HUNTON& WILLIAMS

ACA Update:
Application of the HHS Nondiscrimination Rules to Employee Health Plans

In May 2016, the Department of Health and Human Services (HHS) Office of Civil Rights (OCR) published final rules implementing Section 1557 of the Affordable Care Act (ACA), which prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. It applies to numerous entities, including employee health plans operated by certain employers and group health plans that received federal financial assistance.

Covered Entities

Health Programs and Activities. The entities covered under the rules (called "covered entities") include any entity that operates a "health program or activity" that receives federal financial assistance, as well as entities established under Title I of the ACA that administer health programs or activities (*e.g.*, state exchanges) and HHS.

- The term "health program or activity" is defined broadly to include the provision or administration of health related services, health-related insurance coverage, or other health-related coverage, and assisting individuals in obtaining such services or coverage.
    - If the entity is principally engaged in providing or administering health services or health-related insurance coverage (*e.g.,* a hospital), then all of its operations are considered part of the health program or activity unless otherwise specified in the rules. The regulations specifically identify hospitals, health clinics, group health plans, and health insurance issuers, among other programs, as falling into this category.
    - For other entities, it appears that the rule applies to the extent of their health programs or activities.
- "Federal financial assistance" can include grants, loans, credit, subsidies, contracts and other arrangements by which the federal government provides or makes available assistance in the forms of funds, services of federal personnel, or real and personal property.
    - The rule refers generally to federal financial assistance, but indicates in 45 C.F.R. § 92.1 that this only applies to entities receiving financial assistance from HHS.
- As a result, entities covered by the final rules include the following:
    - Hospitals or other health care providers that receive financial assistance for at least a part of their operations

- Health insurance issuers
- Group health plans that receive federal financial assistance (such as Medicare Part D subsidies)
    - In the preamble to the final rules, OCR noted that the fact that a group health plan must comply with Section 1557 "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," unless one of the circumstances described in the next section applies.[1] However, the plan itself is subject to the requirements if it receives federal financial assistance.
- Third party administrator (TPA) services of covered entities (*e.g.*, health insurers) that receive federal financial assistance
    - The preamble to the rules notes that "Section 1557's coverage of a third party administrator under the rule does *not* extend to the coverage of an employer providing a group health plan that is being administered by the third party administrator."[2]
    - Thus, when reviewing claims of alleged discrimination, OCR will determine whether responsibility for the action in question rests with the employer or the TPA. Where the alleged discrimination relates to benefit design and not plan administration, OCR will not pursue a claim against the TPA.
    - The preamble also notes that where OCR does not have jurisdiction over an employer regarding a benefit design issue, it may refer the matter to the Equal Employment Opportunity Commission (EEOC) to address.
- Other entities that operate a health program or activity that receives federal financial assistance

Application to Employee Health Benefit Programs

Scope of the Rule. A covered entity that provides an employee health benefit program (defined below) to its employees and/or their dependents is liable for violations of the nondiscrimination rules of that program if any of the following apply:

- The entity is principally engaged in providing or administering health services, health insurance coverage, or other health coverage (*e.g.*, a hospital);

[1] 81 Fed. Reg. 31348.
[2] 81 Fed. Reg. 31432.

- The entity receives federal financial assistance, and a primary objective of that assistance is to fund the entity's employee health benefits program; or

- The entity is not principally engaged in providing or administering health services, health insurance coverage, or other health coverage, but operates a health program or activity, which not an employee health benefit program, that receives federal financial assistance – in which case the liability is limited to the provision or administration of health benefits only for those employees in that health program or activity.

An "employee health benefit program" includes any of the following:

- employer-sponsored health benefits coverage or health insurance for employees and/or their dependents, including such coverage provided or administered by an employer, group health plan (as defined in ERISA), third party administrator (TPA), or health insurance issuer;

- employer-provided or employer-sponsored wellness programs;

- employer-provided health clinics; and

- long-term care coverage or insurance provided or administered by an employer, group health plan, TPA or health insurance issuer for the benefit of an employer's employees.

In practice, this means that covered entities such as hospitals or other health care providers will be responsible for complying with the new HHS rules not only with respect to their covered operations, but also the health plans and related programs offered to their employees.

