DON'T RISK, DON'T DWELL: HOW EMPLOYERS' ERISA BENEFIT PLAN OFFERINGS, OR LACK THEREOF, ROUTINELY FAIL LGBTQIA+ EMPLOYEES AND SOLUTIONS FOR EMPLOYERS

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ABSTRACT

Employers who make the choice to self-insure their employee benefit plans have the ability to customize the kind and level of benefits they provide. Employers often make choices, deliberate or not, that lessen or bar access, coverage, and quality of their self-insurance for LGBTQIA+ employees, as they are governed by federal antidiscrimination law in policy but not practice. Due to the Employee Retirement Income Security Act of 1974 (ERISA) preemption of state insurance law, employers who choose to self-insure are not governed by state antidiscrimination laws. This preemption can have unanticipated effects on the employee's estate plan and disrupt their intent. These plans have the potential to discriminate against certain employees, and employers have the authority, ability, and moral obligation to make equitable ERISA plans through simple changes in their plan documents. Change is needed to decrease LGBTQIA+ health care disparities and push for equitable health care outcomes for all. To encourage the business community to do so, Congress should act to incentivize or mandate such changes through legislation. This legislation could take various forms, such as implementing more thorough antidiscrimination rules under ERISA or creating tax breaks for those employers who make substantive changes to their plans. This Comment also addresses the ethical, financial, and other counterarguments to making these plans equitable for all. By ultimately arguing that employers must act to implement change, this Comment breaks new ground in the hope employers will recognize the decisions they make regarding their self-insured ERISA plan offerings have a direct correlation to the health of their workforce, and by denying equitable outcomes for certain employees, employers contribute to very real and unnecessary harm.

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I. INTRODUCTION

The control given to employers who elect to self-insure their employee benefit plans provides loopholes that allow employers to design their plans in a way that excludes certain individuals or does not provide for certain types of care.[1] Discrimination in this context can impact a variety of groups that have been historically discriminated against, including members of different races, sexes, gender identities, and sexual orientations.[2] Despite a plethora of

1. *See infra* Section III.A.

2. *See generally* Jim Probasco, *The Insurance Industry Confronts Its Own Racism*, INVESTOPEDIA (Sept. 1, 2020), https://www.investopedia.com/race-and-insurance-5075141 (giving a general history of racial discrimination within the insurance industry) [https://perma.cc/UYX9-Z7L3]; Joi Ito, *Supposedly 'Fair' Algorithms Can Perpetuate Discrimination*, WIRED (Feb. 5, 2019, 8:00 AM), https://www.wired.

federal antidiscrimination law regulating the workplace, many of these disparities disproportionately affect individuals who identify as LGBTQIA+.[3]

This Comment addresses those loopholes and offers solutions to change employer behavior in a way that creates more equitable and inclusive employee benefit plans.[4] By focusing on incentives to change self-insured employer behavior, this Comment takes a fresh perspective on a problem that has persisted for decades.[5] Historically, unions have had the bargaining power to advocate for employee interests in the workplace, such as implementing employee safety protections or the five day work week.[6] Today, however, just over ten percent of American workers are unionized, leaving over ninety percent of employees without the bargaining power and protections traditionally filled by unions.[7] While the United States is slowly becoming more pro-union, especially with support from younger Americans, workers should not need to belong to a union to have equitable health insurance coverage.[8]

Because of the compensation system the private sector in the United States has embraced, responsibility falls on employers to make decisions that keep the best interests of all their employees at the forefront.[9] Thus, readers should interpret this Comment as a starting point for those who share a desire to remedy past and present discrimination, but would also do well to remember that this author's perspective is limited to that of a heterosexual cisgender woman.[10]

The proposals herein vary from employer mandates, such as expanding the Affordable Care Act's Section 1557 to cover employers or expanding ERISA's nondiscrimination provisions beyond restricting

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com/story/ideas-joi-ito-insurance-algorithms/ (explaining historical tactics used to discriminate against African-Americans and women in insurance) [https://perma.cc/WTB2-W84R].

3. *See generally* John Ferrannini, *California Appellate Court Hears Starbucks Anti-Trans Discrimination Suit*, BAY AREA REP. (Dec. 15, 2021), https://www.ebar.com/news/latest_news/311402 (providing an example of discrimination against a transgender woman) [https://perma.cc/9GEN-5TSZ]; Mark A. Kellner, *Catholic Groups Argue Against Transgender Care Mandates in Preemptive Lawsuit*, WASH. TIMES (Dec. 15, 2021), https://www.washingtontimes.com/news/2021/dec/15/catholic-groups-argue-against-transgender-care-man/ (exemplifying recent efforts to push back against medically necessary care for transgender individuals) [https://perma.cc/SP7Y-PQTC].

4. *See infra* Part III.

5. *See infra* Section III.B.

6. Erik Ortiz, *Where Did the 40-Hour Workweek Come From?*, NBC NEWS (Sept. 1, 2014), https://www.nbcnews.com/news/us-news/where-did-40-hour-workweek-come-n192276 [https://perma.cc/S7A3-H4YX].

7. Megan Dunn & James Walker, *Union Membership in the United States*, U.S. BUREAU OF LAB. STAT. 1, 2 (Sept. 2016), https://www.bls.gov/spotlight/2016/union-membership-in-the-united-states/pdf/union-membership-in-the-united-states.pdf [https://perma.cc/5GFF-Z5NZ].

8. Ramshah Maruf, *Here's Why Gen Z is Unionizing*, CNN BUS. (Nov. 21, 2021, 9:31 AM), https://www.cnn.com/2021/11/21/economy/gen-z-young-workers-union/index.html [https://perma.cc/22KC-FN8F].

9. Author's opinion.

10. Author's opinion.

highly-compensated employee benefits, to incentives, such as an increased contribution limit for both employers and employees for defined-contribution accounts when employers can demonstrate the steps they have taken toward creating equitable ERISA plans.[11] These proposals spotlight how both big and small changes can increase the number of Americans with health insurance coverage that is comprehensive, equitable, and employer-provided.[12] The focus in this Comment to change employer behavior is intentional, as the American labor system is unique: the vast majority of American workers receive their health care benefits through their employer.[13] Almost three-quarters of Americans in public industry jobs had access to employer-offered health insurance in March 2021.[14]

The proposed changes should be made by updating federal law in a manner consistent with both traditional antidiscrimination protections and the modern values inherent in the idea of equity for all, regardless of a person's gender identity, sexual orientation, race, or disability.[15] The term LGBTQIA+ will be used throughout this Comment to encompass individuals who identify as lesbian, gay, bisexual, transgender, queer, or other identities that are not cisgender, existing within the gender binary, or heterosexual; it should be noted that the LGBTQIA+ community is diverse, rather than monolithic, and the use of this term is in no way meant to be exclusionary.[16]

Part I introduces the issue of discrimination in the workplace.[17] Part II provides a background in the applicable federal antidiscrimination statutes and their mandates to employers, identifies health care and insurance issues specific to LGBTQIA+ individuals, explains the relatively new concept of "health care civil rights," discusses the impact of the 2020 Supreme Court case *Bostock v. Clayton County* on the topic at hand, and finally, examines the intersection of the Employee Retirement Income Security Act of 1974 (ERISA) and health care discrimination.[18] In particular, Part II explains the impact of ERISA preemption on state laws that would otherwise provide antidiscrimination protections and control with regard to an employee's estate plan.[19] Part III analyzes the prevalence of current employer discrimination and argues why certain employers are able to discriminate against individuals in the LGBTQIA+ community.[20] The proposed solutions

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11. *See infra* Section III.B.

12. *See infra* Section III.D.

13. *Employee Benefits in the United States—March 2021*, U.S BUREAU OF LAB. STAT. 1, 3 (Sept. 23, 2021, 10:00 AM), https://www.bls.gov/news.release/pdf/ebs2.pdf [https://perma.cc/M5DD-6X7S].

14. *Id.*

15. *See infra* Section III.C.

16. Heather A. McCabe & M. Killian Kinney, *LGBTQ+ Individuals, Health Inequities, and Policy Implications*, 52 CREIGHTON L. REV. 427, 428–30 (2019).

17. *See infra* Part I.

18. *See infra* Part II.

19. *See infra* Section II.E.3.

20. *See infra* Section III.A.

in Part III are divided into two categories, both aimed at changing employer behavior: mandates and incentives.[21] Part III then addresses the main counterarguments to these solutions, including religious beliefs, conscience, cost opposition, conflicts of interest, employer autonomy, and potential increases in grievance lawsuits; in addition, Part III argues for employers to take actionable steps to design more equitable ERISA plans.[22] Part IV then concludes with some final thoughts on the larger goal of this Comment—ensuring equity, rather than equality, in self-insured employee benefit plans.[23]

II. EMPLOYMENT DISCRIMINATION LAW AND ERISA HAVE BROAD IMPACTS ON HEALTH CARE OUTCOMES

Currently, employers are subject to a variety of federal laws and regulations meant to combat the issue of discrimination—The Civil Rights Act of 1964 (Civil Rights Act), the Americans with Disabilities Act of 1990 (Americans with Disabilities Act or ADA), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA)—which are especially relevant to insurance discrimination.[24] Discrimination in the legal context is defined as "[t]he effect of a law or established practice that confers privileges on a certain class or that denies privileges to a certain class because of race, age, sex, nationality, religion, or disability."[25]

Members of the LGBTQIA+ community are in a unique position that leaves them vulnerable to health inequity and a lack of employer-provided insurance.[26] The risk-based model of the American insurance industry also lends to discrimination that makes access to affordable health insurance and health care difficult.[27]

While Section 1557 of the Affordable Care Act has prevented some discrimination, its limits act as an important barrier to relief for LGBTQIA+ individuals.[28] One sign of progress is the Supreme Court's holding in *Bostock v. Clayton County*, which provides that sex discrimination includes

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21. *See infra* Section III.B.

22. *See infra* Section III.C–D.

23. *See infra* Part IV.

24. SANDRA F. SPERINO & JAROD S. GONZALEZ, EMPLOYMENT DISCRIMINATION: A CONTEXT AND PRACTICE CASEBOOK 3, 11–13 (3d ed. 2019).

25. *Discrimination*, BLACK'S LAW DICTIONARY (11th ed. 2019).

26. Jennifer C. Pizer et. al., *Evidence of Persistent and Pervasive Workplace Discrimination Against LGBT People: The Need for Federal Legislation Prohibiting Discrimination and Providing for Equal Employment Benefits*, 45 LOY. L.A. L. REV. 715, 764 (2012).

27. Jessica L. Roberts, *"Healthism": A Critique of the Antidiscrimination Approach to Health Insurance and Health-Care Reform*, 212 U. ILL. L. REV. 1159, 1163 (2012).

28. *See* Katie Keith, *HHS Strips Gender Identity, Sex Stereotyping, Language Access Protections From ACA Anti-Discrimination Rule*, HEALTH AFFS. (June 13, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200613.671888/full/ [https://perma.cc/9263-T7PJ].

discrimination based on one's sexual orientation.[29] Before *Bostock*, it was unclear whether sexual orientation discrimination was protected under federal antidiscrimination legislation.[30]

Most employees in the United States today work for an employer who designs their employee benefit plans through self-insurance.[31] These plans are governed by ERISA, which is a federal law that borrows from trust law to ensure the financial stability of benefit plans.[32] Federal regulations preempt state regulation of self-insured benefit plans through ERISA.[33] This preemption prevents employees from utilizing state antidiscrimination protections to procure benefits and creates loopholes for employers in providing them.[34] Additionally, preemption displaces state laws concerning estate planning beneficiary presumptions.[35]

A. Employer Obligations under Federal Law

While this section is not meant to review all federal antidiscrimination legislation applicable to employers, a good starting point for understanding these issues is to examine three statutes: the Civil Rights Act, the ADA, and HIPAA.[36] The Civil Rights Act provides broad protections for employees against discrimination, the ADA prohibits discrimination based on disability, and HIPAA, as relevant here, attempts to remedy the issue of insurance discrimination in the workplace based on health characteristics.[37]

1. The Civil Rights Act

The purpose of legislation that is "designed to promote antidiscrimination norms [is to] seek to dismantle existing disparities tied to their associated, protected characteristics," meaning that antidiscrimination legislation acts as a disruptor of historical disadvantages.[38] While twenty-seven states, Puerto Rico, and the District of Columbia provide state-level protections for gender identity and sexual orientation discrimination in the workplace, federal law also protects employees from said discrimination under Title VII of the Civil Rights Act (Title VII), which

29. Bostock v. Clayton Cnty., 140 S. Ct. 1731, 1742 (2020).

30. Kelly M. Peña, *LGBT Discrimination in the Workplace: What Will the Future Hold?*, 92 FL. BAR J. 1, 36–37 (2018).

31. U.S. BUREAU OF LAB. STAT., *supra* note 13, at 3.

32. *See* 29 U.S.C. §§ 1021–1191(c).

33. *Id.* § 1144(a).

34. JAMES WOOTEN, THE EMPLOYEE RETIREMENT SECURITY ACT OF 1974: A POLITICAL HISTORY 282–83 (2004).

35. *See* Raymond C. O'Brien, *Equitable Relief for ERISA Benefit Plan Designation Mistakes*, 67 CATH. U. L. REV. 433, 440 (2018).

36. *See* 42 U.S.C. §§ 2000-e(2)(a), 12112(a), (b)(5)(A), 290dd-2(i)(1)(B).

37. *See infra* Sections II.A.1–3.

