Update on Nondiscrimination Regulations Relating to Sex, Gender, Age, and More – for Health Care Providers

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The Patient Protection and Affordable Care Act (ACA) Section 1557 provides that individuals shall not be excluded from participation in, denied the benefits of, or be subjected to discrimination under any health program or activity which receives federal financial assistance from the Department of Health and Human Services (HHS), on the basis of race, color, national origin, sex, age, or disability.

On May 13, 2016, HHS issued a final rule (current rule) implementing Section 1557, which took effect on July 18, 2016. The current 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. For entities that were required to make changes to health insurance or group health plan benefit design as a result of the current rule, the current rule applied as of the first day of the first plan year beginning on or after January 1, 2017.

On October 15, 2019 the U.S. District Court for the Northern District of Texas (District Court) vacated portions of the current rule implementing Section 1557 that prohibit discrimination on the basis of gender identity and pregnancy termination. The District Court remanded the vacated portions of the current rule to HHS for revision. While those portions of the current rule have been vacated, covered entities subject to Section 1557 may still face private lawsuits for discrimination based on gender identity and pregnancy termination.

Health care providers who are subject to Section 1557 should stay informed on this litigation because it is anticipated that the District Court's ruling will be appealed to the Fifth Circuit Court of Appeals.

Background

On May 13, 2016, the Office for Civil Rights (OCR) of the Office of the Secretary of the Department of Health and Human Services (HHS) issued a final rule (current rule) implementing Section 1557 of the Patient Protection and Affordable Care Act (ACA), which took effect on July 18, 2016. It included regulations affecting health and welfare benefit plans as well as health care providers.

On December 31, 2016, the District Court issued a nationwide preliminary injunction prohibiting HHS from enforcing parts of the current rule that prohibit discrimination on the basis of gender identity and pregnancy termination. The Department of Justice asked the court to remand the rule back to HHS so it could be revised to comply with the preliminary injunction. The request was granted, and the case was put on hold. On December 17, 2018, the case was reopened.

On May 24, 2019, the Department of Health and Human Services' Office for Civil Rights (OCR) released a proposed rule to revise its regulations under the Patient Protection and Affordable Care Act's Section 1557. OCR also released a fact sheet and press release.

The proposed rule would eliminate:

- Certain definitions, including the definition of "covered entity"
- Specific nondiscrimination definitions based on sex and gender identity
- Translated taglines in significant consumer communications, the requirement to post information about Section 1557 and nondiscrimination at a covered entity's locations and website, use of language access plans, and certain video standards for individuals with limited English proficiency (LEP)
- Any reference to a private right of action to sue covered entities for violations of the proposed rule
- The requirement to have a compliance coordinator and written grievance procedure to handle complaints about Section 1557 violations
- Enforcement-related provisions

Public comment on this proposed rule closed on August 13, 2019. After considering public comments, OCR will issue a final rule. The final rule will be effective 60 days after it is published in the Federal Register.

Purpose of Section 1557

One of the central aims of the ACA is to expand access to health care and coverage for all individuals. Equal access for all individuals without discrimination is essential to achieving this goal.

To achieve this goal, Section 1557 prohibits an individual from being excluded from participation in, denied the benefits of, or subjected to discrimination on the basis of race, color, national origin, sex, age, or disability in any health program or activity which is receiving federal financial assistance from the HHS or any health program or activity administered by an entity established under Title I of the ACA. If any part of a health care entity receives federal financial assistance, then all of its programs and activities are subject to the discrimination prohibition.

Who is Covered

Section 1557 applies to "covered entities," which include a broad array of providers, employers, and facilities such as:

- Entities receiving federal financial assistance through their participation in Medicare (excluding Medicare Part B) or Medicaid:
  - Hospitals (includes short-term, rehabilitation, psychiatric, and long-term)
  - Skilled nursing facilities/nursing facilities (facility-based or freestanding)
  - Home health agencies
  - Physical therapy/speech pathology programs
  - End stage renal disease dialysis centers
  - Intermediate care facilities for individuals with intellectual disabilities
  - Rural health clinics
  - Physical therapy – independent practice
  - Comprehensive outpatient rehabilitation facilities
  - Ambulatory surgical centers
  - Hospices
  - Organ procurement organizations
  - Community mental health centers
  - Federally qualified health centers

