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Do HHS' Proposed ACA Section 1557 Anti-Discrimination Rules for Health Insurers Constitute Regulatory Overreach?



BY DAVID D. JOHNSON

Introduction

Federal discrimination laws have generally had limited applicability to individual health insurance. Under Section 1557 of the Affordable Care Act¹—especially as interpreted by proposed rules issued by the Department of Health and Human Services on Sept. 8, 2015²—this may be changing. Section 1557 applies four pre-existing laws prohibiting discrimination on the basis of race, color and national origin, sex, disability and age to health programs that receive federal financial assistance (FFA). Section 1557 also authorizes the same enforcement procedures permitted by these prior

¹ 42 U.S.C. § 18116.

² HHS, Nondiscrimination in Health Programs and Activities; Proposed Rule, 80 Fed. Reg. 54172 (Sept. 8, 2015).

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laws—which can include private suits, as well as complaints before the Health and Human Services Office for Civil Rights (OCR). A number of civil suits and OCR complaints against private insurers have already been brought—so far—largely by advocacy groups.

In its proposed rule, HHS states that qualified health plans (QHPs) offered on state exchanges are covered by Section 1557 because they receive FFA in the form of premium tax credits and cost sharing reductions for their enrollees. The proposed rule, however, goes far beyond this. In addition to applying Section 1557 to QHPs, the proposed rule relies on older law, not referenced in Section 1557, to say that all other operations of insurers that offer QHPs must comply as well. This could include operations that do not receive FFA or are not health related. According to the preamble to the proposed rule, this would include health insurance offered outside the exchanges, as well as a covered issuer's work administering other health plans.³

The proposed rule also expands prior law defining discrimination in health benefits. The proposed rule and preamble follow precedent on the four referenced acts and only require insurers to offer “meaningful access” to their benefits—not extra benefits for persons in the covered classes. But they also contain new and open-ended prohibitions on discrimination in health plan terms that could create constraints on health plan design. The proposed rule redefines sex discrimination, which could require plans to cover transgender services for the first time. The proposed rule also adds new rules that require covered entities to provide translation services free of charge for persons with limited English proficiency (LEP) and to comply with the same standards for website accessibility required of government agencies.

The proposed rule repeatedly asks for comment and states that HHS does not consider its work to be done.⁴

³ *Id.* at 54189.

⁴ HHS received almost 2,200 comments to the proposed rule. See [Regulations.gov](http://www.Regulations.gov), Docket No. HHS-OCR-2015-0006 (available at <http://src.bna.com/bsA>) (visited Nov. 23, 2015).

HHS does have work to do, given the ambiguities and problems in its first effort.

I. HHS Would Extend Coverage of Section 1557 to All Operations of Health Insurers Who Operate a Single Covered Program

A. The Structure of ACA Section 1557

Section 1557 was written in an economical manner and incorporates portions of four laws that prohibit discrimination in programs that receive FFA. Here is the statute in outline form:

Except as otherwise provided for in this title (or an amendment made by this title), an individual **shall not, on the ground prohibited under**

title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.),

title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.),

the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or

section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794),

be excluded from participation in, **be denied** the benefits of or **be subjected** to discrimination

under, any **health program** or activity, any part of which is **receiving federal financial assistance**, including credits, subsidies or contracts of insurance, or

under any **program** or activity that is **administered by** an executive agency or any entity established under this title (or amendments).

The **enforcement mechanisms** provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act **shall apply** for purposes of violations of this subsection.

The four referenced laws prohibit discrimination based, respectively, on: (i) race, color and national origin, (ii) sex, (iii) age and (iv) disability.

B. HHS' Expansion of the Coverage of Section 1557

The text of Section 1557 says that it applies to “any **health program or activity**, any part of which is receiving Federal financial assistance.” But the proposed rule repeatedly applies Section 1557 to “covered **entities**.” It further states that a covered entity includes “an **entity** that operates a health program or activity, any part of which receives Federal financial assistance.”⁵ These changes in wording represent a significant expansion of the coverage of Section 1557.

