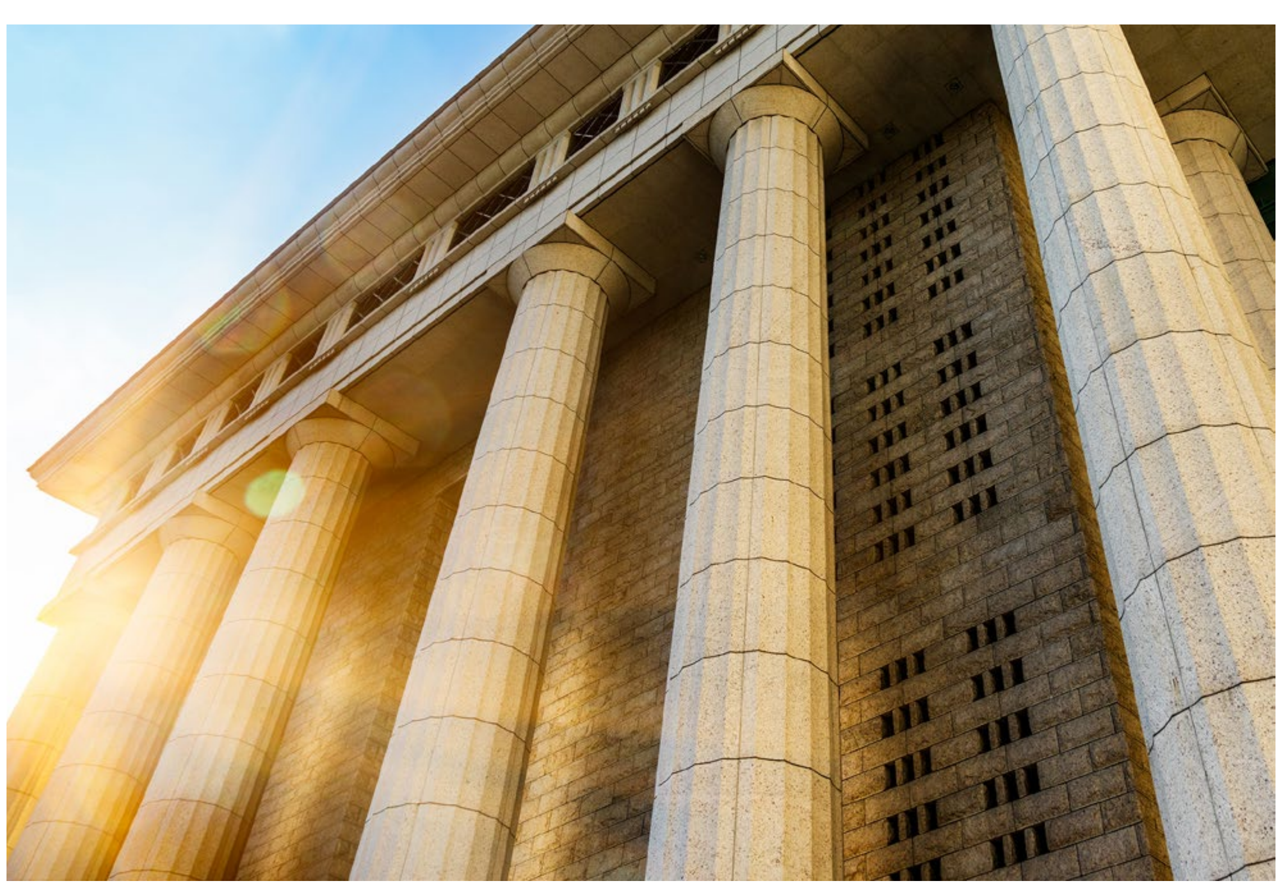

ACA, HIPAA AND FEDERAL HEALTH BENEFIT MANDATES:

PRACTICAL Q&A

The Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal health benefit mandates (e.g., the Mental Health Parity Act, the Newborns and Mothers Health Protection Act, and the Women's Health and Cancer Rights Act) dramatically impact the administration of self-insured health plans. This monthly column provides practical answers to administration questions and current guidance on ACA, HIPAA and other federal benefit mandates.

