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Preventative Services

Beginning with plan years starting on or after September 23, 2010, group health plans are required to cover certain preventive services delivered by in-network providers without cost-sharing. Cost-sharing includes out-of-pocket costs such as deductibles, co-payments, and co-insurance.

Coverage of Preventive Services Does Not Compromise High Deductible Health Plan Status

According to IRS guidance, a health plan will not fail to qualify as a high deductible health plan (HDHP) merely because it provides certain preventive health services without a deductible, as required under Health Care Reform.

Required Coverage of Preventive Services

The term "preventive services" refers generally to routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems. Under the law, group health plans must provide coverage of certain preventive health services—without cost-sharing—based on various agency and advisory committee recommendations and guidelines. Guidelines for preventive services are regularly updated to reflect new scientific and medical advances. As new services are approved, health plans will be required to cover them with no cost-sharing for plan years beginning one year later.

The following is a partial listing of preventive services required to be covered under Health Care Reform. A complete list of required preventive services is available from the U.S. Department of Health and Human Services.

For Adults

- Blood pressure screening
- Cholesterol screening for adults of certain ages or at higher risk
- Colon cancer screening for adults over 50
- Immunization vaccines (doses, recommended ages, and recommended populations vary)
- Obesity and tobacco use screening
- Type 2 diabetes screening for adults with high blood pressure

For Children

- Autism screening for children at certain ages
- Blood pressure screening
- Alcohol and drug use assessment for adolescents
- Developmental screening for children under age 3
- Immunization vaccines from birth to age 18 (doses, recommended ages, and recommended populations vary)
- Lead screening for children at risk of exposure
- Obesity screening and counseling

Guidelines for Women's Preventive Services

Starting with plan years beginning on or after August 1, 2012, non-grandfathered group health plans are required to cover additional women's preventive services such as well-woman visits, breastfeeding support, domestic violence screening, and contraception without cost-sharing.

Coverage of Contraceptive Methods—Exemption for Religious Employers and Other Accommodations

In light of the religious concerns of certain organizations, various accommodations are available with respect to the requirement that non-grandfathered plans cover contraceptive services without cost-sharing (the "contraceptive mandate").

Special Updates: Contraceptive Mandate Violates Federal Law for Certain For-Profit Corporations

The U.S. Supreme Court has ruled that the ACA's contraceptive mandate, as applied to closely held corporations, violates the

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Religious Freedom Restoration Act (RFRA). **As a result of the ruling, closely held for-profit corporations that object to this requirement based on sincerely held religious beliefs cannot be required to provide such coverage.**

According to the opinion, the contraceptive mandate substantially burdens the exercise of religion in violation of the RFRA with respect to closely held corporations. The federal government did not prove that the mandate is the least restrictive means of furthering the governmental interest in guaranteeing cost-free access to certain methods of contraception.

The decision does not address the RFRA's applicability to publicly traded corporations. In addition, the opinion makes clear that the decision concerns only the contraceptive mandate and does not render all insurance-coverage mandates (e.g., for vaccinations or blood transfusions) in violation of the RFRA if they conflict with an employer's religious beliefs.

Proposed Rules to Expand Accommodations to Certain Closely Held For-Profit Entities

As a result of the June 2014 U.S. Supreme Court ruling discussed above, the U.S. Departments of Labor, Treasury, and Health and Human Services have proposed rules to expand existing accommodations to the contraceptive mandate to certain closely held for-profit entities that have religious objections to providing coverage for some or all contraceptive services. The proposed rules describe two alternative approaches for defining such an entity:

- Under one approach, the entity could not be publicly traded, and ownership of the entity would be limited to a certain number of owners.
- Under an alternative approach, the entity could not be publicly traded, and a minimum percentage of ownership would be concentrated among a certain number of owners.

The proposed rules solicit public comment on an appropriate number and/or concentration, other possible approaches, and on documentation and disclosure of a closely held for-profit entity's decision not to provide contraceptive coverage. The proposed rules further provide that valid corporate action taken in accordance with the entity's governing structure, in accordance with state law, stating its owners' religious objection can serve to establish that the entity objects to providing contraceptive coverage on religious grounds.

