Expanding the Definition of “Sex Discrimination” in Health Care:

Transgender Health Benefits

Many health plans must eliminate exclusions for transgender-related services. But doing so likely won’t be as costly as some plan sponsors might fear; such coverage may actually result in savings.
by Erin E. Shick
The 1.4 million people in the United States who are transgender face large challenges accessing health care. Many who sought coverage of gender transition services from their health care plans were denied benefits, and they encounter other difficulties finding health care providers to treat them.

Under recently published final regulations from the U.S. Department of Labor (DOL) under the Affordable Care Act (ACA), blanket exclusions for gender transition services are considered to be discriminatory. Many health plans will be required to modify their current benefit structure.

In May 2016, DOL published final regulations for the implementation of Section 1557, which is ACA’s provision prohibiting discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs or activities.1

Unlike federal discrimination provisions such as those in the Age Discrimination Act, Section 504 of the Rehabilitation Act, and Title IX, Section 1557 defines discrimination “on the basis of sex” broadly. Sex discrimination in Section 1557 includes, but is not limited to, “pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping and gender identification.”2 The prohibition against discrimination on the basis of gender identification is what makes this statute unique.

Gender identification is defined as an individual’s sense of gender, whether that is male, female, neither or both, and the regulations make clear that an individual’s gender identification may be different than the sex he or she was assigned at birth.3 Under Section 1557, the blanket exclusion many health plans currently have regarding benefits relating to gender transition services is considered discriminatory.

In the final regulations, the Department of Health and Human Services (HHS) outlines its rationale for broadening the definition of sex discrimination to include gender identification. In a 2010 study, approximately 27% of transgender individuals—who make up 0.6% of the total population—reported that medical professionals had denied them health care.4,5 Similarly, in a 2011 study, 25% of transgender individuals reported that health care professionals had subjected them to harassment, and 50% reported needing to teach their health care professionals about transgender care.6

The lack of access to and discrimination in health care contributes to higher rates of mental health issues, HIV/AIDS, suicide, tobacco use and cancers in the lesbian, gay, bisexual, transgender, queer and/or questioning (LGBTQ) community.7 By prohibiting discrimination on the basis of an individual’s gender identity, HHS is taking a step toward improving the LGBTQ community’s experience with the U.S. health care system.

Note that Section 1557 contains other regulations and requirements in addition to the sex-discrimination provision, including increased access to health care for non-English-speaking individuals and persons with disabilities. This article, however, focuses on compliance with the sex-discrimination provision.

Who Is Covered?

First, it is important to note that Section 1557 does not apply to all health care insurers or providers. The final rule applies to “health programs or activities” that receive “federal funding.” On its face, the phrase federal funding would seem to imply all federal funding. However, the regulations clarify that the federal funding must come from HHS.8

Although the regulations do not outline specifically what federal funding HHS provides to group health plans, health plans are likely covered under Section 1557 if they accept the “retiree drug subsidy” (RDS) or if they receive funds from

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**takeaways**

- People who identify with the sex opposite to the one they were assigned at birth often face challenges dealing with the U.S. health care system.
- By broadening ACA prohibitions on discriminating based on sex to include gender identification, HHS hopes to improve the LGBTQ community’s experience in the health system.
- Many health plans with blanket exclusions for transgender health services must modify their benefit structure.
- A health plan may not deny or limit services generally available to one sex because of a person’s transgender status.
- The DOL final regulations prohibiting sex discrimination apply to health programs or activities that receive federal funding; not all health insurers or providers are covered.
- Only a very small percentage of the population chooses to have gender reassignment surgery, and the one-time cost plus hormone therapy and related services may well be less extensive than the recurring costs of mental health services due to depression, substance abuse and other risk factors.
HHS for self-insured employer group waiver plans (EGWPs), Medicare Advantage or Medicare prescription drug plans.

An insurer that offers insurance on the marketplace (either federal or state) subjects all of its health programs and activities to Section 1557.

Finally, medical providers that accept Medicare (except Part B and Medicaid) and HHS-administered health programs or activities are covered.9

This list of covered entities could become more expansive as additional guidance is issued. For example, questions remain about whether providing a fully insured EGWP or paying secondary to Medicare for retiree coverage would subject a plan to the regulations.

The regulations define health program or activity as the “provision or administration of health-related services, health-related insurance coverage, or other health-related coverage, and the provision of assistance to individuals in obtaining health-related services or health-related insurance coverage.”10 Importantly, this definition covers all health-related operations of a covered entity. Consequently, if a company offers insurance on the state or federal marketplace, the company’s third-party administrator (TPA) services are covered unless the Office of Civil Rights (OCR) determines through a factspecific inquiry that the TPA services are independent. Currently, there is no guidance as to what factors OCR will consider in making this independence determination. If a TPA administers a noncovered self-insured plan, the TPA is not responsible for noncompliant coverage terms or benefit design. However, the TPA is still required to administer the plan’s benefits in a non-discriminatory manner.

Notice and Grievance Requirements

If an entity determines it is covered under Section 1557, it needs to act now if it has not already done so. The regulations went into effect for every section, except those affecting benefit design, on July 18, 2016. Plans must make any benefit design changes on the first day of the first plan year on or after January 1, 2017.11

Covered health programs or activities should already be complying with the notice requirements. Section 1557 requires that the covered entity include notice language on “all significant publications” and post the notice in places where the plan interacts with the public, including the entity’s website, if one exists.12 Appendix A of the regulations contains the model notice language as well as an abbreviated version for smaller-sized publications.

Along with the notice language available in English, covered entities must also include a tagline (i.e., a sentence saying: “Attention: If you speak [insert language], language assistance services, free of charge, are available to you. Call 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx”) that is then translated into the “top 15 languages spoken by individuals with limited English proficiency in the relevant state or states.”13 For smaller-sized publications, covered entities need to include only the top two languages.

