HEALTH CARE ACCESS: ACCESS AFTER HEALTH CARE REFORM

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I. INTRODUCTION

Health services in the United States are distributed to individuals through a dual system of insurers and providers.[1] Although Americans have the option to pay providers themselves and hospitals are required to provide emergency treatment,[2] in practice, "health care access" requires access to both insurance and willing providers. To expand such access, Congress and the President engaged in an effort to overhaul the health care financing and delivery systems, resulting in the passage of the Patient Protection and Affordable Care Act ("ACA") and the Health Care and Education Reconciliation Act ("HCERA").[3] In 2016, estimated out-of-pocket costs for individuals qualifying for cost-sharing reductions were markedly lower—with plan and health care usage variations—in the largest markets of the thirty-eight states which undertake marketplace enrollment via the federal website.[4] Additionally, since 2017, marketplace insurers have been able to offer consumers standard insurance plans to bring about more equal cost sharing.[5] However, health exchange premiums saw a greater increase for 2023-2024 plans versus 2022-2023 plans.[6]

Part I of this Article provides a brief overview of health care access and includes the status of access prior to the ACA, key changes introduced by the ACA, and legislative and judicial challenges to the ACA. Part II discusses provisions of particular pertinence to women and transgender men. Part III discusses the prohibition on discrimination based on gender identity and the remedies for such individuals.

II. BACKGROUND OF HEALTH CARE ACCESS IN THE UNITED STATES

To wholly appreciate the context and conditions framing the recent history of health care access in the United States, this section will discuss: (A) Americans'

1. *See* Eleanor D. Kinney, *Tapping and Resolving Consumer Concerns About Health Care*, 26 AM. J. L. & MED. 335, 344 (2000).

2. *See* Emergency Medical Treatment and Active Labor Act, 42 U.S.C.A. § 1395dd(a)(h) (West).

3. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) [hereinafter referred to collectively as ACA]; Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

4. S. R. Collins, M. Gunja, & S. Beutel, *How Will the Affordable Care Act's Cost-Sharing Reductions Affect Consumers' Out-of-Pocket Costs in 2016?*, THE COMMONWEALTH FUND (Mar. 17, 2016), https://perma.cc/3PT2-KPK8.

5. *Id.*

6. KFF, *Percent Change in Average Marketplace Premiums by Metal Tier, 2018-2024*, https://perma.cc/8VVB-MVMP.

access to health care prior to the adoption of the ACA; (B) significant transformations to the United States health care landscape advanced by the ACA, including new consumer safeguards, employer and insurance marketplace-related mandates, enhanced quality and access to health care through 2023, and social health care program reforms; and (C) specific cases challenging the legality of the ACA.

A. HEALTH CARE ACCESS LANDSCAPE PRIOR TO THE ACA

Before the ACA was written in 2008, 202.6 million Americans (67.2% of the U.S. population in 2008) were covered by private health insurance,[7] 44.8 million Americans were uninsured,[8] and as many as 25 million more were underinsured.[9] This phenomenon was largely the result of changes in insurance design that increased out-of-pocket costs[10] for both the poor and those earning above 200% of the Federal Poverty Level (FPL).[11]

Under this patchwork system prior to the ACA, there were numerous systemic problems within the individual health care coverage space. Millions of Americans did not have insurance, but even with insurance, nearly one in two people could be discriminated against due to gender or a preexisting condition.[12] Private insurers could deny anyone access to health care coverage due to their "health status," using "pre-existing" conditions like cancer or pregnancy to turn people away.[13] Women in particular faced insurance costs up to 1.5 times more than others and even then, 62% of insurance plans did not cover essential services like maternity coverage.[14] Insurers also increased insurance premiums by an average of 10% yearly for individuals who stayed in the same plan in the three years before the ACA was enacted.[15] Under the ACA, twenty million more Americans, spanning income levels, races, and ages, gained health care coverage between 2010 and 2016.[16]

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7. CARMEN DENAVAS-WALT, BERNADETTE D. PROCTOR, & JESSICA C. SMITH, U.S. CENSUS BUREAU, INCOME, POVERTY, & HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2012 CURRENT POPULATION REPORTS 67, Table C-1 (2013), https://perma.cc/Z5XX-G5DQ.

8. *Id.*

9. "Underinsured" refers to people who "have health coverage that does not adequately protect them from high medical expenses." Cathy Schoen, Sara R. Collins, Michelle M. Doty, & Jennifer L. Kriss, *How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007*, COMMONWEALTH FUND (June 10, 2008), https://perma.cc/Q7SM-4848.

10. *Id.*

11. *Id.*

12. David Simas, *Health Coverage Before the ACA, And Why All Americans Are Better Off Now*, OBAMAWHITEHOUSE.ARCHIVES.GOV (Jan. 23, 2014), https://perma.cc/333P-LC7Q.

13. *See* Nicole Rapfogel, Emily Gee, & Maura Calsyn, *10 Ways the ACA Has Improved Health Care in the Past Decade*, CTR. FOR AM. PROGRESS (Mar. 23, 2023), https://perma.cc/Q7GR-HND9.

14. *Id.*; *see also* Caroline Rosenzweig, Usha Ranji, & Alina Salganicoff, *Health and the 2016 Election: Implications for Women*, 26 WOMEN'S HEALTH ISSUES 585, 585–86 (2016).

15. Press Release, Commonwealth Fund, New Analysis of Health Insurance Premium Trends in the Individual Market Finds Average Yearly Increases of 10 Percent or More Prior to the Affordable Care Act (Jun. 5, 2014), https://perma.cc/N2LW-BNN5.

16. NAMRATA UBEROI, KENNETH FINEGOLD, & EMILY GEE, U.S. DEP'T OF HEALTH & HUM. SERVS., HEALTH INSURANCE COVERAGE AND THE AFFORDABLE CARE ACT, 2010–2016 at 2 (2016), https://perma.cc/H7G6-M5HR. *See also* Rapfogel, Gee, & Calsyn, *supra* note 13.

Protections were added for those with pre-existing conditions and to prevent discrimination by gender or health status. Additionally, the Medicaid expansion under the ACA brought Medicaid coverage to those with incomes up to 138% of the Federal Poverty Level.[17] This expansion significantly decreased the uninsured rate to only 9% in 2016.[18] While the uninsured rate rose again between 2017 and 2019, it hit an all-time low of 7.7% in early 2023.[19]

B. KEY CHANGES INTRODUCED UNDER THE ACA

The Patient Protection and Affordable Care Act ("ACA") was enacted on March 23, 2010, and established comprehensive health reforms for all Americans.[20] Subsequently, on March 30, 2010, President Obama signed the Health Care and Education Reconciliation Act of 2010 ("HCERA") as an amendment to the ACA.[21] HCERA made a number of health-related financing and revenue adjustments to the Congressional budget levels for fiscal years 2011 through 2020 and modified higher education assistance provisions.[22] The ACA established online health insurance marketplaces, which allow consumers to shop for and compare government-regulated health insurance plans.[23] States have the option of establishing their own marketplaces, partnering with the federal government in designing the exchange, or operating under the federal marketplace.[24]

With the objective of increasing access to care and decreasing costs of health insurance, the ACA mandates that most Americans obtain health insurance.[25] To that end, the ACA also establishes private insurance markets by way of state-based health exchanges or health insurance marketplaces, which allow consumers to comparison-shop and enable some people to receive federal subsidies.[26] In

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17. *Id.*

18. *Id.*; *see also* U.S. DEP'T OF HEALTH & HUM. SERVS., ASSISTANT SEC'Y FOR PLAN. & EVALUATION, HP-2023-20, NATIONAL UNINSURED RATE REACHES AN ALL-TIME LOW IN EARLY 2023 AFTER THE CLOSE OF THE ACA OPEN ENROLLMENT PERIOD 2–3 (2023), https://perma.cc/BF2J-2LVY.

19. U.S. DEP'T OF HEALTH & HUM. SERVS., *supra* note 18, at 2–3.

20. *See generally* ACA, Pub. L. No. 111-148, 124 Stat. 119 (2010); Pub. L. No. 111-152, 124 Stat. 1029 (2010).

21. Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) [hereinafter "HCERA"].

22. The HCERA included the Student Aid and Fiscal Responsibility Act of 2009 ("SAFRA") attached as a rider. Although the SAFRA is included in Title II of the HCERA, the SAFRA provisions are mostly outside the scope of this Article. *See id.* Among other educational reforms, however, the SAFRA altered the historic role of banks and lending institutions as "middlemen" in federally guaranteed student loans and instead requires the Department of Education to directly administer federal student loans. *See id.* Title II.

23. *See generally A One-Page Guide to the Health Insurance Marketplace*, HEALTHCARE.GOV, https://perma.cc/4UYL-FKQL; *see also* Alex Nussbaum, *Health Insurance Exchanges*, BLOOMBERG (Mar. 4, 2015), https://perma.cc/5S4D-FJE5; HCERA, Pub. L. No. 111-152, 124 Stat. 1029, Title II (2010).

24. Louise Norris, *Health Insurance Marketplaces By State*, HEALTHINSURANCE.ORG (Aug. 24, 2022), https://perma.cc/CF2N-QDKR.

25. Alvin Tran, *See FAQ: How Will the Individual Mandate Work*? KFF HEALTH NEWS (Sept. 3, 2013), https://perma.cc/8GSY-CRPF.

26. *See* discussion *infra* Part I.B.2.

addition, the ACA expands the eligibility requirements for Medicaid by reducing the growth of Medicare's payment rates for most services and bringing fundamental changes to Part D of Medicare by closing the "donut hole" by 2020.[27] The most substantial ACA reform went into effect in 2014, when the state-based insurance marketplaces became operational and the mandate for most Americans to obtain health insurance took effect.[28]

1. New Consumer Protections Effective September 23, 2010

Certain provisions of the ACA, known as the "Patient's Bill of Rights," were implemented rapidly to prevent insurance companies from limiting access to health care.[29] These provisions (1) prohibit insurance companies from denying coverage to children and adults with pre-existing conditions,[30] (2) bar insurers from rescinding coverage based on an unintentional mistake unless the "mistake" is revealed as fraud or an intentional misrepresentation of material fact,[31] (3) prevent insurers from setting lifetime limits on how much can be paid to individual policyholders, and (4) restrict annual limits on coverage for all plans starting on or after September 23, 2010.[32]

Most health plans must now cover a certain subset of preventative services, including recommended screenings, vaccinations, and counseling, and may not charge a fee for such services.[33] Further, the ACA now secures the right of

27. The "donut hole" refers to a coverage gap in Medicare's drug benefits. Once a Medicare beneficiary's out-of-pocket drug costs exceed a certain amount, they must pay more for prescription drugs up to a certain limit. *See Closing the Coverage Gap—Medicare Prescription Drugs are Becoming More Affordable*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Jan. 2015), https://perma.cc/H7VP-RQ2Y; *see also infra* Part I.B.4.

28. ACA § 1311(b)(1) ("Each State shall, no later than January 1, 2014, establish an American Health Benefit Exchange . . . .").

29. *See generally The Obama Administration's New 'Patient's Bill of Rights,'* KFF HEALTH NEWS (June 22, 2010), https://perma.cc/8WMH-YEBQ (setting forth the provisions pertaining to the Patient's Bill of Rights).

30. *Id.*

31. *See* 42 U.S.C.A. § 300gg-12 (West, Westlaw through Pub. L. No.118-13).

32. These provisions apply to all health care plans, even those "grandfathered" in under Section 1251 of the ACA. A grandfathered policy is a plan that was bought for an individual or a family, which was not received through an employer, and was issued on or before March 23, 2010. Grandfathered plans are permitted to make routine changes without losing grandfather status. However, plans that choose to significantly cut benefits or increase out-of-pocket spending for consumers will lose their grandfather status and policy-holders will gain any new applicable consumer protections. Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets, 45 C.F.R. § 147 (West, Westlaw through Sept. 15, 2023). There has been significant confusion over which plans qualify as grandfathered and which may lose their grandfathered status if they cannot comply with ACA mandates. *See*, *e.g.*, Bob Semro, *Grandfathered Plans, the ACA and the "If You Like Your Plan . . ." Pledge*, HUFFINGTON POST (Nov. 16, 2013), https://perma.cc/W36U-Z856.

