
**ACA Non-Discrimination Protections -**
**Immediate Action Required by July 18**

**IMPACT:**
**Group Health Care Plans, Their Insurers or TPAs,**
**Certain Plan Sponsors**

Section 1557 of the Affordable Care Act (ACA) and related regulations prohibit discrimination on the basis of race, color, national origin, sex, age, or disability, by any health program or activity that receives federal funding or assistance from the federal Department of Health and Human Services (HHS) or that is administered by an executive agency.

Since ACA became effective in 2010, the Office of Civil Rights (OCR) of HHS has enforced Section 1557. Recently, federal courts have held that this section of ACA allows individuals to sue if the individuals experience discrimination based on their protected status.

**If an employer receives federal financial assistance from HHS for any health care program or activity or sponsors a group health care plan through an insurer that receives federal financial assistance from HHS or if the employer uses a third-party administrator related to such an insurer to administer the employer's self-insured plan, odds are 9,999/10,000 that ACA's non-discrimination provisions and related regulations will apply to the employer's group health plan.**

**Quick action is required: the May 2016 Final Regulation and its operations and compliance requirements discussed below go into effect on July 18, 2016. Its posted notice requirements go into effect 90 days later on October 17, 2016.**

What entities are affected? What conduct is covered? What immediate actions are required? What are the penalties and enforcement for non-compliance?

**Entities affected:**

**Plan Sponsors and Group Health Care Plans Receiving Federal Financial Assistance from HHS:**

The Final Regulation applies Section 1557's non-discrimination prohibitions to employer-sponsored group health care plans (including multi-employer plans) if the plans receive federal financial assistance from HHS, or if their plan sponsors receive such assistance for any health program or activity, including wellness programs (for example), whether part of a group plan or not.

If an employer itself does not receive federal financial assistance from HHS, the Final Regulation seems to suggest that discrimination by a group health plan might not necessarily subject the employer offering that plan to Section 1557 liability, as it states:

> The fact that a group health plan is principally engaged in providing health services, health insurance coverage, or other health coverage, and therefore must comply with Section 1557 in all of its operations does not necessarily mean that an employer offering an employee health benefit program will be liable for a Section 1557 violation by the group health plan. 81 Fed. Reg. at 31438.

The Final Regulation also provides that OCR will determine the entity responsible for discriminatory benefit plan design.

**Group Health Care Plans Whose Insurers or TPAs Receive Federal Financial Assistance from HHS:**

The Final Regulation also applies Section 1557's non-discrimination prohibitions to a health insurance issuer's entire operations if any part of those operations receives federal financial assistance from HHS (e.g., by participating in the Marketplace exchanges or Medicare Advantage or by receiving Medicaid funds).

In addition, employers sponsoring self-insured group health care plans may have entered into administrative service agreements with third-party administrators (TPAs) that fall within the operations of covered health care insurers. OCR will determine whether a TPA remains legally separate from an insurer on a case-by-case basis.

Employers that sponsor group health care plans insured by covered health care issuers or that use covered TPAs for their self-insured plans should anticipate plan design changes by the insurers to avoid violating Section 1557. OCR will determine which entity (a TPA, an insurer, or a group health care plan) is responsible for discriminatory benefit plan design on a case-by-case basis.

**Group Health Plans Whose Service Providers Receive Federal Financial Assistance from HHS:**

Group health plan fiduciaries should be aware that ACA Section 1557 requirements and regulations affect all health care providers receiving payments from Medicare Part A, C, D, Medicaid and other federal Department of Health and Human Services (HHS) dollars, including hospitals, health clinics, physician practices, physicians, skilled nursing physicians; home health agencies, nursing homes, hospices, pharmacies, independent and clinic laboratories, outpatient physical therapy and speech pathology providers, and ESRD facilities, among others.

