CHURCH ALLIANCE

Acting on Behalf of Church Benefits Programs

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Internal Revenue Service
CC:PA:LPD:PR (*Notice* 2015-16)
Room 5203
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Re: Notice 2015-16

Comment to Notice 2015-16: Section 4980I – Excise Tax on High Cost Employer-Sponsored Health Coverage

To Whom It May Concern:

I. Introduction

The Church Alliance is submitting this letter as a public comment to *Notice 2015-16*: *Section 4980I – Excise Tax on High Cost Employer-Sponsored Health Coverage* (the "Notice") published by the United States ("U.S.") Department of the Treasury ("Treasury") and the Internal Revenue Service ("IRS") at 2015-10 I.R.B. 732 on February 23, 2015.

The Church Alliance is an organization composed of the chief executives of thirty-eight church benefit boards, covering mainline and evangelical Protestant denominations, two branches of Judaism, and Catholic schools and institutions. The church health benefit plans represented by the Church Alliance ("denominational health plans") provide health plan coverage to over one million participants (clergy and lay workers) serving over 155,000 churches, synagogues and affiliated organizations ("church employers"). For over 50 years, many denominational health plans, mostly nationwide self-funded plans, have allowed the families of clergy and lay church workers the comfort and security of career-long portable, comprehensive medical coverage, on an affordable basis through a plan that reflects their denomination's belief system.

The Church Alliance commends Treasury and the IRS for requesting comments about the excise tax on high cost employer-sponsored health coverage under Internal Revenue Code (the "Code") Section 4980I (the "Excise Tax"). We hope our comments will help Treasury and the IRS

establish reasonable methods for denominational health plans and church employers to comply with the Excise Tax requirements.

II. Executive Summary

As explained in detail below, the Excise Tax is to be assessed on high cost employer-sponsored health coverage, but the determination of the cost of coverage under denominational health plans is difficult to determine, particularly since these plans have not been required to determine such cost for purposes of Code Section 4980B ("COBRA") because Code Section 4980B(d)(3) excludes them from the continuation coverage requirements of that Section. In addition, denominational health plans for decades have been functioning in a manner similar to the way Affordable Insurance Exchanges now are functioning, by covering employees, former employees and their dependents regardless of health risk and continuing to cover them after disablement or retirement, which increases aggregate health coverage costs for such plans. Denominational health plans, providing health coverage to lowly-paid clergy and other church workers, are not the type of lavish plans that the Excise Tax was intended to target.

For these reasons and others explained in this letter, the Church Alliance requests relief from the Excise Tax. Ideally this relief would be similar to the relief accorded in Q&A-21 of Notice 2012-9, which provides that the cost of coverage provided under a self-insured group health plan that is not subject to federal continuation coverage requirements is not required to be included in the cost of coverage reported on Form W-2. The Church Alliance also requests flexibility in the application of the Excise Tax, and adjustments to the applicable dollar limits that trigger the Excise Tax, as further described below.

III. Church Structures and Denominational Health Plan Contributions

The application of the Excise Tax with respect to coverage under denominational health plans presents different challenges than it would for coverage under a typical single or multiemployer group health plan. Each denomination has a unique polity (governance structure) established to reflect its theological beliefs. The governance structures of the Church Alliance members range from purely hierarchical churches to independent churches or denominations that are congregational in nature. The governance structure of a denomination often determines how direct the relationship between each church, clergy member and the denominational plan is, and may affect the way employer and employee contributions for coverage are established or allocated. As a result, the true "cost of coverage" under a self-insured denominational health plan is not always readily evident to the employers and employees participating in such a plan.

The underlying polity of the denomination typically informs the identity of the plan sponsor and the control that it can exert on plan design and contribution limits. In some of the more hierarchical denominations, there is an independent civil corporation that serves as the plan sponsor and has the ability to mandate employer coverage and set contributions. In other denominations, often the more congregational in polity, the health plan can only control the plan design and administration, but participation remains optional for local church employers; in the latter setting, contributions may be more like a risk and experience-based premium. For those health plans, the plan sponsor may be the employer rather than the organization responsible for the health plan design and administration. In some denominations, the health plan charges an established contribution or premium to a regional sub-unit of the denomination, such as a diocese, presbytery or state convention. These intermediate bodies may then alter the method of sharing costs among participating churches. Because there is no centralized human resource or payroll function for any of the denominations, the organization responsible for the health plan design and administration may not actually know the level of contribution that the local unit requires of the employee.

