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Spotlight on Transgender Health Coverage

Recent HHS guidance and litigation in federal courts nationwide have focused attention on coverage of transgender healthcare services. Employers with group health plans that do not cover or limit coverage of such services should work with legal counsel to review plan terms and exclusions, and keep up to date on this complex and evolving compliance area.

Background

Section 1557 of the Affordable Care Act (Section 1557) prohibits "covered entities" from discriminating in health programs and activities based on race, color, national origin, sex, age or disability. Under recent Department of Health and Human Services (HHS) final regulations, a covered entity is a program administered by HHS, a public marketplace, or a health program or activity that receives funding from any HHS agency. These rules define sex discrimination to include discrimination based on sex stereotyping and gender identity. (See our May 17, 2016 *FYI Alert.*) Specifically, the final regulations:

- Prohibit a "categorical coverage exclusion or limitation for all healthcare services related to gender transition"
- Prohibit denials of health coverage based on gender identity or sex stereotyping
- Require individuals to be treated consistent with their gender identity but prohibit denial or limitation of treatment ordinarily or exclusively available to individuals of one gender based on an individual's identification as another gender — for example, a covered entity that covers hysterectomies for women must also cover hysterectomies for transgender men.

Most employers do not meet the final regulations' definition of covered entity (but see the sidebar on page 2 addressing employers and plans that are covered entities subject to the Section 1557 rules). However, many health insurance issuers that serve as third-party administrators (TPAs) for self-funded group health plans are covered entities because, as another part of their business, they participate in an ACA marketplace and receive federal funds (such as through payment of the premium tax credits that subsidize the cost of marketplace coverage). Recognizing that these TPAs generally do not determine the benefit design of the self-

Lexicon

Gender identity: 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.

Transgender: An individual whose gender identity is different from the sex assigned to that person at birth.

Gender dysphoria: A medical condition where an individual's gender identity is different from the sex assigned to that individual at birth.

insured plans they administer, HHS stated in the preamble to the final Section 1557 rules that where a non-covered entity employer is responsible for the alleged discrimination, it "typically will refer or transfer" the matter to the Equal Employment Opportunity Commission (EEOC).

EEOC enforces Title VII of the Civil Rights Act of 1964, which prohibits employers with at least 15 employees from discriminating in "terms, conditions, or privileges of employment" on the basis of race, color, religion, sex, and national origin. Although Title VII does not explicitly prohibit discrimination based on sexual orientation or gender identity (i.e., transgender status), EEOC broadly interprets Title VII's protections against sex discrimination to include discrimination based on sexual orientation, transgender status and gender stereotyping. (See our August 14, 2015 *For Your Information*). The EEOC has not issued specific guidance on what benefit plan designs it would find to discriminate based on gender identity, but generally takes the position that the prohibition on employment discrimination based on gender identity or sexual orientation includes discrimination in "terms, conditions, or privileges of employment."

> **Comment.** The possibility that HHS will refer alleged discriminatory plan designs to EEOC has raised concerns that plan sponsors are now at greater risk of EEOC scrutiny.

Additionally, there are state and local laws that can affect transgender health coverage.

How does being a covered entity affect an employer's own benefit programs?

- If the employer is principally engaged in providing or administering health insurance coverage (e.g., a hospital participating in Medicare or a health insurance issuer participating in the marketplace), it must comply with Section 1557 rules both for its operations as well as for its employee health benefit programs (whether insured or self-insured).
- If the employer is not principally engaged in the above functions, but receives HHS funds for a health program or activity (e.g., a university department receiving an HHS grant to fund cancer research), the employer must comply with the Section 1557 rules with respect to the health benefits (self-funded and/or insured) it provides for employees in that department (but not for health benefits it provides to other employees).
- If an employer receives HHS funds in connection with an employee health benefit program (e.g., the retiree drug subsidy), it is unclear whether the Section 1557 rules would apply to both the retiree drug plan and to the employer as a covered entity (because the employer receives the funds). It is also unclear in the case of a self-insured Employer Group Waiver Plan (EGWP) whether only the plan must comply with Section 1557 or whether the health benefit program covering employees administering the EGWP must also comply. Clarification would be welcome.

Emerging Litigation Landscape

Meanwhile, federal courts nationwide are considering challenges to denials of coverage for transgender health services brought under both Section 1557 and Title VII.

In June 2016, the American Civil Liberties Union sued a large hospital system, alleging that its group health plan discriminated against a transgender male employee by denying coverage for a double mastectomy pursuant to an exclusion of "treatment, drugs, medicines, services and supplies for, or leading to, sex transformation surgery." Currently in early stages of litigation, the lawsuit alleges discrimination under Title VII's prohibition on sex discrimination and violation of Section 1557 (claiming the employer is a covered entity because it receives federal financial assistance). The employer is challenging EEOC's authority to expand Title VII to cover transgender status as a protected class, arguing that Congress must amend the statute to provide this protection. It also asserts that the Section 1557 claim should fail because HHS's final regulation is not effective until the first plan year beginning after January 1, 2017.

