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BENEFIT NEWS BRIEFS

HHS Publishes Final ACA Section 1557 Nondiscrimination Regulations

The Department of Health and Human Services (HHS or the Department) published a final rule implementing Section 1557 of the *Affordable Care Act (ACA)* (Section 1557). Section 1557 prohibits entities that receive federal funds from discrimination on the basis of race, color, national origin, sex, age or disability, including discrimination based on pregnancy, gender identity and sex stereotyping in certain health programs and activities.

The reach of the regulation is very broad and affects nearly 300,000 entities such as hospitals, physicians, laboratories, pharmacies, insurance companies and even self-funded multiemployer group health plans if they receive federal funds through HHS, such as under Medicare Part D, an EGWP or Medicare Advantage Plan, for example. Each multiemployer health plan will need to determine if they receive any federal financial assistance in order to determine if it is a covered entity. The *Preamble* estimates millions of health care workers may need to receive training on the new rules.

The regulations expand the prohibitions on discrimination "on the basis of sex" to include prohibiting discrimination against *transgender* individuals. This regulation will probably necessitate changes to covered group health plans as such plans generally had exclusions or limitations on coverage for gender identity issues that will be prohibited beginning the first day of the first plan year beginning on or after January 1, 2017. However, certain notice requirements apply in October 2016.

Numerous resources and Fact Sheets are available at the HHS Section 1557 webpage located at: *http://www.hhs.gov/civil-rights/for-individuals/section-1557.*

A specially prepared copy of the regulations and Appendices with a table of contents is available by "*clicking here*." Appendices A – C are model notices and language.

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What Entities Are Covered by the New Regulation?

The Final Rule is very broad in its sweep and applies to the following "covered entities":

- An entity that operates a health program or activity, any part of which receives Federal financial assistance;
- An entity established under Title I of the *ACA* that administers a health program or activity; and
- The Department of Health and Human Services.

The regulation will apply to any multiemployer group health plan which receives Federal financial assistance. We are focusing on how the regulation may affect multiemployer group health plans and will phrase our discussion accordingly. Reference to "covered plans" includes all covered entities. Possible Federal financial assistance for a multiemployer plan could include monies the plan would receive under Medicare Part D subsidy, through an EGWP, or possibly for retiree coverage under a Medicare Advantage Plan. Each multiemployer health plan will need to determine if receives any federal financial assistance in order to determine if it is a covered entity.

Prohibition of Discrimination "On the Basis of Sex"

Covered entities are prohibited from discrimination on the basis of race, color, national origin, sex, age or disability in the provision of health services and coverage. The twist under the regulation is the definition of discrimination "*on the basis of sex.*" The term has been defined to include, but is not limited to, discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping and gender identity. The new kid on the block is discrimination based on "gender identity".

"*Gender identity*" is defined to mean an individual's internal sense of gender, which may be male, female, neither, or a combination of male and female, and which may be different from an individual's sex assigned at birth. According to the *Preamble*, The way an individual expresses gender identity is frequently called ''*gender expression*,'' and may or may not conform to social stereotypes associated with a particular gender. A "*transgendered*" individual is an individual whose gender identity is different from the sex assigned to that person at birth (e.g. a male identifying as a female or a female identifying as a male).

The addition of "gender identity" to the classes of individuals protected from discrimination will most likely necessitate design changes in health plans that are considered covered entities, as explained in the *Preamble.* HHS notes that many health-related insurance plans or other health-related coverage (including many multiemployer group health pans) currently have explicit exclusions of coverage for all care related to "gender dysphoria" or associated with "gender transition."

The *Preamble* noted that historically, covered entities have justified these blanket exclusions by categorizing all transition-related treatment as "cosmetic" or "experimental." However, the *Preamble* continues, such across-the-board categorizations are now recognized as outdated and not based on current standards of care. The Department proposes to apply basic nondiscrimination principles in evaluating whether a covered entity's denial of a claim for coverage for *transition-related care* is the product of discrimination.

The *Preamble* explains that under these basic nondiscrimination principles, an *explicit, categorical (or automatic) exclusion* or *limitation o*f coverage for all health services related to gender transition is unlawful on its face. HHS stated that in singling out the entire category of gender transition services such an exclusion or limitation *systematically* denies services and treatments for transgender individuals and is prohibited discrimination on the basis of sex.

