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HHS Issues Final Rule on ACA Nondiscrimination Provisions (Section 1557)

On May 18, 2016, the Office of Civil Rights ("OCR") at the U.S. Department of Health and Human Services ("HHS") published a final rule implementing section 1557 of the Patient Protection and Affordable Care Act ("ACA"). 81 Fed. Reg. 31376. This rule prohibits discrimination on the basis of race, color, national origin, sex, age, or disability, for any health program or activity, any part of which receives federal funding or assistance, or under any program or activity that is administered by an executive agency or any program or activity administered by an entity established by title I of the ACA.

The final rule is of critical importance to health insurance issuers, health care providers (including pharmacies and health clinics), and some group health plans.

As was the case with the proposed rule, the scope of the final rule is quite expansive. For an entity principally engaged in providing or administering health services or health insurance coverage or other health coverage, all of its operations are considered part of the health program or activity (with limited exceptions, as noted below) and are subject to the final rule's requirements if any part of the health program or activity receives federal financial assistance. Further, as discussed in greater detail below, while HHS limited the scope of the final rule as it relates to employer liability for self-funded plans that are not receiving federal financial assistance, self-funded plans that utilize health insurance issuers as third-party administrators ("TPAs") may nonetheless be affected.

Critical issues or changes from the proposed rule:

- While the rule is generally effective July 18, 2016 (60 days after publication in the *Federal Register*), if provisions of the rule require changes to health insurance or group health plan benefit design (*e.g.*, cost sharing, covered benefits, or benefit limitations or restrictions), the rule will be effective on the first day of the first plan year (in the individual market, policy year) beginning on or after January 1, 2017. In addition, the rule's notice requirements, specifically the posting of a nondiscrimination notice and statement and taglines are effective within 90 days of the effective date.

- For health insurance issuers receiving federal financial assistance (*e.g.*, by participating in the Marketplaces, Medicare Advantage, or Medicaid), the final rule applies these nondiscrimination provisions (*i.e.,* prohibiting discrimination under any health program or activity) to the issuer's entire operations, including with respect to its operations as a TPA or an administrative-services-only ("ASO") provider, with certain limited exceptions, such as (1) an entity's actions as an

employer for hiring, firing, promotions, and terms and conditions of employment other than health benefits; and (2) TPAs that are legally separate from the issuer based on a case-by-case inquiry by OCR.

- The final rule broadly prohibits discrimination on the basis of sex in health programs, including significant requirements related to transgender individuals and the treatment of gender dysphoria.

- The final rule modifies some of the proposed requirements for language assistance for individuals with limited English proficiency ("LEP") and accessibility and effective communication for individuals with disabilities.

- Finally, the final rule confirms a private right of action and clarifies the availability of compensatory damages for violations of these nondiscrimination provisions.

What Actions You Should Take

- **Health insurance issuers** should first determine whether they receive federal financial assistance from HHS (they most likely do, so any conclusion to the contrary should be carefully reviewed). An issuer that receives federal financial assistance should review 2017 benefit designs for nondiscrimination issues, and should consider how best to comply with the notice and language access requirements. Issuers that are related to TPAs should consider whether the TPA is "independent" and, if not, should take steps to ensure that benefits are administered in a nondiscriminatory manner.

- **Group health plans** should first determine whether they receive federal financial assistance from HHS. Plans that do receive federal financial assistance from HHS should also consider how best to comply with the notice and language access requirements and should ensure that benefits are administered in a nondiscriminatory manner.

- **Employers sponsoring group health plans** should first determine whether the employer receives federal financial assistance from HHS for any purpose. Employers should also ensure that benefit design decisions made by the employer in its role as a plan settlor are adequately and appropriately documented.

As always, any entity that may be subject to the rule should carefully review all of its requirements to ensure compliance. OCR confirms that covered entities are able to use reasonable medical management techniques and apply neutral, nondiscriminatory standards to health related coverage. Therefore, covered entities should document neutral, nondiscriminatory standards that are used in developing plan designs.

I. Background

ACA section 1557 provides that an individual shall not be excluded from participation in, be denied the benefits of, or be subjected to discrimination on the grounds prohibited under Title VI of the Civil Rights Act of 1964 (race, color, national origin), Title IX of the Education Amendments of 1972 (sex), the Age Discrimination Act of 1975 (age), or Section 504 of the Rehabilitation Act of 1973 (disability), under any health program or activity, any part of which is receiving federal financial assistance, or under any program or activity that is administered by an executive agency or any entity established under title I of the ACA or its amendments. On August 1, 2013, OCR published a Request for Information asking for comments on ACA section 1557.

