COMPLIANCE ALERT

New Considerations for Nondiscrimination in Health Plans

EPIC Insurance Brokers & Consultants

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Quick Facts

- In 2020, the Supreme Court of the United States (SCOTUS) ruled that Title VII protection against employment discrimination based on sex extends to discrimination based on an individual's sexual orientation or gender identity.
- The Affordable Care Act (ACA) §1557 nondiscrimination rules prohibit denying or limiting coverage or imposing additional cost-sharing in health insurance and other health-related coverage based on race, color, national origin, sex, age, or disability.
- Plans subject to §1557 or Title VII risk claims of discrimination for any limits or exclusions tied to gender identity or gender dysphoria.
- Plan should make careful considerations before limiting or excluding coverage related to gender identity or gender dysphoria.

Background

Coverage for gender-related treatment and services is an evolving issue. Over the past decade, legislation, regulations and court decisions all suggest that failure to provide equal access to coverage based on gender or sexual orientation may violate various nondiscrimination laws. Group health plans that exclude or limit coverage for gender affirming care (e.g., care related to gender identity or gender dysphoria) risk discrimination claims on the basis of sex and transgender status in violation of the Constitution's Equal Protection Clause, Title VII of the Civil Rights Act of 1964 and the Affordable Care Act's §1557 nondiscrimination rules.

Court Decisions

The 2020 SCOTUS decision in the case ***Bostock v. Clayton County*** interpreted that Title VII protection against employment discrimination based on sex extends to discrimination based on an individual's sexual orientation or gender identity. While the case was not specifically related to employer-sponsored benefit offerings, employer-sponsored health and welfare benefits are part of the employment package and therefore fall under the broad protection of Title VII. Therefore, employers cannot discriminate in how benefits are provided based on sex, including sexual orientation and gender identity.

Since the SCOTUS decision in 2020, while there is no specific guidance as to exactly what type of coverage must be available, several additional federal court cases have found in favor of individual claims of discrimination for failure to provide equal or medically necessary coverage related to gender identity or gender dysphoria. The courts have found that benefit exclusions or limitations based on sex or transgender status violated the Equal Protection Clause, Title VII and §1557. The following are two recent examples:

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- *Kadel v. Folwell, 2022 WL 2106270 (M.D.N.C. 2022)*
- *Lange v. Houston Cnty.,*2022 WL 1812306 (M.D. Ga. 2022)

ACA §1557

"Covered entities" are required to comply with ACA **§1557 nondiscrimination rules**, which, among other things, prohibit denying or limiting coverage, or imposing additional cost-sharing in health insurance and other health-related coverage based on race, color, national origin, sex, age, or disability. Proposed rules issued in July 2022 interpret "covered entities" to include those entities that receive federal funding and that are principally engaged in providing health programs or activities. Insurance carriers, third party administrators (TPAs), and employers in the medical field may be considered covered entities, but most other employers are not. Further, employer-sponsored group health plans generally do not receive federal funding. However, insurance carriers and TPAs may only be permitted to issue and administer plans that comply with §1557 nondiscrimination rules.

The definition has of "sex" for these purposes has been in flux since the first nondiscrimination rules implementing §1557 were released in 2016. However, in accordance with the SCOTUS decision in *Bostock*, the recently proposed rules interpret the term "sex" to include sexual orientation and gender identity.

For those plans subject to §1557, it is not perfectly clear what coverage is required, but certainly there is risk of claims of discrimination for any limits or exclusions tied to gender identity or gender dysphoria.

Mental Health Parity Rules

Under the Mental Health Parity and Addiction Equity Act (MHPAEA), a plan may exclude coverage for a particular condition. However, in **guidance released in 2019**, the Departments clarified that if the plan provides any coverage for the condition, the plan must provide coverage for the condition in all classifications (or categories) and "in parity" with medical/surgical benefits provided under the plan. Therefore, because the plan may be required to provide at least some level of coverage for gender dysphoria and other related conditions to avoid discrimination claims under the Equal Protections Clause, Title VII and §1557, the plan would then have to provide mental health coverage for the condition in parity with medical/surgical benefits available in each classification.

Summary

Plans should make careful consideration before limiting or excluding coverage related to gender identity or gender dysphoria. At this time the Departments have not indicated what type of coverage must be offered to avoid potential discrimination claims, and additional guidance is welcome. While we await that guidance, we suggest employers consider:

- Providing identical coverage for same-sex and opposite-sex spouses or domestic partners;
- Providing preventive coverage as determined to be medically appropriate by the provider, regardless of sex at birth;
- Providing coverage for both medical/surgical benefits and mental health benefits related to gender dysphoria, gender reassignment surgery, hormone therapy, etc.; and
- Providing broad family planning coverage.

Fully insured plan sponsors should reach out to carriers and verify that they are considering these items in how plans are designed. It seems likely that most major carriers will adjust plan designs to

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decrease the risk of any discrimination claims, especially with the recently proposed §1557 rules applying nondiscrimination rules to health insurance carriers, but there is room for interpretation as to exactly what coverage is required. While employers have very little control over carrier plan design, employers could consider changing carriers if their current plan(s) seems risky.

Self-funded plan sponsors should complete a thorough review of plan definitions, exclusions, and limitations to understand if there is discrimination risk. One benefit of a self-funded plan is more flexibility in plan design, but because plan designs vary, this review will have to be done on a plan-by-plan basis. It may be helpful to look at what is being provided by insured plans in this regard. In addition, TPAs may place restrictions on plan design to the extent they may be subject to the newly proposed §1557 nondiscrimination rules.

EPIC Employee Benefits Compliance Services

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