However, under these principles, plans are ***not*** required to cover ***all*** *medically necessary services* **nor** are plans required to cover ***any*** *particular treatment*, **as long as** the basis for exclusion is evidence based and nondiscriminatory. Thus, the Department rejected commenters' suggestion that the rule require covered entities to provide coverage for all medically necessary health services related to gender transition regardless of the scope of their coverage for other conditions.

In evaluating whether it is discriminatory for a covered health plan to deny or limit a request for coverage for a particular service for an individual seeking the service as part of transition-related care, HHS will start by inquiring whether and to what extent coverage is available when the same service is not related to gender transition. For example, if a covered plan denies a claim for coverage for a hysterectomy that a patient's provider says is medically necessary to treat gender dysphoria, HHS will evaluate the extent of the covered entity's coverage policy for hysterectomies under other circumstances.

At the same time, the rule requires a covered plan to apply the same neutral, nondiscriminatory criteria that it uses for other conditions when the coverage determination is related to gender transition. Thus, if a covered plan covers certain types of elective procedures that are beyond those strictly identified as medically necessary or appropriate, it must apply the same standards to its coverage of comparable procedures related to gender transition.

However, according to the *Preamble*, not every health service that is typically or exclusively provided to individuals of one sex will be a health service that is appropriately provided to a transgender individual. *Nothing in the rule would, for example, require an issuer to cover a traditional prostate exam for an individual who does not have a prostate, regardless of that individual's gender identity.*

The *Preamble* notes that HHS clarified that the prohibition Section 92.207(b)(4) of the regulation on categorically limiting coverage for all health services related to gender transition is intended to prevent plans from placing categorical, arbitrary limitations or restrictions on coverage for all gender transition-related services, such as by singling out services related to gender transition for higher co-pays.

The regulation is not intended to prevent plans from placing nondiscriminatory limitations or restrictions on coverage under the plan.

The range of transition-related services, which includes treatment for gender dysphoria, is not limited to surgical treatments and may include, but is not limited to, services such as hormone therapy and psychotherapy, which may occur over the lifetime of the individual. The *Preamble* discussed problems that may arise for Third Party Administrators (TPAs) that are also covered entities with computer coding systems that may automatically deny coverage for sex-specific services for transgender individuals due to their computer systems flagging a mismatch between the gender of the individual identified at enrollment and the billing code associated with the biological sex that typically receives the health service.

This problem may arise for TPAs in general and plan administrators may need to develop manual overrides for such claims. The *Preamble* recognizes that plan administrators may need to ask transgender enrollees for additional information, including information related to their biological sex or sex assigned at birth, to facilitate overriding denials of coverage for sex-specific health services due to gender billing code mismatches in their computer systems.

The *Preamble* clarified that a covered plan is permitted to ask transgender enrollees to provide such additional information, as long as the covered plan does not unduly burden enrollees or make unreasonable inquiries that serve to delay their receipt of coverage. In addition, a covered plan may request information about the biological sex of the applicant on an enrollment form to assist the covered plan in identifying the medical appropriateness of sex-specific health services, as long as the information requested is not used in a discriminatory manner, and the collection and use of the information is otherwise lawful and complies with applicable *HIPAA* privacy requirements.

The *Preamble* indicates that the costs associated with covering transgendered individuals would be "*de minimis.*" Among other things, the *Preamble* cited to a study by the California Department of Insurance Economic Impact Assessment on Gender Nondiscrimination in Health Insurance found that covering transgender individuals under California's private and public health insurance plans would have an *''insignificant and immaterial''* impact on costs based on evidence of low utilization and the estimated number of transgender individuals in California (estimated to range between 0.0022% and 0.0173% of the population) The study revealed that, contrary to common assumptions, not all transgender individuals seek surgical intervention, and that gender-confirming health care differs according to the needs and preexisting conditions of each individual.

New Required Notices

Covered plans are also required to post certain notices stating that the plan complies with the nondiscrimination requirements of Section 1557, as well as other required information. The Notice requirements are quite detailed and found in Section 92.8 of the regulations. A sample Notice is found in Appendix A to the regulations. In addition to the Notice requirements, covered plans must also use a "tagline" explaining the availability of help to individuals with limited proficiency in

English, as well as set up a grievance policy. Appendixes B and C contain sample language for both of these items, respectively.

