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2023 Benefits Compliance Update

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Agenda

1. COVID Updates
2. Transparency, Reporting, and No Surprises Act
3. ACA Reminders and Updates
4. Other Updates and Reminders

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COVID Updates and Changes

Public Health Emergency / National Emergency

Public Health Emergency

- Declared by Secretary of HHS
- Can only be renewed up to 90 days
- HHS will provide states with 60+ days notice of end
- Public Health Emergency in effect until 5/11/23

Declared National Emergency

- Declared by the President
- Remains in effect for a year unless President declares end of the emergency
- End can be declared at anytime
- Public Health Emergency in effect until 5/11/23

COVID-19 Extensions- COBRA & Special Enrollment Rights

Emergency declaration in effect until **May 11,2023**, unless revoked by the President

COBRA

Timing	Regulations	COVID-19
Election	60 days	60 days following the end of the Outbreak Period
Initial Payment	45 days	45 days following the end of the Outbreak Period
Subsequent Payments	30 days	30 days following the end of the Outbreak Period
Notify Plans of Qualifying Events	30 – 60 days generally depending on event	30 – 60 days following the end of the Outbreak Period

HIPAA Special Enrollment Rights

Event	Regulations	COVID-19
Loss of Other Coverage	30 days	30 days following the end of the Outbreak Period
Acquisition of a New Dependent	30 days	30 days following the end of the Outbreak Period
Eligibility for State Assistance	60 days	60 days following the end of the Outbreak Period

Extensions to ERISA Claims Procedures

Emergency declaration in effect until **May 11,2023**, unless revoked by the President

ERISA Claims Procedures

Timing	Regulations	COVID-19
Initial Claim filing	12 months or as allowed by the plan	Outbreak period is not included in determining if the claim was filed on a timely basis
Appeal a Denied Claim	180 days of denial	Outbreak period is not included in determining if the claim was filed on a timely basis
External Review Determination	Four months after the notice of denial	Outbreak period is not included in determining if the claim was filed on a timely basis
Submit additional information to appeal a claim (external review)	Within the four months of the denial or 48-hours of notice being granted	Outbreak period is not included in determining if the claim was filed on a timely basis

Public Health Emergency Extension

- Public Health Emergency extended for additional 90 days, is set to sunset May 11, 2023.
- Plans will be required to consider changes to the following coverage, upon the announcement that the PHE is over
- **Once the PHE ends**, cost sharing rules change: Action will be needed *SMM / notice* is required *(60-day advance notice)* as it is a reduction in coverage, *unless* employer wants to continue to cover vaccination and testing at no cost***

During Public Health Emergency

In-Network: Coverage without cost-sharing

- At negotiated rates
- COVID-19 vaccine / boosters for both Grandfathered and Non-Grandfathered Plans
- **OTC COVID Test Kits** must cover the cost of FDA approved over-the-counter COVID-19 test kits at no cost to the participant *(no co-payment, coinsurance or deductible applies)*
  - No medical management requirements may apply *(no need for a doctor's note or visit)*
  - Covers up to 8 home test kits per month per covered participant *(for reasons other than employment purposes or public health surveillance)* due to close contact or COVID symptoms.
  - No monthly limit applies to home test kits ordered by a physician *(unlimited)*

Out-of-Network: During the Public Health Emergency, cover without cost-sharing

- Out-of-network providers- tests will be reimbursed for up to $12 per testing kit
- Vaccination / Boosters – Covered at 100%

Post Public Health Emergency

COVID Vaccinations and Boosters

- **In-Network:** For ***Non-Grandfathered Plans:*** COVID vaccine is a preventive care expense and must be covered at 100%
- **Out-of-Network:** Not required to be covered
- ***Grandfathered Plans*** are NOT required to pay vaccines without cost-sharing.

Over-the-Counter COVID Test Kits: Member will be subject to copayments, deductibles and coinsurance for each kit purchased on-line or in a participating pharmacy.

End of Public Health Emergency – CA Fully insured Plans ONLY

- AB 1473- For **six months** following the end of the Federal PHE insured medical plans are required to:

November 10, 2023

6 Months After the End of PHE

COVID Vaccinations and Boosters and COVID-19 Tests

- **In-Network:** For ***Non-Grandfathered Plans:*** COVID vaccine is a preventive care expense and must be covered at 100% including the fee for administering the vaccine or booster for as long as the U.S. Task Force deems COVID vaccine and booster to be preventive care.
  - Grandfathered plans are required to cover the vaccine and booster per CA law

- **Out-of-Network:** Require to cover vaccines and boosters at 100% without prior authorization or approval until November 10,2023. After November 10,2023, the plan's OON coverage provisions would apply.