Attorneys John R. Hickman, Ashley Gillihan, Carolyn Smith, Ken Johnson, Amy Heppner, and Laurie Kirkwood provide the answers in this column. Mr. Hickman is partner in charge of the Health Benefits Practice with Alston & Bird, LLP, an Atlanta, New York, Los Angeles, Charlotte, Dallas and Washington, D.C. law firm. Ashley, Carolyn, Ken, Amy, and Laurie are senior members in the Health Benefits Practice. Answers are provided as general guidance on the subjects covered in the question and are not provided as legal advice to the questioner's situation. Any legal issues should be reviewed by your legal counsel to apply the law to the particular facts of your situation. Readers are encouraged to send questions by E-MAIL to Mr. Hickman at john.hickman@alston.com.

ACA PROPOSED §1557 REGULATIONS: "BACK TO THE FUTURE"

More than 10 years after enactment, much remains unsettled with regard to prohibited discrimination for health plans under the Affordable Care Act (ACA). Now, the third set of "final" rules for §1557 of the ACA are on the horizon, but the controversies surrounding its nondiscrimination provision show no signs of slowing down this year.

Generally, §1557 prohibits health plans or activities that receive Federal funds from discriminating against certain protected classes. Ever since the first set of §1557 final regulations were announced in 2016, and the second set in 2020, the scope of the prohibition against health plan discrimination has been challenged. If current litigation is any indicator, those challenges will not when the 2022 proposed rules are finalized.

In addition to changes in scope for sex discrimination, the 2022 proposed rules expand the types of entities covered under §1557 to include insurers that receive federal funds—even when acting as third-party administrator to self-insured plans.

This restores the 2016 rules' expansive application of "covered entity" status on insurers, which the 2020 rules had removed. A recent case (discussed below) underscores the potential risks for TPAs.

Because of numerous court orders enjoining and invalidating certain portions of both the 2016 and 2020 rules, the current state of §1557 regulations has been called "unworkable" by at least one court.

One key issue in §1557 litigation is how the Supreme Court's 2020 opinion in *Bostock v. Clayton County* fits into determining the scope of prohibited sex discrimination for ACA §1557 covered entities and health plans. In that case, the issue was whether an employer could terminate an employee based on sexual orientation or gender identity.

The Court sided with the terminated employees to say that such termination was prohibited discrimination on the basis of sex.

However, *Bostock* was decided under Title VII of the Civil Rights Act as an employment discrimination case, and §1557 incorporates the prohibition against sex discrimination through Title IX of the Education Amendments--*not* Title VII.

This is significant because although the *Bostock* court specifically cautioned that the holding was limited to Title VII employment discrimination, many courts have looked to Title VII when analyzing Title IX cases.

Some courts that have taken a very strict reading of

Bostock and §1557 maintain that *Bostock's* expansion to include sexual orientation and gender identity do not apply, while other courts have reached the opposite conclusion.

These competing interpretations of *Bostock* may result in a circuit split, taking the issue back to the Supreme Court at some point. We are already seeing two cases—one in the 4th Circuit and one in the 11th—that have the potential to do just that.

The first case, *Fain v. Crouch*, involves the West Virginia Medicaid program, which covers hormone treatments for gender dysphoria but excludes surgical treatments for gender dysphoria. The plaintiffs claim that the exclusion was not allowed under §1557, as well as the equal protection clause of the 14th Amendment and certain requirements under Medicaid.

The U.S. district court agreed and enjoined the West Virginia Department of Health and Human Services from enforcing the exclusion. The court's discussion of the ACA issue under §1557 was simple and direct: the ACA incorporates Title IX, and the 4th Circuit looks to Title VII to evaluate Title IX claims, and therefore Bostock is the appropriate test.

The discussion did not address the Supreme Court's limitation of Bostock to Title VII employment discrimination cases only. West Virginia appealed the case to the Fourth Circuit, and several amicus briefs have been filed. Oral argument before the 4th Circuit is scheduled for March 2023.

The second case, also a state Medicaid program case, was filed in September 2022 in Florida's Northern District (11th circuit). *Dekker v. Marstiller* is strikingly similar to the West Virginia case in that it also involves a state Medicaid plan that has exclusions for treatment for gender dysphoria, and Plaintiffs also claim violations of §1557, as well as the 14th Amendment, and portions of the Medicaid Act.

Whether the Florida district court will take a different approach in the ACA analysis for applying *Bostock* to §1557 remains to be seen. The trial is set for May 2023. There are several other cases in other districts that also touch on the Bostock issue, but the similarity of the facts in these two cases is what makes these interesting to watch for a possible circuit split.

Another important development relates to the reach of ACA §1557 as applied to a TPA that is also an insurer that receives Federal funds for unrelated business activities. In a case out of Washington state that was decided late last year, a plaintiff sued the TPA that denied his claims for gender dysphoria-related treatment (*C.P. v. Blue Cross Blue Shield of Illinois*).