Sometimes contributions set by the denominational health plan, e.g., single coverage rates and family rates, are blended by an intermediate church body or unit of church government in various ways. Rates may be blended to remove any perceived barriers to appointment/employment at a particular church due to a clergyperson's family size. For example, assume a state conference pays the denominational health plan $7,000 to cover single clergy and $13,000 to cover clergy with families. However, when the same state conference establishes charges to the church employers within its jurisdiction, it may blend the rates and charge each church $10,000 for each covered employee. The church employer then would not know the actual cost of coverage for its employees without obtaining additional information from the denominational health plan, at an additional cost to such plan.

Some denominations and intermediate church bodies may cross-subsidize churches through contribution structures. They may charge higher contribution rates to churches with larger memberships, greater revenue (giving), or more assets, and in turn charge a reduced contribution rate to smaller or rural churches or to churches serving economically poorer populations. This cross-subsidization reflects and serves the mission work of these denominations. In these cases, the cost of coverage to the denominational health plan may be substantially different than the cost of coverage charged to a local church for its employees.

Some denominational health plans require a contribution for coverage that is simply a fixed percentage of a clergyperson's, or an employee's, compensation. This percentage charge may not directly reflect the actual cost of coverage provided for its employees, but rather an amount that the denomination has determined is that church's fair share of the overall cost of coverage for all church workers in the plan. In other cases, the contribution under the health plan may be combined with the contribution to the church pension plan, to set one benefits coverage contribution for participating churches. In some cases an intermediate body may combine health plan contributions with other general church remittances for participating churches. These contributions may also be varied within a denomination, e.g., to subsidize poorer or smaller churches, to reflect mission needs and church values. Without some additional information from the denominational health plan or intermediate body, and an associated cost of providing that information, the employing church may not be able to easily determine the cost of coverage.

Though not subject to COBRA or most state continuation coverage requirements, most denominational health plans nonetheless offer continuation coverage of some sort and may offer the continued coverage for a longer duration than required by COBRA. These denominational health plans may require a contribution, i.e., may charge a continuation coverage contribution for such coverage, but this charge may reflect cross-subsidization, rather than actual costs. Also, in some cases these continuation coverage contributions are filtered through intermediate church bodies before reaching the former employee.

IV. Challenges for Denominational Health Plans

A. Excess Benefit

Denominational health plans face unique challenges with the application of the Excise Tax. For decades, denominational health plans have provided coverage in much the same way as the Affordable Insurance Exchanges, by including employees, former employees (including retirees and disabled former employees) and surviving spouses and dependent children, regardless of health condition. Even though providing coverage for such populations increased costs to denominational health plans, because of denominational beliefs, denominational mandates or just because "it was the right thing to do", those high cost individuals were covered, sometimes at little or no cost to the individuals. Denominational health

plans want to continue to cover these vulnerable (and high cost) populations, and request flexibility to adjust the calculation of the excess benefit or cost for such populations, including possibly excluding costs for such high cost populations when no contributions are being charged to those individuals or excluding those individuals from the definition of "employee" under Code Section 4980I(d)(3). Alternatively, perhaps the exception contained in Code Section 4980I(b)(3)(C)(iv), for qualified retirees and high-risk professions, could be applied with respect to such individuals.

B. Applicable Coverage

The requirement for each employer to aggregate the cost of applicable employer-sponsored coverage and the manner in which the employer is required to calculate and report each coverage provider's applicable share of any excess benefit under Code Sections 4980I(c)(3) and 4980I(c)(4) presents challenges for church employers and denominational health plans. As such, the Church Alliance respectfully requests that future guidance provide flexibility to denominational health plans to: 1) permit the plan sponsor to assign the entity responsible for the calculation, and 2) determine the manner in which any excess benefit is allocated to the coverage providers.

As noted above, the varied governance structures of the Church Alliance members often determine the way contributions for group health coverage are established. As a result, the cost of coverage under a self-insured denominational health plan is not always readily evident to individual employers.

The self-insured group health plans offered to employees of the church are often sponsored by a church board that, in accordance with rules established by the denomination, administers the health plans for participating church employers. In addition to sponsoring and administering the group health plans for active employees, the church board often directly provides pension benefits and retiree health benefits to retired clergy and lay employees and their beneficiaries.

