Section 1557 of the Affordable Care Act: Non-Discrimination Requirements in Health Programs or Activities

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Regulatory History

Section 1557 is a non-discrimination provision of the Patient Protection and Affordable Care Act (ACA) which was enacted in 2010. This provision prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in health programs or activities that receive Federal financial assistance or are administered by an Executive agency or any entity established under Title I of the ACA.

In 2016, the HHS office of Civil Rights (OCR) released the final rule to implement the non-discrimination requirements of Section 1557. This final rule required healthcare providers and other covered entities to publicly post and disseminate non-discrimination notices, and the availability of qualified interpreters and language assistance services (e.g., translated documents and oral interpretation).

In 2020, HHS eliminated the requirement for covered entities to send non-discrimination notices and taglines with all significant communications and amended many of the other provisions of the 2016 Rule to relieve undue regulatory burden and clarify the scope of Section 1557.

On May 6, 2024, OCR issued an updated final rule to restore and strengthen civil rights protections for individuals consistent with the plain meaning of the statutory text. The previous version of this rule had a narrower scope and limited nondiscrimination protections for individuals. This rule applies nondiscrimination protections to the use of technology—including telehealth and artificial intelligence. This rule also clarifies that protections against discrimination on the basis of sex include sexual orientation and gender identity. Additionally, this rule reinstates and strengthens Section 1557's application to health insurance issuers that receive Federal financial assistance.

Entities that are subject to the 2020 Rule must continue to comply with the 2020 Rule until the updated final rule goes into effect on July 5, 2024. Some parts of the rule have a later effective date.

Purpose/Scope

What is the purpose of this rule?

The purpose is to implement section 1557 of the Patient Protection and Affordable Care Act (ACA). Section 1557 provides that, except as otherwise provided in title I of the ACA, an individual shall not, on the grounds prohibited under title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, or section

504 of the Rehabilitation Act of 1973, be excluded from participation in, be denied the benefits of, or 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 an executive agency or any entity established under title I of the ACA.

This part applies to health programs or activities administered by recipients of Federal financial assistance from the Department, Department-administered health programs or activities, and title I entities that administer health programs or activities.

This regulation is effective July 5, 2024, unless otherwise specified.

For more information, please review 45 C.F.R. § 92.1 (Purpose and effective date).

To whom does this final rule apply?
This rule applies to:

- Every health program or activity, any part of which receives Federal financial assistance, directly or indirectly, from the Department;
- Every health program or activity administered by the Department; and
- Every health program or activity administered by a title I entity.

This rule does not apply to any employer or other plan sponsor of a group health plan, including but not limited to, a board of trustees (or similar body), association or other group, with regard to its employment practices, including the provision of employee health benefits.

For more information, please review 45 C.F.R. § 92.2 (Application).

Definitions

How is "covered entity" defined in this rule?
Covered entity means:

1) A recipient of Federal financial assistance;
2) The Department; and
3) An entity established under title I of the ACA.

For more information, please review 45 C.F.R. § 92.4 (Definitions).

How is "Federal financial assistance" defined?

1) Federal financial assistance means any grant, loan, credit, subsidy, contract (other than a procurement contract but including a contract of insurance), or any other arrangement by which the Federal Government, directly or indirectly, provides assistance or otherwise makes assistance available in the form of:
    i. Funds;
    ii. Services of Federal personnel; or

iii. Real or personal property or any interest in or use of such property, including:

A. Transfers or leases of such property for less than fair market value or for reduced consideration; and

B. Proceeds from a subsequent transfer or lease of such property if the Federal share of its fair market value is not returned to the Federal Government.

2) Federal financial assistance the Department provides or otherwise makes available includes Federal financial assistance that the Department plays a role in providing or administering, including advance payments of the premium tax credit and cost-sharing reduction payments under title I of the ACA, as well as payments, subsidies, or other funds extended by the Department to any entity providing health insurance coverage for payment to or on behalf of a person obtaining health insurance coverage from that entity or extended by the Department directly to such person for payment to any entity providing health insurance coverage.

For more information, please review 45 C.F.R. § 92.4 (Definitions).

