Employee Relations LAW JOURNAL
Electronically reprinted from Winter 2016

Employee Benefits

New ACA Section 1557 Nondiscrimination Requirements: Lessons for All Plan Sponsors, Despite Seemingly Narrow Scope

Mark E. Bokert and Alan Hahn

Many employers have now settled into a routine when it comes to implementing regulations issued under the Affordable Care Act (ACA). Now, granted, the routine oftentimes resembles the five stages of grief, as those within an organization who are responsible for employee benefit plan compliance move from denial to, ultimately, acceptance. The angst typically is because new regulations carry with them a certain degree of uncertainty and even ambiguity. In this regard, the new final rule issued on May 18, 2016, by the Office of Civil Rights (OCR) at the Department of Health and Human Services (HHS), implementing the nondiscrimination requirements of Section 1557 of the ACA, does not disappoint. This rule has narrow applicability on its face, but after some contemplation will be of great interest to all plan sponsors. Unfortunately, there may be uncertainty as to what exactly a plan sponsor needs to do in order to comply.

Overview

Section 1557 applies to certain "covered entities," as defined below. It prohibits discrimination on the basis of race, color, national origin, sex, age, or disability for any health program or activity that receives certain federal financial assistance.[1] It is somewhat unique among ACA regulations in that it applies to some, but not all, group health plan sponsors.

Mark E. Bokert is a partner and co-chair of the Benefits & Compensation Practice Group of Davis & Gilbert LLP. His practice encompasses nearly all aspects of executive compensation and employee benefits, including matters related to equity plans, deferred compensation plans, phantom equity plans, qualified retirement plans, and welfare plans. Mr. Bokert may be contacted at *mbokert@dglaw.com*.

Alan Hahn is a partner and co-chair of the Benefits & Compensation Practice Group of Davis & Gilbert LLP. His practice is devoted to advising clients of all sizes, including in the design and implementation of a wide variety of creative, unique, and tax-effective employee benefit plans and programs. Mr. Hahn may be contacted at *ahahn@dglaw.com.*

The authors wish to thank Gabrielle White, an associate in the firm's Benefits & Compensation Practice Group, for her assistance with this column.

Plan sponsors will be subject to Section 1557 to the extent they are a covered entity. A covered entity is one that is operating a health program or activity, any part of which receives certain federal financial assistance, as well as other similar entities, as further defined below. As a result, the initial focus of plan sponsors is to first determine whether Section 1557 applies to them in regard to their business or health plan activities. If the rule applies, then employers that have fully insured group health plans should contact their carriers to confirm that the benefits offered under the plan comport with Section 1557 requirements, and that the carrier is prepared to support all other aspects of Section 1557 compliance. If plan sponsors that are subject to Section 1557 sponsor self-insured plans, they will need to do the same with their third-party administrators (TPAs).

Even if an employer is not subject to Section 1557, however, there are two areas of interest to them. First, while such plan sponsors may not themselves be subject to the final rule, they will nevertheless want to carefully review its provisions because OCR specifically declined to exempt TPAs from its scope. This means that if a self-insured plan's TPA receives federal financial assistance, it may nevertheless be subject to the rule in its role as a TPA. If, however, the TPA has created legally separate entities to handle its different roles as TPA and issuer, it may not be subject to Section 1557. If an affiliate of the TPA is a covered entity, the regulators will engage in a case-by-case analysis to determine whether the TPA entity is appropriately subject to Section 1557.[2] However, a TPA is "unlikely to be covered by [Section 1557] where it is a legal entity that is truly independent of an issuer's other, federally funded, activities."[3] Thus, the good news is that many, if not most, TPAs have set themselves up as separate legal entities from their issuer business, which means that even if the insurer business receives federal financial assistance, the TPA business may not be subject to Section 1557.

