No. 13-919

In the Supreme Court of the United States

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

WILLIAM NEWLAND, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

The Religious Freedom Restoration Act of 1993 (RFRA), 42 U.S.C. 2000bb *et seq.*, provides that the government "shall not substantially burden a person's exercise of religion" unless that burden is the least restrictive means to further a compelling governmental interest. 42 U.S.C. 2000bb-1(a) and (b). The question presented is whether RFRA allows a for-profit corporation to deny its employees the health coverage of contraceptives to which the employees are otherwise entitled by federal law, based on the religious objections of the corporation's owners.

PARTIES TO THE PROCEEDINGS

Petitioners are Kathleen Sebelius, in her official capacity as Secretary of the United States Department of Health and Human Services; Thomas E. Perez, in his official capacity as Secretary of the United States Department of Labor; Jacob J. Lew, in his official capacity as Secretary of the United States Department of the Treasury; the United States Department of Health and Human Services; the United States Department of Labor; and the United States Department of the Treasury.

Respondents are William Newland; Paul Newland; James Newland; Christine Ketterhagen; Andrew Newland; and Hercules Industries, Inc., a Colorado Corporation.

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PETITION FOR A WRIT OF CERTIORARI

The Solicitor General, on behalf of Kathleen Sebelius, Secretary of Health and Human Services, *et al.*, respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Tenth Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-10a) is unreported but is available at 2013 WL 5481997. The opinion of the district court (App., *infra*, 11a-33a) is reported at 881 F. Supp. 2d 1287.

JURISDICTION

The judgment of the court of appeals was entered on October 3, 2013. On December 18, 2013, Justice Sotomayor extended the time within which to file a petition for a writ of certiorari to January 31, 2014.

The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

Pertinent statutory and regulatory provisions are set forth in the appendix to this petition. App., *infra*, 34a-78a.

STATEMENT

1. Most Americans with private health coverage obtain it through an employer-sponsored group health plan. Cong. Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* 4 & Tbl. 1-1 (Dec. 2008). The cost of such coverage is typically covered by a combination of employer and employee contributions, *id.* at 4, with the employer's share serving as "part of an employee's compensation package," *Liberty Univ., Inc.* v. *Lew*, 733 F.3d 72, 91 (4th Cir.) (citation omitted), cert. denied, 134 S. Ct. 683 (2013). The federal government subsidizes group health plans through favorable tax treatment. While employees pay income and payroll taxes on their cash wages, they typically do not pay taxes on their employer's contributions to their health coverage. 26 U.S.C. 106.

Congress has established certain minimum coverage standards for group health plans. For example, in 1996, Congress required such plans to cover certain benefits for mothers and newborns. 29 U.S.C. 1185; 42 U.S.C. 300gg-4; see 26 U.S.C. 9811. In 1998, Congress required coverage of reconstructive surgery after covered mastectomies. 29 U.S.C. 1185b; 42 U.S.C. 300gg-6.

2. In the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Affordable

Care Act or Act),[1] Congress provided for additional minimum standards for group health plans and health insurers offering coverage in the group and individual markets.

a. The Act requires non-grandfathered group health plans to cover certain preventive-health services without cost sharing—that is, without requiring plan participants and beneficiaries to make copayments or pay deductibles or coinsurance. 42 U.S.C. 300gg-13 (Supp. V 2011) (preventive-services coverage provision). This provision applies to (among other types of health coverage) employment-based group health plans covered by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, see 29 U.S.C. 1185d (Supp. V 2011), and it can thus be enforced by plan participants and beneficiaries pursuant to ERISA's enforcement mechanisms. See 29 U.S.C. 1132(a)(1)(B) and (3).[2]

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[1] Amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

[2] The Secretary of Labor may likewise bring an ERISA enforcement action with respect to such a group plan. 29 U.S.C. 1132(a)(5). The preventive-services coverage provision is also enforceable through the imposition of taxes on the employers that sponsor such plans. 26 U.S.C. 4980D; see 26 U.S.C. 9815(a)(1), 9834. (Payment of such a tax by an employer, however, would not relieve a plan of its legal obligation to cover recommended preventive-health services without cost sharing, which would remain as a freestanding ERISA requirement for such group health plans, see 29 U.S.C. 1185d (Supp. V 2011).) In addition, with respect to health insurers in the individual and group markets, States may enforce the Act's health insurance market reforms, including the preventive-services coverage provision. 42 U.S.C. 300gg-22(a)(1) (Supp. V 2011). If the Secretary of Health and Human Services determines that a State "has failed to substantially enforce" one of the insurance market reforms with

"Prevention is a well-recognized, effective tool in improving health and well-being and has been shown to be cost-effective in addressing many conditions early." Inst. of Med., *Clinical Preventive Services for Women: Closing the Gaps* 16 (2011) (IOM Report). Nonetheless, the American health-care system has "fallen short in the provision of such services" and has "relied more on responding to acute problems and the urgent needs of patients than on prevention." *Id.* at 16-17.

To address this problem, the Act and its implementing regulations require coverage of a wide range of preventive services without cost, including services such as cholesterol screening, colorectal cancer screening, and diabetes screening for those with high blood pressure, 42 U.S.C. 300gg-13(a)(1) (Supp. V 2011); see 75 Fed. Reg. 41,741-41,744 (July 19, 2010); routine vaccination to prevent vaccine-preventable diseases, such as measles and tetanus, 42 U.S.C. 300gg-13(a)(2) (Supp. V 2011); see 75 Fed. Reg. at 41,740, 41,745-41,752; and "evidence-informed preventive care and screenings" for infants, children, and adolescents, 42 U.S.C. 300gg-13(a)(3) (Supp. V 2011); see 75 Fed. Reg. at 41,753-41,755.

Further, and as particularly relevant here, the Act requires coverage, "with respect to women, [of] such additional preventive care and screenings * * * as provided for in comprehensive guidelines supported by the Health Resources and Services Administration" (HRSA), which is a component of the Depart-

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respect to such insurers, she conducts such enforcement herself and may impose civil monetary penalties. 42 U.S.C. 300gg-22(a)(2) (Supp. V 2011); see 42 U.S.C. 300gg-22(b)(1)(A) and (2) (2006 & Supp. V 2011).

ment of Health and Human Services (HHS). 42 U.S.C. 300gg-13(a)(4) (Supp. V 2011). Congress included this provision because "women have different health needs than men, and these needs often generate additional costs." 155 Cong. Rec. 29,070 (2009) (statement of Sen. Feinstein); see IOM Report 18. In particular, "[w]omen of childbearing age spend 68 percent more in out-of-pocket health care costs than men." 155 Cong. Rec. at 29,070 (statement of Sen. Feinstein). And women often find that copayments and other cost sharing for important preventive services "are so high that they avoid getting [the services] in the first place." *Id.* at 29,302 (statement of Sen. Mikulski); see IOM Report 19-20.

Because HRSA did not have such comprehensive guidelines for preventive services for women, HHS requested that the Institute of Medicine (Institute or IOM) develop recommendations for it. 77 Fed. Reg. 8725-8726 (Feb. 15, 2012); IOM Report 1-2. The Institute is part of the National Academy of Sciences, a "semi-private" organization Congress established "for the explicit purpose of furnishing advice to the Government." *Public Citizen* v. *United States Dep't of Justice*, 491 U.S. 440, 460 & n.11 (1989) (citation omitted); see IOM Report iv.

To formulate recommendations, the Institute convened a group of experts, "including specialists in disease prevention, women's health issues, adolescent health issues, and evidence-based guidelines." IOM Report 2. The Institute defined preventive services as measures "shown to improve well-being, and/or decrease the likelihood or delay the onset of a targeted disease or condition." *Id.* at 3. Based on the Institute's review of the evidence, it recommended a num-

ber of preventive services for women, such as screening for gestational diabetes for pregnant women, screening and counseling for domestic violence, and at least one well-woman preventive care visit a year. *Id.* at 8-12.

The Institute also recommended access to the "full range" of "contraceptive methods" approved by the Food and Drug Administration (FDA), as well as sterilization procedures and patient education and counseling for all women with reproductive capacity. IOM Report 10; see *id.* at 102-110. FDA-approved contraceptive methods include oral contraceptive pills, diaphragms, injections and implants, emergency contraceptive drugs, and intrauterine devices (IUDs). FDA, *Birth Control: Medicines To Help You*, http://www.fda.gov/ForConsumers/ByAudience/ForWomen/FreePublications/ucm313215.htm (last updated Aug. 27, 2013).

In making that recommendation, the Institute noted that nearly half of all pregnancies in the United States are unintended and that unintended pregnancies can have adverse health consequences for both mothers and children. IOM Report 102-103. In addition, the Institute observed, use of contraceptives leads to longer intervals between pregnancies, which "is important because of the increased risk of adverse pregnancy outcomes for pregnancies that are too closely spaced." *Id.* at 103.

HRSA adopted women's preventive-health guidelines consistent with the Institute's recommendations, including a guideline recommending access to all FDA-approved contraceptive methods as prescribed by a health-care provider. HRSA, HHS, *Women's Preventive Services Guidelines*, App., *infra*, 73a-78a.

The relevant regulations adopted by the three Departments implementing this portion of the Act (HHS, Labor, and Treasury) require non-grandfathered group health plans to cover, among other preventive services, the contraceptive services recommended in the HRSA guidelines. 45 C.F.R. 147.130(a)(1)(iv) (HHS); 29 C.F.R. 2590.715-2713(a)(1)(iv) (Labor); 26 C.F.R. 54.9815-2713(a)(1)(iv) (Treasury) (collectively referred to in this brief as the contraceptive-coverage provision).

b. The implementing regulations authorize an exemption from the contraceptive-coverage provision for the group health plan of a "religious employer." 45 C.F.R. 147.131(a). A religious employer is defined as a non-profit organization described in the Internal Revenue Code provision that refers to churches, their integrated auxiliaries, conventions or associations of churches, and the exclusively religious activities of any religious order. *Ibid.* (cross-referencing 26 U.S.C. 6033(a)(3)(A)(i) and (iii)).

The implementing regulations also provide accommodations for the group health plans of religious nonprofit organizations that have religious objections to providing coverage for some or all contraceptive services. 45 C.F.R. 147.131(b). After such an organization accepts an accommodation, the women who participate in its plan will generally have access to contraceptive coverage without cost sharing though an alternative mechanism established by the regulations, under which the organization does not contract, arrange, pay, or refer for contraceptive coverage. 78 Fed. Reg. 39,870, 39,872, 39,874-39,886 (July 2, 2013).

c. The preventive-services coverage provision in general, and the contraceptive-coverage provision in

particular, apply only if an employer offers a group health plan. Employers, however, are not required to offer group health plans. Certain employers with more than 50 full-time-equivalent employees are subject to a tax if they do not offer coverage, 26 U.S.C. 4980H, and they thus are afforded a choice between offering a group health plan and the prospect of paying the tax. See *Liberty Univ.*, 733 F.3d at 98; cf. *National Fed'n of Indep. Bus.* v. *Sebelius*, 132 S. Ct. 2566, 2596-2597 (2012).

3. Respondents are the for-profit corporation Hercules Industries, Inc., and five individuals who are the corporation's controlling shareholders and officers (collectively referred to here as the Newlands). App., *infra*, 3a. Hercules Industries manufactures and distributes heating, ventilation, and air conditioning products and equipment. See *id.* at 15a. It has 265 full-time employees at various locations. See C.A. App. 27 (First Am. Compl. para. 38). Hercules Industries' employees obtain health coverage through a self-insured group health plan. App., *infra*, 16a.

