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Employer Obligations Under New Nondiscrimination Rules: ACA Section 1557 and Requirements for Federal Contractors

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Two new regulations require some employers to make health plan design and administrative changes. While not all employers are subject to these requirements, those who are will need to review their plans and be aware of other obligations these rules impose.

The first regulation relates to Section 1557 of the Affordable Care Act (ACA), which prohibits discrimination in certain health programs and activities on the basis of race, color, national origin, sex, age or disability. Although the statutory provision has been in effect since 2010, the Office of Civil Rights (OCR) within the Department of Health and Human Services (HHS) only issued detailed regulations this summer. These regulations contain specific requirements for employers who are subject to these rules.

The second regulation applies to federal contractors and was issued by the Office of Federal Contract Compliance Programs (OFCCP). These regulations relate to prohibited discrimination on the basis of sex and impose coverage (but not necessarily notice) requirements similar to those under Section 1557.

This advisory discusses these rules as they apply to employer-sponsored health plans.

ACA Section 1557

What is Section 1557?

Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in "health programs or activities" any part of which receives federal financial assistance. It also applies to health program or activities administered by a federal executive agency (such as HHS) or any entity established under Title I of the ACA (including state-based Marketplaces).

Although HHS is the only agency to issue regulations so far, the scope of Section 1557 is broader, and other federal agencies could potentially issue similar regulations for programs involving federal financial assistance within their jurisdiction in the future.

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Who is subject to Section 1557?

The Section 1557 regulations apply to any "health program or activity" any part of which receives "financial assistance" from HHS. A health program or activity is defined as the provision of health-related services, health-related insurance coverage or other health-related coverage and the provision of assistance to obtain such coverage. It also includes programs administered by HHS, including the Marketplace. If an entity is principally engaged in the provision or administration of health services, health insurance or health coverage, ***all*** of the entity's operations are considered part of the health program or activity. Such entities would include health insurance issuers, hospitals and group health plans. HHS also defined "employee health programs," which is a subset of health programs or activities, as a group health plan, wellness program and/or employer-maintained onsite health clinic.

> **Practice Pointer:** HHS clearly views the employer who sponsors or participates in a group health plan as separate and independent from the group health plan.

HHS assistance is defined very broadly as any grant, loan, credit subsidy or contract (other than a procurement contract but including a contract of insurance) in the form of funds, services or property. It also includes funds that HHS plays a role in providing or administering, including all tax credits under Title I of the ACA (i.e., advance premium subsidy) as well as any payments, funds or subsidies extended by HHS to any entity who provides health insurance coverage for payment to or on behalf of an individual obtaining such coverage (or payment directly to that individual for payment to the entity providing health insurance coverage).

Does the rule apply to employers who sponsor or participate in group health plans or employee health benefit programs?

HHS views the employer who sponsors the plan separately from the plan or employee health benefit program it sponsors; however, there are three instances in which the employer entity itself can be liable for violations of Section 1557:

- The entity is principally engaged in the provision or administration of health services.
- The entity receives financial assistance from HHS and the primary purpose of the assistance is to fund an employee health benefit program. In that case, the employer's provision or administration of that employee health benefit plan would be subject to Section 1557.
- The entity operates a health program or activity that receives HHS assistance but is not principally engaged in the provision of health services and has an employee health benefit program that does not receive HHS assistance. In this case, the employer is liable for a Section 1557 violation only for health benefits provided to employees who participate in the health program or activity that receives HHS assistance. For example, a state government may need to comply with Section 1557 for its employees who participate in the state Medicaid program (or another program that receives HHS funding) but would not be required to comply overall, and not for its health benefit plan for employees outside of the Medicaid (or other HHS-funded) operations.

> **Practice Pointer:** Is it possible for an employer who is not otherwise subject to Section 1557 to avoid liability if the group health plan that it sponsors and maintains receives HHS assistance and violates Section 1557? Technically it would appear that such an employer could avoid liability; however, the plan would be liable for Section 1557 violations, and in such a case, the plan sponsor would ultimately be responsible for ensuring that the plan complies.