If a TPA is covered by the rule, they may demand that their customers change their plans to match the TPA's Section 1557 obligations. In that case, if the customer does not amend its plan to comply with Section 1557, a covered TPA may be caught between two conflicting statutes. On the one hand, they are required to comply with the final rule. On the other hand, the Employee Retirement Income Security Act of 1974, as amended (ERISA) requires that they administer plans in accordance with the terms of the plan. Thus, those TPAs subject to the rule may now be unable to administer plans that are not in compliance with the final rule, regardless of whether the plan sponsors are themselves subject to it.

Second, even if plan sponsors are not subject to the rule, because Section 1557 does not apply to both the employer and the TPA, the preamble to the regulations notes that the regulators can nevertheless refer such cases to the Equal Employment and Opportunity Commission (EEOC).

In the Office of Federal Contract Compliance Program's (OFCCP) final regulation, released June 15, 2016, setting forth requirements for federal contractors under Executive Order 11246, the OFCCP indicated that gender identity is covered under sex discrimination, and that this interpretation

is consistent with EEOC interpretations of Title VII of the Civil Rights Act of 1964.[4] Although neither Section 1557 nor the OFCCP rule may apply to many plan sponsors, Title VII almost certainly does. Thus, the OFCCP rule suggests that the EEOC may view any form of discrimination on the basis of gender identity as violating Title VII. Plan sponsors of all types, whether covered by Section 1557 or not, will therefore need to carefully review their plans to determine whether the plans are compliant and keep a close eye on how the EEOC pursues these claims.

Summary of the Final Rule

Under Section 1557, a covered entity cannot discriminate by limiting coverage under health programs and activities, denying a claim, employing a discriminatory marketing or benefits design, or imposing additional cost-sharing based on an individual's race, color, national origin, sex, age, or disability.

The final rule applies to any health program or activity, any part of which receives federal financial assistance from HHS,[5] including any health program HHS administers, the Marketplaces, and all plans offered by issuers that participate in those Marketplaces (each a "covered entity").[6] Even if only a part of that program receives federal financial assistance from HHS, the entire program is covered.[7] This means that health issuers receiving federal financial assistance in any part of their program are subject to this rule for all aspects of their program.

Unfortunately for covered entities, the final rule neither explicitly defines "benefit design," nor provides examples of what designs are discriminatory, instead indicating that OCR will determine whether such a design is discriminatory on a case-by-case basis.[8] However, OCR confirmed that covered entities may apply neutral, nondiscriminatory standards to health-related coverage in their plan designs.[9] In other words, OCR will consider if the design feature contained a discriminatory pretext or was based on a neutral principle. For example, "applying age limits to services that have been found clinically effective at all ages," is not a neutral principle and would be considered discriminatory.[10]

The final rule does not discuss in-depth how benefit designs may discriminate on the basis of age, race, national origin, or disability, but does address discrimination in plan designs based on sex at some length. As expected, traditional forms of sex discrimination, such as discrimination on the basis of pregnancy, are forbidden.[11] However, OCR expanded the definition of sex discrimination to include gender identity.[12] Accordingly, the final rule requires that individuals be treated consistent with their gender identity, including in access to facilities.[13] For example, OCR noted that a covered entity may not deny, based on an individual's identification as a transgendered male, treatment for ovarian cancer where the treatment is medically indicated.[14] Moreover, explicit categorical exclusions or limitations in coverage for all health

services related to gender transition are treated as facially discriminatory.[15] Accordingly, entities apparently cannot have a blanket exclusion of transgendered services in their health plans. While the rule does not contain an outright requirement for health benefit designs to cover a specific service, OCR indicated that denying transition-related services on the basis of the necessity of those services will be reviewed, and are based on an "outdated" perspective of those services.[16]

OCR provided less guidance as to whether discrimination on the basis of an individual's sexual orientation is covered by the rule, noting that the current law is mixed on whether discrimination based on sexual orientation is on the basis of sex.[17] Under the rule, individuals will be discriminated against based on their sexual orientation if the evidence established that the discrimination is based on gender stereotypes.[18] However, OCR declined to resolve whether discrimination based on sexual orientation alone is included under Section 1557.[19]

