Can a Self-Funded Group Health Plan Exclude Coverage for Gender-Affirming Care?

by Kaitlyn Malkin on May 22, 2024

We are sometimes asked whether a self-funded group health plan is required to cover gender-affirming medical services. As this post explains in detail, it is generally impracticable for a self-funded ERISA-covered plan to exclude coverage for gender-affirming care as there are significant risks of litigation, penalties, or loss of federal financial assistance in implementing such an exclusion.

A self-funded group health plan covered by ERISA is not subject to state-level insurance coverage mandates, and there are currently no federal coverage mandates explicitly requiring coverage for gender-affirming care.[1] However, three federal laws must be considered in deciding whether to exclude gender-affirming care under a self-funded group health plan: Section 1557 of the Affordable Care Act ("ACA"), Title VII of the Civil Rights Act of 1964 ("Title VII"), and the Mental Health Parity and Addiction Equity Act ("MHPAEA").

Section 1557 of the ACA

Section 1557 prohibits a covered entity (generally, a recipient of federal financial assistance, as discussed below) from denying, canceling, limiting, or refusing to issue or renew health coverage or denying or limiting coverage of a claim based on sex. If the employer sponsor or third-party administrator ("TPA") of a self-funded plan is covered by Section 1557, the plan may need to provide gender-affirming care coverage to comply with the final rule under Section 1557 recently published by the Department of Health and Human Services ("HHS").[2] The provisions of the nondiscrimination in health insurance coverage portion of the final rule apply as of the first day of the first plan year beginning on or after January 1, 2025.[3]

HHS's final rule strengthens the protections against discrimination based on sex by defining sex discrimination to include discrimination based on sex characteristics, pregnancy, sexual orientation, gender identity, and sex stereotypes. This stance reaffirms 2022 HHS guidance advising that the prohibition against sex discrimination was intended to encompass an

[1] Fully insured group health plans must comply with federal and state coverage mandates. Colorado is currently the only state that categorizes gender-affirming care as an essential health benefit that must be covered in all fully insured plans. Other states, *e.g.*, Maine and Maryland, require Medicaid plans to provide gender-affirming care. This post discusses only the laws and risks affecting self-funded group health plans covered by ERISA.

[2] The final rule was published in the Federal Register on May 6, 2024, and is effective July 5, 2024.

[3] Section 1557 Final Rule: Frequently Asked Questions | HHS.gov.

individual's right to access medically necessary health programs free from discrimination based on gender identity.[4]

The final rule explicitly prohibits having or implementing a categorical exclusion or limitation for all health services related to gender transition or other gender-affirming care.[5] It also prohibits a covered entity from denying or limiting health services sought for purposes of gender transition or other gender-affirming care that the covered entity would provide to an individual for other purposes if the denial or limitation is based on an individual's sex assigned at birth or gender identity.[6]

The final rule applies to all the operations of any covered entity that is a "health program or activity," issuer, or other entity principally engaged in providing or administering health insurance coverage or other health-related coverage, including TPA activities. We note that in the final rule, HHS reasserts its position that a covered TPA should not be held responsible for discriminatory plan design features over which it exercised no control, but if the benefit design feature originated with the TPA, the TPA may be liable for discriminatory plan terms.[7]

Section 1557 covers plan sponsors and TPAs if they receive federal financial assistance directly or indirectly by being a subcontractor to an entity that receives federal financial assistance.[8] The 2022 Proposed Rule excluded group health plans from coverage under Section 1557, but the final rule reverses that stance and posits that Section 1557 can apply to group health plans and health insurance issuers if they receive federal financial assistance.[9] Under the final rule, a group health plan can also be covered by Section 1557 as a subcontractor of a plan sponsor or TPA if it is liable for the actions of a plan sponsor or TPA that is covered by Section 1557.

Many TPAs receive federal financial assistance, either directly or indirectly,[10] and are thus subject to Section 1557. In addition, courts have declined to extend deference to prior versions of the Section 1557 rules that narrowly construed what is a "health program or activity" by concluding that the plain language of Section 1557 "indicates that a health insurance contract and the administration of a health insurance contract is a 'health program or activity.'" *C. P. by &*

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[4] See 2022 HHS Proposed Rule and HHS Notice and Guidance on Gender Affirming Care.

[5] See Section 92.207 of the Final Rule.

[6] See Section 92.206 of the Final Rule.

[7] See page 37626 of the Final Rule.

[8] See page 37625 of the Final Rule. Federal financial assistance is defined as any grant, loan, credit, subsidy, contract (other than a procurement contract), or any other arrangement by which the federal government provides or otherwise makes available funds, including any other type of assistance that HHS provides or administers such as tax credits under Title I of the ACA.

[9] See HHS Notice and Guidance on Gender Affirming Care.

