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HHS Proposes New ACA Section 1557 Rules

Proposed Rules Would Revise ACA's Anti-discrimination Protections

The U.S. Department of Health and Human Services (HHS) recently issued proposed rules revising the nondiscrimination regulations under Section 1557 of the Affordable Care Act (ACA). Section 1557 amended titles VI and VII of the Civil Rights Act to expand the protections from discrimination based on race, color, national origin, sex, age, or disability to certain health programs and activities administered by "covered entities."

The proposed rules indicate a covered entity must not discriminate against any protected class in providing or administering health insurance coverage or other health-related coverage. They also expand protections against discrimination based on sex, which includes sexual orientation, gender identity, and individuals seeking reproductive healthcare services.

This Alert will highlight provisions of the proposed regulations that affect employer-provided group health plans. We will provide a more in-depth review once the final regulations appear.

How we got here

Section 1557 has been the subject of significant controversy, debate, litigation, and change since its inception during the Obama Administration through the Trump and now Biden Administrations.

In 2020, the U.S. Supreme Court (SCOTUS) issued its *Bostock v. Clayton County* decision ruling that discrimination against LGBTQ employees based on their sexual orientation or gender identity is sexual discrimination and prohibited under Title VII of the Civil Rights Act. In 2021, HHS indicated it would apply similar logic to Section 1557 and issue new regulations consistent with the SCOTUS ruling. We will address *Bostock* in more detail at the end of this Alert.

Covered entities

Section 1557 applies to covered entities. The proposed regulations define covered entities as:

1) Any health program or activity that receives direct or indirect funding from HHS;

2) All health programs and activities administered by HHS (e.g. Medicare and Medicaid); and

3) All programs and activities administered by an entity established under ACA Title I, which includes the public health insurance marketplace.

An employer-provided group health plan that receives direct HHS funding, such as a Medicare Retiree Drug Subsidy, is a covered entity. Few employers or their plans will be covered entities, but Section 1557 will still indirectly affect many of them.

In a return to the Obama era regulations, an insurance carrier participating in the public health insurance marketplace and receiving federal premium subsidy payments is a covered entity across its entire insured book of business. This means all of an affected insurance carrier's policies must eventually comply with Section 1557, including policies sold in the group health insurance market.

The proposed regulations also apply to an affected insurer acting as a third party administrator (TPA) to a self-insured plan. The employer/plan sponsor may resist efforts to change the plan design, but any internal plan administrative policies and procedures drafted and implemented by the TPA with respect to the plan – such as medically necessary policies and procedures for covered services – cannot discriminate in violation of Section 1557.

Note: While many employer plans are not subject to Section 1557, "voluntary" compliance with Section 1557 has historically been very high. This is largely due to conservative coverage recommendations by insurance carriers and TPAs intended to help standardize their books of business and mitigate risk in the event a plan is unknowingly or unexpectedly subject to Section 1557.

Back to the future

The Biden Administration's proposed regulations restore many of the original 2016 protections and slightly expand upon them. A few key highlights are:

- As described earlier, the proposed regulations return to applying covered entity status across an insurance carrier's entire book of business rather than just those policies receiving direct federal funding. This will indirectly affect the insurer's fully insured group health plans and self-insured plans as described earlier under Covered entities.
- Consistent with the *Bostock* decision, the proposed rules protect against discrimination based on sex and define sex-based discrimination to include discrimination based on sex stereotypes; sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; and gender identity. This will effectively ban covered entities from applying blanket exclusions for gender-affirming care.
- Most covered entities (including covered health insurance issuers) must adopt written policies and procedures to ensure compliance with Section 1557, appoint a "Section 1557 coordinator" to coordinate compliance efforts, and must provide a notice of nondiscrimination to participants, beneficiaries, enrollees, and applicants of its health programs and activities, as well as members of the public.[1]
- HHS will adopt a process for covered entities and/or affected employer plans with religious objections to seek an exemption or modification from certain provisions of the regulations.

Effective date and next steps

The Section 1557 statute and 2020 rules remain in effect while the new proposed rules are pending. The comment period on these proposed rules is open until October 3, 2022.

Once HHS publishes its final rule, it will be effective for plan years beginning on or after 60 days following its publication date in the Federal Register. Employers sponsoring plans that are covered entities may wish to begin reviewing their plans and programs for potential changes. All other employers may wish to review whether their plans will be affected due to the activities of their insurer/TPA.

[1] When the covered entity is the insurer/TPA itself, the Section 1557 coordinator can be an employee of the insurer/TPA.

The Bostock decision

Although many employer plans are not directly or indirectly subject to Section 1557 (including under the proposed regulations), the SCOTUS decision in *Bostock* has much greater reach. All employers and their group health plans are subject to Title VII of the Civil Rights Act. Although not directly addressed under *Bostock*, we believe its Title VII ruling also prohibits employer-provided benefit plans from discriminating based upon sexual orientation or gender identity and that it is only a matter of time before courts apply it in this context.

We interpret this to mean that plans must provide any services, procedures, and prescriptions already covered under the plan to all participants for whom the treatment is medically necessary and appropriate, regardless of a participant's gender identity or sexual orientation. Examples include extending hormone replacement therapy and breast cancer screening to transgender women and hysterectomies to transgender men. Gender identity disorder (gender dysphoria) should satisfy any medically necessary requirements in order for transgendered participants to receive these treatments. On a related note, we also interpret the *Bostock* decision to mean that a plan providing coverage to same-sex domestic partners must also provide coverage to opposite-sex domestic partners, and vice versa.

Federal districts courts began to agree with both interpretations this year, and we will see what happens as *Bostock*-related litigation continues to play out.

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