33. *Health benefits & coverage*, HEALTHCARE.GOV, https://perma.cc/ZAX6-HYLN. This preventive services provision excludes grandfathered plans. *See* United Benefit Advisors, *FAQs About Grandfathered Health Plans*, SHRM (Aug. 26, 2013), https://perma.cc/64UE-66ZM. The ACA also established the National Prevention, Health Promotion, and Public Health Council to coordinate federal prevention and wellness activities and develop a national strategy to improve the nation's health. *See* JENNIFER HABERKORN,

policyholders to appeal or request that an insurance company reconsider its decision to deny a payment for service or treatment.[34] The plan must explain the basis for any denials on appeal and the procedure for obtaining an independent review of that decision.[35]

Other changes implemented in 2010 included: (1) a 10% Medicare bonus through January 1, 2016 for physicians and surgeons who practice in geographic areas lacking primary care;[36] (2) limitations on contributions to individual flexible savings accounts that set aside tax-free money for health costs;[37] (3) a tax increase on spending money from health savings accounts on ineligible or non-medical expenses;[38] and (4) a 0.9% increase in the Medicare tax rate (to 2.35%) on family earnings over $250,000 and individual earnings over $200,000.[39]

2. The Insurance Marketplace and Employer-Related Mandates from 2014 through 2017

As of January 1, 2014, with some exceptions,[40] most Americans were required to have health insurance or pay a tax penalty;[41] however, Congress reduced the penalty to zero dollars in 2017.[42] In 2015, large employers that failed to offer coverage as required paid penalties for non-compliance.[43]

Small businesses with fewer than 50 employees and individuals who must purchase insurance on their own may shop for health insurance at competitive rates

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HEALTH AFFAIRS, HEALTH POLICY BRIEF: THE PREVENTION AND PUBLIC HEALTH FUND (Feb. 23, 2012), https://perma.cc/3XC4-R3WC. The Prevention and Public Health Fund was established for prevention and public health programs, including prevention research, health screenings, and immunization programs. *See id.* In addition, the ACA established a grant program to support prevention and wellness services that reduce chronic disease and address health disparities. *See also Preventive Care Benefits for Adults*, HEALTHCARE.GOV, https://perma.cc/YE6H-EZQN (noting that these services include, among others, certain immunizations, blood pressure screenings, certain cancer screenings, HIV screenings, diet counseling, STI counseling, and tobacco use screening).

34. 42 U.S.C.A. § 300gg-19(a) (West, Westlaw through Pub. L. No. 118-13).

35. 29 C.F.R. § 2560.503-1 (2023); *see* 42 U.S.C.A. § 300gg-19(b) (West, Westlaw through Sept. 6, 2023).

36. 42 U.S.C. § 1395*l* (2022); Robert F. Rich, Eric Cheung, & Robert Lurvey, *The Patient Protection and Affordable Care Act of 2010: Implementation Challenges in the Context of Federalism*, 16 J. HEALTH CARE L. & POL'Y 77, 83 (2013).

37. 26 U.S.C.A. § 125(i) (West, Westlaw through Pub. L. No.118-13); *see also* Laxmaiah Manchikanti, David Caraway, Allan T. Parr, Bert Fellows, & Joshua A. Hirsch, *Patient Protection and Affordable Care Act of 2010: Reforming the Health Care Reform for the New Decade*, 14 PAIN PHYSICIAN E35, E39 (2011).

38. Under the ACA, individuals can receive tax-preferred treatment of money placed into a health savings account and saved for medical expenses. This option is limited to individuals covered by high deductible health plans. 26 U.S.C.A. § 223(f) (West, Westlaw through Pub. L. No. 118-19). Individuals are permitted to withdraw money from the account for non-medical expenses, but are taxed on the amount used. *Id.*

39. *Id.* § 1411 (West, Westlaw through Pub. L. No. 118-19).

40. *Id.* § 5000A(e) (West, Westlaw through Pub. L. No. 118-19).

41. *Id.* § 5000A(b)(1) (West, Westlaw through Pub. L. No. 118-19).

42. *Id.* § 5000A(c)(2)(B) (West, Westlaw through Pub. L. No. 118-19).

43. *Id.* § 4980H(a) (West, Westlaw through Pub. L. No. 118-19).

through their state's American Health Benefit Exchange and Small Business Health Options Program ("SHOP").[44] Additionally, a Consumer Operated and Oriented Plan ("CO-OP") program was instituted to create non-profit health plans wherein all profits from the CO-OP plans are put toward lowering premiums and improving benefits or the quality of health care delivered to members.[45] As of 2023, seventeen states and the District of Columbia conduct both an individual insurance marketplace and state-run SHOP.[46] Consumers can compare health insurance plans in their state through state-based marketplaces or exchanges and purchase the plan that best fits their needs.[47] All plans are required to provide at least essential health benefits.[48]

Low-income individuals and families with incomes up to 400% of the FPL qualify to receive cost-sharing subsidies[49] and premium tax credits,[50] which are calculated on a sliding scale,[51] to offset the out-of-pocket costs owed on insurance plans purchased through the exchanges. The tax credits are also refundable, such that if the amount of credit is more than the amount of a consumer's tax liability, the consumer will receive the difference as a refund.[52] If an individual or family owes no tax, they are eligible to receive the full amount of credit as a refund[53] or have it paid in advance to an insurance company to help cover the cost of premiums.[54]

3. Improving Quality, Lowering Costs, and Expanding Access to Quality Care Through 2024

In addition to the consumer protections implemented in 2010 and 2014, several other important provisions took effect by 2020. First, the ACA improved the affordability of health care by providing tax credits to small businesses that provide insurance coverage to employees.[55] The full credit is available to eligible businesses with fewer than ten employees, where the business's annual wages average less than $27,000 per full time employee.[56] Businesses with fewer than 25

44. *See* 42 U.S.C.A. § 18031 (West, Westlaw through Pub. L. No.118-13).
45. *See id.* § 18042.
46. *Health Insurance Marketplaces By State*, HEALTHINSURANCE.ORG, https://perma.cc/FM8S-3Z6L.
47. *See* 42 U.S.C.A. § 18031(c)(5) (West, Westlaw through Pub. L. No. 118-19).
48. *See id.* § 18022(b); *see also infra* Part II.D.
49. These subsidies reduce a person or family's out-of-pocket cost when they use health care services. *See Explaining Health Care Reform: Questions About Health Insurance Subsidies*, KFF (Oct. 27, 2022), https://perma.cc/5FXY-SJKP.
50. The premium tax credit reduces the monthly payments owed for plans purchased in the marketplace. *Id.*
51. *Id.*
52. *See Questions and Answers on the Premium Tax Credit*, IRS (Feb. 2022), https://perma.cc/7XKU-S5AR.
53. *Id.*
54. *Id.*
55. *See* 26 U.S.C.A. § 45R(a) (West, Westlaw through Pub. L. No. 118-13).
56. *See The Small Business Health Care Tax Credit*, HEALTHCARE.GOV., https://perma.cc/2J5Z-J3NU.

full-time employees and average annual wages of up to $56,000 are eligible for a smaller tax credit.[57] As of 2023, eligible employers who purchase coverage through the exchange are eligible to receive a tax credit for two years, worth up to 50% of their contribution, and tax-exempt small businesses meeting the above requirements are eligible for tax credits of up to 35% of their contribution.[58]

Moreover, to help prevent cost hikes, the ACA requires insurance companies to justify premium increases and provides $250 million in new grants to states to support efforts to review premium increases.[59] Insurance companies with unjustified premium increases may face exclusion from participation in the state's health insurance exchange upon recommendation from a state's Commissioner of Insurance.[60] Additionally, the ACA created a Community Health Center Fund to increase funding for community health centers, which has enabled them to serve an estimated twenty-eight million patients annually.[61] Further, the Department of Health and Human Services ("HHS") has created an internal portal where consumers can compare insurance options in any state and tailor coverage to their needs.[62] The law accelerates HHS's adoption of uniform standards and operating rules for electronic transactions between providers and health plans governed under the Health Insurance Portability and Accountability Act ("HIPAA").

Finally, the ACA enhances efforts to prevent and detect fraud in Medicare, Medicaid, the Children's Health Insurance Program ("CHIP"),[63] and private insurance. The Act provides funding to hire new officials to combat fraud and requires data from Medicaid, the Veterans Administration, the Department of Defense, Social Security Insurance, and the Indian Health Service to be housed in a central location to better identify waste.[64] The ACA also increases screening

57. *Id.*

58. *See Small Business Health Care Tax Credit and the SHOP Marketplace*, IRS (June 5, 2023), https://perma.cc/XME7-8T5F.

59. Under the ACA, states are responsible for reviewing insurance rates and determining whether they are reasonable. Starting in 2010 and ending in 2014, states could apply for a grant from the Department of Health and Human Services. The grants were to be used for monitoring premium rate increases within the state. *See New Resources to Help States Crack Down on Unreasonable Health Insurance Premium Hikes and to Enhance Health Pricing Transparency*, CTRS. FOR MEDICARE & MEDICAID SERVS., (Sept. 6, 2023), https://perma.cc/UHD4-VYK6.

60. *See* 42 U.S.C.A. § 300gg-94(b)(1)(B) (West, Westlaw through Pub. L. No. 118-13).

61. *See* SARA ROSENBAUM, JESSICA SHARAC, PETER SHIN, & MARIA VELASQUEZ, COMMUNITY HEALTH CENTERS TEN YEARS AFTER THE AFFORDABLE CARE ACT: A DECADE OF PROGRESS AND THE CHALLENGES AHEAD, POLICY ISSUE BRIEF #61 at 3 (Mar. 2020), https://perma.cc/2QQD-JW7G.

62. *See* 42 U.S.C.A. § 18031(c)(5) (West, Westlaw through Pub. L. No. 118-13). The HHS website that allows consumers to compare insurance coverage options is available at https://perma.cc/Z654-SN8E.

63. "CHIP provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid. In some states, CHIP covers pregnant women." *See The Children's Health Insurance Program (CHIP)*, HEALTHCARE.GOV, https://perma.cc/D65S-WRTU.

64. "To integrate claims information, and improve its ability to detect fraud, waste, and abuse in these programs, CMS initiated two information technology system programs: the Integrated Data Repository (IDR) and One Program Integrity (One PI) . . . IDR is intended to be the central repository of

procedures, oversight periods, and compliance programs.[65]

4. Reforms to Medicare, Medicaid, and CHIP

Medicare has been expanded under the ACA in order to improve care quality, reduce costs, and expand access to health care services.[66] Beginning in April 2010, states were given the option to expand state Medicaid coverage using federal funding.[67] The expanded coverage would extend nationally to all individuals under sixty-five years old, including children, pregnant women, and individuals without dependent children who have incomes up to 133% of the FPL.[68] The expansion was set to become mandatory in all states on January 1, 2014.[69] However, pursuant to the Supreme Court's ruling in *National Federation of Independent Business v. Sebelius*,[70] the expansion was deemed optional.[71] Eligible adults receive, at a minimum, essential health benefits.[72] States that opt in to expand their Medicaid programs received 100% federal funding from 2014 through 2016 to support expanded coverage, and support was tapered down to 90% federal funding in 2020 and beyond.[73] As of October 28, 2023, forty states and Washington D.C. have adopted the Medicaid expansion, and ten states have elected not to do so at this time.[74] In the ten states that did not opt-in to the expansion, significant eligibility restrictions exist, preventing many parents and childless adults from obtaining coverage.[75] Many of these individuals experience a

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Medicare and Medicaid data needed to help CMS and states' program[s] . . . prevent and detect improper payments." *See* VALERIE C. MELVIN, U.S. GOV'T ACCOUNTABILITY OFFICE, FRAUD DETECTION SYSTEMS: CENTERS FOR MEDICARE AND MEDICAID SERVICES NEEDS TO EXPAND EFFORTS TO SUPPORT PROGRAM INTEGRITY INITIATIVES (2011), perma.cc/7E5Z-RV6M; *see also* 42 U.S.C.A. § 1320A-7K (West, Westlaw through Pub. L. No. 118-13).

65. *See* 42 U.S.C.A. § 1395cc (West, Westlaw through Pub. L. No. 118-13).

66. *See, e.g.*, 42 U.S.C.A. § 1395 (West, Westlaw through Pub. L. No. 118-13); HARVEY L. MCCORMICK, MEDICARE AND MEDICAID CLAIMS AND PROC. § 13A:130 (4th ed. 2023) (protecting and improving guaranteed Medicare benefits); *id.* § 13A:131 (providing for Medicare coverage of an annual wellness visit); *id.* § 13A:132 (removing barriers to preventative services for Medicare beneficiaries).

67. *States Getting a Jump Start on Health Reform's Medicaid Expansion*, KFF (Apr. 2, 2012), https://perma.cc/33ZT-NPME.

68. *See Medicaid Expansion to the New Adult Group*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N (MACPAC), https://perma.cc/HZT8-R4Y3. The FPL was $11,170 for individuals in 2012. *Computations for the 2012 Annual Update of the HHS Poverty Guidelines for the 48 Contiguous States and the District of Columbia*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://perma.cc/J2G6-QHD9.

69. *See Medicaid Eligibility for Adults as of January 1, 2014*, KFF (Oct. 2013), https://perma.cc/JR2R-L7MP.

70. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012); *see infra* Part I.C for a discussion of the case.

71. *Id.*

72. *Information on Essential Health Benefits (EHB) Benchmark Plans*, U.S. DEP'T OF HEALTH & HUM. SERVS.

(Sept. 7, 2023), https://perma.cc/42KA-8Y5U.

73. Inna Rubin, Jesse Cross-Call, & Gideon Lukens, *Medicaid Expansion: Frequently Asked Questions*, CTR. ON BUDGET & POL'Y PRIORITIES (June 16, 2021), https://perma.cc/MS2U-NVKK.

74. *Status of State Action on the Medicaid Expansion Decision*, KFF (May 8, 2023), https://perma.cc/P4GA-GEF2.