COVID-19 Testing and Over-the-Counter COVID Test Kits: To be provided to members without prior authorization for six months after the end of the federal PHE. After the six-month period:

- **In-Network:** Coverage is still required without cost-sharing
- **Out-out-network:** Not required to covered at 100% after the end of the 6-month period. May apply traditional payment parameters for OON providers after this date.

Telehealth and High Deductible Health Plans

- **High Deductible Health Plans** *(HDHP)* may, but are not required to covered telehealth visits without cost sharing before the member satisfies the deductible
  - Had been in effect in 2020 and 2021, but ended **12/31/2021**
  - Renewed, but only as of **4/1/2022** through **12/31/22**, extension granted for plan years beginning before **1/1/2025**
  - Gap impacting non-calendar year plans as claims are covered through **12/31/22** but extension becomes effective for plan years beginning on or after **1/1/23** and before **1/1/25**.
- **Self-insured plans** – plan determines whether to allow this
- **Fully-insured plans** – carrier to determines whether to allow this

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Transparency & No Surprises Act

Hospital Transparency to Patients

- **Since January 1, 2021**, hospitals operating in the US were required to provide an on-line, consumer friendly, price list of 70 common hospital charges, and another 300 shoppable medical services.
- This requirement helps patients to shop and compare prices across different hospitals and estimate the cost of care before going to the hospital.
- CMS has the authority to audit hospitals for compliance, investigate complaints submitted by consumers, and impose penalties.

GHP Transparency Obligations to Members
ID Cards, Physician Directory, and Continuity of Coverage Options

1. **Distribute Health insurance ID cards, that list:**
   - OOP max for both in and out of network;
   - Carrier/TPA phone number;
   - Website address; and
   - Telephone # for consumer assistance.
2. **Keep physician directories updated**
   - At least every 90 days;
   - Respond to members within 1 business day.
3. **Continuity of Care -** If a member's doctor or facility discontinues in-network participation, the GHP must give the member the option to continue care with the same physician or facility. The GHP can require the provider to accept the in-network rate, if the member is:
   - Being treated for a serious and complex condition;
   - Under institutional or inpatient care;
   - Undergoing non-elective surgery/post-op care;
   - Undergoing a course of treatment for pregnancy
   - Determined to be terminally ill and receiving treatment.

Importantly, these rules apply to all both GF and NGF plans.

GHP Transparency Obligations to Members
Visibility into Rates for Covered Items and Price Comparison Tools

3 Stage Implementation

Stage 1 – July 1, 2022

Visibility to Rates Paid Under Plan - Health insurers and GHPs were required to post files to their public website containing rates for all covered items and services between the plan and in-network providers.

They were also required to post historical amounts paid from out-of-network providers.

Files must remain available at no cost, without any conditions (e.g., fees, registration, password login) and updated monthly.

Stage 2 – January 1, 2023

Price Comparison Tool and Self-Service EOB - Health insurers and GHPs were required to provide an online or paper price comparison tool allowing members to estimate their cost-sharing responsibility **for up to 500 medical services or items offered under the plan**.

Stage 3 - January 1, 2024

… price comparison tool and Self-Service EOB allowing members to estimate their cost-sharing responsibility **for all medical services or items.**

Importantly, these rules apply to all both GF and NGF plans.

GHP Transparency Obligations to Members

Prescription Drug Data Collection

Why is CMS undergoing this Prescription Drug Data Collection (“RxDC”)?

- To ultimately promote transparency in prescription drug pricing, so that members will one day be able to shop for the most economical pharmacy to obtain their prescriptions.

- CMS will first need to aggregate and identify:
  - Spending on prescription drugs and health care services;
  - Prescription drugs that account for the most spending;
  - Drugs that are prescribed most frequently;
  - Prescription drug rebates from drug manufacturers;
  - Premiums and cost-sharing that patients pay.
  - How prescription drug rebates impact premiums and OOP costs.

GHP Transparency Obligations to Members
Prescription Drug Data Collection ("RxDC")

Ongoing Annual Prescription Drug Data Collection and Reporting Obligation

Plan Year 2020-21 Reporting

Original Deadline December 27, 2022

At the last minute, many carriers, TPAs, and PBMs punted to the reporting obligation of data elements P2, D1, and Narrative Data to Employer Plan Sponsors.

