CHURCH ALLIANCE
BENEFITS FOR FAITH LEADERS SERVING COMMUNITIES

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9905–IFC
P.O. Box 8016
Baltimore, MD 21244–8016

Re: Prescription Drug and Health Care Spending (CMS–9905–IFC)

To Whom It May Concern:

The Church Alliance submits this letter in response to the Prescription Drug and Health Care Spending Interim Final Rule ("IFR") published by the Department of Health and Human Services, Department of Labor, Department of the Treasury, and the Office of Personnel Management (the "Departments") at 86 Fed. Reg. 66662 on November 23, 2021. The Church Alliance appreciates the opportunity to comment regarding the reporting requirement under Section 204 of Title II of Division BB of the Consolidated Appropriations Act ("CAA"), 2021, related to pharmacy benefits and prescription drug costs (the "Reporting Requirement").

As discussed below, the Church Alliance's view is that Congress intended to exempt all church plans from the Reporting Requirement. The unique characteristics of church plans strongly support an exemption from the Reporting Requirement. In the alternative, temporary non-enforcement and/or a limited scope exemption for church plan reporting is warranted until such time as practical guidance is issued that would improve the accuracy of the data reported for church plans and reduce the burdens that the Reporting Requirement imposes.

I. Introduction

The Church Alliance is composed of 37 church benefits organizations, covering mainline and evangelical Protestant denominations, three Jewish entities, and Catholic schools and institutions. Church Alliance organizations provide employee benefit plans, including retirement and/or health coverage, to approximately one million participants (clergy, lay workers, and their families), serving approximately 155,000 churches, parishes, synagogues, and church-related organizations.

The plans of the Church Alliance's church benefits organizations ("denominational plans") are defined as "church plans" under section 3(33) of the Employee Retirement Income Security Act ("ERISA") of 1974 and section 414(e) of the Internal Revenue Code of 1986 ("Code"), as amended. In recognition that a church is not confined to the four walls of the church, these organizations carry out the broader mission of the denomination.

II. Background on Church Benefit Plans

A. Church Benefit Plans Generally

Church benefit plans have been in existence for decades and, in some cases, pre-date the enactment of the Code in 1913. Denominational plans are typically maintained by a separately incorporated church benefits organization for eligible employees of ministries in a denomination. In some cases, the sponsor is the church or denomination, not the benefits organization. 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 religious employers throughout the U.S.

Because denominational plans serve multiple employers, they provide efficiency, continuity, and consistency of employee benefits for ministers and lay workers as they move throughout the U.S. from one church or church-related organization to another within a denomination. Most participating employers 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 may be full or part-time workers who assist with administrative duties, although these duties are performed by volunteers in many churches.

In addition to serving churches, denominational plans also cover other nonprofit organizations associated with the denomination or church. Participating employers can include church-affiliated nursing homes, day care centers, seminaries, universities, elementary and secondary schools, food pantries, and other social services organizations. These organizations are essential to fulfilling the mission and ministry of the church and share common bonds of worship with the denomination. Individuals, such as self-employed ministers and missionaries, also may participate in denominational plans.

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 denominational 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 still will present unique challenges, though, 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 regulatory compliance challenges. Moreover, in congregational structures the individual churches are the decision-makers, and are not subject to mandates from other organizations in the denomination.

B. Church Health Care Benefit Plans

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

Notably, self-insured denominational health plans may fund their programs by averaging of contribution rates, so that larger, wealthier, and more-established churches effectively support smaller, poorer, or newer (i.e., evangelizing) churches. This averaging or community rating generally is for theologically-based reasons. However, in many denominations, the church benefits organization may not actually know the level of contributions that the local ministry pays on behalf of its employees, because there is no centralized human resource or payroll function. Similarly, the amount a minister or lay employee may be required to contribute towards the coverage may also vary by employing organization.

III. Statutory Exemption for Church Plans

A. Church Plan Exemption and the First Amendment

Congress has long acknowledged the unique organizational polities of America's churches, which reflect each denomination's or church's underlying theological tenets and religious beliefs. To this end, Congress has provided church plan exemptions, for example, when the requirements of federal law are recognized to have an adverse impact on a church benefits organizations' ability to continue to deliver their programs and to avoid government entanglement with religion in violation of the First Amendment.

By way of background, in 1974, when ERISA was enacted, church plans, including denominational plans, were exempted unless they affirmatively elected to be subject to ERISA. The exemption was granted to avoid government entanglement with religion in violation of the First Amendment. In exempting church plans, Congress recognized that examining the internal arrangements of churches constituted an unnecessary intrusion into religious activities. Since ERISA's enactment, Congress has repeatedly exempted non-electing church plans from certain employer group benefits plan disclosure and reporting requirements under the Code.

