CHURCH ALLIANCE

BENEFITS FOR FAITH LEADERS SERVING COMMUNITIES

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July 23, 2021

Electronically to https://www.regulations.gov

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
U.S. Department of Labor
Attention: Request for Information Regarding Reporting on
Pharmacy Benefits and Prescription Drug Costs
200 Constitution Avenue NW, Room N–5653
Washington, DC 20210

Re: RIN 3206-AO27; Request for Information Regarding Reporting on Pharmacy Benefits and Prescription Drug Costs

To Whom It May Concern:

I. Introduction

The Church Alliance respectfully submits this letter in response to the Request for Information Regarding Reporting on Pharmacy Benefits and Prescription Drug Costs ("RFI") 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. 32813 on June 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, 2021, related to pharmacy benefits and prescription drug costs (the "Reporting Requirement").

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-associated organizations. These plans ("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.

II. Executive Summary

Church benefits organizations exist to provide comprehensive benefits for ministers and church lay employees of the numerous congregational and mission organization employers affiliated with the denomination. The U.S. Congress and the regulatory agencies responsible for the health and welfare benefits laws and regulations have acknowledged the unique organizational polities of America's churches, which reflect each denomination's or church's underlying theological tenets and religious beliefs and have provided church plan exemptions, state law preemption and/or regulatory flexibility, for example, when the requirements of the law have an adverse impact on the church benefits organizations' ability to continue to deliver their programs and to avoid government entanglement with religion in violation of the First Amendment.

As explained further below, the Church Alliance believes that Congress intended to exempt church plans from the Reporting Requirement. However, a technical drafting issue in the language added to the Internal Revenue Code could potentially result in ambiguity regarding the exemption. We respectfully urge the Department of the Treasury to address this issue, possibly through a non-enforcement policy regarding any application of the Reporting Requirement to church plans. Congress' intent to exempt church plans from the Reporting Requirement reflects important Constitutional principles and practical realities related to church plans. Requiring church plans to comply with the Reporting Requirement as a result of a drafting ambiguity would be inconsistent with those Constitutional principles and create significant burden on and cost to church plans, which in turn would impact their ability to serve participants.

In the event church plans are required to comply with the Reporting Requirement, the Church Alliance would like to make the Departments aware of certain challenges that church plans anticipate facing to comply with the Reporting Requirement, including certain challenges and considerations that are unique to church plans.

III. 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 Internal Revenue Code in 1913. Church benefit 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 itself, 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 country.

Most participating employers covered by church benefit plans are small, local churches with only a few employees. In many denominations, the local church's pastor may be that church's only employee. If there are other employees, they 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 local churches, church benefit plans also cover other nonprofit organizations associated with the denomination or church. For example, participating employers can include church-

affiliated nursing homes, day care centers, seminaries, universities, elementary and secondary schools, hospitals, and social services organizations. All of these organizations are essential to fulfilling the mission and ministry of the church. Individuals, such as self-employed ministers and missionaries, also may participate in church plans.

Church plans serve multiple church employers, providing efficiency, continuity, and consistency of employee benefits for ministers and lay workers as they move throughout the United States from one church or church-related organization to another within a denomination.

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

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 the comfort and security of 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 under the plan without impacting provider networks and existing contributions to annual deductibles and out-of-pocket maximums.

Self-insured church health plans may provide for 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 board may not actually know the level of premium contribution that the local ministry provides to its employees, because there is no centralized human resource or payroll function. Sometimes premium contribution rules set by the church benefits board are driven by an intermediate or local church body or unit of church government in various ways.

IV. Statutory Exception for Church Plans

The U.S. Congress has acknowledged the unique organizational polities of America's churches, which reflect each denomination's or church's underlying theological tenets and religious beliefs and has provided church plan exemptions, for example, when the requirements of the law 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. Congress intended to exempt church

plans from the Reporting Requirement, though there is a technical issue in the language of Section 204 of the CAA. This issue may create an ambiguity regarding the exemption.

More specifically, Section 204 of Title II of Division BB of the Consolidated Appropriations Act, 2021 ("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 to provide for the Reporting Requirement. Parallel provisions to the three statutes were 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.

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. In that case, to clearly 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]

Without such language in the Code, there could be ambiguity regarding whether the Reporting Requirement applies to church plans that are self-funded group health plans, though we believe Congress intended to exempt all church plans from the Reporting Requirement. We believe in the rush to pass the CAA, the exemption was inadvertently omitted from Section 9825(a).

We ask the Departments to address this issue. For example, the Department of the Treasury could take a non-enforcement approach with respect to the Reporting Requirement under Section 9825 of the Code for church plans. A non-enforcement approach would not negatively impact the Departments' ability to analyze trends in overall spending on prescription drugs and other health care services by plans and publish analysis that will enable plans and issuers to ultimately negotiate fairer rates and lower costs for participants, which, as noted in the RFI, is the policy goal of the Reporting Requirement. In addition, it will allow church plans to avoid significant upfront efforts and expenses they would otherwise incur to prepare to comply with a requirement that was not intended to apply to them, which would only divert resources from the mission of caring for participants.

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[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.

