

ACA Nondiscrimination in Health Programs and Activities Final Regulations Released

May 25, 2016

Section 1557 of the Affordable Care Act (the “**ACA**”) prohibits discrimination in certain health care programs and activities on the basis of race, color, national origin, sex, age, or disability. HHS recently issued final rules under Section 1557, which specify gender identity discrimination and sexual stereotyping as forms of sex discrimination. However, these rules only apply to “covered entities” as defined for this purpose. The term “covered entity” includes health care systems or providers that accept Medicare Part A or Medicaid and insurance carriers and/or third party administrators (“**TPA**”) that receive federal funding through participation in the public insurance marketplace, which will also have to comply with respect to benefits offered to their own employees. While HHS interprets the rule to impact an insurance carrier’s and/or a TPA’s entire book of business, a TPA is not responsible for discrimination due to a plan sponsor’s self-insured plan design decisions beyond the TPA’s control. Employers that merely provide benefits to their employees, but are not primarily engaged in the business of providing or administering health services or health insurance coverage, are not “covered entities” under Section 1557, and HHS lacks the jurisdictional authority to pursue them. HHS intends to refer matters involving an employer’s discriminatory self-insured plan design to the EEOC, which would then determine if the matter meets the requirements for an EEOC charge, or other agencies as applicable. Among other items, the final rules indicate that a covered entity will be in violation of Section 1557 if coverage offered contains explicit exclusions for all health care services related to gender transition or denies or limits sex-specific health care merely because the person seeking the services identifies as belonging to another gender. For example, the medical plan of a covered entity cannot deny treatment for ovarian cancer for an individual born a woman but identifying as a transgendered man. The final rules do not require covered entities to provide for all gender transition services and also permit the use of reasonable and neutral medical management techniques. The rules are generally effective on July 18, 2016, but provisions of the rules which may require changes to a covered entity’s plan design are effective the first plan year beginning on or after January 1, 2017. The final regulations, fact sheets, and FAQs are available [here](#).