38. Roberts, *supra* note 27, at 1177.

prohibits discrimination in employment based upon an "individual's race, color, religion, sex, or national origin."[39]

Generally, employers with at least fifteen employees are required to comply with Title VII's antidiscrimination provisions.[40] In many instances "[s]tate law often plays an important role in protecting workers against discrimination . . . .[I]ndividuals who work for smaller employers often must rely on state statutes for discrimination protection."[41] Title VII protections extend to employee benefits due to the inclusion of "terms, conditions, or privileges of employment" in the statute.[42] For example, the Supreme Court held in 1983 that a retirement plan governed by ERISA was subject to Title VII protection against discrimination.[43]

While Title VII applies to employee benefits, traditionally, health care discrimination has instead been litigated through Title VI of the Civil Rights Act (Title VI).[44] Title VI—which protects individuals from discrimination based upon race, color, or national origin—contains antidiscrimination provisions that apply to hospitals and nursing homes that receive federal Medicare and Medicaid reimbursements; this includes the majority of hospitals and nursing homes.[45] Because Title VI is more limited in both its reach and legal frameworks, proving health care discrimination by providers is difficult.[46] Unlike Title VII, Title VI does not allow cases of disparate impact or private causes of action, thus self-insured employer discrimination should be litigated through Title VII instead, despite the historical preference for the former in health care litigation.[47]

2. The Americans with Disabilities Act

While wheelchair ramps and other mobility concerns often come to mind for many when discussing the ADA, the statute protects individuals with a wide range of disabilities in varying contexts, including HIV and AIDS patients, individuals suffering from a variety of physical or mental

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39. Iris Hentze & Rebecca Tyus, *Sex and Gender Discrimination in the Workplace*, NAT'L CONF. OF STATE LEGIS. (Aug. 12, 2021), https://www.ncsl.org/research/labor-and-employment/-gender-and-sex-discrimination.aspx [https://perma.cc/ZK42-32UM]; 42 U.S.C. § 2000e-2(a); *see* Bostock v. Clayton Cnty., 140 S. Ct. 1731, 1747 (2020).

40. 42 U.S.C. § 2000e(b).

41. SPERINO & GONZALEZ, *supra* note 24, at 12.

42. Hishon v. King & Spalding, 467 U.S. 69, 74 (1984).

43. Ariz. Governing Comm. for Tax Deferred Annuity & Deferred Comp. Plans v. Norris, 463 U.S. 1073, 1074 (1983).

44. *See* Alexandra Brandes, *The Negative Effect of Stigma, Discrimination, and the Health Care System on the Health of Gender and Sexual Minorities*, 23 TUL. J.L. & SEXUALITY 155, 164 (2015).

45. *Id.*

46. *See generally* Alexander v. Choate, 469 U.S. 287, 293 (1985); Alexander v. Sandoval, 532 U.S. 275, 291 (2001) (illustrating the complexity and constraints for a plaintiff attempting to litigate a successful Title VI discrimination claim).

47. *See* Brandes, *supra* note 44.

impairments, and a great many other conditions.[48] Historically, much of the homophobia and insurance discrimination LGBTQIA+ individuals experience stems from the hysteria directed toward the LGBTQIA+ community when HIV and AIDS became prevalent in America (the disease was first called gay-related immune deficiency, or GRID).[49] From fiscal year 2008 to fiscal year 2010, the U.S. Equal Employment Opportunity Coalition resolved annually an average of 200 ADA cases that alleged discrimination on the basis of HIV status.[50] Like Title VII, the ADA applies to employers with at least fifteen employees.[51] Employers must reasonably accommodate qualified individuals with a known disability.[52] Employees who bring successful suits against employers for discrimination under the Civil Rights Act or the ADA are able to recover back pay, reinstatement, and other similar equitable relief.[53]

While the ADA made a big impact on those in the LGBTQIA+ community when HIV and AIDS were declared to fit within the law's definition of "disability," it is also limited by its own discriminatory view.[54] For example, the ADA expressly excludes protection for "transvestites," an outdated and derogatory term used to describe transgender or gender-fluid individuals.[55]

3. HIPAA

The stigma surrounding members of the LGBTQIA+ community in the health care and insurance setting in recent decades cannot be overstated.[56] Insurance and health care-related discrimination picked up significantly in the 1980s and 1990s.[57] Starting during the height of the AIDS epidemic in the late 1980s, insurance companies and employers began to take steps to

48. Bragdon v. Abbott, 524 U.S. 624, 631 (1998); SPERINO & GONZALEZ, *supra* note 24, at 393–97; 29 C.F.R. § 1630.2(h).

49. *History of AIDS*, HIST. (June 14, 2021), https://www.history.com/topics/1980s/history-of-aids [https://perma.cc/93CC-XPQM].

50. DONALD H.J. HERMANN & WILLIAM P. SCHURGIN, LEGAL ASPECTS OF AIDS: EMPLOYEE ISSUES § 12:5 (1991).

51. 42 U.S.C. § 12111(5)(A).

52. SPERINO & GONZALEZ, *supra* note 24, at 417–18.

53. 42 U.S.C. § 2000e-5.

54. *See* Bragdon v. Abbott, 524 U.S. 624, 631 (1998); Victoria M. Rodríguez-Roldán, *The Intersection Between Disability and LGBT Discrimination and Marginalization*, 28 AM. UNIV. J. OF GENDER, SOC. POL'Y & L. 429, 435 (2020).

55. 42 U.S.C. § 12208.

56. *See* Pizer, *supra* note 26, at 715.

57. Rhonda B. Goldfein & Sarah R. Schalman-Bergen, *From the Streets of Philadelphia: The AIDS Law Project of Pennsylvania's How-to Primer on Mitigating Health Disparities*, 82 TEMP. L. REV. 1205, 1208–10 (2010); Carolyn Palmer & Lynn Mickelson, *Many Rivers to Cross: Evolving and Emerging Legal Issues in the Third Decade of the HIV/AIDS Epidemic*, 28 WM. MITCHELL L. REV. 455, 457–58 (2001).

limit their liability when faced with AIDS patients' health benefit claims.[58] Insurance companies implemented policies requiring HIV testing before they accepted new applicants due to high medical care costs they frequently incurred for HIV and AIDS treatments.[59] Employees were—and continue to be—wrongfully terminated across the United States after disclosing their HIV-positive status to their employers.[60] In some cases, employers refused to hire applicants because of their HIV status.[61] The discrimination against the LGBTQIA+ community became so rampant that Congress enacted "[t]he Health Insurance Portability and Accountability Act of 1996 (HIPAA) . . . to address some of the problems facing people who are infected with HIV/AIDS and need health care coverage."[62] While HIPAA's nondiscrimination provisions have helped address some of the more blatant discrimination, there is room for improvement.[63]

HIPAA, the first law that tied antidiscrimination principles to health insurance, expressly forbids employers from using what it calls "protected health information" to discriminate through the "hiring, firing, or terms of employment, or receipt of worker's compensation" and is important in protecting LGBTQIA+ individuals from adverse employment actions on the basis of their health or LGBTQIA+ status.[64] This information is protected because "[k]nowledge of a patient's [sexual orientation] and [gender identity] can trigger exploration of social history, sexual practices, family support, and social stressors," which, while information necessary to a certain extent for medical providers, is not essential or relevant for employers.[65] Notably, HIPAA includes some exceptions: by necessity, self-insured employers must have *some* access to medical records to administer claims.[66] A main concern

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58. DAVID RAPOPORT & JOHN PARRY, LEGAL, MEDICAL AND GOVERNMENTAL PERSPECTIVES ON AIDS AS A DISABILITY 29 (1987); MARGARET C. JASPER, AIDS LAW 61 (2008); *see also* McGann v. H & H Music Co., 946 F.2d 401, 403 (5th Cir. 1991).

59. JASPER, *supra* note 58; HERMANN & SCHURGIN, *supra* note 50, at §§ 13.28–29.

60. *E.g.*, EEOC v. Gregory Packaging, Inc., 3:14CV00152, 2015 WL 1849126 (N.D. Ga. Mar. 12, 2015); EEOC v. Plasma Biological Servs., LLC, 2:15CV02419, 2015 WL 9315694 (W.D. Tenn. Oct. 26, 2015).

61. *E.g.*, EEOC v. Maxim Healthcare Servs., Inc., 2:14CV00338, 2014 WL 8708252 (W.D. Penn. Mar. 17, 2014); EEOC v. Famous Chicken of Shreveport, LLC, 6:13CV00664, 2014 WL 7463343 (E.D. Tex. Sept. 2, 2014).

62. JASPER, *supra* note 58, at 61; *see* Palmer & Mickelson, *supra* note 57, at 472–73; *see also* Doe v. City of New York, 15 F.3d 264, 267 (2d Cir. 1994) (holding that an individual with HIV has the constitutional right to privacy regarding their condition).

63. Author's opinion.

64. Roberts, *supra* note 27, at 1178; *see* 42 U.S.C. § 290dd-2(i)(1)(B); *Employers and Health Information in the Workplace*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://www.hhs.gov/hipaa/for-individuals/employers-health-information-workplace/index.html (last visited Sept. 9, 2022) [https://perma.cc/MW7N-8EG2].

65. Edward J. Callahan et al., *Eliminating LGBTIQQ Health Disparities: The Associated Roles of Electronic Health Records and Institutional Culture*, 44 THE HASTINGS CTR. REP. 4, S49 (2014).

66. *See Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/phlp/publications/topic/hipaa.html (last visited Sept. 21, 2022) [https://perma.cc/77SW-VS9Y]; *see also infra* Section II.E.1.

of employees whose employers self-insure is that "[s]enior executives and other organizational members can have unrestricted access to employee medical records and detailed insurance billing invoices for the purposes of 'billing' and 'utilization review,' both of which are permissible under HIPAA guidelines."[67] As a result, these employees may be discouraged from disclosing essential health care information to their providers or seeking health care at all for fear of inappropriate disclosure and abuse by employers.[68]

While the antidiscrimination protections provided by the Civil Rights Act, ADA, and HIPAA are beneficial, they are not a catch-all for discrimination.[69]

B. LGBTQIA+ Specific Health Care Issues

Today, a "magnitude of inequities" exist for the LGBTQIA+ community in their places of employment.[70] These inequities represent a long tradition of discrimination, exclusion, and second-class treatment.[71] For example, the 1950s and early 1960s saw widespread persecution that later became known as the "lavender scare," with the United States Senate going so far as to hold congressional hearings investigating the "threat" employing LGBTQIA+ individuals supposedly posed.[72] The early 1980s saw President Ronald Reagan react to the emerging AIDS epidemic with practically callous indifference.[73] Before HIPAA was enacted in 1996, insurers and employers routinely screened applicants to deny coverage to individuals diagnosed with HIV.[74] Studies have shown that LGBTQIA+ individuals, especially those in same-sex relationships, have a disproportionate lack of health insurance access compared to their heterosexual counterparts.[75]

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67. Manuel Hernandez & Shawn L. Fultz, *Barriers to Health Care Access, in* THE HANDBOOK OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER PUBLIC HEALTH: A PRACTITIONER'S GUIDE TO SERVICE 177, 179–80 (Michael D. Shankle ed., 2006).

68. *Id.* at 180.

69. *See infra* Section III.A.

70. Robert C. Preston Jr. et al., *The Need for Change: Bridging Employers and Business*, *in* THE HANDBOOK OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER PUBLIC HEALTH: A PRACTITIONER'S GUIDE TO SERVICE 317, 318 (Michael D. Shankle ed., 2006).

71. *See* Patricia D. Mail & Walter J. Lear, *The Role of Public Health in Lesbian, Gay, Bisexual, and Transgender Heath*, *in* THE HANDBOOK OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER PUBLIC HEALTH: A PRACTITIONER'S GUIDE TO SERVICE 11, 14–24 (Michael D. Shankle ed., 2006).

72. *See* Nancy J. Kennedy, *National and Public Infrastructure and Policy: Are We Experiencing Scientific McCarthyism?*, *in* THE HANDBOOK OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER PUBLIC HEALTH: A PRACTITIONER'S GUIDE TO SERVICE 291, 293 (Michael D. Shankle ed., 2006).

73. *Id.* at 295.

74. *See Pre-Existing Conditions*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://www.hhs.gov/healthcare/about-the-aca/pre-existing-conditions/index.html (last visited Sept. 9, 2022) [https://perma.cc/y73Q-TRUK].

75. Pizer, *supra* note 26, at 764.

Discrimination against LGBTQIA+ individuals can take many forms.[76] Structural discrimination can be described as "the environmental factors that an individual cannot control [that determine one's] ability to access goods and services."[77] Perceived discrimination, on the other hand, is a kind of discrimination that "is linked to health through stress."[78] This type of discrimination can have adverse effects on health, increasing chronic and short-term stress, which in turn can lead to decreased immune system function, sensitivity to viral infection, increased risk of heart disease, and more.[79] Finally, "interpersonal discrimination refers to interactions between individuals of a discriminatory nature that can often be directly perceived."[80]

It is important to note that while some of the discrimination described above is blatant, more often, discrimination is subtle:

> Countless ways exist to consciously, yet covertly, exclude and discriminate without the appearance of explicitly violating the terms of an antidiscrimination policy. Exclusion and discrimination on the basis of sexual orientation and/or gender identity is also a subconscious process that even well-meaning colleagues can unknowingly stride. The result is a spectrum of workplace climates that vary greatly in their true level of comfort with openly LGBT employees, regardless of policy or institutional intent.[81]

The risk model on which the American health insurance industry is built lends itself to outright discrimination, as established historically again and again.[82] In fact, it is "exactly what allow[s] health insurers to profit."[83] Health insurance is more affordable with a larger risk pool because the relative risk that an individual will need to use costly health care services is spread among a larger group of people.[84] It "relies on assessing accurate, calculable risks."[85] Before the passage of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), insurers commonly and legally excluded individuals with certain pre-existing conditions from coverage, whether for a condition like cancer or another terminal illness.[86] However, insurers and employers who designed their self-insured plans still had to be conscious of not violating the ADA when engaging in this exclusionary and discriminatory practice.[87]

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76. *See* Brandes, *supra* note 44, at 157–61.
77. *Id.* at 157.
78. *Id.* at 159.
79. Preston, *supra* note 70, at 318.
80. Brandes, *supra* note 44, at 160.
81. Preston, *supra* note 70, at 318.
82. *See* Brandes, *supra* note 44, at 165–66; Roberts, *supra* note 27, at 1162–63.
83. Roberts, *supra* note 27, at 1163.
84. *See* Brandes, *supra* note 44, at 165.
85. Roberts, *supra* note 27, at 1165.
86. *See* U.S. DEP'T OF HEALTH & HUM. SERVS., *supra* note 74.
87. Bragdon v. Abbott, 524 U.S. 624, 631 (1998).