The general notice found in Appendix A must be posted by October 16, 2016 in the following locations:

- In *significant publications* and *significant communications* targeted to beneficiaries, enrollees, applicants and members of the public, except for significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures;

- In *conspicuous physical locations* where the entity interacts with the public; and

- In a *conspicuous location* on the covered plans home *webpage*.

The *Preamble* states that HHS will allow plans to exhaust their current stock of hard copy publications rather than requiring a special printing of the publications to include the new notice. Fund Counsel should advise the plan what constitutes "significant publications and significant communications" that would require the inclusion of the Appendix A notice. Such publications would probably include SPDs. Whether it would include items like SBCs or other communications should be evaluated with the help of Fund professionals. For SPDs the plan may wish to add language to the next SPD revision and include a handout with SPDs until then. The plan's enrollment materials may also be a good place to add a copy of the Appendix A notice. Posting a copy of the Notice in the Fund Office and on the Fund website should be relatively easy.

In addition, covered plans must also post taglines in at least the top 15 languages spoken by individuals with limited English proficiency of the relevant State or States. Further, covered plans shall post, in a conspicuously-visible font size, in significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures that the covered entity does not discriminate on the basis of race, color, national origin, sex, age or disability in its health programs and activities. In addition to the nondiscrimination language, the covered entity must post taglines in at least the top two languages spoken by individuals with limited English proficiency of the relevant State or States concerning language assistance help available for such individuals.

Individuals responsible for preparation and distribution of notices will want to carefully review Section 92.8 of the regulation as the above is a summary of the rules. Translations of the Notice and taglines are *available at the HHS website*.

Language Aids and Services

A covered plan shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served by it. In evaluating whether a covered plan has met this obligation, HHS shall evaluate the nature and importance of the health program or activity and the particular communication at issue to the individual with limited English proficiency, among other things, in

determining whether a covered plan has developed and implemented an effective written language access plan.

Language assistance services under this section must be provided free of charge, be accurate and timely, and protect the privacy and independence of the individual with limited English proficiency.

A covered plan shall offer a qualified interpreter to an individual with limited English proficiency when oral interpretation is a reasonable step to provide meaningful access for that individual with limited English proficiency. A covered plan shall use a qualified translator when translating written content in paper or electronic form.

A covered plan shall not require an individual with limited English proficiency to provide his or her own interpreter or require an individual to rely on an adult accompanying an individual with limited English proficiency to interpret or facilitate communication, except in an emergency situations involving an imminent threat to the safety or welfare of an individual or the public and there is no qualified interpreter for the individual with limited English proficiency immediately available. In addition, where the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances, the covered entity may allow such adult to interpret.

A covered plan may not rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available.

Finally, a covered plan may not rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency.

A covered plan may provide a qualified interpreter for an individual with limited English proficiency through video remote interpreting services subject to certain quality transmission requirements.

The *Preamble* noted that nothing in this section shall be construed to require an individual with limited English proficiency to accept language assistance services from the covered plan. Translated resources are available at: *http://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources*.

Conclusion

Multiemployer group health plans will need to do the following:

- Determine if they receive any federal financial assistance from HHS.
- If they do receive any type of federal financial assistance from HHS, the Trustees and Plan professionals will need to review the plan for any prohibited exclusions and limitations and amend the plan accordingly.
- With assistance from plan professionals, Trustees will need to determine which publications and communications should be considered "*significant publications* and *significant communications*" for the Notice rules and take steps to post the required Notices and taglines in the appropriate places, including the Fund's webpage.
- Review the steps the plan has taken to provide meaningful access to each individual with limited English proficiency eligible under the plan.

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General Resources

- *Section 1557 HHS Press Release*
- *Summary of the Final Rule*
- *Frequently Asked Questions on Final Rule*

Factsheets on Key Provisions

- *Protecting Individuals against Sex Discrimination*
- *Ensuring Meaningful Access for Individuals with Limited English Proficiency*
- *Ensuring Effective Communication with and Accessibility for Individuals with Disabilities*
- *Coverage of Health Insurance in Marketplaces and Other Health Plan*

Enforcement of Section 1557: *Sex Discrimination Case Examples*

The HHS Office for Civil Rights has been enforcing Section 1557 since it was enacted in 2010. Read case examples that highlight OCR's enforcement results in complaints alleging sex discrimination.

OCR Director's Memorandum to Federal Offices for Civil Rights

All Federal agencies have enforcement responsibility for programs they fund that fall under Section 1557 jurisdiction. Read the Memorandum.