ACA Anti-Discrimination Rules May Apply To 3rd-Party Admin.

By **Kara Backus and Allison Jacobsen** (March 8, 2023)

Kara Backus

Allison Jacobsen

In a significant decision under the Affordable Care Act, the U.S. District Court for the Western District of Washington recently ruled that a third-party plan administrator, or TPA, violated the ACA's anti-discrimination rule when administering a self-insured health plan that excluded gender-affirming care.

The case, C.P. v. Blue Cross Blue Shield of Illinois, involved a transgender youth who sought coverage for gender-affirming care through the health plan sponsored by their mother's employer.[1] The employer's plan was self-insured, meaning the health coverage was paid out of the employer's general assets instead of insurance.

Applying the plan rules, which expressly excluded gender-affirming care, the TPA denied coverage. In doing so, it simply applied the plan terms as required by the Employee Retirement Income Security Act. The TPA was neither the health care provider nor the health insurer.

The mother and her transgender child filed suit on behalf of themselves and a class of individuals who were similarly denied coverage by the TPA based on a gender-affirming care exclusion.

The plaintiffs claimed that the TPA's denial violated Section 1557 of the ACA, which prohibits several types of discrimination, including "on the basis of sex," by "any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance."

The plaintiffs sought an order preventing the TPA from administering and enforcing health plans that exclude coverage for gender-affirming care, as well as an order requiring the TPA to reprocess claims previously denied based on similar exclusions.

The TPA argued that it was not liable because (1) it was not a covered entity under Section 1557 of the ACA; (2) it was merely administering another organization's self-insured plan, as it was required to do under ERISA; (3) there was no medical consensus regarding gender-affirming care; and (4) the Religious Freedom Restoration Act protected the plan because the employer was a religious organization and the exclusion was based on sincerely held religious beliefs.

As described in more detail below, the Washington federal district court was unpersuaded by these arguments, concluding that the TPA was liable under the plain terms of the ACA.

The decision is significant for several reasons:

1. The decision potentially expands the scope of covered entities under Section 1557 of the ACA.

Entities are subject to Section 1557 if they operate "any health program or activity, any part of which is receiving Federal financial assistance," according to the rule. The court held that

the TPA fit this definition despite a substantial history of rulemaking to the contrary.

Since Section 1557 was enacted in 2010, there has been a lack of clarity as to how an employer that sponsors a group health plan, or the entities that provide services to such plan, meet the definition of a health program or activity.

Until recently, many of those analyzing this question, including the U.S. Department of Health and Human Services, the agency responsible for interpreting Section 1557, have taken the position that a self-insured ERISA-governed group health plan is not a health program or activity for the purposes of Section 1557 unless the plan sponsor is in the health care industry or the plan receives federal funding.

Because most group health plans do not receive federal funding, most self-insured plans were thought to be exempt.

Final regulations promulgated by HHS in 2020, as well as their preambles, were consistent with this position, stating that if the entity operating a self-insured plan is not "principally engaged in the business of providing healthcare," the plan is not a health program or activity for the purposes of Section 1557 if it does not receive federal funding.

The 2020 HHS regulations also clarified that the provision of health insurance by a health insurance carrier does not mean that the carrier is principally engaged in the business of providing health care for this purpose, so it would only be subject to Section 1557 if that portion of its business received federal funding. The preamble to the regulations made similar statements regarding third-party administrative services.

The Washington state federal court was not swayed by HHS' interpretation of Section 1557 in the 2020 regulations, acknowledging that those regulations are "arguably in effect," but expressly concluded that the rules were not binding.

The court reasoned that although a "health program or activity" is not defined in the ACA, "it is clearly broader in scope than only the provision of healthcare," concluding that the TPA's administrative activities, distinct from the plan itself, constitute the operation of a health program or activity.

The judge further concluded that the plain language of Section 1557 indicates that a health insurance contract and the administration of a health insurance contract is a health program or activity.

The court did not directly address the difference between third-party administrative services and contracts of insurance, nor did it acknowledge that the case did not involve any insurance contract.

The judge's conclusions are more consistent with the 2022 proposed regulations issued by HHS, which would broaden the definition of health programs or activities to clarify that health insurers principally engaged in providing insurance or administering self-insured plans would be subject to Section 1557.

On the issue of federal funding, the court reasoned that because the TPA received federal funding for some portion of its business, it "receives Federal financial assistance" for purposes of Section 1557.