The case of *Anderson v. Gus Mayer Boston Store of Delaware* is one example of an allegedly cost-conscious insurance carrier change that had an impact on a single employee otherwise protected by the ADA.[88] In this case, in which the employer's plan was fully insured, an employee with AIDS was denied health insurance coverage after his employer switched carriers knowing all too well that the new carrier would not cover the employee.[89] The court found that the employer violated the ADA when it changed its group health plan coverage to an insurer who "would never consider" covering one of its own employees due to his disability "because it has not provided equal access to insurance."[90] Crucially, an employer "may not take into account reservations about the impact of a disabled employee on coverage premiums."[91]

Under the Affordable Care Act, health insurance companies may not refuse to cover a person (or charge a higher premium) due to pre-existing conditions.[92] The Affordable Care Act includes a vitally important exception to this rule, however: special provisions allow older policies that were purchased prior to the passage of the Affordable Care Act to keep their pre-existing condition language.[93] This exception dilutes the power of the traditional risk model and causes premiums to increase for all.[94]

C. Health Care Justice and Provider Discrimination

Health care justice has long been a goal of activists.[95] For example, the passage of the Civil Rights Act, which outlaws the use of federal funds to uphold segregation principles, resulted in over ninety percent of hospitals becoming integrated two years after the Act was passed in 1964.[96] For providers specifically, the general lack of education focused on LGBTQIA+ issues in the United States has historically been limited, and remains so today.[97] Social scientists have identified that health care providers play a vital role in the health of the LGBTQIA+ community:

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88. *See* Anderson v. Gus Mayer Bos. Store of Del., 924 F. Supp. 763, 770 (E.D. Tex. 1996).

89. *Id.*

90. *Id.* at 778.

91. HERMANN & SCHURGIN, *supra* note 50, at § 12:29.

92. U.S. DEP'T OF HEALTH & HUM. SERVS., *supra* note 74.

93. *See* 29 C.F.R. § 2590.715-1251(c).

94. *See* Brandes, *supra* note 44, at 165; Roberts, *supra* note 27, at 1167.

95. Karen S. Palmer, *A Brief History: Universal Health Care Efforts in the US*, PNHP (1999), https://pnhp.org/a-brief-history-universal-health-care-efforts-in-the-us/ [https://perma.cc/Y4BW-9N4F].

96. Christiane S. Cardoza, *Health Care Provider Discrimination Against LGBT Patients in the 2019 HHS Conscience Rights Rule*, 71 ADMIN. L. REV. 881, 887 (2019).

97. *See* Katherine L. Turner et al., *Lesbian, Gay, Bisexual and Transgender Cultural Competency for Public Health Practitioners*, *in* THE HANDBOOK OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER PUBLIC HEALTH: A PRACTITIONER'S GUIDE TO SERVICE 59 (Michael D. Shankle ed., 2006).

> [H]omophobic attitudes . . . will ultimately serve to construct barriers to the delivery of culturally competent care of LGBT patients. Whether it be by limiting the number of out LGBT practitioners in primary care and specialty settings or by creating an environment that is uncomfortable or inhospitable to LGBT patients and their families, actions such as these have a damaging effect on the well-being of the LGBT community.[98]

In the context of health care providers and transgender patients, a "cultural change" is called on to ensure that all patients "receive the same standard of care."[99] According to a study conducted by the National Center for Transgender Equality, half of transgender patients must educate their providers about transgender care.[100] Further education can also be transformative in eliminating stigma and homophobic attitudes.[101] These barriers to patients receiving health care must be resolved in order to ensure health and longevity for all patients, which is broadly the goal of health care justice.[102]

Section 1557 of the Affordable Care Act was enacted, in large part, to combat the pervasive problem of provider discrimination toward LGBTQIA+ individuals in hospitals, doctors' and dentists' offices, nursing homes and clinics; Section 1557 does not apply to employers in an employment discrimination context.[103] It has often been referred to as the "first healthcare civil rights law."[104] Section 1557 creates a cause of action for those who believe they have been discriminated against in a health care setting that receives federal funding.[105]

Section 1557 is unique in that it directly incorporates other federal civil rights laws, including Title VI of the Civil Rights Act and Title IX of the Education Amendment Act of 1972 (Title IX), applying them to health programs that receive federal funding.[106] To "incorporate" something is to "make the terms of another . . . document part of a document by specific reference," for example to "apply the provisions of the Bill of Rights to the states by interpreting the 14th Amendment's Due Process Clause as encompassing those provisions."[107] The longstanding legal frameworks for

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98. Hernandez & Fultz, *supra* note 67, at 188–89.

99. Esther Ju, *Unclear Conscience: How Catholic Hospitals and Doctors are Claiming Conscientious Objections to Deny Healthcare to Transgender Patients*, 2020 UNIV. OF ILL. L. REV. 1289, 1323 (2020).

100. Pamuela Halliwell, *The Psychological & Emotional Effects of Discrimination Within the LGBTQ, Transgender, & Non-Binary Communities*, 41 T. JEFFERSON L. REV. 222, 235 (2019).

101. Ju, *supra* note 99, at 1325.

102. *See* Palmer, *supra* note 95.

103. *Id.*

104. Elizabeth Sepper & Jessica L. Roberts, *Sex, Religion, and Politics, or the Future of Healthcare Antidiscrimination Law*, 19 MARQ. BENEFITS & SOC. WELFARE L. REV. 217, 219 (2018).

105. 42 U.S.C. § 18116(a).

106. *Id.* § 18116.

107. *Incorporate*, BLACK'S LAW DICTIONARY (11th ed. 2019).

determining discrimination under these statutes have been held to apply to Section 1557 as well.[108] The law also protects those individuals protected by Section 504 of the Rehabilitation Act of 1973, which prohibits workplace discrimination against handicapped persons by federal agencies.[109] Section 1557 also incorporates the Age Discrimination Act of 1975, not to be confused with the Age Discrimination in Employment Act of 1967.[110] The Age Discrimination Act, unlike the Age Discrimination in Employment Act, prohibits age discrimination only in activities and programs that receive federal financial assistance.[111] Notably, Section 1557 does not include those groups protected against discrimination from the ADA, nor incorporates Title VII.[112]

Similar to the way the Equal Employment Opportunity Commission handles employer discrimination claims, the federal Department of Health and Human Services' Office of Civil Rights (OCR) division reviews Section 1557 claims.[113] Section 1557 also provides that "[t]he Secretary [of Health and Human Services] may promulgate regulations to implement this section," which has created confusion among competing administrations with differing views on its implementation.[114] As originally described by the Obama-era rule, discrimination "on the basis of sex" Section 1557 addressed broadly included discrimination on the basis of pregnancy, childbirth, sex stereotyping, and gender identity.[115] The rule allows coverage for individuals consistent with their gender identity and will not allow a covered entity to deny coverage that is generally exclusive to one gender.[116] The Obama administration saw a historic increase in protections for transgender people in general.[117] The Trump administration rule, by contrast, dramatically reduced those exclusions by outright removing multiple legal protections for LGBTQIA+ individuals.[118]

By applying Section 1557 to "any health program or activity . . . which is receiving Federal financial assistance," the law prohibits almost all health care providers from discriminating against those classes protected by the

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108. 42 U.S.C. § 18116(a); *see also* Baker v. Aetna Life Ins. Co., 228 F. Supp. 3d 764, 771 (N.D. Tex. 2017).

109. 42 U.S.C. § 18116; 29 U.S.C. § 794.

110. 42 U.S.C. § 18116.

111. *Id.* § 6101.

112. *See id.* § 18116.

113. *Id.* § 18117.

114. *Id.* § 18116(c); Keith, *supra* note 28.

115. Keith, *supra* note 28.

116. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,375, 31,428 (May 18, 2016) (to be codified at 45 C.F.R. pt. 92).

117. *See, e.g.*, Emma Margolin, *With Transgender Military Ban Lifted, Obama Cements Historic LGBT Rights Legacy*, NBC NEWS (June 30, 2016, 1:45 PM), https://www.nbcnews.com/feature/nbc-out/transgender-military-ban-lifted-obama-cements-historic-lgbt-rights-legacy-n600541 [https://perma.cc/W7K2-VAQ2].

118. Keith, *supra* note 28.

antidiscrimination laws it incorporates.[119] According to the Centers for Medicaid and Medicare Services, 326,573 inpatient hospitals, and other providers across the country, accepted Medicaid funds in 2019, and are thus bound by Section 1557.[120]

D. Bostock v. Clayton County*: Sexual Orientation and Gender Identity Discrimination is Sex Discrimination*

The historic 2020 United States Supreme Court decision *Bostock v. Clayton County* represented a huge victory for LGBTQIA+ rights; Justice Gorsuch wrote that Title VII prohibits employment discrimination due to sexual orientation.[121] Gorsuch argued that sex discrimination and gender identity are "inextricably bound" to sex and thus cannot be separated as concepts.[122] Essentially, the argument is that an individual who discriminates on the basis of sexual orientation or gender identity also discriminates on the basis of sex.[123] While the *Bostock* holding is limited to Title VII, this affects Section 1557's treatment of sexual orientation discrimination because "courts often look to Title VII when interpreting Title IX," which is directly incorporated into Section 1557.[124] The implications for how courts interpret *Bostock*'s impact on Section 1557 cannot be overexaggerated:

> The stakes could not be higher for LGBTQ people. Health insurers have singled out people with HIV or AIDS from coverage or imposed harsh annual and lifetime caps on benefits, using sexual orientation as a proxy for HIV status. . . . .Unsurprisingly, these inequalities drive significant health disparities for LGBTQ people who collectively are more likely to suffer from mental illness, substance use disorders, suicidality, and a host of other chronic diseases.[125]

Section 1557 of the Affordable Care Act's focus on entities that receive federal funds limits its impact; however, it is still applicable to countless "health care entities, as most doctors, hospitals, and even private insurers

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119. 42 U.S.C. § 18116.

120. *Medicare Providers: Number of Certified Institutional Providers, Calendar Years 2014–2019*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/files/document/2019cpsmdcrproviders1.pdf (last visited Sept. 9, 2022) [https://perma.cc/QYAP-DAQU].

121. Bostock v. Clayton Cnty., 140 S. Ct. 1731, 1747 (2020).

122. *Id.* at 1742.

123. *Id.* at 1743.

124. 42 U.S.C. § 18116(c); Katie Keith, *Supreme Court Finds LGBT People Are Protected From Employment Discrimination: Implications For The ACA*, HEALTH AFFS. (June 16, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200615.475537/full/ [https://perma.cc/L62Q-97KC].

125. Amy Post, Ashley Stephens & Valarie Blake, *Sex Discrimination in Healthcare: Section 1557 and LGBTQ Rights After Bostock*, 11 CAL. L. REV. ONLINE 545, 546 (2021).

accept some form of federal financial assistance, whether it be Medicare, Medicaid, or insurance subsidies."[126]

Culturally competent, respectful, and aware health care providers, combined with a legal understanding that sexual orientation and gender identity are inherently connected to sex discrimination, increase the likelihood that LGBTQIA+ individuals will be willing to both seek out care and continue in treatment plans, an open-minded employer with an antidiscriminatory ERISA plan can also increase the chances that their LGBTQIA+ employees are granted access and opportunity for said care.[127]

E. The Intersection of ERISA and Health Care Discrimination

ERISA is the primary way the federal government regulates employee benefit plans.[128] ERISA splits benefit plans into two types: pension and welfare plans.[129] ERISA sets minimum standards for plans that private sector employers provide to employees in order to protect the plan participants.[130] A pension plan under ERISA is one that either administers retirement income or "systematically defers compensation until termination of covered employment or beyond . . . ."[131] To be covered by ERISA, a welfare plan, by contrast, must provide at least one benefit enumerated by the statute, including "medical, surgical, or hospital care benefits . . . or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, or day care centers, scholarship funds, or prepaid legal services."[132] In return for complying with certain reporting and disclosure requirements, upholding plan fiduciary standards, and satisfying the minimum standards set by the statute, the employer receives preferential tax treatment, providing participants and beneficiaries with benefits that are subsidized or tax free.[133] ERISA also has some limited-scope antidiscrimination rules.[134]

Borrowing from the model of trust law, ERISA provides that the plan administrator, usually the employer, has fiduciary duties to plan participants and beneficiaries, including duties regarding communications and funding.[135] A plan fiduciary is required to "run the plan solely in the interest of participants and beneficiaries and for the exclusive purpose of providing

126. *Id.* at 547.

127. *See* Hernandez & Fultz, *supra* note 67, at 189; Preston, *supra* note 70, at 327–30.

128. 29 U.S.C. §§ 1021–1191c.

129. PETER J. WIEDENBECK, ERISA PRINCIPLES OF EMPLOYEE BENEFIT LAW 5–6 (Oxford Univ. Press 2010).

130. *ERISA*, U.S. DEP'T OF LAB., https://www.dol.gov/general/topic/health-plans/erisa (last visited Sept. 9, 2022) [https://perma.cc/QMSG-7KLY].

