September 2, 2016

ACA Section 1557 - Nondiscrimination in Health Programs and Activities

The Nondiscrimination in Health Programs and Activities final rule went into effect July 18, 2016 and with it comes additional compliance obligations for "covered entities" subject to its rules. (The term "covered entity" in this case is different from the term under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is explained in more detail below). Employers should determine if they are a covered entity or if they sponsor a group health plan (GHP) that is a covered entity under the final rule. This update focuses on the specific obligations related to GHPs affected by this rule. Necessary plan design changes must be made to the GHP no later than the first day of the first plan year that begins on or after January 1, 2017.

General Background

The final rule implements Section 1557 of the Affordable Care Act (ACA) and generally prohibits "covered entities" from discriminating in health programs and activities that receive federal financial assistance from the Department of Human and Health Services (HHS). According to the HHS, "Section 1557 is important to achieving the Affordable Care Act's goals of expanding access to healthcare and coverage, eliminating barriers, and reducing health disparities" and "…will help to advance equity and reduce health disparities by protecting some of the populations that have been most vulnerable to discrimination in the healthcare context."

The final rule, also referred to as the civil rights provision of the ACA, prohibits discrimination in healthcare on the basis of race, color, national origin, age, disability and sex (including discrimination based on pregnancy, gender identity and sex stereotyping). While the guidance provides for the general prohibition of denying health coverage or care to individuals based solely on gender identity, an area where many have awaited additional guidance since the release of the proposed rule, the final rule also provides for enhanced language assistance for people with limited English proficiency and helps to ensure effective communication for individuals with disabilities.

HHS has a webpage dedicated to Section 1557, which includes links to a Summary of the Final Rule, Frequently Asked Questions (FAQs), and numerous factsheets created to help individuals understand their rights under Section 1557 and to assist covered entities subject this provision in understanding their responsibilities.

Covered Entities

Section 1557 rules apply to employers in the healthcare industry (i.e., hospitals, medical clinics, nursing homes, physician practices, etc.) and employers that sponsor GHPs to the extent that these employers and plan sponsors receive federal financial assistance from HHS. Health insurers and TPAs that are part of a larger insurer's operations, are also subject to these rules if these entities receive federal funding. Specifically, a covered entity includes:

- any health program or activity, any part of which, receives federal financial assistance from HHS (such as hospitals that accept Medicare or doctors who receive Medicaid payments),
- state based and federally facilitated health insurance Marketplaces/Exchanges and all plans offered by issuers that participate in those Exchanges, and
- HHS (all heath programs and activities administered by HHS)

There is no general religious exemption under the final rule, but the Section 1557 rules do not supersede existing protections for religious freedom and conscience, such as the Religious Freedom Restoration Act.

Impact on Certain Employer Sponsored Plans

Not all employers and/or their GHPs will be covered entities for Section 1557 purposes. But all employers should carefully consider this designation and determine if they or their GHPs are subject to these rules. An employer's (plan sponsor's) primary business function and whether the employer receives federal financial assistance in connection with their business operations or GHP will determine if the employer or GHP has compliance obligations under Section 1557. A GHP's funding mechanism (insured or self-insured) may also influence the impact on a GHP since most health plan insurers are also subject to Section 1557, and through compliance efforts of their own, may update policy and claim provisions to adhere to the new rules.

An employer and its GHP are separate legal entities under the provision.

- If an employer is principally engaged in providing health services or activities and receives funding from HHS, the employer is a covered entity and must comply with Section 1557 in its operation. If this covered entity also offers a GHP to its employees, the GHP must also comply with Section 1557. The employer would also be subject to Section 1557 in its provision or administration of employee health benefit programs to its employees. (For example, if a hospital provides health benefits to its employees, it will be covered by Section 1557 not only for the services it offers to its patients, but also for the GHP it provides to employees.)
- Any GHP that receives federal financial assistance to fund its program (such as the Retiree Drug Subsidy or "RDS") is considered a covered entity subject to Section 1557, even if the sponsoring employer is not in the healthcare industry. In this case, the sponsoring employer is not a covered entity based on its primary business so it is not subject to Section 1557 in its operations. However, the GHP that receives monies from HHS to primarily fund the GHP is subject to Section 1557 and the provision or administration of the GHP will be covered by Section 1557, regardless of the business in which the employer is engaged. Any other GHPs of the sponsoring employer (not in the healthcare field) that do not receive federal assistance would not be subject to Section 1557.
- If the employer is not principally engaged in providing health services or activities and the employer does not receive federal financial assistance to fund any of its GHPs, neither the employer nor its GHP is a covered entity subject to Section 1557. However, depending on the GHP's funding arrangement, the employer or GHP may by impacted by Section 1557.

