8th Cir. 1995) (observing that a health benefits plan that provides treatment for one condition but not for a "directly comparable" condition "arguably violates the ADA").

B. Liability for fringe benefits discrimination attaches to third-party administrators.

Exclusions in employer provided health plans are adopted at the direction of a record employer but are given effect by third-party administrators. Where such exclusions discriminate, federal and state employment nondiscrimination laws deem both record employers and third party administrators liable.

Under Title VII and the MHRA, liability for violations attaches to covered entities, which include employers. 42 U.S.C. § 2000e-2; Minn.

Stat. § 363A.08, subd. 2. In both statutes, "employer" operates as a term of art that encompasses record employers (like Essentia), which fall within the common sense of the word, as well as entities that are not employers in the traditional sense but if not covered would frustrate the purpose of the statute. *Baker v. Stuart Broad. Co.*, 560 F.2d 389, 391 (8th Cir. 1977) (liberally construing "employer" as not to frustrate the purpose of Title VII); *Frieler v. Carlson Mktg. Grp., Inc.*, 751 N.W.2d 558, 573 (Minn. 2008) ("we have consistently held that the remedial nature of the Minnesota Human Rights Act requires liberal construction of its terms") (citing *Cummings v. Koehnen*, 568 N.W.2d 418, 422 (Minn. 1997); Minn. Stat. § 363A.04 ("The provisions of [the MHRA] shall be construed liberally for accomplishment of the purposes thereof.")).

Liberally construed, "employer" encompasses third-party administrators of a record employer's health benefits plan under any of three theories.

First, administrators should be treated as statutory employers because they exercise control over an important aspect of employment. *Spirt v. Teachers Ins. & Annuity Ass'n*, 691 F.2d 1054, 1063 (2d Cir.

1982), *vacated and remanded on other grounds*, 463 U.S. 1223 (1983). Where a third-party administers a record employer's health benefits plan, the administrator exercises significant control over the provision of health benefits, which are important employment opportunities given to the record employer's employees. *Carparts Distrib. Ctr. v. Auto. Wholesaler's Ass'n*, 37 F.3d 12, 17 (1st Cir. 1994). Third-party administrators exist solely for the purpose of enabling record employers to delegate their responsibility to provide health benefits to their employees; in such a scheme the administrator and record employers are "so intertwined . . . that they must [both] be deemed an 'employer'." *Id.* at 17 (*citing Spirt*, 691 F.2d at 1063 (interpreting "employer" under Title VII to encompass third party administrator of benefits plan)).

Alternatively, a third-party administrator should be considered the agent of a covered entity. 42 U.S.C. § 2000e(b) (defining "employer" to include the employer's "agents"); *Frieler*, 751 N.W.2d at 569 (recognizing agency liability under MHRA). Where the administrator gives effect to the discriminatory fringe benefits terms it acts on behalf of the record employer. *Carparts* at 17. The fact that an administrator may lack contractual authority to make an independent determination

as to benefits levels is of no moment. *Cf. Ariz. Governing Comm. for Tax Deferred Annuity and Deferred Comp. Plans v. Norris*, 463 U.S. 1073, 1090 (1983) ("both parties to a discriminatory contract are liable for any discriminatory provisions the contract contains, regardless of which party initially suggested inclusion of the discriminatory provisions"). Similarly, the fact that the administrator may face a conflict between abiding by its fiduciary duties under ERISA and state and federal nondiscrimination laws cannot absolve the administrator of liability as to the nondiscrimination laws. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983) (holding that ERISA does not preempt Title VII or parallel state nondiscrimination laws). In that situation, the administrator is presented with a dilemma of its own making—if, in the first instance, the administrator declined to contract to administer a discriminatory benefits scheme there would be no conflict. Moreover, it is well settled that a record employer cannot avoid liability for benefits discrimination that is effectuated by a deputized third-party administrator. *Norris*, 463 U.S. at 1090–91. Finding the administrator directly liable as the record employer's agent simply reflects that without the administrator's complicity in the discriminatory scheme, it would not be effectuated.

