



March 26, 2010

Health Care Reform—Highlights

This week, Congress and the President enacted comprehensive federal health care reform—it is perhaps the most significant piece of social welfare legislation in nearly 50 years. Over the next decade, it will substantially alter the manner in which millions of Americans receive health care coverage. The Patient Protection and Affordable Care Act will have significant short-term and long-term impacts on the health plans of The United Methodist Church. We have prepared these highlights and the attached detailed summary to give you an overview of health care reform and its potential impact on your annual conference.

Immediate Impacts

Within months, annual conferences will need to adjust their health plans to meet the early requirements of the Act, including those pertaining to expanding dependent coverage and restricting lifetime and annual benefit limits. They must also consider the benefits of small-employer tax credits available to nonprofit organizations and a federal reinsurance fund for early retiree coverage.

Intermediate Impacts

Over the next few years, annual conferences will have to carefully examine the costs and viability of their health plans as reporting, disclosure and benefits requirements increase. In addition, if their plans receive the retiree drug subsidy under Medicare Part D, annual conferences will need to monitor the changes to Part D as the coverage gap is eliminated over the next ten years.

Strategic Considerations

There are uncertainties in the Act as it applies to churches—we are working with other denominational benefit providers to clarify them. If the Act considers annual conferences “the employer” of clergy and lay employees, major responsibilities and consequences will accrue to them if they do not provide essential coverage. If local churches are “the employer”, not only could clergy and local church employees benefit from health care subsidies and coverage through new government-regulated insurance exchanges, but annual conferences may also be relieved of one of the major cost drivers in employee benefits—providing health care coverage. The General Conference may need to consider the relationship of annual conferences and local churches to clergy and lay employees in 2012.

Systemic Change

Over the next decade, fewer workers are likely to obtain health insurance through their employers as new benefits, penalties, and programs become effective, and health insurance exchanges become available to larger employers. The current system of employment-based health care coverage may be replaced as even some of the largest employers find it more cost-effective to pay penalties and send their employees to exchanges than to provide coverage themselves.

The attached summary and timeline provide more detailed information regarding the actual provisions of the health care reform acts. Additional detailed information will be available on our website at www.gbophb.org and is being sent to conference benefit officers.

If you have questions regarding this please feel free to contact us at: healthcarereform@gbophb.org.

Health Care Reform and United Methodist Health Plans—Summary

Introduction

The recently enacted federal health care reform legislation will impact the clergy and lay employees covered under health plans provided by the United Methodist annual conferences within the United States.

On March 21, 2010, the U.S. House of Representatives approved the health care reform bill, the Patient Protection and Affordable Care Act (PPACA), passed by the U.S. Senate on December 24, 2009. On March 23, 2010, President Obama signed the PPACA; it is now law. This is perhaps the most significant piece of social welfare legislation since the enactment of Medicare in 1965. Over the next decade, it will substantially alter the manner in which millions of Americans receive health care coverage.

In addition, on March 25, 2010, the House and Senate approved a “sidecar” reconciliation bill, the Health Care and Education Affordability Reconciliation Act of 2010 (the “Reconciliation Act”), which amends certain provisions of the PPACA, such as removing some of the unpopular state-specific items in the bill and delaying the excise tax on high-cost health plans (the “Cadillac plan” tax).

This document summarizes the potential impacts of the PPACA and the Reconciliation Act on church health plans.

Timeline

Accompanying this summary is a timeline of the major provisions of the Acts along with an analysis of the possible effect each provision may have on United Methodist annual conference health plans within the United States.

Effect on Church Plans

Denominational benefit plans receive special treatment as “church plans.” Historically, Congress has accommodated and supported the continuation of church plans for ministers and lay church workers. For example, Congress has exempted church plans from the Employee Retirement Income Security Act of 1974 (ERISA) and many state insurance regulations. However, the Acts do not specifically address the unique nature of church plans, so there is some uncertainty about how they will be affected.

