Insight

IN-DEPTH DISCUSSION

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HHS Final Rule Finds Categorical Exclusions for Health Services Related to Gender Transition Are Generally Unlawful

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The U.S. Department of Health and Human Services (HHS) recently published its Final Rule[1] implementing Section 1557 of the Affordable Care Act (ACA), which prohibits discrimination on the basis of, among other grounds, sex in certain health programs and activities. According to HHS's press release, the Final Rule and Section 1557 outline individuals' rights, as well as the responsibilities of health insurers, hospitals, and health plans administered by or receiving federal funds, in order to advance protections for underserved, underinsured, and often excluded populations.

Section 1557 is the first federal civil rights law to explicitly prohibit discrimination on the basis of sex in federally funded health programs.[2] Importantly, as outlined in the Final Rule, Section 1557 prohibits the denial of health care or coverage based on gender identity and sex stereotyping. The Final Rule goes into effect on July 18, 2016, unless changes to a health insurance plan or group health plan benefit design are required (in which case the effective date is on the first day of the first plan year beginning on or after January 1, 2017), and is expected to have broad implications for the provision of transgender- and gender transition-related medical treatment.

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1 U.S. Department of Health and Human Services, *Nondiscrimination in Health Programs and Activities*, 81 Fed. Reg. 31375 -31473 (May 18, 2016).

2 Section 1557 incorporates other federal laws that explicitly preclude discrimination based on "sex," including Title VII of the Civil Rights Act of 1964 and Title IX of the Education Amendments of 1972, and provides that no one may be excluded from participation in, denied the benefits of, or subjected to discrimination under: any health program or activity, any part of which is receiving federal financial assistance; any program or activity that is administered by an Executive Agency; or any entity established under Title I of the Act or its amendments. Any violations of Section 1557 may be redressed using enforcement mechanisms provided for and available under Title VII and/or Title IX.

Background

Many health insurance plans, including Medicaid programs, historically have categorically excluded coverage for any medical treatment related to gender dysphoria or associated with a gender transition. Plans, owners of those plans, and insurance carriers offering health insurance plans often have justified these exclusions, either explicitly or implicitly, by classifying treatments related to a gender transition as cosmetic, elective or experimental in nature. At the same time, the same treatments that were categorically denied for transgender individuals frequently were provided to non-transgender individuals – and covered by most health insurance plans – when prescribed by their physicians.

Insurance carriers and plan administrators traditionally have used two methods to deny coverage for gender transition-related treatment. Prior to the enactment of the ACA, insurance carriers used prior diagnoses of gender dysphoria or Gender Identity Disorder – with which some transgender individuals were diagnosed – to deny such individuals' application for health care coverage outright.[3] Insurance carriers also traditionally included exclusions for transition-related treatment in all health care contracts. Unless a company requested that such exclusions be removed, these blanket categorical exclusions routinely were included in all health care plans and used to deny coverage for treatments related to a gender transition.

Prior to the enactment of the Final Rule and Section 1557, no federal law explicitly prohibited discrimination in healthcare on the basis of sex and there was no explicit federal legal requirement for group or individual insurance plans to cover care related to gender transitions, gender reassignment surgery or related procedures. Likewise, no court had issued a ruling finding either that health insurance plans were required to cover gender transition-related treatment, or that the inclusion of categorical exclusions for medical treatment related to gender dysphoria or associated with gender transition in a healthcare plan violated federal law.

On the state level, following the passage of the ACA, 11 states explicitly prohibited private health insurance plans sold in the state and Medicaid coverage from including exclusions for transition-related care. An additional six states clarified that their state Medicaid program covered transition-related care. But, the remainder of states remained silent on the issue.

In recent years, numerous medical organizations, including the American Medical Association and the World Professional Association for Transgender Health, have issued statements on the medical necessity of gender transition-related health care treatment. In addition, several courts have issued decisions finding transition-related care to be medically necessary. To date, however, such categorical exclusions largely have remained in many health insurance plans unless specifically excluded by state law.

The Final Rule on Nondiscrimination in Health Programs and Activities

In the proposed rule, HHS sought comments on a number of aspects of the Final Rule, including: (i) the proposal that "sex discrimination" include discrimination based on gender identity, (ii) whether there should be an exemption for religious organizations and, if so, the scope of that exemption, and (iii) the appropriate coverage of the Final Rule and whether it should include all issuers participating in the ACA Marketplace or the Marketplace itself, and/or hospitals and other health care providers. The Final Rule addressed comments on each such issue.

"Sex Discrimination" Includes Discrimination Based On Gender Identity. In the Final Rule, HHS made clear that the provisions prohibiting discrimination on account of "sex" include "gender identity," which it defines as "an individual's sense of gender, which may be male, female, neither, or a combination of male and

3 The passage of the ACA invalidated the existence of pre-existing diagnoses as a basis upon which to deny coverage as of January 1, 2014.

female, and which may be different from an individual's sex assigned at birth." The definition also includes "gender expression," i.e., the way an individual expresses their gender identity, whether or not it conforms to social stereotypes associated with a particular gender, as well as those individuals whose gender identity is different from the sex assigned to that person at birth, often referred to as "transgender." According to HHS, this position is consistent with the position taken by courts and federal agencies.[4] Moreover, in response to those comments suggesting that such legal interpretations were misplaced or erroneous, HHS stated as follows:

> The fact that there may be circumstances in which it is permissible to make sex-based distinctions is not a license to exclude individuals from health programs and activities for which they are otherwise eligible simply because their gender identity does not align with other aspects of their sex, or with the sex assigned to them at birth. The Department has a responsibility to ensure that health programs and activities of covered entities are carried out free from such discrimination.