Expedited Disclosure Requirements May Apply to Closely-Held For-Profit Corporations That Reduce or Eliminate Contraceptive Coverage Mid-Plan Year

According to guidance from the U.S. Department of Labor, closely held for-profit corporations that intend to cease providing health coverage for some or all contraceptive services mid-plan year **will trigger notice requirements to plan participants and beneficiaries** if the plan is subject to the Employee Retirement Income Security Act (ERISA):

- If an ERISA plan excludes all or a subset of contraceptive services from coverage under its group health plan, **the plan's summary plan description (SPD) must describe the extent of the limitation or exclusion of coverage.**
- **For plans that reduce or eliminate coverage of contraceptive services after having provided such coverage, expedited disclosure requirements apply.** The expedited disclosure requirements generally require disclosure within 60 days of adoption of a "material reduction in covered services or benefits."

Other disclosure requirements may apply under state insurance laws. Click here to review the guidance in its entirety.

Existing Religious Employer Exemption & Other Non-Profit Accommodations

Group health plans sponsored by "religious employers" are exempt from the requirement to provide contraceptive coverage. Effective for plan years beginning on or after August 1, 2013, final regulations simplify the definition

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of "religious employer" to mean "an employer that is organized and operates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code."

Accommodations for Other Non-Profit Religious Organizations

Effective for plan years beginning on or after January 1, 2014, the final rules also provide accommodations for non-exempt, non-profit religious organizations that object to contraceptive coverage on religious grounds. Under this accommodation, an eligible organization does not have to contract, arrange, pay or refer for contraceptive coverage. An eligible organization is one that:

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; and
4. Self-certifies that it meets criteria 1-3 above prior to the beginning of the first plan year to which an accommodation is to apply.

A copy of the self-certification must be provided to the eligible organization's health insurance issuer or third-party administrator, who will then provide separate payments for contraceptive coverage for those women enrolled in the health plan, at no cost to the women or to the eligible organization.

For any plan year to which an accommodation applies, a health insurance issuer or a third-party administrator arranging or providing for separate payments pursuant to the accommodation must provide timely written notice about this fact to plan participants and beneficiaries of eligible organizations. Model language that may be used to satisfy this notice requirement (or substantially similar language) is included in the final rules.

Special Update: Interim Final Rules Provide Additional Option for Eligible Organizations to Notify HHS of Religious Objections to Contraception Coverage

In response to the U.S. Supreme Court's July 3, 201 4 Order concerning notice to the federal government that an eligible organization has a religious objection to providing coverage, interim final rules **establish another option for an eligible organization to avail itself of the accommodation.** Under the rules, an eligible organization may notify the U.S. Department of Health and Human Services (HHS) in writing of its religious objection to contraception coverage. HHS will then notify the insurer for an insured health plan, or the Department of Labor will notify the third-party administrator (TPA) for a self-insured plan, that the organization objects to providing contraception coverage and that the insurer or TPA is responsible for providing enrollees in the health plan separate no-cost payments for contraceptive services for as long as they remain enrolled in the health plan. Regardless of whether the eligible organization self-certifies in accordance with the July 2013 final rules, or provides notice to HHS in accordance with the interim final rules, the obligations of insurers and/or TPAs regarding providing or arranging separate payments for contraceptive services are the same. A model notice, with line-by-line instructions, is also available. According to the instructions, the model notice may, but is not required to, be used by an eligible organization to:

- Provide notice to the Secretary of HHS that the eligible organization has a religious objection to coverage of all or a subset of contraceptive services; and
- Provide updated information to HHS.

If the eligible organization establishes or maintains more than one plan, it may submit a separate notice for each plan, or it may modify the form accordingly.

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Temporary Enforcement Safe Harbor
Certain non-profit organizations with religious objections to contraceptive coverage are **provided more time to comply**—until the first plan year beginning on or after January 1, 2014—if specific criteria are met. Among other requirements, the health plan maintained by the organization must provide a notice to plan enrollees which states that some or all contraceptive coverage will not be provided under the plan during the temporary enforcement safe harbor period. The organization also must self-certify that it satisfies the criteria for the safe harbor.