

To: Director Bruce R. Ramge, Market Conduct Examination Standards (D) Working Group

Date: September 3, 2015

RE: Market Regulation Handbook Standard: Section 1557

We write to comment on the proposed Market Conduct Examinations Standard which creates standards for examining health carrier compliance with the nondiscrimination protections in Section 1557 of the Affordable Care Act (ACA).

Section 1557 incorporates existing civil rights laws to the health insurance and health care system and prohibits health carriers from discriminating against individuals on the basis of race, color, national origin, disability, age, and sex (including marital or familial status, gender identity, sexual orientation, sex stereotyping, and pregnancy). This provision applies to health carriers and other entities that receive federal financial assistance, including financial assistance in the form of credits, subsidies, or contracts of insurance.

In addition to specific comments outlined below, we offer four global comments on the proposed examination standard. First, as the draft standard recognizes, the U.S. Department of Health and Human Services (HHS) has not yet promulgated final regulations on Section 1557. Because proposed regulations were released today, note that our comments do not incorporate any clarifications from these rules. As a result, we recommend that the standard be updated and re-released for comments to reflect the requirements in the proposed rule as well as any additional guidance from HHS over time.

Second, we recommend that the standard reflect the need for examiners to conduct a more thorough review of health carrier practices when examining potentially discriminatory activities. Because discrimination can often be subtle or even inadvertent, examiners must look beyond formal written policies and procedures to ensure that health carriers comply with both the letter and the spirit of Section 1557. To do so, we recommend that examiners adopt a more thorough and holistic approach to review through granular data collection and analysis and have included edits that incorporate data requests in the documents to be reviewed.

By collecting and analyzing data and identifying broader trends on, for instance, denied claims as a first step in the examination process, examiners can more easily identify compliance issues and target their reviews or take corrective action. In an era of limited regulatory resources—and the need to identify patterns of activity and trends that could result in discrimination against protected classes—we urge the use of more data collection and analytics to evaluate compliance.

Third, even though HHS has not yet issued regulations to implement Section 1557, federal regulators have taken some steps to interpret this provision. For instance, HHS has issued guidance interpreting Section 1557 to include nondiscrimination protections based on gender identity, sexual orientation, sex stereotyping, and pregnancy. HHS also recently entered into a voluntary resolution agreement with The Brooklyn Hospital Center to resolve a Section 1557 complaint filed by a transgender person who claimed discrimination on the basis of gender identity. In addition, Title IX—which is incorporated by Section 1557—includes or has been interpreted to include protections based on marital or familial status, pregnancy, and sexual orientation. Given these developments, we strongly support the explicit enumeration of marital or familial status, gender

identity, sexual orientation, sex stereotyping, and pregnancy as potential areas of sex-based discrimination throughout the examination standard.

Fourth, we recommend that the proposed standards reflect practical examples of compliance and noncompliance with Section 1557. Given Section 1557's expansive application, examples will be critical to help examiners identify potential violations during their review.

Thank you in advance for your consideration, and we look forward to continuing to work closely with the Market Conduct Examination Standards (D) Working Group to address these issues. If you have any questions, please contact Tim Jost at jostt@wlu.edu.

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Nondiscrimination (Section 1557)

PROVISION TITLE: Nondiscrimination

CITATION: §1557 of the Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18116

EFFECTIVE DATE: Plan years, and in the individual market, policy years beginning on or after March 23, 2010.

PROVISION: The provisions of the health reform act prohibit discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities.

BACKGROUND: 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 (Title VI), 42 U.S.C. 2000d et seq. (race, color, national origin), Title IX of the Education Amendments of 1972 (Title IX), 20 U.S.C. 1681 et seq. (sex), the Age Discrimination Act of 1975 (Age Act), 42 U.S.C. 6101 et seq. (age), or Section 504 of the Rehabilitation Act of 1973 (Section 504), 29 U.S.C. 794 (disability), under any health program or activity, any part of which is receiving Federal financial assistance (including credits, subsidies, or contracts of insurance), or under any program or activity that is administered by an Executive Agency or any entity established under Title I of the Affordable Care Act or its amendments. Section 1557 states that the “enforcement mechanisms provided for and available under” Title VI, Title IX, Section 504, or the Age Act shall apply for purposes of violations of Section 1557. The antidiscrimination provisions of Section 1557 apply to health carriers, hospitals and any employer or entity that receives federal funds.