The Newlands "are practicing and believing Catholic Christians" who believe that all forms of contraception are "intrinsic evils." C.A. App. 26 (First Am. Compl. paras. 27, 30, 31). In this suit, respondents contend that the requirement that the Hercules Industries group health plan cover FDA-approved contraceptives violates the Religious Freedom Restoration Act of 1993 (RFRA), 42 U.S.C. 2000bb *et seq.*, which provides that the government "shall not substantially burden a person's exercise of religion" unless that burden is the least restrictive means to further a compelling governmental interest. App., *infra*, 4a; see 42 U.S.C. 2000bb-1(a) and (b)(2). Specifically,

respondents contend that RFRA entitles the Hercules Industries plan to an exemption from the contraceptive-coverage provision because "the Newlands believe that it would be immoral and sinful for them to intentionally participate in, pay for, facilitate, or otherwise support" contraceptives. C.A. App. 26-27 (First Am. Compl. para. 32).

a. The district court granted respondents' motion for a preliminary injunction without determining whether respondents were likely to succeed on the merits of their RFRA claims. App., *infra*, 11a-33a; see *id.* at 6a.

b. After the government's appeal was fully briefed, the court of appeals issued its decision in *Hobby Lobby Stores, Inc.* v. *Sebelius*, 723 F.3d 1114 (10th Cir. 2013) (en banc), cert. granted, No. 13-354 (oral argument scheduled for Mar. 25, 2014) (*Hobby Lobby*). In light of that decision, the court of appeals affirmed the preliminary injunction in this case. See App., *infra*, 1a-10a.

The court of appeals explained that its decision in *Hobby Lobby* "resolves the likelihood of success factor in Hercules's favor." App., *infra*, 6a. In particular, the court held that *Hobby Lobby* establishes that Hercules Industries is a "person" exercising religion within the meaning of RFRA; that the contraceptive-coverage provision substantially burdens the corporation's religious exercise; and that the contraceptive-coverage provision fails to satisfy RFRA's compelling-interest test. *Id.* at 7a (citing *Hobby Lobby*, 723 F.3d at 1121, 1128, 1142-1143). The court of appeals did not reach the merits of the Newlands' individual RFRA claims. *Id.* at 7a n.1.

The court of appeals further held that the district court did not abuse its discretion in concluding that the other factors that bear on the issuance of a preliminary injunction (irreparable harm, balance of harms, and the public interest) were satisfied. See App., *infra*, 7a-10a; cf. *id.* at 9a (noting that the district court had "failed to address the government's interests of safeguarding the public health, protecting the statutory rights of affected employees, and ensuring the uniform enforcement of health care and employment regulations"). The court remanded to the district court with directions to abate further proceedings until this Court completes its consideration of *Hobby Lobby*. *Id*. at 10a.

DISCUSSION

The court of appeals held that the Religious Freedom Restoration Act of 1993, 42 U.S.C. 2000bb *et seq.*, allows a for-profit corporation to deny its employees the health coverage of contraceptives to which they are otherwise entitled by federal law, based on the religious objections of the corporation's owners. That decision is incorrect for the reasons that the court of appeals' earlier decision in *Hobby Lobby Stores, Inc.* v. *Sebelius*, 723 F.3d 1114 (10th Cir. 2013) (en banc), cert. granted, No. 13-354 (oral argument scheduled for Mar. 25, 2014), is incorrect. See Gov't Br. at 15-58, *Hobby Lobby*, *supra*.

The same question is pending before the Court in *Hobby Lobby* and *Conestoga Wood Specialties Corp.* v. *Sebelius*, cert. granted, No. 13-356 (oral argument scheduled for Mar. 25, 2014). The government respectfully requests that the Court hold this petition for a writ of certiorari pending the Court's decision in *Hobby Lobby* and *Conestoga Wood*, and then dispose

of the petition as appropriate in light of the Court's decision in those cases.

CONCLUSION

The Court should hold the petition for a writ of certiorari in this case pending the disposition of *Sebelius* v. *Hobby Lobby Stores, Inc.*, cert. granted, No. 13-354 (oral argument scheduled for Mar. 25, 2014), and *Conestoga Wood Specialties Corp.* v. *Sebelius*, cert. granted, No. 13-356 (oral argument scheduled for Mar. 25, 2014), and then dispose of it as appropriate in light of the Court's decision in those cases.

Respectfully submitted.

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JANUARY 2014

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

Case No. 12-1380

WILLIAM NEWLAND; PAUL NEWLAND; JAMES NEWLAND; CHRISTINE KETTERHAGEN; ANDREW NEWLAND; HERCULES INDUSTRIES, INC., A COLORADO CORPORATION, PLAINTIFFS-APPELLEES

v.

KATHLEEN SEBELIUS, IN HER OFFICIAL CAPACITY AS SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; HILDA SOLIS, IN HER OFFICIAL CAPACITY AS SECRETARY OF THE UNITED STATES DEPARTMENT OF LABOR; TIMOTHY GEITHNER, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE UNITED STATES DEPARTMENT OF THE TREASURY; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; UNITED STATES DEPARTMENT OF LABOR; UNITED STATES DEPARTMENT OF THE TREASURY, DEFENDANTS-APPELLANTS

AMERICANS UNITED FOR SEPARATION OF CHURCH AND STATE; UNION FOR REFORM JUDAISM; CENTRAL CONFERENCE OF AMERICANS RABBIS; WOMEN OF REFORM JUDAISM; HINDU AMERICAN FOUNDATION; AMERICAN CIVIL LIBERTIES UNION; AMERICAN CIVIL LIBERTIES UNION OF COLORADO; ANTI-DEFAMATION LEAGUE; HADASSAH, THE WOMEN'S ZIONIST ORGANIZATION OF AMERICA, INC.; INTERFAITH ALLIANCE FOUNDATION;

NATIONAL COUNCIL OF JEWISH WOMEN; RELIGIOUS COALITION FOR REPRODUCTIVE CHOICE; UNITARIAN UNIVERSALIST ASSOCIATION; UNITARIAN UNIVERSALIST WOMEN'S FEDERATION; LIBERTY, LIFE AND LAW FOUNDATION; AMERICAN CENTER FOR LAW AND JUSTICE; ASSOCIATION OF AMERICAN PHYSICIANS & SURGEONS; AMERICAN ASSOCIATION OF PRO-LIFE OBSETRICIANS AND GYNECOLOGISTS; CHRISTIAN MEDICAL ASSOCIATION; NATIONAL CATHOLIC BIOETHICS CENTER; PHYSICIANS FOR LIFE; NATIONAL ASSOCIATION OF PRO LIFE NURSES; CATHOLIC MEDICAL ASSOCIA-EAGLE FORUM EDUCATION & LEGAL DEFENSE FUND; ARCHDIOCESE OF DENVER; ARCHDIOCESE OF PUEBLO; ARCHDIOCESE OF COLORADO SPRINGS; ASSOCIATION OF GOSPEL RESCUE MISSIONS; PRISON FELLOWSHIP MINISTRIES; ASSOCIATION OF CHRISTIAN SCHOOLS INTERNATIONAL; NATIONAL ASSOCIATION OF EVANGELICALS; ETHICS & RELIGIOUS LIBERTY COMMISSION OF THE SOUTHERN BAPTIST CONVENTION; INSTITUTIONAL RELIGIOUS FREEDOM ALLIANCE; THE C12 GROUP; CHRISTIAN LEGAL SOCIETY; UNITED STATES JUSTICE FOUNDATION, EAGLE FORUM; BART STUPAK; DEMOCRATS FOR LIFE OF AMERICA; BREAST CANCER PREVENTION INSTITUTE; BIOETHICS DEFENSE FUND; LIFE LEGAL DEFENSE FOUNDATION, AMICI CURIAE

Oct. 3, 2013

ORDER AND JUDGMENT*

SCOTT M. MATHESON, JR., Circuit Judge.

Kathleen Sebelius, Secretary of Department of Health and Human Services ("HHS"), appeals the district court's order granting the plaintiffs' motion for a preliminary injunction barring enforcement of an HHS regulation requiring employer-provided group health plans to cover certain contraceptive drugs and services. Exercising jurisdiction under 28 U.S.C. § 1292(a)(1), we affirm.

I. BACKGROUND

Hercules Industries, Inc., a for-profit Colorado corporation, and five of its controlling shareholders and/or officers (collectively, the "Newlands") brought suit in Colorado district court seeking an exemption from an HHS regulation requiring that employer-provided health plans cover all contraceptive drugs and services approved by the Food and Drug Administration (the "Regulation"). 45 C.F.R. § 147.130(a).

* After examining appellant's brief and the appellate record, and in accord with our order dated August 12, 2013, this panel has determined unanimously that oral argument would not materially assist the determination of this appeal. *See* Fed. R. App. P. 34(a)(2) and 10th Cir. R. 34.1(G). The case is therefore ordered submitted without oral argument. This order and judgment is not binding precedent, except under the doctrines of law of the case, res judicata, and collateral estoppel. It may be cited, however, for its persuasive value consistent with Fed. R. App. P. 32.1 and 10th Cir. R. 32.1.

Hercules and the Newlands contend that compliance with the Regulation would violate their sincerely held religious beliefs about contraceptives.

The plaintiffs sought a preliminary injunction barring HHS from enforcing the Regulation against them, claiming that the Regulation substantially burdens their religious exercise in violation of the Religious Freedom Restoration Act of 1993 ("RFRA"), 42 U.S.C. § 2000bb-1. The district court granted the preliminary injunction, and HHS timely appealed.

After both parties had filed their briefs, this court decided *Hobby Lobby v. Sebelius*, 723 F.3d 1114 (10th Cir. 2013) (en banc). That case involved materially similar facts and resolved questions of law applicable to this case. In *Hobby Lobby*, two for-profit corporations (collectively, "Hobby Lobby") and their individual owners challenged the same Regulation on RFRA grounds. This court reversed an Oklahoma district court's denial of Hobby Lobby's request for preliminary injunction, holding that the corporations were "persons" within the meaning of RFRA; that compliance with the Regulation would substantially burden the corporations' religious exercise; and that the Regulation was not narrowly tailored to achieve a compelling interest. *Id.* at 1121, 1128, 1142-43.

The en banc court therefore determined that the Hobby Lobby plaintiffs had satisfied two of the four preliminary injunction factors: (1) they were substantially likely to succeed on the merits of their RFRA claim, *id.* at 1145; and (2) they would suffer irreparable injury without the injunction, *id.* at 1146.

We remanded to the district court to consider the remaining two preliminary injunction factors: (3) whether the likely harm to plaintiffs without the preliminary injunction outweighed the likely harm to HHS as a result of the injunction; and (4) whether the injunction was adverse to the public interest. *Id.* at 1121-22, 1146; *see also Awad v. Ziriax*, 670 F.3d 1111, 1125 (10th Cir. 2012) (reciting the preliminary injunction factors).

HHS has filed a petition for certiorari with the Supreme Court, seeking review of our *Hobby Lobby* decision. Petition for Writ of Certiorari, *Sebelius v. Hobby Lobby*, No. 13-354 (U.S. Sept. 19, 2013). This petition remains pending as of the date of this order and judgment. For the reasons discussed below, we affirm the district court's preliminary injunction order and remand with instructions to abate further proceedings pending the Supreme Court's completion of its consideration of the *Hobby Lobby* case.

II. DISCUSSION

We review a district court's decision to grant a preliminary injunction for abuse of discretion. *See Awad*, 670 F.3d at 1125. "To obtain a preliminary injunction, [Hercules] must show that four factors weigh in [its] favor: (1) [it] is substantially likely to succeed on the merits; (2) [it] will suffer irreparable injury if the injunction is denied; (3) [its] threatened injury outweighs the injury the opposing party will suffer under the injunction; and (4) the injunction would not be adverse to the public interest." *Id.* (quotations omitted).

A. *Likelihood of Success on the Merits*

The district court granted a preliminary injunction without determining whether Hercules or the Newlands were substantially likely to succeed on the merits. *Newland v. Sebelius*, 881 F. Supp. 2d 1287, 1296-97 (D. Colo. 2012). It applied a relaxed preliminary injunction standard that allows relief without a showing of likelihood of success. Under the relaxed standard, a district court may grant a preliminary injunction when "the equities tip strongly in favor" of the party seeking the injunction and the merits questions "are so serious, substantial, difficult, and doubtful as to make the issue ripe for litigation and deserving of more deliberate investigation." *Id.* at 1294 (quoting *Okla. ex rel. Okla. Tax Comm'n v. Int'l Registration Plan, Inc.*, 455 F.3d 1107, 1113 (10th Cir. 2006)). It is not necessary for us to determine whether the relaxed standard applies because, as we explain below, our decision in *Hobby Lobby* resolves the likelihood of success factor in Hercules's favor.