What does "health program or activity" mean?

Health program or activity means:

1) Any project, enterprise, venture, or undertaking to:

i. Provide or administer health-related services, health insurance coverage, or other health-related coverage;

ii. Provide assistance to persons in obtaining health-related services, health insurance coverage, or other health-related coverage;

iii. Provide clinical, pharmaceutical, or medical care;

iv. Engage in health or clinical research; or

v. Provide health education for health care professionals or others.

2) All of the operations of any entity principally engaged in the provision or administration of any health projects, enterprises, ventures, or undertakings described in paragraph (1) of this definition, including, but not limited to, a State or local health agency, hospital, health clinic, health insurance issuer, physician's practice, pharmacy, community-based health care provider, nursing facility, residential or community-based treatment facility, or other similar entity or combination thereof. A health program or activity also includes all of the operations of a State Medicaid program, Children's Health Insurance Program, and Basic Health Program.

For more information, please review 45 C.F.R. § 92.4 (Definitions).

Where can I find the definitions for the other terms used in this rule?

You can find definitions in 45 C.F.R. § 92.4 (Definitions).

Assurance

Does this rule require an entity applying for federal financial assistance to submit an assurance?

Yes. An entity applying for Federal financial assistance must submit an assurance, on a form specified by the Director, that the entity's health programs and activities will be operated in compliance with section 1557.

For more information, please review 45 C.F.R. § 92.5 (Assurances).

Remedial and Voluntary Action

If a recipient or State Exchange discriminated against an individual, are they required to take remedial and voluntary action to overcome the effects of discrimination?

Remedial Action

If the Director finds that a recipient or State Exchange has discriminated against an individual on the basis of race, color, national origin, sex, age, or disability, such recipient or State Exchange must take remedial action as the Director may require to overcome the effects of the discrimination. If another recipient exercises control over the recipient that has discriminated, the Director, may require either or both entities to take remedial action.

The Director may require a recipient, in its health programs and activities, or State Exchange to take remedial action with respect to:

> (i) Persons who are no longer participants in the recipient's or State Exchange's health program or activity but who were participants in the health program or activity when such discrimination occurred; or
>
> (ii) Persons who would have been participants in the health program or activity had the discrimination not occurred.

Voluntary Action

A covered entity may take nondiscriminatory steps, in addition to any action that is required by section 1557 or this part, to overcome the effects of conditions that result or resulted in limited participation in the covered entity's health programs or activities by persons on the basis of race, color, national origin, sex, age, or disability.

For more information, please review 45 C.F.R. § 92.6 (Remedial action and voluntary action).

Relationship to Other Laws

What is the relationship of this rule to existing laws?

Neither section 1557 nor this rule should be construed to apply a lesser standard for the protection of individuals from discrimination than the standards applied under the following laws:

- Title VI of the Civil Rights Act of 1964;
- Title IX of the Education Amendments of 1972;

- Section 504 of the Rehabilitation Act of 1973;
- The Age Discrimination Act of 1975; or
- The regulations issued pursuant to those laws.

Nothing in this part shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available under title VI of the Civil Rights Act of 1964, title VII of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, section 504 of the Rehabilitation Act of 1973, or the Age Discrimination Act of 1975.

Insofar as the application of any requirement under this part would violate applicable Federal protections for religious freedom and conscience, such application shall not be required.

This rule does not supersede state or local laws that provide additional protections against discrimination on any basis in § 92.1.

For more information, please review 45 C.F.R. § 92.3 (Relationship to other laws).

Section 1557 Coordinator

Who is required to have a Section 1557 Coordinator and what are the responsibilities for this role?

A covered entity that employs fifteen or more persons must designate and authorize at least one employee, a "Section 1557 Coordinator," to coordinate the covered entity's compliance with its responsibilities under section 1557 and this part.

As appropriate, a covered entity may assign one or more designees to carry out some of these responsibilities, but the Section 1557 Coordinator must retain ultimate oversight for ensuring coordination with the covered entity's compliance with this part.

