

update

Compliance News for Multiemployer Plans

June 23, 2016

New Rule Requires Many Plan Sponsors to Cover Transgender Services

On May 18, 2016, the Department of Health and Human Services (HHS) published a final rule that will require many group health plans and employers to cover health care services provided to transgender individuals.¹ Whether and to what extent the regulations apply to a particular plan or employer is complex. However, it is clear that HHS intends to encourage coverage of health care services for transgender individuals in the broadest manner possible.

The effective date of the rule is plan years beginning on or after January 1, 2017. Some aspects of the rule that require notices and accommodations for individuals with disabilities or limited English language skills are effective 90 days after the July 18, 2016 effective date of the final rule.

Prohibited Discrimination on the Basis of Gender Identity

Section 1557 of the Affordable Care Act prohibits covered entities from discriminating in health programs on the basis of race, color, national origin, sex (including gender identity), age or disability. Specifically, covered entities cannot deny, cancel, limit or refuse to issue health coverage; deny or limit a claim; or impose additional cost sharing on a protected individual. (Covered entities are described on the next page.)

With respect to transgender health benefits, a covered entity may not deny or limit coverage or impose additional cost sharing or other limitations for sex-specific health services provided to transgender individuals because the individual's gender identity or recorded gender is different from the one to which such health services are ordinarily provided. For example, when a plan covers medically appropriate pelvic exams, coverage cannot be denied for an individual for whom a pelvic exam is medically appropriate because the individual either identifies as a transgender man or is enrolled in the health plan as a man.

In addition, covered entities are prohibited from categorically excluding coverage for services related to gender transition. Exclusion of transition-related treatment as experimental or cosmetic is also not permissible.

Transition-related services, which include treatment for gender dysphoria,² are not limited to surgical treatments and may include, but are not limited to, services such as hormone therapy and psychotherapy, which may occur over the lifetime of the individual.



Health Compliance News Highlights:

- Plans that receive federal funding from HHS have new nondiscrimination requirements.
- Covered entities can no longer exclude coverage for transgender services.
- New notice language about nondiscrimination will need to be added to plan communications.

¹ The final regulation was published in the [May 18, 2016 Federal Register](#).

² According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM V), gender dysphoria refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender.

Covered entities may still use reasonable medical-management techniques and are not required to cover any particular treatment or procedure. However, they will be expected to provide a neutral, nondiscriminatory reason for the denial or limitation that is not a pretext for discrimination.

Covered entities have additional notice and accommodations requirements discussed further below.

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Covered Entities

In the private sector, covered entities include:

- Group health plans that accept federal funding from HHS;³
- Insurers that participate in the Marketplace/state Exchanges or otherwise receive federal funding and their related third-party administration business; and
- Employers whose primary business is related to health care.

Multiemployer health plans are covered entities if they accept the Retiree Drug Subsidy or receive funds from HHS, including for self-insured Employer Group Waiver Plan (EGWP) Medicare Advantage or Medicare Prescription Drug Plans. If a plan has an insured EGWP, it is likely that the insurer would be the covered entity, not the plan. It is unlikely that other HHS funding exists that would make a multiemployer plan a covered entity if it does not use one of these programs.

Moreover, Section 1557 applies to third-party administrators (TPAs) which either receive federal funding directly from HHS or are affiliated with an insurer that receives such funding. These TPAs are prohibited from administering a plan in a discriminatory manner (e.g., from having systems that automatically exclude coverage for gender dysphoria). If TPA systems have sex-specific codes for certain services, the TPA must have the ability to override them upon request.

Notice and Accommodation Obligations

No later than October 17, 2016,⁴ covered entities must comply with additional requirements to assure protected individuals, including those with limited English proficiency or a disability, have equal access to benefits under this law. Covered entities must accommodate these individuals and assure that communications with them are effective. In some cases, covered entities will need to use a qualified oral interpreter and/or qualified translator when communicating with individuals with limited English proficiency. In addition, covered entities with 15 or more participants must have a grievance procedure and a compliance coordinator.

To implement these requirements, covered entities must post notices of nondiscrimination and taglines that alert individuals with limited English proficiency to the availability of language assistance services. These notices must be included in “significant” publications and communications targeted to participants and beneficiaries, except for small publications, like postcards or trifold brochures. Notices must also be posted in conspicuous public locations and on the entity’s website. Taglines — short statements written in non-English languages that indicate the availability of language assistance services free of charge — must be posted in at least the top 15 non-English languages spoken by individuals with limited English proficiency in the applicable state.⁵ Sample language for both the notice and taglines are available.⁶ Covered entities must update their significant publications and significant communications to include the new notice.

³ Plans applying for federal financial assistance will have to submit an assurance on a form specified by the HHS Office for Civil Rights (OCR) that the plan’s health programs comply with Section 1557.

⁴ This date is 90 days after the effective date of the rule, July 18, 2016.

⁵ The data to be used is based on the [most recent five-year Census data at the state level](#).

⁶ See [Translated Resources for Covered Entities](#) on the HHS website.

However, OCR will allow them to exhaust their current publications rather than do a special printing. Restocked printed materials should include the notice.

Implications

Covered entities should determine whether there are plan exclusions or coverage limitations related to sex, gender dysphoria or sexual orientation. This would include categorical exclusions of gender-transition services. These exclusions should be removed for plan years beginning on or after January 1, 2017.⁷

In most cases, the cost of this additional coverage will be low, particularly because the number of participants that for whom these benefits will be provided is likely to be very low.

Also, covered plan sponsors will have to review the disclosure and accommodations requirements of the Section 1557 rule. Unfortunately, the disclosure requirements for individuals with limited English proficiency are different from similar requirements that govern plans under the Employee Retirement Income Security Act (ERISA) or recent rules implementing the Summary of Benefits and Coverage (SBC) forms that must be distributed by all group health plans. Those rules reference different standards than the Section 1557 rule, so plan sponsors will have to refer to two sources for information as to which languages to use. In addition, the SBC requires only up to four languages, while the Section 1557 rule requires 15 languages — an amount that will not fit on the SBC template. Further guidance from the Department of Labor would be helpful to address how the Section 1557 rule interacts with existing disclosure obligations for group health plans. Some additional health plan sponsor cost will be involved to update publications at an earlier date than might otherwise have been the case.

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How Segal Can Help

Segal works with plan sponsors and their attorneys to address compliance with the new rule, including reviewing existing plan coverage of transgender benefits, designing a new coverage rule, and estimating the cost impact of complying with the new law. Segal can also assist plan sponsors in communicating any benefit changes and in ensuring that plan communications meet the new notice requirements.

Questions?

For more information about how these new rules may affect your plan, please contact your Segal consultant or the [Segal office nearest you](#).

⁷ Plan sponsors should assure that benefit modifications meet all federal standards, including, for example, those under the Mental Health Parity and Addiction Equity Act.

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