131. WIEDENBECK, *supra* note 129, at 43.

132. 29 U.S.C. § 1002(1).

133. *See* WIEDENBECK, *supra* note 129, at 386–89.

134. 29 U.S.C. § 1182.

135. Hozier v. Midwest Fasteners, Inc., 908 F.2d 1155, 1158 (3d Cir. 1990); Variety Corp. v. Howe, 516 U.S. 489, 502–03 (1996); 29 U.S.C. § 1102.

benefits and paying plan expenses."[136] Employer health plans must meet other requirements not enumerated in ERISA as well, including preventive services coverage, a limitation on out-of-pocket expenses for the insured, and no annual or lifetime coverage caps that limit coverage amounts; however, the ERISA-specific requirements are essential to understand for the purposes of this Comment.[137] Additionally, most plans are also required to provide "continuation coverage" for beneficiaries by the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA).[138] This protects spouses and children in the event of an employee's death, termination, or other qualifying event that disrupts their health care coverage.[139]

1. Self-Insurance and Trust Law

Many mid-market and large employers self-insure (sometimes referred to as self-fund) their ERISA plans, which gives them more control over their plan design and coverages.[140] In the case of self-insurance, the employer takes on most or all benefit claim costs.[141] A trust holds benefit premiums and uses those premiums to pay for claims accrued by participants.[142] Due to the fact that the plan is the source for most, if not all, of the benefit claims costs, smaller employers usually cannot afford the risk to self-insure; employers do not have the assets to do so with premiums funded through a smaller number of insured employees, especially if a rather large claim for costly treatment arises.[143] Sometimes, the employer will contract with an insurance company to manage the payments and claims, but the employer is ultimately responsible for the payment of said claims.[144]

"Plan assets" have to be placed in a trust under ERISA.[145] While ERISA has no definition of plan assets, it is generally understood that "any funds or other property, other than those from an employer's general assets, used to provide benefits to plan participants are plan assets."[146] Employers can collect plan assets directly through contribution payments or wage

136. *Fiduciary Responsibilities*, U.S. DEP'T OF LAB., https://www.dol.gov/general/topic/health-plans/fiduciaryresp (last visited Sept. 9, 2022) [https://perma.cc/SKN4-ME4L].

137. *Employer-Sponsored Coverage and Premium Tax Eligibility,* CTR. ON BUDGET AND POL'Y PRIORITIES (Aug. 2020), https://www.healthreformbeyondthebasics.org/key-facts-employer-sponsored-coverage-and-premium-tax-credit-eligibility/ [https://perma.cc/D4GF-KPVC].

138. 29 U.S.C. § 1163.

139. *Id.* § 1167(3).

140. *A Self-Funded Plan can be Part of Your Strategy to Lower Health Care Costs*, AETNA, https://www.aetna.com/employers-organizations/self-insurance-plans.html (last visited Sept. 9, 2022) [https://perma.cc/YB36-VF92].

141. *Id.*

142. Terry Humo, EMPLOYER'S GUIDE TO SELF-INSURING HEALTH BENEFITS ¶ 410 (2016), *available at* WestlawEdge Labor & Employment Texts & Treatises.

143. *Id.* ¶ 120.

144. AETNA, *supra* note 140.

145. *See* 29 C.F.R § 2510.3-101 (1987).

146. Humo*, supra* note 142.

reduction.[147] Employers must set up their ERISA plan as its own separate, legal entity in which the designated plan administrator, often the employer itself, has certain fiduciary duties.[148] All trusts require governing documents in which the plan sponsor in a trust agreement appoints a trustee as a fiduciary of the plan assets; this is almost always done through the ERISA plan document.[149] Importantly, someone in a fiduciary role "occupies a position of confidence or trust" and is thus "personally liable" when they breach their trust.[150] The trust setup can easily become quite complex and thus requires the employer to design and monitor the entire system and administration carefully.[151]

While the self-insured plan may emulate a fully-insured plan in which premiums are paid to an insurance company that combines those payments with premiums from other insureds, the plan is still responsible for the separate trust account that holds all employee premiums separately.[152] Under a fully-insured plan, by contrast, employers have less or no control over larger plan designs because benefit coverages are controlled by insurance companies.[153]

An employer may set up a self-insured plan by contracting with an insurance company to help administer the plan and signing a boilerplate contract regarding benefit coverage.[154] Other times, especially for larger organizations, the employer will decide to draft benefit coverage language on their own, giving their organization complete control over the plan document provisions, including provisions concerning benefit eligibility, benefits covered, denials, and the appeals process.[155] While not all employers have designated ERISA plan documents, those who self-insure their benefits do.[156] Technically, ERISA requires employers to have plan documents in place, but in practice, employers are sometimes careless regarding those requirements, or may not even realize their benefits are ERISA-covered benefits.[157]

As employers often act as plan administrators and plan fiduciaries, they also take on a role comparable to that of an executor in an estate when an employee dies or is terminated.[158] Indeed, "[s]ince plan managers owe a fiduciary duty to participants and beneficiaries under ERISA plans, failure to provide the employee with similar formalities associated with execution of a

147. *Id.*
148. 29 U.S.C. §§ 1002(16), 1021, 1024, 1025; *see also* WEIDENBECK, *supra* note 129, at 58.
149. Humo*, supra* note 142.
150. S. REP. NO. 93-127, at 4864, 4882 (1973).
151. Humo, *supra* note 142.
152. AETNA, *supra* note 140.
153. *See* WIEDENBECK, *supra* note 129, at 165.
154. Humo, *supra* note 142, ¶ 210.
155. *See id.* ¶ 300.
156. *Id.*
157. *Id.* ¶ 130.
158. *See* O'Brien, *supra* note 35, at 460.

last will and testament is a breach of fiduciary duty prompting redress under 29 U.S.C. Section 1132(a)(3)'s guarantee of appropriate equitable relief."[159] Employers must distribute benefits to ERISA beneficiaries, notify the employee and their dependents about COBRA continuation coverage, and take on other responsibilities.[160] Often, however, employers are at a disadvantage because they are not as knowledgeable about how to conduct these duties, which can lead to costly and devastating consequences.[161]

Employers must also be careful not to accidentally promise a benefit or treatment coverage in a summary plan description (the document usually provided to employees) that is not covered under the underlying plan document, as this would create confusion for employees, plan administrators, and more.[162] If this occurs, the employer may be on the hook for providing that benefit out of their own pocket—essentially, self-insuring the uncovered claim—if an employee reasonably relies on the inaccurate documents.[163] Because employers can be held liable under the doctrines of equitable estoppel and breach of fiduciary duty, they must ensure they communicate only intentional benefits and coverages through the ERISA plan document, summary plan description, and informal plan communications, as well as avoid affirmative misrepresentations.[164] "[F]ailing to communicat[e] an excluded benefit to employees" is the "most common mistake" a self-insured employer can make, especially when making the transition from fully-insured to self-insured.[165]

Enforcement of ERISA is split between the Department of Labor (DOL) and the Internal Revenue Service (IRS), with the Department of Health and Human Services (HHS) also responsible for HIPAA enforcement.[166] This complicated interagency enforcement scheme is not only overly confusing for employers attempting to practice compliance, but also for agencies.[167] While its stipulations can be extensive, ERISA compliance is often the last

159. *Id.* at 460–61.

160. *Id.* at 484–86.

161. *Id.*; *see* Sara Hansard, *Employers Cautioned as Suits Over COBRA Coverage Notices Add Up*, BLOOMBERG L. (Apr. 29, 2022, 4:35 AM), https://news.bloomberglaw.com/daily-labor-report/employers-cautioned-as-suits-over-cobra-coverage-notices-add-up [https://perma.cc/4Y4A-BD7C].

162. Hansen v. Cont'l Ins. Co., 940 F.2d 971, 981–82 (5th Cir. 1991).

163. *See* Curcio v. John Hancock Mutual Life Ins. Co., 33 F.3d 226, 235 (3d Cir. 1994).

164. *See, e.g.*, Fischer v. Phila. Elec. Co., 994 F.2d 130, 133–35 (3d Cir. 1993); Haberern v. Kaupp Vascular Surgeons Ltd. Defined Benefit Pension Plan, 24 F.3d 1491, 1502–03 (3d Cir. 1994); *see also* WIEDENBECK, *supra* note 129, at 107–08.

165. Humo, *supra* note 142, ¶ 332.

166. *Relationship with the IRS*, DEP'T OF LAB., https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/enforcement/oe-manual/relationship-with-irs (last visited Sept. 10, 2022) [https://perma.cc/NU39-VJQ9].

167. *See, e.g.*, *Self-Compliance Tool for Part 7 of ERISA: Health Care-Related Provisions*, DEP'T OF LAB., https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-a.pdf (last visited Sept. 10, 2022) [https://perma.cc/4N3Z-A8KF].

item on an employer's workload, and most employers would rather not deal with it.[168]

2. Antidiscrimination under ERISA

Section 510 of ERISA prohibits employers from discriminating against plan participants for exercising their plan rights.[169] Section 510 makes it illegal to "discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan."[170] Crucially, this nondiscrimination provision does not mandate eligibility for specific groups or coverages, but instead makes sure that those who are already eligible under the plan cannot be denied benefits.[171] In *McGann v. H & H Music*, the Fifth Circuit Court of Appeals of the United States held that Section 510 does not, however, bar an employer from adjusting health care benefits in a manner that reduces employer costs, even when the burden of that change impacts a group of employees with specific health care needs.[172]

Plan adjustments cannot be retaliatory against an individual for exercising their rights under the plan.[173] Practically, this means that employers may discontinue or even exclude AIDS coverage or gender-affirming procedures, and other types of LGBTQIA+ care, for example, as long as the decision is not intended to retaliate against an employee who filed an expensive claim for said coverage, even if the employer's decision can be directly linked to that employee's claim history.[174]

While these antidiscrimination provisions apply to employers who fully insure and self-insure alike, discrimination claims in a fully-insured plan would be levelled against the insurance company, not the employer; deciding the correct defendant in ERISA cases can be complex.[175] In the traditional fully-insured arrangement, benefit packages are generally dictated by the insurer, who contracts with the employer to offer those benefits to its eligible

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168. *See, e.g.*, *Staying in Compliance can be a Time-Consuming Chore*, ERISAFIRE, https://www.erisafire.com (last visited Sept. 10, 2022) ("Much like collecting and taking out the garbage, [compliance is] a menial task that employers and their brokers complete simply because ERISA mandates it.") [https://perma.cc/NH5X-UVEJ].

169. 29 U.S.C. § 1182.

170. *Id.*

171. *See id.*; Bridget Schaaff, *Using Federal Nondiscrimination Laws to Avoid ERISA: Securing Protection from Transgender Discrimination in Employee Health Benefit Plans*, 26 DUKE J. GENDER L. & POL'Y 45, 53 (2018).

172. McGann v. H & H Music Co., 946 F.2d 401, 407 (5th Cir. 1991).

173. *Id.* at 408.

174. *See id.* at 407–08.

175. *Compare* Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 101 (1989) (plan participant files suit against employer) *with* Leuthner v. Blue Cross & Blue Shield of Ne. Pa., 454 F.3d 120 (3d Cir. 2006) (plan participants file suit against insurance company).

employees.[176] In these cases, the insurance company "is acting as fiduciary."[177]

Despite the antidiscrimination statutes in place, many employers still lack inclusive and equitable ERISA benefit plans.[178] Employers, especially mid-market employers who bear less risk of being audited by the DOL or IRS or facing lawsuits from employees, are often reluctant to provide certain benefits, or to provide benefits to certain individuals or groups of individuals, for cost or personal reasons.[179]

While some discrimination is directly written into many employers' ERISA policies, much is not.[180] In some cases, discrimination hinges not on eligibility requirements but the medical care the plan does or does not cover.[181] As explained by Pamuela Halliwell, a licensed marriage and family therapist who herself is a transgender woman:

> [There is] a system at play that makes access to care harder. There may be policies that prevent health insurance providers from explicitly discriminating against me and my community with exclusionary language because of my transgender identity, but that doesn't mean that they don't try to deny me as much as they can.[182]

Ms. Halliwell is describing a type of discrimination called disparate impact discrimination, when "a facially neutral practice has a disparate impact on a protected group."[183] The legal framework for proving disparate impact claims in the employment context is codified under the 1991 Amendment to Title VII.[184]

3. ERISA Preemption's Impact on Potential Solutions

According to Section 514(a) of ERISA, "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" are superseded by ERISA's regulation.[185] In fact, ERISA is the typical example of express preemption in many first-year constitutional law casebooks, and it

176. WIEDENBECK, *supra* note 129, at 165.
177. *Id.*
178. *See infra* Section III.A.
179. *See* Preston, *supra* note 70, at 318.
180. *See* SPERINO & GONZALEZ, *supra* note 24, at 175.
181. Janet Hunt, *What Employee Health Insurance Options are Right for You?*, THE BALANCE (Mar. 13, 2022), https://www.thebalance.com/employee-benefit-insurance-options-4582431 [https://perma.cc/K4YA-PJV8].
182. Halliwell, *supra* note 100, at 229.
183. SPERINO & GONZALEZ, *supra* note 24, at 175.
184. 42 U.S.C. § 2000e-2(k).
185. 29 U.S.C § 1144(a).

is "one of the broadest preemption clauses ever enacted by Congress."[186] Eliminating any conflict between state and federal benefit plan regulation was another reason Congress enacted ERISA, and yet conflict still exists.[187] Express preemption, the Supreme Court noted, protects from interference by states and occurs "where Congress, through a statute's express language, declares its intent to displace state law."[188] Field preemption, by contrast, occurs when "the federal interest [in a subject] is so dominant that the federal system will be assumed to preclude enforcement of state laws on the same subject."[189]

The consequence to such broad preemption is that employees have no cause of action based on state law.[190] Thus, plaintiffs who would be able to "recover compensatory, consequential, or punitive damages" under a state tort action can only recover under ERISA "the benefits he would have been entitled to under the terms of the plan, reasonable attorney's fees, and court costs."[191] Affected employees under a plan that is self-insured have no remedies under state law, and the average employee may not even realize that their employer's ERISA plan is self-insured until they review the plan documentation; they certainly will not understand the complexities of recovering under ERISA until conferring with an attorney.[192] By contrast, states can impose requirements on traditional insurance companies who fully-insure ERISA plan beneficiaries.[193]

ERISA preemption can have unforeseen consequences on estate plans as well.[194] State law concerning probate must be ignored in favor of ERISA's procedures for beneficiary determination, which can disrupt a testator's intent.[195] If an employer is not careful in how they set up their ERISA plan, if they set it up in a discriminatory manner, or if they are careless in its administration, this means that an employee may not have access to what

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186. *See, e.g.*, ERWIN CHEMERINSKY, CONSTITUTIONAL LAW 454 (5th ed. 2017); PM Grp. Life Ins. v. W. Growers Assur. Tr., 953 F.2d 543, 545 (9th Cir. 1992) (quoting Evans v. Safeco Life Ins. Co., 916 F.2d 1437, 1439 (9th Cir. 1990)).

