HHS Releases Final PPACA Section 1557
Nondiscrimination Regulations

The Department of Health and Human Services’ (“HHS”) Office for Civil Rights released final regulations in May under the Section 1557 nondiscrimination provisions of the Patient Protection and Affordable Care Act (“PPACA”). The regulations are broad and far-reaching in terms of application and scope and in the requirements placed on certain health programs and activities. The final regulations prohibit discrimination in certain health programs and activities on the basis of race, color, national origin, sex, age, or disability. The regulations have garnered the most attention for the prohibitions against sex discrimination in certain health programs and activities. The final regulations also provide guidance regarding access for individuals with limited English proficiency and communication for individuals with disabilities. The regulations will have the greatest impact on health insurance issuers, health care providers, and select group health plans. The final rules will generally become effective beginning on July 18, 2016. However, if changes to plan design are required, the regulations provide more time for compliance – until the first day of the first plan year beginning on or after January 1, 2017.

This guidance should not be confused with PPACA Section 2716 which prohibits discrimination in favor of highly compensated individuals in fully-insured group health plans – that guidance is still forthcoming and will be based on the regulations under Internal Revenue Code Section 105(h) that are applicable to self-insured group health plans.

Section 1557 of PPACA

Section 1557 has been effective since PPACA was first passed in 2010, however, these rules are the first such guidance relating to its implementation. Generally, Section 1557 provides that an individual shall not be excluded from participation in, be denied the benefits of, or be subjected to discrimination based on race, color, national origin, sex, age, or disability under any health program or activity, any part of which receives any Federal financial assistance, under any program or activity that is administered by an executive agency of the Federal government, or any entity established under Title I of PPACA.

The regulations largely finalized the rules as proposed, with some modification and clarification. The changes and clarifications from the proposed regulations include when the rules will become effective, the application to third party administrators (“TPAs”), as well as changes to the requirements for providing language assistance to individuals with limited English proficiency and communication for individuals with disabilities.
Scope of Section 1557

The scope of Section 1557 is far-reaching with the rule applying broadly to many individual policies, fully-insured group health plans, and possibly self-insured group health plans. Section 1557 applies to “covered entities,” which include:

1. An entity that operates a health program or activity, any part of which receives Federal financial assistance;
2. An entity established under Title I of PPACA that operates a health program or activity (this includes State-based Marketplaces); and
3. Health programs and activities administered by HHS. These include the Federally-facilitated Marketplaces.

As is evident from the definition of a covered entity, Section 1557 only applies to health activities and programs which receive Federal financial assistance. Therefore, the definitions for “health activities and programs” and “Federal financial assistance” are vital. A health program or activity is defined broadly as providing or administering health-related services or insurance coverage and providing assistance to individuals to obtain health-related services or insurance coverage. Federal financial assistance means any grant, loan, credit, subsidy, contract (other than a procurement contract but including a contract of insurance), or any other arrangement by which the Federal government provides funds, services of Federal personnel, or real or personal property (or interest in or use of the property). Based on these definitions, issuers of health insurance that receive premium tax credits through the Marketplace are subject to the Section 1557 rules for any coverage they provided, whether sold inside or outside of the Marketplace, including employer-sponsored group health plans.

TPAs and Self-Insured Employers. The proposed regulations were ambiguous as to whether a TPA that is a part of a health insurance issuer would be subject to Section 1557. These TPAs feared they could be held liable for administering the discriminatory plan design of certain self-insured plans.

Under the final regulations, HHS did not completely exempt TPAs from Section 1557 liability. However, the final regulations do recognize that TPAs are generally not responsible for the benefit design of the self-insured plans they administer and that ERISA requires plans to be administered consistent with the terms of their plan documents. As a result, the regulations provide a framework by which HHS will assign liability for any complaints of discrimination brought against a TPA that is a covered entity. When a complaint is brought, HHS will determine whether responsibility for the decision or other action alleged to be discriminatory rests with the employer or with the TPA. A complaint will be processed against the TPA if the conduct at issue is found to be the responsibility of the TPA. For example, where a TPA denies a claim because the last name of an individual suggests a certain national origin, HHS would proceed against the TPA as the decision-making entity. However, if the alleged discriminatory conduct relates to the benefit design of a self-insured plan (and where the employer is subject to Section 1557), HHS would typically address the complaint against the employer.