75. Rachel Garfield, Kendal Orgera, & Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, KFF (Jan. 2020), https://perma.cc/44GK-CJVA.

"coverage gap" as their incomes surpass the level for Medicaid eligibility but are "below . . . the lower limit for Marketplace premium tax credits."[76]

Further, as a result of the ACA, states have new options for offering home- and community-based services, including extending full Medicaid benefits to individuals receiving such services under a state plan.[77] The Community First Choice Option allows states to offer long-term home support and community-based care rather than institutional care to individuals with disabilities through Medicaid.[78] The ACA also includes several improvements to Medicare including the Community-Based Care Transitions Program, which helps high-risk patients avoid unnecessary hospital readmissions by coordinating care and connecting patients to services in their communities.[79] Cost sharing[80] has been eliminated for some preventive services covered by Medicare and Medicaid.[81]

The ACA issues immediate remedies for the Medicare Part D coverage gap.[82] Most Medicare drug plans have a coverage gap that places a temporary limit on the amount of prescription drug coverage that the Centers for Medicare & Medicaid Services ("CMS") will provide. This coverage gap is informally known as the "donut hole" and applies to a beneficiary's out-of-pocket drug costs.[83] As of 2023, a Medicare beneficiary will enter into the coverage gap after spending $4,660 under their drug plan and will then have to pay for 25% of the cost for the plan's covered brand-name prescription drugs.[84] The coverage limit will increase to $5,030 in 2024.[85] To "fill" the donut hole, beneficiaries who fell within the coverage gap in 2010 received a one-time, tax-free $250 rebate from HHS to help pay for prescriptions.[86] Starting in 2011, the ACA began closing the donut hole by providing a 50% discount on the cost of brand-name drugs to seniors who

76. *Id.* at 1. An estimated two million "poor uninsured adults" fall into the "coverage gap." *See id.* at 2.

77. *See* 42 U.S.C. § 1396(n)(k).

78. *See id.*

79. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3026, 124 Stat. 119, 413–15 (2010).

80. "Cost sharing" refers to the amount that an individual must pay out of pocket for a medical service or item that is covered by his or her health insurance plan. *Cost Sharing*, *Glossary*, HEALTHCARE.GOV, https://perma.cc/S87H-76DY.

81. *See* 42 U.S.C. § 1396o.

82. Medicare Part D is the prescription drug program for Medicare beneficiaries. For most people, the program is voluntary. *See How to Get Prescription Drug Coverage*, MEDICARE.GOV, https://perma.cc/5JKQ-D59G. Individuals who opt to enroll in Part D can get drug coverage either through a "stand-alone" plan, which offers only drug coverage, or a Medicare Advantage Plan, which covers both prescription drugs and medical services. *Id.*

83. *See Costs in the Coverage Gap,* MEDICARE.GOV, https://perma.cc/N86Z-PSCP.

84. *Id.*

85. *Id.*

86. H. COMMS. ON WAYS & MEANS, ENERGY & COMMERCE & EDUC. & LABOR, 111TH CONG., HEALTH INSURANCE REFORM AT A GLANCE: MEDICARE PART D: HEALTH REFORM LEGISLATION CLOSES THE "DONUT HOLE" AND IMPROVES THE MEDICARE PART D DRUG PROGRAM (2010) [hereinafter HEALTH INSURANCE REFORM AT A GLANCE], https://perma.cc/L26F-AK69; *see also* 42 U.S.C. § 1395w-102(c).

reach the coverage gap.[87] The ACA continues to increase the threshold amount that would place a beneficiary in the coverage gap each year and achieved maximum coverage in 2020, with the beneficiary only having to pay 25% of their prescription drug costs.[88] It is estimated that the average senior who reaches the donut hole saved over $700 in 2011 and $3,000 by 2020.[89]

The ACA also sought to improve the quality of Medicare by establishing a hospital Value-Based Purchasing program ("VBP") in traditional Medicare.[90] This program rewards hospitals with incentive payments if they meet specific performance standards.[91] HHS promulgates the performance standards and devises a method for assessing the performance of each hospital.[92] Hospital performance is reported publicly, and quality measures include information relating to common and high-cost conditions.[93] If HHS determines the hospital has met the performance standards, it is eligible for incentive payments.[94]

Finally, the ACA expanded CHIP. States are required to maintain current income eligibility levels for children in both Medicaid and CHIP until 2029 and extended funding for CHIP through 2015.[95] Beginning in 2015, states could receive a 23% increase in matching CHIP funds from the federal government, up to a cap of 100%.[96] Eligible children otherwise unable to enroll in CHIP due to enrollment caps[97] are eligible for tax credits in the state-based exchanges.[98]

5. Changes to Medicaid's Home and Community Based Services ("HCBS") Program

The ACA took measures to pay greater attention to community-based health services in what some have referenced as "one of the most lasting and important legacies of the present health reform era."[99] The expansion of Home and Community-Based Services ("HCBS") is indicative of this effort, as the expansion serves to increase consumer choice in health care delivery by allowing individuals who would

87. HEALTH INSURANCE REFORM AT A GLANCE, *supra* note 86.

88. *See* 42 U.S.C. § 1395w-102(b)(2)(A); *see also id.* § 1395w-102(b)(4)(B)(i)(II)–(VIII); *id.* § 1395w-102(b)(7).

89. *See* HEALTH INSURANCE REFORM AT A GLANCE, *supra* note 86.

90. 42 U.S.C. § 1395ww(o).

91. *Id.* § 1395ww(o)(1)(A).

92. *Id.* § 1395ww(o)(5)(A).

93. *Id.* § 1395ww(o)(2)(B).

94. *See id.* § 1395ww(o)(6)(A).

95. *See id.* § 1397ee.

96. *Id.* § 1397ee(b).

97. In an effort to contain the costs of CHIP, some states have established a limited number of slots for eligible children. *See* Cynthia Pernice & David Bergman, *State Experience with Enrollment Caps in Separate SCHIP Programs*, NAT'L ACAD. FOR STATE HEALTH POL'Y (2004), https://perma.cc/MK4J-PGPQ. Once the slots are filled, no additional children can enter the program until other children unenroll from the program. *See id.*

98. *See* 42 U.S.C.A. § 1396w-3 (West, Westlaw through Pub. L. No. 118-19).

99. Marshall B. Kapp, *Home and Community-Based Long Term Services and Supports: Health Reform's Most Enduring Legacy?*, 8 ST. LOUIS U.J. HEALTH L. & POL'Y 9, 10 (2014).

otherwise be required to seek care in an institutional setting to receive medical care and assistance in the comfort of their own homes.[100] In January 2014, the Final Rule governing the administration of HCBS service in states was promulgated, providing for and defining new flexibilities in optional state plan benefits to furnish HCBS program.[101]

Although Medicaid programs have been required to provide home care services since 1970, that requirement was limited to individuals entitled to nursing facility care.[102] States face significant obstacles when implementing programs to provide more home- and community-based options.[103] The ACA's additional support for states attempting to implement HCBS programs helped address challenges to implementation. SBIP supplied federal-match funding through 2015 to states that adopted strategies and delivery systems aimed at increasing the proportion of Medicaid funding devoted to HCBS.[104] In 2023, there are thirteen states that remain participants in the program.[105] Participating states are required to collect data on quality measures and consumer outcomes and are prohibited from utilizing the appropriated funds for other Medicaid initiatives.[106] The ACA also provides funding through Money Follows the Person ("MFP")[107] to assist states in identifying individuals who receive care in an institution but want to transition to community-based care. Previously, individuals were required to have received care in an institutional setting for 180 days before qualifying for the MFP funding match; the ACA reduced the requirement to ninety days.[108]

Aside from the financial incentives used to embolden state initiatives, the ACA also attempts to facilitate the transition to HCBS through modifications to the

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100. *See* U.S. DEP'T OF HEALTH & HUM. SERVS., UNDERSTANDING MEDICAID HOME AND COMMUNITY SERVICES: A PRIMER (2010), https://perma.cc/M3ZQ-CTZJ (noting that states are now enabling more individuals to receive care in their communities as an alternative to institutionalization).

101. *See* Medicaid Program, State Plan Home and Community-Based Services, 5-Year Period for Waivers, 79 Fed. Reg. 2948 (Jan. 16, 2014) (codified at 42 C.F.R. §§ 430 *et seq*.).

102. *See* UNDERSTANDING MEDICAID HOME AND COMMUNITY SERVICES: A PRIMER, *supra* note 100, at 21; *see also* 42 U.S.C.A. §§ 1396a(10)(D) (West, Westlaw through Pub. L. No. 118-19) ("A state plan for medical assistance must . . . provide . . . for the inclusion of home health services for any individual who, under the State plan, is entitled to nursing facility services.").

103. Among these obstacles was pushback from state legislatures, as a result of fear that increased funds for HCBS would result in an increase in the aggregate costs of providing healthcare for Medicaid beneficiaries. *See* Gretchen Engquist, Cyndy Johnson, Alice Lind, & Lindsay P. Barnette, *Medicaid-Funded Long Term Care: Toward More Home- and Community-Based Options*, CTR. FOR HEALTH CARE STRATEGIES (May 2010), https://perma.cc/7GYM-FB55.

104. For an explanation of this initiative, *see* Diane Justice, *Implementing the Affordable Care Act: New Options for Medicaid Home and Community Based Services*, NAT'L ACAD. FOR STATE HEALTH POL'Y INC. (2010), https://perma.cc/TLJ2-AXVU ("To qualify, a state must submit an application to the Secretary of DHHS, presenting a proposed budget that details the state's plans to expand Medicaid funding for non-institutional services and supports.").

105. *Balancing Incentive Program*, MEDICAID.GOV, https://perma.cc/2MYD-NW5B.

106. *See* Justice, *supra* note 104, at 3.

107. The MFP program was originally created by the Deficit Reduction Act of 2005, and was intended to come to an end in 2011. *Id.* at 4. However, the ACA extended the program until 2016. *Id.*; *see also* Kapp, *supra* note 99, at 24.

108. Justice, *supra* note 104, at 4.

existing Medicaid waivers, the expansion of the 1915(i) State Plan HCBS option, and the addition of the 1915(k) Community First Choice plan. In 1981, Congress enacted Section 1915(c) of the Social Security Act ("SSA") as part of the Omnibus Reconciliation Act ("OBRA"), prior to which comprehensive long-term care services were limited to institutional care settings.[109] In order to receive care under a Section 1915(c) waiver, the individual beneficiary must require an institutional level of care.[110] Using the Section 1915(c) waiver, states are permitted to request the option of providing HCBS care as an alternative to institutionalized care.[111] Such waivers were initially used to provide care to elderly people with disabilities and people with developmental disabilities, but have since expanded to reach people with a variety of conditions.[112] Moreover, states were given the latitude to use the waivers to target specific populations, such as individuals with traumatic brain injuries or AIDS.[113] By doing so, the states circumvented the general Medicaid requirements that all services be made available to eligible groups across the state ("statewideness") and that all services be comparable in amount, duration, or scope ("comparability").[114]

Section 1915(i) of the SSA, known as the State Plan HCBS option, permits states to offer a broad range of HCBS programs under the regular state Medicaid plan, instead of a waiver.[115] Unlike the eligibility requirements of the section 1915(c) waiver, individuals are eligible to receive care under section 1915(i) regardless of whether they require an institutional level of care.[116] Rather, the individual must be in an eligibility group included under the state plan's coverage and meet the financial and non-financial criteria for the particular eligibility

109. *See generally* Valerie J. Bogart & David C. Silva, *Medicaid Home and Community Based Waiver Services in New York State*, SELFHELP CMTY. SERVS., INC (2010), https://perma.cc/CE5G-28LK.

110. *See* Justice, *supra* note 104, at 5.

111. In order to implement HCBS programs under the 1915(c) waiver, states are required to submit a waiver application to CMS; the application must include assurances from the state that safeguards are in place to protect the well-being of beneficiaries who will receive care under the waiver program and a proposal as to which medical services will be provided under the waiver. 42 U.S.C.A. § 1396n(i) (West, Westlaw through Pub. L. No. 118-19).

112. Allen J. LeBlanc, M. Christine Tonner, & Charlene Harrington, *Medicaid 1915(c) Home and Community-Based Services Waivers Across the States*, 22 HEALTH CARE FIN. REV. 159 (2000), https://perma.cc/679T-N6VS.

113. *See* Justice, *supra* note 104, at 4 ("For example, 22 states have waivers for persons with brain injury; 18 target medically frail children, 16 have waivers that provide a distinct benefit package to persons with AIDS, and others have waivers targeted to persons with specific types of developmental disabilities.").

114. *Waivers*, MACPAC, https://perma.cc/XQ6L-7NMM.

115. *See* Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers, 79 Fed. Reg. 2948 (Jan. 16, 2014) (codified at 42 C.F.R. §§ 430 *et seq*.).