**Conduct Prohibited:**

Discrimination by such group health plans and insurers and TPAs can take the form of discriminatory benefit design, coverage carve-outs, limits on health coverage, benefit claim denial, denial or refusal to issue or to renew a health insurance plan or coverage, discriminatory marketing, or the imposition of additional cost sharing. All of these discriminatory plan designs and/or practices must be eliminated by plan amendments.

While group health care plans and their insurers and TPAs may understand most of the protected statuses that fall within Section 1557, they may not fully expect that Section 1557's prohibition against "sex discrimination" includes gender identity discrimination.

The Final Regulation implementing Section 1557 specifically reinforces that lesbian, gay, bi-sexual and transgender (LGBT) individuals cannot be discriminated against in receiving health care services or group health care coverage or health insurance based on their sex, including their gender identity and their nonconformity with sex stereotypes. Discrimination against LGBT people or against any other protected persons under Section 1557 can take the form of refusal of treatment, harassment, delivery of different care or denial of access to facilities.

The Final Regulation provides that 1) individuals must be treated consistent with their gender identity, including in access to facilities; 2) sex-specific health care cannot be denied or limited on the ground that the person seeking such services identifies as belonging to another gender (e.g., a gender different than the gender previously entered in a program's or facility's records for that individual); and 3) express categorical exclusions in coverage for all health services related to gender transition are facially discriminatory.

The Final Regulation does not explicitly require the coverage of any particular service to treat gender dysphoria or gender identity disorder or to treat transitioning to another gender. The Final Regulation also allows group health plans to deny non-medically necessary services. However, the preamble to the proposed rule sent a clear signal that denying coverage of transition-related services on the basis of those services not being medically necessary will be subject to "careful scrutiny." 80 Fed. Reg. 54172, 54190 (Sept. 8, 2015). That preamble also provides that blanket exclusions of transgender services as "cosmetic" or "experimental" are "outdated and not based on current standards of care." 80 Fed. Reg. at 54189. The Final Regulation does not appear to repudiate those preamble comments.

Although Section 1557 does not contain any blanket religious exemption, it does provide that the non-discrimination rules will not be required to apply if doing so would violate applicable federal statutory protections for religious freedom and conscience. Pending cases in the federal courts will provide further guidance in this area.

**Immediate Actions Needed:**

The Final Regulation becomes effective on July 18, 2016, including its compliance and operations requirements, as described below:

**Immediate Attention to Open Enrollment Materials:**

For group health plans offered by health care providers and their insurers, Section 1557 will take effect the first day of the first plan year beginning on or after January 1, 2017. **As a practical matter, however, open enrollment materials in the upcoming fall enrollment periods should reflect the plan changes that go into effect in the next plan year.**

**We recommend plan design review by plan benefits counsel and preparation of notice communications (a letter or other documents) describing anticipated changes to comply with Section 1557, for use during the open enrollment period.**

**Immediate Language Assistance Measures:**

Section 1557 also enhances language assistance for people with limited English proficiency and seeks to improve effective communication for individuals with disabilities through use of auxiliary aids and services (such as alternative formats and sign language interpreters, where necessary).

**Immediate Grievance Procedure and Compliance Coordinator:**

Covered entities **with 15 or more employees** must institute a grievance procedure for resolution of Section 1557 complaints and must designate a compliance coordinator.

**Immediate Record-Keeping for Compliance Reports and Reviews:**

The existing enforcement mechanisms under four long-standing federal civil rights acts apply to redress Section 1557 violations. These mechanisms require covered entities to keep records and to submit compliance reports to the OCR, to conduct compliance reviews and complaint investigations, and to provide technical assistance and guidance.

**Posted Notices No Later Than October 17, 2016:**

Posted notice requirements go into effect **on October 17, 2016**, 90 days after the July 18, 2016 effective date of the Final Regulation.

Posted notices must inform beneficiaries, enrollees, applicants, and members of the public of:

(1) The entity's nondiscrimination policy;
(2) The availability of auxiliary aids and services where necessary, at no cost;
(3) Translation and language assistance services;
(4) How to receive these supplemental services;
(5) The name and contact information of the compliance person (for larger entities only);
(6) Complaint and grievance procedures; and
(7) How to file a discrimination complaint with OCR.