[10] See page 37625 of the Final Rule.

through Pritchard v. Blue Cross Blue Shield of Illinois, No. 3:20-CV-06145-RJB, 2022 WL 17788148, at *5 (W.D. Wash. Dec. 19, 2022). For example, in *Pritchard v. Blue Cross Blue Shield of Illinois*, the court found that even though the plan sponsor was the entity that chose to exclude gender-affirming care from the plan, a Section 1557 violation was nevertheless attributable to Blue Cross. It is unlikely that courts will afford the final rule any more deference than its predecessors, suggesting that cases will continue to be filed against TPAs for discrimination under Section 1557.

Even if a TPA is subject to Section 1557 directly or indirectly, there is no specific mandate that a self-funded group health plan administered by that TPA must cover certain services to comply with Section 1557. Section 1557 does not require coverage where a covered entity has a legitimate, nondiscriminatory reason for denying or limiting coverage of the health service.[11] The plan sponsor of such a self-funded group health plan will need to determine whether the services its plan covers have a disparate impact on transgender or nonbinary persons or whether the plan has explicitly excluded gender-affirming care services for discriminatory purposes. Because it is generally difficult to dismiss a disparate impact claim or explain an exclusion as being non-discriminatory in its purpose, this typically means plans must cover a range of medical, surgical, and mental health services for gender-affirming care.

With the new explicit protections that prohibit targeting gender-affirming care, there will likely be challenges to the final rule seeking to invalidate it, but there also may be more case law finding gender-affirming care exclusions to be discriminatory. For example, the U.S. Court of Appeals for the Fourth Circuit recently held in the combined decision, *Kadel v. Folwell*, 100 F.4th 122 (4th Cir. 2024), that a West Virginia Medicaid program's categorical exclusion of coverage for gender-affirming care violates the Affordable Care Act's anti-discrimination provision under Section 1557.

Section 1557 violations can be discovered through HHS enforcement actions or a civil action brought by an individual. HHS can require the covered entity to take remedial action to correct its discriminatory actions and procedures retroactively.[12] In addition, noncompliance that is not corrected may result in the suspension of, termination of, or refusal to grant or continue federal financial assistance; referral to the Department of Justice with a recommendation to bring proceedings to enforce any rights of the United States; and any other remedy authorized by law.[13]

Title VII

Title VII prohibits discrimination in an employee's compensation, terms, conditions, or privileges of employment, including the scope of health benefits offered to employees. It expressly

[11] See Section 92.207(c) of the Final Rule.

[12] See Section 92.6(a) of the Final Rule.

[13] Summary: Final Rule Implementing Sec 1557 of the ACA | HHS.gov.

prohibits discrimination based on sex. If a self-funded group health plan fails to cover gender-affirming care, the employer sponsoring the plan is at risk of employment discrimination claims.

The Supreme Court, in *Bostock v. Clayton County, Georgia*, 590 U.S. 644 (2020), held that Title VII prohibits discrimination based on sexual orientation as well as transgender status. The Court viewed the employer's employment decisions based on homosexuality and transgender status as intentionally treating individual employees differently because of their sex. In response, the EEOC issued guidance reiterating its position that discrimination in employment, including for the provision of fringe benefits based on gender identity, is prohibited by Title VII.[14] The decision in *Texas v. Equal Emp. Opportunity Comm'n*, 633 F. Supp. 3d 824 (N.D. Tex. 2022) vacated this EEOC guidance because it violated the Administrative Procedure Act. Nevertheless, other cases show that an exclusion for sex reassignment surgery or gender-affirming care may be found discriminatory, not because it excludes coverage explicitly for transgender individuals, but because it functions to categorically exclude services that typically will be needed by transgender individuals.[15]

The U.S. Court of Appeals for the Eleventh Circuit recently held that a health insurance provider can be liable under Title VII for denying "gender-affirming care coverage to a transgender employee because the employee is transgender."[16] This case concerned an employer that set the benefit terms under its group health plan. Those terms excluded drugs and all other services related to a sex change, including medically necessary care. The court found the exclusion to be a facially discriminatory policy under Title VII and found the employer liable because it had delegated its administration of the plan as an agent. Not all jurisdictions have taken this position, but an employer should consider this recent litigation trend (and the uncertainties of litigation in various jurisdictions) before excluding gender-affirming care from its group health plan.

Violating Title VII can result in a variety of remedies: injunctive relief (such as removing the offending provision from the plan document), reinstatement of pay (including reprocessing claims that were impermissibly excluded), compensatory and punitive damages, and attorneys' fees and costs. Compensatory and punitive damages are subject to a statutory cap based on employer size, which ranges from $50,000 for employers with 15 to 100 employees to $300,000

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[14] Protections Against Employment Discrimination Based on Sexual Orientation or Gender Identity | U.S. Equal Employment Opportunity Commission (eeoc.gov).