116. *See id*. at 2950.

group.[117] Under the Section 1915(i) option, states can use HCBS funding to assist beneficiaries transitioning from institutionalized care to HCBS care; however, the funds may not be directed toward funding care in nursing homes, mental institutions, hospitals or for "any other locations that have the qualities of an institutional setting."[118]

Pursuant to Section 1915(k) of the SSA, the ACA also authorizes states to include a Community First Choice (CFC) Option in their state Medicaid plan.[119] Under the CFC Option, states are permitted to use federal Medicaid funding to provide beneficiaries with community-based attendant services and will be provided with an increased FMAP rate of six percentage points.[120] In order to qualify as an eligible beneficiary under Section 1915(k), an individual must first be eligible for medical assistance under the state plan and, second, either be a member of an eligibility group that covers nursing home care or have an income no higher than 150% of the FPL.[121]

C. CHALLENGES TO THE ACA'S CONSTITUTIONALITY—CONGRESSIONAL AUTHORITY

1. *National Federation of Independent Business v. Sebelius*[122]

Upon enactment of the ACA, thirteen states challenged the legality of the new reform bill in the United States District Court for the Northern District of Florida.[123] An additional thirteen states joined the lawsuit.[124] These twenty-six states argued that the ACA's individual mandate provisions[125] violated the Commerce Clause of the Constitution. Judge Roger Vinson denied the federal government's motion to dismiss[126] and held on summary judgment that the individual mandate violated the Commerce Clause, noting that the federal government cannot regulate inactivity under the Commerce Clause and thus, the refusal to purchase health insurance is not an economic activity that can be properly regulated under the Commerce Clause.[127]

Judge Vinson held that the ACA in its entirety was unconstitutional as it lacked a severability clause.[128] Rather than issue an injunction to stop enforcement of the

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117. *Id.* at 2951.

118. *Id.*

119. *See* Kapp, *supra* note 99, at 23.

120. KIRSTEN J. COLELLO, CONG. RSCH. SERV., R43328, MEDICAID COVERAGE OF LONG-TERM SERVICES AND SUPPORTS 18 (2022).

121. *Id.* at 18–19.

122. 567 U.S. 519 (2012).

123. Florida, Alabama, Colorado, Idaho, Louisiana, Michigan, Nebraska, Pennsylvania, South Carolina, South Dakota, Texas, Utah, and Washington. *See 14 States Sue To Block Health Care Law*, CNN (Mar. 23, 2010), https://perma.cc/CK8S-TJ5K.

124. Alaska, Arizona, Georgia, Indiana, Iowa, Kansas, Maine, Mississippi, Nebraska, North Dakota, Ohio, Wisconsin, and Wyoming. *See* Florida *ex rel.* Bondi v. U.S. Dep't of Health & Hum. Servs., 780 F. Supp. 2d 1256, 1294 (N.D. Fla. 2011), *rev'd in part,* Florida *ex rel.* Att'y Gen. v. U.S. Dep't of Health & Hum. Servs., 648 F.3d 1235 (11th Cir. 2011).

125. The "individual mandate" is the portion of the law that requires that all individuals in the United States have health insurance. *See* 567 U.S. 519.

126. *See* Florida *ex rel.* McCollum v. Dep't of Health & Hum. Servs., 716 F. Supp. 2d 1120 (N.D. Fla. 2010).

127. *Bondi*, 780 F. Supp. 2d at 1294.

128. *See id.* at 1301.

ACA, Judge Vinson cited a "long-standing presumption" that the federal government would respect the court's decision.[129] On August 12, 2011, a panel of the Eleventh Circuit, in a two-to-one decision, upheld the district court's determination of unconstitutionality but ruled that the individual mandate provision could be severed.[130] After the Department of Justice indicated that it would not appeal for *en banc* review from the Eleventh Circuit, the Supreme Court granted certiorari on November 14, 2011.[131]

On June 28, 2012, in *National Federation of Independent Business v. Sebelius,* the Supreme Court largely upheld the constitutionality of the ACA.[132] The fractured decision included an opinion by Chief Justice Roberts, a concurring opinion by Justice Ginsburg, a dissenting opinion joined by Justices Scalia, Kennedy, Thomas, and Alito, and a separate dissenting opinion by Justice Thomas.[133] The case was divisive among the Justices and the majority's holdings are obscured; Chief Justice Roberts wrote a numerated opinion, and the Justices joined different parts, sometimes stating which numbers they joined in their respective concurrences or dissents.[134]

The Court first addressed the Anti-Injunction Act at issue in the ACA. The Anti-Injunction Act prohibits challenges to a tax before the tax has gone into effect.[135] The majority found that the Anti-Injunction Act applies only if Congress *intended* a payment to be treated as a tax.[136] Because the ACA referred to the "shared responsibility payment" imposed by the individual mandate as a "penalty" instead of a "tax," a majority of the Court held that the Anti-Injunction Act did not apply to block further consideration of the case on its merits.[137] However, the majority later held that the penalty was operatively a tax, which will be discussed in further detail below.

The Court then analyzed the individual mandate under the Commerce Clause. The government argued that Congress validly created the individual mandate under its Commerce Clause powers because it regulated health insurance as commerce.[138] However, the Court found the mandate exceeded Congress's powers under the Commerce Clause if the Clause alone provided the authority for Congress to pass the ACA.[139] Accepting the states' argument that the individual mandate created commerce, instead of regulated existing commerce, a

129. *Id*. at 1305.
130. *See Florida* ex rel. *Att'y Gen*., 648 F.3d at 1241.
131. *See* Adam Liptak, *Justices to Hear Health Care Case as Race Heats Up*, N.Y. TIMES (Nov. 14, 2011), https://perma.cc/8SN3-9UF6.
132. *See Sebelius*, 567 U.S. 519 (2012).
133. *Id*. at 519.
134. *See id*.
135. *Id*. at 543.
136. *See id*.
137. *Sebelius*, 567 U.S. 519, 543 (2012).
138. *See id*. at 548–58.
139. *See id*. at 558.

majority found that allowing Congress to directly compel commerce in general was unconstitutional.[140]

Ultimately, the Court upheld the individual mandate as constitutional under Congress's taxing powers, rather than under the Commerce Clause.[141] Although described as a "penalty," and therefore not treated as a tax under the Anti-Injunction Act, the "shared responsibility payment" could be reasonably construed as a tax to avoid interpreting the statute so as to conflict with the Constitution.[142] Accordingly, the Court read the penalty to be a tax, and the majority upheld the individual mandate as constitutional under the Taxing Clause.[143] Although a penalty is not permissible, a "tax penalty" is within Congress's power.[144] Because a majority of the Court found the individual mandate to be constitutional, the Court did not consider the severability issue related to the individual mandate.

Lastly, the Court considered the constitutionality of the ACA's Medicaid expansion under the Spending Clause. Chief Justice Roberts and Justices Breyer, Kagan, Kennedy, Alito, Thomas, and Scalia, for the majority, held that the Medicaid expansion was unconstitutionally coercive under the Spending Clause.[145] The ACA Medicaid expansion would have compelled states to expand Medicaid coverage to individuals earning 133% of the FPL and previously ineligible childless adults.[146] The federal government would provide additional funds for the expansion.[147] However, if a state refused to expand its Medicaid coverage, Section 1396(c) of the ACA enabled the federal government to withhold *all* existing funding for the state's Medicaid programs.[148] The Court accepted the states' argument that their reliance on federal funds to administer their Medicaid programs was debilitating and if the federal government removed existing Medicaid funding for noncompliant states, states would be forced to accept the expansion.[149] The majority held that the Medicaid expansion exceeded Congressional power by unconstitutionally coercing states to adopt federal policies.[150]

A different majority—Chief Justice Roberts and Justices Ginsburg, Breyer, Sotomayor, and Kagan—found that the remedy for the Medicaid expansion coercion was to strike the provision that would have allowed the federal government to penalize states by withholding existing funding.[151] The federal government may still predicate Medicaid expansion funding on a state's compliance with the Medicaid expansion program, but it may not remove current Medicaid funding to

140. *Id.*
141. *Id.* at 519.
142. *Id.* at 546, 562–63.
143. *See Sebelius*, 567 U.S. 519, 574 (2012).
144. *See id.* at 566.
145. *See id.* at 580.
146. *See id.* at 576.
147. *Id.*
148. *See Sebelius*, 567 U.S. 519, 581 (2012).
149. *See id.* at 582.
150. *See id.* at 588.
151. *Id.*

compel a state to comply.[152] As of January 2020, fourteen states had opted out of the Medicaid expansion.[153]

2. *King v. Burwell*[154]

On March 4, 2015, the Supreme Court heard arguments in *King v. Burwell*[155] to determine whether federally run exchanges that replace state insurance exchanges in states that opted out of the Medicaid expansion are eligible for tax credits under the ACA as drafted.[156] Petitioners argued that "Virginia's Exchange does not qualify as 'an Exchange established by the state under [the ACA],' so they should not receive any tax credits."[157] If the Court had determined that federally run exchanges were not permissible, the decision could have nullified the insurance of hundreds of thousands of Americans as illegally offered and prevented millions from receiving publicly provided insurance in the nineteen states that opted out.

The Supreme Court released its decision in *King v. Burwell* on June 25, 2015, holding that 26 U.S.C. § 36B tax credits are available to individuals in states that have a federally-facilitated exchange in lieu of a state-facilitated exchange.[158] The majority rejected the Government's argument that it should defer to the IRS's interpretation of the statute as allowing tax credits to be paid to consumers in a federally-run exchange as well as a state-run exchange, reasoning the availability of tax credits on a federal exchange is a matter of "deep 'economic and political significance.'"[159] Moreover, Chief Justice Roberts noted that if the IRS was the agency that was intended to interpret the statute, Congress would have explicitly stated so.[160] Similarly, the Court rejected the plaintiff's literal interpretation that the ACA only allows tax subsidies to be paid "through an exchange established by the state."[161] Instead, the Court adopted its own interpretation, holding that the phrase "established by the State," when read in its statutory context, refers to "*all* exchanges—both State and Federal—at least for the purposes of tax credits."[162] In states using the federal marketplace, 87% of individuals were receiving tax credits amounting to an average of $268.00 a month and totaling

152. *Id.*
153. *See* Garfield, Orgera, & Damico, *supra* note 75.
154. King v. Burwell, 576 U.S. 473 (2015).
155. *Id.* at 472.
156. *See id.* at 479.
157. *Id.* at 474.
158. *See id.* at 476 ("It thus stands to reason that Congress meant for those provisions to apply in every State as well.").
159. *Id.* at 486.
160. *Context is King: Analysis of the US Supreme Court Decision in* King v. Burwell, SQUIRE PATTON BOGGS (June 25, 2015), https://perma.cc/EN3F-V4MR.
161. *Id.*
162. *Burwell*, 576 U.S. at 490 (emphasis in original).

72% of the individual's premium.[163] Under this premise, individual out-of-pocket premiums would have increased on average by 256%.[164] Providing coverage for sick individuals would have raised insurers' costs and would have priced a number of healthy individuals out of the market.[165]

III. ACCESS TO SEX-SPECIFIC HEALTH CARE UNDER THE ACA

Many ACA provisions aimed at increasing access to insurance coverage have disproportionate impacts on women. As of 2007, women were less likely than men to be insured through employers, and thus, more women than men had the potential to take advantage of new subsidies for purchasing health insurance on the individual market, expanded eligibility for Medicaid, and the ability to remain on their parents' insurance plans.[166] In the first open enrollment period in the Health Insurance Marketplace, 54% of people who signed up for coverage were women.[167] Between 2013 and 2014, the rate of uninsured American women decreased by 5.5%, compared to a decrease of 4.7% in uninsured men.[168]

Significantly, the ACA requires that group health plans cover certain preventive medical services, including contraception, sterilization, and related counseling, without cost-sharing to participants.[169] The contraceptive mandate requires all employers make contraceptives available to employees covered by the health plan, including both fully-insured and self-insured employer plans that provide health care coverage to employees.[170] For-profit and non-profit employers with religious objections have challenged this mandate.[171]

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163. Larry Levitt & Gary Claxton, *Insurance Markets in a Post*-King *World*, KFF (Feb. 25, 2015), https://perma.cc/C8ES-RTU8.

164. *Id.*

165. *Id.*

166. ELIZABETH M. PATCHIAS & JUDY WAXMAN, THE COMMONWEALTH FUND, WOMEN AND HEALTH COVERAGE: THE AFFORDABILITY GAP 1-2 (2007), https://perma.cc/CYE2-HUXH.

167. U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTH INSURANCE MARKETPLACE: SUMMARY ENROLLMENT REPORT FOR THE INITIAL ANNUAL OPEN ENROLLMENT PERIOD at 8 (May 1, 2014), https://perma.cc/K7M4-KLZA.

168. *See* Kevin Quealy & Margot Sanger-Katz, *Obama's Health Law: Who Was Helped Most*, N.Y. TIMES (Oct. 29, 2014), https://perma.cc/3F5C-UTBU.

169. *See* Elizabeth Davis, *Preventive Care: What's Free and What's Not*, VERYWELLHEALTH (June 19, 2023), https://perma.cc/HX8E-5HAL. "Cost-sharing" occurs when the insured person has to pay for receiving medical services that insurance partly covers. *See* Louise Norris, *The ACA's Cost-Sharing Subsidies*, HEALTHINSURANCE.ORG, https://perma.cc/C4A8-8TZN.