A covered entity must ensure that, at minimum, the Section 1557 Coordinator:

1) Receives, reviews, and processes grievances, filed under the grievance procedure as set forth in § 92.8(c);
2) Coordinates the covered entity's recordkeeping requirements as set forth in § 92.8(c);
3) Coordinates effective implementation of the covered entity's language access procedures as set forth in § 92.8(d);
4) Coordinates effective implementation of the covered entity's effective communication procedures as set forth in § 92.8(e);
5) Coordinates effective implementation of the covered entity's reasonable modification procedures as set forth in § 92.8(f); and
6) Coordinates training of relevant employees as set forth in § 92.9, including maintaining documentation required by such section.

This requirement goes into effect within 120 days of July 5, 2024.

For more information, please review 45 C.F.R. § 92.7 (Designation and responsibilities of a Section 1557 Coordinator).

Policies and Procedures and Training Requirements

Are covered entities required to implement policies and procedures to comply with this rule?

Yes, covered entities are required to implement the policies and procedures mentioned below.

(a) *General Requirement.*

A covered entity must implement written policies and procedures in its health programs and activities that must include an effective date and be reasonably designed, taking into account the size, complexity, and the type of health programs or activities undertaken by a covered entity.

(b)Nondiscrimination policy.

(1) A covered entity must implement a written policy in its health programs and activities that, at minimum, states the covered entity does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), sex (consistent with the scope of sex discrimination described at § 92.101(a)(2)), age, or disability; that the covered entity provides language assistance services and appropriate auxiliary aids and services free of charge, when necessary for compliance with section 1557 or this part; that the covered entity will provide reasonable modifications for individuals with disabilities; and that provides the current contact information for the Section 1557 Coordinator required by § 92.7 (if applicable).

(2) OCR considers it a best practice toward achieving compliance for a covered entity to provide information that it has been granted a temporary exemption or granted an assurance of exemption under § 92.302(b) in the nondiscrimination policy required by paragraph (b)(1) of this section.

(c) *Grievance procedures.*

(1) A covered entity that employs fifteen or more persons must implement written grievance procedures in its health programs and activities that provide for the prompt and equitable resolution of grievances alleging any action that would be prohibited by section 1557 or this part.

(2) A covered entity to which this paragraph applies must retain records related to grievances filed pursuant to the covered entity's grievance procedures required under paragraph (c)(1) of this section that allege discrimination on the basis of race, color, national origin, sex, age, or disability for no less than three (3) calendar years from the date the covered entity resolves the grievance. The records must include the grievance; the name and contact information of the complainant (if provided by complainant); the alleged discriminatory action and alleged basis (or bases) of discrimination; the date the grievance was filed; the date the grievance was resolved; grievance resolution; and any other pertinent information.

(3) A covered entity to which this paragraph (c) applies must keep confidential the identity of an individual who has filed a grievance under this part except as required by law or to the extent necessary to carry out the purposes of this part, including the conduct of any investigation.

(d) *Language access procedures.*
A covered entity must implement written language access procedures in its health programs and activities describing the covered entity's process for providing language assistance services to individuals with limited English proficiency when required under § 92.201. At a minimum, the language access procedures must include current contact information for the section 1557 Coordinator (if applicable); how an employee identifies whether an individual has limited English proficiency; how an employee obtains the services of qualified interpreters and translators the covered entity uses to communicate with an individual with limited English proficiency; the names of any qualified bilingual staff members; and a list of any electronic and written translated materials the covered entity has, the languages they are translated into, date of issuance, and how to access electronic translations.

(e) *Effective communication procedures.*
A covered entity must implement written effective communication procedures in its health programs and activities describing the covered entity's process for ensuring effective communication for individuals with disabilities when required under § 92.202. At a minimum, a covered entity's effective communication procedures must include current contact information for the Section 1557 Coordinator (if applicable); how an employee obtains the services of qualified interpreters the covered entity uses to communicate with individuals with disabilities, including the names of any qualified interpreter staff members; and how to access appropriate auxiliary aids and services.