On September 8, 2015, OCR published a proposed rule proposing to apply these nondiscrimination requirements to: (1) all health programs and activities, any part of which receives funding from HHS (with the exception of Medicare Part B payments); (2) health programs and activities administered by HHS, including the Federally-facilitated Marketplaces ("Federal Marketplaces"); and (3) health programs and activities administered by entities established under title I of the ACA, including State-based Marketplaces ("State Marketplaces"). For additional information about the proposed rule, please consult our September 11, 2015, client alert, available at: http://www.groom.com/media/publication/1624_HHS_Issues_Proposed_Rule_on_ACA_Section_1557_Nondiscrimination_Provisions.pdf.

II. Final Rule

OCR largely finalized the provisions contained in the proposed rule, but it did alter some of the proposed requirements regarding the effective date of the final rule, as well as regarding language accessibility. The final rule also provides additional detail about enforcement, administrative remedies, and applicability, specifically clarifying how the rule applies to employers of self-funded plans utilizing TPAs.

Effective Date

Section 1557 has been effective since the enactment of the ACA, and, since that time, OCR has been accepting and investigating discrimination complaints under section 1557. As a result, OCR indicated that it was generally unwilling to delay the effective date of the final rule.

The provisions of the final rule generally will be effective on July 18, 2016 (*i.e.*, 60 days after publication in the *Federal Register*), which is a very short time-frame for covered entities to become compliant. The final rule does, however, extend the effective date for benefit design changes: If provisions of the final rule require changes to health insurance or group health plan benefit design (*e.g.*, cost sharing or covered benefits), the rule is effective on the first day of the first plan year (in the individual market, policy year) beginning on or after January 1, 2017.

- While this finalized timing provides some relief for health insurance issuers and group health plans, for example, by allowing them additional time to make any necessary changes to their benefit design and cost-sharing structures, some health insurance issuers may have to make additional changes to the plans and policies already submitted for approval with the Marketplaces and state departments of insurance for the 2017 plan or policy year.

- Covered entities need to comply with the notice and tagline requirements within 90 days of the effective date; however, OCR is allowing entities to exhaust their current stock of publications, rather than do a special printing of the publications to include the new notice.

Key Definitions

Only health programs or activities that receive federal financial assistance are subject to the rule; therefore, the definitions of "health program or activity" and "federal financial assistance" are critical to appreciate the rule's breadth. Entities that are subject to the rule are "covered entities."

Health program or activity: Per the final rule, a "health program or activity" includes providing or administering health-related services or health-related insurance coverage (*e.g.*, the operations of health insurance issuers) and providing assistance in obtaining health-related services or health-related insurance coverage. OCR also added the Children's Health Insurance Program and the Basic Health Program as additional examples of a health program or activity.

- Critically, **all of the operations** of an entity principally engaged in providing or administering health services or health insurance coverage are considered "health programs or activities" for purposes of the final rule. This means that, for health insurance issuers that offer a single health plan that receives federal financial assistance (*e.g.*, a single product on an Exchange or Marketplace), all of the operations of the entity—including other health plans or products that do not receive federal financial assistance—are subject to the rule.

- The final rule also applies to the **third-party administrative services** of a covered entity that receives federal financial assistance. While the proposed rule was unclear regarding how the regulation would apply to a covered entity's TPA services, the final rule clarifies that section 1557's applicability to a TPA does not extend to the *coverage* terms of an employer's group health plan where administered by the TPA. See below for a discussion of how OCR intends to handle complaints related to TPAs.

- Although not a change from the proposed rule, but important for understanding the application/scope of the regulation, the final rule includes a group health plan as an example of a health program or activity "principally engaged in providing or administering health services."

Federal financial assistance: Only health programs or activities that receive federal financial assistance are subject to the rule. The rule generally finalizes the proposed definition of "federal financial assistance," to include any grant, loan, credit, subsidy, contract (other than procurement contracts), or any other arrangement where the federal government provides funds, services of federal personnel, or real or personal property. Federal financial assistance specifically includes federal premium and cost-sharing subsidies for individuals receiving coverage through the Marketplaces (whether federal or state-administered). The rule also clarifies that federal financial assistance from HHS includes federal financial assistance HHS plays a role in providing or administering, including all tax credits under title I of the ACA.

