Compliance with the Affordable Care Act (ACA) has been a financial and administrative challenge for most employers, but the challenge has been even more fundamental for many religious employers.

The ACA mandates that certain preventive-care benefits be covered at no cost by nongrandfathered health plans. Among the required preventive care benefits are all contraceptive methods approved by the Food and Drug Administration (FDA).

Various religious orthodoxies have historically condemned contraceptives, especially items and drugs viewed as terminating life (abortifacients) rather than preventing it. Religious organizations and even private employers teaching and ascribing to these beliefs have lobbied and litigated for a broad religious exemption from the reaches of the contraceptive mandate.

At the same time, federal authorities tasked with enforcing the ACA have attempted to reconcile these religious objections with the wording of the ACA and other laws, the unique health needs of women, and the cost and education barriers that impede many women from obtaining medical care.
This very public debate that has involved federal authorities, the Supreme Court, interest groups and individuals has left many confused about where the mandate comes from, what it says and how it applies to different groups. In this white paper, we attempt to combine and summarize the complex and many times disjointed answers federal authorities have provided to these important questions.

How Did the Contraceptive Mandate Come About?

The contraceptive mandate is part of a broader ACA provision stating that all nongrandfathered health plans must provide certain preventive services based on recommendations made by specified expert medical and scientific federal agencies. These agencies develop and modify lists of recommended services, which trigger coverage by nongrandfathered employer-provided health plans.

*Lockton comment:* Plans subject to the mandate generally must begin covering a newly recommended preventive item, drug or service by the first plan year following the one-year anniversary of the date the item or service is added to the list. When a plan is insured, the insurer might provide the sponsor with the opportunity to begin coverage immediately.

One such agency, the Health Resources and Services Administration (HRSA), is responsible for providing recommendations related to women’s health. In August 2011, the HRSA published its first recommendations for women, which included a broad range of items and services, including all FDA-approved contraceptive methods, sterilization and counseling. Nongrandfathered plans were required to provide these drugs, items and services without imposing cost-sharing (e.g., copayments, deductibles or coinsurance) beginning with the first plan year beginning on or after Aug. 1, 2012.

*Lockton comment:* It is important to note that the literal text of the ACA does not specifically mandate coverage of contraceptives without cost-sharing. Rather, that requirement comes from the HRSA recommendation incorporating the FDA’s findings, both of which are subject to change. Accordingly, the HRSA and the FDA may expand or contract their standards, subject to medical and scientific research and expertise.

What the Contraceptive Mandate Requires

There are 18 different female contraceptive methods outlined in the **FDA’s Birth Control Guide**. These include barrier, injectable, oral and emergency contraceptives. Plans subject to the mandate must make each method available, but the plan can limit the number of options available within each method. Additionally, plans may cover a generic drug or device without cost-sharing and impose cost-sharing for equivalent brand name drugs or devices.
Example: A nongrandfathered plan that makes oral contraceptives available without cost-sharing would still need to make injectables available without cost-sharing; however, it could limit which types of injectables are covered without cost-sharing and/or limit no-cost coverage to generic injectables.

Plans that impose cost-sharing on some options within a contraceptive method, or exclude coverage for certain options, must establish a process by which women can obtain a waiver. Costs that would otherwise be charged to the woman must be waived at the recommendation, based on medical necessity, of the woman’s healthcare provider. Medical necessity can include considerations such as side effects and the woman’s other health factors.

Where services are required as part of the contraceptive mandate (e.g., implantation of an intrauterine device or birth control counseling), the plan may impose cost-sharing for the office visit when the contraceptive services are billed separately by the provider or when the preventive services are not the primary purpose of the visit. Further, plans subject to the mandate may impose cost-sharing when services are performed by an out-of-network provider when an in-network provider is available.

Who Must Comply With the Contraceptive Mandate?

The ACA requires all nongrandfathered employer-provided health plans to comply with the preventive care mandate, including the mandate to provide contraceptives without cost-sharing. This is true regardless of plan size, and regardless of whether the plan is self-funded or fully insured.