The final rule also requires covered entities to ensure that non-English speakers have access to information in their native language. Covered entities must provide language assistance services at no charge, and those services must be accurate, timely, and protect the privacy of the individuals using them.[20] The general threshold is whether the covered entity took reasonable steps to provide "meaningful access" to individuals with respect to their health programs or activities.[21] If it would reasonably provide meaningful access to an individual with limited English proficiency, the rule requires a covered entity to offer qualified interpreters.[22] While the rule does not require covered entities to do so, OCR suggested that an entity that develops and implements a language access plan is a factor it will consider in determining whether a policy is discriminatory.[23]

The rule also requires covered entities to make communications with individuals with disabilities as effective as communications with others in health programs, barring excess administrative and financial burdens or a fundamental alteration in the nature of the program or activity.[24] Plan sponsors will therefore want to carefully review their programs to determine whether they are accessible to all and, if not, whether any modifications can be made that would allow everyone to utilize the programs regardless of any disability. For example, many plan sponsors currently provide web-based programs to educate employees on their plan selections during annual open enrollment. Because these programs tend to be highly visual, plan sponsors should consider whether any adjustments can be made to enable visually impaired employees to utilize the programs. Failure to do so may mean that the plan is not compliant with Section 1557.

The final rule also requires covered entities to take "appropriate initial and continuing steps to notify beneficiaries, enrollees, applicants, and members of the public."[25] This means that covered entities must provide notice of the operative provisions in the final rule in order to comply with the notice requirement. It remains to be seen whether TPAs that are covered by the rule will require that a compliant notice be posted or distributed regardless of whether the plan sponsor is a covered entity.

The final rule also finalizes the requirement that an entity applying for federal financial assistance and seeking certification to participate in a marketplace must submit an assurance that its health programs and activities will be in compliance with Section 1557.[26] If a recipient of federal financial assistance fails to provide OCR with the requested information in a timely, complete, and accurate manner, OCR has the authority to find noncompliance with Section 1557, possibly resulting in fund suspension or termination.[27]

The final rule confirms a private right of action for violation of the nondiscrimination provisions. Moreover, an individual can obtain compensatory damages for Section 1557 violations at both administrative and judicial actions. OCR only requires administrative exhaustion (*i.e.*, filing a complaint with OCR first) for age-related claims.[28] With the exception of age-related claims, a covered entity will not be allowed to require a claimant to exhaust the entity's grievance procedures before taking legal action.[29]

Although the final rule was effective July 18, 2016, HHS acknowledged the difficulty in making plan designs compliant by midyear so it delayed applicability of some aspects of the rule until the first day of the first plan year beginning on or after January 1, 2017.[30]

Potential Pitfalls for Plan Sponsors that Are Not Covered Entities

As discussed above, plan sponsors will only be covered by Section 1557 if any part of their health program or activities receives federal financial assistance. Sponsors of self-funded plans, in particular, may conclude that Section 1557 is inapplicable to them, but they should tread carefully as if even one part of the program receives federal financial assistance, the entire program is subject to the rule and the plan sponsor is a covered entity.[31]

Absent the above scenarios, Section 1557 might nevertheless extend to otherwise uncovered plan sponsors through their TPAs. Although a TPA that only provides administrative services is unlikely to be covered, to the extent that a TPA is also an issuer and is subject to the final rule in that capacity, the TPA will also be a covered entity unless the administrative and issuer functions are contained in completely independent legal entities. It is important to note that, outside the special rules that may extend covered entity status from a TPA to its clients, the final rule does not cover plan sponsors unless the plan sponsor is itself a covered entity.[32] A plan sponsor does not become subject to the rule simply because its plans' TPA is covered. Instead, the final rule attempts to create a procedure for determining whether the discriminatory action was on the part of the TPA or the plan sponsor.[33] In the case of a self-funded plan, the plan sponsor designs the plan and presents the TPA with the completed plan for the TPA to administer. Because TPAs have no control over the design of a self-funded plan, they are not subject to actions on discriminatory designs. In such a case, OCR