The Section 1557 regulations will impact employer-sponsored plans in several ways. Employers looking to assess application of Section 1557 to themselves or their health plan should determine whether they fit into any of these categories:

- The health insurer that insures or administers the plan is subject to Section 1557 because it is an entity principally engaged in the provision of health services. In that case, if the plan or the employer is not otherwise subject to Section 1557, the responsibility to comply will fall solely on the health insurance issuer.

> **Practice Pointer:** The regulations contain special rules that recognize the role a covered health insurance carrier or third-party administrator (TPA) may play in the administration of a self-funded health plan. In particular, if the TPA does not have control over plan design decisions, which is typically the case, then the TPA would not be held responsible for plan designs that violate Section 1557—e.g., when the plan categorically excludes services and treatments for gender identity disorder. The TPA would, however, have to comply with Section 1557 for administration matters that are within the role of the TPA.

- The plan receives the retiree Part D (RDS) subsidy or is an employer group health waiver plan (EGWP).
- The employer receives the retiree Part D (RDS) subsidy whose primary purpose is to fund a group health plan.
- The employer that sponsors the health plan is an entity principally engaged in the provision of health services, health insurance or health coverage that maintains a health program or activity that receives HHS assistance.

There are a number of unanswered questions regarding the extent of the impact in the above situations. For example, if the employer maintains a health plan that covers actives and retirees, and the employer receives a retiree Part D subsidy whose primary purpose is to fund the "plan," does it apply to the entire plan or just the coverage provided to retirees? Due to the broad manner in which "employee health benefit program" is defined, it would appear that the Section 1557 obligations would extend to the employer's administrator of the plan as a whole. In addition, it is unclear whether an employer or the employer's plan is subject to Section 1557 in the case of a fully insured EGWP. Although the insurer is receiving the funds, the employer or the employer's plan is indirectly benefiting from the EGWP maintained by the insurer. Additional guidance would be welcome in this regard.

What is required when Section 1557 applies?

Nondiscriminatory Coverage

Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in health programs or activities. For this purpose, sex discrimination includes discrimination based on:

- An individual's sex.
- Pregnancy (including false pregnancy, termination of pregnancy or recovery therefrom), childbirth and related medical conditions.
- Gender identity.
- Sex stereotyping.

Covered entities subject to Section 1557 may not take the following actions in a discriminatory manner:

- Deny, cancel, limit or refuse to issue or renew a health-related insurance plan or other health-related coverage.[1]
- Deny or limit a claim or impose additional cost-sharing or other limitations or restrictions on coverage.

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[1] Note that the nondiscrimination provisions for Health Insurance Marketplaces and issuers of qualified health plans must comply with both Section 1557 and existing HHS nondiscrimination provisions. 45 Fed. Reg. 31376, 31428 (May 18, 2016) (citing, for example, 42 U.S.C. 300gg-4; 45 C.F.R. 147.104(e); and 45 C.F.R. 155.120).

- Engage in discriminatory marketing practices or adopt or implement discriminatory benefit designs in a health-related insurance plan or policy, 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 any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available.
- Categorically exclude coverage for all health services related to gender transition and may not deny or limit coverage 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.

However, coverage of gender transition is not without limitation. Covered entities are not required to cover any particular benefit or service without regard to medical necessity. Covered entities should note, however, that benefit denials based on medical necessity will be subject to careful scrutiny by HHS.

Covered entities will want to carefully review their group health plans to ensure they do not include categorical exclusions related to gender transition or dependent maternity coverage to avoid potential violations of Section 1557.

Notice to Employees

The HHS regulations require all covered entities to post a notice of consumer civil rights. HHS has provided a model notice that covered entities may use as a basis for their own notices. HHS posted the model notice on its website.