Although HHS limited the scope of its rule to **federal financial assistance administered by HHS**, 45 CFR § 92.1, in the preamble to the rule, HHS made clear that other executive agencies may propose rules under section 1557 that apply to federal financial assistance administered by that agency. We would expect some agencies to adopt rules similar to this rule, but we note that many federal agencies may not provide federal financial assistance to "health programs or activities," and, therefore, that financial assistance should not fall under section 1557's prohibitions. In the preamble, OCR provided that "expeditious implementation of section 1557 by other Departments is desirable," and its hope is that this final rule will "inform enforcement of section 1557 by other Departments with respect to their federally assisted health programs and activities."

Covered entity: As relevant to this summary, a "covered entity" is "an entity that operates a health program or activity, any part of which receives Federal financial assistance."

- This definition of covered entity would seem to include any federal financial assistance (not just assistance from HHS). However, as noted above, the regulation states it applies only to health program or activities administered by recipients of federal financial assistance from HHS.

Prohibited Discrimination

General rule: The final rule generally prohibits discrimination based on an individual's race, color, national origin, sex, age, or disability, so that an individual cannot be (1) excluded from participation in, (2) be denied the benefits of, or (3) otherwise be subject to discrimination under any health program or activity.

- As a practical matter, this means that health programs or activities must comply with HHS's preexisting rules implementing:
  - Title VI (*see* 45 CFR § 80.3(b)(1) through (6));
  - Title IX (*see* 45 CFR § 86.31(b)(1) through (8));
  - Section 504 of the Rehab Act (*see* 45 CFR §§84.4(b), 84.21 through 84.23(b), 84.31, 84.34, 84.37, 84.38, and 84.41 through 84.52(c) and 84.53 through 84.55); and
  - the Age Act (*see* 45 CFR § 91.11(b)).

- While OCR decided against including a **blanket religious exemption** in the final rule, the rule does provide that if applying the rule would "violate applicable Federal statutory protections for religious freedom and conscience, such application shall not be required." 45 CFR § 92.2(b)(2).

Rule as applied to health-related insurance and coverage: Under the rule, discriminatory actions specifically include – on the basis of an individual's race, color, national origin, sex, age, or disability:

- denying or limiting health coverage;
- denying a claim;
- employing discriminatory marketing or benefit designs; and
- imposing additional cost sharing.

Like the proposed rule, the final rule does not define benefit design, nor does it provide any specific examples of benefit designs that would be discriminatory. Rather, OCR will determine whether certain benefits designs are discriminatory on a fact-specific, case-by-case basis.[1]

- OCR confirmed that covered entities are able to use **reasonable medical management** techniques and apply **neutral, nondiscriminatory standards** to health-related coverage. Specifically, OCR will consider whether an entity used "a neutral rule or principle when deciding to adopt the design feature or take the challenged action or whether the reason for its coverage decision is pretext for discrimination." Therefore, documenting a neutral, nondiscriminatory standard may be critical to defending a benefit design against a section 1557 claim.

[1] OCR states that it is avoiding "characterizing specific benefit design practices as per se discriminatory" but notes that CMS has "identified benefit design features that might be discriminatory." 81 Fed. Reg. at 31434 & fn.258. Those design features include "placing most or all prescription medications that are used to treat a specific condition on the highest cost formulary 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 such as anti-HIV protease inhibitors, and/or immune suppressants regardless of medical evidence."

Sex Discrimination

The final rule does not provide much detail with respect to how benefit designs may discriminate on the basis of age, race, national origin or disability. However, the final rule does provide some detail on the prohibition of discrimination based on sex: specifically, discrimination on the basis of sex stereotyping and gender identity.

The prohibition of discrimination on the basis of sex includes sex discrimination related to an individual's sexual orientation where evidence establishes that the discrimination is based on gender stereotypes. Notably, OCR has declined to resolve whether discrimination on the basis of an individual's sexual orientation alone is a form of sex discrimination under section 1557.