will proceed against the employer if it has jurisdiction (generally because the employer is also a covered entity).[34] If OCR does not have jurisdiction over the employer, OCR intends to transfer the complaint to the EEOC.[35] However, if the discriminatory conduct is related to the administration of the plan rather than the plan's design, then OCR will proceed against the TPA.[36] Regardless, OCR's ability to transfer claims to the EEOC should cause plan sponsors to evaluate their compliance with Section 1557; especially in light of the OFCCP's determination that gender identity may be protected under Title VII.

Next Steps for Plan Sponsors

The first thing plan sponsors should do is determine whether any part of their health program receives federal financial assistance from HHS. As noted above, if part of the program receives federal financial assistance, then the entire program is covered under the rule. Because of the complexities of the rule, plan sponsors will want to review any determination with legal counsel.

Sponsors of self-funded plans that contract with TPAs should first determine whether the TPA servicing the plan is subject to the final rule. In the unlikely event that this will be the case, then steps should be taken to ensure that the benefits are administered in a nondiscriminatory manner. OCR will investigate a claim to determine whether the employer or the TPA is liable for the purported discrimination.

Plan sponsors that are not subject to Section 1557 also should be aware of HHS's intention to transfer perceived violations to the EEOC. If the EEOC determines that the filing meets the requirements of an EEOC charge, then the date a complaint was filed with HHS will also be considered the date the complaint was filed with the EEOC.

Conclusion

Now that the final rule under Section 1557 has been published, plan sponsors should work with counsel to determine if they are covered by the rule, and if they are, what they need to do to become compliant. Even if they themselves are not covered by the final rule, plan sponsors should consider whether any TPAs with whom they contract are covered. If so, they will need to consider whether their plans will present administrative concerns for the TPA in light of the final rule and whether any amendments are necessary. Plan sponsors also need to consider whether any policies would potentially create liability if claims are transferred to the EEOC, even if they are exempt from Section 1557. In light of the potential liability associated with Section 1557 and the EEOC's view on discriminatory benefits, plan sponsors should consult with legal counsel to determine the extent of such liability and what actions to take to become compliant if necessary.

Notes

1. 45 C.F.R. § 92.1.
2. 81 Fed. Reg. 31376, 31433.
3. *Id.*
4. 81 Fed. Reg. 39108.
5. 45 C.F.R. § 92.2(a).
6. 45 C.F.R. § 92.4.
7. 45 C.F.R. § 92.2(a).
8. 81 Fed. Reg. at 31434.
9. *Id.*
10. *Id.* at fn.258.
11. 45 C.F.R. § 92.4.
12. *Id.*
13. 45 C.F.R. § 92.206.
14. 81 Fed. Reg. at 31428.
15. *Id.* at 31429.
16. *Id.*
17. *Id.* at 31389-31390.
18. *Id.* at 31390.
19. *Id.*
20. 45 C.F.R. § 92.201(c).
21. 45 C.F.R. § 92.201(a).
22. 45 C.F.R. § 92.201(d).
23. 81 Fed. Reg. at 31414-31415.
24. 45 C.F.R. § 92.202.
25. 45 C.F.R. § 92.8.
26. 45 C.F.R. § 92.5.
27. 81 Fed. Reg. at 31393.
28. 45 C.F.R. § 92.302.
29. *See* 81 Fed. Reg. at 31462.
30. 45 C.F.R. § 92.1.
31. *See* 45 C.F.R. § 92.208.
32. *Id.* at 31432.
33. *Id.*
34. *Id.*
35. *Id.*
36. *Id.*