Lastly, a third-party administrator is liable for fringe benefits discrimination because the administrator is a covered entity by virtue of its own employment practices, and liability attaches to covered entities where they significantly affect another covered entity's employees access to employment opportunities. As the D.C. Circuit observed in a different context, "[t]o permit a covered employer to exploit circumstances peculiarly affording it the capability of discriminatorily interfering with an individual's employment opportunities with another employer, while it could not do so with respect to employment in its own service, would be to condone continued use of the very criteria for employment that Congress has prohibited." *Sibley Memorial Hosp. v. Wilson*, 488 F.2d 1338, 1341 (D.C. Cir. 1973).

III. TRANSGENDER HEALTHCARE EXCLUSIONS ALSO VIOLATE SECTION 1557

A. Section 1557 prohibits transgender discrimination.

Section 1557's sex discrimination proscription reaches discrimination targeting transgender persons, and thus proscribes transgender healthcare exclusions in covered plans.

Section 1557's text is ambiguous as to the scope of status discrimination proscribed. The statute does not delineate protected

statuses. Rather, it incorporates by reference grounds of discrimination prohibited by myriad federal civil rights statutes, including Title IX, which, in turn, prohibits discrimination "on the basis of sex." 42 U.S.C. § 18116 (incorporating by reference grounds of discrimination proscribed by Title IX of the Education Amendments Act of 1972, 20 U.S.C. § 1681 *et seq.*). However, neither Section 1557 nor Title IX define "sex." Without statutory clarification, the meaning of "sex" is ambiguous. *Cf. G.G. ex rel. Grimm. v. Gloucester Cty. Sch. Bd.*, 822 F.3d 709, 720–22 (4th Cir. 2016) (finding "sex" as used in agency regulation to be ambiguous as applied to transgender individuals).

Since "sex" is ambiguous, this Court should liberally construe it to reach all evils reasonably within the term's ambit, including discrimination targeting transgender persons. *Voris v. Eikel*, 346 U.S. 328, 333 (1953) (holding that remedial statutes "must be liberally construed in conformance with its purpose, and in a way which avoids harsh and incongruous results"). This course is sound, as evidenced by this Court's and sister court's decisions interpreting "sex" to reach transgender discrimination in remedial statutes. *See, e.g.*, *Hunter,* 697 F.3d at 702–03 (Title VII); *Glenn v. Brumby*, 663 F.3d 1312, 1318–22

(11th Cir. 2011) (Equal Protection Clause and Title VII); *Smith*, 378 F.3d at 573 (Title VII); *Schwenk v. Hartford*, 204 F.3d 1187, 1201 (9th Cir. 2000) (Prison Rape Elimination Act); *Rosa v. Park West Bank & Trust Co.*, 214 F.3d 213, 214–15 (1st Cir. 2000) (Equal Credit Opportunity Act). *See also G.G.*, 822 F.3d at 727 (Davis, J. concurring) (noting that the "weight of circuit authority concluding that discrimination against transgender individuals constitutes discrimination 'on the basis of sex'"). This interpretation is also in line with lower court decisions construing Section 1557's sex discrimination proscription to reach transgender discrimination. *Rumble*, 2015 WL 1197415 at *2; *Cruz v. Zucker*, 116 F.Supp.3d 334, 348 (S.D.N.Y. 2015).

B. This Court should not create a safe harbor exception for third-party administrators.

Section 1557 does not expressly carve out a safe harbor for third-party administrators; this Court should resist Defendant-Appellee HealthPartner's invitation to create one.

