CHURCH ALLIANCE

Acting on Behalf of Church Benefits Programs

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By Electronic Submission

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N–5653
U.S. Department of Labor
200 Constitution Avenue NW.
Washington, DC 20210

Attention: Preventive Services

CC:PA:LPD:PR (REG–129507–14)
Courier's Desk
Internal Revenue Service
1111 Constitution Avenue NW.
Washington, DC 20224

Re: Interim Final Regulations

Dear Sir or Madam:

The Church Alliance submits this comment in response to the interim final regulations ("IFRs") issued jointly by the Internal Revenue Service (IRS), the Department of Labor (DOL) and the Department of Health and Human Services (HHS) (together, the "Departments") and published at 79 Fed. Reg. 51092 (Aug. 27, 2014).[1]

The Church Alliance has commented three times previously on the topic of the preventive services mandate (the "Mandate") under the Affordable Care Act (ACA):

- on September 28, 2011, on the interim final rules published at 76 Fed. Reg. 46621 (Aug. 3, 2011);
- on June 21, 2012, on the advance notice of proposed rulemaking published at 77 Fed. Reg. 16501 (Mar. 21, 2012); and
- on April 8, 2013 on the notice of proposed rulemaking published at 78 Fed. Reg. 84566 (Feb. 6, 2013).

[1] We include within the IFR the proposed regulations under section 9815 of the Internal Revenue Code (the "Code") published by the IRS at 79 Fed. Reg. 51117-18 (Aug. 27, 2014).

Copies of these earlier comments are available at http://church-alliance.org/initiatives/comment-letters (last visited Oct. 9, 2014).

Executive Summary

The Church Alliance recognizes the Departments' effort to respond to the needs of the community of eligible organizations through the addition of a second means of "accommodating" religious organizations with a religious objection to providing some or all contraceptives required by the Mandate. However, for the reasons set forth below, the Church Alliance respectfully submits that the IFRs fail to protect the religious rights of religious organizations that object to providing some or all contraceptives through their employee benefit plans established for their employees and their dependents (hereinafter, "eligible organizations").

The IFRs continue the Departments' pattern of attempting to create an accommodation under the Mandate for eligible organizations. Nonetheless, this latest version of the accommodation still falls short of the needs of eligible organizations by causing them to act contrary to their beliefs. The Government candidly admits that its revised accommodation merely offers eligible organizations a new "alternative" – submitting a notice to HHS rather than to their insurance company or third-party administrator (TPA) – that ultimately has the "same" effect as the original accommodation.[2] Eligible organizations must still maintain a contractual relationship with a third party authorized to deliver the mandated coverage to their plan beneficiaries, and eligible organizations must still submit a document that facilitates the delivery of such coverage which they believe violates their religious convictions. Thus, the regulations as revised by the IFRs continue to fall short of accommodating eligible organizations. Moreover, they continue to violate the Establishment Clause, artificially dividing religious organizations into two separate spheres.

I. BACKGROUND ON THE CHURCH ALLIANCE

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 Alliance members, listed on the left of this letterhead, provide employee benefit plans, including in many cases, medical coverage to approximately one million participants (clergy and lay workers) serving over 155,000 churches, synagogues and affiliated organizations. These medical programs are defined as "church plans" under section 3(33) of the Employee Retirement Income Security Act of 1974 ("ERISA") and Code section 414(e).

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 care plan for its workers. This is true even though most of the health care plans associated with the members of the Church Alliance do not impose any specific restrictions on contraceptive coverage. A few programs, reflecting the religious beliefs of the churches with which they are associated, exclude coverage for all contraceptives. Other programs whose associated churches do not object to contraception but hold fundamental convictions against abortion, exclude coverage for contraceptives that are or could be abortifacients, such as the so-called "morning-after pills" or "emergency contraceptives."

[2] CCIIO, Fact Sheet: Women's Preventive Services Coverage, http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/womens-preven-02012013.html (last visited Oct. 12, 2014).

