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Gender-Affirming Care—Health Plan Design and Compliance

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Agenda

- *Bostock v. Clayton County*
- Description of Gender-Affirming Care
- State Laws
- ERISA Preemption
- Section 1557 of the Affordable Care Act (ACA)
- Title VII Issues
- Mental Health Parity and Addiction Equity Act (MHPAEA)
- HIPAA Privacy
- Design Considerations and Action Items

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BOSTOCK

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Bostock

- The U.S. Supreme Court in *Bostock v. Clayton* County found that Title VII protection against employment discrimination on the basis of sex to extends to an individual's gender identity
- In *Bostock*, the plaintiff was terminated from his job after receiving criticism for his sexual orientation and identity as a gay man
- He filed a lawsuit against his former employer alleging discrimination based on sexual orientation in violation of Title VII
- The Supreme Court found that firing an employee for being gay or transgender violates Title VII
  - The Supreme Court stated that discrimination on the basis of homosexuality or transgender status requires an employer to intentionally treat employees differently because of their sex—the very practice Title VII prohibits in all manifestations

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Bostock

- While the case was not specifically related to benefit offerings, employer-sponsored health benefits fall under the broad protection of Title VII since benefits are part of the employment package
- Since the *Bostock* decision in 2020, there have been numerous cases that have addressed whether a health plan that excludes coverage for the treatment of gender dysphoria violates federal law, such as under Title VII or Section 1557 of the ACA
- However, there has been no specific guidance indicating what type of coverage must be available under health plans
- We will discuss some of these court cases throughout this presentation

GENDER AFFIRMING-CARE

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Gender-Affirming Care

- The World Health Organization defines gender-affirming care to include a range of social, psychological, behavioral and medical interventions "designed to support and affirm an individual's gender identity" when it conflicts with the gender they were assigned at birth
- The World Professional Association for Transgender Healthcare (WPATH) publishes internationally accepted clinical guidelines for gender-affirming care—however, plans are not required to adopt these guidelines
- Something to consider—certain care that people seek to treat gender dysphoria is routinely provided to non-transgender people and the term "gender affirming care" may have the effect of leaving an impression that the care is unique to transgender individuals
- EXAMPLE: Most plans include coverage for hormone treatment for a woman going through menopause—this could be considered "gender-affirming care"

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Gender-Affirming Care

- The DMS-5 is the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)
- In the United States, the DSM serves as the principal authority for psychiatric diagnoses
- Treatment recommendations, as well as payment by health care providers, are often determined by DSM classifications
- With the publication of DMS-5, "gender identity disorder" was eliminated and replaced with "gender dysphoria"
- Gender dysphoria is recognized as a mental health disorder

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Gender Dysphoria

- DSM-5 Criteria for Gender Dysphoria

A marked incongruence between one's experienced/expressed gender and natal gender of at least 6 months in duration, as manifested by at least two of the following:

A. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
B. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
C. A strong desire for the primary and/or secondary sex characteristics of the other gender
D. A strong desire to be of the other gender (or some alternative gender different from one's designated gender)
E. A strong desire to be treated as the other gender (or some alternative gender different from one's designated gender)
F. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's designated gender)

The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning. Specify if:
A. The condition exists with a disorder of sex development.
B. The condition is post-transitional, in that the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one sex-related medical procedure or treatment regimen—namely, regular sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in natal males; mastectomy or phalloplasty in natal females).

Gender Dysphoria

Many leading medical groups recognize the medical necessity of treatments for gender dysphoria. A list of some of those groups is below:

- **American Academy of Child and Adolescent Psychiatry**
- **American Academy of Dermatology**
- **American Academy of Family Physicians**
- **American Academy of Nursing**
- **American Academy of Pediatrics**
- **American Academy of Physician Assistants**
- **American College Health Association**
- **American College of Obstetricians and Gynecologists**
- **American College of Physicians**
- **American Counseling Association**
- **American Heart Association**
- **American Medical Association**
- **American Nurses Association**
- **American Psychiatric Association**
- **American Psychological Association**
- **American Public Health Association**

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Gender Dysphoria

- Treatments for gender dysphoria can include the following:
  - Gender-affirming surgeries (e.g., chest surgery, genital surgery, facial surgery)
  - Hormone therapy
  - Facial and body hair removal
  - Mental health counseling
  - Voice therapy
  - Fertility preservation