Under RFRA, the government may not "substantially burden a person's exercise of religion" unless it shows that the law or regulation "is the least restrictive means of furthering [a] compelling governmental interest." 42 U.S.C. § 2000bb-1. To succeed on the merits of its RFRA claim, Hercules must show that (1) it is a person protected under RFRA; (2) compliance with the Regulation would substantially burden its religion; and (3) HHS cannot show that the Regulation

is the least restrictive means to meet a compelling government interest.[1]

Given our decision in *Hobby Lobby*, Hercules can likely meet all three elements of its RFRA claim. Our precedent holds that Hercules is a "person" within the meaning of RFRA, the Regulation substantially burdens its religious exercise, and the Regulation fails to satisfy strict scrutiny. *See Hobby Lobby*, 723 F.3d at 1121, 1128, 1142-43.

B. ***Irreparable Harm***

The district court concluded that Hercules made a strong showing that "the injury complained of is of such imminence that there is a clear and present need for equitable relief to prevent irreparable harm." *Newland*, 881 F. Supp. 2d at 1294 (emphasis omitted) (quotations omitted).

This court concluded in *Hobby Lobby* that the harm to the corporations' religious liberties as a result of forced compliance with the mandate was irreparable and met this preliminary injunction factor. *See* 723 F.3d at 1146. Given that decision, we cannot say the district court abused its discretion in making the same conclusion as to Hercules.

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[1] In this case and in *Hobby Lobby*, individual and corporate plaintiffs raised the same claims. In *Hobby Lobby*, this court resolved the RFRA claim as to the corporate plaintiffs without reaching the individual plaintiffs' claims. *See* 723 F.3d at 1126 n.4. "[T]here is no dispute that relief as to [Hercules] would satisfy the [Newlands]." *Id.* Thus, we need not consider whether the Newlands' individual claims are likely to succeed on the merits.

C. *Balance of Harms*

The district court held that the balance of harms tipped in favor of Hercules. To succeed on this third factor, Hercules must show that "the threatened injury outweighs the harm that the preliminary injunction may cause the opposing party." *Greater Yellowstone Coalition v. Flowers*, 321 F.3d 1250, 1255 (10th Cir. 2003) (quotations omitted).

The district court stated that the only harm HHS would face from the injunction would be the inability to "enforc[e] regulations that Congress found [to be in] the public interest" and that this harm "pale[d] in comparison to the possible infringement upon [Hercules's] constitutional and statutory rights." *Newland*, 881 F. Supp. 2d at 1295 (quotations omitted).[2]

We may reverse only if the district court's conclusion was an abuse of discretion. *See eBay Inc. v. MercExchange, LLC*, 547 U.S. 388, 394, 126 S. Ct. 1837, 164 L. Ed. 2d 641 (2006) ("[T]he decision whether to grant or deny injunctive relief rests within the equitable discretion of the district courts."). We recognized in *Hobby Lobby* the considerable importance of a corporation's religious liberty interests. *See Hobby Lobby*, 723 F.3d at 1145-46. *Hobby Lobby* also con-

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[2] In *Hobby Lobby*, neither the district court nor this court resolved this preliminary injunction factor. 723 F.3d at 1121. We remanded this issue for further consideration. *Id.* In the present case, the district court did address this preliminary injunction factor, so we must review its conclusion for abuse of discretion. *See Awad*, 670 F.3d at 1125.

cluded that HHS's interest in enforcing the Regulation was not compelling. *Id.* at 1143-44.

The district court in the present case failed to address the government's interests of safeguarding the public health, protecting the statutory rights of affected employees, and ensuring the uniform enforcement of health care and employment regulations. We cannot say, however, in light of the *Hobby Lobby* decision, that its conclusion on the balance of harms was an abuse of discretion.

D. ***Public Interest***

The district court concluded that "public interest in the free exercise of religion" supported the preliminary injunction. *Newland*, 881 F. Supp. 2d at 1295. It considered HHS's argument that a preliminary injunction would harm Congress's public interest goals of "improving the health of women . . . and equalizing the coverage of preventive services for women and men." *Id.* (quotations omitted). But the district court reasoned that the current regulations exempting many employers, such as small businesses, from the Regulation dilute these interests. It held that the public interest favors the preliminary injunction.

Once again, our review standard is abuse of discretion, which "occurs only when the trial court bases its decision on an erroneous conclusion of law or where there is no rational basis in the evidence for the ruling." *Awad*, 670 F.3d at 1125 (quotations omitted). The district court applied the correct legal standard, and the evidence provides a rational basis for the rul-

ing. We therefore cannot say that it abused its discretion in holding that this preliminary injunction factor favored Hercules.

III. CONCLUSION

We conclude that the district court did not abuse its discretion in granting the preliminary injunction to Hercules. We therefore affirm and remand to the district court. Given the pending petition for certiorari before the Supreme Court in *Hobby Lobby*, the district court is instructed to abate further proceedings until the Supreme Court completes its consideration of the *Hobby Lobby* case. At that time, the abatement may be lifted and the court may undertake all proceedings necessary to resolve the issues remaining before it. Finally, appellees' motion to hear this matter with the *Hobby Lobby* proceeding is denied as moot.

APPENDIX B

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No. 1:12-cv-1123-JLK

WILLIAM NEWLAND; PAUL NEWLAND; JAMES NEWLAND; CHRISTINE KETTERHAGEN; ANDREW NEWLAND; HERCULES INDUSTRIES, INC., A COLORADO CORPORATION, PLAINTIFFS

v.

KATHLEEN SEBELIUS, IN HER OFFICIAL CAPACITY AS SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; HILDA SOLIS, IN HER OFFICIAL CAPACITY AS SECRETARY OF THE UNITED STATES DEPARTMENT OF THE LABOR; TIMOTHY GEITHNER, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE UNITED STATES DEPARTMENT OF THE TREASURY; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; UNITED STATES DEPARTMENT OF LABOR; UNITED STATES DEPARTMENT OF THE TREASURY, DEFENDANTS

Filed: July 27, 2012

ORDER

KANE, District Judge.

This matter is currently before me on Plaintiffs' Motion for Preliminary Injunction (doc. 5). Based on the forthcoming discussion, Plaintiffs' motion is GRANTED.

BACKGROUND

The Patient Protection and Affordable Care Act

Signed into law on March 23, 2010, the Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010), instituted a variety of healthcare reforms. Among its many provisions, it requires most U.S. citizens and legal residents to have health insurance, creates state-based health insurance exchanges, and requires employers with fifty or more full-time employees to offer health insurance.[1] *Id.* The ACA also implemented a series of provisions aimed at insuring minimum levels of health care coverage.[2] Most relevant to the instant suit, the ACA

[1] In a recent decision, the Supreme Court upheld the constitutionality of the so-called individual mandate, but invalidated the portion of the Affordable Care Act threatening loss of existing Medicaid funding if a state declines to expand its Medicaid programs. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, —— U.S. ——, 132 S. Ct. 2566, 183 L. Ed. 2d 450 (2012).

[2] Termed the "Patient's Bill of Rights" these provisions require health plans to: provide coverage to persons with pre-existing conditions, protect a patient's choice of doctors, allow adults under the age of twenty-six to maintain coverage under their parent's

requires group health plans to provide no-cost coverage for preventive care and screening for women. 42 U.S.C. § 300gg-13(a)(4).[3]

Unlike some other provisions of the ACA, however, the preventive care coverage mandate does not apply to certain healthcare plans existing on March 23, 2010.[4] *See* Interim Final Rules for Group Health Plans

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health plan, prohibit annual and lifetime limits on most healthcare benefits, and end pre-existing condition exclusions for children under the age of nineteen. *See* Patient's Bill of Rights *available at* http://www.healthcare.gov/law/features/rights/bill-of-rights/index.html (last viewed on July 27, 2012). As discussed *infra* at n.4, not all health plans are required to meet these conditions.

[3] The ACA did not, however, specifically delimit the contours of preventive care. Instead, it delegated that responsibility to the Health Resources and Services Administration ("HRSA"). On August 1, 2011, HRSA adopted Required Health Plan Coverage Guidelines that defined the scope of women's preventive services for purposes of the ACA coverage mandate. *See* HRSA, Women's Preventive Services: Required Health Plan Coverage Guidelines *available at* http://www.hrsa.gov/womensguidelines/ (last visited July 27, 2012). The HRSA guidelines include, among other things, "the full range of Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity." *Id.*

[4] Numerous provisions of the ACA apply to grandfathered health plans: the prohibition on pre-existing condition exclusions (group health plans only), the prohibition on excessive waiting periods (both group and individual health plans), the prohibition on lifetime (both) and annual (group only) benefit limits, the prohibition on rescissions (both), and the extension of dependent care coverage (both) to name a few. 75 Fed. Reg. at 34542. For a comprehensive summary of the applicability of ACA provisions to grandfathered health plans, see Application of the New Health Reform Provisions of Part A of Title XXVII of the PHS Act

and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34538, 34540 (June 17, 2010). This gap in the preventive care coverage mandate is significant. According to government estimates, 191 million Americans belong to plans which may be grandfathered under the ACA. *Id.* at 34550. Although there are many requirements for maintaining grandfathered status, *see* 26 C.F.R. § 54.9815-1251T(g), if those requirements are met a plan may be grandfathered for an indefinite period of time.

In addition to grandfathering under the ACA, the preventive care guidelines exempt certain religious employers from any requirement to cover contraceptive services.[5] *See* Interim Final Rules for Group

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to Grandfathered Plans, *available at* http://www.dol.gov/ebsa/pdf/grandfatherregtable.pdf. (last visited July 26, 2012).

[5] In order to qualify as a "religious employer" eligible for this exemption, an employer must meet the following criteria:

> (1) The inculcation of religious values is the purpose of the organization.
>
> (2) The organization primarily employs persons who share the religious tenets of the organization.
>
> (3) The organization serves primarily persons who share the religious tenets of the organization.
>
> (4) The organization is a non-profit organization 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.

76 Fed. Reg. 46621, 46626 (Aug. 3, 2011); *See* 77 Fed. Reg. 8725 (Feb. 15, 2012).

Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 Fed. Reg. 46621 (Aug. 3, 2011). The guidelines also contain a temporary enforcement "safe-harbor" for plans sponsored by certain non-profit organizations with religious objections to contraceptive coverage that do not qualify for the religious employer exemption. *See* Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act 77 Fed. Reg. 8725, 8726-8727 (Feb. 15, 2012). The preventive care guidelines take effect on August 1, 2012.

Hercules Industries, Inc.

Plaintiff Hercules Industries, Inc. is a Colorado s-corp engaged in the manufacture and distribution of heating, ventilation, and air conditioning ("HVAC") products and equipment. Hercules is owned by siblings William, Paul and James Newland and Christine Ketterhagen, who also comprise the company's Board of Directors. Additionally, William Newland serves as President of the company and his son, Andrew Newland serves as Vice President.[6]

Although Hercules is a for-profit, secular employer, the Newlands adhere to the Catholic denomination of the Christian faith. According to the Newlands,

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[6] Throughout this opinion, I will refer to William Newland, Paul Newland, James Newland, Christine Ketterhagen, and Andrew Newland as the "Newlands."

"they seek to run Hercules in a manner that reflects their sincerely held religious beliefs" Amended Complaint (doc. 19) at ¶ 2. Thus, for the past year and a half the Newlands have implemented within Hercules a program designed to build their corporate culture based on Catholic principles. *Id.* at ¶ 36. Hercules recently made two amendments to its articles of incorporation, which reflect the role of religion in its corporate governance: (1) it added a provision specifying that its primary purposes are to be achieved by "following appropriate religious, ethical or moral standards," and (2) it added a provision allowing members of its board of directors to prioritize those "religious, ethical or moral standards" at the expense of profitability. *Id.* at ¶ 112. Furthermore, Hercules has donated significant amounts of money to Catholic organizations and causes. *Id.* at ¶ 35.

According to Plaintiffs, Hercules maintains a self-insured group plan for its employees "[a]s part of fulfilling their organizational mission and Catholic beliefs and commitments." *Id.* at ¶¶ 37. Significantly, because the Catholic church condemns the use of contraception, Hercules self-insured plan does not cover abortifacent drugs, contraception, or sterilization. *Id.* at ¶ 41.