187. JON O. SHIMABUKURO, CONG. RSCH. SERV., 98-286A, ERISA'S IMPACT ON MEDICAL MALPRACTICE AND NEGLIGENCE CLAIMS AGAINST MANAGED CARE PLANS 1 (2008); S. REP. NO. 93-127, at 4871 (1973); *see also* O'Brien, *supra* note 35, at 441.

188. Farina v. Nokia Inc., 625 F.3d 97, 115 (3rd Cir. 2010) (citing Hillsbourough Co. v. Automated Med. Labs, Inc., 471 U.S. 707, 713 (1985)).

189. Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230 (1947).

190. WOOTEN, *supra* note 34, at 282–83.

191. SHIMABUKURO, *supra* note 187, at 2.

192. *See id.*; WIEDENBECK, *supra* note 129, at 180–81.

193. *See, e.g.*, Ellen Trachman, *Lawyers: 1, Discriminating Insurance Company: 0*, ABOVE THE L. (Sept. 22, 2021, 5:47 PM), https://abovethelaw.com/2021/09/lawyers-1-discriminating-insurance-company-0/?fbclid=IwAR1tVzd7MvVAsKw46I37FYYVOaW7zlGoFzLBEDOEqJOBNw2hJ6-xpU8fTpE [https://perma.cc/VJ8V-MXYM].

194. O'Brien, *supra* note 35, at 462.

195. *See, e.g.*, Virginia Hammerle, *ERISA–What You Need to Know*, HAMMERLE FINLEY L. FIRM (Jan. 24, 2021), https://legaltalktexas.hammerle.com/probate/erisa-what-you-need-to-know/ [https://perma.cc/BH33-URRC].

might be a potentially more favorable property distribution outcome under state law because the employee must go by the employer's plan specifications.[196]

Self-insuring their employee benefit plans also allows employers to avoid providing benefits mandated by states because they are governed by federal, and not state, regulation.[197] This is especially an issue with self-insured plans, because "[i]f a state law 'relates to' an employee health plan, the plan may avoid complying with the law by self-insuring."[198] Additionally, the Court has differentiated between the state law that applies to benefit plans as opposed to state law that applies to those benefits themselves; ERISA preempts state law that regulates welfare plans but not state law that regulates specific benefits.[199] In fact, a large motivation for employers to choose to self-insure "is to avoid expensive state mandated benefits . . . that could bankrupt the plan."[200]

By self-insuring their welfare plans, employers are able to get around any state insurance regulations and state-mandated benefit law.[201] For example, almost half of states and the District of Columbia forbid the exclusion of transgender individuals in health insurance.[202] Due to ERISA preemption, however, remedies are not available regarding ERISA-specific discrimination claims because self-insured welfare plans are subject only to ERISA regulation.[203] State and local antidiscrimination laws provide additional protections in only certain cases.[204] State insurance law may become relevant when an ERISA plan purchases a stop-loss insurance policy to reduce the risk of loss in the case of a catastrophic claim.[205]

ERISA's broad preemption of state insurance regulations fundamentally means that any solution that addresses the discriminatory aspects of welfare plans must come from Congress because, as established above, many plans have systematic design flaws—whether intentional or not—that have discriminatory aspects.[206] Especially considering the federal government's role in ERISA regulation and health care legislation, state regulation does not remedy the issue at hand.[207]

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196. O'Brien, *supra* note 35, at 462.

197. Humo, *supra* note 142, ¶ 110.

198. WOOTEN, *supra* note 34, at 284.

199. Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 11 (1987); *see also* WOOTEN, *supra* note 34, at 281.

200. Humo, *supra* note 142, ¶ 330.

201. *Id.* ¶ 110.

202. Judson Adams et. al, *Transgender Rights and Issues*, 21 GEO. J. GENDER & L. 479, 501 (2020).

203. DONALD H. J. HERMANN & WILLIAM P. SCHURGIN, LEGAL ASPECTS OF AIDS: INSURANCE AND EMPLOYEE BENEFIT ISSUES § 13.43 (1991).

204. JASPER, *supra* note 58, at 49–50.

205. *See* Moore v. Provident Life & Accident Ins. Co., 786 F.2d 922, 927 (9th Cir. 1986); HERMANN & SCHURGIN, *supra* note 203, § 13:44.

206. *See* WOOTEN, *supra* note 34, at 282, 284.

207. Author's original thought.

The overarching goal of this Comment is to improve the patchwork of current legislation rather than worsen it; despite statutes such as the Civil Rights Act, ADA, Section 1557 of the Affordable Care Act, and HIPAA, employment discrimination remains an issue.[208] Part III explores reasons why these issues are important to address and what simple changes employers can make to ensure equity in their health plans.[209] Part III also advocates for increased responsibility on employers to make these changes and explains why they should be held to a higher standard than they currently are regarding equitable benefits.[210]

III. EMPLOYERS MUST UPDATE THEIR ERISA PLANS TO LESSEN LGBTQIA+ DISCRIMINATION

Due to the self-insured nature of certain employee benefit plans, they are vulnerable to several common areas of discrimination, whether intentional or not.[211] These can include the exclusion of domestic partners, fertility benefits for same-sex couples, and the omission of medically-necessary care for transgender individuals.[212] This Section explains why domestic partnership coverage, comprehensive coverage for transgender-specific care, and extensive fertility benefit coverage are essential to ensure those employees who are part of the LGBTQIA+ community are not excluded or denied essential benefits.[213] Additionally, employee benefit plans must be reevaluated across-the-board to ensure that they do not continue to be written exclusively for heteronormative employees.[214]

There are several avenues that Congress can use to encourage employers to make equitable changes.[215] Congress could consider expanding Section 1557 to apply to employers who self-insure their benefit plans, expand ERISA's nondiscrimination provisions, or increase tax incentives for employers who take steps to update their plan documents.[216]

Of course, there are many reasons why an employer might resist making any changes to their ERISA plans.[217] First, they could be opposed to providing equitable benefits for moral or religious reasons.[218] Second, as a plan administrator, the employer can often struggle to balance its interests to

208. *Infra* Section III.A.
209. *Infra* Part III.
210. *Infra* Part III.
211. *See supra* Section II.E.2.
212. *See infra* Section III.A.
213. *See infra* Section III.A.
214. *See infra* Section III.D.
215. *See infra* Section III.B.
216. *See infra* Section III.B.
217. *See infra* Section III.C.
218. *See infra* Section III.C.1.

both the plan itself, such as keeping costs down, and to the employee beneficiaries.[219] Similarly, the issue of cost to expanding benefits needs to be evaluated.[220] Ensuring employers retain their autonomy is also a relevant issue.[221] Finally, whether or not requiring or encouraging more equitable plans will result in a higher number of grievances is also addressed.[222] Ultimately, several actionable suggestions are given to prevent discrimination by employers who self-insure and design their own coverage and eligibility requirements.[223]

A. Discrimination Remains a Pervasive Problem in ERISA Plans

As a general rule, "[h]ealth systems routinely fail to cover gay and lesbian partners or provide reimbursement for procedures of particular relevance to LGBTQ[IA+] populations."[224] While "ERISA does not mandate levels or types of coverage . . . the employer may not interfere with the right to become eligible for, or the right to collect, benefits by excluding coverage for HIV-related illness after diagnosis."[225] The same holds true for other "medically necessary" care, including gender transition surgery and other benefits, if they are already included as covered benefits.[226] However, because what is medically necessary is relative and often depends upon a doctor's treatment decision, it is difficult, if not impossible, to prove discrimination on the grounds of an individual being denied what they consider medically necessary care.[227]

Employers may sometimes disparately discriminate by deciding not to cover domestic partners.[228] As of 2022, about fifty-six percent of Fortune 500 companies provide domestic partnership coverage in their health plans, and fifty-six percent of Fortune 500 companies provide at least one transgender-inclusive benefit plan option.[229] Before the *Obergefell v. Hodges* decision legalizing same-sex marriage, one of the most common ways that same-sex couples had the ability to add beneficiaries to their employee benefit plans was through domestic partnership, although domestic partnership is also common among heterosexual couples.[230] Coverage of

219. *See infra* Section III.C.2.
220. *See infra* Section III.C.3.
221. *See infra* Section III.C.4.
222. *See infra* Section III.C.5.
223. *See infra* Section III.D.
224. Brandes, *supra* note 44, at 167.
225. HERMANN & SCHURGIN, *supra* note 203, § 13:42.
226. *See* Brandes, *supra* note 44, at 164.
227. *Id.* at 164–65.
228. *See* Preston, *supra* note 70, at 319.
229. *Corporate Equality Index 2022: Rating Workplaces on Lesbian, Gay, Bisexual, Transgender, and Queer Equality*, HUM. RTS. CAMPAIGN, https://www.hrc.org/resources/corporate-equality-index (last visited Sept. 10, 2022) [https://perma.cc/U3GN-7596].
230. Preston, *supra* note 70, at 322.

domestic partners in many states was, and still is, optional, and eligibility can hinge on arduous requirements set by the employer when applying for insurance coverage.[231] Employers can usually decide whether they want to cover domestic partners, which can disparately impact same-sex couples.[232]

As referenced earlier, domestic partnership coverage was provided to employees by fifty-six percent of Fortune 500 companies.[233] While this statistic is important, it is also misleading in gauging the percentage of overall companies that offer it, as over half of the companies in the Fortune 500 qualification are mega-employers with at least 25,000 employees.[234] Fortune 500 employers represent the largest, and thus most financially stable, companies in the United States.[235] While Fortune 500 companies often set trends that smaller companies follow, the key group that engages in discriminatory practices are smaller, mid-market and large employers who have less resources, are subject to less publicity, and demonstrate a greater risk tolerance than those in the Fortune 500 classification.[236] Fortune 500 companies provide generous benefits packages for a variety of reasons, not the least of which is that they have enough plan participants to reasonably predict future losses.[237]

Because same-sex marriage is now legal nationwide, married couples can more easily receive benefits through their spouse's employer's benefit plan.[238] However, while the legalization of same-sex marriage is a step in the right direction, it does not obviate the need for extended partner benefits beyond the confines of marriage, as many same-sex couples still experience discriminatory systems throughout daily life that can act as a barrier to marriage.[239]

Fertility benefits are an area of possible discrimination that has gained recent attention.[240] Many insurance policies, including self-insured plan documentation, provide comprehensive coverage for intrauterine insemination and in-vitro fertilization (IVF) for individuals struggling to become pregnant.[241] Nineteen states, including Texas, mandate that insurance

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231. Mila Araujo, *Understanding Domestic Partnerships and Domestic Partnership Insurance*, THE BALANCE (July 5, 2021), https://www.thebalance.com/domestic-partner-insurance-101-2645680 [https://perma.cc/M36R-NNLM].

232. *See* Preston, *supra* note 70, at 322.

233. HUM. RTS. CAMPAIGN, *supra* note 229.

234. *Fortune 500*, FORTUNE https://fortune.com/fortune500/2019/search/?employees=desc (last visited Sept. 10, 2022) [https://perma.cc/55U4-WS7X].

235. *See id.*

236. *See supra* notes 82–87 and accompanying text.

237. *See* Humo, *supra* note 142, ¶ 330.

238. *See* Gerry W. Beyer, *Estate Planning Ramifications of Obergefell v. Hodges* (Jul. 9, 2016), https://ssrn.com/abstract=2807101 [https://perma.cc/55U4-WS7X].