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STATE LAWS

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State Laws

- Some states (AZ, CA, CO, CT, DC, IL, MD, MA, MN, NJ, NM, NY, OR, VT, WA) have laws protecting gender affirming care
- Some states (AL, AZ, AR, FL, GA, ID, IN, IA, KY, LA, MS, MO, MT, NE, NC, ND, OH, OK, SD, TN, TX, UT, WV) ban gender affirming care for transgender youth

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State Laws – California

- California prohibits insured health plans from denying or limiting coverage based on gender
- California identifies four prohibited practices:
  - Denying or cancelling an insurance policy on the basis of gender identity;
  - Using gender identity as a basis for determining premium amounts;
  - Considering gender identity as a pre-existing condition; and
  - Denying coverage or claims for health care services to transgender people when coverage is provided to non-transgender people for the same services

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ERISA PREEMPTION

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ERISA Preemption

- Many employer-sponsored health plans are subject to ERISA
  - There are some exceptions, such as governmental or church plans
- To qualify as an ERISA plan, the benefit arrangement must provide one of the benefits listed in ERISA §3(1)
- Among the benefits listed in ERISA is "medical, surgical, or hospital care or benefits"
  - In other words, group health plans

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ERISA Preemption

- ERISA generally preempts "any and all state laws insofar as they may now or hereafter *relate to* any employee benefit plan." ERISA § 514(a)
- A state law with an indirect effect on benefits or plan administration may be preempted if the law affects a central matter of plan administration or interferes with nationally uniform plan administration. *Gobeille v. Lib. Mut. Ins. Co*. (2016)

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ERISA Preemption

- However, certain state laws that have an indirect impact on ERISA plans are "saved" from preemption—this is known as the Savings Clause
- Under the Savings Clause, state laws regulating insurance are excepted from ERISA's broad preemption provision
- This means that state insurance laws that apply to insured plans (and similar entities, like HMOs), are saved from preemption
  - i.e., fully insured plans are subject to state laws

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ERISA Preemption

- Any state law requiring or barring coverage of gender-affirming care for a health plan would likely be preempted for self-funded ERISA plans, although it may impact fully insured plans

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Preemption Under ACA 1557

- There is a question about state laws that limit access to gender-affirming care for youth for fully insured plans. This would not be an ERISA preemption issue because ERISA does not preempt state insurance laws.
  - Rather, it would be a preemption argument under ACA Section 1557 (discussed in later slides)
- The preamble to the final ACA Section 1557 rule recognizes that some States may have laws that are contrary to the final rule's nondiscrimination protections
  - The Department of Health and Human Services (HHS) is of the view that these laws are preempted by ACA
- The ACA states that "nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title,"
  - Arguably, this means that States can adopt protections that go beyond what ACA requires but may not prevent a federal law from being implemented
  - This interpretation will likely be challenged at some point

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ACA SECTION 1557

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Section 1557

- Section 1557 is the ACA's primary anti-discrimination provision
- It prohibits health programs or activities that receive federal funds from discriminating based on race, color, national origin, age, disability, or sex
  - Section 1557 also applies to any program or activity that is administered by an agency of the federal government or any entity established under Title I of the ACA
- An individual cannot be excluded from participation in, denied the benefits of, or subjected to discrimination on these bases

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Section 1557

- Section 1557 incorporates existing federal civil rights laws and applies them to federally funded health programs. The prohibited grounds for discrimination are specified by:
  - Title VI of the Civil Rights Act of 1964 ("Title VI") with respect to race, color, national origin
  - Title IX of the Education Amendments of 1972 ("Title IX") with respect to sex
  - the Age Discrimination Act of 1975 ("Age Act") with respect to age, and
  - Section 504 of the Rehabilitation Act of 1973 ("Section 504") with respect to disability
- The statute incorporates the enforcement mechanisms under those laws for purposes of violations of Section 1557

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Section 1557 Implementation

- Section 1557 was to become effective March 23, 2010 (i.e., the enactment date of the ACA), but the Department of HHS was first required to issue regulations implementing it
- In 2016, HHS issued final regulations implementing Section 1557
  - This 2016 version of the regulations provided express protection against discrimination on the basis of gender identity
  - However, a federal court vacated portions of the 2016 regulations relating to gender identity