(f) *Reasonable modification procedures.*
A covered entity must implement written procedures in its health programs and activities describing the covered entity's process for making reasonable modifications to its policies, practices, or procedures when necessary to avoid discrimination on the basis of disability as required under § 92.205. At a minimum, the reasonable modification procedures must include current contact information for the covered entity's Section 1557 Coordinator (if applicable); a description of the covered entity's process for responding to requests from individuals with disabilities for changes, exceptions, or adjustments to a rule, policy, practice, or service of the covered entity; and a process for determining whether making the modification would fundamentally alter the nature of the health program or activity, including identifying an alternative modification that does not result in a fundamental alteration to ensure the individual with a disability receives the benefits or services in question.

(g) *Combined policies and procedures.*
A covered entity may combine the content of the policies and procedures required by paragraphs (b) through (f) of this section with any policies and procedures pursuant to title VI, section 504, title IX, and the Age Act if section 1557 and the provisions in this part are clearly addressed therein.

(h) *Changes to policies and procedures.*

(1) Covered entities must review and revise the policies and procedures required by paragraphs (b) through (g) of this section, as necessary, to ensure they are current and in compliance with section 1557 and this part; and

(2) A covered entity may change a policy or procedure required by paragraphs (b) through (g) of this section at any time, provided that such changes comply with section 1557 and this part.

This requirement is effective within 1 year of July 5, 2024.

For more information, please review 45 C.F.R. § 92.8 (Policies and procedures).

Is a covered entity required to train its employees on this final rule?
A covered entity must train relevant employees of its health programs and activities on the civil rights policies and procedures, as necessary and appropriate for the employees to carry out their functions within the covered entity.

A covered entity must provide training, as follows:

(1) To each relevant employee of the health program or activity as soon as possible, but no later than 30 days following a covered entity's implementation of the policies and procedures required by § 92.8, and no later than 300 days following July 5, 2024;

(2) Thereafter, to each new relevant employee of the health program or activity within a reasonable period of time after the employee joins the covered entity's workforce; and

(3) To each relevant employee of the health program or activity whose functions are affected by a material change in the policies or procedures required by § 92.8 and any other civil rights policies or procedures the covered entity has implemented within a reasonable period of time after the material change has been made.

"Relevant employees" includes permanent and temporary employees whose roles and responsibilities entail interacting with patients and members of the public; making decisions that directly or indirectly affect patients' health care, including the covered entity's executive leadership team and legal counsel; and performing tasks and making decisions that directly or indirectly affect patients' financial obligations, including billing and collections.

A covered entity must contemporaneously document its employees' completion of the training required in written or electronic form and retain said documentation for no less than three (3) calendar years.

This rule is effective following implementation of the policies and procedures required by 92.8, and no later than one year of July 5, 2024.

For more information, please review 45 C.F.R. § 92.9 (Training).

Nondiscrimination Notice Requirements

Are covered entities required to provide notice of nondiscrimination?

(a) A covered entity must provide a notice of nondiscrimination to participants, beneficiaries, enrollees, and applicants of its health programs and activities, and members of the public.

The notice must include the following:

1) The covered entity does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), sex (consistent with the scope of sex discrimination described at § 92.101(a)(2)), age, or disability;
2) The covered entity provides reasonable modifications for individuals with disabilities, and appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, such as braille or large print, free of charge and in a timely manner, when such modifications, aids, and services are necessary to ensure accessibility and an equal opportunity to participate to individuals with disabilities;
3) The covered entity provides language assistance services, including electronic and written translated documents and oral interpretation, free of charge and in a timely manner, when such services are a reasonable step to provide meaningful access to an individual with limited English proficiency;
4) How to obtain from the covered entity the reasonable modifications, appropriate auxiliary aids and services, and language assistance services in paragraphs (a)(1)(ii) and (iii) of this section;
5) The contact information for the covered entity's Section 1557 Coordinator designated pursuant to § 92.7 (if applicable);
6) The availability of the covered entity's grievance procedure pursuant to § 92.8(c) and how to file a grievance (if applicable);
7) Details on how to file a discrimination complaint with OCR in the Department; and
8) How to access the covered entity's website, if it has one, that provides the information required in the notice.