CMS responded by relaxing the rules to file on the Health Insurance and Oversight System (HIOS) in favor of allowing email submissions so long as Employer Plan Sponsors sent a good faith report by January 31, 2023.

Plan Year 2022 Reporting

Due June 1, 2023

Many carriers, TPAs, and PBMs have set earlier deadlines for Employer Plan Sponsors to share P2, D1, Narrative Data.

Annual RxDC Reporting on June 1st for all subsequent years

***P2:** Plan Sponsor and Plan Year, # of participants, market segment (small/large group), fully/self-insured, insurer and other vendors, and the states where offered.

D1: Premium/cost and life-years (average number of covered members) data.

Narrative: Describes the impact of prescription drug rebates on premium and cost-sharing, how the employer size was estimated (for self-insured plan sponsors)

*Importantly, these rules apply to all both GF and NGF plans.

GHP Transparency Obligations to Members

Prescription Drug Data Collection – *an Employer Plan Sponsor Game Plan*

- Regulations impose the RxDC reporting obligation on GHPs.
- CMS can hold the employer plan sponsor liable for non-compliance.
- Each GHP must ensure that the RxDC reporting are satisfied for each plan.
- Not all vendors (carrier, TPA, or PBMs, are willing to accept all reporting duties.
- Employers will need to know which reporting obligations will be fulfilled by which vendor so they can determine which remaining obligations they will have to satisfy, as employer plan sponsor, (usually P2, D1, and the narrative).
- Employers should obtain written agreements from plan vendors (carriers, TPAs, and PBMs) regarding the data each vendor will upload.
- Self-insured GHPs will remain liable for non-compliance (and subject to excise tax and potential civil penalties), even if it has an enforceable agreement with its vendor to ensure compliance.
- Fully-insured GHPs with an agreement with the insurer will not be liable.

GHP Transparency Obligations to Members

Prescription Drug Data Collection – *an Employer Plan Sponsor Game Plan*

- Unfortunately, only the reporting entity can view the files it uploads to HIOS, so there is no way for an employer to confirm on the HIOS module that a vendor uploaded the file(s) it agreed to upload on behalf of the employer's group health plan.
- Instead, the employer should obtain written assurance of completion from each of the plan's vendor(s) and rely on contractual provisions for recourse if a vendor fails to fulfill its RxDC reporting service as agreed.
- Most plan sponsors will be wise to prepare to upload at least some of the data to the HIOS module themselves, which means first setting up a HIOS account on the CMS portal. HIOS accounts can take a couple of weeks to set up, so it's important for plan sponsors to act on this now if they've not already done so. CMS has provided detailed instructions for setting up the HIOS account. Register for Technical Assistance Portal (REGTAP) account at https://regtap.cms.gov.

GHP Transparency Obligations to Members

Prescription Drug Data Collection - *Potential Impact to GHPs*

Unlikely no to minimal near-term impact *until* consumers learn the data is available.

Carriers likely to use available competitor data to negotiate better pricing with their pharmaceutical companies.

Long-term, may drive plan lower, if participants choose low-cost prescription drug providers.

- Medical services are highly personal, unlike commodities – will cost competition change behaviors?
- Will low-cost providers remain low cost, or will availability of data drive price compression?

GHP Transparency Obligations to Members
Broker / Consultant Compensation Disclosure

When? On or after **December 27, 2021,** a compensation disclosure should be presented by the broker/consultant prior to the employer plan sponsor when they engage to perform services or at any renewal/extension of the relationship.*

What? Obtain a services-compensation disclosure from broker/consultant.

This disclosure is different from the information included on the Form 5500 because it contains compensation not disclosed on Schedule A; it will look different; it is provided in advance; and it applies to all ERISA-covered clients.

How? The brokers/consultants is obligated to prepare and deliver the compensation disclosure to a plan fiduciary (plan administrator) of fully insured and self-insured ERISA governed group health plans.

If the fiduciary does not receive the disclosure, it should request one. If no response is received within 90 days, the fiduciary ***must*** report the broker/consultant to the US DOL to avoid being found to be responsible for proceeding with a prohibited transaction. *Why? Because as a plan fiduciary, the plan administrator must act in the best interests of the participants and beneficiaries. Periodically reviewing the terms of the broker/consultant agreement fulfills part of that responsibility.*

*Note, this timing does not necessarily tie to the plan year or policy renewal date.

