Health Care Reform
Bulletin

Final Rule Issued on ACA Contraceptive Coverage Exemptions

Provided by Cottingham & Butler

Quick Facts

- On July 10, 2015, final rules on women's preventive care coverage were released.
- The rules finalize an alternative to self-certification for religious organizations.
- The regulations also extend an accommodations approach to closely held for-profit businesses that object to providing contraceptive coverage.

The rules finalize an accommodations approach for nonprofit and for-profit organizations with religious objections to providing contraceptive coverage

Under the Affordable Care Act (ACA), non-grandfathered health plans must cover certain preventive health services for women, including contraceptives, without imposing cost-sharing requirements for the services.

On July 10, 2015, the Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (Departments) released **final regulations** on the ACA's women's preventive care coverage requirement.

These regulations:

- **Finalize an accommodation** for eligible nonprofit organizations and for-profit businesses with religious objections to providing contraceptive coverage, including related documentation standards.
- **Clarify general rules** on the coverage of preventive services generally.

The regulations are applicable on the first day of the first plan or policy year beginning on or after Sept. 12, 2015.

Accommodations for Religious Organizations

Churches and other houses of worship are exempt from the ACA's requirement to cover contraceptives. Other church-affiliated institutions that object to providing contraceptive coverage on religious grounds, such as schools, charities, hospitals and universities, can be eligible for an **accommodations approach**.

Under these accommodations, eligible organizations are not directly involved with providing any contraceptive coverage to which they object on religious grounds. Payments for these contraceptive services will be provided by an independent third party, such as an insurance company or third-party administrator (TPA), directly and free of charge.

To be eligible for the accommodation, an organization or employer must meet specific requirements and was required to self-certify that it met the criteria (HHS has provided a self-certification form for this purpose).

A number of organizations challenged **the self-certification requirement**, arguing that it infringes on religious liberty because it makes the nonprofit organization complicit in the provision of birth control.

In response to these challenges, the Departments previously provided an **alternative way** for an eligible organization to provide

notification of its objection to covering contraceptives: by notifying HHS in writing of its religious objection to providing contraceptive coverage instead of providing the self-certification to the plan's issuer or TPA. This option has been confirmed in the final regulations.

Accommodation for Closely Held For-profit Businesses

On June 30, 2014, in *Burwell v. Hobby Lobby Stores, Inc. et al*., the U.S. Supreme Court created a narrow exception to the contraceptive mandate for closely held for-profit businesses that object to providing coverage for certain types of contraceptives based on their sincerely held religious beliefs.

In light of the Supreme Court's decision in the Hobby Lobby case, the final regulations **amend the definition of an "eligible organization" for purposes of the accommodations approach** described above to include a closely held for-profit entity that has a religious objection to providing coverage for some or all of the contraceptive services otherwise required to be covered.

Under the final regulations, a qualifying closely held for-profit entity will not be required to contract, arrange, pay or refer for contraceptive coverage. Instead, payments for contraceptive services provided to participants and beneficiaries in the eligible organization's plan would be provided or arranged separately by an issuer or a TPA.

The final rules **define a qualifying closely held for-profit entity** based on an existing definition in the Internal Revenue Code. For this purpose, a "closely held for-profit entity" is an entity that:

- Is not a nonprofit entity;
- Has no publicly traded ownership interests; and
- Has more than 50 percent of the value of its ownership interest owned directly or indirectly by five or fewer individuals.

For purposes of this definition, all of the ownership interests held by members of a family are treated as being owned by a single individual. In addition, the rule provides that entities whose ownership structure is substantially similar to this definition can also qualify for the accommodation. An organization that is unsure about whether its ownership structure qualifies as "substantially similar" can seek guidance from HHS.

To be eligible for the accommodation, the for-profit entity's highest governing body (such as its board of directors, board of trustees or owners, if managed directly by its owners) must adopt a resolution or similar action, under the organization's applicable rules of governance and consistent with applicable state law, establishing that it objects to covering some or all of the contraceptive services on account of the owners' sincerely held religious beliefs.

