HCR ALERT

HHS Issues Final Rule on Nondiscrimination in Health Programs

June 8, 2016

Overview

On May 13, 2016, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) issued a final rule implementing Section 1557 of the Affordable Care Act (ACA) regarding nondiscrimination in Federally-funded health programs, as well as a set of related frequently asked questions (FAQs). The rule is generally effective July 18, 2016, but health plans needing changes in plan design are not required to comply until the first day of the 2017 plan year.

In general, the final rule:

- Prohibits discrimination in health care on the basis of race, color, national origin, age, disability and sex (including discrimination based on pregnancy/childbirth, gender identity and sex stereotyping); and
- Helps to ensure effective communication for people with limited English proficiency and individuals with disabilities.

The final rule applies to health programs or activities, any part of which receives Federal financial assistance administered by HHS, and to health programs or activities administered by HHS or by entities established under Title I of the ACA, such as:

- Issuers participating in insurance Marketplaces and receiving payments for ACA advance premium tax credits or cost-sharing reductions (rule applies to all health policies sold by the issuers both in and out of the Marketplace, as well as to health care benefits the issuers offer their employees);
- Hospitals and other health care facilities and providers receiving Medicare A, Medicare C, or Medicaid payments (rule also applies to health care benefits the organizations offer their employees);
- Employer-sponsored health plans receiving Medicare D subsidies or ACA wellness program grants; and
- State Medicaid and CHIP programs (rule also applies to health care benefits the State

Medicaid/CHIP agencies offer their employees).

Section 1557 applies to employer-sponsored health plans only if an employer receives Federal funds from HHS or a Title I entity and: the employer is principally engaged in providing or administering health services, health insurance, or other health coverage (bullets 1 and 2 above); a primary objective of the Federal assistance is to fund an employee health benefit program (bullet 3 above); or the employer operates a health program that receives Federal assistance (bullet 4 above). Employer-sponsored plans offered through insured group health policies are indirectly subject to the final rule if purchased from issuers participating in a Marketplace, but the employer itself has no direct obligation or liability under the rule.

The proposed rule took a firm stance that requirements would apply to all products and services of Marketplace issuers, including self-insured health plans for which an issuer acts as a third party administrator (TPA), unless the TPA is a legally separate entity from the issuer. OCR softened its position in the final rule by stating self-insured health plans sponsored by employers not otherwise subject to Section 1557 (i.e., not meeting the above criteria) are not subject to the rule even if the plan's TPA is a covered entity. OCR will process a complaint against a TPA that is a covered entity only if alleged discrimination is related to the TPA's administration of a self-insured plan. If alleged discrimination is related to benefit design, OCR will address the complaint with the employer only if the employer is otherwise subject to Section 1557. Where it does not have jurisdiction, OCR may refer the matter to other Federal agencies if they have jurisdiction over the entity (e.g., to the EEOC if claim is related to ADA or ADEA violation).

Protections from Discrimination Based on Race, Color, National Origin, Age, Disability and Sex

The final rule prohibits discrimination in the provision of health insurance and related coverage on the basis of race, color, national origin, sex, age or disability. Specifically, covered entities may not, on a discriminatory basis:

- Deny, cancel, limit or refuse to issue or renew a health-related insurance plan or coverage;
- Deny or limit a claim or impose additional cost-sharing or other limitations or restrictions on coverage;
- Engage in discriminatory marketing practices or adopt or implement discriminatory benefit designs in health-related insurance or other health-related coverage;
- Deny or limit coverage or a claim, or impose additional cost-sharing or other limitations or restrictions on coverage, for sex-specific health services provided to transgender individuals just because the individual seeking such services identifies as belonging to another gender; or
- Categorically exclude coverage for all health services related to gender transition, or deny or limit (or impose additional cost-sharing or other limitations or restrictions on) coverage for specific health services related to gender transition if those result in discrimination against a transgender individual.

With regard to rules pertaining to gender identity, in general, individuals must be treated consistent with their gender identity. 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 those services identifies as belonging to another gender (e.g., treatment for ovarian cancer may not be denied because an individual assigned ‘female’ at birth identifiesas a transgender male). 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).

In the final rule OCR declined requests to define “health services related to gender transition” and identify which services must be covered for a plan to be considered nondiscriminatory, indicating it intends to interpret these services broadly because health services related to gender transition may change as standards of medical care continue to evolve. Covered entities are not required to cover all medically necessary services or any particular treatment related to gender transition, as long as the basis for exclusion is evidence-based and nondiscriminatory. At the same time, the rule does require that a covered entity apply the same neutral, nondiscriminatory criteria that it uses for other conditions when the coverage determination is related to gender transition (i.e., if a covered entity covers certain types of elective procedures 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).

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 under Section 1557. However, OCR will evaluate complaints that allege sex discrimination related to an individual’s sexual orientation in order to determine if they involve the type of stereotyping that can be addressed under Section 1557. OCR supports prohibiting sexual orientation discrimination as a matter of policy, and will continue to monitor legal developments on this issue.