V. Responses to Questions Posed in the RFI

In Section II.A.1 of the RFI, the Departments ask about any challenges that plans anticipate facing in meeting the reporting obligations, and whether plans currently have access to all the information they would be required to report. Similarly, in Section II.A.1 of the RFI, the Departments ask whether the Departments should expect that self-insured group health plans will contract with third-party administrators or other service providers to submit the required data on their behalf. The challenges that self-insured church plans will face with meeting the Reporting Requirement provide additional support for our request that Treasury adopt a non-enforcement position with church plans with respect to the Reporting Requirement.

In our experience, sponsors of church group health plans currently have access to very little of the data that would be necessary to comply with the Reporting Requirement. Most plan sponsors have access to the general 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, the remaining data that would be necessary to comply is not readily accessible by most plan sponsors. Such data is only accessible from records maintained by a church plan's third-party administrator(s). A plan may use more than one third-party administrator (TPA). For example, a plan may use separate TPAs for medical, mental health, and pharmacy benefits. In addition, some church plans use different TPAs for different geographical areas of the country given the geographically dispersed populations covered by church plans. Most plans will need to request and consolidate data from multiple TPAs to comply with the Reporting Requirement.

Most of the information requested by the Reporting Requirement relates to pharmacy benefits and prescription drug costs. A plan would need to request this data from its pharmacy benefits manager (PBM).[2] Given that most PBMs are still reviewing the Reporting Requirement and determining their capability to provide the necessary data, many church plan sponsors have not yet 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 PBM regarding fees that would be charged by the PBM to provide the required data. The Reporting Requirement also requests spending data for a plan's medical benefits. As noted above, many church plans use separate TPAs for medical and pharmacy benefits. In those cases, the medical benefits information would need to be requested from a different entity(ies).

In Section II.A.1 of the RFI, the Departments ask whether there are special considerations for certain types of group health plans that make it challenging or not feasible for the plans to satisfy the Reporting Requirement. In the case of church plans, it would be exceptionally challenging to report the average monthly premiums paid by participants, beneficiaries, and enrollees and paid by participating employers on behalf of participants, beneficiaries, and enrollees. This requirement presents a different challenge to

[2] For purposes of this letter, we are using the term "pharmacy benefits manager" or "PBM" to include any third party that administers claims for pharmacy benefits under a group health plan. That entity may administer all claims under the plan (i.e., a traditional group health plan third-party administrator) or only claims that relate to pharmacy benefits (i.e., a third-party administrator for a carved-out pharmacy benefits component of a group health plan). For purposes of the *pharmacy benefits and prescription drug information* requested by the Reporting Requirement, the difference is not relevant because in all cases a third-party would maintain most of the data necessary to comply with the Reporting Requirement.

denominational church plans than it would to 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 always readily evident by the church plan sponsor, if at all.

In some denominations, the church 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 alter the method of sharing costs among participating churches. Sometimes contributions set by the church plan, e.g., single coverage rates and family rates, are blended by the intermediate body 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 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 church plan may not know the actual contribution amount or premium charged to the churches' employees. 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, rural or underprivileged churches. This cross-subsidization often serves the mission work of these denominations.

Some church plans charge a contribution for coverage that is simply 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 church plans assess a contribution amount that is blended among a variety of health and welfare products, whereby making it almost an impossibility to assess the spend by a church plan employee only on pharmaceutical benefits. These contributions may also be varied within a denomination, e.g., to reflect mission needs and church values.

Accordingly, we urge the Departments to adopt a non-enforcement position of the Reporting Requirement for church plans, or at the least, provide an exemption from the requirement in Section 9825(a)(8) of the Code to report average monthly premiums paid. Such an exemption would not negatively impact the Departments' ability to analyze trends in overall spending on prescription drugs and other health care services by plans and publish analysis that will enable plans and issuers to ultimately negotiate fairer rates and lower costs for participants, beneficiaries, and enrollees, which, as noted in the RFI, is the policy goal of the Reporting Requirement.

Finally, in Section II.C.4 of the RFI, the Departments ask about the role that PBMs will play and whether PBMs could complete some or all the reporting. As noted above, PBMs maintain most of the data requested by the Reporting Requirement. However, PBMs typically do not have all the general plan

information requested by the Reporting Requirement, and in the case of church plans in particular, do not have data to determine the average monthly premiums paid. In addition, when different TPAs are used for medical and pharmacy benefits, the PBM does not maintain the medical benefits data requested by the Reporting Requirement. Accordingly, a church plan could not simply engage its PBM to complete the Reporting Requirement directly on its behalf without providing additional information and data to the PBM from records maintained by the plan sponsor and/or other TPA(s).

VI. Conclusion

The Church Alliance appreciates the opportunity to respond to the RFI. As the Departments draft regulations and establish processes to implement the Reporting Requirement, we respectfully request that the Departments consider the special considerations relating to church plans and our recommendations for accommodating them described in this letter, to prevent our member organizations from being subjected to these burdensome requirements when they do not have the detailed information required to be disclosed, and apparently were intended to be exempted. As the Departments navigate these important issues, please consider the Church Alliance as a resource and do not hesitate to contact us if we can be helpful in any way.

Sincerely,

Karishma S. Page
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On behalf of the Church Alliance