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Legal Sidebar

The Scope of ACA Section 1557: "Health Program or Activity"

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On May 6, 2024, the Department of Health and Human Services (HHS, or the Department) finalized a new rule under Section 1557 of the Patient Protection and Affordable Care Act (ACA). Section 1557 applies various antidiscrimination requirements to "any health program or activity," any part of which receives federal financial assistance. During previous presidential administrations, including in 2016 and 2020, HHS enacted regulations implementing Section 1557. Both rules faced legal challenges. In addition to litigation challenging the HHS rules, other cases have presented to courts the question of what entities are subject to Section 1557, including the statute's applicability to group health plans, health insurance issuers, and third-party administrators (TPAs).

By referencing four other federal civil rights laws, Section 1557 prohibits discrimination on the basis of race, color, national origin, disability, age, and sex in federally funded health care programs or activities. As described by HHS, Section 1557 is significant because it is the "first Federal civil rights law to broadly prohibit discrimination on the basis of sex in all federally funded health care programs." Apart from Section 1557, no other federal antidiscrimination laws directly prohibit sex discrimination by private health insurance issuers or TPAs, although discrimination in some private health plans may be reached by laws directed at other actors, such as Title VII of the Civil Rights Act, which prohibits sex discrimination by employers. Section 1557 is novel in its potential applicability to the private health insurance industry, leading to complex questions about which entities are "health programs or activities," and whether they receive federal financial assistance for purposes of inclusion under the statute.

This Legal Sidebar explores the potential scope of the 2024 Section 1557 rule with respect to HHS's definition of "health program or activity," which the statute does not define, and discusses how the new rule differs from previous interpretations of that term. In addition to the Department's position, federal courts have also begun interpreting Section 1557's scope; this Sidebar discusses a few of those cases. The Sidebar concludes by offering several considerations for the 118th Congress, especially given the possibility of continued litigation surrounding the rule and its potential to impact the availability of and coverage for health care services.

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Background

Section 1557 provides that a person "shall not . . . be subjected to discrimination 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 . . . any entity established in this title . . . ." Rather than banning specific discriminatory practices, Section 1557 prohibits discrimination "on the ground[s] prohibited under" four other civil rights statutes. Consistent with these statutes, all of the activities of an entity that is a "health program or activity" are covered by Section 1557 if that entity receives federal financial assistance. Many entities in the health insurance industry receive federal financial assistance by transacting business with the federal government; for example, by selling plans on the exchanges or offering Medicare Advantage plans. For more information about what constitutes federal financial assistance in the context of federal civil rights laws, see CRS Report R47109, *Federal Financial Assistance and Civil Rights Requirements*, by Christine J. Back and Jared P. Cole.

The Department and federal courts generally agree that many federal health care programs administered by HHS are covered under Section 1557's umbrella, as well as health plans sold through the federal and state exchanges (under Title I of the ACA). There is also general agreement that Section 1557 applies to providers that receive federal financial assistance, including hospitals, nursing homes, and physician practices. Where the Department's 2016, 2020, and 2024 rules differ is with respect to whether and to what extent Section 1557 applies to private health insurance issuers offering plans outside of the exchanges, group health plans, and TPA activities. These disputes have resulted in various lawsuits in federal court as well.

Among the many types of private health insurance coverage are group plans (often sponsored by employers) and nongroup, or individual marketplace, plans. For group health plans, some are "fully insured," meaning that the insurance company (or issuer) bears the financial responsibility for paying claims under the plan. Other group health plans are self-insured (or self-funded), meaning that the plan sponsor (often the insured's employer) bears financial responsibility for paying claims. Employers or plan sponsors may contract with an insurance company to "administer" the plan on the plan sponsor's behalf. For example, TPAs often "administer" a plan by contracting with provider networks and negotiating rates. For more information about the various types of private health insurance, see CRS Report R47507, *Private Health Insurance: A Primer*, coordinated by Vanessa C. Forsberg.

