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Management Alert

Section 1557 of the Affordable Care Act: Implications for Health Care Providers and Health Insurers

By Shad Fagerland and Sheryl Dacso, Dr. P.H.

Section 1557 of the Affordable Care Act (the "ACA") prohibits discrimination on the basis of race, color, national origin, sex (including gender identity), age, or disability under any health program or activity that receives federal financial assistance. Final regulations under Section 1557 published by the Department of Health and Human Services ("HHS") on May 18, 2016, apply to certain health care providers that receive funding from a federal program administered by HHS. These rules impose several requirements that require prompt action from covered entities, including notice requirements and rules regarding coverage of services related to gender transition.

For an overview of Section 1557 and the final regulations, see this Health Care Reform Management Alert. Read below for a more specific discussion of requirements applicable to health care providers, health insurers, and other entities in the health care industry.

What is Section 1557?

Enacted in 2010 as part of the ACA, Section 1557 prohibits discrimination on the grounds prohibited by certain enumerated civil rights laws, including Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, and Section 504 of the Rehabilitation Act of 1973 (Section 504). Section 1557 thus prohibits covered health programs and activities from discriminating on the basis of race, color, national origin, sex, age, or disability.

Who is subject to Section 1557?

The general prohibition against discrimination under Section 1557 applies to any "health program or activity" that receives "federal financial assistance."

Final regulations published by HHS impose several additional requirements on "covered entities" that operate certain health programs or activities that are covered by Section 1557. The final regulations apply only to health programs or activities that receive funding from a program administered by HHS, including Medicare (with the exception of Medicare Part B), Medicaid, and advance payments of premium tax credits through a federal or state marketplace. Examples of covered entities include (but are not limited to) hospitals, certain medical practices, clinics, or similar health care providers that receive Medicare (Part

A or D) or Medicaid payments; health plan administrators, including third-party administrators, that receive any form of HHS funding; and most insurance providers that offer health policies through a state or federal marketplace.

Can a health care provider be subject to Section 1557 but not be a covered entity that is subject to the final regulations?

Yes. If a health care provider does not receive funding from a federal program administered by HHS but operates a health program or activity that receives funding from a different federal agency, the health care provider may be subject to the general prohibition against discrimination under Section 1557 but not the specific requirements of the final regulations.

What effective dates apply under Section 1557?

The general prohibition against discrimination under Section 1557 became effective when the ACA was passed in 2010. Final regulations were published on May 18, 2016 and generally went into effect on July 18, 2016, with the following exceptions:

- Notice requirements under the final regulations become effective on October 16, 2016 (90 days after the July 18, 2016 general applicability date); and
- To the extent that changes to terms of coverage are necessary to bring a covered health program into compliance with the final regulations, such changes are not required to be in place until the first day of the plan year (or policy year) starting on or after January 1, 2017.

What steps is a covered entity required to take to comply with Section 1557 and the final regulations?

Section 1557 generally prohibits a covered entity from discriminating on the basis of any protected category under any health program or activity operated by the covered entity. In addition to this general prohibition against discrimination, the final regulations require that covered entities:

- Provide "assurances" on a form provided by HHS that the entity complies with Section 1557 and the final regulations, as a condition of receiving funding through any program administered by HHS;
- Provide any auxiliary aids and services necessary to enable individuals with disabilities to have meaningful access to the health program or activity, at no cost to the individual;
- Provide language assistance services to individuals with limited English proficiency, at no cost to the individual;
- Post a nondiscrimination notice on the covered entity's website, in physical locations where the covered entity interacts with the public, and in any "significant publications and significant communications" about the covered health program or activity;
- If the covered entity has 15 or more employees, identify a "Civil Rights Coordinator" responsible for overseeing the covered entity's Section 1557 compliance efforts; and
- If the covered entity has 15 or more employees, adopt grievance procedures for resolving complaints about potential violations of Section 1557.

What specific health programs or activities must be operated in compliance with the final regulations?

If *any* health program or activity operated by a covered entity receives funding from HHS, then Section 1557 applies to every health program or activity operated by the covered entity. For example, if an insurer receives premium tax credit payments through individual health insurance policies offered on a federal or state marketplace, the final regulations apply not only to those specific policies that are offered through the marketplace but also to every other health insurance policy or program issued or operated by the covered entity outside the marketplace.

In addition, if the covered entity is "principally engaged" in providing or administering health services, health insurance coverage, or other health coverage, Section 1557 also applies to any group health plans sponsored or administered by the covered entity for its own employees.

What specific requirements apply to coverage of services related to gender transition?

The final regulations specifically prohibit a covered entity from discriminating on the basis of gender identity, including transgender status. Covered health programs may not apply a "categorical exclusion or limitation for all health services related to gender transition." In addition, covered health programs may not deny or limit coverage or impose additional cost-sharing requirements or other restrictions for specific services related to gender transition "if such denial, limitation, or restriction results in discrimination against a transgender individual."

What consequences could be triggered if a covered entity fails to comply with the requirements of Section 1557 and the final regulations?

An individual alleging violation of Section 1557's nondiscrimination requirements may file a legal claim against the covered entity to the extent permitted under any applicable federal statute cross-referenced in Section 1557. Additionally, HHS may investigate complaints about conduct alleged to violate Section 1557 and require covered entities to take appropriate remedial action.

Perhaps more significantly from the perspective of the health care provider community, failure to comply with the requirements of Section 1557 and the final regulations could also result in loss of eligibility for HHS funding. The final regulations require, as a condition of receiving any payment through a program administered by HHS, that a covered entity give "assurances" that the covered entity's health programs will be administered in compliance with Section 1557 and the final regulations. Now that final regulations have become effective, covered entities should consider carefully whether these assurances require the covered entity to represent that it is currently in compliance with all applicable requirements under the final regulations.

What should a health care provider or other covered entity be doing now to develop its Section 1557 compliance strategy?

A health care provider, insurer, or other members of the health care community should first confirm whether it receives funding or subsidies from any program administered by HHS (Medicare (excluding Part B, but including Part A or D); Medicaid; premium tax credit payments received through an Exchange; etc.) and is therefore subject to Section 1557. Participating as a

Medicare Part B provider, alone, is not sufficient to create covered entity status. If the entity is subject to Section 1557, we recommend the following actions:

- Appoint an employee (or group of employees) to oversee the entity's Section 1557 compliance efforts and service as the "Civil Rights Coordinator" required under the final regulations (if the entity has 15 or more employees).
- Ensure that auxiliary aids and services and language assistance services meeting the minimum requirements of the regulations are available under each covered health program.
- Draft the required nondiscrimination notice and, if the entity has 15 or more employees, grievance policy.
- Conduct a thorough survey of covered services, exclusions, limitations, and cost-sharing provisions (including but not limited to coverage of services involving gender transition) to determine if any changes are required to come into compliance with the final regulations, and make put any changes into effect by the first day of the first plan year or policy year starting on or after January 1, 2017.
- Conduct training for appropriate employees to ensure awareness of the requirements of Section 1557.

Shad Fagerland is a senior counsel in Seyfarth Shaw's Washington, D.C. office. Sheryl Dacso is a partner in the firm's Houston office. If you have any questions about the impact of Section 1557 on your organization, please contact your Seyfarth Shaw LLP attorney, Shad Fagerland at sfagerland@seyfarth.com or Sheryl Dacso at sdacso@seyfarth.com.