On May 18, 2016, the Office of Civil Rights (OCR) of the US Department of Health and Human Services (HHS) published final regulations implementing non-discrimination rules under Section 1557 of the Affordable Care Act (ACA). These rules prohibit discrimination on the basis of race, color, national origin, sex, or disability in health activities and programs that receive federal funding from HHS. The rule was generally effective on July 18, 2016, but any changes to health plan design take effect on the first plan year beginning on or after January 1, 2017. The ACA's nondiscrimination provisions are fairly broad and have application for group health insurance carriers, healthcare providers, and some group health plans.

Much of the attention of these regulations has focused on discrimination in health program design and administration and prohibiting plans from any of the following actions on the basis of an individual's race, color, national origin, sex, or disability:

- Denying or limiting health coverage;
- Denying a claim;
- Employing discriminatory marketing or benefit designs; and
- Imposing additional cost sharing.

These rules have garnered attention because discrimination based on sex includes not only gender, but sex stereotyping and gender identity which means that medically appropriate services cannot be denied to a participant based on their sex or gender identity. Additionally, services related to gender and gender transition cannot be blanket excluded from a covered group health plan. This does not mean that these services must be covered by the group health plan either, but group health plans must use neutral and reasonable medical management practices in making coverage decisions. It is important to note that there are no blanket religious exemptions other than those under existing law.

While the final regulations have been in force for over a month, insurance carriers and health care providers are beginning to contact clients about the impact to plans that renew on January 1, 2017, or later. The impact to employers is different based on whether or not they are in the business of providing health care, they operate a fully-insured plan, or a self-funded plan or a combination. Following are the highlights:

- If you are a non-healthcare employer sponsoring a fully-insured plan, the regulations will most likely apply to your plan through the insurance carrier providing the plan. This is because insurance carriers receive federal funding from HHS by nature of providing Medicare, Medicaid, and/or Marketplace programs. Participation in these programs subjects them and the plans they sponsor to these regulations.
- If you are a healthcare provider operating a fully-insured or self-funded health plan and you receive federal assistance from HHS for any reason (for example, Medicare, Medicaid, grant, or otherwise), the rules apply to your organization. The rules apply to a covered entity's entire operations which may impact the services that your business provides, as well as the employer sponsored group health plan that you sponsor for your employees.
- If you are a non-healthcare employer sponsoring a self-funded health plan, the regulations apply to you or your organization if you operate a health program or activity (including your group health plan) that receives federal funding from HHS. Even if you are not a covered entity, if your third-party administrator or administrative services only provider receives funding from HHS,

the rules apply to their entire operation unless they are administering the plan according to the client's discriminatory plan design. Therefore, if you choose not to comply, it is likely you will be asked to indemnify your administrator in the event of any potential action taken against them under Section 1557 of the ACA.

If you believe you are a covered entity, you should seek counsel to ensure that you are complying with all of the new requirements of Section 1557 as compliance involves more than just changes to plan design. For example, compliance also requires covered entities to take reasonable steps to provide meaningful access to individuals with limited English proficiency through notices of nondiscrimination and taglines that alert individuals to the availability of language assistance services. Covered entities must also make electronic information and newly constructed or altered facilities accessible to individuals with disabilities and to provide appropriate auxiliary aids and services for individuals with disabilities.

It is also important to note that HHS has said that if they investigate a complaint against a company or plan and realize that they do not have enforcement authority because that company is not a covered entity, they will turn the company over to the Equal Employment Opportunity Commission (EEOC). The EEOC has the authority to investigate employers as to whether or not they are taking discriminatory action against their employees. Please contact your HORAN account representative with additional questions.