- Laboratories that are hospital-based, office-based, or freestanding that receive federal financial assistance through Medicaid payments for covered laboratory tests
- Community health centers receiving federal financial assistance through grant awards from the Health Resources & Services Administration (HRSA)
- Health-related schools in the United States and other health education entities receiving federal financial assistance through grant awards to support health professional training programs that include oral health, behavioral health, medicine, geriatric, and physician's assistant programs
- Physicians receiving federal financial assistance through Medicaid payments, ''meaningful use'' payments, and other sources, but not Medicare Part B payments

Practically speaking, the regulation covers almost all licensed physicians because they accept federal financial assistance from sources other than Medicare Part B and most physicians participate in more than one federal, state, or local health program that receives federal financial assistance.

What is Prohibited

The ACA prohibits an individual from being excluded from participation in, denied the benefits of, or subjected to discrimination on the basis of race, color, national origin, sex, age, or disability. The current rule discusses particular types of discrimination that are prohibited, including national origin discrimination, sex discrimination, discrimination against people with limited English proficiency (LEP), and discrimination against people with disabilities.

Section 1557 protects individuals present in the United States, whether lawfully or not, who are subject to discrimination based on race, color, national origin, sex, age, or disability.

National Origin Discrimination. The OCR has the authority to address a covered entity's policy or practice, such as requiring the disclosure of Social Security numbers, citizenship, or immigration status information, that raises compliance concerns under Section 1557's prohibition of national origin discrimination. For example, the OCR has authority to address an individual's complaint that a covered entity has implemented a racially-neutral policy, such as requiring the disclosure of immigration status from applicants and non-applicants, that has a disparate impact on individuals of a particular national

origin group. Practically speaking, the OCR's Section 1557 enforcement will include investigation of complaints alleging that covered entities' actions deter eligible individuals from applying for benefits offered by health programs and activities on the basis of their national origin.

Sex, Gender, and Sexual Orientation Discrimination. The current 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.

However, under the District Court's ruling, the portions of the current rule prohibiting discrimination based on gender identity and pregnancy termination have been vacated. Before deciding not to comply with these portions of the current rule, a covered entity should consult with counsel before discriminating based on gender identity and pregnancy termination. Below is an overview of the current rule's prohibition of discrimination based on gender identity before the District Court's ruling.

Before the District Court's ruling, the current rule prohibited 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 were prohibited. Categorical or automatic exclusion of coverage for services related to gender transition was unlawful. Denials for these services were considered discrimination under the current rule if the denial resulted in discrimination against a transgender individual. The current rule does not require covered entities to cover any particular procedure or treatment for transition-related care; nor does it 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. Comparable facilities may not be required under the District Court's ruling.

Under some existing federal, state and local laws, rules or regulations, certain types of sex-specific facilities such as restrooms may be permitted. However, the current rule provided that even where it is permissible to make sex-based distinctions, individuals may not be excluded from health programs and activities for which they are otherwise eligible based on their gender identity. Courts have rejected claims that any legal right to privacy is violated and that one person suffers any cognizable harm simply by permitting another person access to a sex-specific program or facility which corresponds to their gender identity.

The regulations provided 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 current rule does not require a provider that operates a gynecological practice to add or change the types of services offered in the practice, it prohibited the providers of health services from denying or

limiting services based on an individual's sex, without a legitimate nondiscriminatory reason. The current rule provides the following 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. However, this may not be required under the District Court's ruling, particularly as it relates to transgender individuals.

The current rule does not resolve whether discrimination on the basis of an individual's sexual orientation status alone is a form of sex discrimination. The current rule states that Section 1557's prohibition of discrimination on the basis of sex includes, at a minimum, sex discrimination related to an individual's sexual orientation where the evidence establishes that the discrimination is based on gender stereotypes.

