



Highlights of the Section 1557 Final Rule

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This issue brief provides an initial analysis of the Department of Health and Human Services' final rule implementing § 1557 of the Affordable Care Act, the ACA's nondiscrimination provision. The final rule was released for public inspection at the Federal Register on Friday, May 13. It is expected to be published in the Federal Register on May 18, 2016.

Broadly, § 1557 prohibits discrimination on the basis of race, color, national origin, sex, disability and age by:

- any health program or activity any part of which receives federal funding;
- any health program or activity that is administered by an Executive agency; and
- any entity created under Title I of the Affordable Care Act (including health insurance marketplaces).¹

The final rule applies to HHS funded and administered programs and activities.² It retains nearly all of the requirements of the proposed rule and does not make significant changes to it, although a number of clarifications will ensure broad understanding of the provisions. In this issue brief, we summarize selected provisions of the final rule.

¹ Section 1557 of the Affordable Care Act, 42 U.S.C. § 18116 (2012).

² U.S. Dep't of Health & Human Servs., *Nondiscrimination on the Basis of Race, Color, National Origin, Sex, Age, or Disability in Health Programs or Activities Receiving Federal Financial Assistance and Health Programs or Activities Administered by the Department of Health and Human Services or Entities Established under Title I of the Patient Protection and Affordable Care Act*, 45 C.F.R. Part 92 (unpublished version, May 13, 2016), available at <https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-11458.pdf> (hereinafter "Section 1557 Final Rule").

Purpose and Effective Date, § 92.1

For the most part, the rule will take effect 60 days after publication in the Federal Register (expected on May 18, 2016). For entities that have to make changes to health plan benefit design, the rule will be applicable the first day of the first plan year beginning on or after January 1, 2017.³

Relationship to other laws, § 92.3

The regulations prohibit construing any part of § 1557 or the regulations to apply a lesser standard for the protection of individuals from discrimination than the standards applying under Title VI, Title IX, Section 504 of the Rehabilitation Act, the Age Discrimination Act, or the regulations implementing those laws.⁴

Definitions, § 92.4

This section includes a number of definitions applicable to the entire final rule. The following subsections describe a subset of these definitions.

Applicability

The final rule applies only to health programs and activities operated or funded by HHS. NHeLP believes the statutory text of § 1557 delegated rulemaking authority for all health programs and activities to HHS. We recommended that HHS apply the final rule to all health programs receiving federal financial assistance across all federal Departments, rather than solely HHS. HHS declined to extend the scope of its rules to other Departments, noting it lacked the information and expertise necessary to apply the rule to other Departments' programs without further engagement and collaboration. HHS sent a memorandum to other Departments encouraging coordination of enforcement responsibilities under § 1557.⁵

Covered Entity

Section 1557 clarifies nondiscrimination protections for individuals participating in:

- any health program or activity any part of which received funding from HHS;
- any health program or activity that HHS itself administers; and
- health insurance marketplaces and all plans offered by issuers that participate in those marketplace.

³ *Id.* at 9-10, 198.

⁴ See 45 C.F.R. § 92.3.

⁵ Section 1557 Final Rule at 14.

In the final rule, HHS keeps its proposed language which broadly applies § 1557 to all programs and activities of entities “principally engaged in providing or administering health services or health insurance coverage” if “any part” of its operations receives federal financial assistance. Thus § 1557 applies not only to the health plans operating directly pursuant a federal program; but to all the health plans offered by health insurer if that insurers receives any form of federal financial assistance.

However, § 1557 does not necessarily apply to providers who are not directly subject to § 1557. HHS explains that providers contracting with a covered entity do not become recipients of federal financial assistance by virtue of the contract. However, providers may be otherwise subject to § 1557 through other payments (e.g., Medicaid or Medicare payments).⁶

Some insurers and industry groups objected to the broad applicability of § 1557. They argued that its nondiscrimination protections should only extend to health plans sold through the marketplace, and not to plans sold outside the marketplaces or to insurers when they serve as third party administrators (TPA) for self-insured employer plans.⁷

In the final rule, HHS reaffirmed the broad applicability § 1557, noting that its interpretation is consistent with longstanding principles of civil rights laws including the Civil Rights Restoration Act of 1987:

This interpretation serves the central purposes of the ACA, and effectuates Congressional intent, by ensuring that entities principally engaged in health services, health insurance coverage, or other health coverage do not discriminate in any of their programs and activities, thereby enhancing access to services and coverage.⁸

Although HHS declined to exempt TPAs from the final rule, it adopted procedures for processing complaints against TPAs.⁹ HHS acknowledges that TPAs may not have a role in benefit design, for example. Therefore, HHS will determine whether responsibility for the decision or other action alleged to be discriminatory rests with the employer or with the third party administrator.¹⁰

⁶ *Id.* at 30.

⁷ Amy Lotven, *Employers Say HHS Overstepped With ACA Non-Discrimination Rule*, INSIDE HEALTH POLICY (May 3, 2016) available at <http://insidehealthpolicy.com/share/89604>.

⁸ Section 1557 Final Rule at 36, 39.

⁹ *Id.* at 203.

¹⁰ *Id.* at 205.

HHS adds that for TPAs that are legally separate from an issuer that receives Federal financial assistance, it will consider whether that TPA is subject to § 1557 on a case by case basis.¹¹ OCR will consider factors including commonality of ownership and control to determine whether the purpose of the legal separation is a subterfuge for discrimination.¹²

In situations where the employer is principally engaged in health services, health insurance coverage, or other health coverage, the employer meets the definition of “covered entity,” subject to § 1557, and would be held liable for discriminatory practices.¹³

However, for self-insured plans offered by employers that do not meet § 1557 definition of “covered entity” and fall outside of OCR’s jurisdiction, OCR typically will refer the matter to appropriate regulatory agency, such as the Equal Employment Opportunity Commission (EEOC) or the Office of Personnel Management (OPM).¹⁴

HHS also declined to exempt from § 1557 certain limited-benefits plans which are otherwise exempt from the ACA’s market reforms, such as limited scope dental and vision plans; coverage only for a specified disease or illness; and Medicare supplemental health insurance (also known as Medigap).¹⁵

Religious Refusal

In the proposed rule, HHS asked for input as to whether to allow religious refusals under § 1557. HHS decided against including a blanket religious exemption in the final rule, stating:

a blanket religious exemption could result in a denial or delay in the provision of health care to individuals and in discouraging individuals from seeking necessary care, with serious and, in some cases, life threatening results.¹⁶

NHeLP and other allies strenuously objected to any religious exemption to § 1557, as such an exemption would undermine the right of individuals to access comprehensive health care services, including reproductive health care, free from discrimination, and thwart the objectives of the ACA. We appreciate that HHS ultimately decided against incorporating a religious exemption. However, it is important to note that while the final rule itself does not have a religious exemption, it notes that

¹¹ *Id.* at 202.