Under OCR's rule (1) individuals cannot be denied health care or health coverage based on their sex, including their gender identity; (2) individuals must be treated consistent with their gender identity, including in access to facilities; (3) sex-specific health care cannot be denied or limited only because the person seeking such services identifies as belonging to another gender; and (4) explicit categorical exclusions in coverage for all health services related to gender transition are facially discriminatory.

- The rule does not explicitly require the coverage of any particular service to treat gender dysphoria, gender identity disorder, or an individual that is transitioning genders, and the rule allows plans to deny non-medically necessary services. However, the preamble to the proposed rule sends a clear signal that denying coverage of transition-related services on the basis of those services not being medically necessary will be subject to "careful scrutiny." 80 Fed. Reg. 54172, 54190 (Sept. 8, 2015). OCR has also suggested that blanket exclusions of transgender services as "cosmetic" or "experimental" are "outdated and not based on current standards of care." 80 Fed. Reg. at 54189.

Applicability/Scope

Section 1557 of the ACA applies to health programs and activities receiving federal financial assistance, health programs administered by an executive agency, and any health program or activity administered by an entity established by title I of the ACA. OCR declined to extend the final rule to health programs and activities receiving federal financial assistance from Departments other than HHS. Thus, the final rule applies to:

(1) all health programs or activities, any part of which receives federal financial assistance from HHS;

(2) health programs and activities administered by HHS, including the Federal Marketplaces; and

(3) health programs and activities administered by entities under title I of the ACA, including the State Marketplaces.

Therefore, entities subject to the final rule include health insurance issuers that offer qualified health plans on the Marketplaces, issuers with health plans that participate in Medicare Advantage and Medicaid, group health plans that receive Medicare Part D subsidies, and providers that accept Medicare (except for Part B) and Medicaid. For these entities, the nondiscrimination requirements apply to *all of the operations* of the entity (e.g., TPA services), not just the part of the business receiving federal funding.

Although the rule applies to HHS and entities created by title I of the ACA (such as an Exchange or Marketplace), this summary focuses on the applicability of the rule to health insurance issuers, group health plans, and employers that sponsor group health plans.

TPAs Related to Covered Entities

Under the proposed rule, there was a great deal of concern that a health insurance issuer acting in its capacity as a TPA was subject to section 1557, specifically with respect to the TPA's administration of self-funded benefits. For example, it appeared that a TPA could be held responsible for administering an allegedly discriminatory benefit design of a client employer's self-funded group health plan, even when the self-funded plan (or the employer sponsoring the plan) was responsible for benefit design decisions.

In the final rule, OCR **refused to wholly exempt third party administrative services** from the scope of section 1557. However, understanding that TPAs often do not have any responsibility for, or control over, self-funded benefit designs, OCR announced in the preamble to the final rule that it was adopting procedures for its processing of complaints against TPAs. When reviewing a complaint brought against a TPA, OCR will "determine whether responsibility for the decision or other action alleged to be discriminatory rests with the employer or with the third party administrator." 81 Fed. Reg. at 31432. If the conduct is related to the administration of the plan (*e.g.*, timing of claim processing), then OCR will process the complaint against the TPA (assuming the TPA is a covered entity). If the conduct is related to a decision or action by the employer, and if OCR has jurisdiction over the employer (*see below*), then OCR will proceed against the employer. If OCR does not have jurisdiction over the employer, OCR has indicated that it "may refer matters to other [f]ederal agencies with jurisdiction over the" employer (*e.g.*, the Equal Employment Opportunity Commission).

Employer Liability for Discrimination in Employee Health Benefit Programs

The final rule generally does not apply to the employer-employee relationship. However, a covered entity (a health program or activity that receives federal financial assistance) may be subject to the rules with respect to its own "employee health benefit program" under certain circumstances.

- **Employee health benefit program** means health benefits or health insurance coverage, an employer-sponsored or provided wellness program (whether or not offered with a group health plan), an employer-provided health clinic, and long-term care coverage or insurance (provided for the benefit of an employer's employees).

First, if the entity is principally engaged in providing or administering health services, health insurance coverage, or other health coverage, the covered entity shall be liable for violations of this rule with respect to its employee health benefit program. For example, if a health insurance issuer provides health benefits to its employees, it will be subject to section 1557 not only for the coverage it offers to insureds, but also for the health benefits it provides to its employees.

