



A Passionate Voice for Compassionate Care

Overview of Final Rules on Contraceptive Coverage For Religious Employers and Other Religious Organizations Issued June 28, 2013

On June 28, 2013, the Departments of Treasury, Labor, and Health and Human Services (HHS) issued final rules detailing how “religious employers” and nonprofit religious organizations that object to contraception do not have to provide contraceptive coverage under the Affordable Care Act (ACA). The final regulations:

- Simplify the definition of “religious employer” to eliminate provisions from the earlier regulations regarding the inculcation of religion and the serving and employing of co-religionists. Religious employers are exempt from having to provide contraceptive coverage to their employees and such employees will not have access to alternative contraceptive coverage.
- Establish an accommodation for “eligible organizations,” defined as objecting nonprofit religious organizations that do not qualify as religious employers. Such organizations are not required to contract, provide, pay or refer for contraceptive coverage and can continue to provide plans without contraception and sterilization coverage just as they did prior to ACA. Employees of eligible organizations who obtain contraceptive services will have such paid for by the insurer or, in the case of self-insured plans, by or as arranged by a third party administrator (TPA.)
- Extend the temporary safe harbor so that plans that renew between August 1, 2013 and December 31, 2013 do not have to comply with the final rules until their next plan year.
- Require insurers to segregate premiums paid by eligible organizations and pay for contraceptive services using funds from other sources.

Background

The ACA requires group health plans and issuers of group and individual health insurance coverage (including self-insured plans) to cover women’s preventive services without cost-sharing. As defined by the Health Resources and Services Administration (HRSA), women’s preventive services includes contraceptive services and sterilization (referred to herein collectively as “contraceptive services”).

In February 2013, the Administration issued a Notice of Proposed Rulemaking (NPRM) proposing: (1) changes to the definition of “religious employers” that are exempt from the contraception mandate altogether; and (2) creation of a category of “eligible organizations” that would not have to provide contraceptive coverage, but whose employees would have access to such coverage through a separate policy issued by their insurer or, in the case of self-insured plans, arranged by their TPA.

On April 4, 2013, CHA submitted a comment letter in response to the NPRM, noting first that its preferred option would be to have the term “religious employer” broadened to include organizations such as Catholic hospitals and other church-related ministries. We

also submitted recommendations on how the proposed regulations could be improved to better address the concerns of CHA members.

During the comment period which ended April 8, 2013, the Administration received more than 400,000 comments on the NPRM. After reviewing these comments, the final regulations were released on Friday, June 28, 2013.

The Final Rules: FAQs

What is the final definition of a “Religious Employer” that is exempt from the contraceptive mandate?

A “religious employer” is an organization that is referred to in Section 6033(a)(3)(A)(i) and (iii) of the Internal Revenue Code, which describe those entities that are exempt from filing a Form 990. This includes churches, their integrated auxiliaries and conventions or associations of churches, as well as the exclusively religious activities of any religious order.

What is the final definition of an “Eligible Organization” that qualifies for the accommodation?

The final rules define an “eligible organization” for purposes of the accommodation as an organization that meets **all** of the following criteria:

- The organization opposes providing coverage for some or all of the contraceptive services required to be covered under the ACA on account of religious objections.
- The organization is organized and operates as a nonprofit entity.
- The organization holds itself out as a religious organization.
- The organization self-certifies that it satisfies the first three criteria.

The final definition of eligible organization does not extend to for-profit employers, regardless of whether secular or religious.

How does the accommodation work for an Eligible Organization that has an insured group health plan? For eligible organizations that have insured plans, the first step will be to have an authorized individual execute a self-certification in the form specified by HHS prior to the first day of its first plan year beginning on or after January 1, 2014. All that will be asked on the form is for the organization to confirm that it satisfies the first three criteria of the “eligible organization” definition. The form does not have to be filed with any governmental agency, but does have to be maintained under the record retention requirements of ERISA and be made available for inspection on request.

The second step is for the organization to present the self-certification to its insurer. Once that is done, the eligible organization has no further obligations regarding contraceptive coverage, even if the insurer does not satisfy the requirements regarding contraceptive coverage imposed on it by the final regulations. Upon receiving the self-certification, the insurer is required by the federal government to assume sole responsibility, independent of the eligible organization and its plan, to pay for contraceptive services without cost-sharing, premium, fee, or other charge to plan participants and beneficiaries. One change from the proposed rules in this area is that under the final rules, the insurer will not issue the participants a separate contraceptive policy. Instead, the insurer must notify the participants (separately from any application or other materials distributed with regard to enrollment in

the insured group health plan) that it will make payment for contraceptive services. The insurer is required to segregate premium payments made by eligible organizations and to pay for contraceptive services from other funds.