The regulatory impact analysis lists the entity types that HHS says are covered by Section 1557. The list in-

⁵ See 80 Fed. Reg. at 54215, 54217-54220.

cludes state Medicaid and public health agencies, which were already frequent targets of enforcement under the four laws.⁶ It includes most providers, such as hospitals and physicians, which HHS says are covered because they participate in Medicare Part A or Medicaid.⁷ Providers were also frequent targets of the four referenced discrimination laws in the pre-ACA world. And, for the first time, it includes QHP issuers.⁸ According to the preamble, “an issuer participating in any Health Insurance Marketplace is receiving Federal financial assistance when advance payments of premium tax credits and/or cost sharing reductions are provided to any of the issuer’s enrollees.”⁹

Consistent with its rewording of Section 1557 to apply to “covered entities,” the proposed rule also redefines “health program or activity” as follows:

For an entity principally engaged in providing or administering health services or health insurance coverage, **all of its operations** are considered part of the health program or activity. . . . **Such entities include** a hospital, health clinic, **group health plan, health insurance issuer**, physician’s practice, community health center, nursing facility, residential or community-based treatment facility, or other similar entity . . .¹⁰

⁶ Early decisions held that payments by such programs to health-care providers for services rendered to beneficiaries were not FFA but merely payment for services rendered. *Tragaser v. Libbie Rehab. Ctr.*, 462 F. Supp. 424 (E.D.Va. 1977); *U.S. v. Cabrini Med. Ctr.*, 639 F.2d 908 (2d Cir. 1981). In 1981, in *Grove City Coll. v. Bell*, 465 U.S. 555 (1983), the U.S. Supreme Court held that Title IX applied to a college because some of its students received federal grants that they used to pay their tuition. In 1984, in *U.S. v. Baylor Univ. Med. Ctr.*, 736 F.2d 1039 (5th Cir. 1984), the Fifth Circuit held that a hospital’s receipt of Medicaid and Medicare payments for services also constituted the receipt of FFA and subjected the hospital to the Rehabilitation Act. The Supreme Court has not decided whether receipt of Medicaid or Medicare constitutes receipt of FFA. But the Fifth Circuit’s position has been adopted by some other courts. See *Rumble v. Fairview Health Servs.*, No. 14-cv-2037, 2015 BL 70114 (D. Minn. Mar. 16, 2015).

⁷ 80 Fed. Reg. at 54195. In the proposed rule, HHS follows its long-standing policy of not considering participation in Medicare Part B as receipt of federal financial assistance. *Id.* at 54174, 54195. Some comments to the proposed rule have objected to the exclusion of Medicare Part B from FFA.

Notably, the regulatory impact analysis in the proposed rule does not list Medicaid or Medicare managed care organizations as covered entities. In other places, HHS has indicated it believes such organizations are covered by Section 1557. 80 Fed. Reg. 31098, 31114, 31256 (June 1, 2015); Medicare Managed Care Manual, Rev. 120, 10-16-15, Chapter 4, § 10.5.2. Some comments have noted that the proposed rule may conflict with other regulations for these federal programs. It may be that HHS plans to issue separate Section 1557 rules for these entities, as it did for the Mental Health Parity and Addiction Equity Act.

⁸ 80 Fed. Reg. at 54195

⁹ *Id.* at 54174. It is not clear that receipt of premium credits and CSR payments by QHPs constitutes receipt of FFA. A primary reason the court in *Grove City* found that receipt of grant funds constituted assistance to colleges was legislative history showing Congress’ awareness that the program “would significantly aid colleges and universities.” 465 U.S. 565-66. It cannot be said that Congress’ purpose in enacting premium credits and CSR payments was to aid health insurers.

¹⁰ Proposed Rule at 42 C.F.R. § 92.4.

The preamble states that if an insurer operates a single QHP or other program that receives FFA in a single market, this means that it must comply with Section 1557 for *all* of its other products in that market and all other markets. According to the preamble, this includes the insurer's non-QHP health plans, and its activities as a third-party administrator for self-funded plans—even though none of these receive federal funds.¹¹ Some comments on the proposed rule have suggested that this could also mean that Section 1557 would apply to other non-federally subsidized and even non-health activities, such as life, disability, workers' compensation and property-casualty insurance products, or data processing and real estate operations.