No Surprises Act

Effective January 1, 2022, for billing of Emergency and non-emergency services

NSA protects participants from surprise medical bills for certain out-of-network emergency and non-emergency services, issued by providers after the plan has paid its part.

How? Under the NSA, the patient is effectively cut out of the billing dispute—the patient only pays the in-network cost-sharing amounts.

An independent dispute resolution (IDR) process is available if the health plan (carrier or self-insured / level-funded plan) and the healthcare provider fail to agree on the qualified payment amount for services rendered.

If a health plan covers emergency services, they must be covered:

- Without any prior authorization
- In-network and out-of-network claims paid on the same basis;
- Amounts paid for out-of-network care must count toward the in-network deductible and out-of-pocket maximum.

Emergency services and certain non-emergency services provided by out-of-network providers, at in-network facilities must:

- The cost-sharing for these services must be the same as for in-network services.

Air Ambulance Services
Effective Date: TBD

The NSA also includes an objective to reign in the high cost of air ambulance services paid by GHPs to primarily out-of-network providers.

To be able to release rules, CMS must first collect and analyze usage data from reports submitted by health plans, health insurance carriers and air ambulance services for the 2022 plan.

The proposed rules establish a Reporting Deadline of March 31, 2023; however, the Final Rules regarding air ambulance reporting have not been issued yet but are expected soon.
2023 plan year reporting due by March 30, 2024

*Importantly N/A Grandfathered Plans

GHP Transparency Obligations to Members

Air Ambulance Reporting – *an Employer Plan Sponsor Game Plan*

- The carrier will be responsible for reporting on behalf of fully-insured plans.
  Plan sponsors of self-funded plans will retain responsibility for the reports.
- We encourage plan sponsors of self-funded plans to reach out to their TPA ***now*** in order to determine whether the TPA will file the air ambulance reporting on behalf of their plans, or just assist (e.g., provide necessary information), which the self-funded plan will report:
  - Plan name;
  - Plan market type (e.g., large or small, fully insured or self-funded);
  - Date of Air Ambulance services;
  - Billing National Provider Identifier (NPI);
  - Current Procedural Terminology code (CPT);
  - Transport information;
  - Whether the air ambulance provider was contracted with the plan; and
  - Information on claim adjudication and claim payment.

No Surprises Act - Potential Impact to GHPs

Near Term: Potential for higher costs related to covered claims and admin fees.

After Final Rules issued and IDR process starts: Initial employee confusion regarding ground ambulance claims not covered by NSA

Eventual: cost stabilization as payors and plans seek to avoid IDR. Will need to keep an eye on the:

- Role of inflation: and
- Whether out-of-network air ambulance provider move into network

3

ACA Reminders and Updates

IRS Enforcement of ESRP- Letter 226J

Under the new Administration enhanced focus on ACA enforcement efforts from the IRS

IRS is currently auditing employer compliance with the **2020 ESRP** provisions of the ACA

- Letters 226-J mailed to employers informing them of failure to comply with IRS 4980H(a) or (b) provisions
- Letter provides employer 30 days to respond to the inquiry
  - Employer agrees and pays penalty
  - Employer appeals the penalty and supports additional information with the appeal

Employer should file an extension with the IRS to appeal decision- fax request to the number that appears at on right-hand corner of letter. Will be granted a 30-day extension to appeal decision.

NEW: Letters 226J question if a plan is deemed to be affordable under the ACA, new codes used in Form 14765. Employer is required to show proof that plans are deemed to be affordable.

2023 ACA Affordability

Affordability of Employee-only Coverage

Lowest cost plan that is **minimum value. Safe harbor decreased from 9.61% to 9.12%** based on one of the three safe harbors:

1 W-2 Safe Harbor

Use Box 1 of employee's W-2 earnings.
Must use projected 2023 income; amount cannot change throughout the year.

- Box 1 = gross earnings minus pre-tax deductions under a cafeteria plan and a 401(k) plan.

2 Rate of Pay

(Hourly rate of pay x 130)
9.12% Maximum amount to charge for employee-only coverage would be greater in 2022 than 2023

- ***Example:*** An employee earning $13.00 an hour in 2022 cannot pay more than $162.41 per month if the plan is to be deemed affordable; however, in 2023, that same employee cannot pay more than $154.13.