170. Insurance Coverage of Contraceptives, GUTTMACHER INST. (Sept. 1, 2023), https://perma.cc/348F-MTP8. A self-insured plan pays for employees' benefits directly from a cash account held by the employer and does not contract with a separate insurance company to provide health insurance; sometimes the employer does hire an administrator to oversee its books. *See Self-Insured Group Health Plans*, SIIA, https://perma.cc/L4EE-8Z5B. The Employee Retirement Income Security Act of 1983 ("ERISA"), as amended, governs self-insured benefit plans. *See id.*

171. *See* Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682 (2014); Little Sisters of the Poor Home for the Aged v. Burwell, 794 F.3d 1151 (10th Cir. 2015); Laurie Sobel & Alina Salganicoff, *Round 2 on the Legal Challenges to Contraceptive Coverage: Are Nonprofits "Substantially Burdened" by the "Accommodation"?*, KFF (Nov. 9, 2015), https://perma.cc/CWJ9-PF5X.

Besides the contraceptive mandate, a number of the ACA provisions seek to increase access to non-contraceptive health care services that are predominately sex-specific.[172] For example, the provisions provide new protections against sex discrimination in the provision of health care services and fund new research programs and health education initiatives aimed at key women's health issues.[173] The ACA also provides states with the option to expand eligibility for Medicaid-funded family planning services[174] and offers coverage for smoking cessation services during pregnancy.[175] In the new private insurance marketplace, the ACA permits direct access to obstetric and gynecological care,[176] requires insurers to cover maternity care,[177] and requires insurers to cover preventive care and screenings without cost-sharing, including all FDA-approved contraceptives and services designated by the Health Resources and Services Agency.[178] Together, the provisions in the ACA largely serve to increase the resources available to pay for sex-specific services; however, despite efforts by reproductive health and women's health advocates, the ACA places significant limits on insurance coverage of abortion.[179]

A. CHALLENGES TO THE AFFORDABLE CARE ACT'S CONTRACEPTIVE MANDATE (RELIGIOUS FREEDOM OBJECTIONS)

Over one hundred cases were filed to challenge the ACA's contraceptive mandate on religious grounds.[180] A number of these cases received significant media coverage, one of which is *Burwell v. Hobby Lobby Stores, Inc.*[181] In *Burwell*, the Supreme Court held that the ACA's contraception mandate violates the Religious Freedom Restoration Act, which the Court found protects the religious rights of closely held corporations.[182] Religious non-profits, though expressly exempt

172. *See* 42 U.S.C.A. § 300gg-19a(d) (West, Westlaw through Pub. L. No. 118-23); *id.* § 18022(b)(1)(D) (West, Westlaw through Pub. L. No. 118-23); *id.* § 300gg-13(a)(4) (West, Westlaw through Pub. L. No. 118-23); *Women's Preventive Services Guidelines*, HRSA, https://perma.cc/3A46-8LY2.

173. *See Why the Affordable Care Act Matters for Women: Summary of Key Provisions*, NAT'L PARTNERSHIP FOR WOMEN & FAMILIES (Sept. 2015), https://perma.cc/D3B9-EK5X; Sara Rosenbaum, *The Patient Protection and Affordable Care Act: Implications for Public Health Policy and Practice*, PUB. HEALTH REPORTS (Jan.–Feb. 2011), https://perma.cc/P8HK-8XKY.

174. 42 U.S.C.A. § 1396a(ii) *et seq.* (West, Westlaw through Pub. L. No. 118-23).

175. *Id.* § 1396d(bb) (West, Westlaw through Pub. L. No. 118-23).

176. *Id.* § 300gg-19a(d) (West, Westlaw through Pub. L. No. 118-23).

177. *Id.* § 18022(b)(1)(D) (West, Westlaw through Pub. L. No. 118-23).

178. *Id.* § 300gg-13(a)(4) (West, Westlaw through Pub. L. No. 118-23); *Women's Preventive Services Guidelines*, *supra* note 172.

179. *See, e.g.*, Leah H. Keller & Adam Sonfield, *The First 10 Years of the ACA: We Must Protect and Build on Major Gains in Sexual and Reproductive Health*, GUTTMACHER INST. (Mar. 2020), https://perma.cc/P72W-GDHB; *Interactive: How State Policies Shape Access to Abortion Coverage*, KFF (Dec. 11, 2023), https://perma.cc/K3ST-J6VT; *Planned Parenthood Condemns Passage of Stupak/Pitts Amendment*, PLANNED PARENTHOOD (Jan. 30, 2014), https://perma.cc/X9KM-XQTF.

180. *Challenges to the Federal Contraceptive Coverage Rule*, ACLU (May 28, 2015), https://perma.cc/2LKB-FH7P.

181. Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682 (2014).

182. *See id.* at 736.

from federal regulations under the Employee Retirement Income Security Act ("ERISA"),[183] have different reporting requirements in order for an exemption to come into effect.[184] Religious non-profits cannot be penalized for failure to notify their insurers of their religious objections.[185] Instead, if they contract for an insurance plan that does not include coverage for some or all forms of contraception, the information serves as notice to HHS in lieu of written notification.[186] This form of notification triggers third party coverage of contraceptive services in accordance with the ACA's mandate.[187] Self-insured health plans[188] that are administered by a religious third party and are qualified as "church plans" are exempt from ERISA.[189] Because the mandate is currently enforced via authority granted to HHS and the Department of Labor ("DOL") by ERISA, these plans cannot be penalized for failing to provide contraceptive coverage.[190]

Zubik v. Burwell also received nationwide attention.[191] *Zubik* consolidated cases challenging the ACA's objections and contended that religious non-profits should receive a complete exemption from the contraception mandate.[192] Amongst the cases included in the consolidation is *Little Sisters of the Poor Home for the Aged v. Burwell*.[193] In May 2016, the Supreme Court remanded the cases to their respective courts and ordered the lower courts to arrive at an approach that both accommodates the petitioner's religious views and ensures women covered by petitioner's health plans receive contraceptive coverage.[194] In addition, the Court offered "no view on the merits of the case."[195]

1. For-Profit Corporations: *Hobby Lobby*

Both plaintiffs in *Burwell v. Hobby Lobby*, Conestoga Wood Specialties and Hobby Lobby, Inc., are "closely held" corporations whose founders and families own all the corporations' stock and exclusively control the boards.[196] The families, who identify as Mennonite and Christian, respectively, object to the ACA

183. Coverage of Certain Preventive Services Under the Affordable Care Act, 78 Fed. Reg. 39870, 39870–01 (July 2, 2013) (to be codified at 26 C.F.R. pt. 54).

184. *Id.* at 39873–74.

185. *Id.* at 39879.

186. *See* Little Sisters of the Poor Home for the Aged v. Burwell, 794 F.3d 1151, 1166 (10th Cir. 2015).

187. *Id.*

188. Plans are considered self-insured when they pay benefits directly and do not purchase insurance for covered employees through a third party. *Id.* at 1158.

189. Little Sisters of the Poor Home for the Aged v. Sebelius, 6 F. Supp. 3d 1225, 1240 (D. Colo. 2013).

190. *Id.*

191. 578 U.S. 403, 408 (2016).

192. *Zubik*, 578 U.S. 403; Little Sisters of the Poor Home for the Aged v. Burwell, 794 F.3d 1151 (10th Cir. 2015).

193. 578 U.S. 403 (2016); 794 F.3d 1151 (10th Cir. 2015).

194. *Zubik*, 578 U.S. at 408.

195. *Id.* at 409.

196. Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 683 (2014).

contraception mandate because it provides their employees access to contraceptive methods they consider to be "abortifacients."[197]

In an opinion by Justice Alito, the Court held that corporations are protected under the Religious Freedom Restoration Act ("RFRA"), which guarantees religious freedom to any "person."[198] The Court determined that the term "person" is ambiguous, and that persons protected by the Act include artificial persons, such as corporations.[199] The Court also held that it is possible for a corporation to exercise religion through its owners' practices in carrying out the business.[200] The contraceptive mandate, as applied to closely held for-profit corporations with religious objections, therefore violated the RFRA.[201] This ruling paved the way for the Trump administration to issue rules that created a broad basis for employers to exempt themselves from the ACA's contraception mandate.[202]

Furthermore, the Court held that the ACA's contraceptive regulations placed a substantial burden on the plaintiffs, who were faced with either violating their religious beliefs or paying a fine.[203] Applying a least-restrictive means standard, the Court found that the least-restrictive means to provide universal contraception would be for the government to provide it directly to individual employees; the plaintiffs, therefore, had met their burden under the test.[204]

2. Opt-Out Provisions for Religious Non-Profits and Non-Profits Exempt from ERISA: *Little Sisters of the Poor*

Religious non-profits that object to providing contraception to their employees on religious grounds may use the ACA's opt-out provision.[205] Under the rules, employers are to provide written notice confirming their objection to insurers or third party insurance administrators, who must then make arrangements to provide contraception to affected employees.[206] Insurers are compensated for their costs by the government.[207]

The Little Sisters of the Poor (hereinafter referred to as "Little Sisters"), who operate nursing homes in Colorado and Baltimore, and the Christian Brothers Employee Benefit Trust (hereinafter referred to as "the Trust"), which contracts with Little Sisters to provide medical coverage to employees through a self-insured health plan, along with the Administrator, filed an action in District Court

197. *Id.* at 691.
198. *Id.* at 706.
199. *Id.* at 707–08.
200. *Id.* at 709.
201. *Id.* at 736.
202. *See* Pete Williams, *In Win For Trump, Supreme Court Allows Plan For Religious Limits To Obamacare Contraceptive Coverage*, NBC NEWS (July 8, 2020), https://perma.cc/E9SH-A2NJ.
203. 573 U.S. 682, 728 (2014).
204. *Id.*
205. Little Sisters of the Poor Home for the Aged v. Sebelius, 6 F. Supp. 3d 1225, 1231-32 (D. Colo. 2013).
206. *Id.*
207. *Id.*

alleging that the ACA violated their religious rights.[208] They brought claims under the First and Fifth Amendments, the Administrative Procedure Act, and RFRA.[209] Principally, Little Sisters argued that they should not be required to take action that results in provision of contraception to their employees.[210]

The court observed that DOL and HHS are authorized to enforce notification compliance through a provision of ERISA, which grants them authority to penalize employers who fail to self-certify and insurers or administrators who fail to provide the coverage.[211] However, the Trust is a "church plan" and thus exempt from ERISA regulations and enforcement provisions.[212] Therefore, if Little Sisters did file such a certification with their insurer, it would not result in the provision of contraception to their employees.[213]

The court noted that Little Sisters did not face a penalty similar to that in *Hobby Lobby* due to an opt-out provision in this case.[214] Further, the Trust and the Administrator were exempt from ERISA even if proper notice was not filed, so they also could not be fined.[215] The court denied the plaintiffs' motion for an injunction because the injunction would only be effective at a conditional future time when the defendants could penalize the plaintiffs.[216] The court also denied defendants' motion for dismissal, and both parties appealed to the Tenth Circuit.[217]

Meanwhile, the plaintiffs sought an injunction against the defendants in the Supreme Court, fearing the rules would be modified to create an enforceable provision. The Court granted an injunction enjoining the defendants from enforcing new ACA rules, should those rules be modified to require such reporting by religious self-insured plans.[218] Under an administrative procedure invoked by Justice Sotomayor, religious self-insured plans may report religious objections to providing coverage for contraceptive services to the HHS Secretary, and the government will be enjoined from enforcing the ACA contraception mandate against them.[219] However, the Supreme Court's position still essentially required religious non-profits to self-certify in the manner to which the plaintiffs objected.[220]

The government urged the Tenth Circuit to move forward with oral arguments in the appeal to provide more clarity on the law in the issue.[221] In July 2015, the

208. *Id.* at 1232–33.
209. *Id.*
210. *Little Sisters of the Poor*, 6 F. Supp. 3d 1225, 1239–40 (D. Colo. 2013).
211. *Id.* at 1240–41.
212. *Id.*
213. *Id.*
214. *Id.* at 1237.
215. *Id.* at 1237–40.
216. *Id.* at 1245–46.
217. Little Sisters of the Poor Home for the Aged v. Burwell, 794 F.3d 1151 (10th Cir. 2015).
218. *See* Little Sisters of the Poor Home for the Aged v. Sebelius, 571 U.S. 1171 (2014).
219. *See id.*
220. *See* Supplemental Brief for the Respondent at 3, Little Sisters of the Poor Home for the Aged v. Burwell, No. 13-1540 (10th Cir. Sept. 8, 2014).
221. *Id.* at 23.