C. The Questionable Basis for HHS' Expansion of Section 1557

But is HHS' interpretation of Section 1557 consistent with the intent of Congress? HHS bases this expansion of the coverage of Section 1557 on the Civil Rights Restoration Act of 1987 (CRRA) — which amended each of the four discrimination laws. The CRRA redefined the term “program or activity” in the four laws. If an organization is principally engaged in the business of *providing health care* (or education, housing, social services, or parks and recreation) then the term “program or activity” includes *all operations* of the organization (emphasis added). But for other types of business, if FFA is only extended to one distinct unit of the organization, then the term “program or activity” only applies to that unit.¹²

Section 1557, however, nowhere mentions the CRRA, and substitutes its own coverage clause in place of the CRRA's language: The CRRA states that the four laws apply to “*all operations*” of organizations principally engaged in the business of providing health care. But Section 1557 states that it only applies to a “*health program or activity*” which receives FFA. This different choice in wording would appear to reflect Congress' intent that Section 1557 only apply to specific programs, not entire entities. The wording of Section 1557 also appears to be consistent with Congress' general express exclusion of issuers' nonhealth insurance programs from other discrimination and ACA health care reform rules.¹³

HHS' interpretation also creates conflicts of laws. Most third-party administration is performed for employer-sponsored plans that are subject to ERISA. ERISA requires plan administrators to administer plans according to their terms.¹⁴ The proposed rule potentially subjects an administrator to liability if it follows ERISA and faithfully applies plan terms that are not subject to Section 1557 but that put the administrator in violation of Section 1557 for administering them. Such a result would not appear to have been Congress' intent.¹⁵

¹¹ 80 Fed. Reg. at 54189.

¹² Pub. L. 100-259, March 22, 1988, 102 Stat 28. Codified at 42 U.S.C. § 2000d-4a; 29 U.S.C. § 794; 20 U.S.C. § 1687; 42 U.S.C. § 6108.

¹³ See 42 U.S.C. § 300gg-91(c).

¹⁴ 29 U.S.C. § 1104(a)(1)(D).

¹⁵ Alternatively, if an administrator complied with Section 1557, despite the presence of conflicting plan terms, the effect would be a back-door imposition of Section 1557 on ERISA plans—something for which there is no support in the ACA.

It is also questionable that the CRRA modification itself applies to health insurers. By its terms, the “all operations” provisions in the CRRA only apply to organizations that are *principally* engaged in the business of “*providing . . . health care.*”¹⁶ But health care law has traditionally recognized that health care insurers are not classified as providers of health care, because they are engaged in financing, not providing health care.¹⁷

D. Moving Operations to an Entity That Does Not Receive FFA

It might seem an “easy” fix just to isolate QHP products or other products receiving FFA into a separate entity. But the preamble challenges this solution, and states that where an entity that acts as a third-party administrator is legally separate from an issuer that receives FFA for its insurance plans, HHS “will engage in a case-by-case-inquiry to evaluate whether that entity is appropriately subject to Section 1557.”¹⁸

What HHS means by this statement is unclear. Courts have generally held that the four discrimination laws do not apply directly to subcontractors or employees of FFA recipients.¹⁹ The preamble indicates that HHS intends to follow this precedent, noting that “[a] health services provider that contracts with [a covered] issuer does not become a recipient of Federal Financial assistance by virtue of the contract. . . .”²⁰ Some cases have been willing to apply civil rights laws to parties other than direct recipients under alter ego theories, or where a third party controlled the receipt and expenditure of FFA by the nominal recipient.²¹ HHS' case-by-case analysis may look for situations where a third party exercises such day-to-day operational control.

II. HHS Expands the Definition of Discrimination in Health Plan Benefits

A. HHS Adopts the “Meaningful Access” Approach to Benefits Discrimination

Different approaches have been advocated for applying federal discrimination laws to health benefits:

- Plans must provide “meaningful access” to whatever list of benefits the plan offers, but coverage limits do not have to be equal for all conditions.²²

¹⁶ See, e.g., 29 U.S.C. § 794(b)(3)(A).

¹⁷ See, e.g., 42 U.S.C. § 300gg-5.

¹⁸ 80 Fed. Reg. at 54189 n.73.

¹⁹ See *U.S. Dept. of Transp. v. Paralyzed Veterans of Am.*, 477 U.S. 597, 607-10 (1986); *Rose v. Cahee*, 727 F. Supp. 2d 728, 737-38 (E.D. Wis. 2010).