Second, if the entity received federal financial assistance, a primary objective of which is to fund the entity's employee health benefit program, the covered entity shall be liable for violations of this rule with respect to its employee health benefit program. For example, if an entity receives federal financial assistance from HHS specifically designated to support its employee wellness program, section 1557 will apply to the entity's administration of that wellness program.

Third, if the entity is not principally engaged in providing or administering health services, health insurance coverage, or other health coverage, but operates a health program or activity (which is not an employee health benefit program) that receives federal financial assistance; except that the entity is liable under this part with regard to the provision or administration of an employee health benefit program, but only with respect to the employees in that health program or activity. For example, a pharmacy housed within a department store would be subject to section 1557, but only with respect to the employees in the pharmacy.

- **Group health plan or employer?**: One challenge with this provision lies with OCR including a group health plan as an example of a health program or activity "principally engaged in providing or administering health services," which appears to expose an employer plan-sponsor to some liability with respect to the employer's group health plan if the group health plan or employer plan-sponsor receives federal financial assistance.

A commenter noted this anomaly to OCR, suggesting it minimized the value of OCR's exceptions to employer liability. OCR said that the commenter "has misunderstood the relationship between the obligations of an employer and the application of the rule to a separate group health plan providing the employer's employee health benefit program." Specifically, OCR stated:

"The fact that a group health plan is principally engaged in providing health services, health insurance coverage, or other health coverage, and therefore must comply with Section 1557 in all of its operations does not necessarily mean that an employer offering an employee health benefit program will be liable for a Section 1557 violation by the group health plan." 81 Fed. Reg. at 31438.

Thus, it appears an employer's group health plan can be liable for a violation of the rule without also making the employer liable.

Note this logic also seems to travel the other way. Specifically, employers (not group health plans) are often responsible for benefit design decisions, while group health plan administrators may have some discretion in applying plan terms. If an employer wants to limit its group health plan's liability for benefit design, it would seem the employer would need to make benefit design decisions in its capacity as employer (and document the same). If the employer does not otherwise meet the three criteria above, the employer should not be liable (at least, not subject to OCR's jurisdiction under this rule) for its benefit design decisions.

Similarly, following the logic of the TPA-employer process, if faced with a claim against a group health plan for benefit design discrimination, OCR should first determine the actor responsible for the allegedly discriminatory action. If it is not the group health plan, and the employer is not within OCR's jurisdiction, it would appear that OCR would lack jurisdiction over the discriminatory action, and its only recourse would be to refer such a complaint to another federal agency with jurisdiction (if one exists).

Real Relief?

We note that the relief provided to TPAs by OCR in the preamble to the final rule (*i.e.*, OCR's process for determining TPA liability for a specific complaint) as well as our suggested reading of the employer and group health plan relief (*see* "Employer liability for discrimination in employee health benefit programs" analysis above), applies only to complaints filed with OCR. However, as explained below, it appears that only claims based on age are subject to any requirement to exhaust available administrative remedies. As a result, although courts may be similarly inclined to review section 1557 complaints to determine whether the TPA (or employer or group health plan, as the case may

be) was responsible for the alleged discriminatory actions, and whether the TPA (or employer or group health plan, as the case may be) was itself even subject to the rule, courts are not bound by OCR's approach for determining liability.

No Blanket Exception for HIPAA-Excepted Benefits

There is a category of coverage and benefits that are statutorily excepted from various requirements of HIPAA, as well as other federal requirements (such as the ACA's market reform provisions). This is because the coverage and benefits are generally very limited in scope (such as vision- or dental-only coverage or hospital and fixed indemnity insurance). This category is often referred to as "HIPAA-excepted benefits."

The final rule does not include a blanket exception for HIPAA-excepted benefits. OCR states that "the purpose and scope of the coverage provided under health-related insurance or health-related coverage are factors that OCR will consider in determining whether an exclusion of all coverage for a certain condition is discriminatory under this final rule." 81 Fed. Reg. at 31434.

Language Services and Auxiliary Aids and Services

The final rule requires a covered entity to provide language assistance services free of charge, and the services must be accurate, timely, and protect the privacy of LEP individuals. As was proposed, the rule requires a covered entity to offer qualified oral interpreters or written translators to LEP individuals, if these services would reasonably provide meaningful access to that individual. The rule also requires covered entities to make communications with individuals with disabilities as effective as communications with others in health programs.