Tenth Circuit heard arguments for *Little Sisters of the Poor Home for the Aged v. Burwell*[222] and determined that the ACA did not "substantially burden Plaintiffs' religious exercise or violate the Plaintiffs' First Amendment rights."[223] Moreover, the Tenth Circuit affirmed the district court's decision to deny the plaintiffs' preliminary injunction on the ground that the plaintiffs failed to demonstrate a "likely threat of irreparable harm."[224] In May 2016, the Supreme Court effectively sidestepped addressing the merits by vacating and remanding the individual cases to their corresponding lower courts.[225] The Court reasoned that by remanding the case, it granted the parties the ability to develop a solution to both ensuring women's health coverage and preserving employers' religious rights.[226]

3. Opt-Out Provisions for Religious Non-Profits in General Post-*Little Sisters*: *Wheaton College*

In *Wheaton College v. Burwell*,[227] the Supreme Court ruled that a non-profit, liberal arts college should notify the HHS Secretary of its objections to the contraception mandate, after which the Court should grant an injunction against enforcement of the ACA contraception provisions.[228] In a strident dissent, Justice Sotomayor argued that Wheaton College failed to allege a viable RFRA claim.[229] The dissent argued that because it was the federal law itself that triggered the provision of contraception, rather than the plaintiff's notice of its religious objections, the plaintiff could not plausibly claim that it was required to take an action that was against its religious beliefs.[230]

B. EXPANDING ACCESS TO FAMILY-PLANNING SERVICES THROUGH MEDICAID

The Medicaid Family Planning State Option expands on and improves the existing Section 1115 waiver program that twenty-six states use to expand access to Medicaid-funded family planning services.[231] Through the waiver program, the HHS Secretary can approve experimental projects that promote Medicaid's objectives and give states additional flexibility to design and enhance their Medicaid programs.[232] As of 2023, three states provide eligibility under this program to women for two years following a Medicaid-funded birth; one state provides family planning services to women losing Medicaid coverage for any

222. Little Sisters of the Poor Home for the Aged v. Burwell, 794 F.3d 1151 (10th Cir. 2015).
223. *Id.* at 1205.
224. *Id.*
225. Zubik v. Burwell, 578 U.S. 403, 408 (2016).
226. *Id.*
227. Wheaton College v. Burwell, 134 S. Ct. 2806 (2014).
228. *Id.* at 2807.
229. *Id.* at 2808.
230. *Id.*
231. *State Policies In Brief: Medicaid Family Planning Eligibility Expansions*, GUTTMACHER INST. (Aug. 21, 2023), https://perma.cc/JY5T-JZXE [hereinafter *Medicaid Family Planning Eligibility Expansions*].
232. *Section 1115 Demonstrations*, MEDICAID.GOV, https://perma.cc/2TZV-HD4J.

reason, and twenty-four states provide family planning benefits to women on the basis of income, usually below 200% of the FPL.[233] States have implemented income-based eligibility expansions to provide family planning services to all women eligible for Medicaid-funded pregnancy care, thereby achieving substantial savings to state Medicaid programs.[234] The ACA State Option provision allows states simply to elect to expand eligibility to a new category of non-pregnant women with incomes not exceeding a state-determined level.[235] This reduces administrative costs by removing the need to undergo the cumbersome Section 1115 waiver process. The provision also gives states choices regarding verifying citizenship of applicants for Medicaid family planning coverage[236] and allows "presumptive eligibility" for providers to treat apparently-eligible applicants while their applications are still being processed, with the assurance that the provider will be compensated before a final eligibility determination is made.[237] As of March 2024, seventeen states have approved State Plan Amendments for family planning.[238]

C. PROHIBITION ON "GENDER RATING" IN THE PRIVATE INSURANCE MARKETPLACE

The ACA provides protections against sex discrimination in the private insurance marketplace, including a prohibition on discrimination on the basis of pre-existing conditions[239] and a prohibition on gender rating, which is the practice of charging women higher premiums than men.[240] Under prior law, many insurers implemented gender rating policies to charge women more for health insurance, arguing that providing insurance to women costs more because of their higher health care utilization rates.[241]

The ACA bans rate discrimination by qualified health plans with the exception of a few specific categories: insurers may take into account geographic area, the number of individuals covered under the policy, and, subject to certain limits, age and tobacco use.[242] The ratio between the highest rate charged and the lowest rate

233. *Medicaid Family Planning Eligibility Expansions*, *supra* note 231.

234. *See id.*; Deborah Bachrach, Patricia Boozang, Avi Herring, & Dori G. Reyneri, *States Expanding Medicaid See Significant Budget Savings and Revenue Gains*, STATE HEALTH REFORM ASSISTANCE NETWORK (Mar. 2016), https://perma.cc/LWW8-B3SX; Rachel Benson Gold, *Doing More for Less: Study Says State Medicaid Family Planning Expansions are Cost-Effective*, GUTTMACHER INST. (Mar. 17, 2004), https://perma.cc/NTL6-KEF7.

235. *Health Coverage Under the Affordable Care Act: Current Enrollment Trends and State Estimates*, ASPE (Mar. 23, 2023), https://perma.cc/SJE5-XXE8.

236. 42 U.S.C.A. § 1396a (West, Westlaw through Pub. L. No. 118-41).

237. Christine Sebastian, *Presumptive Eligibility: A Step Toward Streamlined Enrollment in Medicaid and CHIP*, FAMILIES USA (Sept. 2011), https://perma.cc/VB7N-B33R; *see also* 42 U.S.C.A. § 1396r-1c (West, Westlaw through Pub. L. No. 118-41).

238. *Medicaid Family Planning Eligibility Expansions*, *supra* note 231.

239. 42 U.S.C.A. § 300gg (West, Westlaw through Pub. L. No. 118-41); 42 U.S.C.A. § 300gg-3 (West, Westlaw through Pub. L. No. 118-41).

240. *Public Opinion on Gender Rating*, KFF (May 2, 2012), https://perma.cc/L33G-YV2V.

241. *See, e.g.*, *id.*

242. 42 U.S.C.A. § 300gg (West, Westlaw current through Pub. L. No. 118-41).

charged for age may not be greater than 3:1, and for tobacco use, not greater than 1.5:1.[243] However, because these protections do not apply to the entirety of the large group market, insurers may still implement gender rating policies for larger employers.[244]

D. EXPANDING ACCESS TO SEX-SPECIFIC HEALTH CARE SERVICES IN THE PRIVATE INSURANCE MARKETPLACE

In addition to expanding coverage through Medicaid, the ACA provides increased access to gender-specific services by including them as part of the essential health benefits package that must be covered by insurance plans participating in the new health insurance exchanges.[245] In particular, the ACA requires that qualified health plans cover maternity and newborn care[246] and prescription drugs and devices.[247] Additionally, it gives the HHS Secretary discretion to expand the list of essential health benefits, provided the package is "equal to the scope of benefits provided under a typical employer plan."[248] The ACA also requires coverage of certain preventive health services without cost-sharing requirements, immunizations recommended by the Centers for Disease Control and Prevention ("CDC"), and additional preventive services and screenings for women, as provided in the Health Resources and Services Administration ("HRSA") guidelines.[249] Non-grandfathered plans are required to provide preventative services, including mammograms for women over the age of forty, screenings for cervical cancer, pregnancy-related diabetes, interpersonal and domestic violence, anxiety, contraceptive care, counseling for STIs, and prenatal screenings and counseling, such as promotion and support of breastfeeding during and after pregnancy.[250] These plans must also cover HPV vaccines for boys and girls at no added cost.[251]

In 2011, HRSA tasked the National Academies of Science, Engineering, and Medicine (formerly known as the Institute of Medicine ("IOM")) with examining the scope of women's preventive health and developing the initial Women's Preventive Service Guidelines.[252] These guidelines on preventive health screenings and services guide clinicians in determining which services they should

243. *Id.*

244. *Id.*

245. *See* 42 U.S.C.A. § 18022 (West, Westlaw through Pub. L. No. 118-41); *What Marketplace health insurance plans cover*, HEALTHCARE.GOV, https://perma.cc/6PPD-CNZB.

246. 42 U.S.C.A. § 18022(b)(1)(D) (West, Westlaw through Pub. L. No. 118-41).

247. *Id.* § 18022(b)(1)(F) (West, Westlaw through Pub. L. No. 118-41).

248. *Id.* § 18022(b)(2)(A) (West, Westlaw through Pub. L. No. 118-41).

249. *Id.* § 300gg-13(a) (West, Westlaw through Pub. L. No. 118-41).

250. *Women's Preventive Services Guidelines*, HEALTH RES. & SERVS. ADMIN., https://perma.cc/P88L-2QEM.

251. *See The HPV Vaccine: Access and Use in the U.S.*, KFF (July 12, 2021), https://perma.cc/9YBC-JT22.

252. *About WPSI*, WOMEN'S PREVENTIVE SERVS. INITIATIVE, perma.cc/LJ76-8N9U; *see* INST. OF MED., CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS (2011), https://perma.cc/4EJL-MMJ2.

routinely offer to their patients.[253] HRSA awarded the American College of Obstetricians and Gynecologists a cooperative agreement in 2016 and 2021 to recommend updates to the Women's Preventive Services Guidelines.[254] On December 30, 2021, HRSA accepted updates to the Women's Preventive Service Guidelines.[255] The guidelines now require no additional cost-sharing for screenings for diabetes after pregnancy, counseling for interpersonal and domestic violence, obesity prevention in midlife women, and screening for urinary incontinence.[256]

IV. THE ACA'S PROHIBITION ON DISCRIMINATION

ACA Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, disability, or age in health care programs that receive federal funding.[257] Section 1557 also authorizes the HHS Secretary to promulgate rules to implement this section. A rule issued by the Obama administration in 2016 included a prohibition on discrimination on the basis of sexual orientation and gender identity, but in 2020 the Trump administration revised the 2016 Final Regulations that implemented Section 1557 to eliminate those prohibitions.[258] Following the Supreme Court's decision in *Bostock v. Clayton County* that under Title VII, discrimination on the basis of sex encompasses discrimination on the basis of sexual orientation and gender, the Department of Health and Human Services published a Federal Register Notice announcing that Section 1557 would be enforced consistent with this decision that sex discrimination includes discrimination on the basis of sexual orientation and gender identity.[259] In August 2022, the Biden administration issued a Proposed Rule which codifies protections against discrimination on the basis of sex as including discrimination on the basis of sexual orientation and gender identity.[260] The Proposed Rule also clarifies that sex discrimination includes discrimination on the basis of sex stereotypes; sex characteristics, including intersex traits; and pregnancy or related conditions including pregnancy termination. Under the 2020 final rule, compliance with

253. WOMEN'S PREVENTIVE SERVS. INITIATIVE, *supra* note 252.

254. *Id.*

255. Press Release, HEALTH RES. & SERVS. ADMIN., *HRSA Updates the Affordable Care Act Preventive Health Care Guidelines to Improve Care for Women and Children* (Jan. 11, 2022), https://perma.cc/TSK6-FFCX.

256. *Women's Preventive Services Guidelines*, *supra* note 250.

257. Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47824, 47824 (proposed Aug. 4, 2022).

258. MaryBeth Musumeci, Jennifer Kates, Lindsey Dawson, Alina Salganicoff, Laurie Sobel, & Samantha Artiga, *The Trump Administration's Final Rule on Section 1557 Non-Discrimination Regulations Under the ACA and Current Status*, KFF (Sept. 18, 2020), https://perma.cc/URH8-R7HY.

259. *Fact Sheet: Nondiscrimination in Health Programs and Activities Proposed Rule Section 1557 of the Affordable Care Act*, DEPT. OF HEALTH & HUM. SERVS. (July 29, 2022), https://perma.cc/DJF3-9QPQ; Notification of Interpretation and Enforcement of Section 1557 of the Affordable Care Act and Title IX of the Education Amendments of 1972, 86 Fed. Reg 27984, 27984 (May 10, 2021).

260. DEPT. OF HEALTH & HUM. SERVS., *supra* note 259; Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47824, 47858 (proposed Aug. 4, 2022).

Section 1557 is required for any health program or activity receiving federal funds from HHS, any program or activity administered by HHS, and health insurance marketplace participants.[261]

The same enforcement measures under Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments Act of 1972, the Age Discrimination Act of 1975, and Section 504 of the Rehabilitation Act of 1973, apply to violations of Section 1557.[262] For example, relevant entities are required to submit an assurance to the Office of Civil Rights (OCR) that the entity's health programs or activities will be operated in compliance with section 1557.[263] In the event that noncompliance cannot be resolved informally, enforcement mechanisms include the authority to review complaints, initiate of and conduct compliance reviews, conduct investigations, make enforcement referrals to the Department of Justice with a recommendation to bring proceedings to enforce any rights of the United States, and take other appropriate remedial action as the Director of the OCR deems necessary.[264] In addition, the 2022 proposed rule implementing 1557 would restore a private right of action and damages for violations of Section 1557—a right of action that existed under the 2016 Final Regulations but was removed in the 2020 Final Regulations by the Trump administration.[265]

A. THE ACA AND THE INTERSECTION OF RACIAL, ETHNIC, AND GENDERED HEALTH DISPARITIES

1. Background

Health inequities are "the systematic, avoidable and unfair differences in health outcomes that can be observed between populations, between social groups within the same population or as a gradient across a population ranked by social position."[266] A social determinants of health approach to health disparities recognizes that social and economic conditions impact health outcomes.[267] The social determinants of health are the circumstances in which people are born, grow up, live, work, and age, as well as the wider set of forces and systems shaping the conditions of daily life.[268] These circumstances are shaped by economic policies and systems, social norms, social policies, and political systems.[269]

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261. *Section 1557: Frequently Asked Questions*, DEPT. OF HEALTH & HUM. SERVS., https://perma.cc/DZD5-8B2L.

