McGraw Wentworth
a Marsh & McLennan Agency LLC company

REFORM Update

Issue Seventy-One July 2013

July 30, 2013

A number of federal agencies and departments recently released final guidance clarifying the requirement to offer 100 percent coverage for FDA-approved contraceptive services and the exception permitted for religious organizations.

The expanded coverage for specific well-woman services was explained in our *Reform Update* at **http://www.mcgrawwentworth.com/Reform_Update/2013/Reform_Update_60.pdf**.

These final regulations clarify how religious organizations should comply with the requirement to cover FDA-approved contraceptives. Certain religious organizations are exempt from covering contraceptive services. Other eligible organizations can exclude this coverage, but their insurance carriers or third party administrators (TPAs) will have to provide it. The final regulations simplify the process of covering contraceptives for employees of these organizations.

Exempt Religious Organizations

The final regulations exempt specific religious organizations from having to offer contraceptive services coverage. Exempt organizations are defined as non-profit organizations as described in Section 6033(a)(1) and Section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

This exemption generally applies to churches, their integrated auxiliaries, conventions or associations of churches, and the exclusively religious activities of any religious order. Only FDA-approved contraceptive methods and contraceptive counseling are exempt. Other well women preventive services must be covered as defined by the well-woman services expansion.

Accommodations for Religious-Affiliated Organizations

Many religious-affiliated organizations were opposed to covering contraceptive services because using contraceptives violates their religious tenets. As a result of their opposition, the government delayed the requirement to cover contraceptive services for specific religious organizations. These organizations would have been required to comply with the requirement as of the first day of the first plan year beginning on or after August 1, 2013.

The final regulations extend that delay. Qualifying religious organizations can now delay the effective date for contraceptive coverage until the first day of the first plan year beginning on or after January 1, 2014. They need this additional time because the final regulations modify the accommodations for qualifying religious-affiliated organizations.

The government will accommodate qualifying religious-affiliated organizations as follows:

1. Eligible organizations will not be required to communicate, fund or provide benefits for FDA-approved contraceptives.
2. Insurance carriers will cover contraceptive services for insured eligible organizations' plan participants at no cost. TPAs will cover contraceptives for plan participants of eligible organizations with self-funded plans at no cost. Insurance carriers and TPAs will pay directly for these services. Plan participants will not need separate insurance policies.

The requirements to be a qualifying religious organization remain the same. A qualifying religious organization is called an eligible organization. An eligible organization is one that:

1. Opposes coverage for some or all of the mandated contraceptive services ***on account of religious objections.***
2. Is organized and operates as a non-profit entity.
3. Presents itself as a religious organization.
4. Self-certifies that it meets these criteria and specifies the contraceptive services to which it objects.

A new self-certification form for 2014 was issued along with the final guidance. It can be found at **www.dol.gov/ebsa/preventiveserviceseligibleorganizationcertificationform.doc**. Employers must complete the self-certification before the first day of the first plan year beginning on or after January 1, 2014. It needs to be completed only once, and should be sent to the eligible organization's insurance carrier or TPA. It will also need to be provided when an eligible organization changes insurance carriers or TPAs. The self-certification does not have to be sent to any governmental agency, but must be produced if the eligible organization is ever audited. It must be retained following ERISA rules for at least six years after the filing date.

An eligible organization will not have to contract, arrange, pay or refer for any contraceptive coverage to which it objects on religious grounds.

Insured Plan Process

If the group health plan is insured, then the process will be as follows:

1. The eligible organization must send the self-certification to its insurance carrier.
2. The insurance carrier must exclude coverage for contraceptive services from the eligible organization's group health insurance contract.
3. The insurance carrier must independently notify plan participants that the insurer will pay for contraceptive services separately, at no cost to the participant, while the participant remains enrolled in the plan. The eligible organization is not involved with notifying participants or paying for contraceptive services.

4. The insurance carrier must separate the premium revenue collected from an eligible organization from funds used to pay for contraceptive services. The insurer cannot impose any fees, premiums or other charges on the eligible organization for covering contraceptive services.

The details on how insurers will pay for contraceptive services are not particularly clear. Insurance carriers will likely determine this. Insurers will **not** be required to establish contraceptive-only individual policies, and will be able to use medical management techniques to manage costs.

