CHURCH ALLIANCE
Acting on Behalf of Church Benefits Programs

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By electronic submission (http://www.regulations.gov)

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9928-NC
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Request for Information – Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act and Improving Healthcare Choices to Empower Patients

To Whom It May Concern:

The Church Alliance is submitting this letter as a public comment to the above Request for Information, published on June 12, 2017 by the Centers for Medicare and Medicaid Services ("CMS"), United States Department of Health and Human Services ("HHS") at 82 Fed. Reg. 26885 ("RFI"). We welcome the opportunity to comment, because the Patient Protection and Affordable Care Act ("ACA") has imposed extraordinary regulatory burdens on the ministries and church health plans served by Church Alliance members.

The Church Alliance is a coalition of the chief executive officers of 37 church benefit boards, affiliated with mainline and evangelical Protestant denominations, two branches of Judaism, and Catholic schools and institutions. While the Church Alliance's members reflect a diversity of beliefs, its members share a common purpose: to provide health care and retirement benefits to more than one million clergy,[1] church lay workers, and their dependents at more than 155,000 churches, parishes, synagogues, and church-associated organizations across the country. The Church Alliance urges that benefit-related regulations and agency guidance take into account the unique nature and needs of church plans, as HHS actively works to reduce regulatory burdens and improve health coverage options.

I. Executive Summary

The ACA's significant regulatory impact on church health plans and associated ministries has been exacerbated by the misalignment of ACA requirements with the unique and diverse church structures surrounding church health plans. These structures are based on religious beliefs and range from autonomous, highly decentralized structures to hierarchical structures. Even the hierarchical structures may have

[1] As used in this comment letter, the term "clergy" refers to ministers, priests, rabbis, imams, and other spiritual leaders.

decentralized facets to them, though, because of the multitude of ministries and workers covered by the associated church plans. In addition to the burden created by this misalignment, at least two ACA requirements directly conflict with the religious beliefs of some Church Alliance members.

The Church Alliance respectfully requests that HHS consider the unique nature of church health plans and the structures surrounding them when reviewing changes to regulations and other guidance. Specifically, we request: 1) flexibility in the application of ACA regulations to account for these unique aspects; 2) relief from burdensome regulations and guidance that adversely impact church health plans and/or the ministries they serve; and 3) appropriate religious exemptions when ACA requirements directly conflict with church religious beliefs.

II. Description of Church Benefit Plans

To understand the regulatory burdens and other challenges the ACA has presented for church health plans and ministries, it is best to have some information about these plans. Church benefit plans have been in existence for decades and, in some cases, pre-date the enactment of the Internal Revenue Code in 1913. Initially, many church benefit plans were akin to benevolence programs that provided for clergy in need (some were even called "worn out preachers' funds"). Over time, these programs expanded to more systematically provide retirement and welfare benefits for both clergy and lay workers.

Church benefit plans are typically maintained by a separately incorporated church benefits board for eligible employees of ministries in a denomination. Often the sponsor is the church or denomination itself, not the benefits board. The plans are generally multiple-employer in nature and provide retirement and welfare benefits to thousands (or, in the case of large denominations, tens of thousands) of clergy and lay workers working for different employers throughout the country.

Most participating employers covered by church benefit plans are small, local churches with only a few employees. In many denominations, the local church's pastor may be that church's only employee. If there are other employees, they are often part-time workers who assist with administrative duties, although these duties are performed by volunteers in many churches.

In addition to serving local churches, church benefit plans cover other church-related organizations. For example, participating employers can include church-affiliated nursing homes, daycare centers, seminaries, universities, elementary and secondary schools, and social services organizations. All of these organizations are essential to fulfilling the mission and ministry of the church.

Church plans capable of serving multiple church employers provide efficiency, continuity, and consistency of employee benefits for ministers and lay workers as they move throughout the United States from one church or church-related organization to another within a denomination. In some denominations, these moves occur frequently and as directed by ecclesiastical supervisors.

Denominations have been organized to reflect their own theological beliefs and church polity (the operational and governance structure of the denomination), which can give rise to unique challenges for church plans. Hierarchical structures, where the parent church organization sets policy for the entire denomination, operate in a manner similar to a large multiple employer plan. Hierarchical structures will present unique challenges, because while policy may be set centrally, many decisions and processes

impacting employee benefits are set and controlled locally, such as payroll, hiring, and termination. Other less hierarchical structures, including synodical or presbyterian structures (local or regional policy-making through representation from area churches) and congregational structures (voluntary cooperation among autonomous churches, or church conventions or associations), operate with less centralized policy decision-making, and can further divide various responsibilities and functions between the national plan and local employer, which can lead to greater compliance challenges.