- **Fully insured health coverage –** The health insurer is likely subject to the ACA's nondiscrimination rules under Section 1557. If so, the insurance carrier must comply with the requirements under the law.
- **Self-insured health coverage –**
  - Self-insured medical plans of employers that are not in the healthcare industry and are not receiving federal financial assistance to fund any of its GHPs are not directly subject to the rules, so these plans are not required to comply with the final rule. Nevertheless, employers who opt not to adopt nondiscrimination practices based on gender identity (or other areas identified under section 1557) may face discrimination claims from employees and should discuss this potential liability with their legal advisors.
  - Also, many self-insured medical plans use third party administrators (TPAs). In the case where the TPA (who receives financial assistance) is also an insurer, or otherwise provides healthcare services, all of the entity's operations are covered. This means that TPAs who are covered entities may not administer plans in a discriminatory manner and the TPA will be responsible for its own discriminatory practices within its operating authority. So, for example, a TPA may be liable if the TPA denies a claim because the individual's last name suggests that he or she is of a certain national origin, or if the TPA threatens to expose an employee's transgender or disability status to his or her employer.
  - Conversely, TPAs under the rule are generally not liable for a discriminatory plan design of the self insured GHP they administer (this liability rest with the plan sponsor). The rule recognizes that ERISA (and likely the contracts into which TPAs enter with the plan sponsors) requires plans to be administered consistent with their terms. As a result, a determination may be made as to whether responsibility for the decision or other action alleged to be discriminatory rests with the employer. So, for example, the employer may be liable if the discrimination is related to a self-insured GHP's benefit design (for example, a plan that excludes coverage for all health services related to gender transition), or where the employer is separately subject to Section 1557 (for example, the employer is a hospital that receives federal funding and provides a discriminatory GHP to its employees).
  - TPAs, including Pharmacy Benefit Managers, directly subject to these rules have began sending out information to employer-sponsored GHPs in an attempt to assist with compliance efforts for plan that may be subject to these rules. Self-insured covered entities may have to provide TPAs with assurances that their plan complies with Section 1557 nondiscrimination rules or submit information to the TPA to assist with compliance efforts.

Requirements Under Section 1557

Section 1557 Frequently Asked Questions (FAQs) summarize the various obligations imposed on covered entities under its rule. The FAQs focus on sex discrimination (including gender identity, pregnancy and sex-stereotyping) and discrimination against disabled individuals and individuals with limited English proficiency. The major prohibitions under this law are as follows:

Sex Discrimination. Covered entities can not discriminate in health insurance or coverage, as Section 1557 broadly prohibits sex discrimination in all federally funded healthcare programs and

activities. The Protecting Individuals Against Sex Discrimination factsheet reviews sex discrimination prohibited under the law. Generally under the requirements, plans may not include a categorical exclusion of “all health services related to gender transition” or categorically exclude such services as “experimental” or “cosmetic”. A definition of “health services related to gender transition” is not provided under the rule, and as explained in the final rule, the “OCR intends to interpret these services broadly and recognizes that health services related to gender transition may change as standards of medical care continue.

Covered entities must provide equal access to health related programs and activities and treat individuals consistent with their gender identity. Covered entities, among other actions, can not deny, limit, or impose additional cost sharing on any health services that are ordinarily or exclusively available to individuals of one gender, based on the fact that an individual’s sex assigned at birth, gender identity, or recorded gender is different than the one to which the healthcare services are ordinarily available. This means that a covered entity should not deny well woman visits to a transgender woman, identified at birth as “male”, if the service being sought are necessary or appropriate. Likewise, treatment for ovarian cancer should not be denied for a transgender male, labeled as “female” at birth needing such treatment.

The guidance is clear that a health plan is not required to cover specific procedures or treatment (for example, covered entities are not required to cover gender transition surgery), nor does the rule require covered entities to provide coverage for all medically necessary health services related to gender transition (regardless of the scope of a plan’s coverage for other conditions), but entities are required to apply nondiscriminatory and neutral standards when administering and offering coverage to individuals. Also categorical coverage exclusions or limitations for health services related to gender transition are considered discriminatory.