Section 1557 Implementation

- In June 2020, HHS reissued final regulations repealing and replacing certain portions of the 2016 regulations
- Shortly before the effective date, a federal court blocked HHS from enforcing the provisions of the 2020 regulations that removed gender identity from the nondiscrimination protections under Section 1557
- The court reasoned that the disputed provisions were contrary to the U.S. Supreme Court's ruling in *Bostock*, which held that discrimination based on sex for Title VII purposes encompasses discrimination based on sexual orientation and gender identity

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Section 1557 Final Rule

- In April 2024, HHS issued a new final rule
- The final rule provides that sex discrimination includes, but is not limited to, discrimination on the basis of sexual orientation, gender identity, sex characteristics (including intersex traits), pregnancy or related conditions, and sex stereotypes
- OCR states that the final rule is consistent with the *Bostock* ruling

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Section 1557 Final Rule

The FAQs for the newly issued final rule state the following:

"The rule does not require a specific standard of care or course of treatment for any individual, minor or adult. Providers do not have an affirmative obligation to offer any health care, including gender-affirming care, that they do not think is clinically appropriate or if religious freedom and conscience protections apply. HHS has a general practice of deferring to a clinician's judgment about whether a particular service is medically appropriate for an individual.

The final rule does not require those covered, including state Medicaid agencies, to cover a particular health service for the treatment of gender dysphoria for any individual, minor or adult. Rather, it prohibits health insurance issuers, state Medicaid agencies, and other covered entities from excluding categories of services in a discriminatory way. Coverage must be provided in a neutral and nondiscriminatory manner."

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Section 1557 Cases

- Section 1557 does not apply to self-insured ERISA group health plans so long as (or to the extent) they do not receive funding from HHS. However, other entities that contract with a group health plan may be covered by Section 1557. This was discussed in *C.P. v. Blue Cross Blue Shield of Ill., 2022 WL 17788148 (W.D. Wash. 2022)*
- In a class action lawsuit brought by a transgender teenager and his parent, the court held that an insurer, acting as a third-party claims administrator (TPA) for self-insured health plans, violated Section 1557 when it administered a discriminatory plan which excluded coverage for gender-affirming care

Section 1557 Cases

- *In C.P. v. Blue Cross Blue Shield of Ill.,* the plaintiff was a dependent covered under his mother's employer-provided group health plan and was receiving medically necessary gender-affirming care. At one point, he and his family were informed that some of his care would not be covered because of an exclusion of any care "for or leading to gender reassignment surgery," including the same care and medical interventions that other cisgender patients could receive under the plan
- In the original 2016 HHS regulations, HHS interpreted Section 1557 as applying to all operations of health insurers that receive federal financial assistance. However, the 2020 regulations narrowed their scope so that entities not "principally engaged in the business of providing healthcare" (such as most health insurers) are regulated "only to the extent" that they receive federal financial assistance

Section 1557 Cases

- The insurer did not receive federal financial assistance for its administration of self-insured plans but did receive such assistance in connection with other products that it provided (e.g., Medicare supplemental coverage)
- The court held that under the plain language of Section 1557, the insurer's TPA activities constituted the operation of a health program or activity
- It explained that Section 1557's phrase "any health program or activity, any part of which is receiving federal financial assistance" includes "all the operations of a business" principally engaged in providing health programs and activities
- The court stated that the 2020 regulations were contrary to the statute and appear to be arbitrary, capricious, and contrary to law

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Section 1557 Final Rule

- The preamble of the April 2024 final rule provides the following guidance on the scope and application of the rule:
  - Scope of the Rule. "A recipient of Federal financial assistance that is principally engaged in the provision or administration of health insurance coverage is covered under this rule for **all of its operations…**This position is also supported by a decision of the District Court for the Western District of Washington, which held that third party administrators operated by health insurance issuers are subject to section 1557 even if the third-party administrators do not receive Federal financial assistance."
- TH Comment—Assume that XX insurance carrier is subject to Section 1557 because it sells Medicare supplemental coverage and receives Federal financial assistance. The third-party administrator (TPA) arm of XX insurance company is also subject to Section 1557

Section 1557 Final Rule

- The preamble also discusses how this works when the TPA is covered by Section 1557, but the employer is not:
  - "When analyzing a claim against a covered third party administrator, OCR will determine whether responsibility for the decision or alleged discriminatory action lies with the third party administrator, group health plan, or the plan sponsor."