Hercules' health insurance plan is not "grandfathered" under the ACA. Furthermore, notwithstanding the Newlands' religious beliefs, as a secular, for-profit corporation, Hercules does not qualify as a "religious employer" within the meaning of the preventive care regulations. Nor may it seek refuge in the enforcement "safe harbor." Accordingly, Hercu-

les will be required to either include no-cost coverage for contraception in its group health plan or face monetary penalties. Faced with a choice between complying with the ACA or complying with their religious beliefs, Plaintiffs filed the instant suit challenging the women's preventive care coverage mandate as violative of RFRA, the First Amendment, the Fifth Amendment, and the Administrative Procedure Act.

Believing the alleged injury to their constitutional and statutory rights to be imminent, Plaintiffs filed the instant Motion for Preliminary Injunction.

DISCUSSION

A preliminary injunction is an extraordinary remedy; accordingly, the right to relief must be clear and unequivocal. *See, e.g., Flood v. ClearOne Commc'ns, Inc.*, 618 F.3d 1110, 1117 (10th Cir. 2010). To meet this burden, a party seeking a preliminary injunction must show: (1) a likelihood of success on the merits, (2) a threat of irreparable harm, which (3) outweighs any harm to the nonmoving party, and that (4) the injunction would not adversely affect the public interest. *See, e.g., Awad v. Ziriax*, 670 F.3d 1111, 1125 (10th Cir. 2012). Although this inquiry is, on its face, relatively straightforward, there are a variety of exceptions. If the injunction will (1) alter the status quo, (2) mandate action by the defendant, or (3) afford the movant all the relief that it could recover at the conclusion of a full trial on the merits, the movant must meet a heightened burden. *See O Centro Espirita Beneficiente Uniao do Vegetal v. Ashcroft*, 389 F.3d 973, 975 (10th Cir. 2004) (en banc), aff'd and remanded,

Gonzales v. O Centro Espirita Beneficente Uniao do Vegetal, 546 U.S. 418, 126 S. Ct. 1211, 163 L. Ed. 2d 1017 (2006).

In determining whether an injunction falls into one of these "disfavored" categories, courts often focus on whether the requested injunctive relief will alter the status quo. The "status quo" is "the last uncontested status between the parties which preceded the controversy until the outcome of the final hearing." *Dominion Video Satellite, Inc. v. EchoStar Satellite Corp.*, 269 F.3d 1149, 1155 (10th Cir. 2001). In making this determination, however, I must look beyond the parties' legal rights, focusing instead on the reality of the existing status and relationship between the parties. *Schrier v. Univ. of Colo.*, 427 F.3d 1253, 1260 (10th Cir. 2005). If the requested relief would either preserve or restore the relationship and status existing ante bellum, the injunction does not alter the status quo.

This determination is not, however, necessarily dispositive. An injunction restoring the status quo ante bellum may require action on behalf of the nonmovant. Such an injunction, one which "affirmatively require[s] the nonmovant to act in a particular way," is mandatory and disfavored. *Id.* at 1261.

Although I follow the Tenth Circuit's guidance in determining whether Plaintiffs seek to disturb the status quo or require affirmative action by Defendants, I am careful to avoid uncritical adherence to the "status quo-formula" and the "mandatory/prohibitory formulation." In making this determination, I must

be mindful of "the fundamental purpose of preliminary injunctive relief under our Rules of Civil Procedure, which is 'to preserve the relative positions of the parties until a trial on the merits can be held.'" *Bray v. QFA Royalties, LLC*, 486 F. Supp. 2d 1237, 1243- 44 (D. Colo. 2007) (citing *O Centro*, 389 F.3d at 999-1001 (Seymour, C.J., concurring)).

Before the instigation of this lawsuit, Plaintiffs maintained an employee insurance plan that excluded contraceptive coverage. Although Defendants have passed a regulation requiring Plaintiffs to include such coverage in their coverage for the plan-year beginning on November 1, 2012, that regulation, as it applies to Plaintiffs, has not yet taken effect. Should the requested injunction enter, Defendants will be enjoined from enforcing the preventive care coverage mandate against Plaintiffs pending the outcome of this suit. The status quo will be preserved, and Defendants will not be required to take any affirmative action.

Because Plaintiffs do not seek a "disfavored" injunction, I must consider whether Plaintiffs are entitled to rely on an altered burden of proof. *Cf. O Centro*, 389 F.3d at 976. If the equities tip strongly in their favor, Plaintiffs "may meet the requirement for showing success on the merits by showing that questions going to the merits are so serious, substantial, difficult, and doubtful as to make the issue ripe for litigation and deserving of more deliberate investigation."[7] *Okla. ex rel. Okla. Tax Comm'n v. Int'l Reg-*

[7] Although some courts in this district have questioned the continued validity of this relaxed likelihood-of-success-on-the-merits

istration Plan, Inc., 455 F.3d 1107, 1113 (10th Cir. 2006).

Accordingly, I begin by considering the equities before turning to Plaintiffs' likelihood of success on the merits.

1. Irreparable Harm

Although it is well-established that the potential violation of Plaintiffs' constitutional and RFRA rights threatens irreparable harm, *see Kikumura v. Hurley*, 242 F.3d 950, 963 (10th Cir. 2001), Plaintiffs must also establish that "the injury complained of is of such *imminence* that there is a clear and present need for equitable relief to prevent irreparable harm." *Heideman v. S. Salt Lake City*, 348 F.3d 1182, 1189 (10th Cir. 2003) (emphasis in original). Imminence does not, however, require immediacy. Plaintiffs need only demonstrate that absent a preliminary injunction, "[they] are likely to suffer irreparable harm before a decision on the merits can be rendered." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 22, 129 S. Ct. 365, 172 L. Ed. 2d 249 (2008) (quoting 11A C. Wright, A. Miller, & M. Kane, Federal Practice and Procedure § 2948. 1, p. 139 (2d ed. 1995)).

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standard in light of the Supreme Court's decision in *Winter v. Natural Resources Defense Council, Inc.*, 555 U.S. 7, 20, 129 S. Ct. 365, 172 L. Ed. 2d 249 (2008) (holding that a plaintiff seeking a preliminary injunction "must establish that he is likely to succeed on the merits"), because the Tenth Circuit has continued to refer to this relaxed standard I assume it still governs the issuance of preliminary injunctions in this circuit. *See RoDa Drilling Co. v. Siegal*, 552 F.3d 1203, 1209 n.3 (10th Cir. 2009).

Absent injunctive relief, Plaintiffs will be required to provide FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity as part of their employee insurance plan. Per the terms of the preventive care coverage mandate, that coverage must begin on the start date of the first plan year following the effective date of the regulations, November 1, 2012. Defendants argue this harm, three months in the future, is not sufficiently imminent to justify injunctive relief. In light of the extensive planning involved in preparing and providing its employee insurance plan, and the uncertainty that this matter will be resolved before the coverage effective date, Plaintiffs have adequately established that they will suffer imminent irreparable harm absent injunctive relief. This factor strongly favors entry of injunctive relief.

2. Balancing of Harms

I must next weigh the irreparable harm faced by Plaintiffs against the harm to Defendants should an injunction enter. Should an injunction enter, Defendants will be prevented from "enforcing regulations that Congress found it in the public interest to direct that agency to develop and enforce." *Cornish v. Dudas*, 540 F. Supp. 2d 61, 61 (D.D.C. 2008). This harm pales in comparison to the possible infringement upon Plaintiffs' constitutional and statutory rights. This factor strongly favors entry of injunctive relief.

3. Public Interest

Defendants argue that entry of the requested injunction is contrary to the public interest, because it would "undermine [their] ability to effectuate Congress's goals of improving the health of women and children and equalizing the coverage of preventive services for women and men so that women who choose to do so can be part of the workforce on an equal playing field with men." Defendants' Response (doc. 26) at 73. This asserted interest is, however, undermined by the creation of exemptions for certain religious organizations and employers with grandfathered health insurance plans and a temporary enforcement safe harbor for non-profit organizations.

These interests are countered, and indeed outweighed, by the public interest in the free exercise of religion. As the Tenth Circuit has noted, "there is a strong public interest in the free exercise of religion even where that interest may conflict with [another statutory scheme]." *O Centro*, 389 F.3d at 1010. Accordingly, the public interest favors entry of an injunction in this case.

On balance, the threatened harm to Plaintiffs, impingement of their right to freely exercise their religious beliefs, and the concomitant public interest in that right strongly favor the entry of injunctive relief. Although the less rigorous standard for preliminary injunctions is not applied when "a preliminary injunction seeks to stay governmental action taken in the public interest pursuant to a statutory or regulatory scheme," *Aid for Women v. Foulston*, 441 F.3d 1101,

1115 (10th Cir. 2006), the government's creation of numerous exceptions to the preventive care coverage mandate has undermined its alleged public interest.[8] Accordingly, I find the general rule disfavoring the relaxed standard inapplicable. Plaintiffs need only establish that their challenge presents "questions going to the merits . . . so serious, substantial, difficult, and doubtful as to make the issue ripe for litigation and deserving of more deliberate investigation." *Okla. Tax Comm'n*, 455 F.3d at 1113.

4. Likelihood of Success on the Merits

Plaintiffs raise a variety of constitutional and statutory challenges. Because Plaintiffs' RFRA challenge provides adequate grounds for the requested injunctive relief, I decline to address their challenges under the Free Exercise, Establishment and Freedom of Speech Clauses of the First Amendment. *See, e.g., United States v. Hardman*, 297 F.3d 1116, 1135-36 (10th Cir. 2002) (en banc).

Passed in 1993, the Religious Freedom Restoration Act ("RFRA") sought to "restore the compelling interest test as set forth in *Sherbert v. Verner*, 374 U.S. 398, 83 S. Ct. 1790, 10 L. Ed. 2d 965 (1963) and *Wisconsin v. Yoder*, 406 U.S. 205, 92 S. Ct. 1526, 32 L. Ed. 2d 15 (1972) and to guarantee its application in all cases where free exercise of religion is substantially burdened." 42 U.S.C. § 2000bb(b). Although unconstitutional as applied to the states, *see City of Boerne v. Flores*, 521 U.S. 507, 117 S. Ct. 2157, 138 L. Ed. 2d

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[8] *See* discussion *supra* at pp. 1291-92 and *infra* at pp. 1297-98.

624 (1997), it remains constitutional as applied to the federal government. *See United States v. Wilgus*, 638 F.3d 1274, 1279 (10th Cir. 2011).

Under RFRA, the government may not "substantially burden a person's exercise of religion even if the burden results from a rule of general applicability." 42 U.S.C. § 2000bb-1(a). This general prohibition is not, however, without exception. The government may justify a substantial burden on the free exercise of religion if the challenged law: "(1) is in furtherance of a compelling governmental interest; and (2) is the least restrictive means of furthering that compelling governmental interest." *Id.* at § 2000bb-1(b). The initial burden is borne by the party challenging the law. Once that party establishes that the challenged law substantially burdens her free exercise of religion, the burden shifts to the government to justify that burden. The nature of this preliminary injunction proceeding does not alter these burdens. *Gonzales*, 546 U.S. at 429, 126 S. Ct. 1211. Thus, I must first consider whether Plaintiffs have demonstrated that the preventive care coverage mandate substantially burdens their free exercise of religion. If so, I must then consider whether the government has demonstrated that the preventive care coverage mandate is the least restrictive means to achieve a compelling interest.

Substantial Burden of Free Exercise

Plaintiffs argue that providing contraception coverage violates their sincerely held religious beliefs. Although the government does not challenge the sin-

cerity of the Newlands' religious beliefs, it argues that Plaintiffs have failed to demonstrate a substantial burden on their free exercise of religion. This argument relies upon two key premises. First, the government asserts that the burden of providing insurance coverage is borne by Hercules. Second, the government argues that as a for-profit, secular employer, Hercules cannot engage in an exercise of religion. Accordingly, the argument concludes, the preventive care coverage mandate cannot burden Hercules' free exercise of religion.[9] Plaintiffs counter, arguing that there exists no law forbidding a corporation from operating according to religious principles.

These arguments pose difficult questions of first impression. Can a corporation exercise religion? Should a closely-held subchapter-s corporation owned and operated by a small group of individuals professing adherence to uniform religious beliefs be treated differently than a publicly held corporation owned and operated by a group of stakeholders with diverse religious beliefs? Is it possible to "pierce the veil" and disregard the corporate form in this context? What is the significance of the pass-through taxation applicable to subchapter-s corporations as it pertains to this

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[9] In the alternative, the government argues that because Plaintiffs routinely contribute to other schemes that violate the religious beliefs alleged here, the preventive care coverage mandate does not substantially burden Plaintiffs' free exercise of religion. This argument requires impermissible line drawing, and I reject it out of hand. *See Thomas v. Review Bd. of Ind. Emp't Sec.*, 450 U.S. 707, 715, 101 S. Ct. 1425, 67 L. Ed. 2d 624 (1981).

analysis? These questions merit more deliberate investigation.