An individual employer therefore cannot always easily ascertain the cost of group health coverage for their active and retired employees and their beneficiaries, and this information is of course necessary to fulfill its obligations under Code Sections 4980I(c)(3) and 4980I(c)(4). In addition, although the church board maintains the information necessary to determine the aggregate cost of group health coverage, the church board does not generally control nor have knowledge of other benefits offered by individual employers that are considered applicable employer-sponsored coverage, such as contributions to health flexible spending accounts ("health FSAs"), health savings accounts ("HSAs"), or health reimbursement arrangements ("HRAs"). Similarly, although the individual church employers will know the amount of their contributions to health FSAs, HSAs, or HRAs, they may not know the cost of denominational health plan coverage. Due to these unique challenges, the Church Alliance requests that future guidance provides flexibility to church employers and the sponsors of denominational health plans to designate the entity that is best suited to obtain the necessary information required by and handle the obligations under Code Sections 4980I(c)(3) and 4980I(c)(4).

The Church Alliance also requests flexibility in the calculation of the allocable share of any excess benefit to a coverage provider. Under Section 4980I(c)(3), the coverage provider that provides the highest cost coverage will be allocated the largest share of any excess benefit. Since church boards sponsor the denominational health plans provided to church employees, the plans may be allocated the largest share of any excess benefit, if the cost of the denominational health plans is larger than the cost of other benefits offered by individual employers that are considered applicable employer-sponsored coverage, such as contributions to health FSAs, HSAs, or HRAs. The Church Alliance understands that any excess benefit directly relating to the cost of a denominational health plan may be allocated to such plan, but requests

flexibility in the allocation of the excess benefit resulting from the cost of coverage provided by other coverage providers. Without this flexibility, the denominational health plans will unfairly bear a large percentage of the Excise Tax associated with excess benefits provided by other coverage providers, which could negatively impact the financial stability of denominational health plans. Therefore, the Church Alliance requests that Treasury and the IRS allow denominational health plans to apply a reasonable, good faith interpretation of the rules relating to the calculation and allocation of the excess benefit in order to provide the flexibility necessary to avoid unnecessary financial hardship on denominational health plans.

C. Determination of Cost of Applicable Coverage

The cost of coverage under Code Section 4980I is to be determined under rules similar to the rules of COBRA for determining "applicable premiums." However, as previously noted, denominational health plans are not subject to COBRA and thus do not calculate "applicable premiums" under COBRA.

In fact, self-insured denominational health plans do not charge premiums at all. The Church Plan Parity and Entanglement Prevention Act, which clarifies the applicability of state insurance laws to church plans described in ERISA Section 3(33), provides that for purposes of determining the status of a church plan that is a welfare plan under provisions of state insurance law, a church plan is deemed to be a plan that reimburses costs from general church assets. Instead of charging premiums, denominational health plans obtain contributions to cover the aggregate amount needed to pay for the health coverage for all plan members.

The "applicable premium" under COBRA is to be determined by reasonably estimating the cost of providing coverage for "similarly situated beneficiaries." It is unclear how that would and should be applied in the case of the denominational health plans. Since, as explained previously, such plans do not determine contribution amounts based solely on cost, they do not divide plan members into various categories based on their similarities and assign cost on that basis.

Moreover, even when categories of "similarly situated" individuals may be determinable, denominational mandates or guidelines often reallocate health plan contribution rates based on principles, rather than cost. Subsidization of certain employee populations and other rate adjustments are made because of religious beliefs and as described earlier, contribution rates may be based on assets of the congregation or other factors, not on cost.

As a result, the Church Alliance requests that Treasury and the IRS establish a very flexible rule for church employers and denominational health plans to determine the cost of applicable health care coverage. The rule should allow such employers and plans to use any reasonable method to determine the cost of coverage. Ideally, the cost of coverage provided under a self-insured group health plan that is not subject to any federal continuation coverage requirements would not be required to be included in cost for purposes of computing the Excise Tax. This could eliminate the calculation and allocation issues described in Section "B", above, of this letter, as between the individual church employer and the denominational health plan. If such relief is not possible, where information on contributions for continuation coverage provided by the denominational health plan is available and appropriate, church employers should be allowed to use such information. Alternatively, such employers should be able to use a reasonable estimate of the "fair market value" or applicable "premium" – blended, cross-subsidized, or otherwise – extrapolated from the church contributions required of them.