The HHS regulations require covered entities to post taglines in at least the top 15 non-English languages spoken in the state in which the covered entity is located or does business. The taglines must be included in all significant publications. The regulations do not define a significant publication, but there seems to be little doubt that claim denial letters, SBCs and COBRA notices would be significant publications.[2] HHS posted the tagline translations on its website. The regulation requires posting of the notice in public spaces of the office or facility and, perhaps of greater significance to health plans, on the entity's website. Many employers and insurers maintain websites for participants and insureds.

Further, the required text is different depending upon whether the publication is considered small or large. While large publications must include taglines in the top 15 non-English languages spoken in the state, "small" publications only must include taglines for the top two languages spoken by individuals with limited English proficiency in the relevant state or states. The regulations do not define small or large publications. However, examples of small publications in the regulations include postcard and tri-fold brochures.

> **Practice Pointer:** Covered entities that operate in multiple states can use the top 15 languages spoken by the aggregate limited English proficient populations of those states, rather than of each individual state.

Meaningful Access for Individuals with Limited English Proficiency

Covered entities must, to satisfy the prohibition on national origin discrimination, take reasonable steps to provide meaningful access to each individual with limited English proficiency. 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

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2 It is not clear how the disclosures are supposed to be provided within the SBC's four-page limit. Further guidance is welcome from both OCR and the U.S. Department of Labor.

understand English." Reasonable steps may include providing language assistance services, such as oral language assistance or written translation. HHS posted the translated sample notices on its website.

Covered entities must take reasonable steps to provide meaningful access to individuals with limited English proficiency who they are likely to serve or encounter. This includes:

- Offering a qualified interpreter when verbal translation is required to provide meaningful access.
- Using a qualified translator to translate written content in paper or electronic form.

Covered entities cannot:

- Require the individual to provide an interpreter.
- Rely on an accompanying adult to interpret or facilitate communications, *except:*
  - In emergencies involving an imminent threat to safety or welfare when no qualified translator is available; and
  - The individual with limited English proficiency specifically requests that the accompanying adult assist, and reliance on the adult is appropriate under the circumstances.
- Rely on a minor child, except in emergencies involving an imminent threat to safety or welfare when no qualified translator is available.

HHS also provided technical requirements for remote translations, which covered entities can only provide by video.

Communications with Individuals with Disabilities

Covered entities must ensure that communications with individuals with disabilities are as effective as with others. Covered entities must use the standards at 28 C.F.R. 35.160 through 35.164. Recipients and Marketplaces must provide appropriate auxiliary aids and services to individuals with impaired sensory, manual or speaking skills if necessary.

Perhaps more significantly, covered entities must ensure that their activities conducted via electronic and information technology are accessible to individuals with disabilities, unless it would result in undue financial and administrative burdens or a fundamental alteration of the programs or activities. In the event of undue financial or administrative burdens, the covered entity will provide non-electronic information. Recipients and Marketplaces must ensure that their websites for health programs and activities comply with Title II of the Americans with Disabilities Act (ADA).

Practice Pointer: Plan administrators should consider if their benefits websites meet the ADA accessibility requirements.

Grievance Procedures

Covered entities with 15 or more employees must implement grievance procedures to address allegations of noncompliance.[3] The grievance procedures must incorporate appropriate due process standards and allow for prompt and equitable resolution of complaints concerning actions prohibited by Section 1557. HHS posted model grievance procedures on its website. The HHS regulations do not provide specific timeframes for filing, resolving and issuing written decisions regarding complaints and appeals. However, their model procedures provide that grievances must be filed

[3] Note that there is no general exception for "small" covered entities. Covered entities with less than 15 employees must comply with Section 1557, but they are not required to implement a grievance procedure.

within 60 days of the date the person becomes aware of the alleged discriminatory action. Those procedures also state that the grievance coordinator must issue its decision within 30 days after its filing. An individual can appeal the decision within 15 days of the initial decision, and the appeal will be decided within 30 days after its filing. Note, however, that the grievance procedure does not prevent an individual from pursuing other legal or administrative remedies.