¹² *Id.* at 207.

¹³ *Id.* at 204.

¹⁴ *Id.* at 194.

¹⁵ *Id.* at 196.

¹⁶ *Id.* at 18.

insofar as application of any requirement under the rule would violate applicable federal statutory protections for religious freedom and conscience, such application would not be required.¹⁷

Language Access Definitions

The rule includes a number of definitions related to language access including: individual with limited English proficiency; language assistance services; qualified bilingual/multilingual staff; qualified interpreter for an individual with limited English proficiency; qualified translator; and taglines.

The rule explicitly defines “individual with limited English proficient”, formalizing in regulations the longstanding definition used in HHS’ LEP Guidance. An individual whose primary language for communication is not English is considered an individual with limited English proficiency if the individual has a limited ability to read, write, speak or understand English.¹⁸

It also includes a definition of “national origin” consistent with the well-established definition used by the Equal Employment Opportunity Commission. This definition includes not only an individual’s place of origin, but also her ancestor’s place of origin. HHS clarifies its intent is to include protections for individuals born in the U.S. who have an ancestry outside of the U.S. Further, national origin also includes the manifestation of physical, cultural or linguistic characteristics of a national origin group.¹⁹

The rule provides a new definition of a “qualified translator”²⁰ and splits the definition of “qualified interpreter” into two different definitions – a “qualified interpreter for an individual with limited English proficiency” and a “qualified interpreter for an individual with a disability.”²¹ These definitions are then also referenced in the definition of “language assistance services.”²² This separation recognized the different qualifications needed for interpreting for each set of individuals. The qualifications for both sets of interpreters recognize the importance of the interpreter’s ability to “interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology and phraseology.”²³

The definition of translator, interpreter and qualified bilingual/multilingual staff all recognize that individuals serving in these roles must demonstrate proficiency in English and at least one non-English

¹⁷ *Id.* at 331.

¹⁸ *Id.* at 40.

¹⁹ *Id.* at 43.

²⁰ *Id.* at 59-60.

²¹ *Id.* at 58.

²² *Id.* at 41-2.

²³ *See* 45 C.F.R. § 92.4.

language; can interpret/translate effectively, accurately and impartially; and has knowledge of any specialized vocabulary, terminology and phraseology. Further, interpreters and translators must adhere to ethics (including client confidentiality).²⁴

Medicare Part B Providers

We had recommended that HHS include Medicare Part B providers in the definition of federal financial assistance. While HHS declined to do this in the final rule, its rationale was that it did not believe this final rule was the appropriate vehicle to change HHS' position. Medicare Part B providers have long been excluded from complying with Title VI but we posited that the rationale for that exclusion does not extend to § 1557 due to differences in the statutory text. We will continue to look for opportunities to clarify that Part B providers are indeed within the purview of § 1557 and to change the Department's policy regarding Title VI.²⁵

Disability Definitions

The final rule did not change the definition of disability or qualified individual with a disability, continuing to reference the Rehabilitation Act and the Americans with Disabilities Amendments Act of 2008. This means that the terms should continue to be read broadly and inclusively. In the preamble, HHS stated it believes it is clear that they it intends to interpret the term "disability" broadly and consistent with the ADA Amendments Act.²⁶ As to the question of whether chronic conditions will be covered, HHS referred back to the disability definition. Therefore, the analysis of protection for individuals with chronic conditions will be based on interpretation of the ADAAA. This should be positive for many individuals with chronic conditions accessing health services as the relevant ADAAA provisions should be those related to Title II as other provisions of the final rules cite to Title II instead of Title III standards. This is important because how individuals with chronic conditions may or may not be protected in employment under Title I of the ADAA is not the same analysis as whether or not that same person may be protected under Title II or III of the ADAAA.²⁷ Although there is potential danger in covered entities attempting to limit protections by setting essential eligibility requirements, HHS' clear intent to read the definitions broadly will help in ensuring that such requirements are found to be discriminatory.

²⁴ *Id.*

²⁵ For an explanation of why Medicare Part B providers should be covered by Section 1557, see NHeLP's comments on the proposed rule at 18, available at <http://www.healthlaw.org/publications/search-publications/1557-comments-final#.VzYPn-QoEsQ>.

²⁶ Section 1557 Final Rule at 24.

²⁷ Under Title I of the ADAAA, to be a qualified person with a disability the individual must be able to meet the essential job functions with or without an accommodation. Under Titles II and III of the ADA the individual need only qualify for the program with or without an accommodation, which is often a much easier barrier to overcome.

As noted above, the final rules created different definitions for a qualified interpreter for an individual with limited English proficiency and a qualified interpreter for an individual with a disability. This separation recognized the different qualifications needed for interpreting for each set of individuals. The qualifications for both sets of interpreters recognize the importance of the interpreter's ability to "interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology and phraseology."²⁸ The definitions of both include on-site appearance and remote interpreting service, which is also defined. The definition of qualified interpreter for an individual with a disability is different than that for individuals with limited English proficiency in that it sets forth that qualified interpreters can include sign language interpreters, oral transliterators, and cue language transliterators. Inclusion of these examples may broaden covered entities' understanding that an interpreter for an individual with a disability is not limited to American Sign Language interpreters and that individuals with disabilities have different needs to enjoy equal access. This concept is further enforced by the rules' adoption of ADAAA Title II requirements, which give primary consideration to the choice of an aid or service requested by the individual with a disability, in § 92.202 regarding effective communication for individuals with disabilities. Although the separate definition of a qualified interpreter for an individual with a disability can be positive, the final rules are confusing in that they define this term and then do not use it.

"On the Basis of Sex" Definitions

Section 1557 prohibits discrimination on the basis of sex, making it the first federal civil rights law to prohibit sex discrimination in the health care context.²⁹ Critically, the final rule defines "on the basis of sex" quite broadly, just as the proposed rule did. This will ensure that the rule contains robust protections for women and LGBTQ individuals, who have often faced discrimination in a myriad of health care situations, including outright refusals of care.

