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ACA Section 1557 Nondiscrimination Provisions Affect Group Health Plans

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On May 18, 2016, the Department of Health and Human Services (HHS) Office of Civil Rights (OCR) published a final rule implementing Section 1557 of the Affordable Care Act (ACA). Section 1557 prohibits discrimination in health care programs or activities on the basis of race, color, national origin, sex, age, or disability. Notably, this rule expands on prior civil rights law to prohibit sex discrimination in health care.

This article highlights the effect of the final rule on employer-sponsored group health plans. As the guidance also applies to certain business practices of covered entities, affected employers should carefully review it.

Applicability

The rule applies to covered entities. A covered entity is any health program or activity that receives funding from HHS (e.g., hospitals that accept Medicare or doctors who receive Medicaid payments, insurance carriers that participate in the Marketplaces and health programs administered by HHS).

The final rule clarifies that the rule shall apply to all of the operations of the covered entity, including third party administrator (TPA) services.

Section 1557 does not provide an exemption for religious entities. However, application of the final rule is not required if doing so would violate applicable federal statutory protections for religious freedom and conscience.

What's Prohibited?

The final rule prohibits covered entities from discriminating on the basis of race, color, national origin, sex, age or disability when providing or administering health-related insurance or other health-related coverage.

Discriminatory Actions

The final rule clarifies that discriminatory actions specifically include:

- Denying or limiting health coverage;
- Denying a claim;
- Employing discriminatory marketing or benefit designs; and
- Imposing additional cost sharing.

Sex Discrimination

The final rule also provides detail on the prohibition of discrimination based on sex; specifically, discrimination on the basis of sex stereotyping and gender identity.

- Individuals cannot be denied health care or health coverage based on their sex, including their gender identity and sex stereotyping.
- Women must be treated equally with men in the health care they receive and the insurance they obtain.
- Categorical coverage exclusions or limitations for all health care services related to gender transition are discriminatory.
- Individuals must be treated consistent with their gender identity, including in access to facilities. However, providers may not deny or limit treatment for any health services that are ordinarily or exclusively available to individuals of one gender based on the fact that a person seeking such services identifies as belonging to another gender.
- Sex-specific health programs or activities are permissible only if the entity can demonstrate an exceedingly persuasive justification, that is, that the sex-specific health program or activity is substantially related to the achievement of an important health-related or scientific objective.

TPAs

An insurer's TPA services will be subject to Section 1557 when the insurer (1) receives federal financial assistance and (2) is principally engaged in providing health insurance and TPA services.

A TPA of a self-insured plan is not automatically subject to Section 1557. The final rule provides that the OCR will review to determine whether the discriminatory decision or conduct was the result of the TPA or the employer's actions. If the conduct is related to the administration of the plan, then OCR will process a complaint against the TPA if the TPA is a covered entity. If the conduct is related to the decision or action by the employer, the OCR will proceed with a complaint against the employer if the employer is a covered entity subject to Section 1557. If the employer is not a covered entity under Section 1557, OCR will refer the matter to the EEOC for additional consideration.

Enforcement

Enforcement mechanisms available for other federal civil rights laws will be available for Section 1557 violations. This means that noncompliance can result in termination of federal financial assistance or referral to the Department of Justice to bring proceedings. Additionally, the rule provides a private right of action for damages for violations of Section 1557.

Effective Date

The final rule is effective July 18, 2016.

However, if changes to health insurance or a group health plan design (e.g., cost sharing, covered benefits, or benefit limitations and restrictions) are required in order to comply with the provisions set forth in Section 1557, the rule will be effective on the first day of the first plan year beginning on or after January 1, 2017.

Implications for Employer-Sponsored Group Health Plans

- Employers should determine whether they are considered covered entities under Section 1557. Employers in the health care services industry should pay special attention to Section 1557, as many receive Federal funding which will make them subject to these rules.
- Effective for plan years that begin on or after January 1, 2017, most group health plans will need to remove any exclusion, restriction or limitation on coverage for specific health services related to gender transition (e.g., an exclusion for reassignment surgery). Employers intending to exclude transgender services from their group health plan should consult with counsel to understand potential ramifications.