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Section 1557 Final Rule

- "Where the alleged discrimination relates to the administration of the plan by a covered third party administrator, OCR will process the complaint against the covered third party administrator because it is the entity responsible for the decision or other action being challenged. For example, if a covered third party administrator applies a plan's neutral, nondiscriminatory utilization management guidelines in a discriminatory way against an enrollee, OCR will proceed against the covered third party administrator as the entity responsible for the decision. In addition, OCR will pursue claims against a covered third party administrator in circumstances where the third party administrator is the entity responsible for developing the discriminatory benefit design feature that was adopted by the employer."

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Section 1557 Final Rule

- "Where the alleged discrimination relates to the benefit design of self-insured group health plan coverage that did not originate with the covered third party administrator, but rather with the plan sponsor or the group health plan, and where the third party administrator played no role in the development of the plan's benefit design, OCR will refer the complaint to the EEOC or DOJ for potential investigation."
- TH Comment: If the employer-sponsored plan has nondiscriminatory provisions (such as for the treatment of gender dysphoria), but it is administered in a discriminatory manner, that Section 1557 claim will be against the TPA. If the TPA gave the plan sponsor a plan provision that was discriminatory, and the TPA was responsible for the design feature, that Section 1557 claim will be against the TPA. If it's the employer's fault (i.e., the employer included a discriminatory design in the health plan), OCR will refer that to the EEOC as a potential Title VII claim.

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Section 1557 Cases

- *Kadel v. Folwell / Fain v. Crouch* (April 29, 2024) are 2 separate cases that were decided at the same time by the Fourth Circuit Court of Appeals
  - *Kadel* challenged North Carolina's categorical exclusion of coverage for gender-affirming medical care for transgender government employees and their dependents enrolled in the state health plan (alleged violations of Title VII and 14th Amendment Equal Protection Clause)
  - *Fain* challenged West's Virginia's exclusion of coverage for gender-affirming surgical care for low-income transgender people enrolled in Medicaid (alleged violations of Section 1557 and the Medicaid Act)

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Section 1557 Cases

- In deciding the 2 cases, the court stated:

"These two cases present the same question: Do healthcare plans that cover medically necessary treatments for certain diagnoses but bar coverage of those same medically necessary treatments for a diagnosis unique to transgender patients violate either the Equal Protection Clause or other provisions of federal law? We hold that they do, and therefore affirm the judgments of the district courts."

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Section 1557 Cases

- The court also stated, "A policy that conditions access to gender-affirming surgery on whether the surgery will better align the patient's gender presentation with their sex assigned at birth is a policy based on gender stereotypes…"
- The decision provided an example of mastectomies, which are procedures that can be performed on anyone who has breast tissue regardless of their "biological sex"
  - If someone who was assigned male were to undergo a mastectomy for gender-affirming purposes (as cis men with gynecomastia) that would be covered under the health plan; if someone were assigned female, however, that procedure would not be covered

TITLE VII

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Title VII

- Title VII prohibits employers with 15 or more employees from:
  - (1) failing or refusing to hire or to discharge any individual, or otherwise discriminating against any individual with respect to compensation, terms, conditions, or privileges of employment, because of the individual's race, color, religion, sex, or national origin; or
  - (2) limiting, segregating, or classifying employees, or applicants for employment, in any way which would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect his/her status as an employee, because of such individual's race, color, religion, sex, or national origin.

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Title VII

- *Lange v. Houston County* (11th Circuit, May 2024)
- Houston County provided a health insurance plan to its own employees, as well as employees of the Houston County Sheriff's Office (where Lange worked)
  - The health plan covered "medically necessary" services, including surgery
- The health plan stated that surgery is considered medically necessary if there is a "significant functional impairment and the procedure can be reasonably expected to improve the functional impairment"
- Houston County set the benefit terms, decided what changes were to be made to the health plan, determined member deductibles and premiums, and provided services to all enrollees

Title VII

- Lange sought health plan coverage for her medically necessary surgery for gender dysphoria. However, this was denied based on the health plan's exclusion of "[d]rugs for sex change surgery" and "[s]ervices and supplies for a sex change and/or the reversal of a sex change" (the "Exclusion")
- The court stated, "Health insurance is squarely a benefit within Title VII's 'compensation, terms, conditions, or privileges of employment.'"
- The court also stated, "Applying *Bostock's* reasoning to the facts in this case, we conclude that the district court was correct in finding that the Exclusion violated Title VII…The Exclusion is a blanket denial of coverage for gender-affirming surgery."