The final rule states that the phrase "on the basis of sex" includes, but is not limited to, discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity.³⁰ Any discrimination on the basis of pregnancy is specifically prohibited in Title IX regulations, and § 1557 has adopted these same restrictions.³¹ While protection against discrimination on the basis of having terminated a pregnancy is a welcome part of § 1557, the final rule makes clear that it does not displace any of the

²⁸ See 45 C.F.R § 92.4(a).

²⁹ Section 1557 Final Rule, discussion beginning at 44.

³⁰ *Id.* at 44, 337.

³¹ See 45 C.F.R. § 86.40(b) (prohibiting discrimination on the basis of "pregnancy, childbirth, false pregnancy, termination of pregnancy, or recovery therefrom").

many restrictions on abortion found within the ACA and other federal and state laws. For example, the ACA permits states to prohibit abortion coverage in qualified health plans offered through an exchange, while the Church Amendment, Weldon Amendment, Coats Amendment, and Religious Freedom Restoration Act, all of which were enacted prior to the passage of the ACA, permit numerous restrictions on reproductive health care on religious grounds.³²

The rule also protects against discrimination based on sex stereotypes. The definition of sex stereotypes includes stereotypical notions of masculinity or femininity, including expectations of how individuals represent or communicate their gender to others, such as behavior, clothing, hairstyles, activities, voice, mannerisms or body characteristics. Sex stereotypes also include gendered expectations related to the appropriate roles of a certain sex.³³

The sex stereotyping prohibition is imported from the Supreme Court case *Price Waterhouse v. Hopkins*, a landmark sex discrimination case that held that discrimination based on stereotypical notions of gender constructs, including appearance, mannerisms, dress, behavior, clothing, hairstyles, activities, voice, body characteristics, or other traditional and stereotypical notions of masculinity and femininity, constitute sex discrimination.³⁴ While the rule does not expressly include discrimination on the basis of sexual orientation, HHS stated that § 1557's prohibition of discrimination on the basis of sex includes, at a minimum, sex discrimination related to an individual's sexual orientation where the evidence establishes that the discrimination is based on gender stereotypes. Other federal agencies, including the EEOC, have stated that a theory of associational theory of discrimination on the basis of sex also provides protection for individuals who experience discrimination on the basis of sexual orientation.³⁵ For more information, § 92.209 (see below) discusses associational discrimination.³⁶

Numerous federal courts have ruled that protections on the basis of sex stereotypes extend to an individual's identity as lesbian, gay, or bisexual. Some courts say that no distinction exists between addressing sexual orientation discrimination under sex stereotyping protections, on the one hand, and, on the other, stating plainly that sexual orientation discrimination is inherently a form of unlawful

³² 42 U.S.C. § 18023(a) (ACA limitations on abortion coverage); 42 U.S.C. § 300a-7 (Church Amendment); Consolidated Appropriations Act, 2005, Pub. L. No. 108-447, § 508(d)(1), 118 Stat. 2809, 3163 (2004) (Weldon Amendment); 42 U.S.C. § 238n. (Coats Amendment); Religious Freedom Restoration Act, Pub. L. No. 103-141, 107 Stat. 1488 (codified as amended at 42 U.S.C. §§ 2000bb to 2000bb-4 (2012)) (RFRA).

³³ See 45 C.F.R. § 92.4.

³⁴ 490 U.S. 228 (1989); see also Section 1557 Final Rule at 339.

³⁵ EEOC has also found that the plain statutory language of Title VII prohibiting sex discrimination covers sexual orientation. See U.S. Equal Employment Opportunity Comm'n Appeal No. 0120133080, Agency No. 2012-24738-FAA-03 (July 15, 2015), <http://www.eeoc.gov/decisions/0120133080.txt>.

³⁶ Section 1557 Final Rule, discussion beginning at 227.

sex discrimination.³⁷ More courts will consider this question, as they did with protections based on gender identity before eventually concluding that the line between gender identity and sex discrimination is a distinction without a difference. As the landscape in the courts evolves, the Administration will provide further clarification on the legal underpinnings of nondiscrimination protections related to sexual orientation.

The rule also defines gender identity as an individual's internal sense of gender, which may be male, female, neither, or a combination of male and female, and which may be different than an individual's sex assigned at birth. This definition also notes that a transgender individual is an individual whose gender identity is different from the sex assigned to that person at birth.³⁸

Finally, the prohibition of gender identity discrimination is consistent with previous HHS interpretations of sex discrimination and several federal district courts and federal Courts of Appeals decisions.³⁹ The rule is particularly important in addressing insurance discrimination against transgender people, who frequently encounter discriminatory insurance plan exclusions that deny them coverage for medically necessary care related to gender transition, even though the same services and procedures are routinely covered for non-transgender individuals.⁴⁰ The rule also confirms that individuals must have access to facilities and programs consistent with their gender identity. Section 92.207 (see below) spells out some of the important protections for transgender or non-binary individuals in § 1557, including an explicit prohibition on categorical coverage exclusions or limitations for all health services related to gender transition.⁴¹

³⁷ See, e.g., *Latta v. Otter*, 771 F.3d 456 (9th Cir. 2014) (suggesting that discrimination on the basis of sexual orientation is impermissible sex stereotyping, in large part because those who discriminate disapprove of LGBTQ people's nonconformity with gender-based expectations); *Muhammad v. Caterpillar Inc.*, 767 F.3d 694 (7th Cir. 2014) (finding that harassment relating to his perceived sexual orientation was sex-based harassment in violation of Title VII); *Koren v. Ohio Bell Telephone Co.*, 2012 WL 3484825 (N.D. Ohio Aug. 14, 2012) (denying defendant's motion for summary judgment where plaintiff alleged his supervisor discriminated against him based on sex stereotypes because he is married to a man and took his husband's last name, the court held "that is a claim of discrimination because of sex." (emphasis in original)).

³⁸ See 45 C.F.R. § 92.4.

³⁹ See, e.g., *Rumble v. Fairview Heath Servs.*, Civ. No. 14-cv-2037, 2015 WL 1197415, at *10 (D. Minn. Mar. 16, 2015) (Section 1557) (order denying motion to dismiss); *Barnes v. City of Cincinnati*, 401 F.3d 729, 737 (6th Cir.), cert. denied, 546 U.S. 1003 (2005) (Title VII); *Smith v. City of Salem, Ohio*, 378 F.3d 566, 575 (6th Cir. 2004) (Title VII); *Schroer v. Billington*, 577 F.Supp.2d 293, 304 (D.D.C. 2008) (Title VII). But see *Johnston v. Univ. of Pittsburgh*, 97 F.Supp.3d 657, 671 (W.D. Pa. 2015) (appeal docketed, No. 1502922) (3d Cir. Apr. 24, 2015) (holding that an individual treated in accordance with sex assigned at birth has not been discriminated against on the basis of sex under Title IX).