Covered entities must also post **notices of nondiscrimination and taglines** alerting LEP individuals that language assistance services are available. While OCR proposed a national threshold for determining in which languages the taglines must be available, the final rule uses a state threshold, requiring covered entities generally to post taglines in at least the top 15 non-English languages spoken in the state in which the entity is located or does business. For smaller communications, entities must post a nondiscrimination statement and taglines in at least the top two non-English languages spoken in the state in which the entity is located or does business. The final rule allows covered entities that serve individuals in more than one state to aggregate the number of individuals with LEP in those states to determine the top 15 (or the top two) languages, where each respective provision applies. OCR has provided (1) a sample notice and nondiscrimination statement; and (2) a sample tagline, in appendices A and B of the final rule, respectively. OCR will provide translated resources at the following link: http://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html.

Notice Requirement

The final rule requires a covered entity to take "appropriate **initial and continuing steps to notify** beneficiaries, enrollees, applicants, and members of the public of" the entity's nondiscrimination policy; (2) that the entity provides appropriate auxiliary aids and services where necessary (free of charge); (3) that the entity provides language assistance services; (4) how to obtain these auxiliary aids and language assistance services; (5) identification of the person responsible for compliance (if applicable); (6) availability of a grievance procedure; and (7) how to file a discrimination complaint with OCR.

- While the notice, auxiliary aid, and language access requirements may be similar to other applicable notice and language access requirements for health insurance issuers and health insurance providers, group health plans (if they receive federal financial assistance), may be surprised by this requirement. Group health plans that are covered entities should carefully analyze how these requirements may affect the operations of the plan.

Assurances

OCR finalizes the requirement that each entity applying for federal financial assistance, each issuer seeking certification to participate in a Marketplace, and each state seeking approval to operate a State Marketplace must submit an assurance that its health programs and activities will be in compliance with section 1557. The final rule also clarifies that, when a recipient of federal financial assistance or a State Marketplace fails to provide OCR with requested information in a timely, complete, and accurate manner, OCR has the authority to find noncompliance with section 1557 and may initiate enforcement procedures, which may include fund suspension or termination.

Deeming

The final rule rejects requests from the health insurance industry that an entity would be deemed to be in compliance with section 1557 if the entity was in compliance with related requirements (*e.g.*, issuers that comply with the Exchange non-discrimination provisions). However, when evaluating complaints, OCR will consider an entity's compliance with other federal laws that overlap with section 1557.

Enforcement

OCR finalized the proposal that the enforcement mechanisms under the federal civil rights laws apply for violations of section 1557. Thus, the final rule provides for a **private right of action** and damages for violations of section 1557 to the same extent that such enforcement mechanisms are provided for under the current federal civil rights laws with respect to recipients of federal financial assistance, making it clear that individuals have the ability to file a lawsuit under section 1557. The final rule affirms that **compensatory damages** for section 1557 violations are available in administrative and judicial actions.

The final rule does not require administrative exhaustion (*i.e.*, filing a complaint first with OCR), except for age discrimination claims; OCR reiterated that it will require administrative exhaustion for claims of age discrimination ("Mediation 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").[2] OCR will not permit a covered entity to require that a claimant exhaust the covered entity's grievance procedures, even with respect to age, *see* Appendix C, Sample Section 1557 of the ACA Grievance Procedure.

Conclusion

Section 1557 applies to a wide range of health programs and services. While OCR has clarified that it will refer complaints of benefit design discrimination against employers that designed group health benefits to other federal

[2] We would welcome additional clarification from OCR on age-related claims and how it intends to enforce the exhaustion requirement, particularly when age-related claims are brought in tandem with other claims (such as disability or race).

Departments, section 1557 still applies to all health plan-related products and services offered by an issuer, including any TPA or ASO services. Moreover, the requirements related to transgender coverage may effectively create a benefit mandate for health services related to gender transition.

In addition, while the final rule extends the effective date for entities that may need to alter benefit design and cost sharing to comply with these nondiscrimination provisions, health insurance issuers and group health plans still must ensure they alter any applicable benefit designs to come into compliance in time for plan or policy year 2017; those benefit design decisions may have already been made and submitted to relevant state and federal regulators.

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Please contact any of the attorneys in the Health and Welfare Practice Group at Groom Law Group or your regular Groom Law Group attorney for further information on this nondiscrimination (ACA section 1557) final rule.