The plan issued to the eligible organization must specifically exclude coverage of contraceptive services.¹ In addition, the rules require the insurer to ensure that such coverage is not reflected in the group health insurance premium, and that no fee or other charge in connection with such coverage is imposed on the eligible organization or its plan. In other words, the eligible organization will continue to purchase insurance without contraceptive coverage just as it did prior to ACA.

How does the accommodation work for an Eligible Organization that is self-insured?

In the case of a self-insured group health plan established or maintained by an eligible organization and administered by a third party, the first step will be for the eligible organization to provide its TPA with an executed copy of its self-certification in the form specified by HHS. In addition to requiring the organization to confirm that it satisfies the first three criteria of the “eligible organization” definition, the form requires the organization to (1) state that it will not act as the plan administrator or claims administrator with respect to contraceptive coverage and will not fund contraceptive services; and (2) cite specified provisions of the ERISA regulations, which explain the obligations of the TPA. The self-insured eligible organization does not have to file the self-certification with any governmental agency, but it does have to be maintained under the record retention requirements of ERISA and be made available for inspection on request.

Upon receipt of the self-certification, the TPA will then decide whether it chooses to become the plan administrator and claims administrator under ERISA for the contraceptive services. There is no legal requirement that a TPA accept this role. However, because the TPA will receive an allowance for administrative costs plus a margin, it will have an incentive to do so. If the TPA does agree to this role, it would then have the legal obligation to provide or arrange for separate payments for contraceptive services for plan participants and beneficiaries without cost. It also would be responsible for notifying participants (separately from any application or other materials distributed with regard to enrollment in the insured group health plan) of the availability of separate payments for contraceptive services. The TPA must ensure that no fee or other charge in connection with such services is imposed on the eligible organization or its plan.

The costs of the payments made for contraceptive services will be reimbursed through an adjustment in Federally Facilitated Exchange (FFE) user fees. The TPA will establish a relationship with an insurer participating in a FFE either directly or through the issuer that pays for the contraceptive services. The participating issuer will receive the adjustment in its user fees whether it made the payments for the contraceptive services on behalf of the third party administrator, or if it seeks the adjustment with respect to such payments made or

¹The final rules state that an insurer is only required to provide an eligible organization with a standard exclusion that excludes **all** mandated contraceptive services. The insurer may (but is not required to) offer a “customized exclusion” if an organization seeks to exclude some, but not all contraceptive services. In states that have mandated coverage of prescription contraception, but not of sterilization, eligible organizations would need to request a customized exclusion to exclude just sterilization.

arranged for by the TPA. The participating insurer and TPA will also receive an added allowance to compensate for administrative costs and margin associated with the contraceptive services provided under the accommodation.²

Is there an “opt out” for those employees who do not want coverage of contraceptive services?

In our comment letter, we requested an “opt out” for employees who did not want to have a separate policy for contraceptive coverage. As noted above, under the final rule there will be no separate contraceptive coverage policy. Therefore, as the rule points out there is nothing to “opt out” of. No employee with objections to contraception will be forced to have an insurance policy that includes contraception. The final rule requires the insurer to pay separately for contraceptive services obtained by such employees who choose to use them. In addition, the insurer must segregate premiums paid by the eligible organization to ensure the premiums are not used to fund the separate payments for contraceptive services.

Does the accommodation cover controlled entities included in our self-insured plan that do not fit the definition of eligible organization (i.e., are for-profit or not “held out” as religious)?

We had requested the Departments to permit all entities (including those that are for-profit) participating in a health plan sponsored by an eligible organization and which are controlled directly or indirectly by such eligible organizations to be covered by the accommodation. Our request was acknowledged in the preamble to the final rules, but the Departments determined that they would not extend the accommodation to such for-profit entities. They did clarify that if you have an objecting nonprofit entity that is 50% or more controlled by an eligible organization and which participates in the eligible organization’s self-insured plan, that nonprofit entity can be covered by the accommodation even if it does not “hold itself out” as religious.

How does the extension of the temporary safe harbor work?

The final rules extend the safe harbor for plans that have a plan year beginning prior to January 1, 2014 (the prior safe harbor period was set to expire for plan years beginning on or after August 1, 2013). Plans that are currently under the safe harbor do not have to execute another self-certification, but if their next plan year begins between August 1, 2013 and January 1, 2014, they will have to provide another notice to plan participants and beneficiaries. Guidance on the safe harbor extension can be found at

http://www.chausa.org/docs/default-source/advocacy/062813_preventive_services_guidance.pdf?sfvrsn=2

A copy of the final rules can be found at <http://www.chausa.org/docs/default-source/advocacy/2013-15530-dhhs.pdf?sfvrsn=2>

² The final rules include a process for an eligible organization to apply for a safe harbor if it is self-insured, but does not use a TPA.