Notices must generally contain taglines in at least the top 15 non-English languages spoken in the state in which the entity is located or does business, or for smaller communities, in at least the top two non-English languages spoken. Translations are available from OCR in 64 languages.

**Plan Design Changes for First Plan Year on or after January 1, 2017:**

We also recommend plan review by benefits counsel for compliance through plan amendments effective for the first plan year on or after January 1, 2017 for calendar-year plans and non-calendar year plans, respectively.

## Action Steps

**Action Steps for Plan Administrators of Group Health Plans:**

- Prepare and disseminate notice communication (such as letters or other notifications of compliance with Section 1557 non-discrimination notice provisions) in 2016 open enrollment materials for plan years beginning on or after January 1, 2017
- Create required notices for posting and required taglines in the appropriate non-English languages and identify the 15 (or 2) languages that must be used in the relevant location, using model notices and translations provided by OCR as reviewed by benefits counsel
- Create policies and procedures to implement non-discrimination requirements in health services, auxiliary aid and language access requirements, including American Sign Language signers and non-English speaking translators
- Draft and implement a grievance procedure and appoint a compliance coordinator if the covered entity has 15 or more employees
- Educate employees and agents through appropriate workplace education and training
- Follow the record-keeping and compliance reporting procedures established for compliance with Title VI of the Civil Rights Act of 1964, Title IX of the Educational Amendments of 1972, the Age Discrimination Act of 1975, and Section 504 of the Rehabilitation Act of 1973
- Monitor the group health plan's covered service providers for compliance with Section 1557

**Action Steps for Plan Sponsors:**

- Determine whether the plan sponsor receives federal financial assistance from HHS for any health program or activity, whether for a group health plan, an employer-provided or an employer-sponsored wellness program, an employer-provided health clinic, or long-term care coverage provided or administered by an employer
- Prepare to provide assurances of compliance with Section 1557 when applying for such federal financial assistance from HHS
- Review health and welfare plan documents for discriminatory provisions and revise as necessary in the role as employer plan sponsor, documenting neutral reasons for plan designs
- Review health and welfare plan documents to insure compliance with gender identity non-discrimination requirements and begin amendment process

**Additional Action Steps for Plan Sponsors Receiving Federal Financial Assistance from HHS in health care programs or activities:**

- Draft and implement a grievance procedure and appoint a compliance coordinator if the plan sponsor has 15 or more employees
- Create required notices for posting and required taglines in the appropriate non-English languages and identify the 15 (or 2) languages that must be used in the relevant location (such as site of wellness programs), using model notices and translations provided by OCR as reviewed by benefits counsel
- Create policies and procedures to implement non-discrimination requirements in health care programs and activities, auxiliary aid and language access requirements, including American Sign Language signers and non-English speaking translators
- Draft and implement a grievance procedure for relevant programs and appoint a compliance coordinator if the covered entity has 15 or more employees
- Follow, in the relevant health care programs and activities, the record-keeping and compliance reporting procedures established for compliance with Title VI of the Civil Rights Act of 1964, Title IX of the Educational Amendments of 1972, the Age Discrimination Act of 1975, and Section 504 of the Rehabilitation Act of 1973

**Penalties and Legal Exposure:**

Failure to act quickly can expose employer-provided group health plans, insurers, and TPAs to considerable penalties or legal sanctions. With respect to enforcement, complaints to OCR can result in reviews and investigations by HHS and by the Department of Justice. Section 1557 also provides a private right of action for aggrieved individuals (including class actions), along with the potential for compensatory damages resulting from discrimination by covered entities. There is no requirement of the exhaustion of administrative remedies.

**If you have any questions regarding the issues raised in this Alert, please contact the authors of this alert, or a member of Butzel Long's Health Care Law or Employee Benefits practices teams.**

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