As a result, the Final Rule specifically provides that to deny or limit coverage, deny a claim, or impose additional cost-sharing or other limitations or restrictions on coverage of any health service, is impermissible discrimination when the denial or limitation is due solely to the fact that the individual's sex assigned at birth, gender identity, or gender otherwise recorded by the plan or issuer is different from the one to which such services are ordinarily or exclusively available. Instead, under the Final Rule, coverage for medically appropriate health services must be made available on the same terms and conditions under the plan or coverage for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. The Final Rule goes further by stating that all health-related insurance plans or other health-related coverage (including Medicaid programs) that currently have explicit categorical or automatic exclusions of coverage for all health services or care related to gender dysphoria or associated with a gender transition are unlawful on their face; in sum, by singling out the entire category of gender transition-related services, such an exclusion or limitation systematically denies services and treatments for transgender individuals and is, by definition, prohibited discrimination on the basis of sex.

No New Exemptions for Religious Organizations. After inviting comment on whether the Final Rule should include a religious exemption for health service providers, health plans, or other covered entities with respect to the requirements related to sex discrimination (and in particular with regard to the nondiscrimination provisions relating to gender identity), HHS decided against including a blanket religious exemption in the Final Rule and Section 1557. In so doing, HHS wanted to ensure the Final Rule appropriately protected sincerely held religious beliefs to the extent that those beliefs conflicted with the nondiscrimination provisions of the Final Rule.

In declining to incorporate an exemption for religious organizations, HHS stated the Final Rule would not displace the protections afforded by provider conscience laws, the Religious Freedom Restoration Act (RFRA), or regulations issued under the ACA related to preventive health services. HHS further addressed any concerns raised by religious organizations by stating that application of RFRA was the proper means to evaluate any religious concerns about the Section 1557's requirements.[5] Since RFRA required an individualized and fact-specific inquiry, any requests for exemption from Section 1557 would be made "on a

4 The Final Rule cited to a number of decisions in support of this assertion, including: *Rumble v. Fairview Heath Servs*., Civ. No. 14–cv–2037, 2015 WL 1197415, at *10 (D. Minn. Mar. 16, 2015) (Section 1557); *Schroer v. Billington*, 577 F. Supp.2d 293, 303 (D.D.C. 2008) (Title VII); Macy v. Holder, EEOC Appeal No. 0120120821, Agency No. ATF–2011–00751, 2012 WL 1435995, at *7 (Apr. 20, 2012) (Title VII).

5 In so stating, HHS provided that RFRA's requirements – i.e., requiring an evaluation of whether a legal requirement substantially burdened the exercise of religion and, if so, then an evaluation of whether that requirement furthered a compelling interest and was the least restrictive means to further that interest – adequately would protect any assertion by a covered entity that Section 1557 burdened its exercise of religion and, if so, whether there were less restrictive means available.

case-by-case basis, based on a thorough analysis and relying on the extensive case law interpreting RFRA standards."

Coverage of the Final Rule is Broad. The Final Rule contains a number of definitions that outline the scope of its coverage. As HHS stated repeatedly in the Final Rule and its accompanying explanations, the nondiscrimination provisions outlined in the Final Rule and Section 1557 of the ACA apply to "every health program or activity, any part of which receives Federal financial assistance provided or made available by [HHS]," as well as "every health program or activity administered by [HHS] and every health program or activity administered by Title I" of the ACA. Those health programs and activities included within the purview of the Final Rule and Section 1557 include all entities engaged in the provision or administration of health-related services, health-related insurance coverage, and other health-related coverage. Such entities include, but are not limited to, hospitals, health clinics, group health plans, health insurance issuers, physicians' practices, community health centers, nursing facilities, residential or community-based treatment facilities, State Medicaid programs, Children's Health Insurance Programs, and Basic Health Programs, to name a few.

Included within the Final Rule – and of particular import to employers – are the health benefits and health insurance coverage provided to employees and/or their dependents that have been "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 third party administrator, or health insurance issuer," as well as employer-provided or sponsored wellness programs, health clinics, and long-term care coverage. Moreover, to the extent employers contract out their health care plans and coverage to third parties, such contracts will not insulate employers from abiding by the Final Rule. In sum, whether an employer's health insurance benefits plan is self-funded, an ERISA plan, or is self-managed or managed and administered by a third-party administrator, the plan may come within the purview of the Final Rule and Section 1557.

Recommendations for Employers

In light of the Final Rule and Section 1557, employers should consider taking the following steps:

- Review the provisions of the Final Rule and Section 1557 to determine whether and to what extent employer-provided health plans and programs are covered by the nondiscrimination provisions issued by HHS;
- Evaluate whether such employer-provided health plans and programs contain blanket, categorical, or automatic exclusions of coverage for health services or care related to gender dysphoria or is associated with a gender transition; and
- Consult with their benefits group, Plan Administrator, and counsel to determine whether and how to bring any employer-provided health plans and programs into compliance with the Final Rule and Section 1557.