239. HUM. RTS. CAMPAIGN, *supra* note 229.

240. Trachman, *supra* note 193.

241. *See* Goidel v. Aetna, Inc., No. 1:21-cv-07619 (VSB) (S.D.N.Y. Sept. 13, 2021).

companies cover fertility benefits.[242] However, the coverage conditions for these treatments indirectly and often unintentionally exclude same-sex couples by covering only individuals who can demonstrate that they have not been able to conceive after twelve months of unprotected sex or some other comparable standard.[243]

To meet this standard of coverage, same-sex couples and couples who cannot become pregnant through intercourse would, in theory, have to pay out-of-pocket for twelve cycles of intrauterine insemination and have all twelve cycles fail to produce a healthy and viable pregnancy prior to becoming eligible for infertility treatment coverage from their insurer.[244] In the recent ongoing class-action lawsuit, *Goidel v. Aetna, Inc.*, which deals with a fully-insured rather than self-insured plan, the complaint alleges that the insurer's policy creates "an illegal tax on LGBTQ individuals that denies the equal rights of LGBTQ individuals to have children" and "exorbitant costs [that] are prohibitive and entirely prevent people who are unable to shoulder them—disproportionately LGBTQ people of color—from becoming pregnant and starting a family."[245] While the *Goidel* lawsuit was against the insurance company, due to the plan's fully-insured nature, the same issues can and will be litigated in coming years against self-insured plans; when that occurs, complaints will be lodged against employers themselves as plan sponsors and fiduciaries.[246]

In some circuits, fertility treatment is not protected as a disability by the ADA or under the Civil Rights Act as amended by the Pregnancy Discrimination Act.[247] In *Krauel v. Iowa Methodist Medical Center*, the Eighth Circuit held that a general exclusion of fertility coverage by a health insurer was permissible because it is not a sex-based classification protected by Title VII.[248] Because sexual orientation discrimination is now protected by Title VII, fertility coverage of same-sex couples should be covered by Title VII.[249]

In another example of discriminatory treatment, not all employers explicitly cover care deemed medically necessary for transgender populations.[250] To determine whether health coverage is inclusive of transgender employees, the Human Rights Campaign analyzes the following criteria: (1) explicit affirmation of coverage without any blanket exclusions

242. *State Laws Related to Insurance Coverage for Infertility Treatment*, NAT'L CONF. OF STATE LEGIS. (Mar. 12, 2021), https://www.ncsl.org/research/health/insurance-coverage-for-infertility-laws.aspx [https://perma.cc/QR6J-7RN8].

243. *See id.*

244. *See id.*

245. *See* Goidel v. Aetna, Inc., No. 1:21-cv-07619 (VSB) (S.D.N.Y. Sept. 13, 2021).

246. *See* Trachman, *supra* note 193.

247. Krauel v. Iowa Methodist Med. Ctr., 95 F.3d 674, 679–80 (8th Cir. 1996).

248. *Id.*

249. *See* Bostock v. Clayton Cnty., 140 S. Ct. 1731, 1737 (2020).

250. HUM. RTS. CAMPAIGN, *supra* note 229.

for employees or beneficiaries who identify as transgender; (2) plan or policy documentation that incorporates the standards of care laid out by the World Professional Association for Transgender Health; (3) plan documents that are accessible to all participants and have clear language illustrating comprehensive insurance options to plan participants and beneficiaries; (4) benefit options, including those associated with gender transition such as gender-affirmation procedures; and (5) a covered maximum for latter services of at least $75,000.[251]

Unless employers have explicit policies for covering claims of transgender individuals, the plan language regarding these criteria is often either lacking, or more likely, completely nonexistent.[252] While the number of large employers who meet the above criteria to qualify as having "transgender-inclusive benefits" has increased by thirty-seven percent since 2015, the number of small- to mid-market employers is likely much lower.[253] A study published in the Journal of Plastic and Reconstructive Surgery found that a "[l]ack of consistent, clinically sound insurance coverage for medically necessary gender-affirming procedures limits the quality of surgical care provided to transgender patients, who already face considerable health disparities."[254] While there are clear barriers to gaining equitable coverage for LGBTQIA+ individuals, cultural and societal shifts are increasingly making equity a possibility for more and more people with the advent of health care justice.[255]

B. Solutions: Carrot or Stick?

Congress has several avenues it can take to combat both intentional and unintentional discrimination.[256] First, they can apply existing antidiscrimination legislation (Section 1557) to self-insured employers so that they take active steps to evaluate their ERISA plans for disparities.[257] Second, they could expand the antidiscrimination provisions of ERISA to include those classes currently protected by Title VII.[258] Third, Congress could incentivize employers to make changes voluntarily by increasing the tax advantages for those who do so, specifically by increasing employer and

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251. *Corporate Equality Index 2015: Rating Workplaces on Lesbian, Gay, Bisexual and Transgender Equality*, HUM. RTS. CAMPAIGN 6, 14–16, (2015), https://assets2.hrc.org/files/documents/CEI-2015-rev.pdf [https://perma.cc/G6QB-HB97].

252. *See id.*

253. *See id.*; Preston, *supra* note 70, at 318.

254. George Kokosis & Joseph H. Dayan, *Limited Coverage of Gender Affirming Breast and Chest Reconstruction in Insurance CPT Coding Criteria*, 146 PLASTIC & RECONSTRUCTIVE SURGERY 239(e), (Aug. 2020).

255. *See* HUM. RTS. CAMPAIGN, *supra* note 251.

256. Author's proposal.

257. *Id.*

258. *Id.*

employee contribution limits for defined contribution accounts.[259] The overarching goal should be to spur employers into action to replace discriminatory policy with inclusive benefit and eligibility requirements.[260]

1. Stick: Employer Mandates

Mandating that employers evaluate their ERISA plans for discrimination will take a huge amount of political will by Congress, but it is the natural extension of the state of the law after the Supreme Court's decision in *Bostock v. Clayton County*.[261] As discussed above with the development of the idea of "health care civil rights," Section 1557 of the Affordable Care Act has become a potent weapon for combating health care discrimination by providers.[262] The advent of the *Bostock* opinion by the Supreme Court has especially opened doors when it comes to the discrimination of LGBTQIA+ individuals and those who identify with a different gender than that assigned at birth.[263] While this is encouraging, Section 1557 provides for antidiscrimination protection only against a very specific group: health care organizations or providers who receive federal funds.[264]

Congress should expand Section 1557 to expressly include language that bans employers from engaging in health care discrimination.[265] Employers with fifteen or more full-time employees are subject to Title VII and its myriad of employee protections.[266] The simplest way to apply Section 1557's protections to employees in a self-insured ERISA plan context would be to apply them to employers with fifteen or more full-time employees, thus mirroring Title VII's language.[267] This would cover the vast majority of employers with self-insured plans; larger employers are more likely to implement self-insurance because they can afford to assume the financial risk of setting up a self-insured plan without threatening the solvency of the business.[268]

The goal in expanding Section 1557 to cover self-insured employers is to require employers to draft more equitable ERISA health plans and fix the plan design flaws that contribute to discrimination.[269] As discussed in the

259. *Id.*
260. *Id.*
261. *See supra* Section II.D.
262. Anna Kirkland & Mikell Hyman, *Civil Rights as Patient Experience: How Healthcare Organizations Handle Discrimination Complaints*, 55 L. & SOC'Y REV. 273, 274 (2021).
263. Keith, *supra* note 124.
264. *See* Wyatt Fore, *Trans/Forming Healthcare Law: Litigating Antidiscrimination Under the Affordable Care Act*, 28 YALE J.L. & FEMINISM 243, 250 (2017).
265. Author's opinion.
266. 42 U.S.C. § 2000e(b).
267. Author's proposal.
268. Humo, *supra* note 142, ¶ 120.
269. *See supra* Section II.E.

background of this Comment, employers have quite a bit of control over the content of their self-insured benefit plans: eligibility and coverage requirements are directly controlled by the ERISA plan documents written by the employer.[270] The essential direct results of adjusting eligibility and coverage requirements will include an improved insured rate for the LGBTQIA+ population and an increase in coverage for the unique health conditions and procedures needed by said groups.[271]

Another solution could be to expand ERISA's nondiscrimination provisions.[272] Currently, self-insured retirement plans are subject to nondiscrimination rules regarding highly compensated employees, while welfare plans' nondiscrimination requirements are unenforced to the point of practical nonexistence.[273] This is a result of ERISA's initial overarching focus on the aging American's pension and retirement plans.[274] At the time ERISA was passed, Congress was concerned with conservative vesting provisions within pension plans, but ERISA can evolve to become a great tool to ensure equitable welfare plans exist.[275] Since the concept of providing benefits rather than raising wages became more commonplace prior to World War II, employers have concentrated the highest quality benefits among the wealthy.[276] Congress actually passed nondiscrimination legislation in the context of employer-sponsored health care in 1986, but it resulted in such an uproar from the business community for being "costly, complex, and unworkable" that the law was repealed in 1989.[277] Thus, Congress has been aware of the problem for decades.[278]

Expanding the nondiscrimination rules to include classes protected from discrimination by the Supreme Court would require employers to reevaluate their ERISA plans, and in the process, include provisions to eliminate the disparate treatment and impacts on minority groups.[279] Nondiscrimination rules would be much more welcome now than they were in 1986, when fear of AIDS and blame on the LGBTQIA+ community was at its height.[280] Now, seven out of ten Americans are in support of marriage equality, including a

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270. Humo*, supra* note 142, ¶¶ 130, 210, 300, 410; REP. NO. 93-127, at 4864, 4882 (1973); AETNA, *supra* note 140; *see* O'Brien, *supra* note 35, at 460–61.

271. *See* Preston, *supra* note 70, at 327–30.

272. Author's opinion.

273. I.R.C. § 105(h); Treas. Reg. § 1.105-11(c); WIEDENBECK, *supra* note 129, at 397.

274. *See* WEIDENBECK, *supra* note 129, at 13.

275. WOOTEN, *supra* note 34, at 77–79.

276. *Id.* at 33.

277. WIEDENBECK, *supra* note 129, at 395–96.

278. *Id.*

279. *See supra* Section II.E.

280. *See* Justin McCarthy, *Record-High 70% in U.S. Support Same-Sex Marriage*, GALLUP (June 8, 2021), https://news.gallup.com/poll/350486/record-high-support-same-sex-marriage.aspx [https://perma.cc/TP6P-UK2U]; Ricardo Alonso-Zaldivar, *Poll: Support for 'Medicare-for-all' Fluctuates with Details*, ASSOCIATED PRESS (Jan. 23, 2019), https://apnews.com/article/health-north-america-donald-trump-ap-top-news-health-care-reform-4516833e7fb644c9aa8bcc11048b2169 [https://perma.cc/HZ66-EGBB].

majority of Republicans, and the same percentage of Americans believe health insurance is a human right.[281]

Codifying an expanded version of ERISA's nondiscrimination rules or expanding Section 1557 would take a huge amount of political will by Congress, but it is clear that other solutions to prevent this issue thus far have failed and a permanent solution is needed.[282] Codification will have another positive effect on the problem by ensuring permanent protections: as demonstrated by the Trump Administration's Section 1557 regulations (2020 Rule) released in July of 2020, not all executive administrations will welcome these protections.[283] The Trump Administration worked diligently to roll back protections for LGBTQIA+ individuals:

> Rather than enacting policy designed to improve the health and wellbeing of the [transgender] population, the Trump [A]dministration ignored medical expertise, science, and public outcry. In pandering to partisan politics, it attempted, at every turn, to increase barriers to healthcare and exacerbate negative social determinants of health for the [transgender] community.[284]

The 2020 Rule, finalized just a few days prior to the *Bostock v. Clayton County* Supreme Court decision, "remove[d] protections against discrimination based on sex stereotyping and gender identity afforded by the 2016 rule" passed by the Obama Administration, which protected individuals against discrimination based on sexual orientation and gender identity.[285] The 2020 Rule was also in direct opposition to the *Bostock* decision, which created confusion for employers who simply wanted to comply with the law.[286] Many of the supposed motivations behind the changes brought on by the 2020 Rule, including cost savings and the potential increase in grievances from affected employees, are addressed in Section III.D of this Comment.[287]

2. Carrot: Employer Incentives

The tax advantages to having employer-financed medical care are practically innumerable.[288] Employer-provided health care does not qualify as gross income under the tax code, which means that it is not taxed.[289] During the 2009 fiscal year, the "revenue loss attributable to the favorable

281. McCarthy, *supra* note 280; Alonso-Zaldivar, *supra* note 280.
282. *See supra* Section III.A.
283. *See* Keith, *supra* note 28.
284. Paula M. Neira & An Na Lee, *Under Attack: Transgender Health in 2020*, 24 J. HEALTH CARE L. & POL'Y 109, 131 (2021).
285. Keith, *supra* note 28.
286. *See* Keith, *supra* note 124.
287. *See infra* Section III.D.
288. *See* WIEDENBECK, *supra* note 129, at 394.
289. *Id.*; I.R.C. § 106.

tax treatment of health care has recently overtaken qualified retirement savings, and is estimated as $127.4 billion."[290] Peter J. Wiedenbeck suggests that this is because:

> [W]orkers place a higher value on health benefits than retirement savings. Relative to pensions, more low- and moderate-income workers are apparently willing to pay for health plan coverage (by accepting less cash compensation) even though they derive little or no benefit from the preferential tax treatment of employer-sponsored health care.[291]

Because the ERISA trust holds plan assets, there are several important tax implications: (1) the employer can deduct contributions to the trust from their taxes; (2) any and all employee contributions are done pre-tax; and (3) any interest the trust earns on plan assets must not be taxed as income.[292] This favorable tax treatment is valued by employers, and the benefits received are similarly valued by employees as about thirty percent of the total value of their compensation comes from benefits.[293]

A voluntary tax incentive would require employers to opt in, perhaps making it a more palatable option politically than an employer mandate.[294] While potentially adding some complexity to the administration of defined contribution accounts, one possible incentive is an increased contribution limit for defined contribution accounts for those who add inclusive, nondiscrimination language to their ERISA plans.[295] The defined contribution method is a funding approach in which "the employer specifies a fixed amount it is willing to contribute to each employee to purchase health benefits."[296] Defined contribution accounts for welfare benefits can include Health Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs).[297] These accounts differ from the traditional defined benefit approach in which a uniform set of benefits is explicitly outlined in the plan document, including "definitions for key coverages, deductibles, coinsurance and copayment amounts," and HSAs, while not regulated by ERISA, are still intimately-tied to many employees' health insurance offerings.[298]

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290. WIEDENBECK, *supra* note 129, at 385.

