ACA Non-Discrimination Protections - Employers: Immediate Action Required by July 18

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IMPACT:
Employer Group Health Care Plans, Their Insurers or TPAs, Certain Plan Sponsors

Section 1557 of the Affordable Care Act (ACA) and related regulations prohibit discrimination on the basis of race, color, national origin, sex, age, or disability, by any health program or activity that receives federal funding or assistance from the federal Department of Health and Human Services (HHS) or that is administered by an executive agency.

If an employer receives federal financial assistance from HHS for any health care program or activity or sponsors a group health care plan through an insurer that receives federal financial assistance from HHS or if the employer uses such an insurer's TPA to administer its self-insured plan, odds are 9,999/10,000 that ACA's non-discrimination provisions and related regulations will apply to the employer's group health plan.

Quick action is required: the May 2016 Final Regulation and its operations and compliance requirements discussed below go into effect on July 18, 2016. Its posted notice requirements go into effect 90 days later on October 17, 2016.

What entities are affected? What conduct is covered? What immediate actions are required?

Entities affected:

Plan Sponsors and Group Health Care Plans That Receive Federal Financial Assistance:

Related People

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Related Services

Employee Benefits

Health Care

Health Care Industry Team

The Final Regulation applies Section 1557's non-discrimination prohibitions to group health care plans if the plans receive federal financial assistance from HHS, or if their plan sponsors receive such assistance for any health program or activity, including wellness programs (for example), whether part of a plan or not.

Group Health Care Plans Whose Insurers or TPAs Receive Federal Financial Assistance:

The Final Regulation also applies Section 1557's non-discrimination prohibitions to a health insurance issuer's entire operations if any part of those operations receives federal financial assistance from HHS (e.g., by participating in the Marketplace exchanges or Medicare Advantage or by receiving Medicaid funds).

In addition, employers sponsoring self-insured group health care plans may have entered into administrative service agreements with third-party administrators (TPAs) related to covered health care insurers. OCR will determine whether a TPA remains legally separate from such an insurer on a case-by-case basis.

Employers that sponsor group health care plans insured by covered health care issuers or that use covered TPAs for their self-insured plans should anticipate plan design changes by the insurers to avoid violating Section 1557. OCR will determine which entity (a TPA, an insurer, or a group health care plan) is responsible for discriminatory benefit plan design on a case-by-case basis.

While the employer's group health plan may fall within the definition of a covered health program or activity subject to liability for violation of Section 1557, the employer itself may not be liable for discriminatory benefit design, so long as it does not receive federal financial assistance from HHS for any health program or activity.

Group Health Plans Whose Service Providers Receive Federal Financial Assistance from HHS

Group health plan fiduciaries should be aware that ACA Section 1557 requirements and regulations affect all health care providers receiving payments from Medicare Part A, C, D, Medicaid and other federal Department of Health and Human Services (HHS) dollars, including hospitals, health clinics, physician practices, physicians, skilled nursing physicians; home health agencies, nursing homes, hospices, pharmacies, independent and clinic laboratories, outpatient physical therapy and speech pathology providers, and ESRD facilities, among others.

Conduct Prohibited:

Discrimination by group health plans, their insurers and TPAs, and perhaps certain plan sponsors can take the form of discriminatory benefit design, coverage carve-outs, limits on health coverage, benefit claim denial, denial or refusal to issue or to renew a health insurance plan or coverage, discriminatory marketing, or the imposition of additional cost sharing. All of these discriminatory plan designs and/or practices must be eliminated by plan amendments.

While group health care plans, their insurers and TPAs, and plan sponsors that receive federal financial assistance from HHS in health care programs or activities (such as wellness programs) may understand most of the protected statuses that fall within Section 1557, they may not fully expect that Section 1557's prohibition against "sex discrimination" includes gender identity discrimination. Lesbian, gay, bi-sexual and transgender (LGBT) individuals cannot be discriminated against in receiving health care services or employee benefits or health insurance based on their sex, including their gender identity or nonconformity with sex stereotypes. Transgender people must be treated consistent with their gender identity.

Discrimination against LGBT people or against any other protected persons under Section 1557 can take the form of refusal of treatment, harassment, delivery of different care or denial of access to facilities.

Immediate Actions Needed:

The Final Regulation goes into effect on July 18, 2016, including its compliance and operations requirements, as described below:

Immediate Attention to Open Enrollment Materials:

For group health plans offered by health care providers and their insurers, Section 1557 will take effect the first day of the first plan year beginning on or after January 1, 2017. **As a practical matter, however, open enrollment materials in the upcoming fall enrollment periods should reflect the plan changes that go into effect in the next plan year.**

We recommend plan design review by plan benefits counsel and preparation of notice communications (a letter or other documents) describing anticipated changes to comply with Section 1557, for use during the open enrollment period. We also recommend plan review by benefits counsel for compliance through plan amendments effective for the first plan year on or after January 1, 2017.

Immediate Language Assistance Measures:

Section 1557 also enhances language assistance for people with limited English proficiency and seeks to improve effective communication for individuals with disabilities through auxiliary aids.

Immediate Grievance Procedure and Compliance Coordinator:

Covered entities with 15 or more employees must institute a grievance procedure for resolution of Section 1557 complaints and must designate a compliance coordinator.

Immediate Record-Keeping for Compliance Reports and Reviews:

The existing enforcement mechanisms under four long-standing federal civil rights acts apply to redress Section 1557 violations. These mechanisms require covered entities to keep records and to submit compliance reports to the OCR, to conduct compliance reviews and complaint investigations, and to provide technical assistance and guidance.

Posted Notices No Later Than October 17, 2016:

Posted notice requirements go into effect on **October 17, 2016,** 90 days after the July 18, 2016 effective date of the Final Regulation.

Posted notices must inform beneficiaries, enrollees, applicants, and members of the public of:

(1) The entity's nondiscrimination policy;
(2) The availability of auxiliary aids and services where necessary, at no cost;
(3) Translation and language assistance services;
(4) How to receive these supplemental services;
(5) The name and contact information of the compliance person (for larger entities only);
(6) Complaint and grievance procedures; and
(7) How to file a discrimination complaint with OCR.

Notices must generally contain taglines in at least the top 15 non-English languages spoken in the state in which the entity is located or does business, or for smaller communities, in at least the top two non-English languages spoken. Translations are available from OCR in 64 languages.

Plan Design Changes for First Plan Year on or after January 1, 2017:

We also recommend plan review by benefits counsel for compliance through plan amendments effective for the first plan year on or after January 1, 2017 for calendar-year plans and non-calendar year plans, respectively.

FOR ACTION STEP CHECKLISTS AND ADDITIONAL INFORMATION, PLEASE CLICK ON THE "READ MORE" LINK.

If you have any questions regarding the issues raised in this Alert, please contact the authors of this alert, or a member of Butzel Long's Health Care Law or Employee Benefits practices teams.

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