Non-Discrimination in Health Programs and Activities

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This document is current as of this date. Healthcare Reform guidance continues to be released. Express Scripts' solutions and support will evolve to meet the needs of a changing regulatory landscape.

Public Information

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Non-Discrimination in Health Programs and Activities

On May 18, 2016, the Department of Health and Human Services (HHS) published the final rule entitled Non-Discrimination in Health Programs and Activities. The rule implements Section 1557 of the Affordable Care Act (ACA) which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain heath programs and activities. HHS has published a summary of the final guidance and an FAQ to support compliance.

The majority of provisions of this rule take effect on July 18, 2016. The tagline and member notice provisions are effective as of October 17, 2016. Provisions in the rule that require changes to health insurance or group health benefit designs (including benefit limitations, restrictions, co-pay, co-insurance, and deductibles) have an effective date of the first day of the first plan year beginning on or after January 1, 2017.

The summary below is intended to assist clients in understanding certain regulatory impacts facing your pharmacy benefits. Express Scripts is continuing to evaluate the impacts on all related business functions. We recognize that for many clients we may serve as a downstream entity and will support compliance activities on all impacted lines of business. We plan to work with each client to meet the unique needs for your pharmacy benefit. As more information becomes available we will share additional detail through your account team.

Application & Key Definitions – Effective July 18, 2016

The rule defines "**covered entities**" as health programs or activities, any part of which receives federal financial assistance from HHS. The term covered entity also includes entities established by HHS and entities established under Title I of the ACA such as the Marketplaces (state and federal). Covered programs may include, but are not limited to: Medicaid, Medicare (excluding Medicare Part B), and public exchanges.

Health program or activity is defined as the provision or administration of health-related services, health-related insurance coverage (including coverage of medical and prescription drug benefits), or other health-related coverage, and the provision of assistance to individuals in obtaining health-related services or health-related insurance coverage.

For entities 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. For example, HHS notes that an issuer participating in a Federally-Facilitated Marketplace (public exchange) and receiving Federal financial assistance for its on- exchange plans would also be covered by this rule for any plans offered off exchange, as well as when the issuer acts as a third party administrator (TPA) for an employer-sponsored group health plan.

However, HHS notes that a **TPA is unlikely to be covered by the rule** when the TPA is a legal entity that is truly independent of an issuer covered entity. Moreover, an employer providing a group health plan (including a plan administered by a TPA that is a covered entity) would not be directly liable for violations for the rule unless the employer itself qualifies as a covered entity.

Covered entities must submit an assurance, on a form to be specified by HHS, that the entity's health programs and activities will operate in compliance with Section 1557. Recipients who are found to have discriminated against an individual must take remedial action as required to overcome the effects of discrimination.

Regulatory Impact: Covered entities must be prepared to comply with and to attest to compliance with the rule.

Express Scripts Action: Express Scripts will continue to provide support to clients that may be considered covered entities under the rule, including, but not limited to: Medicaid plans including CHIPs, Basic Health Plans; Medicare Plans in Parts C or D, including PDP & EGWP; MMPs; and QHPs participating in Federally Facilitated Marketplaces and State Based Marketplaces. **We intend to work with impacted clients to support potential member specific messaging, informational displays online, and any required benefit changes. Ultimately we defer to clients to make the determination of whether they are a covered entity and how this guidance impacts their organization.**

Designation of Responsible Employee and Adoption of Grievance Procedures – Effective July 18, 2016

Each covered entity that employs 15 or more persons is required to designate at least one employee to coordinate its efforts to comply with Section 1557. Additionally, each covered entity that employs 15 or more persons must adopt grievance procedures that provide for the prompt and equitable resolution of grievances relating to alleged violations of Section 1557. This designated employee must be identified to the public through the covered entity's website to receive any alleged grievances related to an action that would be prohibited by Section 1557.

Regulatory Impact: Covered entities must identify designated employees to assist in resolving discrimination (Section 1557) complaints. Clients and Express Scripts will need to assign separate designated employees.

Express Scripts Action: We will be reaching out to covered entity clients to solicit contact information for your designated employee where appropriate for inclusion in website content, member notices, or other communications for which such information is required.

Notice Requirements – Effective October 17, 2016

Member Notices

By October 17, 2016, each covered entity is required to post a notice that conveys the following information:

- The covered entity does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities;
- The covered entity provides appropriate auxiliary aids and services, free of charge and in a timely manner to assist those with disabilities and how to obtain these services;
- The covered entity provides language assistance services, including translated documents and oral interpretation, free of charge and in a timely manner to assist those with limited English proficiency and how to obtain these services;
- Contact information for the employee designated by the covered entity to investigate Section 1557 discrimination complaints;
- The availability of a grievance procedure and how to follow a grievance procedure; and
- How to file a discrimination compliance with Office of Civil Rights within HHS.