The notice must be provided, as follows:

1) On an annual basis to participants, beneficiaries, enrollees (including late and special enrollees), and applicants of its health program or activity;
2) Upon request;
3) At a conspicuous location on the covered entity's health program or activity website, if it has one; and
4) In clear and prominent physical locations, in no smaller than 20-point sans serif font, where it is reasonable to expect individuals seeking service from the health program or activity to be able to read or hear the notice.

A covered entity may combine the content of the notice required in this section with the notices required by 45 CFR 80.6(d), 84.8, 86.9, and 91.32 if the combined notice clearly informs individuals of their civil rights under section 1557 and this part, so long as it includes each of the elements required in this section.

This requirement goes into effect within 120 days of July 5, 2024.

For more information, please review 45 C.F.R. § 92.10 (Notice of nondiscrimination).

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

Is a covered entity required to provide notice of availability of language assistance services and auxiliary aids and services?

A covered entity must provide a notice of availability of language assistance services and auxiliary aids and services that, at minimum, states that the covered entity, in its health programs or activities, provides language assistance services and appropriate auxiliary aids and services free of charge, when necessary for compliance with section 1557 or this part, to participants, beneficiaries, enrollees, and applicants of its health program or activities, and members of the public.

The notice must be provided in English and at least the 15 languages most commonly spoken by individuals with limited English proficiency of the relevant State or States in which a covered entity operates and must be provided in alternate formats for individuals with disabilities who require auxiliary aids and services to ensure effective communication.

The notice must be provided, as follows:

1) On an annual basis to participants, beneficiaries, enrollees (including late and special enrollees), and applicants of its health program or activity;
2) Upon request;
3) At a conspicuous location on the covered entity's health program or activity website, if it has one;
4) In clear and prominent physical locations, in no smaller than 20-point sans serif font, where it is reasonable to expect individuals seeking service from the health program or activity to be able to read or hear the notice; and
5) In the following electronic and written communications when these forms are provided by a covered entity:
    i. Notice of nondiscrimination required by § 92.10;
    ii. Notice of privacy practices required by 45 CFR 164.520;
    iii. Application and intake forms;
    iv. Notices of denial or termination of eligibility, benefits or services, including Explanations of Benefits, and notices of appeal and grievance rights;
    v. Communications related to an individual's rights, eligibility, benefits, or services that require or request a response from a participant, beneficiary, enrollee, or applicant;
    vi. Communications related to a public health emergency;

vii. Consent forms and instructions related to medical procedures or operations, medical power of attorney, or living will (with an option of providing only one notice for all documents bundled together);
viii. Discharge papers;
ix. Communications related to the cost and payment of care with respect to an individual, including medical billing and collections materials, and good faith estimates required by section 2799B-6 of the Public Health Service Act;
x. Complaint forms; and
xi. Patient and member handbooks.

A covered entity is deemed in compliance with this section with respect to an individual if it exercises the option to:

1) On an annual basis, provide the individual with the option to opt out of receipt of the notice required by this section in their primary language and through any appropriate auxiliary aids and services, and:
    i. Does not condition the receipt of any aid or benefit on the individual's decision to opt out;
    ii. Informs the individual that they have a right to receive the notice upon request in their primary language and through the appropriate auxiliary aids and services;
    iii. Informs the individual that opting out of receiving the notice is not a waiver of their right to receive language assistance services and any appropriate auxiliary aids and services as required by this part;
    iv. Documents, on an annual basis, that the individual has opted out of receiving the notice required by this section for that year; and
    v. Does not treat a non-response from an individual as a decision to opt out; or

2) Document the individual's primary language and any appropriate auxiliary aids and services and:
    i. Provides all materials and communications in that individual's primary language and through any appropriate auxiliary aids and services; or
    ii. Provides the required notice in the individual's primary language and through any appropriate auxiliary aids and services in all communications that are identified in § 92.11 (c)(5).

This requirement is effective within 1 year of July 5, 2024.

For more information, please review 45 C.F.R. § 92.11(Notice of availability of language assistance services and auxiliary aids and services).

Discrimination on the Basis of Sex

What does discrimination on the basis of sex include?