In cases where such an estimate is not available, is not estimable without significant cost, and/or is impracticable to obtain, the Church Alliance suggests allowing denominational health plan employers to use either a reasonable good faith estimate of cost or the cost of similar coverage available elsewhere, such as through an Affordable Insurance Exchange or the applicable (based on state of residence, coverage type, etc.) state average premium for the small group market published by the U.S. Department of Health and Human Services as an estimate of the "cost of coverage".

1. Aggregation and Disaggregation

The Notice indicated that a possible approach to determining the cost of applicable coverage would be based on the application of the following aggregation and disaggregation rules:

- First, the initial group of similarly situated employees would be determined by aggregating "all employees ... covered by a particular benefit package provided by the employer."

- Second, the groups resulting from the application of the first step would be separated into two groups each, one for employees covered by employee-only coverage, and another for other than employee-only coverage ("family coverage").

- Third, an employer may aggregate all family coverage regardless of the number of individuals actually covered.

- Fourth, an employer may be able to disaggregate based on distinctions traditionally made in the group insurance market.

The Church Alliance offers the following two comments on the above approach with denominational health plans in mind.

a. Allow Plan-Based Individual Benefit Package Aggregation

The Church Alliance assumes that the grouping under the first step above would be based on the definition of "employer" in Code Section 4980H(f)(9), which provides that all employers treated as a single employer under Code Sections 414(b), (c), (m) or (o) will be treated as a single employer.

Employers in a denominational health plan should be permitted to rely on an individual benefit package based on an aggregation of all employers within the plan. This approach would be consistent with the calculation of the cost of COBRA coverage under Code Section 4980B(f)(4)(A), which defines "applicable premium" to mean, "with respect to any period of continuation coverage of qualified beneficiaries, the cost to the plan for such period of the coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred ...." (emphasis added).

A plan-based approach will have a number of advantages.

First, it will avoid saddling denominational health plans with the expense of calculating cost on an employer-by-employer basis, which few such self-insured plans currently do. The governance structure of a denomination often determines how direct the relationship between each church and the denominational health plan is, and, as noted above, may affect the way contributions for coverage are established. As a result, the "cost of coverage" under a self-insured denominational health plan is not always readily evident. As previously noted, in some denominations the plan charges an established

contribution to a regional sub-unit of the denomination, such as a diocese, presbytery or state convention. These intermediate bodies may alter the method of sharing costs among participating churches. A plan-based approach will save such plans from having to break out cost on an employer-by-employer basis, a task made more difficult by the absence of regulations applying Code section 414(c) to certain church entities. Treas. Reg. § 1.414(c)-5(e).

Second, a plan-based approach will reflect the basis on which some denominational health plans actually allocate cost. As previously noted, some denominations and intermediate church bodies may cross-subsidize churches through contribution structures. They may charge higher contribution rates to churches with larger memberships, greater revenue (giving), or more assets, and in turn charge a reduced contribution rate to smaller or rural churches or to churches serving economically poorer populations. Alternatively, some denominational health plans charge a contribution for coverage that is simply a fixed percentage of a clergyperson's, or an employee's, compensation, thus effectively subsidizing coverage for employers with lower compensated participants. This cross-subsidization may serve the mission work of these denominations.

b. Allow Permissive Disaggregation To Be Based on Broad Standards

Permissive disaggregation under the fourth step above should be permitted to be based on any standard traditionally used within the group insurance market while prohibiting the use of any criterion based on an individual's health. Such disaggregation would allow distinctions to be based on a church's polity and beliefs, such as disaggregation by diocese, presbytery or state convention, which could result in more accurate adjustments for geography and cost-sharing. Prohibiting the use of any criterion based on an individual's health status should allay any concerns about potential abuses.

2. Self-Insured Plans' Methods

The Notice indicates Treasury and the IRS are considering requiring a self-insured plan to use an actuarial basis method to compute the cost of applicable coverage unless the plan administrator elects to use the past cost method and the plan is eligible to use that method. The Church Alliance requests that Treasury and the IRS allow self-funded denominational health plans to compute cost using either method, while also allowing plan-based permissive aggregation as discussed in the section above. Denominational health plans need to be able to freely change between cost computation methods because such plans are often subject to the mandates of their denominations, which could cause the need to change from one method to the other before a set period of five or two years (for example, the plan may need to switch from the past cost method to the actuarial basis method if, due to a new denomination mandate, past costs are no longer likely to be accurate).