262. 45 C.F.R. § 92.5(a) (2024).

263. *Id.*

264. 45 C.F.R. § 92.5(b) (2024).

265. Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47824, 47885 (proposed Aug. 4, 2022). *See also* Cathy Zhang, *Affirming Nondiscrimination Rights: HHS Needs to Acknowledge a Private Right of Action for Section 1557 Violations*, HARV. L. SCH. PETRIE-FLOM CTR.: BILL OF HEALTH (Mar. 11, 2022), https://perma.cc/5E4C-XE8S.

266. *See* Gerry McCartney, Frank Popham, Robert McMaster, & Andrew Cumbers, *Defining Health and Health Inequalities*, 172 PUB. HEALTH 22, 28 (2019).

267. *Social Determinants of Health*, WORLD HEALTH ORG., https://perma.cc/3VR8-LRQ7.

268. *Id.*

269. *Id.*

2. Measures in the ACA to Help Eliminate Health Disparities

One method of resolving the issue of health disparity is to diversify the workforce. Studies indicate that minority health care providers are more inclined to practice in underprivileged areas and treat minority patients.[270] In addition, having more diverse providers has been correlated with patient satisfaction, and "better educational experiences for health profession students, among many other benefits."[271] In addition, the National Health Care Workforce Commission ("NHCWFC") was established to serve as a resource for Congress, the President, and states and localities to facilitate diversity in the healthcare industry. The goals of the commission are that it: "(1) serves as a national resource for Congress, the President, States, and localities; (2) communicates and coordinates with the Departments of Health and Human Services, Labor, Veterans Affairs, Homeland Security, and Education on related activities administered by one or more of such Departments; (3) develops and commissions evaluations of education and training activities to determine whether the demand for health care workers is being met; (4) identifies barriers to improved coordination at the Federal, State, and local levels and recommend ways to address such barriers; and (5) encourages innovations to address population needs, constant changes in technology, and other environmental factors."[272]

In addition, the ACA amended the Public Health Service Act to provide Center of Excellence grants to encourage and support educational programs in health professions for minority students.[273] It offers incentives such as authorizing "loan repayment, scholarships, grants, and other educational assistance for minority health professions students."[274] The ACA also reauthorizes the Area Health Education Centers ("AHEC") grants,[275] which encourage individuals from underrepresented minorities to enter the health profession through community-based training and education.[276] The Workforce Diversity Grants ("WDG") is another program that provides funds, education, and retention services to strengthen educational opportunities for minorities in nursing.[277] The ACA further reauthorizes and expands Health Professional Opportunity Grants ("HPOG"), which is "designed to provide training in high-demand health care professions to Temporary Assistance

270. Daryll C. Dykes, *Health Injustice and Justice in Health: The Role of Law and Public Policy in Generating, Perpetuating, and Responding to Racial and Ethnic Health Disparities Before and After the Affordable Care Act*, 41 WM. MITCHELL L. REV. 1129, 1199 (2015) (citing INST. OF MED. OF THE NAT'L ACADS., IN THE NATION'S COMPELLING INTEREST: ENSURING DIVERSITY IN THE HEALTH-CARE WORKFORCE 29 (Brian D. Smedley, Adrienne Stith Butler, & Lonnie R. Bristow eds., 2004)).

271. *Id.* at 1200 (citing INST. OF MED. OF THE NAT'L ACADS., IN THE NATION'S COMPELLING INTEREST: ENSURING DIVERSITY IN THE HEALTH-CARE WORKFORCE 1 (Brian D. Smedley, Adrienne Stith Butler, & Lonnie R. Bristow eds., 2004)).

272. ACA § 5101.

273. ACA § 5401.

274. Dykes, *supra* note 270, at 1201 (citing ACA § 5402).

275. ACA § 5403.

276. *Id.*

277. ACA § 5404.

for Needy Families ("TANF") recipients and other low-income populations with high concentrations of Native American, Hispanic, and African-American people."[278] All of these programs provide convincing evidence indicating that providers who are culturally adept can improve the quality of care given to diverse patients, in addition to the fact that minority health care providers are more likely to treat minority patients.[279]

Under the ACA, any federal health care program must gather and report "data on race, ethnicity, sex, primary language, and disability status for applicants, recipients, or participants."[280] The HHS Secretary must provide these reports to various federal agencies along with potential solutions to correct health care disparities.[281] In addition, the Secretary must also analyze and monitor trends from the collected data, which will then be reported on the HHS website and made available to the general public.[282]

The ACA also established the Patient-Centered Outcomes Research Institute ("PCORI"), which funds clinical research and programs that specialize in providing information to help patients and providers make educated decisions.[283] PCORI addresses disparities by "identifying potential differences in prevention, diagnosis, or treatment effectiveness, or preferred clinical outcomes across patient populations and the health care required to achieve best outcomes in each population."[284]

3. Additional Measures Used to Implement ACA and Eliminate Health Disparities

Healthy People 2020 was an initiative launched by HHS on December 2, 2010 to provide a 10-year national agenda to improve Americans' health via a framework for public health prevention measures.[285] The disease-prevention agenda "sets goals, identifying baseline data and 10-year targets, monitoring outcomes, and evaluating the collective effects of health-improvement activities nationwide."[286] This program set out to monitor rates of "illness, death, chronic conditions, behaviors, and other types of outcomes in relation to demographic factors,

278. Dykes, *supra* note 270, at 1201 (citing Randall Bovbjerg & Erin McDonald, *Healthcare Occupational Training and Support Programs Under the ACA—Background and Implications for Evaluating HPOG*, ADMIN. FOR CHILD. & FAM. i (Mar. 2014), https://perma.cc/P7A9-LKEN).

279. *Id.*

280. *Id.* at 1203–04.

281. *Id.* at 1204.

282. *Id.*

283. *Id.*

284. *National Priorities and Research Agenda,* PATIENT-CENTERED OUTCOMES RESEARCH INST. (Mar. 24, 2022), https://perma.cc/4LQF-9KVD.

285. *About Healthy People*, HEALTHYPEOPLE.GOV (2014), https://perma.cc/AST7-7CUV. Since 2020, HHS has released Healthy People 2030, which builds on the previous iterations to also endeavor to improve health nationwide. *About Healthy People 2030*, DEPT. OF HEALTH & HUM. SERVS., OFF. OF DISEASE PREVENTION & HEALTH PROMOTION, https://perma.cc/2DRR-KDYB.

286. *See* Dykes, *supra* note 270, at 1206.

including: race and ethnicity; gender; sexual identity and orientation; disability status or special health care needs; and rural or urban geographic location."[287] This type of information enables HHS to target specific problems in order to mitigate health disparities. In 2020, the initiative was renewed for another ten years and retitled as Healthy People 2030.[288] Like its predecessor, Healthy People 2030 provides 10-year, measurable public health objectives, and tools to help track progress toward achieving them. The renewed program has an "increased and overarching focus" on the social determinants of health; one of the report's five overarching goals highlights this focus by promoting "creat[ion of] social, physical, and economic environments that promote attaining the full potential for health and well-being for all."[289]

B. TRANSGENDER HEALTH DISPARITIES AND SECTION 1557

As of 2024, transgender individuals still face discrimination and harassment in a variety of settings, and the healthcare industry is no exception.[290] Historically speaking, transgender individuals have frequently been excluded from medical coverage.[291] Transgender adults face higher rates of unemployment, and relatedly, higher rates of uninsurance, compared to their cisgender counterparts.[292] While the purpose of the ACA is to improve access to affordable, quality health care by reducing the overall cost of care to providers and consumers,[293] it fails to provide the necessary coverage for individuals within the transgender community. This is especially problematic in the context of healthcare, since "transgender individuals are 'uniquely dependent on medical treatments to realize their identities and to live healthy, authentic lives.'"[294] The conflict that transgender individuals feel between their gender identity and their sex assigned at birth can ultimately lead to severe distress.[295] Without gender-affirming procedures, a transgender individual's "sexual functioning, self-esteem, body image, socioeconomic adjustment, family life, relationships, psychological status and general life

287. *Id.*

288. *About Healthy People 2030*, *supra* note 285.

289. *Social Determinants of Health - Healthy People 2030*, DEPT. OF HEALTH & HUM. SERVS., OFF. OF DISEASE PREVENTION & HEALTH PROMOTION, https://perma.cc/6TQF-TXDW.

290. *See* Sarah E. Gage, *The Transgender Eligibility Gap: How the ACA Fails to Cover Medically Necessary Treatment for Transgender Individuals and How HHS Can Fix It*, 49 NEW ENG. L. REV. 499, 500 (2015); Caroline Medina, Thee Santos, & Lindsay Mahowald, *Protecting and Advancing Health Care for Transgender Adult Communities*, CTR. FOR AM. PROGRESS (Aug. 18, 2021), https://perma.cc/5KUT-YSKG.

291. Gage, *supra* note 290, at 500.

292. *See* Wyatt Koma, Matthew Rae, Amrutha Ramaswamy, Tricia Neuman, Jennifer Kates, & Lindsey Dawson, *Demographics, Insurance Coverage, and Access to Care Among Transgender Adults*, KFF (Oct. 21, 2020), https://perma.cc/6WLL-7HQS.

293. Gage, *supra* note 290, at 510; *see also About the Affordable Care Act*, HHS (Mar. 17, 2022), https://perma.cc/6DF7-8DH5.

294. Gage, *supra* note 290, at 500 (citing Kellan Baker & Andrew Cray, *Why Gender-Identity Nondiscrimination in Insurance Makes Sense*, CTR. FOR AM. PROGRESS 6 (May 2, 2013), https://perma.cc/3YW9-TVEP).

295. Gage, *supra* note 290, at 504.

satisfaction are all negatively affected."[296] This severe distress may result in a condition called gender dysphoria, which may manifest in intense emotional pain and suffering that may then lead to depression and severe self-harm including genital self-mutilation, suicide, and death.[297]

There are several particular provisions of the ACA that are most important for transgender individuals: the Patient's Bill of Rights, the individual and provider nondiscrimination provisions, and the "essential health benefits" ("EHB") categories of care.[298] With regard to the Patient's Bill of Rights, the following provisions are particularly relevant for transgender individuals: the prohibition on exclusion from coverage for pre-existing conditions, the ban on rescission, and the prohibition of coverage denials for certain services.[299] The prohibition on exclusion due to pre-existing conditions means that individuals who are already experiencing gender dysphoria cannot be excluded from coverage. Additionally, the ban on rescission in the Patient's Bill of Rights prohibits a health insurance plan from canceling coverage "due to unintentional mistakes or omissions in applications because of gender transition or other changes in health."[300] Lastly, insurance companies may not deny coverage to anyone solely because of transgender status.[301] While these provisions help transgender individuals, insurance companies may still deny coverage initially, and the ACA's appeals mechanism for these denials does not "ensure the reversal of those denials for gender-confirming" procedures.[302]

The daily harassment that many transgender individuals face can ultimately lead to negative social and economic consequences for these individuals, including "lost jobs, eviction, physical and sexual assault, homelessness, denial of medical services, and incarceration."[303] A domino effect can occur and lead to high risk health issues such as "HIV/AIDS infection, drug and alcohol abuse, anxiety, depression, and suicide."[304] These health issues not only affect individual lives,

296. Brynn Tannehill, *Myths About Gender Confirmation Surgery*, HUFFPOST (Dec. 8, 2013, 4:28 PM), https://perma.cc/K494-2937; *see also* Christopher S. Carpenter, Samuel T. Eppink, & Gilbert Gonzales, *Transgender Status, Gender Identity, and Socioeconomic Outcomes in the United States*, 73 ILR REV. J. WORK & POL'Y 573, 574–76 (Feb. 11, 2020); Nita Bhatt, Jesse Cannella, & Julie P. Gentile, *Gender-Affirming Care for Transgender Patients*, 19 INNOVATIONS IN CLINICAL NEUROSCI. 23 (2022).

297. Gage, *supra* note 290, at 504–05; Garima Garg, Ghada Elshimy, & Raman Marwaha, *Gender Dysphoria*, STATPEARLS (July 11, 2023), https://perma.cc/XKZ3-PTF7.

298. Gage, *supra* note 290, at 514. EHB packages must include services within the following ten categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services including oral and vision care for children. 42 U.S.C.A. § 18022(b)(1)(A)–(J) (West, Westlaw through Pub. L. No. 118-39).

299. Gage, *supra* note 290, at 514.

300. *Id.*

301. *Id.*

302. *Id.* at 514–15.

303. *Id.* at 516.

304. *Id.*

but they also impact the general public.[305] One solution for addressing these disproportionate impacts is to increase access to gender-affirming healthcare by mandating that insurance companies include these medically necessary treatments in an individual's plan.[306] Another crucial step toward improving access to healthcare is to consider gender-affirming healthcare as medically necessary treatments and not elective procedures.[307] With this improvement, transgender individuals will be able to have economic and social stability, ultimately allowing them to live comfortably and happily.