Summary of Nondiscrimination Requirements

No Discrimination in Health Programs or Activities. An individual may not be excluded from participation in, denied the benefits of or otherwise be subjected to discrimination under, any health program or activity to which the rules apply, on the basis of race, color, national origin, sex, age or disability.

No Discrimination in Health-Related Insurance or Other Health Coverage. Similarly, covered entities may not discriminate on the basis of race, color, national origin, sex, age or disability in providing or administering health-related insurance or other health-related coverage. The rules include explicit prohibitions on the following:

- Denying, cancelling, limiting or refusing to issue or renew coverage, denying or limiting coverage of a claim, or imposing additional cost sharing or other restrictions or limitations on a discriminatory basis;

- Having or implementing marketing practices or benefit designs that are discriminatory;

- Denying or limiting coverage, denying or limiting coverage of a claim, 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 individuals' sex assigned at birth, gender identity, or gender otherwise recorded is different from the sex to which such services are available;

- Having or implementing a categorical coverage exclusion or limitation for all health services related to gender transition; and

- Otherwise denying or limiting coverage, denying or limiting a claim, or imposing additional cost sharing or other limitations or restrictions on coverage for specific health services related to gender transition if it results in discrimination against a transgender individual.

In the preamble to the rules, OCR notes that the rules do not "affirmatively require covered entities to cover any particular procedure or treatment of transition-related care" so long as the basis for exclusion is nondiscriminatory.[3] However, it will be difficult to exclude procedures associated with gender transition if the same procedures are covered in other contexts. OCR also stated that blanket exclusions of transition-related treatment as "cosmetic" or "experimental" are considered "outdated and not based on the current standards of care."[4]

Meaningful Access for Individuals With Limited English Proficiency. The rules also require covered entities to offer timely and accurate language assistance services free of charge, in a manner that protects the privacy and independence of the individual. The rules include several specific requirements applicable to interpreter and translation services and place restrictions on who may be relied upon to provide translation – for example, limiting the ability to rely on a minor child to provide interpretation except in emergency circumstances.

Accessibility and Communication for Individuals with Disabilities. The rules set forth additional accessibility standards for buildings and facilities as well as electronic and information technology, and requires that covered entities make communications with individuals with disabilities as effective as communications with others. Covered entities must also make reasonable modifications to policies, practices or procedures when necessary to avoid discrimination on the basis of disability, unless it would fundamentally alter the nature of the health program or activity.

[3] 81 Fed. Reg. 31435.
[4] 81 Fed. Reg. 31429.

Equal Program Access on the Basis of Sex. Covered entities are required to provide equal access to health programs or activities without discrimination on the basis of sex, and to treat individuals consistent with their gender identity – except that a covered entity may not deny or limit health services that are usually available to individuals of one sex to a transgender individual on the basis that the individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are generally available (*e.g.*, a mammogram for a transgender man).

Designation of Responsible Employee and Grievance Procedures. Covered entities that employ 15 or more persons are required to designate an employee to coordinate compliance with Section 1557 and the final rules, and to adopt grievance procedures for allegations of violations.

Notice Requirement. Each covered entity is required to notify beneficiaries, enrollees, applicants and members of the public of the following:

- That it does not discriminate on the basis of race, color, national origin, sex, age or disability in its health programs activities;
- That it provides language assistance services and appropriate aids and services for individuals with disabilities, and how to obtain such aid and services;
- The designated responsible employee (if applicable), and contact information for such person;
- The availability of grievance procedures and how to file a grievance (if applicable); and
- How to file a discrimination complaint with OCR.

By October 16, 2016 (90 days after the effective date of July 18) covered entities must post a notice, including taglines in the top 15 languages spoken by individuals with limited English proficiency in the relevant state(s), in significant publications and communications, conspicuous physical locations, and in a conspicuous location on the covered entity's web site. Slightly abbreviated notice and tagline requirements apply to significant publications and communications that are small sized.

Effective Date

The final rules are generally effective July 18, 2016. However, to the extent that certain provisions of the rules require changes to health insurance or group health plan benefit design including covered benefits, limitations or restrictions, and cost-sharing mechanisms (*e.g.*, copayments, coinsurance and deductibles), such provisions are applicable the first day of the first plan year beginning on or after January 1, 2017.