HHS's Interpretations of "Health Program or Activity" in Section 1557

This section highlights the various interpretations of Section 1557's scope that HHS has adopted through rulemaking over the past decade. As discussed below, this section focuses on how HHS has interpreted the statute's words "health program or activity, any part of which is receiving federal financial assistance," and how that interpretation affects the various entities involved in the private health insurance business, as well as a few other selected differences between the rules.

The 2016 Rule

The Department's initial Section 1557 rule, issued in May 2016, broadly defined "health program or activity," in part as the "provision or administration of health-related services, health-related insurance coverage, or other health-related coverage." The rule listed examples of regulated entities, including hospitals, health clinics, the Medicaid program, and individual marketplace plans under Title I of the

ACA. The Department also included health insurance issuers and group health plans generally, as well as TPAs, stating that TPA services "are undeniably a health program or activity…"

The Department also explained that, consistent with the understanding of other federal civil rights laws, if any part of a covered entity receives federal financial assistance, all of its services would also be covered. For example, if a health insurance issuer receives federal funding for offering a plan in a health insurance exchange, then all of its services (even those outside the exchange) would be subject to Section 1557. In support of its position on the applicability of the rule, HHS pointed to the specific words "any part of which," in the statute, which it understood as "any part of a healthcare entity." As a result, HHS concluded that all services of a health care entity would be subject to Section 1557, even if only certain parts of that health care entity received federal financial assistance. HHS stated that such an application of the rule was consistent with the "central purpose" of the ACA and "effectuate[d] Congressional intent," by eliminating "discriminat[ion] in any of [a covered entity's] programs or activities, thereby enhancing access to services and coverage."

Many stakeholders objected to the rule's inclusion of group health plans and TPAs that provide administrative services to self-insured group health plans, arguing that Congress did not intend for Section 1557 to reach them, as many do not receive federal financial assistance, and TPAs often do not design plans or determine benefit coverage. Commenters also warned that the rule could have a chilling effect on insurance companies' willingness to contract with the federal government (e.g., to offer Medicare supplement plans), and that the rule's application to group health plans could conflict with provisions of the Employee Retirement Income Security Act (ERISA). The agency acknowledged that TPAs often do not design benefit plans, and thus that when evaluating claims of discrimination involving a TPA administering a self-insured group health plan, the agency would "determine whether responsibility for the . . . action alleged to be discriminatory rests with the employer" or the TPA.

The 2020 Rule

In 2020, the Department revised much of its initial interpretation in the 2016 rule and issued a new rule which narrowed the scope of Section 1557. HHS did not specifically define "health program or activity," but it stated that the term would apply to "all of the operations of entities principally engaged in the business of providing healthcare that receive Federal financial assistance . . . ." HHS provided examples of entities it considered to be "principally engaged in the business of providing healthcare," many of which were covered by the 2016 rule, such as hospitals and activities administered under Title I of the ACA (e.g., federal and state health insurance exchanges). However, the 2020 rule specified that the Department would not consider entities that provide health insurance coverage or administer group health plans to be "principally engaged in the business of providing healthcare," simply because they provide health coverage. In other words, HHS did not consider health insurance issuers and TPAs to be a "health program or activity" subject to Section 1557's antidiscrimination requirements.

The 2020 rule was consistent with the 2016 rule in that if an entity was a "health program or activity" and received federal financial assistance, then all of its activities would be covered by the rule. For entities not "principally engaged in the business of providing healthcare," and thus not a "health program or activity," HHS said that Section 1557's requirements would still apply to the entity, but "only to the extent [that] any [of its] operation[s] receive[] Federal financial assistance." For example, HHS explained that for health insurance issuers receiving federal funds from offering Medicare Advantage plans, such activities would be covered, but the issuer's other activities for which it did not receive federal financial assistance would not be covered.

The Department characterized the 2016 rule as "overly broad," and said that it "subjected many insurance products that were not intended to be covered by the ACA to burdensome regulation, inconsistent with Congressional intent." According to HHS, many commenters responded positively to the rule's narrower

scope, arguing that "the 2016 rule was overly expansive . . . and resulted in disincentives for issuers to participate in HHS-funded programs . . . ." Other comments were not as supportive of the rule, saying that exempting health insurance issuers' operations "would allow [them] to conduct their other activities in a discriminatory manner."