As part of establishing a grievance procedure, covered entities will need to designate an employee who is responsible for coordinating the covered entity's compliance with Section 1557. HHS does not prescribe who must fill that role. But employers considering who to assign to this position will need to consider issues such as HIPAA and related compliance factors when making this determination.

When does Section 1557 apply?

Health plan designs must comply with Section 1557 beginning with the plan year starting on or after January 1, 2017. However, covered entities must have posted the required notice and taglines by October 16, 2016.

Practice Pointer: Covered entities that are distributing materials, such as open enrollment materials, should ensure that those materials contain the notice or, for small publications, the taglines for the top two non-English languages since the compliance deadline is approaching quickly.

How is Section 1557 enforced?

The enforcement mechanisms provided for and available under the civil rights laws referenced in Section 1557 apply to discriminatory actions by covered entities. As a result, the OCR can suspend, terminate or refuse to grant or continue federal financial assistance, as well as refer to the Department of Justice with a recommendation to bring proceedings to enforce any rights of the United States, and take any other action the law permits. In addition, Section 1557 permits private actions by individuals and allows compensatory damages in administrative and judicial actions.

OFCCP Nondiscrimination Rule Update for Federal Contractors

What is the OFCCP nondiscrimination rule update for federal contractors?

On June 15, 2016, the OFCCP released its "Discrimination on the Basis of Sex; Final Rule." The final rule "set forth the obligations that covered Federal Government contractors and subcontractors and federally assisted construction contractors and subcontractors (contractors) must meet under Executive Order 11246, as amended." The OFCCP's final rule clarifies that sex discrimination includes discrimination based on "gender identity, transgender status, and sex stereotyping." A contractor that violates E.O. 11246 "may be liable for make-whole and injunctive relief and subject to suspension, cancellation, termination, and debarment of its contract(s)…."

Who is subject to the new OFCCP rules?

The new OFCCP rules apply to contractors with federal contracts entered into or modified on or after April 8, 2015. A federal contractor is an organization that: (1) holds a single federal contract, subcontract or federally assisted construction contract exceeding $10,000; (2) has federal contracts or subcontracts that combined exceed $10,000 in any 12-month period; or (3) holds government bills of lading, serves as a depository of federal funds or is an issuing and paying agency for U.S. savings bonds and notes.

Exceptions apply for some contracts, such as:

- Work outside the U.S. by employees not recruited in the U.S.
- State and local governments.
- Religious entities.
- Religious educational institutions.
- Work on or near Indian reservations.
- National security.
- Specific contracts the DOL determines to be in the national interest.

Practice Pointer: Federal contractors should consider complying even if they are not aware of any contracts that were executed or modified on or after April 8, 2015. In many cases, benefits and HR departments are not and will not be told if a contract has been executed or modified.

What is required when the OFCCP nondiscrimination rules apply?

Under the OFCCP rules, a federal contractor cannot:

- Deny coverage for medically appropriate sex-specific health care services because of gender identity or because of enrollment in a health plan as one gender where the medical care is generally associated with another gender. For example, denial of treatment for ovarian cancer or ob-gyn visits because the employee enrolled as male.
- Categorically exclude coverage for health services associated with gender dysphoria or gender transition.
- Retain any other exclusions that have the effect of targeting transgender persons or persons with gender dysphoria, such as exclusions for sex change and sex transformation.

Contractors must "ensure that coverage for health-care services be made available on the same terms for all individuals for whom the services are medically appropriate, regardless of sex assigned at birth, gender identity, or recorded gender. For example, where an individual could benefit medically from treatment for ovarian cancer, a contractor may not deny coverage based on the individual's identification as a transgender male." However, it is not discriminatory to deny or limit health services based on neutral reasons, such as lack of medical necessity, lack of appropriate medical documentation and presumably even experimental and investigative treatments.