²⁰ 80 Fed. Reg. at 54174.

²¹ *Johanson v. Huizenga Holdings, LLC*, 963 F. Supp 1175 (S.D. Fla. 1997); *Doe v. City of Chicago*, 883 F. Supp. 1126, 1136-37 (N.D. Ill., 1994); *Horner v. Ky. High Sch. Athletic Ass'n*, 43 F.3d 265 (6th Cir. 1994). But, c.f., *Cureton v. NCAA*, 198 F.3d 107 (3d Cir. 1999); *Smith v. Metro. Sch. Dist.*, 128 F.3d 1014, 1019-21 (7th Cir. 1997).

²² *Alexander v. Choate*, 469 U.S. 287 (1985).

- The comprehensiveness of the benefits covered by the plan must be equal between groups.²³
- The cost of benefits to the plan must be equal between groups.²⁴
- The plan must provide adequate or equal health results for all enrollees.²⁵

Another approach was taken in the federal Mental Health Parity and Addiction Equity Act (MHPAEA). This has been interpreted by regulators as not requiring coverage of additional services, but as prohibiting different cost-sharing terms and other treatment limitations for mental health services.²⁶ This is a variant of the “equal/meaningful access” approach.

There is a substantial amount of precedent on the application of Section 504 of the Rehabilitation Act to health benefit programs, such as Medicaid. In the leading case, *Alexander v. Choate*, the Supreme Court held that Section 504 required programs to provide the disabled with access to whatever benefits the program offered—but did not require them to provide benefits that met the needs of the disabled or that treated the needs of all disabled people equally:

... an otherwise qualified handicapped individual must be provided with **meaningful access to the benefit that the grantee offers**. The benefit itself, of course, cannot be defined in a way that effectively denies otherwise qualified handicapped individual; the meaningful access to which they are entitled; to assure meaningful access, **reasonable accommodations** in the grantee’s program have to be made.²⁷

While a covered entity must provide meaningful access, it does not have to make a “fundamental alteration in the nature of the program.”²⁸

The court considered, but decided against holding that the Rehabilitation Act prohibited all forms of disparate impact discrimination.²⁹ In *Alexander v. Choate*, disabled persons were suing to prevent the Tennessee

Medicaid program from limiting inpatient coverage to 14 days, claiming this would have a disparate impact on them. The court noted that this limitation was neutral on its face and did not distinguish between the disabled and nondisabled—both classes were subject to the same durational limitation. The court then held that Section 504 does not require states to alter their benefits “to meet the reality that the handicapped have greater medical needs” or to “view certain illnesses particularly affecting the handicapped, as more important than others or more worthy of cure through greater subsidization.”³⁰ Hence, the Court upheld the 14-day limit.

The court also approved of a prior decision that held that a state may impose lower durational limits on coverage (e.g., days covered) for inpatient psychiatric care than physical care.³¹ Subsequent cases have held that Section 504 does not prohibit similar durational differences in treatment limitations, regardless of the impact on the disabled.³²

The proposed rule builds on the pre-existing case law and regulations for the four discrimination laws. The nondiscrimination rules begin with a lengthy section incorporating most of HHS’ prior non-discrimination rules for the four laws by reference.³³ And the proposed rule’s approach to discrimination in health benefits is largely consistent with *Alexander v. Choate*: A plan is nondiscriminatory if it provides equal access to whatever benefits the plan offers, but a plan is not required to offer special services to individuals based on their status.

The proposed rule contains two regulations that concern health coverage. Both follow the “meaningful access” approach. The first rule, Proposed § 92.206, labeled “Equal program access on the basis of sex,” provides that “[a] covered entity shall provide individuals **equal access** to its health programs or activities on the basis of sex.” The second rule, Proposed § 92.207, provides specific rules for “Non-discrimination in health-related insurance and other health related coverage.” It does not expressly articulate the “meaningful access” principle, but uses more general language:

A covered entity shall not, in providing or administering health-related insurance coverage or other health-related coverage, discriminate on the basis of race, color, national origin, sex, age or disability.

tended § 504 to embrace all claims of disparate-impact discrimination”).