A covered entity may combine the content of this notice with other required notices if the combined notice clearly informs the individuals of their rights under Section 1557.

Taglines

Also by October 17, 2016, each covered entity must post taglines in at least the top 15 languages spoken by individuals with limited English proficiency of the relevant State or States that indicate the availability of language assistance services free of charge.

The notice and taglines must be included in a conspicuously-visible font size:

- In significant publications and communications targeted to beneficiaries, enrollees, applicants and members of the public;
- In conspicuous physical locations where the entity interacts with the public; and
- In a conspicuous location on the covered entity's website accessible from the home page.

In significant publications that are small-sized, such as post cards and tri-fold brochures, covered-entities are required to:

- Include a brief non-discrimination statement (in lieu of the full notice requirement outlined above); and
- Include taglines in at least the top two languages spoken by individuals with limited English proficiency (in lieu of 15 taglines as outlined above).

HHS provides sample notices, notice statements, and taglines in the appendices to the rule.

HHS affords covered entities who serve individuals in more than one state the flexibility to aggregate the number of individuals with limited English proficiency in the relevant states in order to determine the top 15 languages for taglines. HHS does not intend to require a covered entity that operates health plans in multiple states to tailor the taglines for each state.

Regulatory Impact: By October 17, 2016, clients and Express Scripts will need to modify existing or create new notices to inform members of non-discrimination requirements and publish key documents with the notice and 15 language taglines.

Express Scripts Action: Express Scripts is evaluating the significant publications that will be updated with the notice and tagline requirements as outlined above. Our applicable websites and mobile applications will be updated to include the necessary notices and provide access to the designated employee to receive grievances related to discrimination. Please work with your account teams to identify key documents requiring updates to include with the nondiscrimination notice and 15 language taglines.

Access, Language & Facilities Requirements – Effective July 18, 2016

Covered entities must:

- Take reasonable steps to provide meaningful access to each individual with limited English proficiency;
- Develop and implement an effective written language access plan;
- Offer a qualified interpreter to an individual with limited English proficiency;
- Provide auxiliary aids and services to persons with impaired sensory, manual or speaking skills;
- Ensure that the portions of their facilities that are used for health programs or activities meet certain ADA accessibility standards;
- Ensure that information provided through electronic and information technology is accessible to individuals with disabilities, unless doing so would result in undue financial and administrative burden. When undue burdens exist, the covered entity shall provide information in a format other than an electronic format that would not result in such a burden to ensure that individuals with disabilities receive the benefits of the health program; and
- Ensure that websites comply with the requirements of Title II of the ADA.

Regulatory Impact: Clients and Express Scripts will need modify existing or create new policies and procedures to support these access, language and facilities requirements.

Express Scripts Action: Express Scripts is currently evaluating our policies and procedures, as applicable, to meet the stated access requirements.

Discrimination Rules – Effective January 1, 2017 (to the extent benefit design changes are required)

Covered entities are also prohibited from providing or administering health-related insurance or other health-related coverage that discriminates against an individual based on the individual's race, color, national origin, age, disability or sex (or based on an individual's relationship or association with an individual in a protected class). The rule requires covered entities to treat all individuals consistent with their gender identity, which may be male, female, neither, or a combination of male and female, and which may be different from an individual's sex assigned at birth.

A covered entity may not deny or limit health services to a transgender individual that are ordinarily or exclusively available to individuals of one sex, based on that individual's sex assigned at birth, gender identity, or recorded gender differing from the usual gender status for the service. For example, treatment for ovarian cancer cannot be denied on the basis of an individual's status as a transgender male if the treatment is medically necessary for the individual (e.g., where the individual has ovarian cancer). However, HHS also clarifies that the rule does not require covered entities to cover services that are not appropriate for a transgender individuals (e.g., plans are not required to cover a prostate exam for an individual without a prostate). Covered entities may not utilize a process that will automatically deny or limit services for an individual based solely on an automated indicator of binary gender ("male" or "female").

Covered entities may not:

- Deny, cancel, limit, or refuse to issue or renew a health-related insurance plan or policy or other health related coverage, or deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, on the basis of race, color, national origin, sex, age, or disability;
- Have or implement marketing practices or benefit designs that discriminate on the basis of race, color, national origin, sex, age, or disability in a health-related insurance plan or policy, or other health-related coverage;
- Deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an 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;
- Have or implement a categorical coverage exclusion or limitation for all health services related to gender transition;
- Otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual.

Regulatory Impact: Both covered entity clients and Express Scripts must allow for claims to process without barriers to health care based on gender status.

Express Scripts Action: Express Scripts is conducting an evaluation of our programs and processes to ensure members have access to appropriately prescribed drugs, regardless of gender status. Covered entity clients should evaluate their own benefit designs and coverage rules in light of the rule and work with their account teams to facilitate any required changes.