Amwins Connect Brief

Final §1557 Nondiscrimination Rules
May 2024

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The Department of Health & Human Services (HHS) finalized rules that expand several of the requirements previously set forth in agency interpretations of the §1557 nondiscrimination requirements of the Affordable Care Act (ACA), which prohibit discrimination in health programs and activities on the basis of race, color, national origin, sex, age, or disability.

For the average employer sponsoring a group health plan, it is important to understand that the definition of a "covered entity" will now include health insurance carriers receiving any federal financial assistance from HHS as well as third party administrators (TPAs) or pharmacy benefit managers (PBMs) operated by such carriers. That being the case, even under the expanded rules, most employers other than those in a health-related role will not be covered entities, and the rules clarify that employers and plan sponsors are not directly subject to §1557 requirements on behalf of their group health plan offerings unless the group health plan itself receives federal financial assistance from HHS (e.g., Medicare Part D subsidies). However, because many employers obtain group health plan coverage from carriers or TPAs who will be covered entities required to offer plan designs and/or perform plan administration in accordance with §1557 nondiscrimination requirements, the group health plan offerings available via such covered entities beginning in 2025 may look a little different.

As covered entities, insurance carriers and their TPAs and PBMs, will need to focus on how the requirements apply to health insurance and coverage administration, but for other employers who are covered entities, the nondiscrimination requirements pertain primarily to how healthcare, education and research are carried out for patients and recipients.

Link to Dept of Health and Human Services Press Release and FAQ Sheet and Final Regulations

Background

§1557, added by the ACA, prohibits covered entities from discriminating against individuals on account of race, color, national origin, sex, age, or disability in providing and administering health programs and activities.

In 2016, the agencies released a set of final regulations defining a covered entity as providers, insurance carriers, TPAs, and group health plans receiving federal funding from HHS. Covered entities were required to administer their health programs or activities without discriminating, including requirements to make services accessible, and more specifically requiring covered entities to designate a compliance coordinator, establish a grievance procedure, and provide notices of nondiscrimination and availability of language assistance services. Finally, discrimination "on the basis of sex" was defined to include discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity.

In 2020, a new set of final regulations were released narrowing the definition of a covered entity to exclude insurance carriers and removing the requirement to designate a coordinator, implement grievance procedures, and to provide notices. There was also an attempt to narrow the definition of discrimination "on the basis of sex" not to include gender identity and termination of pregnancy.

The most recent set of final regulations is more in line with the 2016 regulations and actually expands a bit beyond those requirements. The definition of covered entity has been redefined to include insurance carriers, and the definition of sex has been redefined to include sexual orientation and gender identity to be consistent with the ruling in *Bostock v. Clayton County*, 590 U.S. 644 (2020). In addition, the requirements to designate a coordinator, implement grievance procedures, and to provide notices are reinstated, and there is additional guidance on handling accessibility for information technology,

telehealth, and patient care decision support tools. However, there are broad exceptions available for any portion of the requirements that would violate applicable Federal religious freedom or conscience laws.

In general, the final rules go into effect within 60 days of being published in the federal register (published May 6, 2024), but due to the significance of the changes, various delayed effective dates apply for many of the bigger changes.

Covered Entity

A "covered entity" subject to §1557 rules include the following:

- Health programs or activities that receive Federal financial assistance from HHS;
- Health programs or activities administered by HHS; and
- Health programs or activities administered by a Title I entity (public Marketplaces).

Which Employers Provide "Health Programs or Activities"?

Health programs and activities broadly include providing, assisting with, or administering health-related services or health coverage; engaging in health or clinical research; or providing health education for health care professionals or others. So, while not an exhaustive list, it would generally include any hospitals or clinics, labs, pharmacies, medical supply companies, medical and clinical research companies, and educational institutions providing medical training. It also includes insurance carriers (i.e., health coverage).

For entities principally engaged in providing or administering health programs or activities, all operations of the entity are subject to the rules. However, no employer (even a covered entity) is subject to these rules in regard to their employment practices, including the provision of employee health benefits, unless the group health plan itself receives federal funding from HHS (e.g., Medicare Part D subsidies). In other words, ***employers (even employers who are covered entities) are not directly subject to the requirements on behalf of the group health plan coverage offered to their employees UNLESS the group health plan receives funding from HHS.***

Insurance Carriers, TPAs & PBMs

As mentioned above, ***the definition of a covered entity clearly includes insurance carriers that are receiving any federal funding from HHS, which will likely include most insurance carriers.*** In addition, the regulations clarify that TPAs and PBMs operated or owned by the insurance carrier will also be covered entities in which case they must comply with §1557 nondiscrimination requirements to the extent they play a role in designing and/or administering health coverage, even in cases where the employer or plan sponsor requests otherwise.