Practice Pointer: Federal contractors will want to remove exclusions like "transgender and related services," which are common.

Is there a notice requirement?

The OFCCP gender identity rules do not contain a specific notification requirement like the Section 1557 rules. However, contractors might want to inform employees of any new rights that they will receive due to the rules. Employees might learn of these new requirements because the OFCCP posted a Q&A for employees, which states:

> "You may be entitled to a remedy that places you in the position you would have been in if the discrimination had never happened. You may be entitled to be hired, promoted, reinstated, or reassigned; and you may be entitled to receive back pay, front pay, a pay raise, or some combination of these remedies. In addition, if OFCCP

finds that the federal contractor or subcontractor violated Executive Order 11246, OFCCP could seek to have the company debarred or removed from consideration for future federal contracts or have the company's current contracts cancelled."

Practice Pointer: If you must change your plan to comply with the OFCCP rules, you must send a summary of material modifications (SMM) to notify participants of the changes if your plan is subject to ERISA. Thus, while the OFCCP does not contain specific notice requirements, you might have a separate obligation to notify employees.

When must federal contractors comply with these rules?

The final regulations are generally effective August 15, 2016. Although this was only two months after the OFCCP issued the final regulations, the OFCCP takes the position that contractors have been subject to these rules and should already be complying. However, the OFCCP acknowledges that the impact of E.O. 11246 on benefits was not clear. As a result, the OFCCP may not enforce the requirements beginning August 15, 2016, if the contractor is making good-faith progress to update the plan as necessary. It is not clear what constitutes "good-faith" progress nor what date after August 15, 2016, is reasonable. Some contractors have taken the position that they can make the required changes effective January 1, 2017, since that is when their plan changes generally become effective.

What happens if a contractor doesn't comply?

The DOL can take the following actions against a contractor that violates E.O. 11246:

- Publish, or cause to be published, the names of contractors or unions that it has concluded have complied or have failed to comply with the provisions of a DOL order or of the rules, regulations and orders.
- Recommend to the Department of Justice that, in cases in which there is a substantial or material violation or the threat of a substantial or material violation that appropriate proceedings be brought to enforce the contract's provisions, including the enjoining, within the limitations of applicable law, of organizations, individuals or groups who prevent directly or indirectly, or seek to prevent directly or indirectly, compliance with the provisions of a DOL order.
- Recommend to the EEOC or the Department of Justice that appropriate proceedings be instituted under Title VII of the Civil Rights Act of 1964.
- Recommend to the Department of Justice that criminal proceedings be brought for the furnishing of false information to any contracting agency or to the DOL, as the case may be.
- After consulting with the contracting agency, direct the contracting agency to cancel, terminate, suspend or cause to be canceled, terminated or suspended any contract, or any portion or portions thereof, for failure of the contractor or subcontractor to comply with equal employment opportunity provisions of the contract. Contracts may be canceled, terminated or suspended absolutely or continuance of contracts may be conditioned upon a program for future compliance approved by the DOL.
- Provide that any contracting agency shall refrain from entering into further contracts, or extensions or other modifications of existing contracts, with any noncomplying contractor until such contractor has satisfied the DOL that such contractor has established and will carry out personnel and employment policies in compliance with the provisions of the order.

Ultimately, the OFCCP controls the purse strings, which will generally drive contractors to comply.

Conclusion

ACA Section 1557 and the OFCCP nondiscrimination rules might require significant changes to plan design. Covered entities subject to Section 1557 must ensure they have complied with the notice requirement deadline of October 16, 2016, but need not change their coverage until the plan year that begins on or after January 1, 2017. In contrast, contractors subject to the OFCCP do not have specific notice requirements (other than the SMM requirement for plan changes), but were required to change their plan design by August 15, 2016.

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