The 2024 Rule

On May 6, 2024, HHS finalized a new rule under Section 1557, which in many ways returned to the 2016 rule's definition of "health program or activity." HHS defines the term, in relevant part, as "any project, enterprise, venture, or undertaking to: [p]rovide or administer health-related services, health insurance coverage, or other health-related coverage . . . ." The term also encompasses the provision of medical and pharmaceutical care as well as health research and education for health care professionals. The Department stated that, consistent with the 2016 rule, the new rule will be applied to "all health programs and activities of the department," rather than just those under Title I of the ACA, and that where an entity is "principally engaged" in the business of health care (such as a health insurance issuer), then all of its operations are subject to the rule.

With respect to the rule's application to group health plans, HHS advised that group health plans and their sponsors "are generally separate entities from one another that require a separate, fact-specific analysis to determine whether each entity is subject to this rule." The Department also declined to list group health plans in its list of entities that are "principally engaged in the provision or administration of" health care within the definition of "health program or activity." At the same time, HHS posits that group health plans are "health programs or activities" and would be subject to the rule if they receive federal financial assistance, though the agency says that many group health plans do not receive such funds. Similarly, the Department says that entities that contract with group health plans, including TPAs, "could be subject to [the] rule themselves, regardless of the group health plan's liability."

Many commenters supported HHS's inclusion of health insurance issuers and all of their operations within the definition of "health program or activity," arguing that the 2020 Rule was "contrary to the text of section 1557, the [Civil Rights and Restoration Act], and the broad remedial intent of Congress in enacting the ACA to ensure access to health insurance." These commenters opined that the 2020 rule was "arbitrary and contrary to the plain language of section 1557, which applies to 'any health program or activity, *any part of which is receiving Federal financial assistance*' (emphasis added)," and which should be "construed broadly." Other commenters argued that the rule is overly broad and that all of a health insurance company's activities should not be subject to the rule, particularly those for which it does not receive federal financial assistance. One commenter specifically urged that HHS's expansive reading may lead to higher costs for health insurance issuers and result in "reduced coverage options" for Medicare Advantage, Medicaid managed care, and the health insurance exchanges, if issuers do not wish to do business with the government and thereby be subject to the rule.

Court Interpretations of the Scope of Section 1557

In addition to the various agency interpretations of Section 1557, federal courts have also begun to interpret Section 1557's applicability to various "health programs or activities," including Medicaid, employer-sponsored group health plans, and TPAs. Many courts have not deferred to the agency's various rules interpreting Section 1557, instead relying on their own interpretations of the statute's "unambiguous" text. This section explores some of the ways in which courts have interpreted Section 1557 to determine which entities should be subject to the rule.

Courts Find the Language of Section 1557 Unambiguous

A few federal courts have interpreted the plain language of Section 1557 to include private health insurance issuers and TPAs as "health programs and activities." For example, in *Pritchard v. Blue Cross Blue Shield of Illinois*, the U.S. District Court for the Western District of Washington considered whether a plaintiff parent whose transgender child was denied coverage for medical treatment stated a claim for sex discrimination under Section 1557. Blue Cross, the insurance company, was acting as a TPA for the plaintiff's self-funded employee health benefit plan. It argued that it could not be liable under Section 1557 because its administration of the plaintiff's plan was not a health program or activity for which it received federal financial assistance. Blue Cross pointed to HHS's 2020 Section 1557 rule, arguing that it was not a health program or activity because, as a TPA, it was not "principally engaged in providing healthcare."

The court disagreed with Blue Cross and declined to give HHS's 2020 Section 1557 rule deference under *Chevron*, citing a Ninth Circuit decision in support of its finding that "the plain language of Section 1557 indicates that a health insurance contract and the administration of a health insurance contract is a 'health program or activity.'" The *Pritchard* court reasoned that the phrase "any health program or activity" was "clearly broader in scope than only the provision of healthcare," as the 2020 rule described it. It also determined that the phrase "including . . . contracts of insurance" modified the term "health program or activity," bringing insurance companies and TPAs within its scope. The court also stated that in the statute, Congress unambiguously communicated that Section 1557's antidiscrimination requirements applied to health insurance companies broadly, including their TPA activities. The insurance company appealed the court's decision to the U.S. Court of Appeals for the Ninth Circuit on December 20, 2023; a decision has not yet been issued.