The text of Section 1557 makes clear that Congress desired for Americans to be free from discrimination in an array of healthcare contexts, broadly prohibiting discrimination in "any health program or activity," with the only limit being that liability is triggered only where

the covered entity receives "Federal financial assistance." 42 U.S.C. § 18116(a). This Court should decline to create an exception that Congress did not expressly provide. *Andrus v. Glover Const. Co.*, 446 U.S. 608, 616–17 (1980) ("Where Congress explicitly enumerates certain exceptions to a general prohibition, additional exceptions are not to be implied, in the absence of evidence of a contrary legislative intent."). Indeed, if Congress desired to treat third-party administrators differently than other covered entities it would have so stated in the text of Section 1557 much like it did in the Medicare laws. 42 U.S.C. § 1395y (b)(2)(B)(iii) (expressly excepting third-party administrators from some enforcement actions). The remedial purpose of Section 1557 demands that a plan administrator's active complicity in a discriminatory health plan scheme go neither unregulated nor unpunished. Section 1557's aim is to ameliorate discrimination in healthcare. This important statutory goal will be frustrated if administrators are given a free pass to discriminate.

Below, Defendant-Appellee HealthPartners argued that third-party administrators should be insulated from liability because their conduct is secondary to the record employer. J.A. 3 at 3–5. This

argument strains credulity. Third-party administrators are not passive witnesses to discrimination, rather, their activities directly carry out and further the discriminatory enterprise. Among other activities, administrators draft and promulgate plan documents including coverage determination guidelines that are relied upon by claim adjudicators, process claims for pre-authorization in accordance with plan terms and coverage determination guidelines thereby giving effect to discriminatory terms, and similarly process internal administrative appeals which can also further give effect to discriminatory terms. That the third-party administrators bear no direct financial burden for providing treatment is of no moment; administration of a health plan is an insurance activity and should be regulated as such. *Cf. Ky. Ass'n of Health Plans v. Miller*, 538 U.S. 329, 336 n.1 (2003) (Scalia, J.) ("[N]oninsuring HMOs would be administering self-insured plans, which we think suffices to bring them within the activity of insurance . . . ."). Moreover, an administrator's complicity in the discriminatory scheme is itself sufficient to impose liability. *Cf. Norris*, 463 U.S. at 1090 ("[B]oth parties to a discriminatory contract are liable for any

discriminatory provisions the contract contains, regardless of which party initially suggested inclusion of the discriminatory provisions.”).

Troublingly, if this Court were to create a safe harbor for third-party administrators, such a rule could *incentivize* discrimination. Under a safe harbor, administrators could actively solicit business from employers that desire to provide discriminatory health plans to their employees, in essence rewarding administrators for aiding and abetting employers’ discriminatory schemes.

CONCLUSION

Transgender exclusions deprive transgender persons treatments otherwise available to nontransgender persons simply because they are transgender. These exclusions are anathema to our nation’s core values and patently discriminatory. Our robust antidiscrimination laws command that all Americans be afforded equal health benefits. Employers and third-party administrators bear direct responsibility for transgender healthcare exclusions—both entities should be liable for the discrimination they sow. For all the foregoing reasons, *amici* urge reversal.

Dated: October 11, 2016

Respectfully submitted,

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CERTIFICATE OF SERVICE AND FILING

I hereby certify that on October 11, 2016, I electronically filed the foregoing documents described as the Motion for Leave to File Brief *Amici Curiae* of Transgender Legal Defense and Education Fund, World Professional Association for Transgender Health, and Whitman Walker Health and [Proposed] Brief *Amici Curiae* of Transgender Legal Defense and Education Fund, World Professional Association for Transgender Health, and Whitman Walker Health in Support of Appellant Urging Reversal with the Clerk of Court for the United States Court of Appeals for the Eighth Circuit by using the appellate CM/ECF system.

Participants in the case who are registered CM/ECF users will be served by the appellate CM/ECF system.

Dated: October 11, 2016

/s/ Ezra Young

CERTIFICATE OF COMPLIANCE WITH FED. R. APP. P. 32(a)(7)(B)

1. This Brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because it contains 6719 words, exclusive of the matters exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

2. This Brief also complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirement of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportional spaced typeface using MS Word MAC 2011 in 14 point Century font.

/s/ Ezra Young