# Section 1557: Removing the Gender Divide in Employer Medical Plans

*Written by: Jennifer M. McCormick*

The fourth quarter is exciting. Not only do we have the holidays to look forward to, but we have so many opportunities and ideas to contemplate for the upcoming plan year. Generally, over the course of the year we see regulations take effect and guidance clarified, and even learn some new cost containment techniques. Unfortunately, this does not always mean that we know exactly what must be revised in our health plan documents for the upcoming plan year in order to ensure we fully implement these compliance updates and cost savings. To complicate matters, we're on the edge of our seats to see whether (and how) the recent presidential election could further disrupt the Affordable Care Act (ACA).

This is particularly true for some employer groups who are questioning what (if anything) they must modify in their health plan to comply with the ACA non-discrimination rule. In order to alleviate any heartburn this specific aspect of ACA may cause for the upcoming renewal season, let's try and break down what Section 1557 really means for plan sponsors.

### What Is Section 1557?

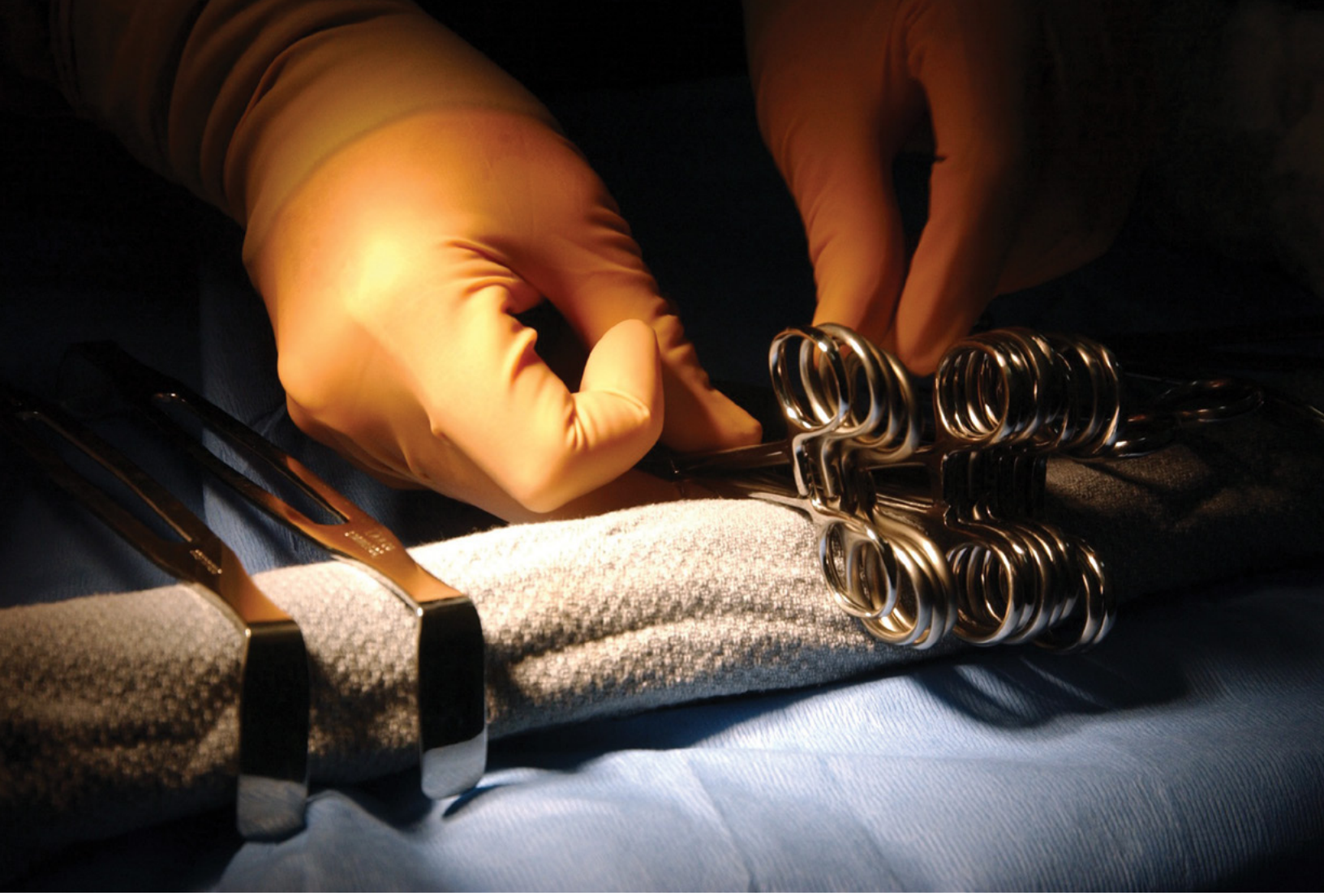
Section 1557 prohibits discrimination in certain health programs and activities on the basis of race, color, national origin, sex, age, or disability. It's not news that discrimination against an individual on the basis of race, color, national origin or disability is prohibited – but – Section 1557's expansion of these protected classes to now include discrimination on the basis of sex, is. As with other new regulations, the issued guidance leaves us with a lack of clarity and many unanswered questions; however, despite confusion and uncertainty, employers are still required to review and potentially revise internal processes and documents.