Comment. The HHS rule generally is effective as of July 18, 2016. However, provisions requiring changes to plan benefit design (including covered benefits, benefits limitations or restrictions and cost-sharing mechanisms) are effective the first day of the first plan year beginning on or after January 1, 2017.

In May 2016, before the HHS issued its final Section 1557 regulations, a Minnesota federal district court dismissed claims brought against an employer and the TPA administering its self-insured group health plan under Title VII, Section 1557, and state law alleging that an employer's plan wrongfully denied coverage for the gender reassignment surgery of an employee's transgender son, as well as for drugs prescribed in connection with his gender dysphoria diagnosis. The plan excluded from coverage "services and/or surgery for gender reassignment." The court rejected the employee's Title VII claim on the grounds that Title VII protects employees, and not covered beneficiaries, and that the employee could not establish that she herself (as distinct from her son) suffered the alleged discrimination. The court also rejected the Section 1557 claim, finding that that the non-covered entity employer — rather than the covered entity TPA — was responsible for the coverage exclusion. The employee recently filed an appeal with the 8th US Circuit Court of Appeals.

Additionally, in November 2015, a transgender woman sued her employer and the TPA that administered her employer's health and short-term disability plan, alleging violations of Section 1557, Title VII, and ERISA where the TPA denied coverage for breast implant surgery on the grounds that the procedure was cosmetic rather than medically necessary and denied her request for short-term disability leave following the surgery on the grounds that it was not on account of an illness. The court has not yet issued decision on the merits of these claims.

Plan Design Considerations

Section 1557 regulations, coupled with recent litigation, have raised many employers' awareness of transgender healthcare coverage issues and generated questions. What, if any, transgender health services must they cover? Can their plans exclude any, or all, transgender health services from coverage? There are few clear answers to these complicated questions. Employer considerations will depend on whether the employer or plan is a covered entity, whether the plan is self-funded or insured, interpretation of HHS and/or EEOC guidance, application of relevant state or local law, and consideration of overall risk tolerance.

Last year, President Obama signed Executive Order 13672, which prohibits employment discrimination by federal contractors and subcontractors on the basis of sexual orientation and gender identity. Regulations recently issued by the Office of Federal Contract Compliance Programs (OFCCP) require federal contractors to ensure that the health insurance plans they offer do not discriminate on the basis of gender identity or transgender status. Like HHS, OFCCP notes that plans with categorical exclusions of coverage for all health services associated with gender dysphoria or gender transition would be facially discriminatory. See our *FYI* from **August 5, 2016**.

If the employer or plan is a covered entity. An employer that is a covered entity (for example, a hospital that receives Medicare payments) is subject to the Section 1557 rules, which provide that a blanket exclusion of "all health care services related to gender transition" is discriminatory. But what if the hospital sponsors a self-funded plan that excludes coverage for gender reassignment surgery (sometimes referred to as "transsexual surgery," "transgender surgery," or "gender confirmation surgery"), yet covers other health services related to gender transition — such as drugs prescribed to treat gender dysphoria? Because it is unclear whether HHS would find that this type of plan design, which it is not a categorical exclusion of coverage, violates Section 1557, the hospital should evaluate its risks in maintaining the exclusion.

Likewise, as noted above, the Section 1557 rules would apply to a self-funded EGWP, but may not apply to the employer or the other plans that employer sponsors unless the employer is itself a covered entity — the rules are not clear on this possible distinction. Application of the Section 1557 rules is also not clear in the case of an employer that receives the retiree drug subsidy — do the rules apply only to the retiree plan or to all of the employer's plans? Additional clarification from HHS is needed on these issues.

Coverage for transgender health services is currently a hot topic in the healthcare field. We understand that some employers have received notice from their pharmacy benefit manager that, in light of emerging laws and regulations, it had updated its standard utilization management criteria to permit approval for certain hormone therapies and medications relating to transgender healthcare.

> **Comment.** In the case of an insured plan, the insurer — not the employer — may be a covered entity obligated to comply with Section 1557 requirements for all of its operations, including its policy terms. Carriers may (or may not) reach out to plan sponsors to alert them of changes to coverage in light of the final Section 1557 rules. It is not clear if the Section 1557 rules would allow an insurer to offer policies that would let an employer opt out of coverage for transgender healthcare services.

If the employer or plan is not a covered entity. As discussed above, the Section 1557 rules do not apply where neither the employer nor the plan are covered entities. However, an employer is still subject to Title VII, and the EEOC could conclude that the employer's plan design discriminates on the basis of sex. Lack of specific EEOC guidance, along with emerging (and, to date, inconclusive) litigation, makes it difficult to determine what, if any, coverage EEOC requires.

For example, it is not clear if EEOC would consider a plan discriminatory if it covers mastectomies to treat a breast cancer diagnosis but not for a gender dysphoria diagnosis.

In Closing

Given this complex and evolving area, employers should work with legal counsel to assess applicable federal, state and local requirements concerning their plans' transgender health coverage — and risks associated with any coverage gaps.

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