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ACA Nondiscrimination Requirements: Are You In Compliance?

Section 1557 of the Patient Protection and Affordable Care Act of 2010 ("ACA") prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs or activities. The U.S. Department of Health and Human Services ("HHS") recently issued a final regulation implementing the nondiscrimination requirements of Section 1557. In general, the final regulation provides guidance as to which entities (referred to as "covered entities") are subject to the requirements of Section 1557 and the actions covered entities must take in order to comply with the nondiscrimination requirements. Most of the requirements of the final regulation became effective as of July 18, 2016. However, as discussed below, the regulation contained certain delayed effective dates. Entities that have yet to determine whether they are subject to the Section 1557 nondiscrimination requirements should take steps to do so now to ensure compliance.

Covered Entities For Purposes of Section 1557

A covered entity is defined as: (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 the ACA that administers a health program or activity (i.e., the Health Insurance Marketplace); and (3) the Department of Health and Human Services.

In most instances, the key determination for an employer, health plan or other entity regarding covered entity status is whether it operates a "health program or activity" that receives "Federal financial assistance" and, therefore, is subject to Section 1557. The regulations define the term "health program or activity" to mean:

The provision or administration of health-related services, health-related insurance coverage, or other health-related coverage, and the provision of assistance to individuals in obtaining health-related services or health-related insurance coverage.

The regulation further provides that if an entity is "principally engaged" in providing or administering health services or health insurance coverage or other health coverage, all of its operations are considered part of the health program or activity, unless specifically exempted by the regulation. Entities that are principally engaged in providing or administering health services or health insurance coverage include hospitals, health clinics, group health plans, health insurance issuers, community health centers, nursing facilities, residential or community-based treatment facilities, and other similar entities.

The regulation defines the term "Federal financial assistance" to mean any grant, loan, credit, subsidy, contract (other than a procurement contract but including a contract of insurance) or any arrangement by which the Federal government provides funds, services of Federal personnel, or real and personal property. It also includes tax credits available under the ACA for purchase of coverage through the Marketplace as well as certain other HHS payments and subsidies provided by HHS.

Entities considered "covered entities" under this rule include group health plans that receive HHS funds (e.g., Medicare Part D subsidies for those plans providing Medicare-equivalent prescription drug coverage) and hospitals, physician practices and other health providers that receive Federal financial assistance through their participation in Medicare or Medicaid. Other entities, such as colleges and universities, that receive Federal financial assistance from HHS with respect to health research activities also may be considered covered entities under the regulation.

Health Coverage

The regulation states that in providing or administering health coverage, a covered entity is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability and may not engage in discrimination on such basis by:

- Denying, canceling, limiting or refusing to issue or renew a health-related insurance plan;
- Denying or limiting coverage of a claim, or imposing additional cost sharing or other limitations or restrictions;
- Having or implementing marketing practices or benefit designs that discriminate;
- Denying or limiting coverage or imposing additional cost sharing or other limitations or restrictions on coverage for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily available;
- Categorically excluding coverage for all health services related to gender transition;
- Denying or limiting coverage, or denying or limiting coverage of a claim, or imposing additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition if such denial, limitation or restriction results in discrimination against a transgender individual.

Among other changes, these rules may require covered entities to review their health plan design regarding coverage and exclusions for gender dysphoria or gender identity disorders. While the final regulation does not explicitly mandate such coverage, HHS noted in the preamble to the regulation, if a plan covers elective procedures that are beyond those strictly identified as medically necessary or appropriate, it must apply those same standards to its coverage of comparable procedures related to gender transition. For example, a hysterectomy to treat gender dysphoria is substantially similar to a hysterectomy performed for a cancer patient. Under the nondiscrimination provisions of the regulation, it would be difficult to justify coverage only for the cancer patient hysterectomy and not provide the same coverage for the treatment of gender dysphoria.

If a covered entity is required to change its health plan design to comply with the final regulation, such changes are required to be made effective with the first day of the first plan year beginning on or after January 1, 2017.

Individuals With Disabilities

The final regulation also imposes certain requirements on covered entities with respect to individuals with disabilities, including making reasonable modifications to policies, practices and procedures to accommodate individuals with disabilities, complying with accessibility standards for buildings and facilities, and ensuring the accessibility of electronic and information technology for individuals with disabilities.

Language Assistance Requirements

A covered entity is required to take reasonable steps to provide meaningful access to health programs and activities for individuals with limited English proficiency. These requirements include offering, free of charge, a translator to individuals with limited English proficiency and issuing "taglines" informing such individuals of the availability of language assistance services.

Notice Requirement

Each covered entity is required to take appropriate initial and continuing steps to notify beneficiaries, enrollees, applicants and members of the public:

- That the covered entity does not discriminate in its health programs and activities;
- That the covered entity provides auxiliary aids and services (including interpreters) in accordance with the requirements of the regulation;

- That the covered entity provides required language assistance services;
- How to obtain auxiliary aids and language assistance services;
- If applicable, the availability of a grievance procedure and the contact information for the individual designated to coordinate compliance efforts regarding Section 1557 (only covered entities that employ 15 or more persons are required to adopt a grievance procedure and designate a responsible employee to coordinate grievances); and
- How to file a discrimination complaint.

Covered entities are also required to post "taglines" in at least the top 15 languages spoken by individuals with limited English proficiency in the state or states where the covered entity operates.

The notice and taglines are required to be set forth in significant communications targeted to beneficiaries, enrollees, applicants and members of the public, in conspicuous physical locations, and on the covered entity's website. For significant publications that are small-sized (e.g., postcards and tri-fold brochures), less-extensive disclosures are permitted. Covered entities are permitted to exhaust their current stock of hard copy publications rather than requiring a special printing of the publications to include the new notice.

Covered entities may develop their own notice or use a sample notice developed by HHS. The HHS website contains a sample notice and taglines. http://www.hhs.gov/civil-rights/for-individuals/section-1557

The deadline for posting the notice and taglines was October 17, 2016.

Recommended Action

An employer that has yet to determine whether the employer (or the employer's group health plan) is a covered entity subject to the nondiscrimination requirements of Section 1557 should take steps to do so as soon as possible. For employers and group health plans that are considered covered entities under the final regulation, prompt action is required to comply with the regulation's notice requirement and health plan design requirements, if applicable. Additional actions also may be required by covered entities to the extent that they have not yet initiated compliance efforts with respect to the regulation's other nondiscrimination requirements (e.g., those that apply with respect to individuals with disabilities).

If you have any questions about this memorandum, please contact John C. Godsoe, any of the attorneys in our Employee Benefits and Executive Compensation Practice Group, or the attorney in the firm with whom you are regularly in contact.

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