Grandfathered plans are completely exempt from the preventive care mandate. If preventive care benefits are provided, a grandfathered plan may impose cost-sharing requirements.

Lockton comment: For a plan to be grandfathered, it must have been in existence on the date the ACA became law (Mar. 23, 2010) and must not have made significant plan design changes (e.g., eliminating benefits or increasing coinsurance percentages). Increased cost pressures and the desire to make plan design changes have led most employers to forgo the grandfathered status of their health plans.
The ACA does not include an exception from the preventive care mandate for plans of religious employers. Instead, federal regulators—sometimes with the prodding of the courts—have carved out exemptions and accommodations for certain religious employers. As a result, some plans are exempt from the contraceptive mandate, some must comply with the mandate subject to an accommodation and others must strictly comply.

*Lockton comment:* Note that the exemption and accommodations for religious employers apply only to the contraceptive mandate and not the other preventive benefits established by the ACA. This is different than the exemption for grandfathered plans, which applies to all preventive benefits, not just contraceptives.

Some religious employers have maintained the grandfathered status of their health plans in order to avoid the need to take advantage of the broader exemption available to grandfathered plans. The added bonus for these employers is they do not have to worry about qualifying for the exemption or accommodation discussed below.

### Plans Exempt From the Contraceptive Mandate

In the wake of vocal opposition to the contraceptive mandate, federal rules were established to provide a narrow exemption that applies only to nongrandfathered plans sponsored by the following nonprofit employers:

- Churches
- An integrated auxiliary of a church
- Conventions or associations of churches
- An entity performing the exclusively religious activities of a religious order

This exception has been colloquially termed the “house of worship” exception because of its narrow application.

*Lockton comment:* The exemption as originally written would have required that the employer’s purpose be the inculcation of religious values and that the employer primarily employ and serve individuals who share the religious tenants of the organization. These onerous requirements were abandoned in the present exemption.

Employers that meet this exemption are not required to offer contraceptives to their health plan’s female enrollees, and they are not required to certify as to their exempt status. Instead, exempt employers may simply communicate to their insurer or third-party administrator (TPA) which contraceptives, if any, are covered, and the insurer or TPA is not required to separately provide the contraceptives objected to by the exempt employer. Although not clear, it appears that no cost-sharing can be applied to contraceptive benefits voluntarily covered by the plan.
Plans Eligible for an Accommodation

The narrow exemption discussed previously does not apply to many other employers with religious objections to contraceptives. Instead, these other employers are offered an accommodation. The accommodation is meant to allow eligible employers to avoid the requirement to provide some or all contraceptives while still providing access to no-cost contraceptives to women covered by those health plans. This is accomplished by transferring to the plan’s insurer or TPA the responsibility to offer and pay for the contraceptives to which the employer objects.

**Lockton comment:** Employers can, consistent with their religious beliefs, claim an accommodation for some or all contraceptives; however, contraceptives for which an accommodation is not obtained must be covered without cost-sharing. For example, at the time of the *Burwell v. Hobby Lobby* decision, the Supreme Court decision (discussed below) that extended the accommodation to for-profit private companies whose owners opposed certain contraception methods, Hobby Lobby objected to four of the FDA-approved contraceptive methods but included coverage in its health plan for the remaining methods.

The accommodation applies to both nonprofit religious employers (e.g., religiously affiliated hospitals and schools, including student health plans for schools) and private, closely held employers that object to contraceptives (e.g., Hobby Lobby; see discussion below).

A nonprofit religious employer for this purpose includes one that meets four criteria. The employer:

1. On account of religious objections, opposes providing coverage for some or all of any contraceptive services otherwise required to be covered.
2. Is organized and operates as a nonprofit entity.
3. Holds itself out as a religious organization.
4. Self-certifies that it meets these criteria in accordance with the provisions of the final regulations.

In light of the 2014 Supreme Court decision in *Burwell v. Hobby Lobby*, federal authorities extended the accommodation to closely held for-profit employers. For this purpose, closely held means two things:

1. No ownership interest in the for-profit entity is publicly traded.
2. More than 50 percent of the value of the for-profit entity is owned directly or indirectly by five or fewer individuals (or a “substantially similar” ownership structure applies).

