HERE WE GO AGAIN:

AGENCIES REVISE AND REVAMP ACA §1557 NONDISCRIMINATION REQUIREMENTS

Written By Alston & Byrd Health Benefits Practice

On May 6, 2024, the Department of Health and Human Services ("HHS") finalized the latest rule for Nondiscrimination in Health Programs and Activities ("2024 Rule") under §1557 of the Affordable Care Act ("ACA"). Section 1557 prohibits a "health program or activity" that receives Federal financial assistance ("FFA") from discriminating against an individual on the basis of race, color, national origin, sex, age, or disability. The mandate also applies to a program or activity that is administered by an executive agency or by an entity established by Title I of the ACA. HHS has issued final regulations under §1557 twice before—once in 2016 ("2016 Rule") and again in 2020 ("2020 Rule").

The 2024 Rule resurrects and revises several concepts and policies from the 2016 Rule that the 2020 Rule had repealed or amended (e.g., notices and grievance procedures). HHS also revised its interpretation of Medicare as constituting FFA (and

thus triggering §1557) and provisions related to discrimination on the basis of sex. The 2024 Rule is complex and far-reaching; in this article, we focus only on its applicability to self-insured group health plans. We also discuss briefly §1557's impact but will delve further into that topic in a subsequent article.

§1557 OVERVIEW

Section 1557 incorporates into the ACA a prohibition of discrimination based on any of the grounds found in each of the following four statutes: Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, and Section 504 of the Rehabilitation Act of 1973 (i.e., race, color, national origin, sex, age, or disability). This prohibition applies to any health program or activity that receives FFA or is administered by an executive agency or entity established under Title I of the ACA.

Congress also incorporated the enforcement mechanisms for each of these statutes into the ACA, and the Supreme Court has held that an implied private right of action is available under §1557. HHS's Office of Civil Rights ("OCR") enforces the 2024 Rule. Since the 2016 Rule, regulations promulgated under §1557 have been the subject of litigation, and the 2024 Rule is no different, with at least one lawsuit already filed the day the 2024 Rule was published in the Federal Register (State of Florida et al. v. Department of Health and Human Services et al.).

WHO'S COVERED—AND NOT COVERED--UNDER THE 2024 RULE

Generally, any health program or activity that receives FFA from HHS is covered by the 2024 Rule (although there is a limited exemption for Federal religious freedom and conscience protections). FFA includes credits, subsidies, and other types of assistance from HHS. HHS provides a new definition for "health program or activity" that is quite broad and includes a non-exhaustive list of the entities that HHS considers to be a health program or activity. Group health plans are notably absent from the list.

Does this mean that §1557 will never apply to a group health plan? No. A group health plan--even a grandfathered group health plan--would be subject to §1557 if it were a recipient of FFA, but, as discussed below in Self-insured Group Health Plans and Retiree Drug Subsidies, the employer or plan sponsor is more likely to be the actual recipient of FFA. Whether and how an employer's or plan sponsor's receipt of FFA may be imputed to the group health plan is not clear.

The 2024 Rule does not apply to any employer or other plan sponsor of a group health plan with regard to its employment practices, including the provision of employee health benefits. This is in contrast to the 2016 Rule, which, for example, applied to employee health benefit programs of a §1557-covered entity if that covered entity were principally engaged in providing or administering health services or health insurance coverage. HHS now excludes employers and plan sponsors--including but not limited to a board of trustees (or similar body), association or other group--from the scope of §1557 with respect to providing employee health benefits. HHS believes that limiting the scope §1557 in this way will minimize confusion for employees seeking relief under Federal equal opportunity laws.

Health insurance issuers are included in the list of entities that HHS considers to be a health program or activity, which is a complete reversal of the 2020 Rule. Under the 2024 Rule, if any line of an insurer's book of business is a recipient of FFA (e.g., participation in Medicare Advantage or Medicaid Managed Care) or if the insurer offers qualified health plans on an exchange, then the 2024 Rule applies to all lines of business, even the insurer's activities as a third party administrator ("TPA").

As discussed below, the inclusion of insurers in this definition is consequential for self-insured group health plans because even if the group health plan is not subject to §1557, the 2024 Rule prohibits a covered TPA from

administering any discriminatory provisions of the self-insured plan. Even if the plan has no discriminatory provisions, it is unclear to what extent the TPA's other compliance burdens (e.g., notices, language assistance, grievance procedures) could carry over to the self-insured plans that the TPA administers.