II. REVISED ACCOMMODATION FOR ELIGIBLE ORGANIZATIONS

The IFRs provide that in lieu of executing and delivering a Form 700 to the insurer or TPA for its plan, an eligible organization will be deemed to comply with the Mandate if it notifies HHS in writing of the organization's objection. The IFRs provide that the notice must include the following information:

- the name of the eligible organization;
- the basis on which the eligible organization qualifies for an accommodation;
- the eligible organization's objection based on sincerely held religious beliefs to coverage of some or all contraceptives (including an identification of the subset of contraceptives to which coverage the eligible organization objects, if applicable);
- The plan name and type (i.e., whether it is a student health insurance plan or a church plan within the meaning of ERISA section 3(33)); and
- The name and contact information for the eligible organization's insurer and/or TPA.

If there is any change in the information required to be included in the notice, the eligible organization must provide the updated information to HHS.

Upon receipt of this notice and based upon it, the Government will contact the eligible organization's insurer or TPA to inform it of its obligation to provide or arrange payments for contraceptives to plan enrollees.

A. The Application of the Mandate, as Revised by the IFRs, Continues to Violate RFRA

The new notification alternative under the IFRs continues to violate RFRA as applied to eligible organizations, because it requires them to facilitate the provision of contraceptive coverage to which they have a religious objection. The intent of the IFRs is the same as the old rule – "preserving participants' and beneficiaries'…access to coverage for the full range of Food and Drug Administration (FDA)-approved contraceptives." *Id.* And it has the same effect as the old rule.

Some may argue that the "augmented" compliance system *should* be satisfactory to eligible organizations because the addition of a middle-man makes the complicity more "attenuated" in the Government's eyes. But *Hobby Lobby* forecloses that argument entirely. The relevant question is only whether an eligible organization sincerely believes it is forbidden from participating in the Government's system to promote and facilitate contraceptive access. *Hobby Lobby*, 134 S. Ct. at 2778.

1. The IFRs continue to cause eligible organizations to violate their religious beliefs

The effect under the IFRs is the same as under the old rule. "Regardless of whether the eligible organization self-certifies in accordance with the July 2013 final rules [using Form 700], or provides notice to HHS in accordance with the August 2014 IFRs, the obligations of insurers…regarding providing or arranging separate payments for contraceptives services are the same." *See* CCIIO Fact Sheet, *supra* n.2. Thus, any eligible organization will remain substantially involved in the provision of contraceptives with either form of accommodation, to wit:

- an eligible organization will maintain its contract with the TPA or insurer that may provide objectionable coverage;

- an eligible organization must formally notify its TPA or insurer or provide the TPA or insurer name and contact information to HHS;

- an eligible organization must update any information provided to HHS; and

- in the case of a self-insured plan being administered by a TPA, if the insurance company providing the contraceptive services is not affiliated with the TPA, the insurer will not have any information on participants, thus requiring the TPA to share personal information on plan participants provided by the eligible organization, without the consent of the organization.

Under either accommodation, an eligible organization will continue to serve as a gatekeeper, providing notice so that its TPA or insurer can provide objectionable products and services.

Importantly, employees of an eligible organization relying on either accommodation will consider the contraception coverage provided by the organization's insurer or TPA to be provided under the organization's plan for the following reasons:

- The obligation to provide contraception coverage is coterminous with the period a participant or beneficiary remains covered in the eligible organization's health plan. No individual is entitled to "independent" coverage before he or she becomes a plan participant, and any separate coverage will immediately cease when the employee's participation in the employer's plan terminates.[3]

- When an eligible organization's plan changes its insurer or TPA, the former insurer's or TPA's "independent" obligation to provide contraceptives to plan participants automatically terminates.

- If an insurer requires its insurance policy plan participants to use network providers, it may also impose the very same network requirement on the access to contraceptive services provided by the insurer.[4]

- The ACA consumer protections required to be provided by insurers under the independent arrangement are identical to those required to be provided under an insurance policy.[5]

- The independent contraceptive coverage will be provided on the same no cost basis (i.e., no copayment, coinsurance or deductible) as if the coverage were offered directly under the organization's plan.[6]

For certain purposes, HHS will also treat an insurer providing independent contraceptive coverage as if the insurer provided such coverage under the policy issued to the plan. For example, HHS has indicated that it intends to clarify in future guidance that an issuer of group health insurance coverage that makes

[3] *See, e.g.*, 45 C.F.R. § 147.131(c)(2)(B) where the obligation imposed on an insurer with respect to plan participants and beneficiaries continues "…so long as they remain enrolled in the plan."

