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REFORM UPDATE

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FINAL NONDISCRIMINATION RULES IN HEALTH PROGRAMS AND ACTIVITIES

The Department of Health and Human Services (HHS) recently released the Section 1557 final nondiscrimination rules. These rules are separate and distinct from the Section 105(h) nondiscrimination rules, which the Affordable Care Act (ACA) extended to fully insured plans. The effective date of this extension will be determined once regulations are issued, but, to date, that has not occurred. Employers will continue to wait for regulations detailing the 105(h) nondiscrimination rules and their application to insured plans.

The Section 1557 final nondiscrimination rules could affect specific employer health plans. These rules prohibit discrimination in health programs and activities based on race, color, national origin, age, disability and sex. The sex category includes pregnancy, gender identity and sex stereotyping. It bans discrimination against individuals with limited English proficiency and requires reasonable accommodations to ensure effective communication with disabled individuals.

The Section 1557 nondiscrimination rules apply directly only to health programs and activities funded or administered by HHS. The rules apply to covered entities, which are defined as:

- An entity that operates a health program or activity that receives federal financial assistance through HHS. For example, these rules would apply to a hospital that accepts payments under Medicare Part A.
- An entity established under Title I of the ACA that administers a health program or activity. For example, these rules would apply to state-based Health Insurance Marketplaces.
- The HHS and programs that it administers. For example, this would include federally-run Health Insurance Marketplaces.

The final rules addressed a situation that would affect a broader range of entities. The proposed rules state that a health insurance issuer receiving federal financial assistance due to participation in an ACA Marketplace is a covered entity subject to these rules. They must comply, even when acting in the capacity of a third-party administrator (TPA) for a self-funded employer group health plan. This substantially broadens the number of organizations subject to these rules. For example, if a self-funded plan uses Blue Cross Blue Shield of Michigan (BCBSM) as a TPA, their plan will need to comply with the rules. Why? Because BCBSM received federal financial assistance for the plans offered in Michigan's Marketplace.

The final rules spend more time detailing the potential impact. The rules acknowledge that TPAs are generally not responsible for the plan design of a self-funded medical plan. Employers establish the benefit plan design. ERISA requires plans to be administered according to the terms of the plan, which puts the covered entity in a bind. How can they comply with the nondiscrimination requirements when they do not determine plan design, and they are obligated to administer the plan as written? If the Office of Civil Rights (OCR) receives a claim of discrimination, it will conduct an investigation. If discrimination has occurred, it will determine if the TPA or the employer is responsible. The OCR will process the complaint if the TPA is responsible or when the employer is an actual covered entity (for example, the group health plan for a hospital system). If the employer is responsible for alleged discrimination, then the OCR will refer or transfer the matter to the appropriate federal agency. For example, if a self-funded health plan excludes coverage for health services related to gender transition, the OCR will refer the situation to the Equal Employment Opportunity Commission (EEOC).

The final regulations do not address whether discrimination on the basis of sexual orientation alone is considered a form of sex discrimination. The rules indicate that the OCR will evaluate complaints of discrimination related to sexual orientation to determine if there is an issue under the Section 1557 rules.

Discrimination based on gender identity is a hot-button issue. Unfortunately, these rules do not provide practical guidance on what is permitted in terms of gender identity. For covered entities to which these rules directly apply, it appears their health plans may not:

- Include a direct exclusion for health services related to gender transition. HHS intends a broad interpretation of these services, which include hormone therapy, psychotherapy, and even surgical treatment.
- Deny or limit benefits (including imposing different cost-sharing requirements) for medically appropriate gender-specific health care simply because a person who identifies as a certain gender may not normally receive such care. For example, a plan may not deny coverage for ovarian cancer treatment for a transgender individual who now identifies as a man. Similarly, a plan may not deny coverage for recommended well-woman care simply because the health plan identifies the individual as a man, even though the person is a transgender female.
- Exclude coverage for gender transition-related services by categorizing them as experimental or cosmetic.

The application of these rules can be confusing. It depends whether you are considered a covered entity, or if you use a covered entity to provide benefits.

1. Determine if your organization would be considered a direct covered entity. Is your organization a health care provider that receives payments from federal programs such as Medicare, Medicaid, or the Department of Health and Human Services? If so, your organization and the health plan you sponsor for employees are directly affected by this rule.
2. If you are not a direct covered entity and your medical plan is fully insured, you may be indirectly subject to these rules because of your health insurance carrier. Many carriers sponsor health plan coverage in the Marketplace. If you are unsure whether your insurance carrier receives some form of federal financial assistance, ask.

3. If you are not a direct covered entity and your medical plan is self-funded, you may be tangentially subject to these rules because of your third-party administrator (TPA). If your TPA is also an insurance carrier, then they likely receive some form of federal financial assistance. You should ask your TPA if they are a covered entity under Section 1557 as related to the nondiscrimination rules.

Action steps will differ depending on the type of entity.

Covered entities are required to eliminate any discrimination in health programs and activities based on race, color, national origin, age, disability and sex. To meet these requirements:

- Review programs and health plan coverage for discriminatory practices or coverages. Amend practices or coverage that discriminates based on race, color, national origin, age, disability and sex.
- Name a compliance officer to handle the Section 1557 nondiscrimination requirements.
- Create a grievance procedure for individuals to voice complaints related to the nondiscrimination rules.
- Provide aids for communications about compliance and rights. Sample communication materials can be found at http://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html. Assistance must be made available based on the different languages predominantly spoken in your area. Tag line information is available in a host of languages, advising individuals of their right to translation services.
- The required non-discrimination notices must be posted no later than October 17, 2016. Sample notice language can be found at http://www.hhs.gov/sites/default/files/sample-ce-notice-english.pdf. Notice language is available in a number of different languages.

If you are an employer that is indirectly subject to these rules, you should do the following:

- Confirm with your insurer or TPA that they are subject to these rules.
- If your plan is insured, your carrier may make coverage changes to comply with these rules.
- If your TPA is a covered entity, request a recommendation on what aspects of your program should be modified to avoid potential discrimination issues.
- Review your plan document and flag any provisions that would be considered discriminatory based on race, color, national origin, age, disability or sex. Seek your vendor's input on whether these provisions need to be eliminated or modified.
- Confirm that your vendor has designated a compliance officer and established grievance procedures.
- Consult an attorney if you have questions regarding recommended plan provisions.

Section 1557 does not contain any blanket religious exemptions. However, it does provide that the nondiscrimination rules are not required to apply if doing so would violate applicable federal statutory protections for religious freedom and conscience.

These final Section 1557 nondiscrimination rules are far broader than the initial proposed rules. If your organization is a covered entity, it makes sense to consult with an attorney to ensure that you are in proper compliance. They do not apply solely to your health plan, but also to the activities you perform that receive federal financial support.

If you are indirectly subject to these rules (because your insurance carrier or TPA is a covered entity), consult your vendor on recommended steps to address potential discrimination issues in your plan. If you are self-funded and not a covered entity, you will not be violating Section 1557 if you maintain potentially discriminatory coverage rules. However, if the OCR investigates a potential discrimination issue and determines that it is related to an employee action (as opposed to a covered entity action), then they will refer the situation to the EEOC. One of the EEOC's top enforcement priorities is discrimination against lesbian, gay, bisexual and transgendered individuals. The EEOC could file suit against you because of discriminatory plan design.