Nondiscrimination Regulations Relating to Sex, Gender, Age, and More Finalized

On May 13, 2016, the Department of Health and Human Services (HHS) issued a final rule implementing Section 1557 of the Patient Protection and Affordable Care Act (ACA), which will take effect on July 18, 2016. If entities need to make changes to health insurance or group health plan benefit design as a result of this final rule, such provisions have an applicability date of the first day of the first plan year beginning on or after January 1, 2017.

ACA Section 1557 provides that individuals shall not be excluded from participation, denied the benefits of, or be subjected to discrimination under any health program or activity which receives federal financial assistance from HHS on the basis of race, color, national origin, sex, age, or disability. The rule applies to any program administered by HHS or any health program or activity administered by an entity established under Title I of the ACA. These applicable entities are "covered entities" and include a broad array of providers, employers, and facilities. State-based Marketplaces are also covered entities, as are Federally-Facilitated Marketplaces.

The final regulations are aimed primarily at preventing discrimination by health care providers and insurers, as well as employee benefits programs of an employer that is principally or primarily engaged in providing or administering health services or health insurance coverage, or employers who receive federal financial assistance to fund their employee health benefit program or health services. Employee benefits programs include fully insured and self-funded plans, employer-provided or sponsored wellness programs, employer-provided health clinics, and longer-term care coverage provided or administered by an employer, group health plan, third party administrator, or health insurer.

Affected employers include:

- Hospitals
- Nursing homes
- Home health agencies
- Laboratories
- Community health centers
- Therapy service providers (physical, speech, etc.)
- Physicians' groups
- Health insurers
- Ambulatory surgical centers
- End stage renal dialysis centers
- Health related schools receiving federal financial assistance through grant awards to support 40 health professional training programs

When determining if it receives federal financial assistance through Medicaid payments, meaningful use payments, or other payments a physician or physicians' group would not count Medicare Part B payments because that is not considered federal financial assistance. In the proposed rule, HHS estimated that most physicians will still be a covered entity because they accept federal financial assistance from other sources. The final rule includes the same estimate of physicians receiving

federal financial assistance as in the proposed rule because almost all practicing physicians in the United States accept some form of federal reimbursement other than Medicare Part B. As a result, most physicians are reached by this rule.

Covered entities must take steps to notify beneficiaries, enrollees, applicants, or members of the public of their nondiscrimination obligations with respect to their health programs and activities. Covered entities are required to post notices stating that they do not discriminate on the grounds prohibited by Section 1557, and that they will provide free (and timely) aids and services to individuals with limited English proficiency and disabilities. These notices must be posted in conspicuous physical locations where the entity interacts with the public, in its significant public-facing publications, and on its website home page. In addition, covered entities that employ 15 or more persons must designate a responsible employee to coordinate the entity's compliance with the rule and adopt a grievance procedure.

Sex, Gender, and Sexual Orientation Discrimination

The final rule bans discrimination based on sex, gender, sexual orientation, and gender identity. Sex discrimination includes discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery from childbirth or related medical conditions.

The final rule prohibits discrimination faced by transgender individuals trying to access coverage of health services. The rule prohibits denying or limiting coverage, denying a claim, or imposing additional cost sharing on any health service due to the individual's sex assigned at birth, gender identity, or gender otherwise recorded by the plan or issuer which is different from the one to which services are ordinarily or exclusively possible.

For example, a pelvic or prostate exam could not be denied based on a person's sex assigned at birth, gender identity, or recorded gender, if it was medically appropriate. Medically appropriate coverage could not be denied for a pelvic exam or ovarian cancer treatment for an individual who identifies as a transgender man, or is enrolled in a health plan as a man.

Furthermore, blanket exclusions for coverage of care associated with gender dysphoria or associated with gender transition is prohibited. Categorical or automatic exclusion of coverage for services related to gender transition are unlawful. Denials for these services would be discrimination if the denial results in discrimination against a transgender individual. These provisions do not require covered entities to cover any particular procedure or treatment for transition-related care; nor do they preclude neutral standards that govern the circumstances under which coverage will be offered.

The regulations do not prohibit single-sex toilets, locker rooms, or shower facilities so long as comparable facilities are provided regardless of sex. The final rule provides that sex-specific health programs are allowable only where the covered entity can demonstrate an exceedingly persuasive justification that the sex-specific program is substantially related to the achievement of an important health-related or scientific objective. While the rule does not require a provider that operates a gynecological practice to add or change the types of services offered in the practice, it prohibits the providers of health services from denying or limiting services based on an individual's sex, without a legitimate nondiscriminatory reason.