[4] 78 Fed. Reg. at 39876.

[5] *See*, *e.g.*, 45 C.F.R. § 147.131(c)(2)(B)(ii) and preamble at 78 Fed. Reg. at 39876-77, which states:

> Although these payments for contraceptive services are not benefits under a health insurance policy, to fulfill an issuer's responsibilities under section 2713 of the PHS Act and the companion provisions of ERISA and the Code and consistent with the proposed regulations, an issuer must make them available in a way that meets minimum standards for consumer protection, which would ordinarily accompany coverage of recommended preventive health services without cost sharing under section 2713 of the PHS Act and the companion provisions of ERISA and the Code. Thus, issuers, in order to satisfy their regulatory obligations under these final regulations, must make these payments for contraceptive services in a manner consistent with the requirements under the following provisions of the PHS Act and the companion provisions of ERISA and the Code (and their implementing regulations): PHS Act sections 2706 (non-discrimination in health care), 2709 (coverage for individuals participating in approved clinical trials), 2711 (no lifetime or annual limits), 2713 (coverage of preventive health services), 2719 (appeals process), and 2719A (patient protections), as incorporated by reference into ERISA section 715 and Code section 9815.

[6] 45 C.F.R. § 147.131(c)(2)(B)(ii).

payments for contraceptive services under the accommodation procedure "may treat those payments as an adjustment to claims costs for purposes of medical loss ratio and risk corridor program calculations." 78 Fed. Reg. at 39878 (July 2, 2013).

For these reasons, the Mandate continues to impose a substantial burden on eligible organizations that do not want to violate their religious beliefs. The Departments have simply given the eligible organizations an alternative way of doing what their faith forbids them to do: converting their conscience-compliant health plan into a plan that violates their conscience.

2. The Mandate continues to expose eligible organizations to substantial penalties

If an eligible organization, large or small, sponsors a medical plan for its employees, but the plan does not provide required contraception coverage, Code section 4980D will impose an excise tax equal to $100/day for each covered individual denied such coverage. As with the employees in *Hobby Lobby*, because "the contraceptive mandate forces [the eligible organizations] to pay an enormous sum of money…if they insist on providing insurance coverage in accordance with their religious beliefs, the mandate clearly imposes a substantial burden on those beliefs." 134 S. Ct. at 2779.

If an eligible organization with an average of 50 or more full-time employees discontinues its plan to avoid violating its religious tenets and beliefs, it will be subject to a penalty under Code section 4980H of $2,000/year for each full-time employee if any employee obtains subsidized coverage through one of the exchanges established under the ACA. *Hobby Lobby* rejected the argument that the option of "dropping insurance coverage eliminates the substantial burden that the HHS mandate imposes." 134 S. Ct. at 2777.

3. The Mandate continues to fail to satisfy the strict scrutiny requirement

a. The IFRs do not establish a compelling interest requiring eligible organizations to provide contraceptive coverage

The Government has identified its compelling interests in imposing the Mandate as "public health" and "gender equality." 134 S. Ct. at 2779. But the Court in *Hobby Lobby* rejected those interests as being "couched in very broad terms," whereas RFRA requires a "more focused" inquiry that "loo[ks] beyond broadly formulated interests." *Hobby Lobby*, 134 S. Ct. at 2779. Indeed, "[b]y stating the public interests so generally, the Government guarantee[d] that the mandate will flunk the test." *Korte v. Sebelius*, 735 F.3d 654, 686 (7th Cir.), *cert. denied* 134 Sup. Ct. 2903 (2014). The Government cannot claim a compelling interest because, as of the end of 2013, its regulations exempted health plans covering 90 million employees through, among other things, "grandfathering" provisions. *Korte*, 735 F.3d at 686; *Geneva Coll. v. Sebelius*, 941 F. Supp. 2d 672, 684 & n.12 (W.D. Pa. 2013). Simply put, "the interest here cannot be compelling because the [Mandate] presently does not apply to tens of millions of people." *Hobby Lobby*, 723 F.3d at 1143; *Korte*, 735 F.3d at 686.