While the ACA benefits American society by allowing ease of access to health care at a lower cost, it has thus far been questionable whether this promise applies equally to the transgender community.[308] According to the 2022 U.S. Transgender Survey, the largest survey ever conducted to examine the experiences of transgender and nonbinary people in the United States, more than one-quarter of respondents (28%) did not see a doctor when they needed to in the last 12 months due to cost and approximately 1 in 4 respondents (26%) had at least one issue with their insurance company in the last 12 months, such as being denied coverage for hormone therapy, surgery, or another type of health care related to their gender identity/transition; gender-specific health care because they were transgender; or routine health care because they were transgender.[309] Higher costs of care for transgender people may be impacted by what benefits are covered as EHBs. A major shortcoming of the ACA is that HHS leaves it to the states to define and enforce EHB coverage, which has resulted in inconsistent and inadequate coverage.[310] Starting with plans beginning on or after January 1, 2020, states may keep their selected benchmark plan, select the benchmark plan from another state in its entirety, select categories of EHB from benchmarks in another state, or create a new benchmark altogether.[311] There are multiple issues with EHB benchmarking: first, most states use small group plans as their EHB benchmark, which is the least generous of the benchmark options, embed discriminatory benefit design, and perpetuate disparities.[312] This leads to vast

305. Gage, *supra* note 290, at 516–17.

306. *Id*. at 517 (citing Eve Glicksman, *Transgender Today*, 44 MONITOR ON PSYCH. 36 (Apr. 2013), https://perma.cc/9ZHE-Q8XQ).

307. Gage, *supra* note 290, at 505–10.

308. *Id*. at 527–28.

309. SANDY E. JAMES, JODY L. HERMAN, LAURA E. DURSO, & RODRIGO HENG-LEHTINEN, NAT'L CTR. FOR TRANS EQUAL., EARLY INSIGHTS: A REPORT OF THE 2022 U.S. TRANSGENDER SURVEY 16–17 (2024).

310. 45 C.F.R. § 156.111 (West, Westlaw through April 8, 2024, 89 FR 24676); *Information on Essential Health Benefits (EHB) Benchmark Plans*, *supra* note 72; NAT'L HEALTH L. PROGRAM, *Comment Letter on Request for Information on the Essential Health Benefits* (Dec. 6, 2021), https://perma.cc/VB8L-QGUG.

311. *See* 45 C.F.R. § 156.111 (West, Westlaw through April 8, 2024, 89 FR 24676).

312. Héctor Hernández-Delgado & Wayne Turner, NAT'L HEALTH L. PROGRAM, *Addressing Health Disparities Through the Essential Health Benefits Presentation at National Association of Insurance Commissioners Special Committee on Race and Insurance September 2023 Meeting* (Sept. 19, 2023), https://perma.cc/R3DA-HYBG.

inconsistencies and coverage gaps.[313] Second, 41 EHB benchmark plans (out of 51 across the country) continue to use discriminatory and outdated blanket exclusions of gender-affirming care.[314] This is in spite of the fact that the EHB nondiscrimination provision states that "a non-discriminatory benefit design that provides EHB is one that is clinically-based"[315] and the AMA's continued support for gender-affirming care as "medically-necessary, evidence-based care that improves the physical and mental health of transgender and gender-diverse people."[316]

Additionally, these exclusions are out of step with trends in employer coverage. According to the 2023–2024 Human Rights Campaign Corporate Equality Index ("CEI"), 73% of the Fortune 500 and 94% of all CEI-rated businesses (1,298 of 1,384) offer transgender-inclusive health insurance coverage—25 times as many businesses as in 2009.[317] Further, of the 1,298 businesses with at least one inclusive plan, 1,231 also eliminated all exclusions across plans.[318] The EHB benchmark plans' exclusions of gender-affirming care are also out of step with other types of coverage: 46 states and territories, as well as D.C., do not have exclusions of gender-affirming care in their Medicaid programs, and 24 states and D.C. have explicit laws or regulatory guidance in place prohibiting transgender-specific exclusions in state-regulated private insurance.[319] Colorado proactively took the step in 2022 of removing the transgender-specific exclusion from its EHB benchmark plan, which CMS approved.[320] However, this state-by-state approach violates CMS's professed commitment to health equity and nondiscrimination by continuing to allow plans to discriminate against transgender EHB plan enrollees in a manner prohibited by federal law and by half of the states themselves.[321] A more effective solution is to amend the EHB to explicitly include gender-confirming treatment as medically necessary.[322] The 2022 Proposed Rule issued

313. *Id.*

314. WHITMAN-WALKER INST., *Comment Letter on Request for Information on the Essential Health Benefits* (Jan. 31, 2023), https://perma.cc/8HRR-J2ZP.

315. 45 C.F.R. § 156.125 (West, Westlaw through April 8, 2024, 89 FR 24676).

316. Press Release, Am. Med. Assoc., AMA Reinforces Opposition to Restrictions on Transgender Medical Care (June 15, 2021), https://perma.cc/3W7S-HQT4.

317. *Corporate Equality Index 2023-2024*, HUM. RTS. CAMPAIGN (Nov. 2023), https://perma.cc/CMU4-5H8N.

318. *Id.*

319. WHITMAN-WALKER INST., *supra* note 314. Even state laws banning transgender-specific exclusions have limitations: banning transgender-specific exclusions has little effect if gender-affirming care remains unavailable under general state exclusions for "cosmetic" or "medically unnecessary" care. The best of existing state antidiscrimination provisions make clear that categorically deeming gender-affirming treatments to be "cosmetic" or "unnecessary" is a form of discrimination. Richard Luedeman, *Health Plan Coverage for Gender-Affirming Care: Continued Shortcomings at the Federal Level and a Role for Progressive States*, 22 NEV. L.J. 1071, 1104–05 (2022).

320. WHITMAN-WALKER INST., *supra* note 314; *Biden-Harris Administration Greenlights Coverage of LGBTQ+ Care as an Essential Health Benefit in Colorado*, CTR. FOR MEDICARE & MEDICAID SERVS. (Oct. 12, 2021), https://perma.cc/JBS5-PJQY.

321. WHITMAN-WALKER INST., *supra* note 314.

322. *Id.*

by the Biden administration seeks to prohibit categorical exclusions of gender-affirming care by amending 45 C.F.R. § 92.206(b)(4) to prohibit a covered entity[323] from denying or limiting "health services sought for the purposes of gender transition that the covered entity would provide to an individual for other purposes, if the denial is based on sex assigned at birth, gender identity, or gender otherwise recorded."[324] Additionally, the 2022 Proposed Rule would amend 45 C.F.R. § 92.207(b)(4) and (b)(5) to prohibit a covered entity from having or implementing a categorical coverage exclusion or limitation for all health services related to gender transition or other gender-affirming care or otherwise deny or limit coverage or deny a claim for specific health services related to gender transition, if such a policy results in discrimination against the individual seeking services. The language of § 92.207(b)(5) implicitly prohibits treatment-specific exclusions of gender-affirming care, but advocates have expressed support for making treatment-specific exclusions explicitly prohibited given that a substantial portion of marketplace insurers continue to exclude a range of specific treatments despite removing categorical exclusions of *all* kinds of gender-affirming care (for example, an insurer may exclude coverage for breast augmentation for transgender women but include coverage for other procedures).[325] Notably, HHS states in the Proposed Rule that these provisions do not affirmatively require covered entities to cover any particular procedure or treatment for transition-related care.[326] Advocates have asked the Department to clarify that exclusions of specific treatments for gender transition may be discriminatory regardless of whether those same treatments are covered for other purposes.[327] This is because insurers may justify denial of coverage for certain procedures by claiming that those procedures are purely cosmetic for both cisgender and transgender individuals, however, the assumption that such surgeries are purely cosmetic for transgender people is in itself discriminatory.[328]

Despite the efforts of the Biden administration to prohibit discrimination on the basis of gender identity via Section 1557 of the ACA, discrimination in health care against transgender patients persists. According to the 2022 U.S. Transgender Survey, 24% of respondents did not see a doctor when needed in the last 12 months due to fear of mistreatment.[329] Of those who had seen a provider within the last twelve months, 48% reported having at least one negative experience because they were transgender, such as being refused health care, being

323. Under the Biden administration's proposed rules, health insurance issuers are covered entities. Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47824, at 47868 (proposed Aug. 4, 2022) (to be codified at 45 C.F.R. pt. 92).

324. *Id*. at 47867.

325. NAT'L WOMEN'S L. CTR., *Comment Letter on Nondiscrimination in Health Programs and Activities* (Oct. 3, 2022), https://perma.cc/Q9TJ-HQC3; OUT2ENROLL, SUMMARY OF FINDINGS: 2021 MARKETPLACE PLAN COMPLIANCE WITH SECTION 1557, at 1 (2020), https://perma.cc/ARJ5-658N.

326. Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47824, at 47872 (proposed Aug. 4, 2022).

327. NAT'L WOMEN'S L. CTR., *supra* note 325.

328. *Id*.

329. James, Herman, Durso, & Heng-Lehtinen, *supra* note 309.

misgendered, having a provider use harsh or abusive language when treating them, or having a provider be physically rough or abusive when treating them.[330] HHS summarized comments it received during rulemaking in 2020 by noting that:

> providers . . . used excessive precautions, avoided touching the patient, engaged in unnecessary physical roughness in pelvic examinations, made insensitive jokes, intentionally concealed information about options for different treatments, asked unnecessarily personal questions, referred to transgender patients by pronouns and terms of address based on their biological sex [assigned at birth] rather than their gender identity, and/or disclosed a patient's medical history without authorization.[331]

While Section 1557 provides a recourse for transgender patients who face discrimination in health care, it is not a panacea. Remedying transgender health disparities also requires training physicians not to engage in discrimination in the first place. In the American Medical Association Journal of Ethics, Antonio Garcia and Ximena Lopez, M.D. outline several recommendations for physicians to help prevent harm when interacting with cisgender patients.[332] First, they recommend signaling an inclusive clinical environment to patients by openly communicating a commitment to gender-affirming care and prominently displaying nondiscrimination policies in provider offices.[333] Next, they recommend employing gender sensitivity in communication by respecting the name and pronouns by which patients identify.[334] They also recommend keeping in mind multiple marginalized experiences when caring for transgender patients with multiple marginalized identities.[335] Finally, they recommend enrolling in cultural competency trainings and avoiding pathologizing and gatekeeping by following the World Professional Association for Transgender Health's ("WPATH") Standards of Care.[336] Eliminating health disparities in the transgender community will require collaboration between the legal and medical communities, along with continued dialogue with and guidance from the trans community. The ACA has made great steps in combating discrimination within the healthcare industry, and the 2022 Proposed Rule interpreting Section 1557 will help tremendously, though the Proposed Rule will likely face many legal challenges in the years ahead.

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330. *Id.*

331. Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37160, at 37191 (June 19, 2020).

332. Antonio D. Garcia & Ximena Lopez, *How Cisgender Clinicians Can Help Prevent Harm During Encounters with Transgender Patients*, 24(8) AM. MED. ASS'N J. ETHICS 753, 756 (2022).

333. *Id.*

334. *Id.*

335. *Id.*

336. *Id.* at 757.

V. CONCLUSION

The ACA has expanded access to health care significantly, particularly health care specific to gender-marginalized people such as women and the LGBTQIA+ community. However, legislative and regulatory updates, combined with legal challenges, have ensured that the relative roles of insurers, patients, and providers remain unsettled. The law continues to be contentious. Unsuccessful challenges to the constitutionality of the ACA in 2012, 2015, and 2021 in *National Federation of Independent Businesses v. Sebelius*,[337] *King v. Burwell*,[338] and *California v. Texas*,[339] respectively, have not deterred its opponents from their continued opposition. One recent challenge is *Neese v. Becerra*, in which Judge Kacsmaryck of the U.S. District Court for the Northern District of Texas ruled in favor of Texas doctors who challenged the 2021 Federal Register Notice announcing that Section 1557 would be enforced consistent with the decision in *Bostock v. Clayton County* that sex discrimination includes discrimination on the basis of sexual orientation and gender identity under the Administrative Procedure Act ("APA") and the Declaratory Judgment Act ("DJA").[340] As of 2024, the case is on appeal to the Fifth Circuit, and will likely be dismissed once the 2022 Proposed Rule which codifies protections against discrimination on the basis of sex as including discrimination on the basis of sexual orientation and gender identity is finalized.[341] The final rule will likely be subject to various legal challenges once promulgated. It is likely that the upcoming open enrollment period for 2025 will be a trying one for the ACA and the government infrastructure that is designed to deliver its key services. The ACA is sure to remain a divisive issue, even as implementation goes forward and its full impact is realized.

337. 567 U.S. 519 (2012).
338. 576 U.S. 473 (2015).
339. 141 S. Ct. 2104 (2021).
340. Neese v. Becerra, 640 F. Supp. 3d 668 (N.D. Tex. 2022).
341. Mary Anne Pazanowski, *US Seems Likely to Prevail in LGBTQ+ Health Bias Standing Fight*, BLOOMBERG L. (Jan. 8, 2024, 1:49 PM), https://perma.cc/GH6K-QMHA.