A. Church Health Plans

Many church health plans have been in existence for over 50 years. Most denominations offer a nationwide plan (often on a self-funded basis), which provides clergy and their families the comfort and security of career-long, portable, comprehensive, and affordable medical coverage through a plan that reflects their denomination's beliefs. In addition, workers who move from one church to another may be able to continue coverage under the plan without impacting provider networks and existing contributions to annual deductibles and out-of-pocket maximums.

Because church health plans are national in scope, these plans are able to take advantage of "economies of scale," allowing churches and individual members of the clergy to purchase coverage for less than it would cost to purchase similar coverage through the small group or individual insurance markets. This approach has allowed thousands of churches and affiliated organizations, many in rural or disadvantaged areas, to provide meaningful health care benefits to clergy, lay employees, and their families. Historically, church health plans have successfully contained costs and minimized fluctuations that could be damaging to smaller employers, particularly given the above-average age and health risk profile of the covered population.

Church health plans are structured to meet the unique needs of church workers and employers. Eligible employees often have access to pastoral counseling and colleague groups, behavioral health professionals that are specially trained to assist ministers, and health and wellness programs that address spiritual health.

The application of federal and state benefit laws to church health plans presents different challenges than it would to a typical single or multiple employer group health plan. As discussed above, each denomination has a unique polity that reflects its theological beliefs. As a result, each denomination has a different level of authority and control over individual churches as employers. For instance, in some denominations, the church plan sponsor may mandate employer coverage decisions, while in other denominations, the national plan can control only the plan design and administration but not the eligibility and participation rules or employer contributions toward the employee's cost of coverage. In many of these denominations, the national church benefit boards may not refuse to provide coverage to individual churches. As a result, churches often have the ability to opt in and out of the denominational plan at will.

Due, in part, to the ACA, church health plans have faced challenges in recent years that, if not addressed, may threaten their long-term ability to serve clergy and church lay workers as they have for decades.

III. ACA's Challenges for Church Health Plans

As described above, church health plans have been carefully designed over the years to reflect each church's theological beliefs and polity. However, the ACA has created unique challenges for some church health plans because of those beliefs. All of the members of the Church Alliance share the common view that a church, or an employer associated with a church, should not have to face the choice of violating its religious tenets and beliefs or violating the law in order to maintain a health plan for its workers. This is true even though some of the health plans associated with the members of the Church Alliance do not impose restrictions on covering health or medical services that would conflict with the requirements of the ACA. Specifically, the application of the ACA preventive services mandate with respect to contraceptive services and certain provisions of the ACA Section 1557 nondiscrimination regulations conflict directly with the religious beliefs of some Church Alliance members. These burdens rise to the level of infringing upon the rights of those Church Alliance members and the ministries they serve to freely exercise their religion.

More broadly, Church Alliance members have been burdened by the incentives that the ACA has provided for health coverage decisions to be made solely on the basis of price. The availability of premium subsidies for individuals purchasing public exchange coverage and small businesses purchasing coverage through the Small Business Health Options Program ("SHOP") put church health plans at a disadvantage because their cost cannot be offset by premium subsidies, making it more difficult for church and church-related employers to continue to provide benefits through such plans.

Small churches, in particular, have faced significant challenges. Small churches that offer church health plan coverage to their employees have not qualified for the ACA's Small Business Health Care Tax Credit since 2014. As a result, many small churches have been faced with the difficult choice of maintaining participation in a plan designed specifically for the denomination at a higher cost or, alternatively, terminating church plan participation and either switching to a SHOP plan or forgoing employer-provided health coverage altogether. The likelihood that individual churches will forgo church health plan participation jeopardizes risk pool stability and threatens the future viability of these plans.

These circumstances have led some clergy and lay workers to seek coverage on the public exchanges. Such individuals, who could otherwise continue with church health plan coverage on an individual basis (with no employer funding), are incentivized to end church plan coverage, since tax credits are unavailable to them in those plans but are available if they choose exchange plans. Such situations reflect another way in which church health plans are unique — since they typically are sponsored by the denomination instead of the local ministry, church workers may remain eligible to participate in church health plans as individuals even when the local ministry does not pay for coverage. Unfortunately, when such individuals are covered by exchange plans, these plans lack many valuable benefits offered through church health plans, including pastoral counseling, broad national provider networks that ensure uniformity of benefits to all ministers, geographic portability of coverage, and the ability to influence the direction and scope of health benefits through the denomination. Additionally, premiums in exchange plans may pay for benefits and services that are inconsistent with their religious beliefs.