Disability Discrimination. The Ensuring Effective Communication with and Accessibility for Individuals with Disabilities factsheet summarizes protections for individuals with disabilities. The final rule sets standards for accessibility of newly constructed or altered buildings and facilities, requires that covered entities adopt effective communication measures by using auxiliary aids and services to assist disabled individuals, and requires that health programs provided by electronic means and information technology be assessable. Covered entities are expected to modify policies and procedures as needed to provide disabled individuals with access to health related programs and activities.

Limited English Proficiency (LEP) Discrimination. Covered entities must take action to ensure individuals non-proficient in English have meaningful access to information and imposes a new notification requirement. The Ensuring Meaningful Access for Individuals with Limited English Proficiency identifies protections for individuals with limited English proficiency. Covered entities are expected to take reasonable steps to include language assistance services, such as oral language assistance or written translation. Covered entities are also required to post a notice for individuals with limited English proficiency explaining their rights to communication assistance. This notice requirement is explained in more detail below.

Administrative Requirements. A number of administrative requirements may be imposed on covered entities under the final rule. Among such requirements:

- Covered entities must provide HHS with assurances of compliance as a condition of applying for federal financial assistance.

- Covered entities with 15 or more employees must appoint an individual responsible for compliance under Section 1557 and must establish a grievance procedure for individuals who feel their rights have been violated.
- No later than October 17, 2016, a covered entity must post a nondiscrimination notice as a means to notify beneficiaries, enrollees, applicants, and members of the public of its nondiscrimination practices. The notice must alert individuals of the following:
    1. that the entity does not discriminate on the basis of race, color, national origin, sex, age, or disability in health related programs or activities
    2. that the entity provides auxiliary aids and services for disabled individuals and language services free of charge (information must be provided on how to obtain such services)
    3. provide the name and contact information of the individual responsible for Section 1557 compliance (if applicable)
    4. state general information about the grievance policy (if applicable) and how to file a grievance
    5. give information on how to file a discriminatory complaint with the OCR
- Covered entities must post nondiscrimination statements and taglines. Taglines are short statements in non-English notifying an individual of language assistance services and must be posted in at least the top 15 languages spoken within the state the entity does business or is located. Nondiscrimination statements and taglines must also appear in significant publications, be posted in prominent locations, and on the entity's website. Smaller size publications must include nondiscrimination language and taglines in the top two most prevalent non-English languages of the state.
- Sample nondiscrimination notices, statements, and taglines have been provided by the HHS in 64 languages to assist covered entities with notice obligations. Click here to access this information. HHS has also provided training materials for covered entities, which includes a presentation and presenter's guide.

Employer Next Steps

- Employers should first determine if they are a covered entity or if they sponsor a health plan that is a covered entity under Section 1557. Employers should work with their attorney as needed if questions arise regarding this designation.
- If an employer determines they or their GHP is a covered entity, the employer should take steps to comply as noted below with the advice of qualified counsel.
- Carefully review policies and practices to ensure there is no prohibited discrimination of any Section 1557 protected status. With respect to GHPs, the terms of benefits and coverage, cost sharing, claims processing and exclusions are common areas that may need to be reviewed. Blanket exclusions for services or benefits for transgender services may need to be removed from plan provisions.
- Appoint an individual to oversee Section 1557 compliance and adopt a formal grievance policy and process if 15 or more employees are employed by the covered entity.
- Review and implement any necessary administrative requirements imposed by Section 1557 which may include:
    - complying with the notice and posting requirements
    - drafting/updating policies and procedures as needed
    - implementing policies and procedures to comply with auxiliary aids and services and language assistance services

    - train employees on nondiscrimination requirements under Section 1557
- Work with insurers and TPAs as needed to make plan design changes or other updates needed to comply with the law.

Plan sponsors are encouraged to consult with legal counsel regarding how this guidance and other regulations impact their employer-sponsored GHPs. All self-insured GHP sponsors should monitor additional guidance and developing case law and review their plans to determine whether the plans categorically exclude or otherwise discriminate against transgender employees and whether any changes are required.

Please contact your Conner Strong & Buckelew account representative toll free at 1-877-861-3220 with any questions. For a complete list of Legislative Updates issued by Conner Strong & Buckelew, visit our online Resource Center.

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