HHS Issues Final Rule on ACA Nondiscrimination Provisions (Section 1557)

In May, the Department of Health and Human Services (HHS) published a final rule implementing Section 1557 of the Affordable Care Act (ACA), which prohibits discrimination on the basis of, among other grounds, sex (including gender identity) in certain health programs and activities. Specifically, entities covered under the rule cannot deny, cancel, limit or refuse to issue health coverage; deny or limit a claim; or impose additional cost sharing on a protected individual.

The rule will require many group health plans and employers to cover health care services provided to transgender individuals and is expected to have broad implications for the provision of transgender- and gender transition-related medical treatment. The extent to which the rule may apply to a particular plan or employer involves some analysis. However, it is clear that HHS intends to encourage coverage of health care services for transgender individuals in the broadest manner possible.

The rule is effective for plan years beginning on or after January 1, 2017. Some aspects of the rule that require notices and accommodations for individuals with disabilities or limited English language skills are effective 90 days after the July 18, 2016 effective date of the final rule.

Nondiscrimination Requirements

With respect to transgender health benefits, a covered entity may not deny or limit coverage or impose additional cost sharing or other limitations for sex-specific health services provided to transgender individuals because the individual’s gender identity or recorded gender is different from the one to which such health services are ordinarily provided. For example, when a plan covers medically appropriate pelvic exams, coverage cannot be denied for an individual for whom a pelvic exam is medically appropriate because the individual either identifies as a transgender man or is enrolled in the health plan as a man.

In addition, covered entities are prohibited from categorically excluding coverage for services related to gender transition. Exclusion of transition-related treatment as experimental or cosmetic is also not permissible. Transition-related services, which include treatment for gender dysphoria, are not limited to surgical treatments and may include, but are not limited to, services such as hormone therapy and psychotherapy, which may occur over the lifetime of the individual.

Covered entities may still use reasonable medical-management techniques and are not required to cover any particular treatment or procedure. However, they will be expected to provide a neutral, nondiscriminatory reason for the denial or limitation that is not a pretext for discrimination.

Covered Entities

The rule is sweeping in its coverage and scope. It applies to all health programs and activities that receive federal financial assistance through HHS, including Medicaid/CHIP, most providers that accept Medicare, student health plans, and issuers of Marketplace plans.

So the rule will apply directly to many health insurance issuers as well as hospitals, health clinics, state Medicaid agencies, community health centers, physician’s practices and home health care agencies. These entities may not discriminate in the operation of their employee health benefit programs.
For other employers, the rule will apply to many fully insured and self-funded group health plans through either their insurance carrier or third party administrator (TPA). The rule generally applies to insurance carriers that operate as TPAs if they receive funds through HHS, unless the TPA is legally separate from the carrier. One distinction, though, from insurance carriers, is that a covered TPA is only liable for its own discriminatory actions, not those of the health plan that it administers. A TPA would, for example, be liable for discriminatory denial of claims, but not for an employer’s discriminatory benefit design.

If an employer has a discriminatory plan design but HHS does not have jurisdiction (e.g., because the employer is not principally engaged in providing or administering health services or health coverage), it will refer the matter to the Equal Employment Opportunity Commission (EEOC). The EEOC may pursue a claim under federal laws including Title VII and the Americans with Disabilities Act, both of which require that employee benefits be provided in a non-discriminatory manner.

Exemptions
The rule doesn’t contain a new blanket religious exemption. HHS has stated that the rule doesn’t displace existing protections for religious freedom and conscience that already exist in federal laws such as the Religious Freedom Restoration Act. HHS also declined to exempt benefits that are excepted from the ACA's market reforms and portability requirements (e.g., limited scope dental and vision plans) from the Section 1557 final regulations. According to HHS, many excepted benefits are a "health program and activity" for Section 1557 purposes. Wellness programs are covered as an employee health benefit program whether or not they are part of the employer’s health benefit plan as are employer-provided health clinics.

Implications
Covered entities should determine whether there are plan exclusions or coverage limitations related to sex, gender dysphoria or sexual orientation. This would include categorical exclusions of gender-transition services. These exclusions should be removed for plan years beginning on or after January 1, 2017. In most cases, the cost of this additional coverage will be low, particularly because the number of participants for whom these benefits will be provided is likely to be very low.

While many employers will not be subject to Section 1557 directly, it will impact their plan design if their carrier or TPA is a covered entity. Employer sponsors of self-insured plans should consult with their TPA to determine if the TPA is a covered entity and whether any plan design changes are recommended.

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