When using the actuarial basis method to compute the cost of applicable coverage, the Church Alliance supports a broad standard using an estimate of the actual cost the plan is expected to incur for a determination period, and not the minimum or maximum exposure the plan could have for that period. Using a minimum or maximum exposure could result in much higher or lower costs than the plan expects to experience. Denominational health plans should be able to perform actuarial estimates "in house". The use of outside accredited consultants should not be required because this could increase plan costs. In addition, the Church Alliance feels that specifying a list of factors to be utilized when making an actuarial determination of the cost of applicable coverage would further complicate an already-complicated set of rules.

The Church Alliance asks for flexibility in determining the measurement period used under the past cost method because, as stated above, denominational health plans are often subject to the mandates of their denominations, which could result in the need to change measurement periods before a specific period of time passes. In determining past cost, the Church Alliance would like self-insured denominational health plans to be able to use either the claims incurred or claims submitted measurement – whichever provides the most reasonable cost measure for the particular plan.

The Church Alliance suggests that additional guidance on what constitutes reasonable overhead expenses would not be beneficial and would instead prefer flexibility in allowing the plan to determine what is reasonable. An elective safe harbor allowing a self-administered, self-insured plan to assume that the amount of reasonable overhead expenses is equal to a defined percentage of claims may be of assistance to some self-insured plans.

3. Health Reimbursement Arrangements

Although HRAs meet the definition of applicable coverage under Section 4980I(d)(1)(A) of the Code and are not specifically excluded by another provision of 4980I, HRAs are excepted from the aggregate reportable cost of coverage reported on Form W-2 (under Notice 2012-09) and the Church Alliance asks that HRAs be similarly excepted from being included in the cost of coverage under Code Section 4980I. If HRAs are included in the cost of coverage for church employers, church workers will be harmed. Church budgets are typically strained, which is the reason church employers turned to the solution of HRAs to allow the limited financial resources of the church to be set aside for use when and if needed for health care costs. Requiring church employers' HRAs to be included in the cost of coverage will result in the elimination by church employers of HRAs, which will harm low-paid church workers. If HRAs are not excepted from the cost of applicable coverage, the Church Alliance recommends that HRA cost should only include claims for a particular period and should not be based on amounts made newly available or carried over from a prior year because this could over-value the HRA, if total contributions are not spent during the current period.

Moreover, the cost of applicable coverage should not include an HRA that can be used only to fund the employee contribution towards coverage because including that value would result in double counting. In addition, the cost of applicable coverage should not include an HRA that can fund a wide range of benefits, some of which would not be applicable coverage. Providing only one method to determine the cost of applicable coverage would decrease administrative complexity, but may not work for church employer HRAs that could be impacted by denominational mandates.

4. Form W-2 Reporting of Cost

The Church Alliance remains very grateful for the relief accorded for W-2 reporting of health care cost under Q&A-21 in Notice 2012-9. The Church Alliance respectfully requests similar relief under Code Section 4980I, specifically that the cost of coverage provided under a self-insured group health plan that is not subject to any federal continuation coverage requirements will not be required to be included in the cost of coverage under Code Section 4980I.

Alternatively, the Church Alliance requests Treasury and the IRS to grant employers providing coverage through a denominational health plan a lengthy transition period before the Excise Tax becomes applicable to them, similar to the transition relief that was accorded church health plans with respect to the Form W-2 reporting of cost requirements. Church employers and denominational health plans are making their best efforts to implement all of the requirements of the Affordable Care Act, but given the atypical

employment and polity structures of churches and denominations, longer time periods to implement these changes are necessary. As such, the Church Alliance suggests delaying making the Excise Tax mandatory for these employers and plans until at least after 2020.

D. Applicable Dollar Limit

The Church Alliance appreciates the invitation from Treasury and the IRS to comment on adjustments to the baseline per-employee dollar limits. [1] We support the development of safe harbors that adjust dollar limit thresholds for employee populations, in particular those that recognize age characteristics that are different from those of the national workforce. Denominational health plans serving pastors provide health care coverage to the clerical workforce of many of the churches across our nation. The median age of pastors is 55, which, on average, is 15 years older than the U.S. labor force.[2] Because there is a direct correlation between an insured's age and the increased cost of health care,[3] the Excise Tax will result in denominational health plans paying an Excise Tax, per employee, that is higher than another employer whose workforce represents the median age of the labor force. An age-based safe-harbor can help mitigate the potential unfairness associated with the higher cost of health care provided to an older workforce by reducing or eliminating the Excise Tax attributable to older workers' health benefits. Accordingly, the Church Alliance suggests implementation of a safe harbor that recognizes and accommodates the increased expenses associated with employing an older workforce by establishing an inverse relationship to age and phasing out the Excise Tax for older employees.