291. *Id.* at 396.

292. Humo, *supra* note 142.

293. HUM. RTS. CAMPAIGN, *supra* note 229.

294. *See* Ezra Klein, *Unpopular Mandate: Why Do Politicians Reverse Their Positions?*, THE NEW YORKER (June 25, 2012), https://www.newyorker.com/magazine/2012/06/25/unpopular-mandate [https://perma.cc/RQ9Z-Y6SV].

295. Author's proposal.

296. Humo, *supra* note 142, ¶ 400.

297. *FAQ: Defined Contribution for Employee Health Care Benefits*, AFLAC, https://www.aflac.com/business/resources/advisories/faq-defined-contribution-for-employee-health-care-benefits.aspx (last visited Sept. 10, 2022) [https://perma.cc/QVZ4-JTRC].

298. Humo, *supra* note 142, ¶ 400.; *see* I.R.C. § 125.

The defined contribution approach not only gives employees more control over their own benefits and incentivizes employees to pursue cost-conscious health care, but also allows the employer to know in advance what its contribution will be, thus more precisely predicting and accounting for benefit costs.[299] Giving LGBTQIA+ employees more control over their health care will increase their access to both preventative and LGBTQIA+-specific care; by increasing contribution limits, they can use their HSA funds as necessary, whether for standard preventative health care, fertility treatment, gender confirmation surgery, or other necessary care.[300] Defined contribution accounts are also popular in the retirement context through qualified retirement savings plans such as Individual Retirement Arrangements (IRAs), Roth IRAs, and 401(k) plans.[301] These accounts are beneficial to both employers and employees in that contributions are tax-exempt; contributions made by an employer and interest earned are not taxed, giving the account holder more resources to spend on health care.[302] The limitations on what both employers and employees can contribute to these accounts are regulated by the IRS.[303]

Allowing for increases to HSA or FSA contribution limits can benefit both employers and employees because tax-free contributions are valued by both groups.[304] Employees can use tax-free funds to pay for health care expenditures, and employers can deduct any contributions they make from their business income.[305] Creating an incentive for employers to implement more inclusive self-insured plans will motivate employers to examine their ERISA plan provisions in order to take advantage of the incentive.[306]

C. Counterarguments

1. Religious Opposition and Conscience Rights

"Conscience rights" limit protections for LGBTQIA+ individuals by "enforc[ing] and promot[ing] religious freedom protections for providers, individuals, and other health care entities refusing to participate in certain procedures on religious grounds."[307] While around twenty-five federal conscience rights laws are in place today, the Affordable Care Act forced

299. Humo, *supra* note 142, ¶ 400.

300. Author's proposal.

301. *Types of Retirement Plans*, IRS, https://www.irs.gov/retirement-plans/plan-sponsor/types-of-retirement-plans (last visited Dec. 9, 2021) [https://perma.cc/9K5S-28VC].

302. *Health Savings Accounts and Other Tax-Favored Health Plans*, IRS 1, 3, 9 (Jan. 6, 2022), https://www.irs.gov/pub/irs-pdf/p969.pdf [https://perma.cc/7N7N-2KN7].

303. *See id.* at 5, 16.

304. *See* WIEDENBECK, *supra* note 129, at 384–85.

305. IRS, *supra* note 302, at 10.

306. *See infra* Section III.D.

307. Cardoza, *supra* note 96, at 882.

HHS to update those rules, eliminating the so-called "midnight provider refusal rule" passed during the Bush Administration; the rule, which expanded health care workers' ability to morally object against abortion at work without consequence, would have a limiting effect on reproductive health care, among other effects.[308] Many of the federal conscience rules concern a provider's right to refuse a patient access to abortion or sterilization or a pharmacist's right to refuse a patient certain medications; many of these rights are concerned with religious opposition to abortion.[309]

While the "religious freedom" argument is persistent in Affordable Care Act and employment discrimination litigation, church plans are exempt from ERISA "apparently out of concern for separation of church and state."[310] This exemption does not apply to all nonprofits because "[t]here is no substantial reason why employees covered by plans of non-profit organizations should be entitled to less protection or less disclosure than employees covered by plans of profit-making organizations."[311] Subsequently, Catholic hospitals, which are among the largest nonprofit health care providers in the United States, are not exempted from having to conform to ERISA's requirements.[312]

The solutions proposed in this Comment will affect these church plans differently: expanding Section 1557 is likely to force religious institutions to adopt nondiscriminatory policies, while expanding ERISA's nondiscrimination provisions would completely exempt said institutions.[313] It should be noted, however, that as providers, Catholic hospitals are already subject to patient nondiscrimination under Section 1557.[314] Consequently, religious based or influenced policies should not control passage of law or protections for LGBTQIA+ individuals, nor hold greater weight than the majority, even if they may infringe on religious freedoms.[315]

Title VII includes exemptions for religious employers and their ministerial employees.[316] No matter how religious employers are treated under the nondiscrimination requirements, the bottom line is that in *Bostock*

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308. *Id.* at 888; Christina Jewett, *Midnight Reg on 'Right of Conscience' for Health Workers Moves Forward*, PROPUBLICA (Dec. 16, 2008, 12:24 PM), https://www.propublica.org/article/midnight-reg-on-right-of-conscience-for-health-workers-moves-forward-1216 [https://perma.cc/Z2N5-TU43].

309. Cardoza, *supra* note 96, at 885.

310. *See, e.g.*, Franciscan All., Inc. v. Burwell, 227 F. Supp. 3d 660, 669–70 (N.D. Tex. 2016); *see* Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 682–83 (2014); WIEDENBECK, *supra* note 129, at 52.

311. S. REP. NO. 93-127, at 4864 (1973).

312. *Facts & Statistics*, CATH. HEALTH ASS'N OF THE U.S. (June 2022), https://www.chausa.org/about/about/facts-statistics[https://perma.cc/G97K-B6UZ]; 29 U.S.C. § 1002(33)(B)(i).

313. *See* WIEDENBECK, *supra* note 129, at 50; 29 U.S.C. § 1002(33)(B)(i).

314. *See* 42 U.S.C. § 18116(a).

315. *See* Elizabeth B. Deutsch, *Expanding Conscience, Shrinking Care: The Crisis in Access to Reproductive Care and the Affordable Care Act's Nondiscrimination Mandate*, 124 YALE L. J. 2470, 2483 (2015).

316. *See* Hosanna-Tabor Evangelical Lutheran Church & Sch. v. E.E.O.C., 565 U.S. 171, 188 (2012).

v. Clayton County, the Supreme Court designated sexual orientation as a protected class from discrimination under Title VII.[317]

While conscience rights are primarily discussed in regard to vaccine mandates, abortion, and reproductive health care, "[o]verly broad accommodations have a slippery-slope effect, allowing more parties connected to the healthcare industry to opt out of more services and related actions."[318] Of course, now that the Supreme Court has declared there is no constitutional right to an abortion, it remains to be seen how the conscience rights debate will proceed, but it will likely have broad impacts for the LGBTQIA+ community, as well as those providers, employers, and insurers with same-sex objections.[319] Those who experience discrimination during the course of care by a provider or insurer have the option to sue under Section 1557 of the Affordable Care Act, and "[b]ecause the definition of sex discrimination incorporated into Section 1557 includes discrimination on the basis of pregnancy, Section 1557 may be read as a counterweight to expansive protections for religious liberty at the federal and state levels."[320]

Ultimately, when analyzing employers' ability to discriminate against their own employees, those employers should first understand the results of said discrimination on employees and the potential hardships faced by same-sex couples in obtaining health care coverage when they are excluded from such opportunities.[321]

2. The Employer's Conflicting Interests

Under ERISA, the plan administrator, who is assigned information and communication responsibilities, is a fiduciary who "shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries."[322] The fiduciary must work "for the exclusive purpose of: providing benefits to participants and their beneficiaries; and defraying reasonable expenses of administering the plan . . . with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity" would have.[323] This is known as the exclusive benefit rule.[324] The rule complicates the administration of the plan: "By permitting a fiduciary to wear multiple hats in his relation to the plan, ERISA accepts the existence of pervasive conflicts of interest, while at the same time the exclusive benefit rule purportedly demands that those conflicts

317. Bostock v. Clayton Cnty., 140 S. Ct. 1731, 1744 (2020).

318. Deutsch, *supra* note 315.

319. Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228, 2242, (2022); *see also Dobbs*, 142 S. Ct. at 2303 (Thomas, J., concurring).

320. Deutsch, *supra* note 315, at 2493–94.

321. Author's opinion.

322. 29 U.S.C. § 1104(a).

323. *Id.* § 1104(a)(1).

324. *See* WIEDENBECK, *supra* note 129, at 125.

never influence decision making."[325] This means that an employer acting as a fiduciary cannot be both loyal to the employee beneficiaries of the plan and make objective decisions on behalf of the plan trust.[326] The trustee's duty to act in the interest of the employee benefit plan "reflect[s] Congress' policy of 'assuring the equitable character' of the plans."[327]

At common law, trustees make asset and property distribution decisions solely in the interest of the beneficiary; however, an ERISA "fiduciary may have financial interests adverse to beneficiaries."[328] While traditional trust law resolves this problem by ensuring someone cannot serve as a trustee when they have an inherent conflict of interest, ERISA plan trusts clearly do not do the same.[329] The tension between these "inherent or 'structural' conflicts of interest are pervasive facts of life in benefit claims decisions."[330] This becomes a problem, according to Professors Daniel Fischel and John Langbein, because the exclusive benefit rule encourages employers to make decisions that, when in the employee's best interest, actually end up discouraging employers from creating ERISA plans in the first place.[331] In *Metropolitan Life Insurance Co. v. Glenn*, the Supreme Court of the United States held courts must consider the plan administrator's "dual role" of both evaluating and paying benefit claims, which "creates a conflict of interest" that must be considered when evaluating whether the administrator properly denies benefit claims.[332] The Supreme Court has explained the tension thusly: "Employers, for example, can be ERISA fiduciaries and still take actions to the disadvantage of employee beneficiaries, when they act as employers . . . or even as plan sponsors."[333]

Because employer motivations differ from those of plan beneficiaries, without either mandates or incentives, employers will make it more difficult to justify providing more generous benefits to their employees, even when medically necessary.[334] The employer's overarching motivation to contain costs results in benefit denial, which inherently contradicts the beneficiaries' interests.[335]

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325. *Id.* at 126.
326. *See id.*
327. Cent. States, Se. & Sw. Areas Pension Fund v. Cent. Transp., Inc., 472 U.S. 559, 570 (1985).
328. Pegram v. Herdrich, 530 U.S. 211, 225 (2000); *see* O'Brien, *supra* note 35, at 484.
329. WIEDENBECK, *supra* note 129, at 126.
330. *Id.* at 165.
331. *Id.* at 126.
332. Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 108 (2008).
333. *Pegram*, 530 U.S. at 225.
334. *See id.*
335. WIEDENBECK, *supra* note 129, at 127.

3. Cost Opposition

As addressed above, self-insured ERISA plans can be risky, especially for smaller or mid-market employers without the assets of a much larger company.[336] An employer assumes the risk of paying catastrophic claims in a self-insured plan in which "premature childbirth, major trauma or conditions like AIDS and cancer can outstrip premium receipts and push a plan into substantial and extraordinary loss."[337] The inclusion of AIDS as a specific example above is telling: employer resistance to cover this condition is directly correlated with the risk assumption associated with self-insured plans.[338] In fact, a "plan sponsor that fails to estimate the impact of a generous benefits program will not be successful in reducing the cost of its benefits program."[339]

Providing equitable access to benefits and comprehensive coverage of medically necessary treatments, however, is not actually cost prohibitive for the average employer.[340] The Human Rights Campaign, which advocates for inclusive benefits, stated that employers report "an overall increase of less than one percent in total benefits costs when they implement partner benefits and marginal increases related to transgender-inclusive healthcare coverage."[341] Of course, avoiding comprehensive coverage plans makes sense for relatively smaller employers who still go the self-insured route to look for ways to cut corners.[342] However, this does not exclude said employers from enacting and administrating plans that do not have a disparate impact on any one protected group.[343]

ERISA grants a fiduciary duty to the plan administrator, usually the employer's head of human resources or some other equivalent, to prevent financial abuse and ensure plan information disclosure to participants.[344]

The purpose of stop-loss insurance is to cover large claims that the employer might not be prepared to reimburse.[345] Many employers with self-insured plans already take out stop-loss policies as a matter of course to underwrite large claims, thus offsetting costs to provide for additional claims, rendering the argument that a large claim prevents employers from expanding benefits for cost reasons moot.[346] Increasing benefit availability to same-sex domestic partners also increases available fund assets by increasing the

336. WOOTEN, *supra* note 34, at 281–82; Humo, *supra* note 142, ¶ 200.
337. Humo, *supra* note 142, ¶ 110.
338. *Id.*
339. *Id.* ¶ 330.
340. *See* HUM. RTS. CAMPAIGN, *supra* note 229.
341. *Id.*
342. *See* Humo, *supra* note 142, ¶ 100.
343. *See id.* ¶ 120.
344. WIEDENBECK, *supra* note 129, at 110.
345. WOOTEN, *supra* note 34, at 282.
346. *Id.* at 281; Humo, *supra* note 142, ¶ 230.

amount of individuals paying premiums, allowing employers to take advantage of the law of large numbers, wherein "the variation of outcomes will decrease as the number of units in the sample increases," and thus offsetting any rise in stop-loss premiums.[347]

Examining and updating ERISA plans to be more inclusive of LGBTQIA+ employees and their beneficiaries may actually save employers money in an unexpected way.[348] The Harvard Business Review reports that "a large and growing body of research on positive organizational psychology demonstrates that . . . a positive environment will lead to dramatic benefits for employers, employees, and the bottom line."[349] Health care costs at high-pressure companies are almost fifty percent higher than at other organizations.[350] Stress and lack of inclusion in the workplace directly correlate with health conditions such as cardiovascular disease, metabolic syndrome, and mortality.[351] Additionally, employee engagement negatively correlates with a high-stress culture.[352] Engagement at work means "feeling valued, secure, supported, and respected."[353] A less inclusive, less engaged workforce leads to higher absenteeism, more accidents, and more errors on the job.[354]

4. Employer Autonomy

When ERISA was enacted in 1974, preserving employer autonomy was of utmost importance.[355] ERISA provides for very specific statutory rules governing pension plans but does not create equivalent rules for welfare plans; this has been interpreted to grant employers autonomy to design their health care benefit plans.[356] The flexibility that comes with this autonomy has created problems with employer compliance and increased costs.[357] Additionally, attitudes toward health care inequality, the cost of health care, and the increasing prevalence of health care civil rights have transformed in the past several decades, with more of the public supporting ideas such as

347. *See* Humo, *supra* note 142, ¶¶ 110, 330.