⁴⁰ Section 1557 Final Rule at 307.

⁴¹ *Id.* at 354.

Assurances, § 92.5

All entities applying for federal financial assistance to which § 1557 applies must, as a condition of that application, assure that it will operate its health programs and activities in compliance with § 1557 and these regulations.

NHeLP advocated for robust data collection as a method of documenting compliance (and then investigating noncompliance) with the requirements of § 1557. While HHS declined to require data collection outright for all covered entities, it did recognize its importance. HHS notes it has the authority to require data collection and obtain access to that information.⁴² A recipient who fails to provide requested data in a timely, complete and accurate manner may be subject to a finding of noncompliance with § 1557 which could subject it to enforcement procedures. HHS added a new section to the final regulation clarifying this authority.⁴³

Designation of Responsible Employee and Adoption of Grievance Procedures, § 92.7

This section had a technical correction, but otherwise did not change from the proposed rules. NHeLP had suggested minimum factors for the grievance procedure in efforts to set forth clear expectations for the procedure, including timelines for the different pieces of the process, requirement for written responses, information about the right to appeal, notice about protection from retaliation and availability of accommodations, auxiliary aids and services, and interpreters, and, importantly, that the availability and use of the grievance procedure “does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services.”⁴⁴ In the preamble, HHS made it clear that “[m]ediation and exhaustion of administrative remedies will still be required for age discrimination allegations in complaints, but not for allegations of other covered types of discrimination.”⁴⁵ While HHS did not adopt standards, it did outline a model policy with sample procedures that entities could utilize to ensure the prompt and equitable resolution of complaints.⁴⁶ These are included in Appendix C, which is the sample grievance procedure. The sample grievance procedure is very positive as it is a much more specific policy than a previous HHS example and will hopefully prevent some of the problems individuals with have experienced with

⁴² *Id.* at 63-4.

⁴³ See new § 92.302(c).

⁴⁴ Section 1557 Final Rule at 361-62.

⁴⁵ *Id.* at 238.

⁴⁶ *Id.* at 69-70.

similar procedures, such as with ADA grievance coordinators and procedures that are often slow and feel unproductive for the individual filing the grievance.

HHS also maintained the provision that only entities with 15 or more employees have to designate an employee to ensure compliance.⁴⁷ It declined to extend the requirement to smaller entities saying the costs likely outweigh the benefits. But it does note that nothing prohibits a smaller entity from designating an employee to coordinate compliance with § 1557 and from adopting and implementing a grievance procedure.

Notice Requirement, § 92.8

Each covered entity must take initial and continuing steps to notify beneficiaries, enrollees, applicants and members of the public of factors including: the covered entity does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities; the covered entity provides appropriate auxiliary aids and services (including qualified interpreters and information in alternate formats); the covered entity provides language assistance services (including translated documents and oral interpretation); how to obtain the auxiliary aids and services, materials in other formats, translated materials and interpreters; the contact information for a responsible employee (only for entities with 15 or more employees); the availability of a grievance procedure and how to file a grievance; and how to file a discrimination complaint with OCR.⁴⁸

Covered entities must post a notice including this information. The proposed rule required including taglines on the notice in the top 15 languages *nationwide*. We are pleased that HHS responded to comments suggesting that a covered entity be required to, at a minimum, use the top 15 languages *statewide*.⁴⁹ HHS recognized that a state-based approach is more attuned to the diversity of languages, provides more notice to LEP individuals, and harmonizes with requirements for taglines in the marketplaces and for Qualified Health Plans (QHPs).⁵⁰ HHS has provided a model notice and will provide translated taglines for covered entities.

The notice must also be posted in “significant publications and significant communications” targeted to beneficiaries, enrollees, applicants and members of the public. The final rule clarifies that “significant communications and significant publications” includes vital documents (as listed in the HHS Guidance) but is not the same. It distinguishes that translation of vital documents addresses how an entity can meet its Title VI requirements per the HHS LEP Guidance. The § 1557 rule’s use of

⁴⁷ *Id.* at 70-2.

⁴⁸ 42 C.F.R. § 92.8(a).

⁴⁹ Section 1557 Final Rule at 88.

⁵⁰ *Id.* at 88-89.

“significant communications and significant publications” refers to documents in which covered entities are required to post the notice of individuals’ rights and taglines. The notice is not required in small-sized communications such as postcards and tri-fold brochures.

Unfortunately, HHS also declined to adopt standards for translating written documents into threshold languages.⁵¹ NHeLP recommended including the “safe harbor” thresholds from the HHS LEP Guidance as standards for § 1557 compliance but HHS noted that due to the large variety of organizations subject to this rule, it would not establish uniform standards.

In response to comments, HHS clarified that § 1557’s prohibition of discrimination does reach intersectional discrimination. For example, discrimination against an African-American woman could be discrimination on the basis of both race and sex.⁵² Consistent with interpretation of other civil rights laws, the final rule also prohibits all forms of unlawful harassment based on a protected characteristic.⁵³

Discrimination Prohibited, § 92.101

The final rule specifies that an individual shall not, on the basis of race, color, national origin, sex, age or disability be excluded from participation in, or denied the benefits of, or otherwise be subjected to discrimination under any health program or activity to which the final rule applies.⁵⁴ The other provisions in this section provide additional details of implementation and application. For example, an entity may operate a sex-specific program or activity if an exceedingly persuasive justification exists that the sex-specific health program or activity is substantially related to the achievement of an important health-related or scientific objective.

The final rule also requires that covered entities must provide auxiliary aids and services to all individuals who need them, including those with impaired sensory, manual or speaking skills. The rule changed the application of this provision to all covered entities, regardless of size. This is an important clarification since an HHS notice issued in 2000 required recipients with fewer than 15 employees to provide auxiliary aids but some court decisions had questioned whether the notice was binding on entities.⁵⁵ The preamble also reiterates longstanding bans on unnecessary segregation of individuals with disabilities and that services for individuals with disabilities must be provide in the most

⁵¹ *Id.* at 97.

⁵² *Id.* at 110.

⁵³ *Id.*

⁵⁴ 45 C.F.R. § 92.101(a).