Religious Exemption. In the preamble, HHS states that it declines to include a blanket religious exemption into the final regulations. HHS cites that, in the healthcare context, an individual may have a limited choice of providers (especially in a rural area) where hospitals have merged with or are run by religious institutions. HHS also cites that a blanket religious exemption could have the effect of delaying necessary...
healthcare. Finally, the final regulations include a provision that would prevent the application of Section 1557 where the result would be the violation of any Federal protections for religious freedom and conscience. For example, although no protection exists under Section 1557, protections may exist under the Religious Freedom Restoration Act (“RFRA”).

Prohibited Discrimination

As mentioned, Section 1557 prohibits discrimination in certain health programs or activities based on an individual’s race, color, national origin, sex, age, or disability. Prohibited discrimination would include denying, canceling, or limiting a health insurance plan or policy due to one or more of these factors. Additional cost sharing or other limitations could also not be imposed on the basis of race, color, national origin, sex, age, or disability.

Although the final regulations do not require a plan to cover any particular benefit or service, a covered entity could not have a coverage policy that operates in a discriminatory manner. For example, if a plan limits or denies coverage for certain services for a specific condition, HHS will evaluate whether coverage for a similar service or treatment is available to other individuals, including those with different health conditions and will evaluate the reasons for any differences in coverage. Covered entities should be prepared to provide a neutral, nondiscriminatory reason for the denial or limitation.

Notice Requirements

Covered entities are required to provide notice to beneficiaries, enrollees, applicants, and members of the public that:

- They do not discriminate based on race, color, national origin, sex, age, or disability,
- Appropriate auxiliary aids and services will be provided free of charge (including interpreters),
- The entity provides language assistance services,
- Include information on how to obtain such assistance,
- Identification of the individual responsible for compliance within the covered entity (including contact information),
- Grievance procedures are available (including information on how to file a grievance), and
- Describe how to file a discrimination complaint with HHS’s Office for Civil Rights.

Covered entities must also post a notice of nondiscrimination (with the above information) and taglines within 90 days of the effective date, which let individuals with limited English proficiency know language services are available. The taglines must be posted in at least the top 15 languages spoken by individuals with limited English proficiency within the relevant state. A covered entity must include a nondiscrimination statement in lieu of the full notice, and taglines in two non-English languages in lieu of all 15 taglines, on small-size significant publications and significant communications. HHS has provided a sample notice, nondiscrimination statement, and taglines as part of the final regulations. HHS’s translated resources can be found at: http://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html.

Discrimination on the Basis of Sex

The most notable part of these regulations is focused on the protections provided to transgender individuals. While most covered entities have already had to deal with prohibitions against discrimination
on the basis of race, disability, or national origin, the prohibition against discrimination on the basis of sex with respect to transgender individuals is new to many covered entities.

The regulations establish that covered entities must provide individuals with equal access to health programs or activities without discrimination on the basis of sex. Moreover, covered entities would be required to treat individuals consistent with their gender identity, rather than the gender assigned at birth. Gender identity, for the purposes of Section 1557, means an individual’s internal sense of gender, which may be different from an individual’s sex assigned at birth. HHS indicates that an individual has a “transgender identity” when the individual’s gender identity is different from the sex assigned to that person at birth. Failure to treat an individual consistent with their gender identity may constitute prohibited discrimination. However, HHS notes that not every health service that is typically provided to one gender would be appropriate for a transgender individual. For example, a covered entity would not be required to provide a traditional prostate exam to an individual that does not have a prostate, regardless of their gender identity.