Discrimination on the basis of sex includes, but is not limited to, discrimination on the basis of:

(i) Sex characteristics, including intersex traits;

(ii) Pregnancy or related conditions;

(iii) Sexual orientation;

(iv) Gender identity; and

(v) Sex stereotypes.

For more information, please review 45 C.F.R. § 92.101(Discrimination prohibited).

Meaningful Access for Individuals with Limited English Proficiency

What are the meaningful access requirements for individuals with limited English proficiency?

A covered entity must take reasonable steps to provide meaningful access to each individual with limited English proficiency (including companions with limited English proficiency) eligible to be served or likely to be directly affected by its health programs and activities.

Language assistance services requirements. Language assistance services must be provided free of charge, be accurate and timely, and protect the privacy and the independent decision-making ability of the individual with limited English proficiency.

Specific requirements for interpreter and translation services.

1) When interpretation services are required under this part, a covered entity must offer a qualified interpreter in its health programs and activities.
2) When translation services are required under this part, a covered entity must utilize the services of a qualified translator in its health programs and activities.
3) If a covered entity uses machine translation when the underlying text is critical to the rights, benefits, or meaningful access of an individual with limited English proficiency, when accuracy is essential, or when the source documents or materials contain complex, non-literal or technical language, the translation must be reviewed by a qualified human translator.

Evaluation of compliance. In evaluating whether a covered entity has met its obligation under this section, the Director shall:

1) Evaluate, and give substantial weight to, the nature and importance of the health program or activity and the particular communication at issue, to the individual with limited English proficiency; and

2) Take into account other relevant factors, including the effectiveness of the covered entity's written language access procedures for its health programs and activities, that the covered entity has implemented pursuant to § 92.8(d).

Restricted use of certain persons to interpret or facilitate communication. A covered entity must not, in its health programs and activities:

1) Require an individual with limited English proficiency to provide their own interpreter, or to pay the cost of their own interpreter;
2) Rely on an adult, not qualified as an interpreter, to interpret or facilitate communication, except:
    i. As a temporary measure, while finding a qualified interpreter in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available and the qualified interpreter that arrives confirms or supplements the initial communications with an initial adult interpreter; or
    ii. Where the individual with limited English proficiency specifically requests, in private with a qualified interpreter present and without an accompanying adult present, that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, the request and agreement by the accompanying adult is documented, and reliance on that adult for such assistance is appropriate under the circumstances;
3) Rely on a minor child to interpret or facilitate communication, except as a temporary measure while finding a qualified interpreter in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available and the qualified interpreter that arrives confirms or supplements the initial communications with the minor child; or
4) Rely on staff other than qualified interpreters, qualified translators, or qualified bilingual/multilingual staff to communicate with individuals with limited English proficiency.

Video remote interpreting services. A covered entity that provides a qualified interpreter for an individual with limited English proficiency through video remote interpreting services in the covered entity's health programs and activities must ensure the modality allows for meaningful access and must provide:

1) Real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication;
2) A sharply delineated image that is large enough to display the interpreter's face and the participating person's face regardless of the person's body position;
3) A clear, audible transmission of voices; and
4) Adequate training to users of the technology and other involved persons so that they may quickly and efficiently set up and operate the video remote interpreting.

Audio remote interpreting services. A covered entity that provides a qualified interpreter for an individual with limited English proficiency through audio remote interpreting services in the covered entity's health programs and activities must ensure the modality allows for meaningful access and must provide:

1) Real-time audio over a dedicated high-speed, wide-bandwidth connection or wireless connection that delivers high-quality audio without lags or irregular pauses in communication;
2) A clear, audible transmission of voices; and
3) Adequate training to users of the technology and other involved persons so that they may quickly and efficiently set up and operate the remote interpreting services.

Acceptance of language assistance services is not required. An individual with limited English proficiency is not required to accept language assistance services.

For more information, please review 45 C.F.R. § 92.201 (Meaningful access for individuals with limited English proficiency).

Effective communication for individuals with disabilities

What are the requirements for effective communication for individuals with disabilities?

A covered entity must take appropriate steps to ensure that communications with individuals with disabilities (including companions with disabilities), are as effective as communications with non-disabled individuals in its health programs and activities, in accordance with the standards found at 28 CFR 35.130 and 35.160 through 35.164. Where the regulatory provisions referenced in this section use the term “public entity,” the term “covered entity” shall apply in its place.