The Church Alliance also supports an adjustment to the applicable dollar limit for denominational health plans and respectfully requests that the applicable annual limitation for denominational health plans, like multiemployer plans, equal the amount associated with other-than-self-only coverage. Denominational health plans (as defined in Code Section 414(e)) have a structure similar to multiemployer plans (as defined in Code Section 414(f)[4]) – both offer health plans to employees where more than one employer is required to contribute. In addition, health benefits are mandated by the church or its polity with some denominational health plans, in much the same way as benefits are mandated by collective bargaining agreements with multiemployer plans. Our request is also based on the reality that many pastors' wages

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[1] Two annual dollar limits are set out in Section 4980I(b)(3):
1) Employee only coverage, with the baseline per-employee dollar limit at $10,200 for 2018 (with the potential for adjustments).
2) Employee other-than-self-only coverage, with the baseline per-employee dollar limit at $27,500 for 2018 (with the potential for adjustments).

[2] In 2009, the average, median age of ordained senior/solo pastors was 55 years of age. See Associate Pastors, Research Services, A Ministry of the General Assembly Mission Council, Presbyterian Church (U.S.A.), September 2010, at www.uscongregations.org. Compare that to the median age of the U.S. labor force that same year of approximately 40 years of age. See Median Age of Labor Force; Employment Projections Program, U.S. Department of Labor, U.S. Bureaus of Labor Statistics, December 19, 2013.

[3] "[T]he use of medical care services by adults rises with age, and per capita expenditures on health care are relatively high among older age groups." See Global Health and Aging by National Institute of Aging/National Institutes of Health, U.S. Department of Health and Human Services and the World Health Organization, NIH Publication no. 11-7737, October 2011.

[4] Section 414(f)- Multiemployer plan: (1) Definition. For purposes of this part, the term "multiemployer plan" means a plan— (A) to which more than one employer is required to contribute, (B) which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and (C) which satisfies such other requirements as the Secretary of Labor may prescribe by regulation.

are lower than the wages of their peers.[5] A number of the denominational plans started providing financial protection to ministers and their families for retirement and health costs as early as 1717 in recognition of the fact that pastors' wages were too low (or unreliable) to allow them to adequately save for unanticipated personal costs. The heritage of providing a comprehensive benefits program to supplement low wages continues as a covenant between the church and its workers. It is part and parcel of their call to serve. Unlike other employers, churches have been slow to shift the cost of coverage to the ministers or to reduce the benefits provided. Moreover, when a secular employer shifts more costs to employees to reduce plan costs, the employer still pays half of the FICA taxes on the increase in wages that may result from reduced health benefits. For clergy, however, who are statutorily self-employed for SECA tax purposes, such cost shifting results in a higher tax burden. As a result of this proud tradition of caring for its workers, the application of employee-only coverage as the applicable dollar limit will result in penalizing pastors and other church workers, who receive health benefits from denominational health plans, when those benefits are intended to care for those who spend their lives caring for others. To borrow a phrase common in the media, perhaps these health benefits can be categorized as something less than a Cadillac, but more than a Chevrolet. We don't believe the intent of the Excise Tax was to penalize pastors and church workers. Adjustment of the applicable dollar limit for denominational health plans to the amount associated with other-than-self-coverage will mitigate this consequence.

V. Conclusion

Based on the foregoing, the Church Alliance respectfully requests relief from the Excise Tax, including transition relief and relief with respect to the cost of coverage provided under a self-insured group health plan that is not subject to federal continuation coverage requirements, flexibility in the application of the Excise Tax and adjustments to the applicable dollar limits, as further described above.

Thank you for your consideration of our views on this important issue to church employers and employees. If you have questions or wish to discuss this matter further, please feel free to contact the undersigned at (202) 661-3882 or stephen.cooper@klgates.com.

Sincerely,

Stephen H. Cooper
Government Affairs Counselor, K&L Gates
On Behalf of the Church Alliance

[5] The annual, median wage for clergy is $43,950, as compared to the annual, median wage for full-time salary workers with a professional degree, which is $85,228. See U.S. Bureau of Labor Statistics, Occupational Employment and Wages, 2011 Clergy, May 2014; and Employment Projections, Earnings and Unemployment Rates by Education Attainment, updated April 2, 2015.