Note: Examiners need to be aware that Section 1557(c) of the Affordable Care Act authorizes the Secretary of the Department of Health and Human Services (HHS) to promulgate regulations to implement the nondiscrimination requirements in Section 1557. The HHS Office for Civil Rights (OCR), in coordination with other divisions in HHS, has developed proposed regulations for implementation of Section 1557, however, final regulations have not yet been issued regarding implementation of Section 1557.

42 U.S.C. §18116 sets forth requirements regarding health plans sold on the Marketplace, as well as individual and group employer plans offered outside of the Marketplace if the health carrier is receiving federal funds. In such cases, the health plans shall not discriminate against individuals, on the basis of:

- Race;
- Color or national origin;
- Disability;
- Age; and
- Sex (to include marital or familial status, gender identity, sexual orientation, sex stereotyping and pregnancy).*

*State laws may also be applicable in these situations as well.

Section 1557 of the Patient Protection and Affordable Care Act of 2010, 42 U.S.C. §18116, requires that a health carrier (and other covered entities) not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, national origin, present or predicted disability, age, sex (including marital or familial

Comment [CR1]: The title of Section 1557 is simply “Nondiscrimination.” Alternatively, this should be “Prohibition on Discrimination.”
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status, sexual orientation, gender identity, sex stereotyping, and pregnancy) in admission to, participation in, or receipt of the services and benefits under any of its health programs and activities.

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Note: The following nondiscrimination standards are based upon Section 1557; these standards intersect with other provisions of the ACA regarding nondiscrimination, such as nondiscrimination in benefit design, nondiscrimination in eligibility based on health status-related factors, and nondiscrimination in the provision of cultural and linguistic materials and competency, etc. It is important to review other areas of Chapter 20A for further guidance regarding other applicable health reform provisions regarding nondiscrimination.

Comment [CR2]: Although these entities do have to comply with nondiscrimination requirements under 45 CFR 155.120(c), these standards are separate and distinct from those outlined in Section 1557. However, because many of these entities receive federal funds or were created under Title I of the ACA, they would be included in the list of covered entities. As such, we removed the reference to 155.120(c) but added these entities to the list below.

This provision applies to all health carriers in the individual market, small group and large group employer plans. This provision applies to grandfathered and non-grandfathered individual, small group and large group market health plans and policies.

Deleted: Under 45 CFR 155.120(c), titled Non-interference with Federal Law and Non-Discrimination Standards, nondiscrimination provisions also apply to exchange contractors, all exchange activities (including but not limited to marketing, outreach and enrollment), navigators, non-navigator assistance personnel, certified application counselors.

The scope of the civil rights protections of Section 1557 applies to:

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- Any health program or activity of a recipient of federal financial assistance, such as hospitals, clinics, employers, or insurance companies that receive federal money. Visiting nurse programs, community health education interventions, and similar programs that receive federal dollars also must comply with Section 1557. Section 1557 specifically applies to entities that receive federal financial assistance in the form of contracts of insurance, credits, or subsidies;
- Any program or activity administered by an executive agency, including federal health programs like Medicare, Medicaid, and CHIP; and
- Any program or activity created under Title I of the ACA, including state health insurance exchanges, exchange contractors, and all exchange activities (including but not limited to marketing, outreach, and enrollment), navigators, non-navigator assistance personnel, certified application counselors.

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Note: Consumers have a variety of enforcement options under Section 1557, which incorporates the enforcement mechanisms of Title VI, Title IX, Section 504, and the Age Act. These civil rights laws may be enforced in different ways through administrative processes and/or through private litigation in federal court, subject to some restrictions. In addition, consumers can file complaints directly with OCR, which accepts and investigates complaints under Section 1557. Examiners should be aware that OCR may have complaint data or other information relevant to an examination.

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FAQs: See HHS Office for Civil Rights (OCR) website for guidance.

