

Employee Benefit ■ Plan Review

Gender-Affirming Benefits: Best Practices for Group Health Plans

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Federal legislative and regulatory activity related to employer-sponsored group health plans shows no signs of slowing, particularly with the issuance of interpretive guidance regarding the transparency and surprise-billing rules enacted by the Consolidated Appropriations Act, 2021. States also have been active, both in their regulation of licensed health-insurance carriers and by aggressively seeking ways to regulate self-funded arrangements at the margins. The latter trend has already manifested in laws governing reproductive health, which received significant attention following the U.S. Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*.

Now, attention has also turned to whether – and to what extent – group health plans must cover gender-affirming medical or surgical treatments (gender-affirming care), especially regarding minors.

Group health plan sponsors encounter coverage of gender-affirming care differently, depending on whether they purchase insurance or self-fund their health benefits. Fully insured plans must follow applicable state mandates, while self-funded plans generally have more flexibility in plan design. However, employers will struggle with certain state laws related to travel for the purpose of gender-affirming care, irrespective of plan funding. The issues they

encounter are similar to the questions concerning reproductive health that have followed the *Dobbs* decision.

The World Health Organization defines gender-affirming care (which includes but is not limited to gender-reassignment surgery) 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. Interventions fall along a continuum, from counseling, to changes in social expression, to medications such as hormone therapy.

The World Professional Association for Transgender Healthcare, an influential standard-setting organization, publishes internationally accepted clinical guidelines for gender-affirming care, the most recent of which addresses for the first time the treatment of adolescents, providing that an inquiry into whether gender-affirming care is appropriate must be determined case by case, based on an assessment of emotional and cognitive maturity.

APPLICABLE LAWS

The ERISA Preemption Doctrine

The Employee Retirement Income Security Act (ERISA) bars the application of “any and all State laws insofar as they now or hereafter relate to any employee benefit plan. . . .” The

term commonly used for this broad prohibition against state involvement in ERISA plans is “ERISA preemption” of state law. There are some exceptions to ERISA preemption of state law, primarily allowing states to enforce insurance, banking and securities laws of general application. Thus, for example, a state may not be able to regulate a benefit plan directly, but within limits it can regulate an insurance company that insures plan benefits, which in turn affects fully insured plans. Any state law requiring or barring coverage of gender-affirming care would likely be preempted for self-funded ERISA plans, although it may impact fully insured plans. However, state criminal laws of general application are not preempted.

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Section 1557 of the Affordable Care Act

Section 1557 of the Affordable Care Act (ACA) prohibits discrimination on the basis of race, color, national origin, sex, age or disability in a health program or activity, any part of which receives federal financial assistance. A 2022 proposed regulation issued by the U.S. Department of Health and Human Services (HHS) would modify prior to make clear that discrimination based on gender identity is prohibited. This position is in accord

with the Supreme Court’s ruling in *Bostock v. Clayton County, Georgia*, which held that the references to “sex” in Title VII of the Civil Rights Act include sexual orientation and gender identity. Where gender dysphoria qualifies as a disability, restrictions that prevent individuals from receiving medically necessary care based on a diagnosis or perception of gender dysphoria may also violate Section 504 and the Americans with Disabilities Act.

Group health plan sponsors, third-party administrators and other health plan service providers should understand the costs of their plan design options and assess gender-affirming care coverage.

The Mental Health Parity Act

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) generally requires that group health plans and group health insurance issuers 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 (M/S) benefits (e.g., more restrictive lifetime or annual dollar limits, financial requirements or treatment limitations) and that there are no separate financial requirements or treatment limitations applicable to MH/SUD benefits.

Gender dysphoria is generally considered a mental-health condition; thus, MHPAEA might impose limits on cost-sharing for gender-affirming

care to match the limits imposed on a plan’s M/S benefits.

State Laws Protecting Access to or Barring Gender-Affirming Care

States have increasingly passed laws to penalize parents aiding minors in accessing gender-affirming care, permitting individuals to file for damages against providers who violate such laws, limiting insurance coverage or payment for gender affirming services, or prohibiting the use of state funds for such services. Other states have established “shield” laws, which protect access to gender-affirming care.¹

The Health Insurance Portability and Accountability Act (HIPAA)

State 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 HIPAA. HIPAA permits, but does not require, covered entities and business associates to disclose PHI without individual authorization when such disclosure is required by law. Examples of such requirements include, but are not limited to, information requests in court-ordered warrants, subpoenas, or summons issued by a court or grand jury. States may attempt to leverage this “required by law” exception to PHI disclosures under HIPAA to impose sanctions or penalties. HHS issued a proposed rule that would bar this approach in the context of reproductive health, and it has also expressed the view in sub-regulatory guidance that this use does not meet the “required by law” definition.²

APPROACHES TO COVERAGE OF GENDER-AFFIRMING CARE

Group health plan sponsors, third-party administrators and other health plan service providers must determine how best to navigate potentially conflicting and rapidly shifting laws,

regulations, and changing cultural norms and clinical standards relating to gender-affirming care, especially in relation to minors:

- Fully insured plans must follow the terms of underlying group health insurance policies, which are required to follow applicable state law.
- Although self-funded plans have greater plan-design latitude, categorically denying access to gender-affirming care may violate Section 1557 of the ACA. This poses a challenge for self-funded plans that cover individuals in multiple states, including those that have restricted or prohibited gender-affirming care. While ERISA should preempt state civil laws on the subject, the extent

to which preemption extends to state criminal laws is unclear.

- Self-funded plans may implement medical travel benefit plans to supplement their coverage in states that restrict or prohibit gender-affirming care, similar to the increase in medical travel benefits post-*Dobbs*.
- Laws and regulations regarding gender-affirming care for minors are still shifting, although federal policy and current clinical standards appear to favor covering gender-affirming care for minors on a case-by-case basis where medically necessary.

Group health plan sponsors, third-party administrators and other health plan service providers should understand the costs of their plan design

options and assess gender-affirming care coverage, especially in light of conflicting federal and state laws, increased litigation in several states (e.g., Texas), regulatory guidance, and increased enforcement of ERISA fiduciary duties with respect to health and welfare plans. 🌟

NOTES

1. For a survey of gender-affirming care state law, see KFF's Policy Tracker: Youth Access to Gender Affirming Care and State Policy Restrictions, available at <https://www.kff.org/other/dashboard/gender-affirming-care-policy-tracker/>.
2. <https://www.govinfo.gov/content/pkg/FR-2023-04-17/pdf/2023-07517.pdf>.

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