⁵⁵ Section 1557 Final Rule at 113-4.

integrated setting appropriate to their needs (unless doing so is a fundamental alteration of the entity's service delivery system).⁵⁶

Regarding sex discrimination, some comments referred to the limited applicability of Title IX, designed for the education realm, and that Title IX does not encompass the full range of activities prohibited under § 1557 as sex discrimination. HHS revised the final regulation to incorporate additional language to help clarify the full breadth of discriminatory actions that can constitute sex discrimination under § 1557.⁵⁷ Further, HHS adopted the constitutional standard established by the Supreme Court to apply when evaluating the lawfulness of sex-specific health programs or activities.⁵⁸ Thus, a sex-based classification would be unlawful unless the covered entity can show an exceedingly persuasive justification for it, that is, that the sex-based classification is substantially related to the achievement of an important health-related or scientific objective.⁵⁹

Meaningful Access for Individuals with Limited English Proficiency, § 92.201

In general, this section requires a covered entity to take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered.

HHS proposed to codify standards described in the Department's LEP Guidance regarding qualified interpreters for individuals with limited English proficiency and the use of family members or friends as interpreters or to facilitate communication.⁶⁰ Having these provisions officially in regulations helps ensure their longevity.

Regarding the scope of language services an entity must provide, the final rule replaced the phrase "that it serves or encounters" with "eligible to be served or likely to be encountered."⁶¹ This mirrors the HHS guidance and recognizes the importance of an entity not just of serving those who come through its doors but having a responsibility to serve those eligible to be served. That is, if a lack of language services means no LEP individuals attempt to get services from the entity, the entity likely could be in violation of § 1557 if LEP individuals are eligible to be served by the entity.

⁵⁶ *Id.* at 115-6.

⁵⁷ *Id.* at 119-120.

⁵⁸ *Id.* at 120, *see United States v. Virginia*, 518 U.S. 515 (1996).

⁵⁹ *Id.* at 121.

⁶⁰ *Id.* at 128.

⁶¹ *Id.* at 133.

In response to comments about the cost of providing language services, HHS notes that states can use Medicaid and Children’s Health Insurance Program (CHIP) funds to help providers pay for the costs of language services.⁶² It also mentions that QHPs must have a quality improvement strategy that is eligible for increased reimbursement or other incentives for implementing activities that reduce health and health care disparities.⁶³ And the final Medicaid managed care rule released earlier this month requires covered entities to have a quality improvement plan that reduces disparities.⁶⁴

Language services must be provided free of charge, be accurate and timely, and protect the privacy and independence of the individual with limited English proficiency.⁶⁵

The final rule also requires HHS to consider if an entity has developed and implemented an effective written language access plan. A language access plan has been recognized as an “essential tool” to ensure adequate and timely provision of language services.⁶⁶ The rule does not require entities to develop a language access plan but encourages entities to engage in advance planning to facilitate meeting the obligations of this provision.

In the proposed rule, HHS listed one overriding factor to consider in evaluating compliance – the nature and importance of the health program or activity, including the particular communication at issue, to the individual with limited English proficiency. In addition, the proposed rule listed five additional factors to consider if a covered entity complies with § 1557.⁶⁷ The HHS LEP guidance has

⁶² *Id.* at 137. For more information on how states can pay for language services in Medicaid and CHIP, see NHeLP, Medicaid and SCHIP Reimbursement Models for Language Services (Dec. 2009), available at <http://www.healthlaw.org/issues/medicaid/medicaid-expansion-toolbox/2009-Language-Access-Update#.VzYlMuQoEsQ> (Note: since publication of this issue brief, NY initiated reimbursement for language services); and How Can States Get Medicaid and CHIP for Language Services (July 2009), available at <http://www.healthlaw.org/publications/how-can-states-get-medicare-and-chip-for-language-services#.VzYlqOQoEsQ>.

⁶³ *Id.* at 138.

⁶⁴ 42 C.F.R. § 438.340(b)(6).

⁶⁵ 45 C.F.R. § 92.201(d).

⁶⁶ Section 1557 Final Rule at 140-1.

⁶⁷ These five factors were: (1) The length and complexity of the communication involved; (2) The context in which the communication is taking place; (3) The prevalence of the language in which the individual communicates among those eligible to be served or likely to be encountered by the health program or activity; (4) All resources available to the covered entity; and (5) The cost of language assistance services. See U.S. Dep’t of Health & Human Servs., *Nondiscrimination in Health Programs and Activities, Proposed Rulemaking*, 80 Fed. Reg. 54,172, 54, 218 (Sept. 8, 2015), available at <https://www.regulations.gov/#!documentDetail;D=HHS-OCR-2015-0006-0001>.

utilized 4 factors since 2000.⁶⁸ In the final rule, HHS says it will evaluate and give substantial weight to the nature and importance of the health program or activity and the particular communication at issue to the LEP individual.⁶⁹ HHS will also take into account all other relevant factors such as whether the entity has developed and implemented an effective language access plan. While the regulation does not enumerate the additional factors, the preamble provides a list of factors including:

- length, complexity, and context of the communication;
- prevalence of the language in which the individual communicates among those eligible to be served or likely to be encountered by the health program or activity;
- the frequency with which a covered entity encounters the language in which the individual communicates;
- whether a covered entity has explored the individual's preference, if any, for a type of language assistance service;
- the cost of language assistance services and whether a covered entity has availed itself of cost-saving opportunities; and
- all resources available to the covered entity, including the entity's capacity to leverage resources among its partners or to use its negotiating power to lower the costs at which language services can be obtained.⁷⁰

HHS notes that, similar to the HHS LEP Guidance, costs and resources are necessarily intertwined and thus this principle also applies to § 1557.

HHS added requirements to the final rule to use qualified translators when translating written content.⁷¹ HHS also added a new provision restricting covered entities from relying on staff to interpret who do not meet the definition of "qualified bilingual/multilingual staff."⁷²

⁶⁸ These four factors are: (1) The number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee; (2) the frequency with which LEP individuals come in contact with the program; (3) the nature and importance of the program, activity, or service provided by the program to people's lives; and (4) the resources available to the grantee/recipient and costs. See U.S. Dep't of Health & Human Servs., *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*, 68 Fed. Reg. at 47,314 (Aug. 8, 2003), available at <http://www.gpo.gov/fdsys/pkg/FR-2003-08-08/pdf/03-20179.pdf>.

⁶⁹ Section 1557 Final Rule at 144.

⁷⁰ *Id.* at 145.

⁷¹ *Id.* at 149.