³⁰ *Id.* at 303-304. The Court added that state Medicaid programs are not required to provide services that are precisely tailored to the needs of the disabled. *Id.* See also *Cerpac v. Health & Hosp. Corp.*, 147 F.3d 165 (2d Cir. 1998) (“the disability statutes do not guarantee any particular level of medical care for disabled persons, nor assure maintenance of service previously provided.”); *Cohon v. Bass*, 646 F.3d 717 (10th Cir. 2011) (program required to provide equal benefits, not aid sufficient for disabled to meet treatment goals of disabled person).

³¹ *Alexander v. Choate*, 469 U.S. at 304, citing *Doe v. Colautti*, 592 F.2d 704 (3d Cir. 1979).

³² *Traynor v. Turnage*, 485 U.S. 535 (1988); *Moddero v. King*, 82 F.3d 1059 (D.C. Cir. 1996); *Parker v. Metro. Life Ins. Co.*, 121 F.3d 1006 (6th Cir. 1997); *Rogers v. Dept. of Health & Envtl. Control*, 174 F.3d 431 (4th Cir. 1999); *Mendocino Cmty. Health Clinic v. State Dept. of Health Care Servs.*, 215 Cal. App. 4th 1471 (Cal. App. 2013).

³³ Proposed 45 C.F.R. § 92.101.

²³ Proposed by advocates, but rejected as the test for parity under the Mental Health Parity and Addiction Equity Act (MHPAEA), 42 U.S.C. § 300gg-26). See 78 Fed. Reg. 68240, 68246 (Nov. 13, 2013). Variations in this approach include whether benefits are compared for the affected groups as a whole, or on a granular level for the type of procedure. See, *In re Union Pac. R.R. Emp’t Practices Litig.*, 479 F.3d 936 (8th Cir. 2007).

²⁴ 29 U.S.C. § 623(f)(2)(B)(i) (not discrimination under Age Discrimination in Employment Act of 1967 if “for each benefit or benefit package, the actual amount of payment made or cost incurred on behalf of an older worker is no less than that made or incurred on behalf of a younger worker”).

²⁵ Rejected in *Alexander v. Choate*, 469 U.S. at 303.

²⁶ Depts. of Treasury, Labor, Health & Human Services, Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68240 (Nov. 13, 2013). See 42 U.S.C. § 300gg-26.

²⁷ *Alexander v. Choate*, 469 U.S. at 301. See *Wis. Cmty. Servs., Inc. v. City of Milwaukee*, 465 F.3d 737 (7th Cir. 2006) (Act’s promise of “meaningful access” to state benefits means that reasonable accommodations in the grantee’s program or benefit may have to be made.”).

²⁸ *Alexander v. Choate*, 469 U.S. at 300.

²⁹ *Id.* at 295-99 (“just as there is reason to question whether Congress intended § 504 to only reach intentional discrimination, there is similarly reason to question whether Congress in-

The preamble to the proposed rule, however, states that HHS understands both rules as requiring plans to follow the meaningful access standard. According to the preamble,

The proposed rule does not require plans to cover any particular benefit or service, but a covered entity cannot have a coverage policy that operates in a discriminatory manner. For example, a plan that covers inpatient treatment for eating disorders in men but not women would not be in compliance with the prohibition of discrimination based on sex. Similarly, a plan that covers bariatric surgery in adults, but excludes such coverage for adults with particular developmental disabilities would not be in compliance with the prohibition on discrimination based on disability.³⁴

In other words, compliance is measured based on whether the plan provides all groups equal access to whatever benefits the plan offers. The proposed rule, however, does not require plans to provide equally comprehensive benefits to all members, or that the benefits members receive be equal in cost or adequate for their needs.

B. The New Rules on Plan Terms

Where the proposed rule may break new ground is on health plan cost-sharing terms. *Alexander v. Choate* and its progeny held that plans may impose different durational limits and cost-sharing terms on benefits. Section 92.207 of the proposed rule, however, states that health plans may not “limit . . . a health insurance plan or policy, or other health coverage . . . or limit coverage of a claim or impose additional cost sharing or other limitations or restrictions” for discriminatory reasons; and they may not “employ benefit designs” that discriminate.³⁵

The preamble does not state when HHS would consider this rule to be violated. In recent guidance for the Essential Health Benefits rules, HHS stated that it is permissible for a plan to have different cost-sharing tiers for pharmaceuticals. And that it could also be permissible to place all drugs for particular diseases in higher tiers, if this was based on cost.³⁶ If HHS ultimately goes in the same direction here, different coverage limits for different services could be permissible, if based on neutral rationales, such as cost or medical management principles.³⁷ The ACA specifically permits plans to use cost-sharing to pass on a portion of the costs of care to plan members, without regard to whether particular diseases create more costs and thus result in some members paying more dollars in cost-sharing.³⁸

³⁴ 80 Fed. Reg. at 54189.