A qualifying closely held for-profit entity seeking the accommodation may use either of the two notification options available to qualifying nonprofit entities that seek the accommodation.

Disclosure of the Decision to Assert a Religious Objection to Contraceptive Services

A for-profit entity taking advantage of the accommodation must make its self-certification or notice of objection available for examination upon request by the first day of the plan year to which the accommodation applies. The self-certification or notice of objection must be maintained consistent with ERISA's record retention requirements.

The final regulations do not establish any additional requirements to disclose the decision. The Departments believe that the current notice and disclosure standards for health plans provide individuals with an adequate opportunity to know that the employer has elected the accommodation for its group health plan and that they are entitled to separate payment for contraceptive services from another source without cost sharing.

The current standards require that, for each plan year to which the accommodation applies, a TPA that is required to provide or arrange payments for contraceptive services and a health insurance issuer required to provide payment for these services, provide to plan participants and beneficiaries written notice of the availability of separate payments for these services contemporaneous with (to the extent possible), but separate from, any application materials distributed in connection with enrollment or re-enrollment in health coverage.

Additional Clarifications on Coverage of Recommended Preventive Services

The final regulations also include the following clarifications related to the women's preventive care coverage requirement:

- ***Scope of recommended preventive services***: The regulations finalize the requirement to provide coverage without cost sharing with respect to the following three categories of recommendations and guidelines (in addition to those provided for in the Health Resources and Services Administration (HRSA) guidelines for women):
    - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force;
    - Immunizations for routine use that have in effect a recommendation from the CDC's Advisory Committee on Immunization Practices; and
    - Evidence-informed preventive care and screenings for infants, children and adolescents, provided for in guidelines supported by HRSA.
- ***Office visits***: The final regulations clarify that, when a recommended preventive service is not billed separately (or is not tracked as individual encounter data separately) from an office visit, plans and issuers must look to the **primary purpose** of the office visit when determining whether they may impose cost sharing with respect to the office visit. The Departments anticipate that the determination of the primary purpose of the visit will be resolved through normal billing and coding activities, as they are for other services.
- ***Out-of-network providers***: The final regulations do not require plans or issuers to provide coverage for recommended preventive services delivered by an out-of-network provider. However, the regulations clarify that a plan or issuer that does not have a provider in its network who can provide a particular recommended preventive service is required to cover the preventive service when performed by an out-of-network provider, and the plan or issuer may not impose cost sharing with respect to the preventive service.
- ***Reasonable medical management:*** Plans and issuers may use reasonable medical management techniques to determine the frequency, method, treatment or setting for required preventive coverage items or services to the extent they are not specified in the relevant recommendation or guideline. A plan or issuer may rely on the relevant clinical evidence base and established reasonable medical management techniques to determine the frequency, method, treatment or setting for coverage of a recommended preventive health service.
- ***Services not described***: The final regulations clarify that a plan or issuer may cover preventive services in addition to those required to be covered under the ACA. For these additional preventive services, a plan or issuer may impose cost sharing at its discretion, consistent with applicable law. A plan or issuer may also impose cost sharing for a treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service.

- ***Timing***: The preventive coverage requirement took effect for plan years beginning on or after Sept. 23, 2010. Coverage pursuant to recommendations or guidelines issued after that date must be provided for plan years beginning one year after the date the recommendation or guideline is issued.

  Also, required coverage must be provided through the end of the plan year, even if the recommendation or guideline changes during the plan year. This rule does not apply if a recommendation or guideline is downgraded to a "D" rating or if any related item or service is subject to a safety recall or is otherwise determined to pose a significant safety concern by an authorized federal agency.

More Information

Contact Cottingham & Butler if you would like more information on the ACA's requirement to provide preventive care coverage or on the exemptions or accommodations available.