Actuaries, economists and insurance carriers estimate that this coverage will be cost-neutral. Because contraceptive services may improve women's overall health and decrease unwanted pregnancies, the coverage may even reduce costs. HHS intends to issue new guidance on these direct payments. Insurance carriers may treat them as an adjustment to claim costs when it comes to medical loss ratio and risk corridor program calculations.

Self-Funded Plan Process

The process for self-funded plans will be slightly different. Self-funded plans typically hire TPAs to manage eligibility and process claims. The initial guidance proposed three options that TPAs could use to cover contraceptives for employees of eligible organizations. The final guidance gives just a single option.

The process will be as follows:

1. The eligible organization sends the self-certification to the TPA. The self-certification must:
    a. State that the eligible organization will not act as the plan administrator or claims administrator for contraceptive services. Further, the eligible organization will not fund contraceptive services.
    b. Explain the TPA's obligations to pay for contraceptive services directly. The TPA will need to assume the role of the ERISA plan administrator for the direct payments for contraceptive services. A limited number of ERISA responsibilities will apply to a TPA in this situation.
2. The TPA may accept or decline the responsibility to provide administrative services to the eligible organization.
3. If the TPA accepts the responsibility, then it must arrange to pay for contraceptive services separately.
    a. The TPA can arrange with a health insurance carrier offering coverage through a Federally Facilitated Exchange to provide direct payments to the eligible organization's plan participants for contraceptive services.
    b. If the TPA opts to provide direct payments to participants, they must do so without cost-sharing, premium, fees or any other charge to plan participants. If the TPA makes the payments directly, the TPA can apply medical management programs for cost control purposes.

4. The TPA must notify plan participants that it or the insurer will pay the total cost for contraceptive services separately while the participant remains enrolled in the plan. The eligible organization will not inform participants or pay for contraceptive services.
5. Either the TPA or the insurance carrier will be reimbursed for the cost of providing direct payments.
    a. If the insurance carrier pays directly, the funds paid can be offset by the user fees that a Federally-Facilitated Exchange (FFE) charges.
    b. A TPA paying directly must arrange for credit against the Exchange fees with a carrier in an FFE and then the carrier must reimburse the TPA.

    An allowance can be included for administrative costs and margin. HHS will establish a process that insurers can use to take credits against the FFE user fees. Insurers must pay TPAs that provide direct funding within 60 days of receiving the credit to the user fees.

Either the health insurer or TPA (whichever is paying directly for contraceptive services) must notify the plan participants of this arrangement at the beginning of the plan year. The notice should state that the eligible organization does not fund or administer direct payments for contraceptive services. It must indicate that the insurer or TPA will pay for contraceptive services separately. The notice should also explain how the participants can access the no-cost contraceptive services and include contact information if plan participants have questions.

The final regulations include the following model notice:

> ‘‘Your employer has certified that your group health plan qualifies for an accommodation with respect to the federal requirement to cover all Food and Drug Administration-approved contraceptive services for women, as prescribed by a health care provider, without cost sharing. This means that your employer will not contract, arrange, pay, or refer for contraceptive coverage. Instead, [name of third party administrator/health insurance issuer] will provide or arrange separate payments for contraceptive services that you use, without cost sharing and at no other cost, for so long as you are enrolled in your group health plan. Your employer will not administer or fund these payments. If you have any questions about this notice, contact [contact information for third party administrator/health insurance issuer].’’

The final regulations retained the determination of eligible organization at the employer level.

Concluding Thoughts

This final guidance actually simplifies the original rules for eligible organizations. It extends their safe harbor. Eligible organizations will need to adopt these accommodations for covering contraceptives as of the first day of the first plan year beginning on or after January 1, 2014.

These organizations must complete the new self-certification and send it to their insurance carriers and TPAs. If the eligible organization is self-funded, it should send the self-certification as soon as possible. TPAs can refuse to pay directly for contraceptive services. If this is the case, eligible organizations may need time to find a TPA willing to take on the increased responsibility.

The court cases challenging the requirement to cover contraceptive services continue. It is possible the Supreme Court will issue a ruling on these challenges. So far, however, the Court has not added this issue to its docket.