b. Less restrictive alternatives are available to provide contraceptives

As every court to consider the question has held, "[t]here are many ways to promote public health and gender equality, almost all of them less burdensome on religious liberty" than forcing eligible organizations to participate in the delivery of free contraception in violation of their beliefs. *Korte*, 735 F.3d at 686. Most obviously, as the Supreme Court explained in *Hobby Lobby*, "[t]he most straightforward way of doing this would be for the Government to assume the cost of providing the ... contraceptives at issue to any women who are unable to obtain them under their health-insurance policies due to their employers' religious objections." 134 S. Ct. at 2780.

There are any number of ways the Government could provide free contraceptive coverage without using eligible organizations' plans as a conduit. It "could provide the contraceptives services or insurance coverage directly to eligible organizations' employees, or work with third parties—be it insurers, health care providers, drug manufactures, or nonprofits—to do so without requiring [eligible organizations'] active participation." *Roman Catholic Archdiocese of N.Y. v. Sebelius*, 987 F. Supp. 2d 232, 255-56 (E.D.N.Y. 2013). More specifically, it could:

- "provide tax incentives to consumers or producers of contraceptive products," *Id.*;
- "give tax incentives to contraception suppliers to provide these medications and services at no cost to consumers." *Korte*, 735 F.3d at 686; *Roman Catholic Archdiocese of N.Y.*, 987 F. Supp. 2d 232 at 255-56 (same);
- modify the eligibility requirements for existing federal programs that provide health care subsidies on a massive scale, such as the Title X family planning program and the Medicaid program, or any number of other federal programs that already provide cost-free contraceptives to women; or
- permit employees of objecting eligible organizations to purchase fully subsidized coverage (either for contraceptives alone, or full plans) on the state and federal exchanges established under the ACA.

There are no doubt other alternatives. While many eligible organizations may oppose many of these alternatives on policy grounds, all of them are "less restrictive" than the "accommodation" because they would deliver free contraception without forcing eligible organizations to violate their beliefs.

Moreover, these alternatives are eminently workable because, as noted above, the Government's objectives could be achieved through minor regulatory tweaks to existing programs.[7] Even if a new regulatory program were necessary, the Government can hardly object, as it has shown its willingness to create (and repeatedly modify) such programs – by, among other things, establishing the infrastructure by which TPAs are compensated under the accommodation. 45 C.F.R. § 156.50; *Hobby Lobby*, 134 S. Ct. at 2781 (stating that "nothing in RFRA" suggests that a less restrictive means cannot involve the creation of a new program). The Government may attempt to claim that it is more convenient to commandeer eligible organizations' plans, but administrative convenience cannot justify forcing eligible organizations to violate their beliefs, particularly where the Government submitted no evidence of any compelling need to do so.

Finally, any suggestion that *Hobby Lobby* endorsed the "accommodation" as a viable least-restrictive means in all cases is mistaken. In fact, the Court expressly did "not decide" that question. 134 S. Ct. at 2782 & n.40; *Id.* at 2763 n.9. Instead, it simply found the accommodation *less* restrictive than requiring eligible organizations to pay for contraceptives in the context of a challenge brought by eligible organizations who *did not object* to the accommodation. *Id.* at 2782 & n.40; *Id.* at 2786 (Kennedy, J., concurring) ("[T]he eligible organizations have not criticized [the accommodation]."). While the accommodation may "effectively exempt[]" eligible organizations that do not object to complying with the accommodation requirements, *Id.* at 2763 (majority op.), it does no such thing for entities like eligible organizations, who *do* object to complying with the accommodation requirements. Indeed, if there was ever any suggestion that *Hobby Lobby* blessed the accommodation, the Court dispelled that notion in *Wheaton*. Far from foreclosing challenges to the accommodation, the dissenters in *Wheaton College v.*

[7] This remains true even if legislative action would be necessary. *McCutcheon v. FEC*, 134 S. Ct. 1434, 1458 (2014) (describing less restrictive alternatives requiring congressional action).