³⁵ Proposed 45 C.F.R. § § 92.207(b)(1), (2).

³⁶ HHS, Notice of Benefit and Payment Parameters for 2016, Final Rule, 80 Fed. Reg. 10750, 10823 (Feb. 27, 2015).

³⁷ HHS’ EHB guidance permits plans to use different benefit limits if based on “reasonable medical management practices.” *Id.* at 10822-23.

³⁸ 42 U.S.C. § 18022(c).

C. HHS’ Expansion of Sex Discrimination Rules

Title IX prohibits sex discrimination—but only in education programs that receive FFA.³⁹ Title IX exempts certain entities, such as religious institutions, social fraternities and sororities and traditional single-sex colleges.⁴⁰ The proposed rule assumes that Congress intended Section 1557 to prohibit sex discrimination in covered health programs in general. However, because HHS’ regulations for Title IX were written for the education context, the proposed rule incorporates them selectively. It incorporates affirmative prohibitions on different treatment in determining eligibility for benefits and providing benefits.⁴¹ But it omits the regulations that implemented the exclusions.⁴² The preamble explains this was done because some exceptions were only relevant to education.⁴³ It then adds:

However, we continue to seek comment on what other sex-based distinctions, if any, should be permitted in the context of health programs and activities and the standards for permitting the distinctions . . . Examples of sex-based distinctions include a women’s health clinic or a counseling program limited to male victims of domestic violence.⁴⁴

The preamble also indicates that HHS is considering whether a religious exemption should exist to its sex discrimination regulations.⁴⁵ Some commenters on the proposed rule contend that the final rule should not reflect the Title IX exclusions, because these were not specifically incorporated by Section 1557. Others argue that the exclusions were incorporated because they modify and thus are part of the “ground” for discrimination prohibited by Title IX.

HHS’ prior regulations for Title IX used a traditional two-gender definition of sex.⁴⁶ The proposed rule redefines discrimination “on the basis of sex” to include discrimination on the basis of “pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, or gender identity.”⁴⁷ Some religious organizations have expressed concern that this expansion could be interpreted as requiring covered entities to cover or provide abortions or transgender services, despite their religious convictions. While this will not completely address these concerns, the proposed rule indicates that HHS’ approach to sex discrimination in

³⁹ 20 U.S.C. § 1681.

⁴⁰ 20 U.S.C. § § 1681(a)(2)-(9).

⁴¹ Proposed 45 C.F.R. § 92.101(b)(3) (incorporating 45 C.F.R. § § 86.31(b)(1)-(8)).

⁴² Proposed 45 C.F.R. § 92.101(c).

⁴³ 80 Fed. Reg. at 54173.

⁴⁴ *Id.* at 54181.

⁴⁵ *Id.* at 54173. See 20 U.S.C. § 1681(a)(3).

⁴⁶ See, e.g., 45 C.F.R. § § 86.32(a)(2), (c)(2), 86.33 (referring to “one sex” and “the other sex”).

⁴⁷ Proposed 45 C.F.R. § 92.3. HHS decided not to add sexual orientation to its definition of discrimination based on sex at this time, because it did not believe that there was sufficient precedent for this. However, the preamble states that it is HHS policy to support banning such discrimination, and that it may add this to the final rule, depending on the state of the law at that time. See 80 Fed. Reg. 54176.

health benefits—even under its expanded definition—will follow the “equal” or “meaningful access” principle. The proposed rule does not directly address abortion coverage, but it states that prohibited discrimination based on gender identity will now include:

- Denying coverage or imposing additional limitations “on any health services that are ordinarily or exclusively available to individuals of one sex” based on the fact that an individual’s sex assigned at birth or gender identity is different from the one to which such health services are ordinarily or exclusively available;
- Categorically excluding all health services related to gender transition; or
- Otherwise denying or limiting coverage that results in discrimination against a transgender individual.⁴⁸