If a covered entity has 15 or more employees, it must designate an employee who is responsible for compliance. In addition, the covered entity must develop a grievance procedure.14 A covered entity can choose to modify its existing grievance procedure or use the model grievance procedure provided in Appendix C of the regulations.

Gender Transition-Related Services

Under the sex-discrimination portion of the new regulations, a health program or activity may not discriminate on the basis of sex.15 For group health plans, this means that blanket exclusions for gender transition procedures and related services are prohibited. Furthermore, a health plan may not deny or limit services generally available to one sex due to an individual’s transgender status.16 For example, a plan cannot deny a mammogram to a participant solely because he is listed as a male. Such a denial would be discriminatory because the participant may be a trans-male (a person who was born female but whose gender identity is male) and have a medically necessary reason for needing a mammogram.

The regulations do not specifically require plans to provide gender transition-related services, and plans can still make the determination of medical necessity.17 However, practically speaking, plans will need to cover some gender transition services. The American College of Physicians, American Medical Association and American Psychological Association are a few of the many health organizations that consider gender transition services “medically necessary.”18 However, plans may impose reasonable criteria for determining whether gender transition services are medically necessary. For example, a plan may require a referral from a qualified mental health professional and/or require a documented history of gender
dysphoria (discomfort or distress because of an emotional and psychological identity as male or female that is opposite to a person's biological sex).

Penalties for Noncompliance

Due to the perceived cost of providing gender transition related-services, some health plans are evaluating the potential penalties for noncompliance with Section 1557. If applicable, HHS may revoke the covered entity's federal funding. Given the actual cost of compliance, as discussed below, plan fiduciaries should consider carefully whether jeopardizing a plan's federal funding is in the best interest of plan participants. A plan should rely on a consultant to provide this analysis.

In addition, Section 1557 provides a private right of action to individuals to file a lawsuit to recover compensation for violations of Section 1557. An individual would not have to file a claim with OCR first, and covered entities cannot require an individual to exhaust an entity's grievance procedures prior to filing suit. The regulations provide OCR with a separate enforcement mechanism for noncompliance as well.

The Cost of Benefits for Plans Covering Gender Transition-Related Services

Many health plans incorrectly assume that compliance with Section 1557, specifically the sex-discrimination provisions, will be a large cost to the plan. Studies have proved that covering gender transition services can result in overall net cost savings for health plans. The Journal of Internal Medicine estimates that gender reassignment surgery is a one-time cost of between $20,000 and $30,000 plus the additional cost of hormone replacement therapy and other related services. Without gender transition services, a transgender person typically will cost a plan $10,712 a year due to the increased prevalence of depression, substance abuse and other risk factors. For example, 41% of transgender individuals have attempted suicide, compared with the national rate of 4.6%.

Furthermore, the number of individuals who use the benefit most likely will be minimal. It is estimated that only 3,000 to 9,000 Americans undergo sex reassignment surgery each year. In 2001, the city of San Francisco included transgender services in its employee insurance. To address the additional expenditures, the city established a surcharge for each employee. By 2006, it had spent only $386,417 of the $5.6 million it had collected and therefore ended the surcharge completely. The San Francisco Human Rights Commission determined that actuaries overestimated the actual utilization of the benefit, finding that: "[d]espite actuarial fears of over-utilization and a potentially expensive benefit, the Transgender Health Benefit Program has proven to be appropriately accessed and undeniably more affordable than other, often routinely covered, procedures."

Ultimately, even if a health plan is not required to provide gender transition-related services under Section 1557, covering these services may prove economically beneficial for the health plan.

Conclusion

Due to its recent publication date, many aspects of Section 1557 are currently unclear. Health care benefit professionals should continue to carefully monitor the regulations for additional guidance as well as case law interpreting the regulations. In the interim, covered entities should be complying with the notice and grievance procedure requirements and should review their plans’ benefits and exclusions for any changes that are necessary to comply with Section 1557.

Four Next Steps

1. Notice: Covered entities should immediately begin adding the required notice with the appropriate tagline to all significant publications. The notice also needs to be added to any websites, and posters should be created for locations where the covered entity interacts with the public, such as a benefit office.
2. Procedures: Covered entities with more than 15 employees should immediately designate an employee who is responsible for compliance and establish grievance procedures.
3. Benefit design: Health plans should review all plan documents and at minimum remove any blanket pro-
hibitions against gender transition-related services and any sex-specific prohibitions contained within the plan.

4. **Training:** Covered entities will need to conduct a significant amount of training. Claims administrators must be trained on how to process claims under Section 1557 and how to inform employees in group health plans of their rights under Section 1557. HHS has already published some training materials on its website.  

### Endnotes

1. 81 Federal Register at 31375 (May 18, 2016).
2. 45 C.F.R. §92.4, “on the basis of sex.”
3. 45 C.F.R. §92.4, “gender identification.”
8. 81 Federal Register at 31379 (May 18, 2016).
10. 45 C.F.R. §92.4, “health program or activity.”
11. 45 C.F.R. §92.1.
15. 45 C.F.R. §92.101(a)(1).
16. 45 C.F.R. §92.207(b)(3).
17. 45 C.F.R. §92.207(a).
19. 45 C.F.R. §92.301.
20. 45 C.F.R. §92.302. Note that for age discrimination claims, an individual would need to file with OCR first because of the requirements of the Age Discrimination Act.
21. Id.
22. Id.
24. Id.
27. The training materials are available at www.hhs.gov/civil-rights/for-individuals/section-1557/trainingmaterials/index.html.

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