B. Church Plan Exemption from the Reporting Requirement

The Church Alliance believes that Congress similarly intended to exempt church plans from the Reporting Requirement. Specifically, Section 204 of Title II of Division BB of the CAA added parallel provisions at Section 2799A–10 of the Public Health Service Act ("PHSA"), Section 725 of ERISA, and Section 9825 of the Code for the Reporting Requirement. Incorporating parallel provisions to the three statutes was necessary to broadly cover group health plans given that each of those statutes has slightly different definitions of "group health plan," and, as such, applies to different types of group health plans. In this regard, Section 204(a) of the CAA amended Section 2799A–10(a) of the PHSA to provide, in pertinent part, as follows:

> ‘‘(a) IN GENERAL.—Not later than 1 year after the date of enactment of the Consolidated Appropriations Act, 2021, and not later than June 1 of each year thereafter, a group health plan or health insurance issuer offering group or individual health insurance coverage (*except for a church plan*) shall submit to the Secretary, the Secretary of Labor, and the Secretary of the Treasury the following information with respect to the health plan or coverage in the previous plan year: ….” (emphasis added).

This PHSA language provides a statutory exemption for church plans, such that the Reporting Requirement does not apply to church plans under the PHSA. However, the PHSA does not apply to church plans that are self-funded group health plans. *See* Section 2722(a)(1)(B) of the PHSA. To provide an exemption for *all* church plans, the “(except for a church plan)” language or similar language should have been carried over to Section 9825(a) of the Code, which was added by Section 204(c) of the CAA.[1]

IV. Church Alliance Comments on the Departments’ RFI

Given the above, the Church Alliance submitted comments on July 23, 2021, in response to the Request for Information Regarding Reporting on Pharmacy Benefits and Prescription Drug Costs (“RFI”) published by the Departments at 86 Fed. Reg. 32813 on June 23, 2021. In its comments, the Church Alliance highlighted the ambiguity with respect to the applicability of the requirements, as well as the difficulty presented to sponsors of denominational plans to access the necessary data to comply with the requirements.

It is the Church Alliance’s view that Congress intended to exempt all church plans from the Reporting Requirement. This is based in part on discussions with drafters of legislative text of the Lower Health Care Costs Act, which formed part of the basis for Division BB of the CAA, when that draft text only modified the PHSA. Accordingly, as part of its comments, the Church Alliance requested that the Department of the Treasury take a non-enforcement approach with respect to the Reporting Requirement under Section 9825 of the Code for church plans.

The Church Alliance is disappointed in the Department’s definition of “group health plan” in the IFR that “includes both insured and self-funded group health plans, and includes private employment-based group health plans subject to ERISA, non-federal governmental plans (such as plans sponsored by states and local governments) subject to the PHS Act, and church plans subject to the Code.”[2] Applying the Reporting Requirement to self-insured church plans creates the same entanglement issues as would have been created with insured plans that were exempted, and this inconsistency can be rectified with non-enforcement.

V. Executive Summary

The Church Alliance again requests that the Department of the Treasury take a non-enforcement approach with respect to the Reporting Requirement for church plans subject to the Code, to avoid

[1] An exemption was not necessary in the language added to ERISA by the CAA because Section 4(b)(2) of ERISA provides that Title I of ERISA (which includes Section 725 of ERISA) does not apply to a church plan, as defined in Section 3(33) of ERISA, unless such a plan affirmatively elects to be subject to ERISA under Section 410(d) thereof.

[2] 86 Fed. Reg. 66662, 66665 (November 23, 2021).

governmental entanglement with religion, and to provide consistency with the church plan exemption from the Reporting Requirement for church plans subject to the PHSA.

If the Department of the Treasury chooses not to take that approach, further guidance will be necessary for compliance with the Reporting Requirement by church plans, as explained below. Church plans do not have the information needed to comply with the Reporting Requirements. Accordingly, in order to comply, church plans must either: (i) attempt to collect this information from potentially thousands of ministries, which for some denominations would be contrary to church polity and independence based on strongly-held religious beliefs, and would be a significant drain on resources; or (ii) submit the best data available, which may result in substantial inaccuracies.