Plans also are still not required to cover medically unnecessary services.⁴⁹ The preamble explains that these rules require plans to make services that are available to other members also available to transgender members, including for the purposes of transition. But they don’t require plans to provide novel services to transgender patients.⁵⁰ Depending on the services provided by a plan, the net effect could still be to require significant coverage of gender transition services.⁵¹

D. Can Plans Have Special Programs for Age, Sex, Disability and Ethnic Groups?

One problem with the “equal access” approach to health benefits discrimination is that it could be interpreted as prohibiting plans from offering special benefits to particular sex, age, disability or ethnic groups. Some advocacy groups have requested HHS to permit special programs such as pediatric clinics that are restricted to children, behavioral health clinics that are restricted to persons with particular conditions, female rape clinics that exclude men or disease support groups that happen primarily to be composed of persons of ethnic groups that are particularly susceptible to a disease.⁵²

HHS has shown some difficulty in creating rules that permit such exceptions. However, there are specific exclusions in at least some of the four laws that expressly permit such special programs. For example, the Age Discrimination Act provides that it is not discrimination to take age into account as a factor necessary to the “normal operation or achievement of the statutory ob-

jectives of a program or activity.”⁵³ HHS’ rules for the Age Discrimination Act provide:

If a recipient operating a program or activity provides **special benefits to the elderly or to children**, such use of age distinctions shall be **presumed** to be **necessary to the normal operation** of the program or activity . . .⁵⁴

The exclusions in Title IX also suggest that it was not Congress’ intent to prohibit all special programs geared at particular sexes. More recently, as part of the Essential Health Benefits rules, Congress directed plans to design benefits in a way “take[s] into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups.”⁵⁵ I have previously suggested that HHS use a balancing test that would permit a plan to limit coverage to meet the special needs of a segment if the limitation was justified by affordability factors.⁵⁶ Others have suggested that special programs be permitted if narrowly tailored and necessary to accomplish an essential health purpose.⁵⁷

III. Operational Requirements

A. Language Accessibility Requirements

The proposed rule contains specific LEP regulations. The basis for these regulations is the 1973 Supreme Court decision, *Lau v. Nichols*, 414 U.S. 563 (1974), that found that a school district’s failure to provide education services to Chinese-speaking children was national origin discrimination under Title VI.

In 2003, at the instigation of an executive order from President Clinton, HHS issued guidance (but not regulations) on LEP obligations for FFA recipients. This guidance required FFA recipients “to take reasonable steps to ensure meaningful access to their programs and activities to LEP persons.” The guidance provided a flexible standard that did not require the provision of oral translation in all cases, but only where reasonable. It required written translations, but only of “vital” documents, and a safe harbor if written translations were provided for LEP language groups that were “five percent or 1,000, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered.”⁵⁸ While this guidance document was not a regulation *per se*, OCR often enforced its terms as if they were mandatory.

In recent years, federal agencies have promulgated actual LEP regulations rules for ERISA plans, Medicare Part C and D and EHB plans. These regulations tend to

⁴⁸ Proposed 45 C.F.R. § 92.206; 92.207(b)(3)-(5).

⁴⁹ *Id.* at § 92.207(d).

⁵⁰ *Id.* at 54189-90.

⁵¹ HHS considered, but decided not to include sexual orientation in its definition of discrimination based on sex, although it may add this depending on the state of the law at the time it issues the final rule *See id.* at 54276-77. The proposed rule does contain a prohibition on discrimination based on the basis of association. 80 Fed. Reg. at 54220; Proposed 45 CFR § 92.209. Some commenters contend that this could be interpreted as a ban on discrimination based on sexual orientation.

⁵² *See, e.g.,* American Hospital Assn., Comment Letter to Proposed Rule (Nov. 5, 2015).

⁵³ 42 U.S.C. § 6103(b)(1)(A), (B).

⁵⁴ 45 C.F.R. at § 91.17.

⁵⁵ 42 U.S.C. § 18022(b)(4)(C).

⁵⁶ David D. Johnson, Anti-Discrimination Law Comes to Health Benefit Design: Is HHS Getting the Rules Right? *AHLA Connections*, November 2015, 32, 34.