Other provisions of the ACA, particularly those relating to employer notice, information, reporting, or coverage requirements, have been extraordinarily challenging for church health plans and ministries. For example, denominational benefit boards do not have direct and immediate information about the hiring

and termination of employees and do not have access to payroll, so requirements on providing to new employees notices (such as the Notice to Employees of Coverage Options) or information (such as the Summary of Benefits and Coverage ("SBC")) create compliance challenges. In addition, requirements with respect to affordability, reporting, and other requirements that are more easily met by a large, multi-location employer with control of — or at least access to — information on hiring, termination, and payroll become much more burdensome and challenging.

Fundamentally, the ACA rules do not work within the unique structure and purpose of church plans. Church polity and religious teachings have informed the structure of church plans and the terms of call for clergy and church lay workers. Imposing upon church plans the same requirements applicable to large employer group health plans, without appropriate flexibility, has generated compliance and financial risks for church health plans and ministries.

A. Seeking relief from regulatory burdens

The Church Alliance respectfully seeks relief from the regulatory burdens that the ACA imposes on church health plans. The unique and diverse structures of denominations and the varied relationships between church health plans and individual employers participating in the plans has been particularly challenging.

One example of a regulatory burden that has been challenging for church benefit boards, and from which we seek relief, is the requirement to provide a SBC upon eligibility for health coverage, because church benefit boards generally produce that document but are not generally informed immediately or in advance of the hiring of a new employee. The new template also may be burdensome to some church benefit boards that have not yet changed from the original template to the new one because they have not yet been required to do so based on their plan years. The new template for the SBC unnecessarily imposes upon the scarce resources of church benefit boards, and the new calculators are proving particularly challenging and burdensome. The Church Alliance requests flexibility and at least a reasonable amount of leniency in the application of the SBC requirements to church health plans and ministries, including the flexibility to utilize either the current or new SBC template. Similarly, the Church Alliance seeks relief from the burdens of other ACA notice and information requirements, including flexibility and at least a reasonable amount of leniency, due to the unique challenges presented by church structures.

In addition to the unique regulatory burdens faced by church health plans due to the structures of various denominations, unique regulatory burdens are imposed upon some church benefit plans because ACA requirements are diametrically opposed to the church's religious beliefs.

One ACA requirement that conflicts with the religious beliefs of some Church Alliance members is the contraceptive services coverage requirement. The Church Alliance respectfully requests that in new regulations HHS broaden the religious employer exemption to include church-affiliated organizations and church plans.

Another ACA requirement that conflicts with the religious beliefs of a few Church Alliance members is contained in the regulations implementing Section 1557 of the ACA. Like the contraceptive services coverage requirement, the Church Alliance respectfully requests new rulemaking to protect the religious

liberty interests of employers in church plans and the plans themselves. The Church Alliance requests an explicit religious exemption from the nondiscrimination provisions under Section 1557 of the ACA to include church plans and church-affiliated organizations. In addition, due to the non-centralized structure of church employers and church health plans, we respectfully request flexibility in the application and enforcement of Section 1557's notice, disclosure, communication, and technology requirements.

B. Specific HHS goals set forth in RFI, on which HHS requested comments

In the RFI, HHS expressed particular interest in comments about changes to existing regulations or guidance, or other actions within HHS's authority, that could further certain specific goals. HHS specifically noted that a response to every question is not required, so the Church Alliance is commenting on three of the goals.

1. Empowering patients and promoting choice

The Church Alliance would like HHS to consider furthering its goal of empowering patients and promoting consumer choice by allowing the establishment of an interstate church health plan "exchange" to help preserve the important role of church health plans and stabilize that choice for self-insured church health plan coverage. The Church Alliance submitted a comment letter detailing this proposal on October 31, 2011. Link. Section 1311(f) of the ACA gives the Secretary the flexibility to approve regional or other interstate exchanges if each state in which such exchange operates permits such operation and the Secretary approves such regional or interstate exchange. If the Administration uses the flexibility granted by Section 1311(f), HHS can exercise reasonable discretion to "harmonize" other provisions of federal law with the ACA.

Health plans operating as part of an interstate church health plan exchange would meet many of the same requirements applicable to plans operating as part of a state or federal exchange, but because of the uniqueness of church health plans, certain modifications would be required. For example, an interstate church health plan exchange would include health plans that are deemed issuers but are not licensed by a state because the Church Plan Parity and Entanglement Prevention Act of 1999, Pub. L. No. 106-244, 114 Stat. 499 (codified as amended at 29 U.S.C. § 1144a) ("Parity Act") exempts church health plans from most state laws regulating insurance. The exchange would limit coverage to clergy and employees of churches and church-associated organizations, so alternative risk adjustment mechanisms would be utilized because of the closed group. Interstate church health plan exchanges would adjust for risk across subscribers, again because the exchange would not be open to members of the general public. A church health plan offered through an interstate exchange would be treated as a single entity for the purposes of calculating the medical loss ratio and to provide flexibility in the definition of "premium." A church exchange health plan would be allowed to exercise its First Amendment rights and offer goods and services that do not violate the religious beliefs of the church or denomination (e.g., coverage of contraceptive products). Flexibility in the design of the exchange would be needed because the public exchanges would not be utilized.