This also contradicts the reasoning contained in the 2020 regulations that an entity not

principally engaged in the business of providing health care will be subject to Section 1557 only to the extent of its operations that receive federal funding.

These conclusions by the Washington court are noteworthy because they could effectively extend the coverage mandates of Section 1557 not only to some TPAs, but also to all sponsors of self-insured plans that use those TPAs. Plan sponsors who do not receive federal funding and would not otherwise be subject to Section 1557 may be surprised by this result.

Further, insurance carriers who receive federal funding and understand the business of administering group health plan claims are significant providers of TPA services to self-insured plans. For this reason, under the court's analysis, numerous self-insured plans would likely be subject to Section 1557.

2. The decision extends Section 1557 violations to TPAs applying rules of self-insured plans, as ERISA requires.

ERISA mandates that group health plans be administered in accordance with its terms. Accordingly, TPAs must apply the terms of ERISA-governed health plans that have been designed, in many cases, not by the TPA but by the sponsor of the plan.

In this case, consistent with ERISA's mandate, the TPA applied the gender-affirming care exclusions under the ERISA-governed plan to deny coverage.

The TPA argued that it would be liable under Section 1557 only if it had been responsible for putting in place the discriminatory provision, but that in this case, the plan sponsor was actually responsible for that decision. It also cited comments to the HHS rules providing that "only where the discriminatory terms of the group health plan originated with the third party administrator rather than with the plan sponsor [is it possible that] the third party administrator could be liable."

But the court disagreed, finding that the TPA's administration of the exclusionary provisions violated Section 1557's anti-discrimination provision, regardless of the ERISA mandate. The judge concluded that ERISA could not be read to invalidate or impair Section 1557, nor could ERISA insulate the TPA from liability.

3. Medical consensus is irrelevant when coverage is denied on the basis of sex.

Section 1557 prohibits discrimination against individuals in several types of protected classes.

One such type of prohibited discrimination is set forth under Title IX of the Education Amendments of 1972, which provides that individuals cannot "on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance."

Based on this, the court first concluded that Section 1557 forbids sex discrimination based on transgender status, relying on prior decisions by the U.S. Supreme Court and the U.S. Court of Appeals for the Ninth Circuit. The judge noted that gender dysphoria cannot be explained without referencing a person's sex or identification as transgender.

The TPA argued that there was no discrimination on the basis of sex in this case because there was no medical consensus about the appropriate treatments for gender dysphoria.

The court rejected this argument, determining that the alleged lack of medical consensus on gender-affirming care was not relevant because the TPA denied coverage on the basis of the lead plaintiff's transgender status — and not because of medical necessity.

4. The Religious Freedom Restoration Act does not insulate TPAs from private action.

Finally, the TPA argued that the employer was a religious organization with sincerely held religious beliefs that would be burdened by covering medical treatments related to gender dysphoria under its plan, and accordingly, that the Religious Freedom Restoration Act provided an exemption from the application of Section 1557 to the plan.

This argument failed because the RFRA applies to government actions or lawsuits where the government is a party and does not apply to a matter between private individuals.

The court also noted that the TPA itself is not an entity with sincerely held religious beliefs, but it did not address whether the TPA could assert the employer's religious beliefs in its own defense.

Ultimately, the court held that the TPA was a covered entity that discriminated against the plaintiffs in violation of Section 1557 of the ACA by denying them services for gender-affirming care under the group health plans that covered them.

The judge said Congress enacted Section 1557 to prohibit discrimination in the health system, which includes third-party administrators of health plans. Specific relief sought by the plaintiffs will be determined in future proceedings.

What should plan sponsors and administrators do now?

Plan sponsors and plan administrators should review the terms of their group health plans to determine if the plan excludes gender-affirming care.

If the plan contains such an exclusion, it will be a good idea to analyze how this recent case might affect the plan and the plan sponsor's business. For example, self-insured plans that use TPAs that receive federal funding may face similar challenges.

The law regarding Section 1557 of the ACA is far from settled, as the court's decision has been appealed, so stay tuned for additional developments.

Kara Backus is a shareholder and Allison Jacobsen is counsel at Lane Powell PC.

[1] C.P. v. Blue Cross Blue Shield of Illinois, No. 20-cv-6145, 2022 WL 17788148 (W.D. Wash. Dec. 19, 2022).