3 Federal Poverty Level (FPL)

Calendar year plans must use **2022 FPL x 9.12% / 12** to assess affordability for 2023 *($13,590 x 9.12% / 12) =* ***$103.28*** *vs. the 2022 rate of* $103.14 per month.

- Non-calendar year plans – 2023 FPL is $14,580 x 9.12% = $110.81

2023 Affordability Observations

- The affordability percentage of 9.12% for 2023 is the lowest it has ever been
- Employers who based 2022 affordability on the maximum allowable percentage will need to increase employer contributions to meet 2023 affordability
- Employer contributions must be further increased to offset premium increases
- Plans will use the 2022 Federal Poverty Level to determine 2023 affordability under the FPL Safe Harbor (FPL indexed for inflation and increases each year)

Rate of Pay Calculation – **Constant Lowest** Hourly Rate

Year	2022	2023	Change
Employee Only Premium	$500	$545.00	9.00%
Hourly Rate for Lowest Paid Employee	$13.00	$13.00	
Affordability Percentage	9.61%	9.12%	
Max Employee Contribution	$162.41	$154.13	-5.37%
Employer Contribution	$337.59	$390.87	15.78%

Rate of Pay Calculation – **Increased Lowest** Hourly Rate

Year	2022	2023	Change
Employee Only Premium	$500	$545.00	9.00%
Hourly Rate for Lowest Paid Employee	$13.00	$14.00	
Affordability Percentage	9.61%	9.12%	
Max Employee Contribution	$162.41	$165.98	2.20%
Employer Contribution	$337.59	$379.02	12.27%

The Family Glitch

- Employees who are not offered affordable, MV coverage are eligible to receive subsidies on the exchange
- **The Glitch:** If the employee is offered affordable, MV coverage, **the spouse and dependent children are not eligible** for subsidies on the exchange
  - This has led to many employers offering affordable coverage to the employee, but paying little towards the cost of dependents
- **The Fix:** Beginning in 2023, even if the employee is offered affordable, MV coverage, the spouse and dependent children may still be eligible for subsidies on the exchange
- Does not increase employer penalties
- May result in lower enrollment for spouses and dependents
- New status change now allows employees to drop coverage mid-year

The Family Glitch – Status Changes

- IRS now allows (but does not require) Cafeteria Plans to allow for election changes related to removal of the family glitch when
  - One or more related individuals are eligible for a special enrollment period to enroll in a QHP through an Exchange or one or more already-covered related individuals seeks to enroll in a QHP during Exchange open enrollment
  - The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the related individual or related individuals in a QHP through an Exchange for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.
- Employers seeking to allow these changes must amend their cafeteria plans – can be done retroactively so long as the plan operates in accordance with the guidance and informs participants of the amendment
- Potentially impacts both calendar year and non-calendar year plans

Penalties Through the Years

		2019	2020	2021	2022	2023
4980H(a) Penalty	**Annual Amount**	$2,500.00	$2,570.00	$2,700.00	$2,750.00	$2,880.00
	Monthly Amount	$208.33	$214.17	$225.00	$229.17	$240.00
	MEC Offer % of FT	95%	95%	95%	95%	95%
	FT Headcount Reduction	30	30	30	30	30
4980H(b) Penalty	**Annual Amount**	$3,750.00	$3,860.00	$4,060.00	$4,120.00	$4,320.00
	Monthly Amount	$312.50	$321.67	$338.33	$343.33	$360.00
	Affordability Safe Harbor %	9.86%	9.78%	9.83%	9.61%	9.12%
	FPL Annual Amount *(individual)*	$12,140.00	$12,760.00	$12,880.00	$12,880.00	$13,590.00
			Current Enforcement	←	**No good faith**	→

ACA Reporting

- **2022 reporting deadlines**
  - Distribute Forms 1095-C to employees: March 2, 2023 - **PERMANENT**
  - File Forms 1095-B & -Cs with the IRS (electronic): March 31, 2023
  - File Forms 1095-B & -Cs with the IRS (paper): February 28, 2023

Employers who don't complete reporting on time must still complete ASAP

- Less than 30 days late – maximum penalty of $50 per form
- **More than 30 days late, but filed by August 1st – maximum penalty of $110 per form**
- Filed after August 1st – maximum penalty of $290 per form

Must correct reporting errors within 30 days of filing

Beginning with 2021, IRS is no longer considering employer's good faith efforts when assessing penalties