Burwell, 134 Sup. Ct. 2806 (2014) confirmed that the order "entitle[s] hundreds or thousands of other [nonprofits]" to relief. 134 S. Ct. at 2814 n.6 (Sotomayor, J., dissenting).

B. The Mandate Continues to Violate the First Amendment

1. Religious discrimination

The IFRs continue the Government's discrimination among religious organizations by continuing the exemption for "religious employers" but not "eligible organizations," a discrimination based on mere speculation about the religious beliefs of the eligible organizations and their employees – and speculation "cannot support a compelling interest." *Awad v. Ziriax*, 670 F.3d 1111, 1130 (10th Cir. 2012) (noting that, to pass strict scrutiny under *Larson v. Valente*, 456 U.S. 228 (1982), the Government must provide "evidence" proving a challenged law's necessity).

2. Free speech

a. Compelled speech

As with the earlier "accommodation," the IFRs require eligible organizations to speak in a manner and for a purpose that they cannot: to trigger payments for the use of contraceptive and abortion-inducing drugs and devices. The Government states that this compelled speech – as reflected in either the Form EBSA 700 or the alternative notice to HHS under the IFRs – provides "the minimum information necessary for the Departments…to implement" their employer-based contraceptive distribution scheme. 79 Fed. Reg. at 51095. To this end, the IFRs compel eligible organizations – for the first time, and in contrast to the innocuous content of the Supreme Court's *Little Sisters* and *Wheaton College* notices – to specifically provide their TPA's identity and contact information.[8] Just as with Form 700, then, the eligible organizations do not wish to (and religiously cannot) speak in this way, since the purpose of the speech is to further the Government's scheme to deliver contraceptives via the eligible organizations' plan.

b. Restrictions on speech

The IFRs removed the Government's regulatory gag rule as set forth in the final regulations. 79 Fed. Reg. at 51095. But the Departments still purport to restrict what eligible organizations may say to their TPAs. *Id*. ("[A]n attempt to prevent a third party administrator from fulfilling its independent legal obligations to provide … contraceptive services" remains "generally unlawful" and "prohibited under other state and federal laws."). The new rules, then, still embrace the position repeatedly stated by the Government that eligible organizations cannot instruct their TPAs not to provide objectionable services for their plan participants.

This restriction is particularly important to eligible organizations with self-insured non-ERISA plans. Although the Government concedes it has no authority to regulate such plans,[9] it nevertheless seeks to reform those plans to allow their TPAs to "voluntarily" provide or arrange separate payments for contraceptive services.[10] Any attempt by eligible organizations to prevent the offer of such objectionable services appears to be prohibited by the Departments. The Government cannot prohibit such eligible

[8] At the Supreme Court in *Hobby Lobby*, the Government claimed that what Form 700 "accomplishes" in the church-plan context is merely a "regularized, orderly means" for the Government to identify objectors. Brief of Respondents at 33, *Little Sisters of the Poor v. Sebelius*, No. 13A691, 2014 WL 108374 (U.S. Jan. 3, 2014). But if Form 700 merely identifies *objectors*, and if the new notice to HHS is merely an "alternative" that has the "same" effect as the Form 700, why does the new notice to HHS require identifying TPAs and providing their contact information?

[9] *See* Section II.C, *infra, at* page 9.

[10] 79 Fed. Reg. at 51096 n.8.

organizations from dissuading their TPAs from doing so, for such a prohibition restricts the organizations' free speech rights.

C. The IFRs Fail to Exclude Self-Insured Non-ERISA Church Plans

The Departments acknowledge in a footnote in the preamble to the IFRs that "[c]hurch plans are exempt from ERISA" and that they cannot use ERISA regulations to turn church plan TPAs into plan administrators. 79 Fed. Reg. at 51095 n.8.[11] And they say that [the Department of Labor] will send out notifications to TPAs "[w]hen an eligible organization that establishes…a self-insured plan *subject to ERISA*" turns in a notice. 79 Fed. Reg. at 51095 (emphasis added). But the interim final regulations themselves state in absolute terms the Government's obligation to notify the TPAs, and the TPA's obligation to provide for contraceptives.[12] And, the Government continues to hold out the "carrot" of federal reimbursement for TPAs for plans of eligible organizations that "voluntarily provide" contraceptive services in conjunction with the plans. 79 Fed. Reg. at 51095 n.8. Thus, whatever the mechanism, the Government appears to remain intent on causing the conscience-compliant benefit plans of eligible organizations to provide contraceptives.