Title VII and ACA 1557

- It seems that one main aspect of these cases/guidance (both under ACA 1557 and Title VII) is that a blanket ban on gender-affirming care in a health plan will likely be in violation of one of these federal laws
- In addition, a plan would likely be in violation of one of these federal laws if, for example, it denied coverage of a medically necessary treatment for gender dysphoria if that same treatment was offered otherwise under the plan
- For example, assume that the health plan covered breast reconstruction for cancer treatment, but did not cover that same procedure to treat gender dysphoria—this would likely violate Title VII and/or ACA 1557

Title VII and Religious Exemptions

- For certain employers, a defense in these cases can be based on the employer's religious beliefs
- In *Braidwood Management, Inc. v. the Equal Employment Opportunity Commission* (5th Circuit, 2023), the Appeals Court held that religious employers may be exempt from Title VII requirements concerning sexual orientation and gender identity discrimination if those requirements are found to substantially burden the employer's religious beliefs

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MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)

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MHPAEA

- MHPAEA generally requires that group health plans ensure that the financial requirements and treatment limitations applicable to mental health/substance use disorder (MH/SUD) benefits are no more restrictive than those applicable to medical/surgical benefits
- MHPAEA Applies to:
  - Quantitative limitations, such as co-payments, reimbursement limits, and number of visits
  - Nonquantitiative limitations ("NQTLs"), such as the processes, strategies, evidentiary standards, or other criteria that limit the scope or duration of benefits for services provided under the plan

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MHPAEA

- Plans may categorically exclude certain mental health disorders from coverage, such as gender dysphoria, without violating MHPAEA
  - But categorical exclusions for treatment of gender dysphoria can run afoul of Title VII and Section 1557
- If a plan provides coverage for gender dysphoria, then the plan must provide coverage for the condition "in parity" with medical/surgical benefits provided under the plan
- Important to note that plan participants can bring lawsuits alleging MHPAEA violations under ERISA

MHPAEA

- Under MHPAEA, which was amended by the Consolidated Appropriations Act of 2021 (CAA), plans are required to perform comparative analyses of the design and application of NQTLs
  - Plans are also required to provide documentation of their comparative analyses to plan participants on request
- Exclusions for certain treatments, such as gender reassignment surgery, are considered NQTLs and must be analyzed as part of the plan's NQTL analysis

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MHPAEA

- In *Duncan v. Jack Henry & Assocs., Inc.* (W.D. Mo. 2022), a transgender woman's preauthorization request for facial feminization surgery was denied, even though it was determined by her doctor that the surgery was medically necessary treatment for her gender dysphoria
  - The plan denied it under its cosmetic exclusion
- The Court denied the motion to dismiss. The Court found that the plaintiff successfully plead that the NQTL under the plan facially violated MHPAEA because the plan language limited the scope of the availability of cosmetic surgery

MHPAEA

"Reading these provisions together as Plaintiff suggests, the Court concludes at this early stage that Plaintiff adequately pleads a facial Parity-Act challenge. …under the terms of the Cosmetic Treatment exclusion, whether a procedure is sought for psychological or emotional reasons (as opposed to physical or medical reasons), the procedure is excluded when its primary use is to improve, alter, or enhance appearance. At the same time, a reconstructive surgery - that is, a surgery on an abnormal structure of the body caused by a physical or mental sickness - is excluded when performed only to achieve a normal or nearly normal appearance. Such reconstructive surgery is not excluded, however, when performed to correct an underlying medical condition or impairment (of which neither term is explicitly defined by the Plan), including when the procedure restores or improves function vis-a-vis an existing physical impairment, regardless of whether the surgery impacts or changes one's physical appearance. Simply, Plaintiff sufficiently pleads that under the terms of the Plan, a surgical treatment prescribed for a mental health condition is excluded, whereas a surgical treatment prescribed for a medical or physical reason is allowed (because it would be exempted from the Cosmetic Treatment exclusion)."