ACA 1557 Nondiscrimination

- New proposed rules were released in 2022
- They largely go back to pre-Trump Administration rules, with some changes
  - They would expand what entities are covered so that if an entity receives any federal financial assistance, all of its operations would be subject to Section 1557
  - The proposed rules have a specific list of communications that must include the taglines (*e.g.,* HIPAA privacy notice, EOBs, etc.)
- Rules may be finalized in 2023, so plans may be required to send the notices again

4

Other Reminders & Updates

Midterm Election Impact on Employee Benefit Plans

A Congress Divided

- Republicans control the House; Democrats control the Senate
- Major legislation is unlikely
- Some minor changes around the edges may occur
- Democratic control of the Senate means any appointments to agency posts (DOL, IRS, HHS) are more easily confirmed

More Regulation

- With expected gridlock in Congress, the Biden Administration will look to regulate more
- Reminder: Executive Orders themselves are of no effect until acted on by agencies

NQTL Comparative Analysis

MHPAEA = Mental Health Parity and Addiction Equity Act

- MHPAEA prohibits a group health plan from applying financial requirements or treatment limitations to mental health and substance abuse disorder benefits that are more restrictive than the financial requirements or treatment limitations that apply to the medical / surgical benefits that are provided by the plan

NQTL = Non-quantitative Treatment Limitation

- Under the terms of the plan, any processes, strategies, evidentiary standards, or other factors used to apply the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification must be comparable to *(and applied no more stringently than)* the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical / surgical benefits in the classification
- Group health plans are required to conduct and document an analysis of their In general, a group health plan offering mental health or substance use disorder *("MH / SUD")* benefits cannot apply more restrictive NQTLs than it applies for medical/surgical benefits. The NQTLs do not have to be identical for both MH / SUD and medical or surgical *(M/S)* benefits, but the processes, strategies, evidentiary standards, and other factors underlying those NQTLs must be comparable.
- The required analysis is designed to demonstrate that the NQTLs for MH / SUD benefits are applied no more stringently than those for medical / surgical benefits.

NQTL Comparative Analysis

DOL audits will keep coming!
The NQTL analysis does not have to be filed or provided to the government, but after February 10, 2022 the Department of Labor *(DOL)* or Health and Human Services *(HHS)*, or state enforcement authorities, could start requesting reports from employers and carriers.

Requirement: Group health plans / heath insurance issuers that offer both M/S and MH/SUD benefits and impose NQTLs on MH / SUD benefits, must conduct and document a comparative analysis of the design and application of their nonquantitative treatment limitations *("NQTLs")*

What is my NQTL deadline? The CAA specifies that group health plan NQTL results must be documented and ready to hand over to the government. It also requires the government to audit and report findings as well as create and update guidance documents.

Initial Review. The initial report from the government showed that no plan sponsors (out of 150+) generated a compliant report. Lobbying groups are actively pushing the agencies for clearer guidance on what a compliant report looks like.

NQTL Comparative Analysis – Next Steps

Fully insured plan sponsors: Confirm that plans are in compliance and request documentation

Self-insured plan sponsors: Ensure the comparative analysis is conducted *(at least start process)* and correct any issues *(ASO / TPAs likely won't do it for you)*

The DOL does not give much time to respond, so waiting to perform the analysis until you get a request may not work

Note: Reviewing plan designs and Summary Plan Descriptions is not sufficient to determine compliance

- Where complaints are made, the DOL follows

Bostock, Title VII, and Group Health Plans

Title VII applies to all terms and conditions of employment including employee benefits

In *Bostock*, the U.S. Supreme Court decided that Title VII protections extend to homosexual and transgender employees.

Denying healthcare coverage "because of" sex would seem to unquestionably violate Title VII because those benefits are "compensation, terms, conditions, or privileges of employment" under the Act.

"[T]here is no reason to believe that Congress intended a special definition of discrimination in the context of employee group insurance coverage."
Lange v. Houston County, GA, et al., M.D. Georgia, June 2, 2022

Federal Court in WA state ruled that BCBS of IL has violated the antidiscrimination provision of ACA Section 1557 by administering a self-insured plan (subject to ERISA) that excluded coverage for transgender care. Court ruled BCBS of IL could not administer plan as it was a recipient of federal funds for its insured plans.

C.P v. Blue Cross Blue Shield of IL, W.D. Wash. Nov. 9,2022

Q&A

Thank you.

For more information and resources, visit:
www.hubinternational.com