SELF-INSURED GROUP HEALTH PLANS AND RETIREE DRUG SUBSIDIES

The 2024 Rule applies when a health program or activity receives FFA from HHS, either directly or indirectly. FFA includes any grant, loan, credit, subsidy, contract, or any other arrangement. Although employer group health plans generally are not the recipients of FFA, entities that receive a subsidy, such as a retiree drug subsidy ("RDS"), are subject to §1557. Under the RDS rules, the plan sponsor is technically the recipient of the RDS funds, not the plan. Does §1557 apply to a self-insured retiree group health plan if the plan sponsor applies for and receives RDS? And would receipt of RDS by the employer/plan sponsor cause the employer's self-insured group health plan for active employees to be subject to §1557 as well?

HHS tiptoed around these questions. First, HHS states clearly in the preamble that entities that receive RDS are subject to the 2024 Rule and that a group health plan that receives FFA itself is distinct from other entities that might separately receive FFA, such as the plan sponsor or the TPA. If OCR were to receive a complaint about a plan, OCR would conduct a fact-specific analysis to determine if the group health plan is a recipient or subrecipient of FFA. Even though this explanation sounds like OCR could, at the very least, conduct an inquiry, HHS goes on in this same discussion to reiterate the 2024 Rule, stating that "employers and other plan sponsors are not subject to this rule with regard to their employment practices," which "includes when the Federal financial assistance received is for their employee health benefits." HHS seems to be signaling that receipt of RDS by an employer/plan sponsor does not necessarily subject the employer's retiree group health plan to §1557. But would the existence of a trust for the retiree plan into which the RDS funds are deposited complicate the analysis? Additional guidance on HHS's position regarding RDS would be welcome.

THIRD-PARTY ADMINISTRATORS

Even if neither the self-insured plan nor the employer/plan sponsor receives FFA from HHS, the TPA administering the plan may be (and likely is, if an insurer) subject to §1557 under the 2024 Rule. The 2024 Rule prohibits a covered TPA from administering any discriminatory terms of a group health plan that would violate §1557 and the 2024 Rule. The requirement to administer a plan according

to its terms under the Employee Retirement Income Security Act ("ERISA") provides no cover here because, as HHS points out, ERISA expressly provides that it is not to be construed to invalidate or impair Federal laws like §1557.

If OCR receives a complaint about a discriminatory provision in a self-insured group health plan, OCR will determine whether the provision originated with the TPA or with the plan. If the provision originated with the plan, OCR likely will refer the matter to the EEOC. If the provision originated with the TPA, OCR may use its enforcement authority to compel the TPA to comply.

However, if the provision originates with the plan, it is unclear which entity—the plan or the TPA--is ultimately responsible for remediation. For example, if a self-insured group health plan that is not subject to §1557 were to exclude gender-affirming care, OCR may refer the matter to the EEOC, but the 2024 Rule would still prohibit a TPA from denying the claim. If the plan does not cover gender-affirming care, OCR does not appear to have any authority to compel a plan not otherwise subject to §1557 to pay the claim. Additional guidance in this area would be welcome. A case with similar facts (and brought by the plaintiff through the implied right of action) is currently on appeal in the 9th Circuit (C.P. v. Blue Cross Blue Shield of Ill).

SELF-INSURED RELIGIOUS EMPLOYERS

The 2024 Rule does include a process for covered entities to receive an assurance from HHS that the entity can rely on Federal religious freedom and conscience protections. This exemption, if granted, would be limited in scope to the aspect of the 2024 Rule from which the entity believes it is exempt. Note, however, that this exemption is available only to entities covered by §1557, and recall that employers, plan sponsors, and group health plans are each viewed as separate entities by HHS.

What is clear is that this exemption likely would not, for example, be available in a situation in which a covered TPA administers a self-insured plan group health for a religious employer that receives no FFA whatsoever (either for its group health plan or as an employer or plan sponsor). Would religious employers with self-insured group health plans that include discriminatory provisions then be limited to only those TPAs that are not covered under §1557? HHS addressed this in the preamble, stating that a "religious employer is able to obtain health insurance coverage or administration of its self-insured group health plan coverage from any entity not subject to section 1557, which would fall outside of the application of this rule."

WHAT DOES A COVERED ENTITY NEED TO DO TO COMPLY WITH THE 2024 RULE?