If the proposed rule is finalized as is and published as a final rule:

- Sex discrimination would not include discrimination based on sexual orientation, gender identity, pregnancy, false pregnancy, pregnancy termination, or recovery from childbirth or related medical conditions
- No aspect of the final rule will apply or be imposed on a covered entity if the rule's application would violate certain religious freedom, conscience, and nondiscrimination statutes (and their successor statutes), including:
  - The Church Amendments: conscience protections related to abortion and sterilization
  - The Coats-Snowe Amendment: conscience protections related to abortion, training, and accreditation
  - The Weldon Amendment: protections against discrimination for health care entities and individuals who do not further abortion or other services
  - The ACA: conscience protections related to abortion

Discrimination Against People with Limited English Proficiency (LEP). 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 current 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.

Discrimination Against People with Disabilities. Covered entities are required to provide effective communication and facility access for individuals with disabilities. Covered entities may not provide individuals with disabilities with an aid, benefit, or service that is not as effective as that provided to others; such benefits include medical treatment, though covered entities are not required under the rule to ensure equally effective outcomes.

Covered entities must provide access to auxiliary aids and services, including alternative formats and sign language interpreters, to people with impaired sensory, manual, or speaking skills where necessary to afford such individuals an equal opportunity to benefit from the service in question, unless the entity can show undue burden or fundamental alteration. The current rule requires reasonable modifications where necessary to facilities and technology to provide equal access for individuals with disabilities.

The OCR requires covered entities to ensure that health programs and activities provided through electronic and information technology are accessible to individuals with disabilities, unless doing so would impose undue financial and administrative burdens or would result in a fundamental alteration in the nature of an entity's health program or activity. Practically speaking, when a covered entity chooses to provide a health program or activity through electronic and information technology, it must ensure that the

technology is accessible as necessary for individuals with disabilities to have equal access to the health program or activity.

Each covered facility must comply with the 2010 ADA Standards for Accessible Design (2010 Standards), if the construction or alteration started on or after July 18, 2016. However, if a covered facility was not covered by the 2010 Standards prior to July 18, 2016, then it must comply with the 2010 Standards if the construction starts after January 18, 2018.

What is Required

The current rule requires covered entities to implement nondiscriminatory practices so that individuals are not excluded from participation in, denied the benefits of, or subjected to discrimination on the basis of race, color, national origin, sex, age, or disability.

The current rule describes certain actions that most covered entities must perform; these actions are described in the current rule as four categories of information collection. The OCR has the authority to request information from covered entities collected under these four categories.

When a covered entity fails to provide the OCR with requested information in a timely, complete, and accurate manner, the OCR may find noncompliance with Section 1557 and initiate enforcement procedures, including fund suspension or termination.

The four categories of information collection are:

1. Submission of an assurance of compliance form
2. Posting of a nondiscrimination notice and posting of taglines
3. Development and implementation of a language access plan
4. Designation of a compliance coordinator and adoption of grievance procedures for covered entities with 15 or more employees

Compliance Assurance Form. Each entity applying for federal financial assistance, each health insurance issuer seeking certification to participate in a Marketplace, and each entity seeking approval to operate a Title I entity is required to submit an assurance that its health programs and activities will be operated in compliance with Section 1557. HHS provides the assurance of compliance document.

Notices and Taglines. 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.

Each covered entity is required to post a notice of individuals' civil rights and covered entities' obligations. The notice should state that the covered entity provides auxiliary aids and services, free of charge, in a timely manner, to individuals with disabilities, when such aids and services are necessary to provide an individual with a disability an equal opportunity to benefit from the entity's health programs or activities.

Further, the notice should state that the covered entity provides language assistance services, free of charge, in a timely manner, to individuals with limited English proficiency, when those services are necessary to provide an individual with limited English proficiency meaningful access to a covered entity's health programs or activities.

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.

The current rule provides a sample notice for significant publications and significant communications. Each covered entity is required to post taglines in the top 15 languages spoken by individuals with limited English proficiency by a relevant state or states, informing individuals with limited English proficiency that language assistance services are available. The current rule provides a sample tagline:

> ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call 1–xxx– xxx–xxxx (TTY: 1–xxx–xxx–xxxx).

HHS provides sample taglines in 64 languages.

