CHURCH ALLIANCE

BENEFITS FOR FAITH LEADERS SERVING COMMUNITIES

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The Honorable Ron Wyden
Senate Committee on Finance Chairman
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Mike Crapo
Senate Committee on Finance Ranking Member
219 Dirksen Senate Office Building
Washington, D.C. 20510

Re: Behavioral Health Request for Information

Dear Chairman Wyden and Ranking Member Crapo:

Thank you for your ongoing leadership in responding to the COVID-19 pandemic and commitment to enhancing behavioral health care during this time of need. The Church Alliance appreciates the opportunity to submit this letter in response to the Request for Information ("RFI") issued on September 21, 2021. As the committee develops behavioral health legislation, the Church Alliance requests that you take into account the special considerations concerning church health care benefit plans described in this letter, particularly with regard to the need to strengthen the behavioral health workforce and expand telemedicine.

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 denominational 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. The mission of denominational plans is to serve the health and retirement needs of clergy, lay workers, and their families. Beyond providing benefits to clergy and lay employees in local congregations, these plans may also cover clergy and lay employees of other church-related organizations that serve communities and vulnerable populations.

Such church-related organizations are tax-exempt and closely affiliated with a congregation or denomination, such as nursing homes, children's homes, other social service organizations, day care centers, schools and colleges. 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. Since 1974, the Church Alliance has worked on policy that impacts faith leaders, church-related organizations, and their employee benefits.

II. Caring for Faith Leaders and Their Families

Church benefit plans and programs have a long history in meeting the retirement, health care, and other welfare plan needs of clergy, lay workers, and their families. Denominational plans have been in existence for decades and, in some cases, pre-date the enactment of the Internal Revenue Code in 1913. Some denominational health plans have been in existence for over 50 years. Many denominations offer a nationwide plan (most often on a self-funded basis) that provides key advantages to clergy, lay workers, and their families.

Importantly, denominational health plans are mission-driven and structured to meet the unique needs of clergy, lay workers, and their families. Faith leaders and their families spend their lives in service, devoted to the communities that they serve. Denominational health plans provide faith leaders career-long, portable, comprehensive, and affordable coverage. In addition to reflecting their denominational belief system, denominational health plans offer benefits targeted to the needs of faith leaders and their families.

Behavioral health coverage is a critical part of how we care for the workers we serve. Faith leaders face unique challenges that take a toll on behavioral health. Many are caregivers by profession, who must tend to their own emotional well-being in order to effectively care for others. More faith leaders are accessing medical care for mental health and self-reporting higher levels of anxiety and depression than the general population in the nation. Those treated for mental health conditions also have higher non-mental health care medical claims costs.

As the committee notes in its RFI, the COVID-19 pandemic has exacerbated unmet behavioral health care needs across the country. COVID-19 has changed the way we live, work, connect, worship, and care for our loved ones, creating new levels of stress, anxiety, grief, and depression. This is particularly true of faith leaders devoted to caring for the communities they serve.

III. Strengthening the Workforce

The Church Alliance supports efforts to strengthen the behavioral health workforce. Denominational health plans are national in scope, which provides them with unique advantages in caring for faith leaders and their families. Denominational health plans are able to take advantage of "economies of scale," allowing churches and ministries to purchase health coverage for their workers for less than it would generally cost to purchase similar coverage through the small group or individual insurance markets.

Denominational health plans aim to provide clergy and lay employees, some of whom work in small churches or ministries in disadvantaged or rural communities, the benefit of robust benefits that are tailored to their and their families' needs. Denominational health plans offer nationwide provider networks and other design features in an effort to bring equitable access to behavioral health care for rural and urban workers. An example of such a design feature is applying the same coinsurance rates for in-and out-of-network providers for mental health visits.

Despite significant efforts by denominational church plans, ensuring a robust network of behavioral health providers is challenging. The nation has a shortage of behavioral health providers, particularly in rural

areas. According to the Health Resources & Services Administration, over 130 million people live in mental health professional shortage areas.[1] Based on the above, the Church Alliance supports efforts to support and strengthen the behavioral health workforce.

IV. Expanding Telehealth

The Church Alliance also supports efforts to expand telehealth. Denominational plans provide consistent support for itinerant clergy families. Workers who move from one church to another have the comfort and security of career-long, portable, comprehensive medical coverage that reflects their denomination's belief system. Through denominational plans, itinerant clergy families are able to continue coverage without impacting provider networks and existing contributions to annual deductibles and out-of-pocket maximums.

However, access to behavioral health services has been challenging to faith leaders and their families. In addition to provider shortages, lack of transportation, particularly when located in rural areas where individuals are more likely to have to travel long distances to receive care, and stigma concerns relating to in-person visits have limited access to these services. The ability for providers to treat patients across state lines through telehealth has greatly increased the providers available to individuals in cities and in rural areas. The waiver of the copays for telehealth visits throughout the COVID-19 pandemic has also contributed to the higher, more sustained, use of services.

Moreover, as faith leaders and their families move from vocational call to call, often from state to state, the ability for them to start and continue their behavioral health care with the same provider through telehealth services, regardless of the state provider licenses involved, is critical to the consistent and effective delivery of behavioral health services. Accordingly, the Church Alliance strongly supports the adoption of laws and regulations that would make current COVID-19 waivers of certain telehealth state-based restrictions permanent.

V. Conclusion

The Church Alliance appreciates the opportunity to respond to the RFI. The Church Alliance looks forward to the opportunity to work together and respectfully requests that the committee consider the special considerations of church health plans as it develops behavioral health legislation. Please consider the Church Alliance as a resource and do not hesitate to contact us if you have any questions.

Sincerely,

Karishma S. Page
Partner, K&L Gates LLP
On behalf of the Church Alliance

[1] *See* Health Resources & Services Administration, *Health Workforce: Shortage Areas* (data as of October 14, 2021).