A covered entity must provide appropriate auxiliary aids and services where necessary to afford individuals with disabilities an equal opportunity to participate in, and enjoy the benefits of, the health program or activity in question. Such auxiliary aids and services must be provided free of charge, in accessible formats, in a timely manner, and in such a way to protect the privacy and the independence of the individual with a disability.

For more information, please review 45 C.F.R. § 92.202 (Effective communication for individuals with disabilities).

Accessibility for buildings and facilities

Are there accessibility requirements for buildings and facilities?

Yes, no qualified individual with a disability shall, because a covered entity's facilities are inaccessible to or unusable by individuals with disabilities, be denied the benefits of, be excluded from participation in, or otherwise be subjected to discrimination under any health program or activity to which this part applies.

Information on the standards a building or facility must follow can be found in 45 C.F.R. § 92.203 (Accessibility for buildings and facilities).

Accessibility of information and communication technology for individuals with disabilities

Are there any accessibility requirements for information and communication technology?

A covered entity must ensure that its health programs and activities provided through information and communication technology are accessible to individuals with disabilities, unless doing so would result in undue financial and administrative burdens or a fundamental alteration in the nature of the health programs or activities. If an action required to comply with this section would result in such an alteration or such burdens, a covered entity shall take any other action that would not result in such an alteration or such burdens but would nevertheless ensure that, to the maximum extent possible, individuals with disabilities receive the benefits or services of the health program or activity provided by the covered entity.

A recipient or State Exchange shall ensure that its health programs and activities provided through websites and mobile applications comply with the requirements of section 504 of the Rehabilitation Act, as interpreted consistent with title II of the ADA (42 U.S.C. 12131 through 12165).

For more information, please review 45 C.F.R. § 92.204 (Accessibility of information and communication technology for individuals with disabilities).

Requirements to Make Reasonable Modifications

Is a covered entity required to make reasonable modifications?

A covered entity must make reasonable modifications to policies, practices, or procedures in its health programs and activities when such modifications are necessary to avoid discrimination on the basis of disability, unless the covered entity can demonstrate that making the modifications would fundamentally alter the nature of the health program or activity.

For the purposes of this section, the term “reasonable modifications” shall be interpreted in a manner consistent with the term as set forth in the ADA title II regulation at 28 CFR 35.130(b)(7).

For more information, please review 45 C.F.R. § 92.205 (Requirement to make reasonable modifications).

Equal Program Access on the Basis of Sex

What are the requirements to provide equal program access on the basis of sex?

A covered entity must provide individuals equal access to its health programs and activities without discriminating on the basis of sex.

In providing access to health programs and activities, a covered entity must not:

1) Deny or limit health services, including those that have been typically or exclusively provided to, or associated with, individuals of one sex, to an individual based upon the individual's sex assigned at birth, gender identity, or gender otherwise recorded;
2) Deny or limit, on the basis of an individual's sex assigned at birth, gender identity, or gender otherwise recorded, a health care professional's ability to provide health services if such denial or limitation has the effect of excluding individuals from participation in, denying them the benefits of, or otherwise subjecting them to discrimination on the basis of sex under a covered health program or activity;
3) Adopt or apply any policy or practice of treating individuals differently or separating them on the basis of sex in a manner that subjects any individual to more than de minimis harm, including by adopting a policy or engaging in a practice that prevents an individual from participating in a health program or activity consistent with the individual's gender identity; or
4) Deny or limit health services sought for purpose of gender transition or other gender-affirming care that the covered entity would provide to an individual for other purposes if the denial or limitation is based on an individual's sex assigned at birth, gender identity, or gender otherwise recorded.

Nothing in this section requires the provision of any health service where the covered entity has a legitimate, nondiscriminatory reason for denying or limiting that service, including where the covered entity typically declines to provide the health service to any individual or where the covered entity reasonably determines that such health service is not clinically appropriate for a particular individual. A covered entity's determination must not be based on unlawful animus or bias, or constitute a pretext for discrimination. Nothing in this section is intended to preclude a covered entity from availing itself of protections described in §§ 92.3 and 92.302.