D. The IFRs Lack Statutory Authority

1. Insured plans

Section 2792 of the PHSA (42 U.S.C. §300gg-92) authorizes the issuance of regulations "as may be necessary or appropriate to carry out the provisions of this subchapter [currently, 42 U.S.C. §300gg-1 to §300gg-95]."") Section 2713 of the Public Health Service Act (PHSA) (42 U.S.C. §300gg-13) provides that a "health insurance issuer offering group or individual insurance coverage shall…provide coverage for and shall not impose any cost sharing requirements" for certain preventive services that include contraceptive services. Section 2713 requires the coverage for contraceptive services to be part of the underlying group coverage, not separate and apart from it. Stated otherwise, although the PHSA can require a group contract to include coverage for certain things, such as the coverages required by the Newborns' and Mothers' Health Protection Act of 1996 (P.L. 104-204) (42 U.S.C. §300gg-25); the Women's Health and Cancer Rights Act (part of P.L. 105-277) (42 U.S.C. §300gg-4); and the Mental Health Parity and Addition Equity Act of 2008 (P.L. 110-343) (42 U.S.C. §300gg-26), it cannot serve as the basis for the Departments requiring an insurer to do certain things outside of an insurance contract.

Perhaps in light of the statutory limitation described above, the Departments carefully use the word "payments" in lieu of "coverage" throughout the IFRs. However, payments are just the end result of coverage. The IFRs make clear that these "payments" are the same thing as "coverage" under a plan. See, e.g., 78 Fed. Reg. 39870, 39875 (July 2, 2013) (rejecting initial proposal to require insurers to issue separate contraception-only policies); *Id.* at 39876 (requiring that "payments" be made in ways that meet "minimum standards for consumer protection, which would ordinarily accompany coverage"); 45 C.F.R. § 147.131(c)(2)(B)(ii) (providing that an issuer must provide payments for contraceptive services in a manner that is "consistent with the requirements" for providing coverage under the ACA); 78 Fed. Reg. at 39876-77 (allowing insurer to limit provision of contraception through the plan's network of providers); and 29 C.F.R. § 2590.715-2713A(e) (providing that if employer's eligibility claim is later deemed false, issuer will not be liable for failure to provide "coverage" as long as it has been making the "payments").

[11] *See also* Section II.D.3, *infra,* at page 11.

[12] 79 Fed. Reg. at 51097-98 (citing Code sections 7805 and 9833 as authority for the temporary and proposed regulations under Code section 9815). This is important because Treasury Regulations such as 26 C.F.R. § 54.9815–2713AT are fully binding on eligible organizations, including those whose plans are not covered by ERISA.

2. Self-insured plans covered by ERISA

The previous version of the "accommodation" required an eligible organization that sponsored a self-insured plan covered by ERISA to submit a self-certification to its TPA. The final regulations provided that the self-certification form provided by the eligible organization:

> shall be an instrument under which the plan is operated, shall be treated as a designation of the third party administrator as the plan administrator under section 3(16) of ERISA for any contraceptive services required to be covered under § 2590.715–2713(a)(1)(iv) of this chapter to which the eligible organization objects on religious grounds.