⁷² *Id.*

HHS finalizes the provision restricting the use of family members, friends and other informal interpreters to interpret except when the situation meets an applicable exception as described in the final rule.⁷³ Thus, an individual may not be required to provide his own interpreter and an adult accompanying an individual may not be relied on to interpret except in an emergency or when requested by the individual. Minors may also not be relied on to interpret except in emergency situations.⁷⁴

HHS also adopted performance standards for the use of video remote interpreting services to ensure comprehensible communication.⁷⁵ The standards are meant to achieve parity with the regulation in the disability rights context.

NHeLP and many others requested HHS include standards for translating documents in the final rule, incorporating the “safe harbor” provisions from the HHS LEP Guidance. HHS declined to do so. It stated that while standards may improve access for some national origin populations, the approach does not comprehensively effectuate § 1557’s prohibition of national origin discrimination. Setting thresholds would be both under-inclusive and over-inclusive, given the diverse range, type, and sizes of entities covered by § 1557 and the diverse national origin populations within the service areas of entities’ respective health programs and activities. This is in part due to the fact that these regulations govern a widely diverse array of covered entities rather than other HHS regulations which set thresholds that address entities of a more uniform size/type (e.g. marketplace regulations governing QHPs).⁷⁶

Effective Communication for Individuals with Disabilities, § 92.202

This section outlines the steps a covered entity must take to ensure that communications with individuals with disabilities are as effective as communications with others in health programs and activities.⁷⁷

The final rule added a new subsection to clarify that covered entities, regardless of the number of people they employ, are required to “provide appropriate auxiliary aids and services to persons with impaired sensory, manual, or speaking skills” if needed to have equal opportunity to benefit from the service.⁷⁸ This addition recognizes a broader understanding of the communication needs of people

⁷³ *Id.* at 151.

⁷⁴ *Id.* at 349-50.

⁷⁵ *Id.* at 153.

⁷⁶ *Id.* at 157.

⁷⁷ 45 C.F.R. § 92.202, citing 28 C.F.R. § 35.160-.164.

⁷⁸ 45 C.F.R. § 92.202(b).

with disabilities and that effective communication is not just about interpreters, sound amplification, and speech devices, but also considers other barriers.

Although commenters tried to change HHS' use of Title II of the ADAAA, HHS maintained that recipients of Federal financial assistance should be held to the higher Title II standards, including giving primary consideration to the choice of an aid or service requested by the individual with a disability. Also, by incorporation provisions of the ADA, the rules incorporate the restrictions in the ADA on the use of certain persons to interpret. Those restrictions are similar to the ones in the 1557 rules regarding restrictions on the use of certain persons to interpret for individuals with limited English proficiency. While HHS declined to incorporate the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards), it stated those standards provide valuable guidance to covered entities and encouraged their adoption.⁷⁹

Accessibility Standards for Buildings and Facilities, § 92.203

In the preamble, HHS recognized that most entities are already subject to the 2010 ADA Standards for Accessible Design (2010 Standards).⁸⁰ NHeLP recommended that the effective date of these accessibility provisions not be delayed because most entities should already meet the cited standards. The changes to the final rule reflect an expectation of such compliance, although entities that were not previously covered have 18 months to comply with respect to new construction and or alterations. In response to advocate's comments that the Uniform Federal Accessibility Standards (UFAS) was not a good standard for accessibility as it allowed considerable barriers to people with disabilities, HHS removed UFAS from the list of deemed compliance and only allow a facility to use UFAS if it was not covered by the 1991 or 2010 Standards.

Unfortunately for universal accessibility, HHS indicated that the § 1557 building accessibility requirements do not apply to facilities or parts of facilities that are visited only by employees of the covered entity, except as provided in § 92.208. However, these spaces would still be covered by the ADA and § 504 for employees of the covered entity. Similarly, HHS cited existing requirements under the ADA and § 504 regarding accessibility in declining to directly address accessibility for medical equipment, despite comments from advocates like NHeLP that waiting on the United States Access Board regulations for such equipment is too late.⁸¹ We hope that in the planned training materials to

⁷⁹ Section 1557 Final Rule at 165-66. For more on the CLAS Standards issued by the HHS Office of Minority Health, <https://www.thinkculturalhealth.hhs.gov/content/clas.asp>.

⁸⁰ See 28 C.F.R. § 35.104.

⁸¹ The U.S. Access Board is a federal agency that promotes equality for people with disabilities. See <https://www.access-board.gov/>.

be developed regarding accessibility for individuals with disabilities, HHS will provide stronger guidance about accessibility and accessible equipment.⁸²

Accessibility of Electronic and Information Technology, § 92.204

Similar to the accessibility requirements under § 92.203, the accessibility of electronic and information technology only applies to that which is used by consumers or other program beneficiaries and not to electronic and IT used only by employees of a covered entity and that does not affect or impact customers or beneficiaries, except as in § 92.208. NHeLP recommended the accessibility of all electronic and information technology not only to ensure individuals could access information and other electronic features independently and privately, but because such an approach would also improve access for potential employees with disabilities of these covered entities. Such inclusion of healthcare providers would likely benefit more than just potential providers by creating a more inclusive system. While not all electronic and information technology of a covered entity may be required to be accessible, HHS was clear in the preamble that the requirements of the rule are not just limited to the provision of health services, but it also includes activities such as online appointment systems, electronic billing, and comparison of health plans offered by the marketplace. NHeLP was very supportive in its comments that this provision should apply to more than just web access. The preamble also recognized the importance of confidentiality of health information when considering accessibility and that an entity's electronic and information technology must be functional for an individual with a disability to have equal access to the entity's programs and activities.⁸³

Importantly, HHS declined to delay compliance on this accessibility. NHeLP strongly opposed delaying compliance. Although HHS did not adopt specific accessibility standards, it did point out in the preamble that it would be difficult for an entity to be accessible without adherence to such standards. The preamble to the final rules did not mention changes to the approach set forth in the preamble to the proposed rules that an examination of an entities fundamental alteration defense considers the resources available to the entity as a whole, not just the technology department.

⁸² Section 1557 Final Rule at 173.

⁸³ *Id.* at 186.

Nondiscrimination in Health-Related Insurance and Other Health-Related Coverage, § 92.207

This provision prohibits providing or administering health-related insurance and other health-related coverage that discriminates on the basis of race, color, national origin, sex, age or disability.⁸⁴ This includes:

- denying, canceling, limiting or refusing to issue or renew a health-related insurance plan/policy or other health-related coverage;
- denying or limiting coverage of a claim or imposing additional cost-sharing or other limitations or restrictions on coverage; and
- having or implementing marketing practices or benefit designs.