To avoid entanglement or inaccurate reporting before further guidance is issued, we request that the Department of the Treasury temporarily forgo enforcing the Reporting Requirement on church plans, and/or provide a limited exemption for data that is unavailable to either the church plans or their third-party administrators ("TPAs"). The purpose of the IFR Section 204 reporting is to provide the Departments with information to draw conclusions about market trends for purposes of developing a meaningful and accurate section 204 public report.[3] The incremental data that would be reported by church plans would not impact the ability of the Departments to develop meaningful and accurate reports about health care prescription drug reimbursements, pricing trends, the impact of rebates, fees and other price concessions for purposes of its reporting and meeting its statutory requirements. On the other hand, the impact on church plans of enforcement prior to the issuance of necessary guidance would be substantial and unreasonably burdensome, and likely would result in the submission of inaccurate data.

Temporary non-enforcement and/or a limited exemption would be reasonable because many church plans do not fit within any of the market segments to be specified in the reporting, multi-state church plans do not fit the existing guidance for state aggregation, and many church plans do not know the average monthly contribution paid by employees, as explained below. Until further guidance is issued, we question whether it is possible for accurate data to be submitted on many church plans.

VI. Church Alliance Comments on the Department's IFR

A. Lack of Access to Information for Church Plans and Lack of Clarity for TPAs and pharmacy benefits managers ("PBMs") to Provide Data on Church Plans

As discussed in more detail in the Church Alliance's comments on the Departments' RFI, sponsors of denominational health plans have access to very little of the data that would be necessary to comply with the Reporting Requirement. Most denominational plan sponsors have access to the general enrollment information on the plan, such as the beginning and end dates of the plan year, the number of participants, beneficiaries, or enrollees, as applicable, and each state in which the plan or coverage is offered. However, denominational plan sponsors will not know the individual enrollees' health coverage

[3] "The Departments will issue biennial public reports on prescription drug pricing trends and the impact of prescription drug costs on premiums and out-of-pocket costs starting in 2023. These reports are expected to enhance transparency and shed light on how prescription drugs contribute to the growth of health care spending and the cost of health coverage." (See https://www.cms.gov/newsroom/fact-sheets/prescription-drug-and-health-care-spending-interim-final-rule-request-comments, last visited January 2, 2022.)

contribution amounts established by their individual employing organization, nor will they likely know the employer size and may not know the contribution amounts paid by employers.

The remaining data that would be necessary to comply with the Reporting Obligation is only accessible from records maintained by a denominational plan's TPA(s). A plan may use more than one TPA. For example, a plan may use separate TPAs for medical, mental health, wellness and pharmacy benefits. In addition, some plans use different TPAs for different geographical areas of the country given the geographically dispersed populations covered by denominational plans. Additionally, as described below, neither the TPAs nor the plans generally have information on the average monthly premium paid by employees and may not know the amount paid by employers.

1. Prescription Drug Costs

Much of the information requested by the Reporting Requirement relates to pharmacy benefits and prescription drug costs. A church health plan would need to request this data be provided by its PBM. Given that most PBMs are still assessing the Reporting Requirement and determining their capability to provide the necessary data, many church plan sponsors have not received confirmation from their PBM that they can provide the necessary data. In addition, many church plan sponsors have not yet received confirmation from their PBMs regarding fees that would be charged by the PBM to provide the required data. As noted above, many plans use separate TPAs for medical and pharmacy benefits, as well as wellness programs. In those cases, medical benefits and wellness program information would need to be requested from a different entity(ies), each which may charge a separate fee for this data.

2. Market Segment/Employer Size

For all of the TPAs with information on self-insured health plans, data is to be reported by market segment, and many church health plans do not neatly fit into any of the specified market segments, since they are multiple employer plans and the employers vary in size. Moreover, denominational church benefits organizations have varying approaches to offering group health plans to their individual church or church-associated employers, typically driven by the underlying polity of the denomination, which is based on religious belief. This means that one denominational church benefits organization may be managing each of its eligible employers' self-funded individual employer plans, sponsored by the individual employers. Another denomination's church benefits organization may be managing plans for its eligible employers on a synod, conference or other denominational regional governing body plan basis, with the regional group as the sponsor. A third model exists where the denomination sponsors the same plan designs for all the individual employers in the denomination and administers those designs centrally as a single plan.

Therefore, the TPAs cannot simply assume that the benefits organization is the plan sponsor (treating that organization as the "employer" and basing market segment on that) or assess the market segment based on the number of plan members. In addition, the TPAs generally do not have information about the sizes of the various employers participating in the denominational church plan because they are processing claims and administering the program as if the plan was a large single employer plan. Finally, since the church benefits organization generally does not have payroll information, it also does not have accurate information about employer size. Thus, reporting from a TPA or PBM by market size would be next to impossible without significant input from each church or other ministry, which would put significant strain on the ministry, church benefits organization, TPAs and PBMs.