29 C.F.R. § 2510.3-16(b); 78 Fed. Reg. at 39894.

Now, the IFRs assert that once an eligible organization submits an alternative notification pursuant to the IFRs, the subsequent notice from the DOL to the TPA "shall be an instrument under which the plan is operated" and shall designate the TPA as the plan administrator for the provision of contraception services. 29 C.F.R. § 2510.3-16(b); 79 Fed. Reg. at 51099-00.[13]

There is no authority under ERISA for the DOL to designate a TPA as a "plan administrator" or amend a plan. Absent narrow exceptions inapplicable here, a "plan administrator" under ERISA is "the person specifically so designated by the terms of the instrument under which the plan is operated." 29 U.S.C. § 1002(16)(A). ERISA sets forth specific requirements regarding the amendment of employee benefit plans. Plans must be "established and maintained pursuant to a written instrument," which must include "a procedure for amending [the] plan, and for identifying the persons who have authority to amend the plan." 29 U.S.C. § 1102(a)(1), (b)(3). Courts have repeatedly held that those procedures are the exclusive means to amend a plan instrument. *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 79 (1995); *Overby v. Nat'l Ass'n of Letter Carriers*, 595 F.3d 1290, 1295-97 (D.C. Cir. 2010) ("[T]here must be amendment procedures in a plan, and those amendment procedures must be followed for the valid adoption of an amendment.").[14]

3. Self-insured non-ERISA church plans

Section 9833 of the Code authorizes the issuance of regulations "as may be necessary or appropriate to carry out the provisions of this chapter. The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this chapter." The referenced chapter is Chapter 100 of the Code – Group Health Plan Requirements. Section 9815 of the Code, part of Chapter 100, states that "the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subchapter…."

Part A of title XXVII of the PHSA (as amended by the ACA) includes section 2713, which provides that "[a] group health plan…shall, at a minimum provide coverage for and shall not impose any cost sharing requirements" for certain preventive services that include contraceptive services. As with insured plans, section 2713 requires the coverage of self-insured plans for contraceptive services to be part of the underlying group coverage, not separate and apart from it. In other words, although the PHSA can require

[13] Confusing things further, the EBSA Form 700 as revised in August 2014 provides that the alternative notice to the Secretary of HHS "is an instrument under which the plan is operated."

[14] Having the Government appoint a TPA as a "plan administrator" raises a number of questions under ERISA. For example, who is responsible for monitoring the TPA as "plan administrator?" If the "plan administrator" breaches a fiduciary duty, is the eligible organization potentially responsible under ERISA section 405 (29 U.S.C. § 1105) as a co-fiduciary?

a group health plan to include coverage for certain things, such as the coverages required by the Newborns' and Mothers' Health Protection Act of 1996 (P.L. 104-204)(42 U.S.C. § 300gg-25), it cannot serve as the basis for the Departments requiring a TPA to do certain things outside of the group health plan, nor can ERISA require a TPA to provide certain coverage or make certain payments for a self-insured plan that is not covered by ERISA.

As described earlier,[15] the IFRs require that the notice provided to HHS by an eligible organization must include the name and contact information for the eligible organization's TPA. The IFRs state that the DOL then "will send a separate notification to each of the plan's third party administrators…describing the obligations of the third party administrator under 29 CFR 2510.3-16 and this section and under §54.9815-2713A." 29 C.F.R. § 54.9815-2713AT(b)(1)(ii)(B). According to sections 54.9815-2713A and 54.9815-2713AT, if a TPA receives a self-certification from an eligible organization or a notification from the DOL, "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…." As with insured plans[16] the Departments carefully use the word "payments" in lieu of "coverage". As stated earlier,[17] the IFRs make clear that "payments" are the same thing as "coverage." However, these "payments" are outside of a group health plan, so they may not be mandated or enforced with respect to group health plans under the regulatory authority described in Code section 9833.

E. The IFRs Fail to Provide Clarity as to the Timing of Notices

When an eligible organization chooses to provide a notice to HHS, the deadline for the notice is unclear from the IFRs, which state that the plan "complies for one or more plan years…if the eligible organization…provides…a notice to the Secretary of Health and Human Services…" So, must the notice be provided each year, prior to the beginning of the plan year? If so, how far in advance must it be provided?

III. EXEMPTION FOR "RELIGIOUS EMPLOYERS" CONTINUES TO EXCLUDE BONA FIDE ELIGIBLE ORGANIZATIONS

The IFRs make no changes to the definition for "religious employers" in the final regulations published in July 2014. The regulations continue to exclude bona fide religious organizations because they continue to reference statutory exemptions set out in Code sections 6033(a)(3)(A)(i) and (iii) that were crafted for another purpose – specifically, to exempt churches, their integrated auxiliaries, conventions or associations of churches and the exclusively religious activities of a religious order from the annual Form 990 filing requirement under Code section 6033.