Protections for Individuals with Limited English Proficiency

Consistent with longstanding principles under civil rights laws, the final rule clarifies that the prohibition on national origin discrimination requires covered entities to take reasonable steps to provide meaningful access to each individual with limited English proficiency who is eligible to be served or likely to be encountered within the entities’ health programs and activities. An individual with limited English proficiency is a person whose primary language for communication is not English and who has a limited ability to read, write, speak or understand English.

Reasonable steps may include the provision of language assistance services, such as oral language assistance or written translation. The standards in the final rule are flexible and context-specific, taking into account factors such as the nature and importance of the health program and the communication at issue, as well as other considerations, including whether an entity has developed and implemented an effective language access plan. Covered entities are prohibited from using low-quality video remote interpreting services or relying on unqualified staff or translators when providing language assistance services. Instead, they are encouraged to develop and implement a language access plan to ensure they are prepared to take reasonable steps to provide meaningful access to each individual who may require

assistance.

Protections for Individuals with Disabilities

Section 1557 requires covered entities to take appropriate steps to ensure that communications with individuals with disabilities are as effective as communication with others and it requires covered entities to provide appropriate auxiliary aids and services (such as alternative formats and sign language interpreters) where necessary for effective communication. Section 1557 incorporates the 2010 Americans with Disabilities Act (ADA) Standards for Accessible Design as the standards for physical accessibility of new construction or alteration of buildings and facilities, with which almost all covered entities are already required to comply. In addition, under Section 1557, covered entities:

- Must make all programs and activities provided through electronic and information technology accessible to individuals with disabilities, unless doing so would impose undue financial or administrative burdens or would result in a fundamental alteration in the nature of the covered entity's health program or activity;
- Cannot use marketing practices or benefits designs that discriminate on the basis of disability; and
- Must make reasonable changes to policies, practices and procedures, where necessary, to provide equal access for individuals with disabilities, unless the covered entity can demonstrate that making the changes would fundamentally alter the nature of the health program or activity.

Adoption of Grievance Procedures

Each covered entity that employs 15 or more employees must adopt grievance procedures and designate at least one employee to coordinate its efforts to comply with and carry out its responsibilities under the final rule, including investigation of noncompliance grievances. OCR provides a sample grievance procedure in Appendix C of the final rule.

Notice Requirements

Covered entities must take initial and continuing steps to notify beneficiaries, enrollees, applicants, and members of the public who are eligible to be served or likely to be encountered within the entities' health programs and activities of the following:

- The covered entity does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities;
- The covered entity provides auxiliary aids and services to free of charge individuals with disabilities (and information on how to obtain them);
- The covered entity provides language assistance services free of charge to individuals with limited English proficiency (and information on how to obtain them);

- The availability of grievance procedures (and information on the contact person and how to file a grievance); and
- How to file a discrimination complaint with OCR.

Within 90 days of the effective date of the final rule, the information listed above, along with taglines in at least the top 15 languages spoken by individuals with limited English proficiency of the relevant state(s), must be posted in a conspicuously-visible font size in:

- Significant communications targeted to beneficiaries, enrollees, applicants, and members of the public (except for significant publications and communications that are small-sized, such as postcards and tri-fold brochures);
- Conspicuous physical locations where the entity interacts with the public; and
- A conspicuous location on the covered entity's web site accessible from the home page of the site.

Also within 90 days of the effective date, the general nondiscrimination statement and taglines in at least the top 2 languages spoken by individuals with limited English proficiency of the relevant state(s) must be posted in a conspicuoulsy-visible font size in publications and communications that are small-sized (e.g., postcards and tri-fold brochures). HHS has translated a sample notice of nondiscrimination and the taglines for use by covered entities into 64 languages. The translated materials are available on HHS' website.

Conclusion – Employer's Perspective

It's likely this Section 1557 final rule will not directly affect many employee group health plans, but all employer plan sponsors should review the rule carefully and confirm your organization's standing, as prompt action is required of those that are covered entities. Employers should begin by determining whether the organization receives federal financial assistance as described in the rule.

Employers that are covered entities must consider how the new rule might affect 2017 health plan design and operation. Because some standards in the final rule pertain to whether medical management techniques are "reasonable" and "neutral", sponsors of self-insured plans subject to the rule should discuss relevant medical management techniques and clinical policies, and documentation of such, with their TPAs.

Finally, affected employers need to address the related administrative matters. Most importantly, covered employers must consider how best to comply with the nondiscrimination notice and language access requirements. Development of grievance procedures and appointment of a compliance coordinator will be also required.

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Your Trion Strategic Account Managers are here to answer any questions you might have as you prepare to comply with upcoming ACA requirements. If you are not currently a Trion client and would like assistance navigating the changes required by health care reform, please contact us today by emailing trionsales@trion-mma.com.

ACA Guidance Released in the Last Two Months

May 2016:	EEOC Issues Final ADA and GINA Rules on Wellness Programs and ADA FAQs and
May 2016:	HHS Issues Final Rule on Section 1557 Nondiscrimination in Health Programs and A
May 2016:	ACA FAQs 31 – Patient Bill of Rights Topics
Apr. 2016:	IRS Issues Rev. Proc. 2016-24 2017 Affordability Threshold & Marketplace Required Percentages
Apr. 2016:	Agencies Issue Revised SBC Template, Instructions, Uniform Glossary, and Other Re Documents

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