For example, if a hospital has specific protocols in place for domestic violence victims and only engages that protocol for women, the provider must revise its procedures to require that protocol for all domestic violence victims regardless of sex.

The final rule does not resolve whether discrimination on the basis of an individual's sexual orientation status alone is a form of sex discrimination. The Office for Civil Rights (OCR) will evaluate complaints alleging sex discrimination based on sexual orientation status on a case-by-case basis to determine if they are the sort of discrimination that can be addressed under this rule.

Marketplace and Other Health Plans

A health insurance issuer seeking certification to participate in a Health Insurance Marketplace or a state seeking approval to operate a State-based Marketplace to which Section 1557 applies is required to submit an assurance that the health program or activity will operate in compliance with this rule.

Marketplaces must operate in a nondiscriminatory way. Issuers that participate in the Marketplace cannot deny, cancel, limit, or refuse to issue or renew any policies that employ practices or benefit designs that discriminate on any of the protected bases.

An insurer that participates in a Marketplace would be subject to the nondiscrimination rules in the Marketplace, in its individual market business, in the group market, or when it serves as a third-party administrator for a self-insured plan.

Third-Party Administrators (TPAs)

The OCR will investigate a TPA when the alleged discrimination is in the administration of the plan. However, if the alleged discrimination is in benefit plan design, OCR will process the complaint against the employer or plan sponsor. If the OCR lacks jurisdiction over the employer, it will refer the

matter to the Equal Employment Opportunity Commission (EEOC).

Discrimination against Persons with Limited English Proficiency (LEP) and Disabilities

An individual with LEP is someone for whom English is not the primary language for communication, and who has a limited ability to read, speak, write, or understand English. The final rule increases assistance for individuals with LEP so that they can communicate with their health care providers and have meaningful access to health programs and activities.

Covered entities are required to post taglines in at least the top 15 non-English languages spoken in the state in which the entity is located or does business. These taglines will alert LEP individuals to the availability of free language assistance services and how these services can be obtained. The proposed rule provided a list of relevant factors to consider when determining if language obligations have been met; whereas, the only relevant factor listed in the final rule is whether a covered entity implemented an effective written language access plan.

Covered entities are required to provide effective communication and facility access for individuals with disabilities. Covered entities must provide access to auxiliary aids and services, including alternative formats and sign language interpreters, unless the entity can show undue burden or fundamental alteration. The final rule requires reasonable modifications where necessary to facilities and technology to provide equal access for individuals with disabilities.

Enforcement

The enforcement mechanisms under Title VI, Title IX, Section 504 of the Rehabilitation Act, and the Age Discrimination Act of 1975 apply for redress of violations of Section 1557, which include requiring covered entities to keep records and submit compliance reports to the OCR, conducting compliance reviews and complaint investigations, and providing technical assistance and guidance.

If noncompliance cannot be corrected by informal means, enforcement mechanisms include suspension of, termination of, or refusal to grant federal financial assistance.

Key Differences between the Proposed and Final Rule

While the final rule adopts the same structure and framework as the proposed rule, significant changes include the following.

- The final rule does not include any blanket religious exemptions; however, application of any requirement of the rule will not be required if it violates federal statutory protections for religious freedom and conscience.
- The final rule modifies the notice requirement to exclude publications and significant communications that are small in size from the requirement to post all of the content; instead, covered entities will be required to post a shorter nondiscrimination statement in such communications and publications.
- The final rule replaces the national threshold with a state-specific threshold requiring taglines in at least the top 15 non-English languages spoken by LEP populations in each state.
- The final rule provides that sex-specific health programs are allowable only where the covered entity can demonstrate an exceedingly persuasive justification that the sex-specific program is substantially related to the achievement of an important health-related or scientific objective.
- The final rule takes reasonable steps to provide meaningful access by requiring the Director of the OCR to evaluate, and give substantial weight to, the nature and importance of the health program or activity and the particular communication at issue to the individual with LEP, and take into account all other relevant factors, including whether the entity has developed and implemented an effective language access plan. The final rule deletes the specific list of illustrative factors in the proposed rule.

5/20/2016

Our access to ACA Advisor resources can help you clear up ACA questions and better craft your company's benefit strategy for the future.

UBA United Benefit Advisors PARTNER FIRM

This information is general and is provided for educational purposes only. It reflects UBA's understanding of the available guidance as of the date shown and is subject to change. It is not intended to provide legal advice. You should not act on this information without consulting legal counsel or other knowledgeable advisors.