For more information, please review 45 C.F.R. § 92.206 (Equal program access on the basis of sex).

Is there any prohibition on sex discrimination related to marital, parental, or family status?

Yes, in determining whether an individual satisfies any policy or criterion regarding access to its health programs or activities, a covered entity must not take an individual's sex, as defined in § 92.101(a)(2), into account in applying any rule concerning an individual's current, perceived, potential, or past marital, parental, or family status.

For more information, please review 45 C.F.R. § 92.208 (Prohibition on sex discrimination related to marital, parental, or family status).

Nondiscrimination on the Basis of Association

What are the nondiscrimination requirements on the basis of association?

A covered entity must not exclude from participation in, deny the benefits of, or otherwise discriminate against an individual or entity in its health programs and activities on the basis of the respective race, color, national origin, sex, age, or disability of the individual and

another person with whom the individual or entity has a relationship or association.

For more information, please review 45 C.F.R. § 92.209 (Nondiscrimination on the basis of association).

Patient Care Decision Support Tools

What are the nondiscrimination requirements for the use of patient care decision support tools?

General prohibition. A covered entity must not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs or activities through the use of patient care decision support tools.

Identification of risk. A covered entity has an ongoing duty to make reasonable efforts to identify uses of patient care decision support tools in its health programs or activities that employ input variables or factors that measure race, color, national origin, sex, age, or disability.

Mitigation of risk. For each patient care decision support tool identified in paragraph (b) of this section, a covered entity must make reasonable efforts to mitigate the risk of discrimination resulting from the tool's use in its health programs or activities.

The effective date for § 92.210 (b) Identification of risk and (c) Mitigation of risk is within 300 days of July 5, 2024.

For more information, please review 45 C.F.R. § 92.210 (Nondiscrimination in the use of patient care decision support tools).

Telehealth Services

Does the rule address nondiscrimination when using telehealth services?

Yes, a covered entity must not, in delivery of its health programs and activities through telehealth services, discriminate on the basis of race, color, national origin, sex, age, or disability.

For more information, please review 45 C.F.R. § 92.211 (Nondiscrimination in the delivery of health programs and activities through telehealth services).

Enforcement Mechanisms

What are the enforcement mechanisms for this rule?

The enforcement mechanisms available for and provided under title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975 shall apply for purposes of section 1557.

For more information, please review 45 C.F.R. § 92.301(Enforcement mechanisms).

Please also review the following:

- 45 C.F.R. § 92.302 (Notification of views regarding application of Federal religious freedom and conscience laws).
- 45 C.F.R. § 92.303 (Procedures for health programs and activities conducted by recipients and State Exchanges).
- 45 C.F.R. § 92.304 (Procedures for health programs and activities administered by the Department).

Medicare Part B

Does the rule apply to Medicare Part B?

Yes, the updated rule applies to Medicare Part B funds. Previously, Medicare Part B funds were excluded from the rule. However, that interpretation is outdated. Medicare Part B funds constitute Federal financial assistance for the purpose of coverage under the Federal civil rights statutes the Department enforces.

Legal Proceedings

How do I find out if there are any current legal proceedings related to this rule?

Please consult with your legal counsel for information on legal proceedings, if any, related to this rule.

Resources

Are there any other resources for this rule?

Yes, please review the following:

- Final Rule: https://www.federalregister.gov/documents/2024/05/06/2024-08711/nondiscrimination-in-health-programs-and-activities
- HHS Section 1557 Final Rule FAQ: Section 1557 Final Rule: Frequently Asked Questions | HHS.gov
- HHS Section 1557 Fact Sheet: Strengthening Nondiscrimination Protections and Advancing Civil Rights in Health Care through Section 1557 of the Affordable Care Act: Fact Sheet | HHS.gov
- HHS Resource for Covered Entities: Resources for Covered Entities | HHS.gov
- HHS Press Release: HHS Issues New Rule to Strengthen Nondiscrimination Protections and Advance Civil Rights in Health Care | HHS.gov