Even if, upon further examination, Plaintiffs are able to demonstrate a substantial burden on their free exercise of religion, however, the government may justify its application of the preventive care coverage mandate by demonstrating that application of that mandate to Plaintiffs is the least restrictive means of furthering a compelling interest.

Compelling Interest

In order to justify a substantial burden on Plaintiffs' free exercise of religion, the government must show that its application of the preventive care coverage mandate to Plaintiffs furthers "interests of the highest order." *Hardman*, 297 F.3d at 1127. It is well-settled that the interest asserted in this case, the promotion of public health, is a compelling government interest. *See Buchwald v. Univ. of N.M. Sch. of Med.*, 159 F.3d 487, 498 (10th Cir. 1998). The government argues that the preventive care coverage mandate, as applied to Plaintiffs and all similarly situated parties, furthers this compelling interest.

Assuming, *arguendo*, that application of the preventive care coverage mandate to Plaintiffs *and all similarly situated parties* furthers a compelling government interest,[10] that argument does not justify a

[10] Plaintiffs strenuously challenge whether the preventive care coverage mandate actually furthers the promotion of public health. I need not address that argument to resolve the instant motion, and I decline to do so.

substantial burden on *Plaintiffs*' free exercise of religion: "RFRA requires the Government to demonstrate that the compelling interest test is satisfied through application of the challenged law to the person—the particular claimant whose sincere exercise of religion is being substantially burdened." *Gonzales*, 546 U.S. at 430-31, 126 S. Ct. 1211.

I do not mean to suggest that the government may not establish a compelling interest in the uniform application of a particular program. To make such a showing, however, the government must "offer[ ] evidence that granting the requested religious accommodations would seriously compromise its ability to administer this program." *Id.* at 435, 126 S. Ct. 1211. Any such argument is undermined by the existence of numerous exemptions to the preventive care coverage mandate. In promulgating the preventive care coverage mandate, Congress created significant exemptions for small employers and grandfathered health plans.[11][12] 26 U.S.C. § 4980H(c)(2) (exempting from

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[11] The government's attempt to characterize grandfathering as "phased implementation" is unavailing. As noted above, health plans may retain their grandfathered status indefinitely. Most damaging to the government's alleged compelling interest, even though Congress required grandfathered health plans to comply with certain provisions of the ACA, it specifically exempted grandfathered health plans from complying with the preventive care coverage mandate. *See* 42 U.S.C. § 18011(a)(3-4) (specifying those provisions of the ACA that apply to grandfathered health plans).

[12] The government argues that because these provisions are generally applicable, and not specifically limited to the preventive services coverage regulations, they are not exemptions from the

health care provision requirement employers of less than fifty full-time employees); 42 U.S.C. § 18011 (grandfathering of existing health care plans). Even Defendants created a regulatory exemption to the contraception mandate. 76 Fed. Reg. 46621, 46626 (Aug. 3, 2011) (exempting certain religious employers from the contraception requirement of the preventive care coverage mandate).

"[A] law cannot be regarded as protecting an interest of the highest order when it leaves appreciable damage to that supposedly vital interest unprohibited." *Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 547, 113 S. Ct. 2217, 124 L. Ed. 2d 472 (1993); *see also United States v. Friday*, 525 F.3d 938, 958 (10th Cir. 2008). The government has exempted over 190 million health plan participants and beneficiaries from the preventive care coverage mandate;[13] this massive exemption completely under-

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preventive care coverage mandate. This is a distinction without substance. By exempting employers from providing health care coverage, these provisions exempt those employers from providing preventative health care coverage to women. If the government has a compelling interest in ensuring no-cost provision of preventative health coverage to women, that interest is compromised by exceptions allowing employers to avoid providing that coverage—whether broadly or narrowly crafted.

[13] Even if, as is estimated under the government's high-end estimate, 69% of health plans lose their grandfathered status by the end of 2013, millions health plan participants and beneficiaries will continue to be exempted from the preventive care coverage mandate. *See* 75 Fed. Reg. 34538, 34553.

mines any compelling interest in applying the preventive care coverage mandate to Plaintiffs.[14]

Least Restrictive Means

Even if the government were able to establish a compelling interest in applying the preventive care coverage mandate to Plaintiffs, it must also demonstrate that there are no feasible less-restrictive alternatives. *Wilgus*, 638 F.3d at 1289. The government need not tilt at windmills; it need only refute alternatives proposed by Plaintiffs. *Id.*

Plaintiffs propose one alternative, government provision of free birth control, that could be achieved by a variety of methods: creation of a contraception insurance plan with free enrollment, direct compensation of contraception and sterilization providers, creation of a tax credit or deduction for contraceptive purchases, or imposition of a mandate on the contraception manufacturing industry to give its items away for free. Defendants argue Plaintiffs' "misunderstand the nature of the 'least restrictive means' inquiry." Brief in Opposition (doc. 26) at 43. According to Defendants, this inquiry should be limited to whether Plaintiffs and other similarly situated parties could be exempted without damaging Defendants' compelling interest.

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[14] To the extent the government argues creating an exemption for Plaintiffs threatens to undermine the preventive care coverage mandate, that argument is inconsistent with RFRA and irrelevant in this context. *See Gonzales*, 546 U.S. at 436, 126 S. Ct. 1211 (rejecting "slippery slope" argument as inconsistent with RFRA).

It is, however, not Plaintiffs but Defendants who misunderstand the least restrictive means inquiry. Defendants need not refute every conceivable alternative, but they "must refute the alternative schemes offered by the challenger."[15] *Wilgus*, 638 F.3d at 1289.

Despite their categorical argument, Defendants attempt to refute Plaintiffs' proposed alternative. First, Defendants argue that because Plaintiffs' alternative "would impose considerable new costs and other burdens on the Government and are otherwise impractical," they should be rejected as not "feasible" or "plausible." Brief in Opposition (doc. 26) at 44. Although a showing of impracticality is sufficient to refute the adequacy of a proposed alternative, Defendants have failed to make such a showing in this case. As Plaintiffs note, "the government already provides free contraception to women." Reply Brief in Support (doc. 27) at 38.

Defendants also argue Plaintiffs' alternative would not adequately advance the government's compelling interests. They acknowledge that Plaintiffs' alternative would achieve the purpose of providing contraceptive services to women with no cost sharing, but argue

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[15] Furthermore, both parties impermissibly expand the scope of this determination. As noted above, my inquiry is limited to the parties before me; I do not consider all other "similarly situated parties." To the extent Plaintiffs' alternative would apply to other parties, it is overinclusive. Because the parties frame this discussion, however, I analyze the alternative as presented by Plaintiffs and responded to by Defendants.

that Plaintiffs' alternative will not "ensur[e] that women will face minimal logistical and administrative obstacles to receiving coverage of their care." Brief in Opposition (doc. 26) at 45. Although Plaintiffs argue that this amounts to a redefinition of Defendants' compelling interest, it is instead a logical corollary thereto.[16] Nonetheless, Defendants have failed to adduce facts establishing that government provision of contraception services will necessarily entail logistical and administrative obstacles defeating the ultimate purpose of providing no-cost preventive health care coverage to women. Once again, the current existence of analogous programs heavily weighs against such an argument.

Defendants bear the burden of demonstrating that refusing to exempt Plaintiffs from the preventive care coverage mandate is the least restrictive means of furthering their compelling interest. Given the existence of government programs similar to Plaintiffs' proposed alternative, the government has failed to meet this burden.

Conclusion

The balance of the equities tip strongly in favor of injunctive relief in this case. Because this case presents "questions going to the merits . . . so serious, substantial, difficult, and doubtful as to make

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[16] To be clear, I do not believe Defendants have sufficiently demonstrated a compelling interest in enforcing the preventive care coverage mandate against Plaintiffs. For purposes of my analysis under "least restrictive means" prong of RFRA, however, I assume the existence of such an interest.

the issue ripe for litigation and deserving of more deliberate investigation," I find it appropriate to enjoin the implementation of the preventive care coverage mandate as applied to Plaintiffs. Accordingly,

Defendants, their agents, officers, and employees, and their requirements that Plaintiffs provide FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity, are ENJOINED from any application or enforcement thereof against Plaintiffs, including the substantive requirement imposed in 42 U.S.C. § 300gg-13(a)(4), the application of the penalties found in 26 U.S.C. §§ 4980D & 4980H and 29 U.S.C. § 1132, and any determination that the requirements are applicable to Plaintiffs.

Pursuant to Fed. R. Civ. P. Rule 65(c), Plaintiffs shall post a $100.00 bond as security for any costs and damages that may be sustained by Defendants in the event they have been wrongfully enjoined or restrained.

Such injunction shall expire three months from entry of an order on the merits of Plaintiffs' challenge. In order to expedite the resolution of this case, the parties shall file a Joint Case Management Plan on or before August 27, 2012.

And, finally, I take this opportunity to emphasize the *ad hoc* nature of this injunction. The government's arguments are largely premised upon a fear that granting an exemption to Plaintiffs will necessarily require granting similar injunction to all other for-profit, secular corporations voicing religious objec-

tions to the preventive care coverage mandate. This injunction is, however, premised upon the alleged substantial burden on Plaintiffs' free exercise of religion—not to any alleged burden on any other party's free exercise of religion. It does not enjoin enforcement of the preventive care coverage mandate against any other party.

APPENDIX C

1. 42 U.S.C. 300gg-13 (Supp. V 2011) provides:

Coverage of preventive health services

(a) In general

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—

(1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and[1]

(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.[2]

(4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guide-

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[1] So in original. The word "and" probably should not appear.

[2] So in original. The period probably should be a semicolon.

lines supported by the Health Resources and Services Administration for purposes of this paragraph.[3]

(5) for the purposes of this chapter, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

Nothing in this subsection shall be construed to prohibit a plan or issuer from providing coverage for services in addition to those recommended by United States Preventive Services Task Force or to deny coverage for services that are not recommended by such Task Force.

(b) Interval

(1) In general

The Secretary shall establish a minimum interval between the date on which a recommendation described in subsection (a)(1) or (a)(2) or a guideline under subsection (a)(3) is issued and the plan year with respect to which the requirement described in subsection (a) is effective with respect to the service described in such recommendation or guideline.

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[3] So in original. The period probably should be a semicolon.

(2) Minimum

The interval described in paragraph (1) shall not be less than 1 year.

(c) Value-based insurance design

The Secretary may develop guidelines to permit a group health plan and a health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance designs.

2. 42 U.S.C. 2000bb provides:

Congressional findings and declaration of purposes

(a) Findings

The Congress finds that—

(1) the framers of the Constitution, recognizing free exercise of religion as an unalienable right, secured its protection in the First Amendment to the Constitution;

(2) laws "neutral" toward religion may burden religious exercise as surely as laws intended to interfere with religious exercise;

(3) governments should not substantially burden religious exercise without compelling justification;

(4) in Employment Division v. Smith, 494 U.S. 872 (1990) the Supreme Court virtually eliminated the requirement that the government justify bur-

dens on religious exercise imposed by laws neutral toward religion; and

(5) the compelling interest test as set forth in prior Federal court rulings is a workable test for striking sensible balances between religious liberty and competing prior governmental interests.

(b) Purposes

The purposes of this chapter are—

(1) to restore the compelling interest test as set forth in Sherbert v. Verner, 374 U.S. 398 (1963) and Wisconsin v. Yoder, 406 U.S. 205 (1972) and to guarantee its application in all cases where free exercise of religion is substantially burdened; and

(2) to provide a claim or defense to persons whose religious exercise is substantially burdened by government.

3. 42 U.S.C. 2000bb-1 provides:

Free exercise of religion protected

(a) In general

Government shall not substantially burden a person's exercise of religion even if the burden results from a rule of general applicability, except as provided in subsection (b) of this section.