NOTES: For additional examination standards related to nondiscrimination, please review the other sections of Chapter 20A—Conducting the Affordable Care Act (ACA) Related Examination—in the Market Regulation Handbook related to nondiscrimination.

Nondiscrimination (Section 1557)

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Standard 1: A health carrier that receives federal financial assistance (including in the form of contracts of insurance, credits, or subsidies), shall not discriminate, exclude from participation, or deny coverage or benefits to any individual on the basis of race, color, national origin, sex, age, or disability.

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Apply To: All health carriers offering group health products, (grandfathered and non-grandfathered products) for plan years beginning on or after March 23, 2010.

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Apply To: All health carriers offering individual health products, (grandfathered and non-grandfathered products) for policy years beginning on or after March 23, 2010.

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Priority: Essential

Documents to be Reviewed

Data for all applications for coverage (including the underwriting and rating characteristics of the applicant and the outcome of the application) and claims (including a description of the benefit requested and the outcome of the claim)

Health carrier underwriting, complaint handling and claim handling policies and procedures

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Underwriting files and supporting documentation, including letters, notices, telephone scripts, etc.

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Applications/pre-enrollment forms and questionnaires

Questionnaires or assessments related to wellness or disease management programs and health carrier policies and procedures for using this information

Declinations/disenrollment files

Complaint register/logs/files

Health carrier complaint records (supporting documentation, including, but not limited to written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

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Claim files

Informal complaints/internal appeals/grievance register/logs/files

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Health carrier utilization management policies and procedures

Health carrier network access plans

Applicable external appeals register/logs/files, external appeal resolution and associated documentation

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Health carrier form approvals (policy language, enrollment materials, and advertising materials, as required under state statutes, rules and regulations)

Health carrier policy form language and benefit design documents

Health carrier marketing and sales policies and procedures

Health carrier communication and educational materials provided to applicants, enrollees, policyholders and certificateholders, including communications with producers

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Any information that health carriers request before an individual is accepted for coverage, including, but not limited to, claims history, family history, genetic information, and credit information

News reports or other publicly available information about potentially discriminatory practices or behaviors by a health carrier

Complaints filed with HHS OCR

Training materials

Producer records

Applicable state and federal statutes, rules and regulations, and guidances

NAIC References

Individual Market Health Insurance Coverage Model Regulation (#26)

Small Group Market Health Insurance Coverage Model Regulation (#126)

Other References

HHS/OCR regulations and FAQs

OCR voluntary resolution agreements that address complaints under Section 1557

Comment [CR3]: Section 1557 is enforced by HHS and is not one of the provisions that falls under the jurisdiction of the tri-agencies (HHS, DOL, Treasury). As such, we have removed references to the tri-agency structure.

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Review Procedures and Criteria

Verify that the health carrier has established and implemented policies and procedures regarding prohibition of discrimination on the basis of race, color, national origin, present or predicted disability, age, or sex (including marital or familial status, gender identity, sexual orientation, sex stereotyping, and pregnancy) in accordance with federal statutory and regulatory guidance.

Review health carrier underwriting, complaint handling and claim handling and utilization management policies and procedures to verify adequate and appropriate policies/procedures are in place to ensure a health carrier which offers health benefit plans providing individual market health insurance coverage, small group or large group market health insurance coverage does not discriminate based on an individual's race, color, national origin, present or predicted disability, age, or sex (including marital or familial status, gender identity, sexual orientation, sex stereotyping, and pregnancy) in accordance with federal statutory and regulatory guidance.

Review the health carrier's underwriting, complaint and claim files to verify that health carrier does not discriminate, exclude from participation or deny benefits to individuals on the basis of race, color, national origin, present or predicted disability, age, or sex (including marital or familial status, gender identity, sexual orientation, sex stereotyping, and pregnancy) in accordance with federal statutory and regulatory guidance.

Review health carrier applications/pre-enrollment forms and questionnaires to verify that the health carrier does not deny application or enrollment to prospective insureds on the basis of race, color, national origin, present or predicted disability, age, or sex (including marital or familial status, gender identity, sexual orientation, sex stereotyping, and pregnancy) in accordance with federal statutory and regulatory guidance.