This article focuses on the new classification of "sex" and the new corresponding considerations for plan sponsors. For instance, if Section 1557 is applicable to an employer's health plan, that plan cannot discriminate based on gender identity, meaning it cannot deny coverage based on an individual's sex or gender identity (i.e. an individual's internal sense of gender, which may be male, female, neither or a combination).

Prior to making any Section 1557 related updates, however, it is important to understand what is required, and of whom. For example: (1) who must comply with Section 1557; (2) what does Section 1557 exactly require; (3) are there exceptions; and (4) what must change?

### Who Must Comply?

When more closely examined, the scope of Section 1557 is not particularly vast as it is only applicable to particular covered entities. For the purpose of this rule, a covered entity is an entity that operates a health program or activity, any part of which receives Federal financial assistance. Specifically, covered entities include all health programs and activities, any part of which receive federal assistance from HHS, health programs and activities administered by HHS (including the Federal Marketplace), and health programs and activities administered by entities under Title I of the ACA (including State Marketplaces).



This generally means that an entity that receives a grant, loan, or subsidy or has another arrangement whether the federal government provides funds, services of federal personnel or property (real or personal) is subject to the Section 1557.

Entities likely subject to Section 1557 include those involved in the administration of health care. For example, health insurance issuers, hospitals, health clinics, physicians' practices, pharmacies, nursing homes, dialysis facilities, community health centers, providers that accept Medicare, and issuers on the Marketplace are generally subject to Section 1557.

Once applicability of Section 1557 is confirmed, the entity must next make compliance related changes. Ensuring compliance is difficult, particularly since the text of Section 1557 describes what must not be done, instead of what must be done.

## What's Required?

According to the rule, an entity subject to Section 1557 must not: (1) deny, cancel, limit or refuse to issue health coverage based on sex; (2) deny or limit a claim; (3) impose additional cost sharing; or (4) employ discriminatory marketing or benefit design. Specifically, this means a health plan must not deny or limit treatment for any health care that is ordinarily or exclusively available to individuals of one gender based on the fact that the person seeking services identifies as belonging to another or different gender.

While effective as of July 18, 2016, if Section 1557 requires changes to a health plan, the rule does not become effective for the health plan until the first day of the first plan year beginning on or after January 1, 2017.

Changes to a health plan will be necessary if the plan design denies coverage based on gender identity, denies treatment or access to facilities for sex-specific ailments, categorically excludes services related to gender transition or excludes transition related treatment as experimental or cosmetic. As a result, health plan documents must be carefully reviewed and any relevant exclusionary language timely removed.

Additionally, entities subject to Section 1557 must comply with certain notice and tagline requirements. Unlike the health plan changes, these notice requirements took effect 90 days after the July 18, 2016 effective date.

One of the requirements is that notice be placed in significant publications and significant communications targeted to beneficiaries, enrollees, applicants, and members of the public. While the term 'significant publications and significant communications' has not been explicitly defined, the agencies suggested they will interpret this term broadly and it will not be limited to those publications or communications intended for a broad audience, but could also include those directed at individuals. As a result, it will be important for employers to review their communications to ensure compliance with the notice requirements.