(b) Exception

Government may substantially burden a person's exercise of religion only if it demonstrates that application of the burden to the person—

(1) is in furtherance of a compelling governmental interest; and

(2) is the least restrictive means of furthering that compelling governmental interest.

(c) Judicial relief

A person whose religious exercise has been burdened in violation of this section may assert that violation as a claim or defense in a judicial proceeding and obtain appropriate relief against a government. Standing to assert a claim or defense under this section shall be governed by the general rules of standing under article III of the Constitution.

4. 42 U.S.C. 2000bb-2 provides:

Definitions

As used in this chapter—

(1) the term "government" includes a branch, department, agency, instrumentality, and official (or other person acting under color of law) of the United States, or of a covered entity;

(2) the term "covered entity" means the District of Columbia, the Commonwealth of Puerto Rico, and each territory and possession of the United States;

(3) the term "demonstrates" means meets the burdens of going forward with the evidence and of persuasion; and

(4) the term "exercise of religion" means religious exercise, as defined in section 2000cc-5 of this title.

5. 42 U.S.C. 2000bb-3 provides:

Applicability

(a) In general

This chapter applies to all Federal law, and the implementation of that law, whether statutory or otherwise, and whether adopted before or after November 16, 1993.

(b) Rule of construction

Federal statutory law adopted after November 16, 1993, is subject to this chapter unless such law explicitly excludes such application by reference to this chapter.

(c) Religious belief unaffected

Nothing in this chapter shall be construed to authorize any government to burden any religious belief.

6. 42 U.S.C. 2000bb-4 provides:

Establishment clause unaffected

Nothing in this chapter shall be construed to affect, interpret, or in any way address that portion of the First Amendment prohibiting laws respecting the establishment of religion (referred to in this section as the "Establishment Clause"). Granting government funding, benefits, or exemptions, to the extent permissible under the Establishment Clause, shall not constitute a violation of this chapter. As used in this section, the term "granting", used with respect to government funding, benefits, or exemptions, does not include the denial of government funding, benefits, or exemptions.

7. 45 C.F.R. 147.130 provides:

Coverage of preventive health services.

(a) *Services*—(1) *In general.* Beginning at the time described in paragraph (b) of this section and subject to § 147.131, a group health plan, or a health insurance issuer offering group or individual health insurance coverage, must provide coverage for all of the following items and services, and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or a deductible) with respect to those items and services:

(i) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task

Force with respect to the individual involved (except as otherwise provided in paragraph (c) of this section);

(ii) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

(iii) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

(iv) With respect to women, to the extent not described in paragraph (a)(1)(i) of this section, evidence-informed preventive care and screenings provided for in binding comprehensive health plan coverage guidelines supported by the Health Resources and Services Administration.

(A) In developing the binding health plan coverage guidelines specified in this paragraph (a)(1)(iv), the Health Resources and Services Administration shall be informed by evidence and may establish exemptions from such guidelines with respect to group

health plans established or maintained by religious employers and health insurance coverage provided in connection with group health plans established or maintained by religious employers with respect to any requirement to cover contraceptive services under such guidelines.

(B) For purposes of this subsection, a "religious employer" is an organization that meets all of the following criteria:

(*1*) The inculcation of religious values is the purpose of the organization.

(*2*) The organization primarily employs persons who share the religious tenets of the organization.

(*3*) The organization serves primarily persons who share the religious tenets of the organization.

(*4*) The organization is a nonprofit organization 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.

(2) *Office visits*—(i) If an item or service described in paragraph (a)(1) of this section is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(ii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office

visit is the delivery of such an item or service, then a plan or issuer may not impose cost-sharing requirements with respect to the office visit.

(iii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(iv) The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* An individual covered by a group health plan visits an in-network health care provider. While visiting the provider, the individual is screened for cholesterol abnormalities, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit and for the laboratory work of the cholesterol screening test.

(ii) *Conclusion.* In this *Example 1*, the plan may not impose any cost-sharing requirements with respect to the separately-billed laboratory work of the cholesterol screening test. Because the office visit is billed separately from the cholesterol screening test, the plan may impose cost-sharing requirements for the office visit.

Example 2. (i) *Facts.* Same facts as *Example 1*. As the result of the screening, the individual is diag-

nosed with hyperlipidemia and is prescribed a course of treatment that is not included in the recommendations under paragraph (a)(1) of this section.

(ii) *Conclusion.* In this *Example 2*, because the treatment is not included in the recommendations under paragraph (a)(1) of this section, the plan is not prohibited from imposing cost-sharing requirements with respect to the treatment.

Example 3. (i) *Facts.* An individual covered by a group health plan visits an in-network health care provider to discuss recurring abdominal pain. During the visit, the individual has a blood pressure screening, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit.

(ii) *Conclusion.* In this *Example 3*, the blood pressure screening is provided as part of an office visit for which the primary purpose was not to deliver items or services described in paragraph (a)(1) of this section. Therefore, the plan may impose a cost-sharing requirement for the office visit charge.

Example 4. (i) *Facts.* A child covered by a group health plan visits an in-network pediatrician to receive an annual physical exam described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. During the office visit, the child receives additional items and services that are not described in the comprehensive guidelines supported by the Health Resources and Services Administration, nor otherwise described in

paragraph (a)(1) of this section. The provider bills the plan for an office visit.

(ii) *Conclusion.* In this *Example 4*, the service was not billed as a separate charge and was billed as part of an office visit. Moreover, the primary purpose for the visit was to deliver items and services described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. Therefore, the plan may not impose a cost-sharing requirement for the office visit charge.

(3) *Out-of-network providers.* Nothing in this section requires a plan or issuer that has a network of providers to provide benefits for items or services described in paragraph (a)(1) of this section that are delivered by an out-of-network provider. Moreover, nothing in this section precludes a plan or issuer that has a network of providers from imposing cost-sharing requirements for items or services described in paragraph (a)(1) of this section that are delivered by an out-of-network provider.

(4) *Reasonable medical management.* Nothing prevents a plan or issuer from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service described in paragraph (a)(1) of this section to the extent not specified in the recommendation or guideline.

(5) *Services not described.* Nothing in this section prohibits a plan or issuer from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immuniza-

tion Practices of the Centers for Disease Control and Prevention, or provided for by guidelines supported by the Health Resources and Services Administration, or from denying coverage for items and services that are not recommended by that task force or that advisory committee, or under those guidelines. A plan or issuer may impose cost-sharing requirements for a treatment not described in paragraph (a)(1) of this section, even if the treatment results from an item or service described in paragraph (a)(1) of this section.

(b) *Timing*—(1) *In general.* A plan or issuer must provide coverage pursuant to paragraph (a)(1) of this section for plan years (in the individual market, policy years) that begin on or after September 23, 2010, or, if later, for plan years (in the individual market, policy years) that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(2) *Changes in recommendations or guidelines.* A plan or issuer is not required under this section to provide coverage for any items and services specified in any recommendation or guideline described in paragraph (a)(1) of this section after the recommendation or guideline is no longer described in paragraph (a)(1) of this section. Other requirements of Federal or State law may apply in connection with a plan or issuer ceasing to provide coverage for any such items or services, including PHS Act section 2715(d)(4), which requires a plan or issuer to give 60 days advance notice to an enrollee before any material modification will become effective.

(c) *Recommendations not current.* For purposes of paragraph (a)(1)(i) of this section, and for purposes of any other provision of law, recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current.

(d) *Applicability date.* The provisions of this section apply for plan years (in the individual market, for policy years) beginning on or after September 23, 2010. *See* § 147.140 of this Part for determining the application of this section to grandfathered health plans (providing that these rules regarding coverage of preventive health services do not apply to grandfathered health plans).

8. 45 C.F.R. 147.131 provides:

Exemption and accommodations in connection with coverage of preventive health services.

(a) *Religious employers.* In issuing guidelines under § 147.130(a)(1)(iv), the Health Resources and Services Administration may establish an exemption from such guidelines with respect to a group health plan established or maintained by a religious employer (and health insurance coverage provided in connection with a group health plan established or maintained by a religious employer) with respect to any requirement to cover contraceptive services under such guidelines. For purposes of this paragraph (a), a "religious employer" is an organization that is organized and oper-

ates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

(b) *Eligible organizations.* An eligible organization is an organization that satisfies all of the following requirements:

(1) The organization opposes providing coverage for some or all of any contraceptive services required to be covered under § 147.130(a)(1)(iv) on account of religious objections.

(2) The organization is organized and operates as a nonprofit entity.

(3) The organization holds itself out as a religious organization.

(4) The organization self-certifies, in a form and manner specified by the Secretary, that it satisfies the criteria in paragraphs (b)(1) through (3) of this section, and makes such self-certification available for examination upon request by the first day of the first plan year to which the accommodation in paragraph (c) of this section applies. The self-certification must be executed by a person authorized to make the certification on behalf of the organization, and must be maintained in a manner consistent with the record retention requirements under section 107 of the Employee Retirement Income Security Act of 1974.

(c) *Contraceptive coverage—insured group health plans*—(1) *General rule.* A group health plan established or maintained by an eligible organization that provides benefits through one or more group

health insurance issuers complies for one or more plan years with any requirement under § 147.130(a)(1)(iv) to provide contraceptive coverage if the eligible organization or group health plan furnishes a copy of the self-certification described in paragraph (b)(4) of this section to each issuer that would otherwise provide such coverage in connection with the group health plan. An issuer may not require any documentation other than the copy of the self-certification from the eligible organization regarding its status as such.

(2) *Payments for contraceptive services*—(i) A group health insurance issuer that receives a copy of the self-certification described in paragraph (b)(4) of this section with respect to a group health plan established or maintained by an eligible organization in connection with which the issuer would otherwise provide contraceptive coverage under § 147.130(a)(1)(iv) must—

(A) Expressly exclude contraceptive coverage from the group health insurance coverage provided in connection with the group health plan; and

(B) Provide separate payments for any contraceptive services required to be covered under § 147.130(a)(1)(iv) for plan participants and beneficiaries for so long as they remain enrolled in the plan.

(ii) With respect to payments for contraceptive services, the issuer may not impose any cost-sharing requirements (such as a copayment, coinsurance, or a deductible), or impose any premium, fee, or other charge, or any portion thereof, directly or indirectly, on the eligible organization, the group health plan, or

plan participants or beneficiaries. The issuer must segregate premium revenue collected from the eligible organization from the monies used to provide payments for contraceptive services. The issuer must provide payments for contraceptive services in a manner that is consistent with the requirements under sections 2706, 2709, 2711, 2713, 2719, and 2719A of the PHS Act. If the group health plan of the eligible organization provides coverage for some but not all of any contraceptive services required to be covered under § 147.130(a)(1)(iv), the issuer is required to provide payments only for those contraceptive services for which the group health plan does not provide coverage. However, the issuer may provide payments for all contraceptive services, at the issuer's option.

(d) *Notice of availability of separate payments for contraceptive services—insured group health plans and student health insurance coverage.* For each plan year to which the accommodation in paragraph (c) of this section is to apply, an issuer required to provide payments for contraceptive services pursuant to paragraph (c) of this section must provide to plan participants and beneficiaries written notice of the availability of separate payments for contraceptive services contemporaneous with (to the extent possible), but separate from, any application materials distributed in connection with enrollment (or reenrollment) in group health coverage that is effective beginning on the first day of each applicable plan year. The notice must specify that the eligible organization does not administer or fund contraceptive benefits, but that the issuer provides separate payments for con-

traceptive services, and must provide contact information for questions and complaints. The following model language, or substantially similar language, may be used to satisfy the notice requirement of this paragraph (d): "Your [employer/institution of higher education] has certified that your [group health plan/ student health insurance coverage] 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/ institution of higher education] will not contract, arrange, pay, or refer for contraceptive coverage. Instead, [name of health insurance issuer] will provide 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/student health insurance coverage]. Your [employer/institution of higher education] will not administer or fund these payments. If you have any questions about this notice, contact [contact information for health insurance issuer]."

(e) *Reliance*—(1) If an issuer relies reasonably and in good faith on a representation by the eligible organization as to its eligibility for the accommodation in paragraph (c) of this section, and the representation is later determined to be incorrect, the issuer is considered to comply with any requirement under § 147.130(a)(1)(iv) to provide contraceptive coverage if the issuer complies with the obligations under this section applicable to such issuer.