Exceptions for Religious or Conscience Objections

There is no blanket exception for covered entities that claim a religious or conscious objection to §1557 requirements that would allow them to disregard all of the §1557 requirements, but a covered entity is permitted to disregard any part of the regulations that would violate the entity's rights under the First Amendment or the Religious Freedom Restoration Act (RFRA).

Requirements for Covered Entities

Nondiscrimination Requirements

Covered entities must operate and administer their health programs and activities in a way that does not discriminate against race, color, national origin, sex, age, or disability, any combination thereof. Among other things, this includes:

- Meaningful access for individuals with limited English proficiency;
- Effective communication for individuals with disabilities;
- Accessibility for buildings and facilities;
- Accessibility of information and communication tech for individuals with disabilities;
- Requirement to make reasonable modifications when applicable;
- Equal program access on the basis of sex;
- Nondiscrimination in health insurance coverage and other health-related coverage;
- Nondiscrimination in the use of patient care decision support tools; and
- Nondiscrimination in the delivery of health programs and activities through telehealth.

Designate a Coordinator

Within 120 days of the effective date of the final regulations, if a covered entity employs 15 or more persons, the covered entity is required to designate a coordinator to establish and implement nondiscrimination procedures, including grievance procedures, and ensure proper notices are provided and posted. A covered entity is not required to be a named individual; it is adequate to list a position title with a phone number, email address, and mailing address.

Establish Policies & Procedures

Within one year of the effective date of the final regulations, covered entities are required to adopt and implement a written nondiscrimination policy, grievance procedures (for covered entities employing 15 or more persons), language access procedures, auxiliary aids and services procedures, and procedures for reasonable modifications for individuals with disabilities.

Training

Following a covered entity's implementation of the policies and procedures set forth above, but no later than 300 days from the effective date of the final rules, covered entities must train relevant employees on the covered entity's policies and procedures.

Notice of Nondiscrimination & Notice of Availability

Covered entities must provide two separate notices: (i) a notice of nondiscrimination; and (ii) a notice of availability.

- Within 120 days of the effective date of the final rules, the notice of nondiscrimination must be provided annually and upon request, on the health program or activity's website (if applicable), and in a clear and prominent physical location.
- Within one year of the effective date of the final rules, the notice of availability of language assistance services and auxiliary aids and services must be provided in English and at least 15 of the most commonly spoken non-English languages. Similar to the notice of nondiscrimination, it must be made available on an annual basis and upon request, on the health program or activity's website (if applicable), and in a clear and prominent physical location. In addition, it is

required to be included in specified disclosures such as the notice of privacy practices and an explanation of benefits (EOB).

Link to Sample Nondiscrimination and Availability Notices

Group Health Plan Coverage Requirements

For covered entities designing and administering group health plan coverage (as well as any other health insurance coverage or health-related coverage), the covered entity providing or administering such coverage must not discriminate on the basis of race, color, national origin, sex, age, disability, or any combination thereof. Things such as eligibility rules, cost-sharing, coverage exclusions and limitations, and medical management techniques should all be designed and administered in a nondiscriminatory fashion. The rules do not provide much in the way of specific examples for types of exclusions or limitations that might be discriminatory. Therefore, it is unclear what types of exclusions or limitations might be allowed for different conditions. It is likely that there will be lawsuits and additional agency guidance over time making it more clear exactly how plans must be designed and administered to comply with §1557 requirements.

As mentioned above, employers or other plan sponsors are not directly subject to §1557 rules on behalf of their group health plans unless the group health plan itself receives federal assistance from HHS (e.g., Medicare Part D subsidies), BUT, since most health insurance carriers will be covered entities, and TPAs and PBMs owned or operated by carriers will likely be covered entities, employers may indirectly have to comply on behalf of their group health plans because the carrier or TPA will be required to design and administer plans in accordance with §1557 requirements. In addition, while a covered entity may be able to avoid compliance with certain aspects of §1557 requirements based on a religious or conscience objection, the guidance suggests a covered entity may not make an exception based on an employer's religious or conscience objection. Instead, if the employer objects to something required under §1557, the employer may be forced to find a different carrier, TPA or PBM; perhaps one that is not a covered entity.

To the extent that changes are needed for the group health plan to comply with the latest §1557 guidance, the changes must be in place for plan years beginning in 2025.

Discrimination Based on Sex

The definition of "on the basis of sex" has been in flux since §1557 requirements first went into effect. The final rules expanded the definition to include discrimination based on: (i) sex characteristics, including intersex traits; (ii) pregnancy or related conditions; (iii) sexual orientation; (iv) gender identity; and (v) sex stereotypes. In addition, a covered entity must not take an individual's sex into account in applying any rule concerning an individual's current, perceived, potential, or past marital, parental, or family status.

For group health plan coverage, it is not clear exactly what this expanded definition of sex may require, but the guidance makes it clear that nothing in the rules specifically requires coverage for abortion. However, broad exclusions or limitations tied to coverage of treatment or services related to gender identity may violate §1557 nondiscrimination rules.