[15] See *Kadel v. Folwell*, 620 F. Supp. 3d 339 (M.D.N.C. 2022), aff'd, 100 F.4th 122 (4th Cir. 2024) (exclusion of treatments leading to or in connection with sex changes or modifications violates Title VII and Equal Protection Clause); *Boyden v. Conlin*, 341 F.Supp. 3d 979 (W.D. Wis. 2018) (a state employers' policy excluding procedures, services and supplies related to surgery and sex hormones associated with gender-affirming treatment treated transgender employees differently and violated Title VII and the Equal Protection Clause and does not rely upon *Bostock*); *Lange v. Houston County, Georgia*, 608 F. Supp. 3d 1340 (M.D. Ga. 2022) (exclusion of transition surgery discriminates because of transgender status, which constitutes discrimination based on sex). *But see The Religious Sisters of Mercy v. Xavier Becerra,* 55 F.4th 583 (8th Cir. 2022) (plaintiffs obtained a permanent injunction to enjoin HHS from enforcing the prohibition against discrimination under Section 1557 in a form that would compel the plaintiffs from providing coverage for gender-affirming care under the Religious Freedom Restoration Act related to the *Bostock* case).

[16] See *Lange v. Houston County, Ga*, No. 22-13626, 2024 WL 2126748 (11th Cir. May 13, 2024).

for employers with 501 or more employees. Punitive damages are available in cases where a plaintiff proves intentional discrimination with malice or reckless indifference.

State law may also prohibit discrimination based on gender identity in employment. For example, Maine explicitly prohibits discrimination based on gender identity, with compensatory and punitive damages ranging from $100,000 for employers with 15-100 employees to $1 million for employers with at least 501 employees.

MHPAEA

If a group health plan provides any coverage for medically necessary gender-affirming care, the MHPAEA requires that the plan cover gender dysphoria mental health treatment "in parity" with medical/surgical benefits.

A categorical exclusion for a named mental health condition, such as gender dysphoria, is treated differently than an exclusion for services that are typically provided for that mental health condition. Department of Labor ("DOL") regulations indicate that a categorical exclusion of an entire mental health or substance use disorder condition would not be considered a treatment limitation under the MHPAEA.[17] To categorically exclude a mental health condition, a plan must ensure that all claims for that condition for all six benefit classifications under the MHPAEA are denied. (The six benefit classifications are inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care, and prescription drugs.) In practice, it is difficult to ensure that no claims, especially those with multiple diagnosis codes, are approved. If a group health plan has a categorical exclusion for gender dysphoria, and at least one claim was approved for this condition, the exclusion would be under the purview of the MHPAEA.

Instead of excluding all care for an entire condition, it is more likely that a group health plan will exclude certain treatments or services for that condition. Exclusion for certain treatments, such as gender reassignment surgery and sex hormone therapy, would be considered a non-quantitative treatment limitation (NQTL) that must be analyzed as part of the plan's NQTL comparative analysis. In particular, the plan must analyze whether limitations on coverage for gender-affirming care are more restrictive than comparable restrictions for medical or surgical services under the plan, both in terms of how the plan is written and how the plan applies the restriction in practice.

There is a private right of action for violations of the MHPAEA through its codification in ERISA, and the DOL and CMS can also bring suit for noncompliance. If a violation is found, the DOL typically requires plans to remove the noncompliant plan provision and reprocess claims denied

[17] See 29 CFR § 2590.712(a) and (e)(3)(i). In defining "treatment limitations," the regulation provides: "A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition. . . This section does not . . . require the plan or health insurance coverage under this section to provide benefits for any other mental health condition or substance use disorder."

in violation of parity requirements.[18] MHPAEA violations can also result in a breach of fiduciary duty claim under ERISA and IRS penalties of $110 per covered individual per day.

Risk Assessments

While a plan sponsor typically has discretion to determine the scope of services to be covered by its ERISA-covered group health plan (outside of preventive care mandates), there is a significant risk of litigation, penalties, and potential loss of federal financial assistance under state and federal laws in not providing coverage for gender-affirming care. The risk is heightened in that claims may be brought by an individual adversely affected by the exclusion, and governmental authorities at both the state and federal levels may investigate or bring suit. If the reason for considering such an exclusion is cost, a plan sponsor may want to consider adding utilization management tools such as medical necessity reviews and prior authorization to its group health plan to ensure that only medically necessary, non-experimental services are being covered.

If you have questions about covering or excluding coverage for gender-affirming care, please contact a member of Verrill's Employee Benefits & Executive Compensation Group.

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[18] FY 2021 MHPAEA Enforcement: Ensuring Parity EBSA Fact Sheet (dol.gov).