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Review health carrier declinations and disenrollment files to verify that the health carrier has not discriminated against applicants/enrollees on the basis of race, color, national origin, present or predicted disability, age, or sex

(including marital or familial status, gender identity, sexual orientation, sex stereotyping, and pregnancy) in accordance with federal statutory and regulatory guidance.

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Analyze data on applications, the outcome of applications, claims presented, and claim outcomes to assess whether there are unusual frequencies related to application or claims denials and the reasons for denials. An unusual frequency for a certain type of denial could indicate failure to comply with Section 1557's nondiscrimination requirements.

Review complaint register/logs and complaint files to identify complaints pertaining to coverage denial/restriction of coverage to assess whether there are unusual frequencies related to complaints, denials, or restrictions. An unusual frequency for a certain type of complaint could indicate failure to comply with Section 1557's nondiscrimination requirements.

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Review complaint records, to verify that, when an individual has been the subject of a restriction of coverage or denied coverage, the health carrier has taken appropriate corrective action/adjustments in a timely and accurate manner.

Ascertain if the health carrier error could have been the result of some systemic issue (e.g. programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, including website notifications, supporting corrective action provided to an individual for whom coverage was inappropriately restricted or denied.

Review health carrier claim files to identify any coverage denials for claimants for whom coverage was improperly restricted or denied, on the basis of discrimination.

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Review health carrier internal appeals/grievance register/logs/files to identify any individuals for whom coverage was improperly restricted or denied.

Review any external appeal requests and the conclusions of external appeals addressing improper denial/restriction of coverage.

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Note: Examiners need to be aware that other areas of potential discrimination regarding race, color, national origin, present or predicted disability, age, or sex (including marital or familial status, gender identity, sexual orientation, sex stereotyping, and pregnancy), may include:

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- Cost sharing;
- Narrow or tiered provider networks;
- Drug formularies;
- Visit limits;
- Restrictive medical necessity definitions;
- Exclusions;
- Age limits;
- Utilization management;
- Waiting periods;
- Service areas;
- Marketing of products;
- Rating; and
- Benefit substitution.

Therefore, examiners should review the health carrier's health benefit plans to verify these benefit design elements are consistent with reasonable medical management techniques and are not discriminatory.

Review policy form file and health carrier network access plans to verify approval(s) from the applicable state and, (if applicable) from the Marketplace.

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Review health carrier policy form language and benefit designs to verify that the policy forms/benefit designs do not contain language that has the effect of discrimination (e.g., arbitrary limits, exclusions or lower standards of service, etc.) based on an individual's race, color, national origin, present or predicted disability, age, or sex (including marital or familial status, gender identity, sexual orientation, sex stereotyping, and pregnancy).

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Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information pertaining to the prohibition of discrimination in health insurance coverage on the basis of the provisions outlined in Section 1557.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders and certificateholders provide complete and accurate information pertaining to the prohibition of discrimination in health insurance coverage on the basis of the provisions outlined in Section 1557.

Verify that the health carrier has established training programs designed to inform its employees, producers, and other downstream entities (such as customer service centers) about the requirements pertaining to the prohibition of discrimination in health insurance coverage on the basis of the provisions outlined in Section 1557.

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Review health carrier training materials to verify that information provided therein is complete and accurate with regard to the prohibition of discrimination in health insurance coverage on the basis of the provisions outlined in Section 1557.

Review producer records and health carrier communications with producers to verify that information provided by producers to insureds and claimants is complete and accurate with respect to nondiscrimination and verify that health carrier contracts with producers require compliance with the nondiscrimination protections in Section 1557.

Determine if the health carrier monitors producer-generated coverage denials/restrictions of coverage. Review any such producer records of coverage denials/restrictions of coverage for compliance with statute and regulatory guidance pertaining to the prohibition of discrimination in health insurance coverage on the basis of the provisions outlined in Section 1557.

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Finalize the examination report and assess whether to refer the results to a federal or state regulatory entity or a self-regulatory entity for further action. Examiners should also assess whether to notify other states of the results and/or enter into a Regulatory Information Retrieval System action.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or creates a more generous benefit, and thus not preempted, as set forth in federal law.