(2) A group health plan is considered to comply with any requirement under § 147.130(a)(1)(iv) to provide contraceptive coverage if the plan complies with its obligations under paragraph (c) of this section, without regard to whether the issuer complies with the obligations under this section applicable to such issuer.

(f) *Application to student health insurance coverage.* The provisions of this section apply to student health insurance coverage arranged by an eligible organization that is an institution of higher education in a manner comparable to that in which they apply to group health insurance coverage provided in connection with a group health plan established or maintained by an eligible organization that is an employer. In applying this section in the case of student health insurance coverage, a reference to "plan participants and beneficiaries" is a reference to student enrollees and their covered dependents.

9. 29 C.F.R. 2590.715-2713 provides:

Coverage of preventive health services.

(a) *Services*—(1) *In general.* Beginning at the time described in paragraph (b) of this section and subject to § 2590.715-2713A, a group health plan, or a health insurance issuer offering group health insurance coverage, must provide coverage for all of the following items and services, and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or a deductible) with respect to those items and services:

(i) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved (except as otherwise provided in paragraph (c) of this section);

(ii) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

(iii) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

(iv) With respect to women, to the extent not described in paragraph (a)(1)(i) of this section, evidence-informed preventive care and screenings provided for in binding comprehensive health plan coverage guidelines supported by the Health Resources and Services Administration, in accordance with 45 CFR 147.131(a).

(2) *Office visits*—(i) If an item or service described in paragraph (a)(1) of this section is billed sep-

arately (or is tracked as individual encounter data separately) from an office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(ii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a plan or issuer may not impose cost-sharing requirements with respect to the office visit.

(iii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(iv) The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* An individual covered by a group health plan visits an in-network health care provider. While visiting the provider, the individual is screened for cholesterol abnormalities, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit and for the laboratory work of the cholesterol screening test.

(ii) *Conclusion.* In this *Example 1*, the plan may not impose any cost-sharing requirements with respect to the separately-billed laboratory work of the cholesterol screening test. Because the office visit is billed separately from the cholesterol screening test, the plan may impose cost-sharing requirements for the office visit.

Example 2. (i) *Facts.* Same facts as Example 1. As the result of the screening, the individual is diagnosed with hyperlipidemia and is prescribed a course of treatment that is not included in the recommendations under paragraph (a)(1) of this section.

(ii) *Conclusion.* In this *Example 2*, because the treatment is not included in the recommendations under paragraph (a)(1) of this section, the plan is not prohibited from imposing cost-sharing requirements with respect to the treatment.

Example 3. (i) *Facts.* An individual covered by a group health plan visits an in-network health care provider to discuss recurring abdominal pain. During the visit, the individual has a blood pressure screening, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit.

(ii) *Conclusion.* In this *Example 3*, the blood pressure screening is provided as part of an office visit for which the primary purpose was not to deliver items or services described in paragraph (a)(1) of this section. Therefore, the plan may impose a cost-sharing requirement for the office visit charge.

Example 4. (i) *Facts.* A child covered by a group health plan visits an in-network pediatrician to receive an annual physical exam described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. During the office visit, the child receives additional items and services that are not described in the comprehensive guidelines supported by the Health Resources and Services Administration, nor otherwise described in paragraph (a)(1) of this section. The provider bills the plan for an office visit.

(ii) *Conclusion.* In this *Example 4*, the service was not billed as a separate charge and was billed as part of an office visit. Moreover, the primary purpose for the visit was to deliver items and services described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. Therefore, the plan may not impose a cost-sharing requirement with respect to the office visit.

(3) *Out-of-network providers.* Nothing in this section requires a plan or issuer that has a network of providers to provide benefits for items or services described in paragraph (a)(1) of this section that are delivered by an out-of-network provider. Moreover, nothing in this section precludes a plan or issuer that has a network of providers from imposing cost-sharing requirements for items or services described in paragraph (a)(1) of this section that are delivered by an out-of-network provider.

(4) *Reasonable medical management.* Nothing prevents a plan or issuer from using reasonable medi-

cal management techniques to determine the frequency, method, treatment, or setting for an item or service described in paragraph (a)(1) of this section to the extent not specified in the recommendation or guideline.

(5) *Services not described.* Nothing in this section prohibits a plan or issuer from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or provided for by guidelines supported by the Health Resources and Services Administration, or from denying coverage for items and services that are not recommended by that task force or that advisory committee, or under those guidelines. A plan or issuer may impose cost-sharing requirements for a treatment not described in paragraph (a)(1) of this section, even if the treatment results from an item or service described in paragraph (a)(1) of this section.

(b) *Timing*—(1) *In general.* A plan or issuer must provide coverage pursuant to paragraph (a)(1) of this section for plan years that begin on or after September 23, 2010, or, if later, for plan years that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(2) *Changes in recommendations or guidelines.* A plan or issuer is not required under this section to provide coverage for any items and services specified in any recommendation or guideline described in paragraph (a)(1) of this section after the recommendation

or guideline is no longer described in paragraph (a)(1) of this section. Other requirements of Federal or State law may apply in connection with a plan or issuer ceasing to provide coverage for any such items or services, including PHS Act section 2715(d)(4), which requires a plan or issuer to give 60 days advance notice to an enrollee before any material modification will become effective.

(c) *Recommendations not current.* For purposes of paragraph (a)(1)(i) of this section, and for purposes of any other provision of law, recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current.

(d) *Applicability date.* The provisions of this section apply for plan years beginning on or after September 23, 2010. *See* § 2590.715-1251 of this Part for determining the application of this section to grandfathered health plans (providing that these rules regarding coverage of preventive health services do not apply to grandfathered health plans).

10. 29 C.F.R. 2590.715-2713A provides:

Accommodations in connection with coverage of preventive health services.

(a) *Eligible organizations.* An eligible organization is an organization that satisfies all of the following requirements:

(1) The organization opposes providing coverage for some or all of any contraceptive services required to be covered under § 2590.715-2713(a)(1)(iv) on account of religious objections.

(2) The organization is organized and operates as a nonprofit entity.

(3) The organization holds itself out as a religious organization.

(4) The organization self-certifies, in a form and manner specified by the Secretary, that it satisfies the criteria in paragraphs (a)(1) through (3) of this section, and makes such self-certification available for examination upon request by the first day of the first plan year to which the accommodation in paragraph (b) or (c) of this section applies. The self-certification must be executed by a person authorized to make the certification on behalf of the organization, and must be maintained in a manner consistent with the record retention requirements under section 107 of ERISA.

(b) *Contraceptive coverage—self-insured group health plans*—(1) A group health plan established or maintained by an eligible organization that provides benefits on a self-insured basis complies for one or more plan years with any requirement under § 2590.715-2713(a)(1)(iv) to provide contraceptive coverage if all of the requirements of this paragraph (b)(1) are satisfied:

(i) The eligible organization or its plan contracts with one or more third party administrators.

(ii) The eligible organization provides each third party administrator that will process claims for any contraceptive services required to be covered under § 2590.715-2713(a)(1)(iv) with a copy of the self-certification described in paragraph (a)(4) of this section, which shall include notice that—

(A) The eligible organization will not act as the plan administrator or claims administrator with respect to claims for contraceptive services, or contribute to the funding of contraceptive services; and

(B) Obligations of the third party administrator are set forth in § 2510.3-16 of this chapter and § 2590.715-2713A.

(iii) The eligible organization must not, directly or indirectly, seek to interfere with a third party administrator's arrangements to provide or arrange separate payments for contraceptive services for participants or beneficiaries, and must not, directly or indirectly, seek to influence the third party administrator's decision to make any such arrangements.

(2) If a third party administrator receives a copy of the self-certification described in paragraph (a)(4) of this section, and agrees to enter into or remain in a contractual relationship with the eligible organization or its plan to provide administrative services for the plan, the third party administrator shall provide or arrange payments for contraceptive services using one of the following methods—

(i) Provide payments for contraceptive services for plan participants and beneficiaries without impos-

ing any cost-sharing requirements (such as a copayment, coinsurance, or a deductible), or imposing a premium, fee, or other charge, or any portion thereof, directly or indirectly, on the eligible organization, the group health plan, or plan participants or beneficiaries; or

(ii) Arrange for an issuer or other entity to provide payments for contraceptive services for plan participants and beneficiaries without imposing any cost-sharing requirements (such as a copayment, coinsurance, or a deductible), or imposing a premium, fee, or other charge, or any portion thereof, directly or indirectly, on the eligible organization, the group health plan, or plan participants or beneficiaries.

(3) If a third party administrator provides or arranges payments for contraceptive services in accordance with either paragraph (b)(2)(i) or (ii) of this section, the costs of providing or arranging such payments may be reimbursed through an adjustment to the Federally-facilitated Exchange user fee for a participating issuer pursuant to 45 CFR 156.50(d).

(4) A third party administrator may not require any documentation other than the copy of the self-certification from the eligible organization regarding its status as such.

(c) *Contraceptive coverage—insured group health plans*—(1) *General rule.* A group health plan established or maintained by an eligible organization that provides benefits through one or more group health insurance issuers complies for one or more plan years with any requirement under § 2590.715-

2713(a)(1)(iv) to provide contraceptive coverage if the eligible organization or group health plan furnishes a copy of the self-certification described in paragraph (a)(4) of this section to each issuer that would otherwise provide such coverage in connection with the group health plan. An issuer may not require any documentation other than the copy of the self-certification from the eligible organization regarding its status as such.

(2) *Payments for contraceptive services*—(i) A group health insurance issuer that receives a copy of the self-certification described in paragraph (a)(4) of this section with respect to a group health plan established or maintained by an eligible organization in connection with which the issuer would otherwise provide contraceptive coverage under § 2590.715-2713(a)(1)(iv) must—

(A) Expressly exclude contraceptive coverage from the group health insurance coverage provided in connection with the group health plan; and

(B) Provide separate payments for any contraceptive services required to be covered under § 2590.715-2713(a)(1)(iv) for plan participants and beneficiaries for so long as they remain enrolled in the plan.

(ii) With respect to payments for contraceptive services, the issuer may not impose any cost-sharing requirements (such as a copayment, coinsurance, or a deductible), or impose any premium, fee, or other charge, or any portion thereof, directly or indirectly, on the eligible organization, the group health plan, or plan participants or beneficiaries. The issuer must

segregate premium revenue collected from the eligible organization from the monies used to provide payments for contraceptive services. The issuer must provide payments for contraceptive services in a manner that is consistent with the requirements under sections 2706, 2709, 2711, 2713, 2719, and 2719A of the PHS Act, as incorporated into section 715 of ERISA. If the group health plan of the eligible organization provides coverage for some but not all of any contraceptive services required to be covered under § 2590.715-2713(a)(1)(iv), the issuer is required to provide payments only for those contraceptive services for which the group health plan does not provide coverage. However, the issuer may provide payments for all contraceptive services, at the issuer's option.

(d) *Notice of availability of separate payments for contraceptive services—self-insured and insured group health plans.* For each plan year to which the accommodation in paragraph (b) or (c) of this section is to apply, a third party administrator required to provide or arrange payments for contraceptive services pursuant to paragraph (b) of this section, and an issuer required to provide payments for contraceptive services pursuant to paragraph (c) of this section, must provide to plan participants and beneficiaries written notice of the availability of separate payments for contraceptive services contemporaneous with (to the extent possible), but separate from, any application materials distributed in connection with enrollment (or re-enrollment) in group health coverage that is effective beginning on the first day of each applicable plan year. The notice must specify that the eligible or-

ganization does not administer or fund contraceptive benefits, but that the third party administrator or issuer, as applicable, provides separate payments for contraceptive services, and must provide contact information for questions and complaints. The following model language, or substantially similar language, may be used to satisfy the notice requirement of this paragraph (d): "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]."

(e) *Reliance—insured group health plans*—(1) If an issuer relies reasonably and in good faith on a representation by the eligible organization as to its eligibility for the accommodation in paragraph (c) of this section, and the representation is later determined to be incorrect, the issuer is considered to comply with any requirement under § 2590.715-2713(a)(1)(iv) to provide contraceptive coverage if the issuer complies

with the obligations under this section applicable to such issuer.

(2) A group health plan is considered to comply with any requirement under § 2590.715-2713(a)(1)(iv) to provide contraceptive coverage if the plan complies with its obligations under paragraph (c) of this section, without regard to whether the issuer complies with the obligations under this section applicable to such issuer.