348. *See* Emma Seppälä & Kim Cameron, *Proof that Positive Work Cultures are More Productive*, HARV. BUS. REV. (Dec. 1, 2015), https://hbr.org/2015/12/proof-that-positive-work-cultures-are-more-productive [https://perma.cc/5P5W-ZUZ5].

349. *Id.*

350. *Id.*

351. *Id.*

352. *Id.*

353. *Id.*

354. *Id.*

355. WIEDENBECK, *supra* note 129, at 18–19.

356. Edward A. Zelinsky, *Travelers, Reasoned Textualism, and the New Jurisprudence of ERISA Preemption*, 21 CARDOZO L. REV. 807, 812 (1999).

357. WIEDENBECK, *supra* note 129, at 18–19.

"Medicare for All" and "health care is a human right."[358] While this Comment will not go into the viability of those ideas, it is still important to recognize that attitudes regarding health care access are changing.[359] Logically, these attitudes could continue to contribute to the transformation of health care law and regulation seen in the past decade.[360]

The concept of employer autonomy has a rich history and is still very much valued in American society.[361] However, the continued pervasiveness of discrimination despite the passage of Title VII makes clear that given the choice, many employers will not implement anti-discriminatory and inclusive self-insured ERISA plans.[362] Additionally, whether employer autonomy is easily reconciled with ERISA's other goals, namely the consumer protection of injustices in providing insurance benefits as part of a compensation package, is an issue that the courts have struggled to ascertain.[363] While not a perfect solution, increased regulation will provide a path for more equitable health care insurance coverage for the majority of Americans who get their insurance from a self-insured employer ERISA plan.[364] Balancing employer autonomy against individual LGBTQIA+ rights is a valuable discussion; however, human rights ought to be considered above the capitalistic employer's rights.[365]

5. Increase in Grievance Caseload

One of the primary justifications for stripping protections from LGTBQIA+ individuals in the 2020 Rule for Section 1557 is that, in comparison to the prior version of the Rule, the 2020 Rule would result in over $100 million in savings for businesses.[366] This is because, historically, around sixty percent of grievances directed toward hospitals, insurers, and other covered entities would no longer be valid, as those claims could no longer be made.[367] However, stripping protections from a group historically discriminated against in health care and insurance settings also makes health care more expensive and health outcomes worse for those groups over

358. Margot Sanger-Katz, *The Basics of 'Medicare for All'*, N.Y. TIMES (June 9, 2021), https://www.nytimes.com/2020/02/25/upshot/medicare-for-all-basics-bernie-sanders.html. https://perma.cc/M7E4-FC59].

359. *Id.*

360. *See, e.g.*, Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18001.

361. *See, e.g.*, Lochner v. New York, 198 U.S. 45, 54 (1905).

362. *See supra* Section III.A.

363. WIEDENBECK, *supra* note 129, at 14.

364. *See* Kathryn Linehan, *Self-Insurance and the Potential Effects of Health Reform on the Small-Group Market*, Nat'l Health Pol'y F. 1, 7 (Dec. 21, 2010), https://www.ncbi.nlm.nih.gov/books/NBK558470/pdf/Bookshelf_NBK558470.pdf [https://perma.cc/A8E8-SCXB].

365. Author's opinion.

366. Keith, *supra* note 28.

367. *Id.*

time.[368] In much the same way that employers can save money by loosening their eligibility requirements, assuring that all Americans have access to equitable insurance will decrease the overall cost of health care by ensuring that more people engage in preventative and routine health care measures.[369] Additionally, employees must be able to hold their employers accountable, especially if Congress were to implement the mandates rather than the incentives discussed in Section III.C.[370] Employer discrimination suits will decrease if and when employers take proactive steps to ensure their ERISA plans provide equitable coverage for their LGBTQIA+ employees.[371]

D. Employers Have the Authority, Ability, and Obligation to Make Equitable ERISA Plans

Employers, of course, are not required to provide employee benefits.[372] However, when they make the decision to do so, employers should provide benefits equally to all employees.[373]

The irony of the situation at hand is that employers who choose to self-insure have the ability to change their ERISA plan requirements to prevent the type of discrimination described above.[374] Not only can self-insured employers decide eligibility requirements, such as whether to cover domestic partners, but they also can determine the parameters and coverage of defined benefits.[375] Employers are encouraged to carefully evaluate their risk by engaging in risk management.[376] This is when an individual manages "the planning for, organizing around and controlling of the elements of uncertainty facing an organization."[377] Traditionally, risk management encompasses four steps: (1) identify and measure the risk; (2) evaluate risk treatments; (3) select and implement risk financing mechanisms; and finally, (4) monitor the program's success and make changes as necessary.[378]

This approach to risk management puts costs before people and is at risk of being out-of-step with current medical and cultural practices, as acknowledged by Terry Humo in his treatise:

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368. *See* Hernandez & Fultz, *supra* note 67, at 178–79.
369. *See* Humo, *supra* note 142, ¶ 540.
370. Author's opinion.
371. *Id.*
372. *See* 26 U.S.C. § 4980H.
373. Author's opinion.
374. Humo, *supra* note 142, ¶ 300.
375. *Id.*
376. *See* Roberts, *supra* note 27, at 1163, 1165; Brandes, *supra* note 44, at 165.
377. Humo, *supra* note 142, ¶ 310.
378. *Id.*

> Traditionally, risk measurement for self-funding has taken the loss cost approach. . . .This simplistic approach disregards the possibility that new risk management measures may actually reduce losses in the future. Conversely, it ignores the development of new exposures . . . that are already present in society but have not yet arisen in the organization.[379]

It is only natural for an employer to wish to balance the ability to attract and retain talented employees while keeping health care costs down.[380] However, as demonstrated above, maintaining an inclusive ERISA plan has not been shown to cost more than one percent of an employer's overall benefits expenses.[381] As illustrated before, "[b]arriers to healthcare access have a significant impact on mental and physical health for LGBTQIA+ individuals" because "[s]tructural and personal forces can work to either assist in access or make it more difficult."[382]

Some of the most prevalent disparities for the LGBTQIA+ community with standard insurance policies and ERISA plan document coverage exist because many of these policies "continue to be written on the binary spectrum, and, thus, exclude nonbinary individuals."[383] One cited example involves policies on gender confirmation surgery and hormone replacement treatments; if the language used in a policy or plan document for top surgery describes the surgery as medically necessary for someone to "affirm their male identity," nonbinary patients are excluded from coverage.[384]

To create more equitable and inclusive ERISA plans, employers who self-insure should evaluate their plan documents in the following ways.[385] First, domestic partners should be eligible for coverage, with reasonable measures in place to determine said eligibility and reassure employers that this coverage will not be abused.[386] This inclusion is a simple way to provide the life partners of LGBTQIA+ employees with health care access.[387] Second, employers should review their plan documents for binary language that can have a disparate impact on employees who identify as nonbinary.[388] Third, employers should evaluate whether any of the requirements for benefit coverage could result in different requirements for same-sex individuals as

379. *Id.*
380. *See supra* Section III.C.3.
381. *See id.*
382. McCabe & Kinney, *supra* note 16, at 439.
383. *Id.* at 441.
384. *Id.*
385. Author's proposal.
386. *See* Preston, *supra* note 70, at 319, 332; HUMAN RTS. CAMPAIGN, *supra* note 229; Araujo, *supra* note 231.
387. *See* Preston, *supra* note 70, at 319, 332; HUMAN RTS. CAMPAIGN, *supra* note 229; Araujo, *supra* note 231.
388. *See* Keith, *supra* note 28; Neira & Lee, *supra* note 284.

compared to heterosexuals, especially regarding fertility coverage.[389] Fourth, employers should also evaluate whether their plan documents include language regarding transgender care and add those benefits and coverages as necessary.[390] Fifth, employers should be encouraged to train human resources and benefits personnel on diversity, equity, and inclusion, as well as their benefits administration specifically as it relates to LGBTQIA+ employees.[391] A final consideration employers should make is to update their benefits procedures to ensure that senior executives cannot access individualized employee medical records; this will encourage LGBTQIA+ employees to use their benefits without fear of retaliation, discrimination, or retribution.[392] Lastly, estate planners need to be aware of ERISA and how more informed plans could mitigate conflicts with state probate law.[393]

IV. CONCLUSION

At the core of this Comment is the belief that all should be able to access equitable health care coverage, whether through their employer or otherwise.[394] Although employers do not have a legal obligation to provide health care benefits, America has embraced the employer benefits model for providing everything from health and dental insurance to paid time off to retirement savings.[395] The importance of this decision can be described thusly:

> The World Health Organization (WHO) defines health as a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity (World Health Organization, 1948). Work acts as a defining characteristic of most of our lives and is, at the very least, a tremendous time and energy commitment . . . Supportive workplace climates, protective policies, and fair benefits help generate the sense of well-being that WHO defines as central to the *very definition of health*.[396]

There is evidence, however, that the employer-provided benefits model may be changing.[397] According to a survey taken in 2021, gig work increased

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389. *See* Trachman, *supra* note 193; NAT'L CONF. STATE LEGIS., *supra* note 242; Goidel v. Aetna, Inc., No. 1:21-cv-07619 (VSB) (S.D.N.Y. Sept. 13, 2021); Krauel v. Iowa Methodist Med. Ctr., 95 F.3d 674, 679–80 (8th Cir. 1996); Bostock v. Clayton Cnty., 140 S. Ct. 1731, 1737 (2020).

390. *See* HUMAN RTS. CAMPAIGN, *supra* note 229; HUMAN RTS. CAMPAIGN, *supra* note 251, at 6, 14-16; Preston, *supra* note 70, at 318; Kokosis & Dayan, *supra* note 254.

391. Author's opinion.

392. *See supra* Section II.A.3.

393. *See supra* Section II.E.3.

394. Author's opinion.

395. *See* WIEDENBECK, *supra* note 129, at 3–4.

396. Preston, *supra* note 70, at 319 (emphasis added).

397. Rani Molla, *More Americans are taking jobs without employer benefits like health care or paid vacation*, VOX (Sept. 3, 2021, 9:00 AM), https://www.vox.com/recode/22651953/americans-gig-independent-workers-benefits-vacation-health-care-inequality [https://perma.cc/P96G-EZ2B].

by thirty-four percent in the first six months of 2021 alone, whether that be self-employment, temporary labor, or contract work, all of which generally do not provide benefits.[398] Whether this trend is due to the novel coronavirus pandemic or is here to stay remains to be seen; however, this trend could have drastic consequences on employers, both large and small.[399] Prioritizing inclusivity in ERISA plans could have a positive impact on employee retention and satisfaction, and will only benefit employers in an increasingly competitive labor market.[400]

In the introduction of his book, *AIDS and the Sexuality of Law*, Joe Rollins argues that with the development of AIDS law at the beginning of the AIDS/HIV epidemic, the "fear, hysteria, uncertainty, and moral panics" of the time created "some very slippery and problematic legal decisions" that still impact individuals with the condition today.[401] Further, he says, "these opinions are built on a heteronormative logic that works to the detriment of people who organize their intimate lives in non-traditional ways."[402] Evidence is stark that a critical cultural shift has occurred in the last decade or so regarding equality for the LGBTQIA+ community.[403] While some larger companies in corporate America have embraced responsibility for equitable solutions in the ERISA benefits sphere, more work needs to be done to ensure that all have access to these benefits.[404]

Additionally, while they derive from the same Latin root word, the true goal of this Comment is not to promote equality but equity.[405] This distinction matters; according to Merriam-Webster, e*quity* is often related to justice or proportional fairness, and equality relates more to sameness or equal distribution.[406] In society, equal treatment does not always produce an equitable result.[407] When employers enact the policy changes to their ERISA plans outlined in this Comment, they must do so with equity in mind; American society must bridge the gap in health outcomes between those who identify as part of the LGBTQIA+ community and those who do not.[408]

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398. *Id.*
399. *See id.*
400. Author's opinion.
401. JOE NEIL ROLLINS, AIDS AND THE SEXUALITY OF LAW: IRONIC JURISPRUDENCE 11 (2004).
402. *Id.*
403. HUM. RTS. CAMPAIGN, *supra* note 229.
404. Author's opinion; *See also* HUM. RTS. CAMPAIGN, *supra* note 229.
405. '*Equity' and 'Equality': How They Differ and Overlap*, MERRIAM-WEBSTER, https://www.merriam-webster.com/words-at-play/equality-vs-equity-difference (last visited Sept. 12, 2022) [https://perma.cc/66S9-AA8T].
406. *Id.*
407. *See id.*
408. Author's opinion.