Carefully review benefit provisions in any covered health plan. There are a number of benefits-specific provisions and limitations that should be carefully examined to ensure compliance with ACA §1557's nondiscrimination requirements. A careful examination (with counsel) should be undertaken of any provision(s) that could be considered to discriminate based on race, color, national origin, sex, age, or disability. In this regard, the 2024 Rule clarifies that "discrimination on the basis of sex" specifically includes discrimination based on sexual orientation, gender identity, sex characteristics, pregnancy or related conditions, and sex stereotypes, gender, or because of pregnancy.

Comply with Notice and procedure requirements. Within 120 days of July 5, 2024, covered entities must begin providing an annual notice of nondiscrimination along with a notice of the availability of language assistance services and auxiliary aids at no cost to participants, beneficiaries, enrollees, and applicants. This information must be provided in English and 15 of the most common languages spoken by people with limited English proficiency in the state where the covered entity operates and also be posted on the covered entity's website. The covered

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entity must also ensure that any services available telephonically are accessible to those with disabilities and limited English proficiency. HHS has prepared sample notices in multiple languages to assist with this requirement. The 2024 Rule also requires that policies and training be implemented by the covered entity and that a "Section 1557 Coordinator" be designated to ensure compliance with the §1557 requirements.

ENFORCEMENT

The 2024 Rule incorporates the enforcement mechanisms available for and provided under all the nondiscrimination statutes incorporated into §1557, as well as the procedural provisions applicable to Title VI that apply with respect to administrative enforcement actions. These Title VI procedures allow OCR to attempt cooperative voluntary compliance, and if that fails, then OCR can obtain compliance by (1) suspension or termination of or refusal to grant or to continue FFA or (2) by any other means authorized by law.

Upon receiving a complaint OCR will determine whether it has jurisdiction over the matter, and if it does not, then OCR may refer the complaint to the appropriate Federal government entity (e.g., the EEOC if the discrimination originates with the terms of a self-insured group health plan). If OCR does have jurisdiction, then it has the authority to investigate the alleged violation.

What may be more consequential for a self-insured group health plan (which may not fall within OCR's jurisdiction) is the implied right of action in §1557. The 2016 Rule specifically allowed for a private right of action; however, the 2020 Rule repealed that right under the regulations and acknowledged that an implied right of action exists under the statute. In the preamble to the 2024 Rule, HHS announced that it would not be reinstating the 2016 private right of action under the regulations, instead acknowledging the implied private right of action under §1557 itself.

Although the Supreme Court has already determined that damages for emotional distress are not available under this implied right, other types of compensatory damages and injunctive relief may be available. Also, courts have not always been in alignment with HHS's interpretation of §1557. See, for example, T.S. v. Heart of CarDon, in which the 7th Circuit did not rely on HHS's reading of §1557 and applied §1557 to the employee benefit plan of a skilled nursing facility that received FFA, even though the skilled nursing facility's employee plan did not receive FFA.

EFFECTIVE DATES

Although the 2024 Rule is generally effective on July 5, 2024 (60 days after its May 6th publication in the Federal Register), the complexities of this rule require separate effective dates for various provisions:

Section 1557 Requirement	Date by which covered entities must comply
Designate a §1557 Coordinator	Within 120 days of July 5, 2024.
§1557 Policies and Procedures	Within one year of July 5, 2024.
§1557 Training	Following a covered entity's implementation of the policies and procedures, and no later than 300 days of July 5, 2024.
Notice of Nondiscrimination	Within 120 days of July 5, 2024.
Notice of Availability of Language Assistance Services and Auxiliary Aids and Services	Within one year of July 5, 2024.
Nondiscrimination in health insurance coverage and other health-related coverage (benefit design changes)	For health insurance coverage or other health-related coverage that was not subject to the 2024 Rule as of May 6, 2024, by the first day of the first plan year beginning on or after January 1, 2025.

Attorneys John R. Hickman, Ashley Gillihan, Steven Mindy, Ken Johnson, Amy Heppner, and Laurie Kirkwood provide the answers in this column. John is partner in charge of the Health Benefits Practice with Alston & Bird, LLP, an Atlanta, New York, Los Angeles, Charlotte, Dallas and Washington, D.C. law firm. Ashley and Steven are partners in the practice, and Ken, Amy, and Laurie are senior members in the Health Benefits Practice. Answers are provided as general guidance on the subjects covered in the question and are not provided as legal advice to the questioner's situation. Any legal issues should be reviewed by your legal counsel to apply the law to the particular facts of your situation. Readers are encouraged to send questions by E-MAIL to John at john.hickman@alston.com. ■