11. 26 C.F.R. 54.9815-2713 provides:

Coverage of preventive health services.

(a) *Services*—(1) *In general.* Beginning at the time described in paragraph (b) of this section and subject to § 54.9815-2713A, a group health plan, or a health insurance issuer offering group health insurance coverage, must provide coverage for all of the following items and services, and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or a deductible) with respect to those items and services:

(i)-(iii) [Reserved]

(iv) With respect to women, to the extent not described in paragraph (a)(1)(i) of this section, evidence-informed preventive care and screenings provided for in binding comprehensive health plan coverage guidelines supported by the Health Resources and Services Administration, in accordance with 45 CFR 147.131(a).

(2) *Office visits.* [Reserved]

(3) *Out-of-network providers.* [Reserved]

(4) *Reasonable medical management.* [Reserved]

(5) *Services not described.* [Reserved]

(b) *Timing.* [Reserved]

(c) *Recommendations not current.* [Reserved]

(d) *Effective/applicability date.* April 16, 2012.

12. 26 C.F.R. 54.9815-2713A provides:

Accommodations in connection with coverage of preventive health services.

(a) *Eligible organizations.* An eligible organization is an organization that satisfies all of the following requirements:

(1) The organization opposes providing coverage for some or all of any contraceptive services required to be covered under § 54.9815-2713(a)(1)(iv) on account of religious objections.

(2) The organization is organized and operates as a nonprofit entity.

(3) The organization holds itself out as a religious organization.

(4) The organization self-certifies, in a form and manner specified by the Secretaries of Health and Human Services and Labor, that it satisfies the criteria in paragraphs (a)(1) through (3) of this section, and makes such self-certification available for examination upon request by the first day of the first plan year to which the accommodation in paragraph (b) or (c) of

this section applies. The self-certification must be executed by a person authorized to make the certification on behalf of the organization, and must be maintained in a manner consistent with the record retention requirements under section 107 of ERISA.

(b) *Contraceptive coverage—self-insured group health plans*—(1) A group health plan established or maintained by an eligible organization that provides benefits on a self-insured basis complies for one or more plan years with any requirement under § 54.9815-2713(a)(1)(iv) to provide contraceptive coverage if all of the requirements of this paragraph (b)(1) of this section are satisfied:

(i) The eligible organization or its plan contracts with one or more third party administrators.

(ii) The eligible organization provides each third party administrator that will process claims for any contraceptive services required to be covered under § 54.9815-2713(a)(1)(iv) with a copy of the self-certification described in paragraph (a)(4) of this section, which shall include notice that—

(A) The eligible organization will not act as the plan administrator or claims administrator with respect to claims for contraceptive services, or contribute to the funding of contraceptive services; and

(B) Obligations of the third party administrator are set forth in 29 CFR 2510.3-16 and 26 CFR 54.9815-2713A.

(iii) The eligible organization must not, directly or indirectly, seek to interfere with a third party admin-

istrator's arrangements to provide or arrange separate payments for contraceptive services for participants or beneficiaries, and must not, directly or indirectly, seek to influence the third party administrator's decision to make any such arrangements.

(2) If a third party administrator receives a copy of the self-certification described in paragraph (a)(4) of this section, and agrees to enter into or remain in a contractual relationship with the eligible organization or its plan to provide administrative services for the plan, the third party administrator shall provide or arrange payments for contraceptive services using one of the following methods—

(i) Provide payments for contraceptive services for plan participants and beneficiaries without imposing any cost-sharing requirements (such as a copayment, coinsurance, or a deductible), or imposing a premium, fee, or other charge, or any portion thereof, directly or indirectly, on the eligible organization, the group health plan, or plan participants or beneficiaries; or

(ii) Arrange for an issuer or other entity to provide payments for contraceptive services for plan participants and beneficiaries without imposing any cost-sharing requirements (such as a copayment, coinsurance, or a deductible), or imposing a premium, fee, or other charge, or any portion thereof, directly or indirectly, on the eligible organization, the group health plan, or plan participants or beneficiaries.

(3) If a third party administrator provides or arranges payments for contraceptive services in accord-

ance with either paragraph (b)(2)(i) or (ii) of this section, the costs of providing or arranging such payments may be reimbursed through an adjustment to the Federally-facilitated Exchange user fee for a participating issuer pursuant to 45 CFR 156.50(d).

(4) A third party administrator may not require any documentation other than the copy of the self-certification from the eligible organization regarding its status as such.

(c) *Contraceptive coverage*—insured group health plans—(1) *General rule.* A group health plan established or maintained by an eligible organization that provides benefits through one or more group health insurance issuers complies for one or more plan years with any requirement under § 54.9815-2713(a)(1)(iv) to provide contraceptive coverage if the eligible organization or group health plan furnishes a copy of the self-certification described in paragraph (a)(4) of this section to each issuer that would otherwise provide such coverage in connection with the group health plan. An issuer may not require any documentation other than the copy of the self-certification from the eligible organization regarding its status as such.

(2) *Payments for contraceptive services* (i) A group health insurance issuer that receives a copy of the self-certification described in paragraph (a)(4) of this section with respect to a group health plan established or maintained by an eligible organization in connection with which the issuer would otherwise provide contraceptive coverage under § 54.9815-2713(a)(1)(iv) must—

(A) Expressly exclude contraceptive coverage from the group health insurance coverage provided in connection with the group health plan; and

(B) Provide separate payments for any contraceptive services required to be covered under § 54.9815-2713(a)(1)(iv) for plan participants and beneficiaries for so long as they remain enrolled in the plan.

(ii) With respect to payments for contraceptive services, the issuer may not impose any cost-sharing requirements (such as a copayment, coinsurance, or a deductible), or impose any premium, fee, or other charge, or any portion thereof, directly or indirectly, on the eligible organization, the group health plan, or plan participants or beneficiaries. The issuer must segregate premium revenue collected from the eligible organization from the monies used to provide payments for contraceptive services. The issuer must provide payments for contraceptive services in a manner that is consistent with the requirements under sections 2706, 2709, 2711, 2713, 2719, and 2719A of the PHS Act, as incorporated into section 9815. If the group health plan of the eligible organization provides coverage for some but not all of any contraceptive services required to be covered under § 54.9815-2713(a)(1)(iv), the issuer is required to provide payments only for those contraceptive services for which the group health plan does not provide coverage. However, the issuer may provide payments for all contraceptive services, at the issuer's option.

(d) *Notice of availability of separate payments for contraceptive services—self-insured and insured group health plans.* For each plan year to which the accommodation in paragraph (b) or (c) of this section is to apply, a third party administrator required to provide or arrange payments for contraceptive services pursuant to paragraph (b) of this section, and an issuer required to provide payments for contraceptive services pursuant to paragraph (c) of this section, must provide to plan participants and beneficiaries written notice of the availability of separate payments for contraceptive services contemporaneous with (to the extent possible), but separate from, any application materials distributed in connection with enrollment (or re-enrollment) in group health coverage that is effective beginning on the first day of each applicable plan year. The notice must specify that the eligible organization does not administer or fund contraceptive benefits, but that the third party administrator or issuer, as applicable, provides separate payments for contraceptive services, and must provide contact information for questions and complaints. The following model language, or substantially similar language, may be used to satisfy the notice requirement of this paragraph (d): "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 par-

ty 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]."

(e) *Reliance—insured group health plans* (1) If an issuer relies reasonably and in good faith on a representation by the eligible organization as to its eligibility for the accommodation in paragraph (c) of this section, and the representation is later determined to be incorrect, the issuer is considered to comply with any requirement under § 54.9815-2713(a)(1)(iv) to provide contraceptive coverage if the issuer complies with the obligations under this section applicable to such issuer.

(2) A group health plan is considered to comply with any requirement under § 54.9815-2713(a)(1)(iv) to provide contraceptive coverage if the plan complies with its obligations under paragraph (c) of this section, without regard to whether the issuer complies with the obligations under this section applicable to such issuer.

Health Resources and Services Administration, Department of Health and Human Services

Women's Preventive Services Guidelines

Affordable Care Act Expands Prevention Coverage for Women's Health and Well-Being

The Affordable Care Act—the health insurance reform legislation passed by Congress and signed into law by President Obama on March 23, 2010—helps make prevention affordable and accessible for all Americans by requiring health plans to cover preventive services and by eliminating cost sharing for those services. Preventive services that have strong scientific evidence of their health benefits must be covered and plans can no longer charge a patient a copayment, coinsurance or deductible for these services when they are delivered by a network provider.

Women's Preventive Services Guidelines Supported by the Health Resources and Services Administration

Under the Affordable Care Act, women's preventive health care—such as mammograms, screenings for cervical cancer, prenatal care, and other services—generally must be covered by health plans with no cost sharing. However, the law recognizes and HHS understands the need to take into account the unique health needs of women throughout their lifespan.

The HRSA-supported health plan coverage guidelines, developed by the Institute of Medicine (IOM), will help ensure that women receive a comprehensive set of pre-

ventive services without having to pay a co-payment, co-insurance or a deductible. HHS commissioned an IOM study to review what preventive services are necessary for women's health and well-being and therefore should be considered in the development of comprehensive guidelines for preventive services for women. HRSA is supporting the IOM's recommendations on preventive services that address health needs specific to women and fill gaps in existing guidelines.

Health Resources and Services Administration Women's Preventive Services Guidelines

Non-grandfathered plans (plans or policies created or sold after March 23, 2010, or older plans or policies that have been changed in certain ways since that date) generally are required to provide coverage without cost sharing consistent with these guidelines in the first plan year (in the individual market, policy year) that begins on or after August 1, 2012.

Type of Preventive Service	HHS Guideline for Health Insurance Coverage	Frequency
Well-woman visits.	Well-woman preventive care visit annually for adult women to obtain the recommended preventive	Annual, although HHS recognizes that several visits may be needed to obtain all necessary rec-

	services that are age and developmentally appropriate, including preconception care and many services necessary for prenatal care. This well-woman visit should, where appropriate, include other preventive services listed in this set of guidelines, as well as others referenced in section 2713.	ommended preventive services, depending on a woman's health status, health needs, and other risk factors.* (see note)
Screening for gestational diabetes.	Screening for gestational diabetes.	In pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant

		women identified to be at high risk for diabetes.
Human papillomavirus testing.	High-risk human papillomavirus DNA testing in women with normal cytology results.	Screening should begin at 30 years of age and should occur no more frequently than every 3 years.
Counseling for sexually transmitted infections.	Counseling on sexually transmitted infections for all sexually active women.	Annual.
Counseling and screening for human immunedeficiency virus.	Counseling and screening for human immune-deficiency virus infection for all sexually active women.	Annual.
Contraceptive methods and counseling. ** (see note)	All Food and Drug Administration approved contraceptive methods,	As prescribed.

	sterilization procedures, and patient education and counseling for all women with reproductive capacity.	
Breastfeeding support, supplies, and counseling.	Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.	In conjunction with each birth.
Screening and counseling for interpersonal and domestic violence.	Screening and counseling for interpersonal and domestic violence.	

* *Refer to guidance issued by the Center for Consumer Information and Insurance Oversight entitled Affordable Care Act Implementation FAQs, Set 12, Q10. In addition, refer to recommendations in the*

July 2011 IOM report entitled Clinical Preventive Services for Women: Closing the Gaps concerning distinct preventive services that may be obtained during a well-woman preventive services visit.

*** The guidelines concerning contraceptive methods and counseling described above do not apply to women who are participants or beneficiaries in group health plans sponsored by religious employers. Effective August 1, 2013, a religious employer is defined as 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. HRSA notes that, as of August 1, 2013, group health plans established or maintained by religious employers (and group health insurance coverage provided in connection with such plans) are exempt from the requirement to cover contraceptive services under section 2713 of the Public Health Service Act, as incorporated into the Employee Retirement Income Security Act and the Internal Revenue Code. HRSA also notes that, as of January 1, 2014, accommodations are available to group health plans established or maintained by certain eligible organizations (and group health insurance coverage provided in connection with such plans), as well as student health insurance coverage arranged by eligible organizations, with respect to the contraceptive coverage requirement. See Federal Register Notice: Coverage of Certain Preventive Services Under the Affordable Care Act (PDF - 327 KB)*