Other courts have also not relied on the HHS rule when addressing the extent to which Section 1557 may apply to group health plans. For example, in 2022, the U.S. Court of Appeals for the Seventh Circuit decided *T.S. v. Heart of CarDon*, where a plaintiff's self-funded group health benefit plan denied coverage for autism treatment for her child. The court's decision addresses whether the defendants, who were the plaintiff's employer, a skilled nursing facility (SNF), and its health benefit plan, could be subject to Section 1557. CarDon did not dispute that, as a SNF, it was a health program or activity that received federal funding, and that it sponsored the plaintiff's group health plan. Instead, it argued that the group health plan that it offered to its employees was not covered by Section 1557 because that part of its operation did not receive federal financial assistance. The court found that because CarDon was a health care entity, Section 1557 applied to all of its activities, including its group health plan, regardless of whether that specific part received federal financial assistance. The court noted HHS's various interpretations of "health program or activity" but did not rely on the agency's reading of the statute to decide the case, instead finding that "the phrase 'health program or activity' … plainly includes all the operations of a business principally engaged in providing healthcare." Because defendant conceded that it was a health program or activity, the Seventh Circuit found "that ends the inquiry."

Court Finds ERISA Is Not a Defense to Section 1557 Liability for a TPA

TPAs have made other arguments against being included within Section 1557's purview. For example, in *Tovar v. Essentia Health*, which concerned a self-funded employee health benefit plan's categorical exclusion for certain medical care for transgender people, the TPA argued that it could not be held liable for the plan's allegedly discriminatory action because the employer who sponsored the plan had "sole control" over the plan terms. In support of its argument, the TPA pointed to a provision of ERISA, a federal law that regulates self-funded group health plans, arguing that it was legally obligated to administer the plan terms as they were written. The court was unpersuaded, finding that "[n]othing in

Section 1557, explicitly or implicitly, suggests that TPAs are exempt from the statute's nondiscrimination requirements," and thus that the TPA was subject to Section 1557.

Considerations for Congress

Courts have considered a number of challenges to the 2016 and 2020 rules, some of which are discussed in CRS Legal Sidebar LSB10813, *Proposed HHS Rule Addressing Section 1557 of the ACA's Incorporation of Title IX*, by Christine J. Back. It is unclear what, if any, effect litigation will have on the Department's ability to enforce its 2024 Section 1557 rule. As discussed above, if a court finds the statute may be interpreted on its face, federal judges are not limited by HHS's interpretation of the rule. As with what happened in several of the cases discussed herein, courts could continue to find that Section 1557 is unambiguous and thus that *Chevron* deference is not owed to the agency's interpretation. In other words, regardless of what the Department's rule says that Section 1557 means, a court could disagree and choose to apply its own interpretation. Another federal court might disagree with the reasoning of cases like *Pritchard* and *Tovar* and hold that Section 1557 is ambiguous, which could lead to different interpretations of the statute applied in different jurisdictions. Additionally, if the Supreme Court were to overrule *Chevron*, as it is considering in its 2023-2024 term, such a decision, absent a new interpretive standard supporting agency deference, could lead to more courts interpreting the words of Section 1557 without giving deference to HHS. More direction from Congress as to the statute's application could provide clarity.

Subsequent presidential administrations could reinterpret Section 1557 and issue a new rule, which could once again change the scope of its applicability. As is demonstrated by HHS's rules and in several of the court decisions, the application of Section 1557 can be complicated by the different entities with varying levels of responsibility with respect to the scope of discrimination that a person might experience. If Congress is dissatisfied with the way in which either HHS or courts are interpreting the statute, including the potential uncertainty of whether a particular type of entity is subject to Section 1557, it could amend Section 1557 to provide a definition of a health program or activity and/or provide more specifics about which entities should be covered by it.

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