3. State Level Reporting

Similarly, the guidance on state aggregation for multi-state self-insured church plans generally does not fit. Often this coverage is provided through a group trust with multiple employers in multiple states, so the guidance for group trusts to report based on where the employer has its principal place of business does not work. Even if the church benefits organization would be interpreted as akin to an association, that guidance only applies if the association qualifies as an employer under ERISA or has no principal place of business, and church plans are not subject to ERISA, but the benefits organizations have principal places of business. Also self-insured church plans are not multiple employer welfare arrangements ("MEWAs") so those aggregation rules do not apply.

Depending on the denomination, the group health plan managed by the church benefits organization may exist at the individual employer level, a regional level or the denominational level. It is unclear whether the IFR requires a denominational benefits organization that administers individual employer-level plans to be attributed to the state where the individual employer has its principal place of business and how the regional-level plan would aggregate by state.

4. Conclusion

Thus, self-insured church plans will neither be able to report on their own, nor do their TPAs have the guidance to report information accurately on their behalf. TPAs will only be able to report the data as part of a large single employer market segment and on the basis of the state of the church benefits organization's principal place of business (though much of the enrollees' data has no bearing to the state of the church plan benefits organization's principal place of business). The Church Alliance believes the value for government reporting purposes is de minimis at best and could in fact have a skewing effect. While we agree that this irregularity will not have an outsized impact on the top 50 lists and trends in a state, it nonetheless demonstrates the futility of the church plan reporting for purposes of Section 204, at least before further clarifying guidance is issued.

B. Monthly Premium Reporting

Reporting the average monthly contributions for health coverage paid by participants, beneficiaries, and enrollees and paid by participating employers on their behalf presents a unique challenge to denominational church plans, which does not exist with a typical single employer and many other multiple employer group health plans.

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 and the denominational plan is and may affect the way contributions for coverage are established. As a result, the "average monthly premiums" paid by participants, beneficiaries, and enrollees, as well as employers in some denominations, under a self-insured church health plan is not usually known by the church benefits organization.

In some denominations, the church plan invoices a regional sub-unit of the denomination for an established contribution. These intermediate bodies, such as a diocese, presbytery, or state convention, may alter the method of sharing costs among participating churches. Sometimes contributions set by the church plan are 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 plan $7,000 to cover single clergy and $13,000 to cover clergy with families. The conference blends the rates and charges each church $10,000 for coverage. The denominational plan will not know the actual contribution amount charged to the churches' employees or to the church. Some denominations and intermediate church bodies 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, rural or underprivileged churches. This cross-subsidization often serves the mission of these denominations.

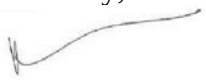
Some denominational plans charge a contribution for coverage that is a fixed percentage of a clergyperson's, or an employee's, compensation. In other cases, the contribution under the health plan may be combined with the contribution to the church pension plan to set one benefits coverage contribution for the church. In addition, in some cases, an intermediate body may combine health plan contributions with other general church remittances for participating churches. Yet other denominational plans assess a contribution amount that is blended among a variety of health and welfare products. These contributions may also be varied within a denomination (e.g., in order to reflect mission needs and church values).

Requiring denominational plans to obtain this information would be unduly burdensome on the denominational plan and on churches, and contrary to church polity and belief in some denominations, dwarfing any possible public benefit from the information, and therefore it would be of questionable constitutionality. The independence of individual churches in some denominations is strongly based on religious beliefs, so requiring the disclosure of this information from churches would violate the separation of church and state. Therefore, a limited exemption from this reporting requirement is warranted for church plans. Alternatively, the reporting format and guidance should allow the submission of an answer such as "unknown" in the field for average monthly premium paid by employees.

VII. Conclusion

As highlighted above, it is the Church Alliance's view that Congress intended to exempt all church plans from the Reporting Requirement. The unique characteristics of church plans cry out for an exemption from the Reporting Requirement. In the alternative, temporary non-enforcement and/or a limited scope exemption for church plan reporting is warranted until such time as practical guidance is issued that would improve the accuracy of the data reported for church plans and reduce the substantial administrative and financial burdens that the Reporting Requirement imposes on denominational plans. The Church Alliance appreciates the opportunity to comment on the Departments' IFR with respect to prescription drug and health care spending. As the Departments navigate these issues, the Church Alliance looks forward to the opportunity to work together and requests that the Departments consider the special considerations of church health plans and the difficulty in obtaining the required information. Please consider the Church Alliance as a resource and do not hesitate to contact us if you have any questions.

Sincerely,



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On behalf of the Church Alliance