The final rule retains language unchanged from the proposed rule which expressly prohibits discriminatory benefit designs or marketing practices.⁸⁵ NHeLP first identified discriminatory benefit design in its 2014 OCR complaint (with The AIDS Institute) against four Florida health plans that placed all HIV medications, including generics, in the highest tier.⁸⁶ This practice, named “adverse tiering” by researchers at the Harvard School of Public Health, discourages people with significant health needs from enrolling in the plan.⁸⁷

NHeLP and other health advocates urged HHS to define “benefit design” and “marketing practices” and provide further explanation on what constitutes discriminatory practices.⁸⁸

Benefit Design

NHeLP identified several areas where issuers have employed discriminatory practices in benefit design, including:

- adverse tiering in prescription drug formularies;
- narrow provider networks that exclude specialists for specific health conditions;

⁸⁴ 45 C.F.R. § 92.207(a).

⁸⁵ 45 C.F.R. § 92.207(b)(2).

⁸⁶ For more information on NHeLP’s complaint, see *NHeLP and The AIDS Institute File HIV/AIDS Discrimination Complaint Against Florida Health Insurers*, available at <http://www.healthlaw.org/news/press-releases/224-nhelp-and-the-aids-institute-file-hiv-aids-discrimin>.

⁸⁷ Douglas B. Jacobs, ScB, and Benjamin D. Sommers, MD, PhD, *Using Drugs to Discriminate — Adverse Selection in the Insurance Marketplace*, *N Engl J Med* 2015; 372:399-402 (Jan. 29, 2015)

⁸⁸ See NHeLP Comments, *supra* note 25, at 86-89.

- arbitrary or unreasonable utilization management (e.g., prior authorization, step therapy, age or quantity limits on treatment); and
- coercive wellness programs that prevent participation by persons with disabilities.

However, HHS declined to establish a definition for either benefit design or marketing, saying to do so would be “overly prescriptive.”⁸⁹ In the preamble, HHS states it will consider benefit design on a case-by-case basis.⁹⁰

HHS cites to the discussions on potentially discriminatory benefit designs appearing in the 2016 and 2017 Letters to Issuers, as well as the Benefit and Payment Parameters rules.⁹¹ These include placing all medications used to treat a certain condition on the highest cost sharing tiers, applying age limits to services that have been found clinically effective at all ages, and requiring prior authorization and/or step therapy for most or all medications in drug classes regardless of medical evidence.⁹²

HHS repeated its comment from the proposed rule that § 1557 does not require plans to provide a particular procedure or treatment; nor does the final rule prevent covered entities from “utilizing reasonable medical management techniques.”⁹³ However, HHS acknowledges that that adding coverage of a benefit or service could be the solution to a potentially discriminatory benefit design.⁹⁴ HHS further states that “we do not affirmatively require covered entities to cover any particular treatment, as long as the basis for exclusion is evidence-based and nondiscriminatory.”⁹⁵

⁸⁹ Section 1557 Final Rule at 209, 210.

⁹⁰ *Id.* at 210.

⁹¹ *Id.*, see footnote 258, citing to U.S. Dep’t of Health & Human Servs., *Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters Rule (Final Rule)*, 80 Fed. Reg. 10750, 10822 (Feb. 27, 2015); U.S. Dep’t of Health & Human Servs., *Final 2016 Letter to Issuers in the Federally Facilitated Marketplace*, 37 (Feb. 20, 2015) available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf>; U.S. Dep’t of Health & Human Servs., *Final 2017 Letter to Issuers in the Federally Facilitated Marketplace*, 45-48 (Feb. 29, 2016) available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers-2-29-16.pdf>.

⁹² *Id.*

⁹³ *Id.* at 210, 212.

⁹⁴ *Id.* at 212.

⁹⁵ *Id.* at 215.

Evaluating discriminatory benefit design

HHS describes factors it will consider when evaluating whether a prohibited discriminatory action occurred under § 92.207(b) as follows:

- whether a covered entity utilized, in a nondiscriminatory manner, a neutral rule or principle when deciding to adopt the design feature or take the challenged action;
- whether the reason for its coverage decision is a pretext for discrimination;
- whether coverage for the same or a similar service or treatment is available to individuals outside of that protected class or those with different health conditions; and
- by evaluating the reasons for any differences in coverage.⁹⁶

Provider access

HHS also rejected the contention that lack of access to specialists could be a form of discriminatory plan benefit design under § 1557. In comments, NHeLP cited to a study published in the *Journal of the American Medical Association* which examined specialty provider access in 135 plans sold on HealthCare.gov across 34 states.⁹⁷ The specialists included those sought by individuals with common chronic medical conditions or those with high health needs, including in-network specialist physicians in obstetrics and gynecology, dermatology, cardiology, psychiatry, oncology, neurology, endocrinology, rheumatology, and pulmonology. Researchers found that 15% of those plans lacked in-network physicians for at least one specialty.

Narrow provider networks may also discriminate against other protected classes. Failure to provide access to child psychiatrists, for example, may constitute discrimination based upon age. However, in the final rule, HHS declared that that “is beyond the scope of this regulation to establish uniform or minimum network adequacy.”⁹⁸

Marketing practices

Although declining to define marketing practices in the regulatory text, the preamble describes marketing activities as “any activity of a covered entity that is designed to encourage individuals to participate or enroll in the covered entity’s programs or services or to discourage them from doing so,

⁹⁶ *Id.* at 207.

⁹⁷ Stephen C. Dorner, MSc, Douglas B. Jacobs, ScB, and Benjamin D. Sommers, MD, PhD, *Adequacy of Outpatient Specialty Care Access in Marketplace Plans Under the Affordable Care Act*, *JAMA*, 2015;314(16):1749-1750 (Oct. 27, 2015).

