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ATTORNEYS

Health Care Reform Management Alert Series

Contraceptive Coverage Mandate for Religious Non-Profits

Issue 68

This is the sixty-eighth issue in our series of alerts for employers on selected topics in health care reform. (Click here to access our general summary of health care reform and other issues in this series) This series of Health Care Reform Management Alerts is designed to provide an in-depth analysis of certain aspects of health care reform and how it will impact your employer-sponsored plans.

[ ] Applies to grandfathered plans

[X] Applies to new health plans

As part of the requirement to cover preventive care and screening for women, the Affordable Care Act (ACA) requires all non-grandfathered group health plans to provide first dollar coverage for contraceptive services. The IRS, DOL and HHS (the "Agencies") have now issued final regulations updating their prior guidance on contraceptive coverage. This Alert supplements our prior Issues *10*, *25*, and *51*.

Background

In 2011, the Health Resource Services Administration (HRSA) had exempted "religious employers" from the requirement to provide contraceptive coverage. Many organizations who have an objection to the contraceptive mandate requirement felt left out of the definition. In response to the concern, HHS issued a one-year enforcement safe harbor and the Agencies issued proposed regulations which allowed eligible organizations to opt out of paying for some or all contraceptive services.

The Agencies have now issued final regulations implementing the contraceptive coverage mandate for the first plan year starting on or after January 1, 2014 and extending the safe harbor to this date. The final regulations provide some additional flexibility for those non-profits who object to such coverage on the basis of their religious beliefs. However, for profit employers must comply with the full contraceptive coverage mandate.

The Agencies believe the final regulations balance the concern for protecting religious freedom with the concerns for safeguarding public health and ensuring women have equal access to health care.

Type of Employer	Contraceptive Coverage Mandate
For Profit Employer	Applies
Religious Employer	Exempt
Eligible Organization	Limited Application for those self-certifying religious objections
Other Non-Profit Employer	Applies

Religious Employer Exemption

The final regulations adopt the definition of religious employer from the proposed regulations for purposes of the exemption. Thus, a religious employer is any employer that is:

- organized and operates as a non-profit entity, and
- a church, an integrated auxiliary of the church, a convention or association of churches, or the exclusively religious activities of any religious order.

Accommodations for Eligible Organizations

The proposed regulations had suggested an accommodation whereby "eligible organizations" -- non-profit religious employers who voice objections to the contraceptive coverage mandate on the basis of religious beliefs -- would be allowed to exclude the coverage from their plan, and instead the insurer would be required to issue a separate policy to cover contraceptives. The final regulations keep the definition of eligible organizations. However, separate policies are no longer required.

Self-Certification

Each employer who wants to be treated as an eligible organization must self-certify that it meets the definition of an eligible organization prior to the first plan year that they wish an accommodation. A standard form (EBSA Form 700) has been provided for use by these employers. The self-certification needs to be in writing and executed, and a copy must be provided to the insurer or the third party administrator (TPA). The employer is not required to file the self-certification with any of the Agencies. Rather, the employer must maintain the self-certification in its records in a manner consistent with the ERISA record retention requirements and make the self-certification available for examination upon request.

Insured Arrangements

Health insurance issuers no longer need to issue a separate policy for contraceptive coverage. Instead, insurers must expressly exclude coverage for contraceptive services from the policy for an eligible organization. The issuer must also notify participants and beneficiaries of such a plan that the issuer provides payments for contraceptive services at **no cost** separate from the plan as long as the participant or beneficiary remains enrolled in the plan. In this manner, the cost (if any) of providing such coverage falls on the insurer.

Self-Funded Arrangements

For plans of eligible organizations which are self-funded, the TPA will become a "plan administrator" within the meaning of ERISA as well as the "claims administrator" for purposes of providing payments for contraceptive services at no cost. Upon receipt of the self-certification, which must also state that the eligible organization will not act as the plan administrator or claims administrator and must cite to the final regulation, the TPA may decide whether to continue the relationship with the eligible organization. If it does so, the TPA must arrange separately (through insurance or otherwise) for payments for contraceptive services for the plan's participants and beneficiaries without cost sharing, premiums, fees or other charges. The eligible organization may not influence or interfere with the TPA's decision to provide such payments. The TPA must also notify participants and beneficiaries of such a plan that it provides payments for contraceptive services at **no cost** separate from the plan as long as the participant or beneficiary remains enrolled in the plan. Further, the TPA in its role as plan administrator must:

- set up and follow ERISA's claims and appeals procedures for contraceptive services
- provide ERISA's required notifications, such as an SPD and SMM.

Similarly to the insured context, the cost of covering these services will fall on the TPA. However, in this case, the TPA (unlike the insurer) will not be able to reap the savings of other health plan costs due to use of contraceptive services. As a result, the final regulations provide a mechanism for a TPA to seek "reimbursement" through an adjustment to the Federally-Facilitated Exchange (FFE) User Fee, which was established under regulations issued in March of 2013.

Federally-Facilitated Exchange User Fee Adjustment

Under the final regulations, a participating issuer who is offering a plan under an FFE may qualify for an FFE User Fee adjustment to the extent that the issuer either:

- made payments for contraceptive services on behalf of a TPA for an eligible organization's self-funded plan; or
- seeks an adjustment to the FFE User Fee with respect to a TPA that made payments for contraceptive services for an eligible organization's self-funded plan.

To take advantage of the adjustment, the TPA and issuer do not need to be part of the same affiliated group. The TPA must notify HHS that it intends for an issuer to seek a FFE User Fee adjustment following its receipt of the self-certification from an eligible organization.

Employer's To Do List:

- Determine if you are a "religious employer" who is exempt
- Determine if you are a nonprofit "religious organization" who wishes to self-certify as an "eligible organization"
    - If so, complete self-certification and provide to insurer or TPA

Also, follow the Health Care Reform Team on  *@SeyfarthEBLaw*

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