Church health plans play an important role in providing health benefits to clergy and lay employees across the country. The ACA has placed the health benefits of scores of clergy and church employees in jeopardy. The Church Alliance recommends that HHS create the opportunity for clergy and lay employees to keep the health benefits they trust by creating an interstate church health plan exchange.

Such an exchange would meet HHS's goal of empowering patients and promoting consumer choice by allowing these individuals to receive comprehensive health coverage that meets their needs and complies with church beliefs. Without an interstate church health plan exchange, many church workers who do not have employer-provided coverage have little choice but to subscribe to a health plan that does not work for them, because it is the only one they can afford. For those individuals, providing the choice of church plan coverage allows them to continue with affordable coverage that is consistent with their religious beliefs.

2. Enhancing affordability

On May 15, 2017, CMS issued an announcement that it intends to propose rulemaking to make it easier for small employers to offer SHOP plans to their employees, while maintaining access to the Small Business Health Care Tax Credit. While the proposed rules and details have not yet been established, CMS noted that participation in federally facilitated SHOP exchanges has been much lower than anticipated. Thus, it explained that, in the future, small employers would enroll directly with an insurance company approved to offer SHOP plans. The employer would simply go online and demonstrate its eligibility, select an issuer that has been approved by HealthCare.gov, and contract directly with the issuer for the coverage it will provide. By demonstrating its eligibility through HealthCare.gov, the employer thus participates in the federally facilitated exchange, as modified by the regulations HHS will issue, and can qualify for the tax credit under Internal Revenue Code ("Code") Section 45R.

In light of this modified program, it would be appropriate to apply the determinations of Internal Revenue Service ("IRS") Notice 2010-82 *pro tanto*. The goal of the modified program, as articulated by CMS, is for "small employers [to] access coverage through … an issuer of their choice." IRS Notice 2010-82 recognized that church health plans should be treated as the equivalent of an issuer pursuant to the Parity Act. Thus, assuming the church plan satisfies the other requirements for an issuer to be approved to offer a plan under the SHOP or equivalent requirements, small church employers should be allowed to access coverage through a church plan and receive the tax credit under Code Section 45R.

To enable this would require some coordination between HHS and IRS, but the Church Alliance respectfully requests that HHS allow such coordination, and establish that church plans may qualify to offer coverage to clergy and other church employees under the modified SHOP to enable these small churches to receive the tax credit under Code Section 45R. Providing for such tax credits would certainly enhance the affordability of coverage for these small church employers.

3. Affirming the traditional regulatory authority of the state in regulating the business of health insurance

In implementing any changes to existing regulations or guidance affecting the authority of states to regulate the business of health insurance, we urge HHS to keep in mind the unique nature of church health plans and continue to preserve the state law exemptions for such plans under current federal law. Church health plans are employer group health plans, many sponsored at the denominational level and administered by nonprofit organizations established by the denomination to administer benefits to its related organizations. These plans often cover clergy and employees of affiliated religious employers throughout the United States. Church plans are deemed under the Parity Act to be single employer plans, notwithstanding the number of individual employers participating in the plan. They are not in the

"business" of providing health insurance. Unlike commercial insurance companies, church plans are not operated to make a profit and do not offer coverage to the general public. Depending on the denomination, the funding of the plans may involve cross-subsidization of the cost of coverage among the participating employers other than on a traditional underwriting basis.

With the enactment of the Parity Act, Congress recognized the unique nature of self-funded church plans and the risks presented by multi-state insurance regulation. The Parity Act preempted church plans from state licensing and other laws that threatened the continued operation of "church plan" welfare plans.

Church plans should not be exposed to the laws of each state in which a plan participant resides. Unlike large national insurance companies, self-funded church plans do not select the states in which they provide coverage and are not equipped to comply with various requirements that could apply to an insurance company offering coverage in 50 states. A self-funded church plan should also be able to determine the coverage it offers based on the affiliated church's needs and religious convictions.

Some church plans, particularly those of smaller denominations or independent churches, are fully insured. In the case of a fully insured church plan, the church plan should be permitted to elect a primary state and only the insurance laws of such state should apply.

The Church Alliance appreciates this opportunity to comment and hopes HHS finds our comments helpful. We are happy to meet or provide further clarification. The ACA has posed considerable challenges for church health plans, and the Church Alliance welcomes the opportunity to play a constructive role in ensuring future rulemakings appropriately address church plans.

Please contact the undersigned at (202) 778-9000 if you have any questions or wish to discuss further.

Sincerely,

Karishma S. Page
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On Behalf of the Church Alliance