SEYFARTH SHAW

Health Care Reform Management Alert Series

Final ACA Nondiscrimination Rules Under Section 1557 Now Effective

Issue 101

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This is the one hundred and first issue in our series of alerts for employers on selected topics on health care reform. (Click here to access our general Summary of Health Care Reform and other issues in this series.) This series of Health Care Reform Management Alerts is designed to provide an in-depth analysis of certain aspects of health care reform and how it will impact your employer-sponsored plans.

On July 18, 2016, the final Department of Health and Human Services (HHS) regulations under Section 1557 of the Affordable Care Act (ACA) officially went into effect, although as described below, many of the standards included under those rules have a delayed effective date. Section 1557 generally prohibits "covered entities", which includes certain health plans, health plan administrators, providers and insurers, from discriminating on the basis of race, color, national origin, sex, age, or disability. Despite the fact that these rules are final, many uncertainties remain, leaving health plans and other entities struggling to determine (a) whether they are subject to the rule, and (b) if so, what that means.

Who is Subject to Section 1557?

Covered entities include the following entities and programs:

1. An entity operating a health program or activity, any part of which receives funding from HHS.

    a) "Health program or activity" means the provision or administration of health-related services, health-related insurance coverage, or other health-related coverage, and the provision of assistance to individuals in obtaining health-related services or health-related insurance coverage.

    b) If an organization is "principally engaged" in providing or administering health services or health insurance or health coverage, the law applies to the entire organization, not just the health program or activity receiving HHS funding. The rules specifically provide that this includes hospitals, health clinics, group health plans, health insurance issuers, physician's practices, community health centers, nursing facilities, residential or

What types of HHS Funding Trigger Section 1557?

HHS provides the following examples of funding that could require Section 1557 compliance:

- grants,
- property,
- Medicaid,
- Medicare Parts A, C and D payments, and tax credits and cost-sharing subsidies under the ACA. (Medicare Part B is not included.)

community-based treatment facilities, or other similar entities. (For example, all health plans offered by a hospital employer would be covered.)

2. Federal and State Health Insurance Marketplaces

3. Employee Health Benefit Programs that receive HHS funding, including:

    a) Health coverage provided to employees and/or their dependents;

    b) An employer- sponsored wellness program;

    c) An employer-provided health clinic; or

    d) Long-term care coverage.

InSeyt: For many employer-sponsored plans, Section 1557 will be triggered by receipt of a Medicare Part D subsidy, the HHS subsidy provided to plans covering Medicare-equivalent prescription drug coverage. Because the final rules apply to "an entity that operates a health program", it is unclear whether the rules allow disaggregation of health plans offered by an employer. For example, if an employer maintains a separate retiree-only plan that offers prescription drug coverage and receives a Part D subsidy under the retiree plan, but does not receive a Part D subsidy under the active plan, a strong argument exists that only the retiree plan would be subject to Section 1557 final rules. (This argument may not apply if one trust fund covers both active employees and retirees, or in other cases where a multiemployer plan is involved.)

Notably, the final rules do not include an exemption based on religious beliefs. Notwithstanding the foregoing, the rule notes that where application of Section 1557 would result in a violation of applicable Federal statutory protections for religious freedom, HHS will not enforce the standards. In addition, the rules do not exempt benefits excepted from the ACA market reforms and HIPAA portability rules.

What is Required by Section 1557?

1. *No discrimination in health coverage.* In providing health coverage, a covered entity may NOT on the basis of race, color, national origin, sex, age, or disability:

- Deny, cancel, limit or refuse to issue or renew health coverage.
- Deny or limit a claim or impose additional cost-sharing or other limitations or restrictions on coverage.
- Engage in discriminatory marketing practices or adopt or implement discriminatory benefit designs.

2. *On the basis of sex.* In addition, a covered entity may not:

- Deny or limit coverage or a claim (or impose additional cost-sharing or other limitations or restrictions on coverage) for health services provided to a transgender individual based on the fact that the individual's sex assigned at birth or gender identity is different from the one to which such services are ordinarily available. (For example, the covered entity may not deny a mammogram or pap smear for a transgender man simply because their recorded gender is male.)
- Categorically exclude coverage for all health services related to gender transition.
- Deny or limit coverage or a claim (or impose additional cost-sharing or other limitations or restrictions on coverage) for specific health services related to gender transition if such denial or limitation results in discrimination against a transgender individual.

Although the rules prohibit discrimination on the basis of sex stereotyping and gender identity, the final rules do not go so far as to prohibit discrimination on the basis of sexual orientation. The final rules note that case law on this point is evolving and HHS will continue to monitor those developments.