For the reasons discussed in its prior comments, the Church Alliance again urges the Departments to extend the religious employer exemption, and suggests they extend it to all employers that maintain or participate in "church plans", as defined in Code section 414(e). The Departments' continuing struggle with an employer-by-employer approach highlights once again the advisability of a plan-based approach. As we noted in prior comments, focusing the exemption on benefit plans rather than employers avoids entanglement problems. In addition, a plan-based exemption recognizes that in many churches the plan is not at an individual employer level but may be at a local, state, regional or even national level. Depending on a church's polity as determined by its theological beliefs, some religious employers are required to participate in a multiple employer church plan while others may elect to do so. Finally, under the final regulations as revised by the IFRs there are now two different accommodation procedures for

[15] *See* Section II, *supra,* at page 3.
[16] *See* Section II.D.1, *supra,* at page 9.
[17] *Id.*

eligible organizations. One involves the filing of an EBSA Form 700, while the other involves the filing of a notice with HHS. Both methods effectively amend the plan in which an eligible organization seeking an accommodation participates. For an eligible organization participating in a multiple employer church plan, this means that that the plan sponsor – which may be a "religious employer" exempt from the Mandate – will be involved in a program to deliver objectionable drugs and devices in violation of the plan sponsor's religious objections as the result of plan amendments beyond the plan sponsor's control.

However, if the Departments are unwilling to expand the exemption as described above because they are concerned that such an exemption would be too broad, the Departments could draft the exemption more narrowly so that if the church plan is established or maintained by a religious employer, and substantially all of the employers in the church plan are either religious employers or eligible organizations (or substantially all of the participants are employees of religious organizations or eligible employers), all employers in the church plan would be treated as religious employers, exempt from the contraception coverage requirement. This approach would prevent the avoidance of the contraception coverage requirement by employers that are neither religious employers nor eligible organizations. At the same time, this approach would avoid the administrative challenges and possible governmental entanglement for the Departments or courts in determining whether religious organizations were religious enough to be categorized as religious employers or eligible organizations. In addition, this would allow one uniform set of benefits for plan participants and decrease the cost of plan administration for employers providing benefits under church plans.

This approach would be narrower than an exemption based solely on Code section 414(e). It would result in some church plans being exempt (multiple employer church plans that only include employers that are closely tied to the church), while others, such as certain single employer church plans, would not be exempt unless the individual employer satisfies the religious employer definition.

Applying the multiple employer church plan exemption in this manner would recognize the unique nature of multiple employer church plans, particularly the fact that such plans cover many houses of worship (often primarily covering clergy and employees at churches) but also cover some employers associated with the church that may not clearly be religious employers, but that clearly are eligible organizations.

IV. CONCLUSION

For the reasons explained above, we believe that the application of the Mandate to eligible organizations violates the RFRA and the First Amendment. However, if the IFRs are finalized, we suggest that the final version of the regulations implementing the Mandate expand the types of religious organizations exempt from the Mandate to include any religious organization that objects to providing contraceptive coverage on the basis of religious beliefs; or at least any such religious organization that provides benefits through a church plan.

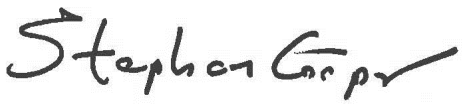
If the Departments will not expand the exemption, the Church Alliance respectfully requests that the Departments at least adjust the alternative process for the accommodation in the following ways:

- Amend the IFRs to delete the requirement to provide third party administrator or health insurance issuer information in an eligible organization's notice to HHS; and

- Allowing the option for a multiple employer church plan to submit one notice to HHS on behalf of all eligible organizations that have adopted the plan. Allowing one form would be easier for HHS, and would avoid inadvertent paperwork lapses by small, unsophisticated eligible organizations.

Please contact the undersigned at 202-661-3882 if you have any questions or wish to discuss this matter further.

Sincerely,



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