⁹⁸ Section 1557 Final Rule at 200.

and activities that steer or attempt to steer individuals towards or away from a particular plan or certain types of plans.”⁹⁹

HHS also confirmed that targeted outreach and marketing strategies focusing on uninsured or underserved populations is consistent with the goals of the ACA and would not run afoul of § 1557.¹⁰⁰

Enforcement of benefit design and marketing

HHS states that determining whether a particular benefit design results in discrimination will be a fact-specific inquiry that OCR will conduct through its enforcement of § 1557.¹⁰¹ In comments, NHeLP and other health advocates urged HHS to clarify how OCR will coordinate with other federal and state agencies to monitor compliance and enforce § 1557 protections, noting that states and the HHS Center for Consumer Information and Insurance Oversight (CCIIO) are responsible for plan certification and compliance monitoring. HHS confirms that:

OCR is responsible for enforcement with respect to benefit design issues under Section 1557. States have an important role in ensuring compliance with nondiscrimination requirements respecting insurance, including benefit design, under CMS regulations and applicable State laws.¹⁰²

HHS also rejected suggestions from insurers and others that it provide “good faith compliance” for § 1557 and also rejected calls to delay its applicability and enforcement, noting that the provision has been in force since the ACA was signed in 2010.¹⁰³

Protections for Transgender Individuals

This section also addresses coverage of services for transgender individuals which NHeLP fully supports and commented on. The rule prohibits denying or limiting coverage or a claim or imposing additional cost-sharing or other limitations or restrictions for any health services that are ordinarily or exclusively available to individuals of one sex to a transgender individual based on the fact that the individual’s sex assigned at birth, gender identity or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available.¹⁰⁴ Further, the rule prohibits having or implementing a categorical coverage exclusion or limitation for all services related to gender

⁹⁹ *Id.* at 208.

¹⁰⁰ *Id.*

¹⁰¹ *Id.* at 210.

¹⁰² *Id.* at 234.

¹⁰³ *Id.* at 197.

¹⁰⁴ 45 C.F.R. § 92.207(b)(3).

transition; and otherwise denying or limiting coverage or coverage of a claim or imposing additional cost-sharing or other limitation or restrictions on coverage for specific health services related to gender transition if the denial, limitation or restriction results in discrimination against a transgender individual.¹⁰⁵

The provision was finalized with mostly technical revisions for clarity. One change clarifies that the final rule broadly prohibits having or implementing a categorical exclusion or limitation of coverage.¹⁰⁶ The change was to clarify HHS' intent as prohibiting categorical exclusions or limitations in both benefit design and administration.

Nondiscrimination on the Basis of Association, § 92.209

This provision protects individuals from discrimination based on relationship or association. The final rule included a text change that altered the order, not the substance of the section. In the preamble, HHS stated that "individual or entity" includes providers, which should protect providers from adverse treatment based on providing services to a protected class of beneficiaries.¹⁰⁷ For example, as HHS noted in the preamble, a health plan could not exclude an otherwise eligible provider from its network because the provider's patient population is primarily LEP.¹⁰⁸ That exclusion would discriminate against the provider based on the provider's association with a national origin group.

HHS also said it believes the text as it is includes deterrence in the word "exclude" as such interpretation is long recognized in civil rights law. HHS also said it plans to interpret the language in this section consistent with the interpretation of the term "on the basis of sex" as described in § 92.4. NHeLP strongly supported this section in the proposed rule and is pleased to see no changes were made and HHS provided strong interpretations in the preamble.

Enforcement Mechanisms, §§ 92.301-92.302

The final regulations verify the administrative and judicial remedies that are available to address discrimination under section 1557.

Most notably, the regulations verify the private cause of action established by § 1557. Thus, HHS clarifies that § 1557 authorizes an express private right of action for an individual to go to court on claims of discrimination—either disparate impact discrimination or intentional discrimination—on the

¹⁰⁵ 45 C.F.R. § 92.207(b)(4), (5).

¹⁰⁶ Section 1557 Final Rule at 221.

¹⁰⁷ *Id.* at 228-29.

¹⁰⁸ *Id.* at 229.

basis of *any* of the criteria covered by the statute: race, color, national origin, sex, disability, or age.¹⁰⁹ A newly added provision makes it clear that compensatory damages are available for violations.¹¹⁰

The regulations also describe the administrative enforcement procedures that HHS will follow for health programs and activities conducted by federal fund recipients and State-based Marketplaces (§ 92.302) and by the Department of Health and Human Services (§ 92.303). Allowing for consistency with existing enforcement mechanisms, the regulations incorporate the existing procedures for processing of administrative complaints. In other words, HHS will use its current administrative complaint processes to address age discrimination on the one hand and race, color, national origin, sex, or disability on the other hand. However, HHS makes explicit that this approach to administrative complaints and investigations “is not intended to limit the availability of judicial enforcement mechanisms.”¹¹¹

Thus, the final regulation provides clear verification that § 1557 provides an injured party with the ability to go to court to challenge actions that have a disparate impact on the basis of race, color, national origin, sex, disability, or age. This should help ameliorate the access-to-court barriers that resulted from the Supreme Court’s holding in *Alexander v. Sandoval* that individuals do not have a private right of action for disparate impact litigation under Title VI of the Civil Rights Act of 1964 (prohibiting discrimination on the basis of race, color, or national origin).¹¹² The enforcement regulations do not provide specifics on what a plaintiff must prove to establish a claim of disparate impact discrimination; however, other parts of the regulations provide detailed guidance as to the policies and practices that health care entities need to undertake to comply with § 1557.

Finally, HHS rejected recommendations from insurers and others requiring complainants to exhaust internal grievance procedures or mediation before pursuing the private right to action.¹¹³ Instead, HHS acknowledges that exhaustion of administrative remedies will be required for age discrimination allegations in complaints, but not for allegations of other covered types of discrimination.¹¹⁴

¹⁰⁹ *Id.* at 231-32 (citing *Rumble v. Fairview Health Services*, No. 14-CV-2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015)).

¹¹⁰ 45 C.F.R. § 92.301(b).

¹¹¹ Section 1557 Final Rule at 232.

¹¹² 532 U.S. 275 (2001).

¹¹³ Section 1557 Final Rule at 238.

¹¹⁴ *Id.*

Appendices

The final rule includes three appendices:

- Appendix A – Sample Notice Informing Individuals about Nondiscrimination and Accessibility Requirements and Sample Nondiscrimination Statement: Discrimination is Against the Law;¹¹⁵
- Appendix B – Sample Tagline Informing Individuals with Limited English Proficiency of Language Assistance Services;¹¹⁶ and
- Appendix C – Sample Section 1557 of the Affordable Care Act Grievance Procedure.¹¹⁷

Conclusion

The full text of the final rule is available [here](#) and is expected to be published in the Federal Register on May 18. For more information, contact Mara Youdelman, Youdelman@healthlaw.org.

¹¹⁵ *Id.* at 358.

¹¹⁶ *Id.* at 360.

¹¹⁷ *Id.*