A covered entity must include a nondiscrimination statement in lieu of the full notice, and taglines in two non-English languages in lieu of all 15 taglines, on small-size significant publications and significant communications. The current rule provides a sample notice for small-size significant publications and communications.

Covered entities may combine the content of the notice with the content of other notices as long as the combined notice clearly informs individuals of their civil rights under Section 1557. In addition to having flexibility with respect to combining notices, covered entities also have flexibility in determining the exact size and location of notices and taglines within their facilities as long as they do not compromise the intent of the notice to clearly inform individuals of their civil rights under Section 1557.

Practically speaking, whether a covered entity's provision of notice and taglines is sufficiently conspicuous and visible will depend on whether individuals seeking services from, or participating in, the health program or activity could reasonably be expected to see and be able to read the information.

Language Access Plan. Although the final rule does not require covered entities to develop a language access plan, the development and implementation of a language access plan is one factor that the Director will consider when evaluating a covered entity's compliance with the current rule.

The current rule defines a qualified translator as someone who translates effectively, accurately, and impartially; adheres to generally accepted translator ethics principles; and is proficient in both written English and at least one other written non-English language, including any specialized vocabulary, terminology and phraseology necessary to translate written content in paper or electronic form regarding the covered entity's health programs or activities.

Practically speaking, posting taglines is not a substitute for complying with the prohibition of national origin discrimination as it affects individuals with limited English proficiency; covered entities must still take reasonable steps to provide meaningful access to individuals with limited English proficiency who communicate in other languages not covered by the taglines.

To determine whether a covered entity has taken reasonable steps to provide meaningful access, the OCR will 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 limited English proficiency, and consider other relevant factors, including whether the entity has an effective language access plan.

Grievance Procedures. Each covered entity that employs 15 or more people is required to adopt grievance procedures that include due process standards and that provide for the prompt and equitable

resolution of grievances regarding actions prohibited by Section 1557. Each covered entity that employs 15 or more people is also required to designate at least one individual to coordinate its efforts to comply with and carry out its responsibilities under Section 1557, including the investigation of any grievance communicated to it alleging Section 1557 noncompliance.

The current rule provides a sample procedure of how to structure grievance procedures that give individuals appropriate procedural safeguards and provide for the prompt and equitable complaint resolution. An individual is not required to exhaust a covered entity's grievance procedure prior to filing a Section 1557 complaint.

If the proposed rule is finalized as is and published as a final rule:

- Covered entities would not be required to post Section 1557 nondiscrimination notices at their locations and websites
- Covered entities with 15 or more employees would not be required to appoint a compliance coordinator and adopt a grievance procedure
- Covered entities would not be required to use translated taglines in significant consumer communications, develop language access plans, or meet certain video standards for individuals with LEP

Also, OCR will use the following four factors to determine whether a covered entity met its obligation to provide language assistance services to people with LEP:

1. The number or proportion of LEP individuals eligible to be served or likely to be encountered in the eligible service population;
2. The frequency with which LEP individuals come in contact with the entity's health program, activity, or service;
3. The nature and importance of the entity's health program, activity, or service; and
4. The resources available to the entity and costs.

Enforcement

The enforcement mechanisms under Title VI, Title IX, Section 504 of the Rehabilitation Act, and the Age Discrimination Act of 1975 apply to address Section 1557 violations. Individuals have a private right of action. Further, compensatory damages are available. If noncompliance cannot be corrected by informal means, enforcement mechanisms include suspension of, termination of, or refusal to grant federal financial assistance.

If the proposed rule is finalized as is and published as a final rule:

- All current enforcement procedures would be eliminated. Full enforcement authority would be designated to the OCR Director, including the authority to receive complaints, conduct compliance reviews, initiate investigations, and take enforcement actions.
- OCR will no longer take a position on whether Section 1557 provides a private right of action to sue covered entities for violations.

As of June 14, 2019, the publication date of the proposed rule in the Federal Register, OCR has suspended all sub-regulatory guidance that is inconsistent with its proposed rule and its new interpretation of Section 1557. OCR may revoke the suspension in part or in whole at any time before the proposed rule is finalized. Further, OCR will automatically lift the suspension if the proposed rule is withdrawn.

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