HIPAA Privacy

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HIPAA PRIVACY

- States with laws penalizing or discouraging gender-affirming care may seek to gain access to health records of individuals receiving such care
- This information is protected health information (PHI) under the HIPAA privacy rules
  - The HIPAA privacy rules permit, but do not require, covered entities and business associates to disclose PHI without individual authorization when such disclosure is "required by law"
- HHS has issued guidance regarding when PHI may be used or disclosed in response to a court order or subpoena

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HIPAA PRIVACY

- **Court Order—**A HIPAA-covered health care provider or health plan may share your protected health information if it has a court order. This includes the order of an administrative tribunal. However, the provider or plan may only disclose the information specifically described in the order.
- **Subpoena—**A subpoena issued by someone other than a judge, such as a court clerk or an attorney in a case, is different from a court order. A HIPAA-covered provider or plan may disclose information to a party issuing a subpoena only if the notification requirements of the Privacy Rule are met. Before responding to the subpoena, the provider or plan should receive evidence that there were reasonable efforts to: (1) Notify the person who is the subject of the information about the request, so the person has a chance to object to the disclosure, or (2) Seek a qualified protective order for the information from the court.

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HIPAA PRIVACY

- On April 22, 2024, HHS issued a final rule to support reproductive health care privacy under the HIPAA privacy rules
- The rule introduces a new category of protected health information to the HIPAA Privacy Rule — "reproductive health care" — and imposes new obligations for the collection, use, and disclosure of this information by covered entities and business associates

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HIPAA PRIVACY

- Reproductive health care means "health care [as currently defined under HIPAA] that affects the health of an individual in all matters relating to the reproductive system and to its functions and processes."
- When an individual is "seeking, obtaining, providing, or facilitating reproductive health care" and the covered entity or business associate has determined that the reproductive health care is lawful in the state, protected by federal law, or "presumptively lawful" under the final rule, the covered entity or business associate must take certain actions that restrict the use and disclosure of such information

HIPAA PRIVACY

- When a covered entity or business associate is collecting or using protected health information that pertains to reproductive health care, the entity must ensure that the information is not used for certain prohibited purposes
  - i.e., for conducting a criminal, civil, or administrative investigation into an individual for their seeking reproductive health care, imposing liability on someone for seeking reproductive health care, or identifying someone for the purpose of such investigation or imposition of liability

HIPAA PRIVACY

- The preamble to the final rule states the following:
  - Comment: A commenter urged the Department to define the term "sexual and reproductive health care" to ensure that individuals have reproductive health care privacy, regardless of their sexual orientation or gender identity….
  - Response: After consideration, we have finalized a definition grounded in the Privacy Rule's long-established term "health care." We provide a non-exhaustive list of examples in the preamble above. We do not explicitly address all of the many types of health care suggested in comments to avoid creating the impression of a complete list. This is also consistent with our approach regarding the definition of "health care." We emphasize that this definition does not set or affect standards of care, nor does it affect uses and disclosures of PHI for treatment purposes. Operational concerns expressed by some commenters are addressed in response to comments on the prohibition.

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DESIGN CONSIDERATIONS & ACTION ITEMS

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Plan Design Considerations for Employers

- If your plan is fully-insured, consider whether applicable state law impacts the plan's coverage of gender-affirming care
- For self-funded plans:
  - Designing plans such that they categorically exclude coverage for gender-affirming care can implicate Title VII for discriminating on the basis of sex
  - Even if medically necessary treatment for gender dysphoria is covered, limiting coverage for certain treatments related to gender dysphoria may violate MHPAEA
  - If your TPA receives federal funding (many do), consider whether the administration of the plan could be the basis for a claim under Section 1557

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Action Items

- Review self-funded plan design, including definitions and exclusions, to determine whether there is any risk of discrimination under Title VII
  - This should also be considered if the TPA is subject to Section 1557
- Perform and review NQTL comparative analysis to determine whether gender dysphoria coverage is offered in parity with medical/surgical benefits
- Update HIPAA policies and procedures and notice of privacy practices to be compliant with final rule on reproductive healthcare

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