The TPA was an insurance company, and presumably not a covered entity in its role as TPA under the 2020 rules. The employer, which

is part of the Catholic Health Initiatives Franciscan Health System, controlled the design of its self-insured group health plan, and the TPA believed that ERISA required the plan to be administered according to this design. The TPA made the following arguments in its defense, but the district court was not persuaded by any of them:

- The TPA claimed that it was not a covered entity under the 2020 rules, which distinguish insurers as entities principally engaged in the business of providing "insurance", rather than the business of providing health "healthcare" (the latter category would be a "covered entity" under the 2020 rules, but the former is not). The district court refused to defer to the 2020 rules, calling the rules arbitrary and capricious and contrary to the statutory language, which was not ambiguous.

- The TPA said that it received no Federal funds for its TPA business, but the court took the company's activities as an insurance company into account as a whole and said that the statute covers such entities, "any part of which" receives Federal funds.

- The TPA did not design the plan exclusions —the religious-based employer did. Also, the TPA is required under ERISA to administer the plan according to its terms. Notably, the preambles to the 2016 rules and 2022 proposed rules suggest that whether the discriminatory provision in a plan design originates with the TPA will be taken into consideration when processing complaints. Even so, the court refused to apply deference to this guidance because statutory text contains no

exclusion for TPAs that did not design the plan. Nor was the ERISA argument persuasive, because ERISA 1144(d) states that ERISA will not be construed to alter/invalidate/impair/supersede any other U.S. law.

- The TPA argued that there is no medical consensus on gender affirming treatment, which the court also denied as immaterial to the issue.
- Lastly, the TPA claimed that the employer/plan sponsor has sincerely held religious beliefs that are protected under the Religious Freedom Restoration Act (RFRA). The court pointed out that RFRA is not a defense for the TPA, and that RFRA provides relief only when the government is a party. Neither the government nor the employer/plan sponsor were parties here.

The outcome of the case is significant for TPAs that may be part of an entity that receives Federal funds because neither the exclusion for insurers under the 2020 rules (which are technically still in effect) nor the plan design defense saved the TPA on summary judgement.

The proposed 2022 rules clearly bring insurer/TPAs back under the §1557 covered entity umbrella, so these TPAs will need to evaluate exposure when administering plan designs that discriminate under §1557.

Included below is a brief, high-level summary of the evolution of the §1557 regulations with regard to how they apply to insurers and TPAs:

2016 Final Regulations ("2016 Rules")

- Defined the term "on the basis of sex" to include (among other things) "gender identity" and "sex stereotypes," which included transgender individuals.
- Applied to insurers that received Federal funds, even when acting as a TPA for a self-insured plan.
- Key challenges: the *Franciscan Alliance* line of decisions ultimately resulted in limitations on the application of the ACA §1557 rules for the prohibition against discrimination on the basis of "gender identity" (and "termination of pregnancy").

2020 Regulations ("2020 Rules")

- Repealed and replaced parts of 2016 Rules, deleting the definitions for "on the basis of sex" and "gender identity" and incorporated Title IX's religious exemption.
- Distinguished insurers as entities principally engaged in the "business of providing insurance", thereby excluding insurers

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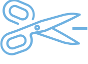

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from entities engaged in "the business of providing health healthcare."

- Key challenges: *Whitman-Walker Clinic v. HHS and Walker v. Azar* collectively resulted in injunction against HHS from enforcing the 2020 Rule's repeal of the 2016 Rule's definition for "on the basis of sex" and incorporation of Title IX's religious exemption.

2022 Proposed Regulations

- Effectively (though not in an identical manner) re-instates 2016 "on the basis of sex" definition by incorporating sex stereotypes, sex characteristics, and gender identity (as well as pregnancy and sexual orientation) into the term "sex."
- Allows entities to notify OCR if the entity believes it is exempt under Federal consciences or religious freedom laws. OCR will "promptly" consider the views in responding to complaints.
- Applies to insurance issuers and TPAs administering self-insured plans but does not categorically include group health plans. A fact-specific inquiry may be required to determine if the plan or the plan sponsor is the recipient of Federal funds.

"But for" the authority of the Bostock opinion to buttress HHS's interpretation of "sex", the 2022 proposed rule is not fundamentally different from the 2016 rules. Whether *Bostock* is appropriately applied to §1557 will be something for plan sponsors and TPAs to watch in the coming months. ■

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