The regulations provide that an explicit, categorical (or automatic) exclusion of coverage for all health services related to gender transition would be outdated and not based on current standards of care. Furthermore, a covered entity would be barred from denying or limiting coverage (or a claim for coverage), for specific health services related to gender transition where a denial results in discrimination against the transgender individual. In determining whether discrimination has occurred, HHS will evaluate whether a covered entity utilized, in a nondiscriminatory manner, a neutral rule or principle when deciding to adopt the design feature or take the challenged action or whether the reason for its coverage decision is a pretext for discrimination. For example, if a plan limits or denies coverage for certain services or treatment for a specific condition, HHS will evaluate whether coverage for the same or a similar service or treatment is available to individuals outside of that protected class or those with different health conditions and will evaluate the reasons for any differences in coverage. Covered entities will be expected to provide a neutral, nondiscriminatory reason for the denial or limitation that is not a pretext for discrimination. These provisions do not, however, affirmatively require covered entities to cover any particular procedure or treatment for transition-related care; nor do they preclude a covered entity from applying neutral standards that govern the circumstances in which it will offer coverage to all its enrollees in a nondiscriminatory manner.

Access for Individuals with Limited English Proficiency

In order to better effectuate the Section 1557 prohibition against discrimination based on national origin, the regulations provide guidance intended to provide greater access for individuals with limited English proficiency. A covered entity must take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities. HHS has indicated that a covered entity must develop and implement an effective written language access plan that is appropriate to its circumstances.

For Section 1557 purposes, language assistance services would need to be provided free of charge, be accurate and timely, and protect the “privacy and independence” of the individual with limited English proficiency.
Specifically, a covered entity may be required to offer a qualified interpreter for an individual with limited English proficiency when oral interpretation is a reasonable step towards providing meaningful access. The rules prohibit requiring an individual to provide their own interpreter or relying on an adult or child to provide interpretation unless under certain circumstances such as an emergency.

**Communication for Individuals with Disabilities**

A series of standards applicable to communication and accessibility of individuals with disabilities are also provided in the final regulations. These requirements incorporate protections under Title II of Americans with Disabilities Act and longstanding Department of Justice interpretations to provide clear communications with individuals with disabilities.

The final regulations also require covered entities to ensure that health programs and activities that are provided through electronic and information technology are accessible to individuals with disabilities, unless doing so would impose undue financial and administrative burdens, or would fundamentally alter the nature of the health program or activity. An example of providing accessible electronic or information technology is a Marketplace creating a website that ensures access to the blind or those with low vision, while still allowing access to comparison tools and information regarding eligibility. Where an undue financial or administrative burden or fundamental alteration exists, the covered entity would be required to provide information in a format other than electronic that would provide the maximum possible benefits or services to the individual with disability.

**Assurances**

An entity that is applying for Federal financial assistance (or an issuer seeking to participate in Marketplace coverage) must, as a condition of application for the assistance, submit an assurance (on a form specified by HHS) that the entity’s health programs and activities will be operated in compliance with Section 1557. HHS has the authority to find noncompliance if an entity or issuer fails to provide requested information in a timely, complete, and accurate manner.

**Enforcement**

The enforcement for Section 1557 falls under the mechanisms available under the laws that are incorporated. For example, the enforcement mechanisms under Title VI of the Civil Rights Act will apply to discrimination based on race, color, and national origin; Title IX of the Education Amendments will apply to discrimination on the basis of sex; the Age Discrimination Act will apply to discrimination based on age; and Section 504 of the Rehabilitation Act will apply to discrimination based on disability.

The existing enforcement mechanisms carried over from the underlying laws include the requirement that covered entities keep records and submit compliance reports to HHS and conduct compliance reviews and investigations, and provide technical assistance and guidance. Where noncompliance or threatened noncompliance cannot be corrected by informal means, the enforcement mechanisms available under the civil rights laws include suspension or termination of Federal financial assistance; referral to the Department of Justice with a recommendation to bring proceedings; and any other means authorized by law. Individuals also have a private right of action and damages for violations under Section 1557.
Gallagher Benefit Services, through its compliance experts and consultants, will continue to monitor developments on healthcare reform legislation and regulation and will provide you with relevant updated information as it becomes available. In the interim, please contact your Gallagher Benefit Services representative with any questions that you may have.

The intent of this analysis is to provide general information regarding the provisions of current healthcare reform legislation and regulation. It does not necessarily fully address all your organization’s specific issues. It should not be construed as, nor is it intended to provide, legal advice. Your organization’s general counsel or an attorney who specializes in this practice area should address questions regarding specific issues.