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# Final Regulations Under the ACA Section 1557 Nondiscrimination Rules: Highlights for Group Health Plans

As a reminder, Section 1557 of the Affordable Care Act (ACA) prohibits discrimination on the basis of race, color, national origin, sex, age, or disability, in certain health programs or activities provided by certain covered entities that receive federal financial assistance.

Section 1557 has been an ongoing source of uncertainty for employers and group health plan sponsors since the enactment of the ACA due to differing interpretations due to changes in presidential administrations and multiple legal challenges. As a result, the U.S. Department of Health and Human Services (HHS) has issued rules related to Section 1557 multiple times.[1] The recently published 2024 final rules are generally effective on July 5, but there are varied effective dates for specific provisions.[2]

**Key Points for Group Health Plans in Final Rules**

Covered entities under the rules include all health programs and activities administered by HHS, state and federal health insurance exchanges, and health plans and health insurance issuers that receive direct or indirect financial assistance from HHS.[3] While the preamble discusses how these rules apply to group health plans, HHS specifically declined to clarify the application to group health plans in the text of the regulations.

Most group health plans are likely not covered by the rules directly (except for self-funded multiemployer plans that receive financial assistance from HHS, for example, by participating in the Retiree Drug Subsidy Program). However, many self-funded

plans receive administrative services from third-party administrators (TPAs) who are covered entities (TPAs are often part of large health insurance companies). While a plan administered by a covered TPA is not subject to the rules by extension, the preamble devotes some discussion to liability for discriminatory plan design that may lead to changes in the way self-funded plans and TPAs currently operate and document responsibility for plan design decisions.

All group health plans (even those that are not subject to the final rules) should pay attention to the application of the rules with respect to gender-identity and gender affirming health care. Related issues are the subject of current litigation and raise potential concerns under other federal nondiscrimination laws applicable to group health plans. Stay tuned for a more in-depth discussion of these issues in the coming months.

*This blog was drafted by Natalie Miller, an attorney in the Spencer Fane Overland Park, Kansas office. For more information, visit www.spencerfane.com.*

1 The first final regulations were issued in 2016. Final rules issued in 2020 revised and rescinded large portions of the 2016 rules. Proposed amendments to the regulations were issued in 2022, and the final version of those rules was published on May 6, 2024. You can review the HHS related fact sheet, the FAQs, and the 2024 final regulations.

2 Newly covered group health plans must comply with the rules for the first plan year beginning on or after January 1, 2025. In addition, such plans must implement certain policies and procedures and comply with notification requirements by specified dates.

3 The rules reiterate that an otherwise covered entity may rely on applicable federal protections for religious freedom and conscience to exempt such entities from compliance with a particular provision.