For-profit, closely held employers claiming the accommodation must also self-certify in order to claim the accommodation.
An eligible religious employer that is not a house of worship can self-certify and obtain an accommodation in one of two ways:

1. Complete EBSA Form 700 and send a copy to each health insurance issuer and TPA for the plan.
2. Notify the Department of Health and Human Services (HHS) of its name, its eligibility for the accommodation and its religious objection and identify each of its plans’ insurers and TPAs. A model notice is available for use in notifying HHS. HHS will then notify each insurer or TPA.

Regardless of the method chosen, the result is the same: An insurer or TPA that receives notification is responsible for providing the objected-to contraceptives at no cost to enrollees in the employer’s plan.

Insurers and TPAs must annually notify participants and dependents covered under a plan sponsored by a customer that self-certifies. The notice lets covered individuals know that the sponsor does not fund contraception benefits, but the insurer or TPA will pay for them.

**Lockton comment:** For certifying employers whose plans are self-insured and subject to ERISA, the TPA literally becomes the ERISA “plan administrator” when it comes to contraception benefits. The TPA picks up the obligation to establish and operate procedures for processing claims for contraception benefits, and complying with disclosure and other requirements applicable to group health plans under ERISA for such benefits. Presumably, the TPA has an obligation to provide an SPD-like summary of contraception benefits and provide other disclosures and reports.

Initially, the insurer or TPA is on the hook for paying the costs associated with providing the contraceptives to which the employer objects.

The insurer or TPA cannot pass along to employers requesting accommodation, directly or indirectly, the cost of providing the contraception benefits. Insurers must segregate premium revenue collected from the objecting employer from the monies used to pay for contraceptives supplied to the plan’s female enrollees.

**Lockton comment:** An insurer may claim an offset against the user fees it pays to offer products in the federally facilitated public health insurance exchange (think Healthcare.gov) in an amount equal to the cost of providing the contraception benefits. TPAs, which don’t offer products in the exchanges, must find an insurer that does and ask it to submit a request for an offset of exchange user fees on behalf of the TPA. When the insurer receives the offset, it must promptly forward the money to the TPA. Both insurers and TPAs must keep records of these transactions for 10 years.
Additional Modifications to the Accommodation Process Might Be Forthcoming

Six federal circuit courts of appeal have upheld the accommodation process after considering arguments that the accommodation itself is a substantial restriction on an objecting employer’s religious beliefs. Employers challenging the accommodation have argued that the process violates their religious beliefs by coercing them to cause another party (an insurer or TPA) to do something (provide contraceptives) that the objecting employer finds reprehensible.

One circuit court of appeals (the Eighth Circuit, with jurisdiction over several midwestern states) has sided with the objecting employers, and concluded that the government can and must find an accommodation process that is less restrictive to the religious rights of objecting employers. In a recent opinion, the court suggested alternatives to the current process, including a less descriptive notice that would merely voice the employer’s objection. The government could then independently identify and notify the employer’s insurer or TPA, which would then provide the objected-to contraceptives. Two additional alternatives were suggested:

- The government could provide the contraceptives itself through individual insurance policies in exchanges or directly through health centers, clinics and hospitals.
- The government could offer some combination of subsidies, reimbursements, tax credits or tax deductions to women not otherwise able to obtain contraceptives through an employer-provided health plan.

In light of the differing opinions at the circuit court of appeals level, the Supreme Court has agreed to review the validity of the current accommodation process. Arguments before the court are set for March 2016, and a decision is expected no later than June 2016.

More Lockton Resources

Please click to learn more about the government’s initial attempt at an accommodation and the obligation of insurers and TPAs.

Read our recap of the Hobby Lobby decision.

Please click to learn more about the current accommodation process established in the wake of Hobby Lobby and related cases.

Read our blog post that defines which for-profit businesses can claim an accommodation.
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