⁵⁷ The Leadership Conference, Comment Letter to Proposed Rule (Nov. 9, 2015).

⁵⁸ HHS, Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47311 (Aug. 8, 2003).

be more rigid and require translations when specific population thresholds are met.⁵⁹ The LEP regulations in the proposed rule, however, adopt a flexible approach in the tradition of HHS' original 2003 guidance and require covered entities to "take reasonable steps to provide meaningful access to each individual with limited English proficiency it serves or encounters . . ."⁶⁰

Language assistance services must be provided "free of charge."⁶¹ But this does not mean that an insurer must provide a translator for every non-English tongue it encounters in every situation. Written translations may only be required for higher-frequency languages, and specific thresholds are not defined for when written translations must be provided.⁶² The preamble states, however, that HHS expects entities to be generally able to provide telephonic oral interpretation.⁶³ The flexible approach taken in the proposed rule is consistent with the fact that it will be applied to a wide variety of entities—from sole practitioner physicians to large corporations. Despite the flexibility, many commenters still contend that compliance with the proposed rule will be costly, especially for small providers.

B. Communication and Information Technology Accessibility Standards

Following recent trends, the proposed rule includes new information technology (IT) accessibility regulations. A covered entity must make IT accessible to individuals with disabilities unless doing so will result in undue financial and administrative burdens or a fundamental alteration of the program. If the burdens are too great, a covered entity can provide the information in a nonelectronic form.⁶⁴ The preamble states that this means that a state exchange that offers a website to permit comparison of products must "make its new Web site accessible to individuals who are blind or who have low vision."⁶⁵ There might be a way to modify such a site for persons with some level of low vision. In many cases, compliance would require alternative methods of communication.⁶⁶

⁵⁹ See 29 C.F.R. § 2590.715-2719(e); 45 C.F.R. § 422.111; 45 C.F.R. § 422.2264; 45 C.F.R. § 155.205.

⁶⁰ Proposed 45 C.F.R. § 92.201(a).

⁶¹ *Id.* at § 92.201(c).

⁶² 80 Fed. Reg. at 54183.

⁶³ *Id.* at 54184.

⁶⁴ Proposed 45 C.F.R. § 92.204.

⁶⁵ 80 Fed. Reg. 54187.

⁶⁶ This is another area in which the rules are in flux. See *id.* at 54187-88.

C. Prior General Compliance Requirements Are Expanded

HHS' regulations for the four discrimination laws of ten require covered entities to provide assurances of compliance, create grievance procedures, and provide notices of these to the public. The proposed rule also includes these types of requirements, but provides a unified set of compliance requirements for purposes of Section 1557. These rules require covered entities to:

- *Provides assurances of compliance.* An issuer seeking to sell on a State exchange must "as a condition of certification for approval" submit an assurance to HHS-OCR that it will comply with Section 1557 and HHS regulations.⁶⁷
- *Designate a responsible employee* to coordinate compliance with Section 1557 and corporate and grievance procedures. (Applies only to covered entities with 15 or more employees.)⁶⁸
- *Create grievance procedures* to address discrimination complaints. (Applies only to covered entities with 15 or more employees.)⁶⁹
- *Post notices and "taglines."* Covered entities must publish a notice in English in significant publications and conspicuous locations and on its Website stating that it does not discriminate on the prohibited grounds and providing information about language services and grievance procedures. They must also post "taglines" in the same locations in the top 15 non-English languages nationally that state how to obtain this information in these non-English languages.⁷⁰

IV. Conclusion

Section 1557, as written, imposes significant obligations on covered programs. Obligations made especially potent by the enforcement mechanisms available under the Affordable Care Act. The proposed rule broadens these obligations. This makes the extension of the coverage of Section 1557 in the proposed rule to programs and activities that do not receive federal financial assistance, and may not even be health-related, especially burdensome. HHS is in the early stages of work on the final rule for Section 1557. It is well-advised to rethink this overreach, so that it can focus its regulatory work on the programs that are squarely in the ambit of the ACA.

⁶⁷ Proposed 45 C.F.R. § 92.5(a).

⁶⁸ Proposed 45 C.F.R. § 92.7(a).

⁶⁹ Proposed 45 C.F.R. § 92.7(b).

⁷⁰ Proposed 45 C.F.R. § 92.8.