Section 1557 outlines what must not be done with respect to benefits and requires that notices be included in certain materials, and hints at potential exceptions to these requirements.

### Are There Any Exceptions?

This rule does not include an exception, unlike other ACA requirements which allow for certain exemptions and accommodations (i.e. the contraceptive piece of the preventive care requirement).

The rule, however, does state that certain protections already exist and Section 1557 would not displace regulations issued under the ACA related to preventive health services. Further, HHS did note that application of any requirement under Section 1557 which would violate applicable federal statutory protections for religious freedom and conscience is not required. Cases in multiple jurisdictions are currently underway and we expect to see additional guidance on this issue as a result of the litigation.

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Additionally, a third party administrator (TPA) subject to Section 1557 does not render a plan for which it administers benefits automatically subject to Section 1557 (and vice versa). A TPA will only be liable for Section 1557 non-compliance if their own actions are discriminatory.

As it relates to the notice requirement, the preamble to Section 1557 did note that entities subject to the rule may exhaust their current supplies of significant publications and communications prior to incorporating the required notice.

## What Must Change?

Guidance implies that Section 1557 will be interpreted broadly so entities must first decide if they are subject to the rule.

If subject to the rule, the health plan should be reviewed for compliance. Note that the rule does not explicitly require coverage of any particular service (either surgical or non-surgical) to treat gender dysphoria, gender identity disorder, or any individual that is transitioning genders, exclusions or coverage limitations related to sex, gender dsyphoria or sexual orientation must be removed. However, if a plan has an exclusion for sex change surgery for individuals diagnosed with gender dysphoria, it should be removed or modified.

Further, the rule does not require a plan to cover health care that is based on gender when the care is not deemed to be medically necessary (e.g. prostate exam for a woman that identifies as a transgender male). Additionally, a plan may use reasonable medical management to apply neutral, non-discriminatory standards (as long as it resulted from "a neutral rule or principle" when adopted and the reason for its coverage decision was not a pretext for discrimination).

If not subject to Section 1557, the health plan is not required to make benefit changes. The entity, however, should evaluate their risk tolerance as there is still the potential for the U.S. Equal Employment Opportunity Commission (EEOC) to investigate complaints of discrimination by the employer. Cases regarding plan exclusions of sex reassignment surgery are currently pending in the courts. Further, this should be a significant consideration after a federal court ruled on November 7, 2016 to deny a motion to dismiss a sex discrimination case that the EEOC had filed. Specifically, the EEOC's motion explained that sexual orientation discrimination was a form of prohibited sex discrimination.

Even if an entity has a high tolerance for risk (or is not concerned about potential employment discrimination), consider other reasons for complying with Section 1557, including the impact on potential claims. According to a June 2016 study from the Williams Institute, there are an estimated 1.4 million adults who identify as transgender in the United States, or 0.6 % of the population. Many entities are opting to cover these benefits and coverage could be seen as a competitive advantage or good public relations.

## Summary

Since the final rules were issued, insurers and other industry entities are taking a position on how to address Section 1557. Insurers are directly subject to 1557 and fully insured plans taking a conservative approach are being modified to include surgical and non-surgical treatment for gender dysphoria.

Employers subject to Section 1557, and those not subject but who wish to avoid EEOC scrutiny, should remove any exclusions from health plans which could be viewed as categorical exclusions of transgender services. The decision to cover or exclude transgender benefits, however, ultimately depends on the risk adversity of the employer. As a result, every employer and plan sponsor must review their situation on a case by case basis for Section 1557 applicability and modify relevant materials accordingly.

Of course all of this could become irrelevant if the ACA is repealed or replaced, so I guess we'll have to wait and see… ■

*Jennifer M. McCormick joined The Phia Group, LLC as corporate counsel in 2008. She is admitted to the Bar of the Commonwealth of Massachusetts. As an attorney with The Phia Group, Attorney McCormick concentrates on a variety of healthcare and regulatory issues facing employee benefit plans and their administration. In addition, she focuses on health plan document design and drafting matters affecting employers, third party administrators, stop loss carriers, and health carriers.*