Update on Nondiscrimination Regulations Relating to Sex, Gender, Age, and More

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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 (2016 rule) implementing Section 1557, which took effect on July 18, 2016. The 2016 rule applied 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 were "covered entities" and included 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 2016 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. The District Court's ruling was appealed to the Fifth Circuit Court of Appeals. The Fifth Circuit granted a stay of the case until after the Supreme Court issues an opinion on whether discrimination based on sexual orientation or gender identity is prohibited under Title VII of the Civil Rights Act (CRA). On June 15, 2020, the Supreme Court issued an opinion holding that an employer that fires an individual for being gay or transgender violates Title VII of the CRA.

On June 12, 2020, HHS announced a final rule implementing Section 1557 that revises or repeals many provisions contained in the prior 2016 rule. The final rule will be published on June 19, 2020, and will take effect 60 days from publication.

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Background

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 2016 rule implementing Section 1557 of the Patient Protection and Affordable Care Act (ACA), which took effect on July 18, 2016. The 2016 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 2016 rule applied as of the first day of the first plan year beginning on or after January 1, 2017.

The 2016 rule was 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 long-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

Practically speaking, employers with fully insured group health plans were subject to the 2016 rule (because the carrier is a covered entity and is prohibited from selling discriminatory plans), and many self-funded employers were considered a covered entity based on their business model or financial details. Furthermore, most third-party administrators (TPAs) were considered covered entities.

When determining if an employer 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 they are not considered federal financial assistance. Most physicians are

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subject to the current rule because almost all practicing physicians in the United States accept some form of federal reimbursement other than Medicare Part B.

Covered entities were required to 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 were 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 were required to 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 were required to designate a responsible employee to coordinate the entity's compliance with the rule and adopt a grievance procedure.

The OCR provided a model notice and model statement of nondiscrimination, and taglines for employers to use. The OCR also created an FAQ and table relating to the top 15 languages spoken in each state.

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 October 15, 2019 the U.S. District Court for the Northern District of Texas (District Court) vacated portions of the 2016 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. The District Court's ruling was appealed to the Fifth Circuit Court of Appeals. The Fifth Circuit granted a stay of the case until after the Supreme Court issues an opinion on whether discrimination based on sexual orientation or gender identity is prohibited under Title VII of the Civil Rights Act (CRA). On June 15, 2020, the Supreme Court issued an opinion holding that an employer that fires an individual for being gay or transgender violates Title VII of the CRA.

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Final Rule

On June 12, 2020, the Department of Health and Human Services' Office for Civil Rights (OCR) released a final 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 final rule eliminates:

- 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

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- The requirement to have a compliance coordinator and written grievance procedure to handle complaints about Section 1557 violations
- Enforcement-related provisions

Practically speaking, the final rule , and therefore Section 1557, does not apply to self-funded plans and many fully insured plans. OCR specifically states that the final rule would not apply to self-funded plans and that health insurers are not principally engaged in the business of providing health care. This means the final rule would not apply to a fully insured plan unless the plan received federal financial assistance from HHS or unless the plan is operating a program that is principally engaged in the business of providing health care.

Under the final rule:

- Self-funded plans will no longer be subject to the final rule
- Fully-insured plans will only be subject to the final rule if the plan receives federal financial assistance from HHS or if the plan is operating a program that is principally engaged in the business of providing health care
- Short-term limited duration insurance plans will only be subject to the final rule if the plan receives federal financial assistance from HHS or if the plan is operating a program that is principally engaged in the business of providing health care
- Covered entities will not be required to post Section 1557 nondiscrimination notices at their locations and websites
- Covered entities with 15 or more employees will not be required to appoint a compliance coordinator and adopt a grievance procedure
- Covered entities will not be required to use translated taglines in significant consumer communications, develop language access plans, or meet certain video standards for individuals with limited English proficiency (LEP)

Sex, Gender, and Sexual Orientation Discrimination

The 2016 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 2016 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 2016 rule's prohibition of discrimination based on gender identity before the District Court's ruling and final rule.

Before the District Court's ruling, the 2016 rule prohibited discrimination faced by transgender individuals trying to access coverage of health services. The 2016 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

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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 2016 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. Employers that seek to implement neutral standards limiting gender dysphoria or gender transition services in relationship to their group health plan should only do so after consulting their legal counsel.

The 2016 rule 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 2016 rule did 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 final rule amends the 2016 rule as follows:

- Sex discrimination does 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

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 the current 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.

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The final rule amends the 2016 rule as follows:

- The final rule would not apply to an insurer's entire business. Instead, the final rule would only apply to the specific operations and lines of business for which the insurer receives federal financial assistance.

Discrimination Against Persons with Limited English Proficiency and Disabilities

An individual with limited English proficiency (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 2016 rule increased assistance for individuals with LEP so that they can communicate with their health care providers and have meaningful access to health programs and activities.

Under the 2016 rule, covered entities were 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. Under the 2016 rule, to determine whether language obligations have been met, the only relevant factor listed was 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. Reasonable modifications are required where necessary for facilities and technology to provide equal access for individuals with disabilities.

The final rule amends the 2016 rule as follows:

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

Also, under the final rule, 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 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.

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

The final rule amends the 2016 rule as follows:

- All current enforcement procedures are 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 suspended all sub-regulatory guidance that is inconsistent with its proposed rule and its new interpretation of Section 1557. As of June 19, 2020, the publication date of the final rule in the Federal Register, the inconsistent guidance is withdrawn and is in the process of being removed from the HHS website.

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