These prohibitions may cause many plans that are subject to Section 1557 to revisit their plan design and/or exclusions, as many third-party administrators routinely exclude services relating to gender dysphoria or gender reassignment. Notably, the rules do not *mandate* coverage for gender transition related surgery, but if the plan intends to cover those types of procedures for other purposes (e.g., corrective surgery for a child born with under-developed genitalia or a hysterectomy for cancer treatment), then it would be difficult to exclude coverage for such service for a transgender individual with gender dysphoria.

The rule notes that many plans not subject to Section 1557 may nonetheless use a third-party administrator (TPA) that is subject to Section 1557. HHS notes that use of a Section 1557-governed TPA alone will not render a plan subject to Section 1557. When evaluating whether there is a Section 1557 violation, HHS will attempt to discern whether the discrimination is in operation (in which case the liable entity would be the TPA), or in design (in which case the liable entity might be the plan sponsor, to the extent the plan is subject to Section 1557).

Finally, the rule notes that plans may not circumvent these standards based on a medical necessity standard. HHS notes that medical evidence does not support the argument that treatments related to gender dysphoria are, by their very nature, not medically necessary.

Can a Plan Exclude Coverage for Transgender Services if it is not Subject to Section 1557?

As we have noted previously, courts continue to scrutinize whether Title VII prohibits employers from discriminating on the basis of gender identity. It is the position of the EEOC and the Obama administration generally that Title VII prohibits employers from discriminating on the basis of gender identity. Further, Federal contractors are subject to a separate but similar set of nondiscrimination requirements under OFCCP rules. As such, employers should carefully consider whether gender identity- exclusions could give rise to liability under applicable federal and state laws.

3. *No discrimination based on disability.* This standard requires covered entities to make reasonable changes to policies, practices and procedures to accommodate persons with disabilities. Also, covered entities must make any electronically-provided services or systems (such as an online enrollment platform) accessible to persons with disabilities. (See our blog on accessible technology requirements here http://www.adatitleiii.com/2016/06/new-healthcare-regulations-impose-accessible-technology-requirements/) Newly constructed or altered facilities must be made accessible, and covered entities must make auxiliary aids and services (e.g., sign language interpreters, TTY, captioning, etc.) for disabled persons, free of charge.

4. *Language Assistance.* The final rule requires covered entities to take various steps to provide persons with limited English proficiency (LEP) meaningful access to health programs. These steps would include:

- Providing oral language assistance through a qualified interpreter (free of charge) or written translations.
- Publishing taglines (short statements in non-English languages) informing LEP individuals about the availability of language assistance services, as explained below.

Notice Requirements

Communications should be posted in a conspicuously visible font size:

- In significant publications and significant communications;
- In conspicuous physical locations where the covered entity interacts with the public; and
- In a conspicuous location on the covered entity's Web site.

Small communications, such as postcards and tri-fold brochures - Only the nondiscrimination statement and taglines should be posted in a conspicuously-visible font size.

Each covered entity must post:

1. A notice conveying the following information:

- That the covered entity does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities;
- That the covered entity provides appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner, when such aids and services are necessary to ensure an equal opportunity to participate to individuals with disabilities;
- That the covered entity provides language assistance services, including translated documents and oral interpretation, free of charge and in a timely manner, when such services are necessary to provide meaningful access to individuals with limited English proficiency;
- How to obtain the aids, services and assistance described above;
- If applicable*, the availability of a grievance procedure and the contact information for the Civil Rights Coordinator with whom the grievance may be filed; and
- How to file a discrimination complaint with the Office of Civil Rights (OCR) at HHS.

2. A nondiscrimination statement that states the covered entity does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs or activities.

3. Taglines in at least the top 15 languages spoken by individuals with limited English proficiency of the relevant state or states. (For small communications such as post cards, post taglines in at least the top two languages.)

   The HHS website contains translated resources for covered entities: http://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html

*Only covered entities that employ 15 or more persons are required to adopt grievance procedures and designate a responsible employee to coordinate grievances.

When is the Rule Effective?

The rule is generally effective July 18, 2016 (60 days following issuance of the final regulations). Notwithstanding the foregoing, the rules contain a delayed effective date in two circumstances:

- If the rule requires changes to a health plan design, the rule applies the first day of the first plan year beginning on or after January 1, 2017.
- The notice and tagline requirements discussed above are effective October 16, 2016, except that covered entities may exhaust their current stock of hard copy publications rather than printing entirely new publications.

Enforcement

The enforcement provisions in the final rule are fairly robust. Where noncompliance cannot be corrected with the OCR informally, available enforcement mechanisms include termination of HHS funding, referral to the Department of Justice, and any other means authorized by law. The final rules also provide that compensatory damages are available in appropriate administrative and judicial actions.

To Do List

- Determine if you are a covered entity that received funds from HHS.
- Determine if the covered entity has 15 or more employees.
- Determine if the covered group health plan requires benefit plan design changes.
- Prepare necessary communications.

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