The Acts rely on certain controlled group and affiliated employer definitions that apply to secular employers but that have not generally been applied to churches. By considering unrelated small churches in the same denomination (or annual conference) to be a single large employer, these rules may (1) deny small church employers tax credits available to similar-sized secular employers; (2) impose excise taxes (employer penalties) on small church employers not assessed on similar-sized secular employers; and (3) deny small church employers necessary access to coverage from the insurance exchanges to be established under the Acts in later years, despite otherwise qualifying. These rules could also penalize denominations or church entities for not covering lay employees at local churches.

The Acts offer premium and cost-sharing subsidies for employees who purchase health insurance through an insurance exchange but not from a church plan. These subsidies may encourage small church employers and their employees to abandon church plans for health insurance offered through exchanges. If many church plan participants qualify for income-based subsidies, their departure could make church health plans unsustainable.

The Acts do not include clarifications that apply specifically to church plans. Working with other church benefit plans, the General Board of Pension and Health Benefits (General Board) will continue to pursue needed clarification through the regulatory process as the federal agencies begin to promulgate guidance under the Acts.

Effect on The United Methodist Church

The Acts will have both short-term and long-term effects on The United Methodist Church, its annual conferences, clergy, lay employees, and the health plans that cover them. In the near term, insurance market reforms, such as extended dependent coverage and elimination of lifetime benefit limits, will require some plan design changes and some additional costs for annual conference health plans. Small employer subsidies for health coverage and federal reinsurance of early retiree coverage may help abate the costs of continuing to cover clergy and lay employees through annual conference plans. These beneficial aspects of the legislation may help church plans adjust to the more significant long-term changes included in the Acts.

In the long term, regional insurance exchanges will offer individuals an array of coverage options regardless of health history, and will provide affordability subsidies to help lower-income individuals pay for exchange coverage. A survey done by Guidestone (the Southern Baptist Convention benefit board) found that 80% of its participants would be eligible for the individual affordability subsidies in the Acts.

Whether the local church, the annual conference, the church plan or the denomination is considered the “employer” (i.e., the health plan provider) under the Acts depends on how the affiliated employer rules are applied to churches. Regulatory guidance may clarify how church employers and church plans are treated. It may become a matter for the denomination, through General Conference action, or for each annual conference, to establish for the Church whether the annual conference or the local church is considered the “employer” for the Acts’ purposes.

How the employer is defined may determine whether clergy and lay employees have access to the insurance exchanges and whether employer penalties will accrue to annual conferences that do not offer affordable coverage. If local church small employers are eventually able to obtain coverage for clergy and lay employees from the exchanges, it may eventually reduce the need for annual conference health plans. It may also lead to attrition and a loss of scale for these plans, which may increase plan costs, but also may ultimately relieve annual conferences of the costs of health coverage. Some may see advantages to allowing clergy and small churches to seek coverage from the exchanges. Others may continue to see advantages to maintaining annual conference plans that provide consistent coverage across appointments.

The denomination may need to thoughtfully consider many aspects and future consequences of the Acts before the 2012 General Conference.

Legal Challenges

Attorneys General in seven states have already filed a lawsuit in federal court challenging the constitutionality of several of the provisions of the Acts. They argue that certain Medicaid mandates on states violate the Tenth Amendment of the Constitution and infringe upon state sovereignty. In addition, they argue that (i) the individual mandate requiring everyone to have health insurance or face a penalty and (ii) the employer penalty for not providing coverage are unconstitutional exercises of federal power. Some legal scholars feel that the cases have merit and could result in nullification of certain parts of the legislation. Many other scholars feel that the challenges are unlikely to succeed, because the penalties take the form of a tax, and courts have construed Congress’s taxing power under the Constitution very broadly.

Questions and Information

If you have questions or would like additional information, please send your inquiries to healthcarereform@gbophb.org.

Health Care Reform—a UMC Timeline

This is a timeline of the effective dates for the major provisions of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Affordability Reconciliation Act of 2010 (together, the “Acts”), along with analysis about the effect each provision may have on United Methodist annual conference health plans.

2010

Six months after enactment, the following provisions of the Acts will take effect—most group health plans will have to incorporate these changes by January 1, 2011.

Small Business Tax Credit

Qualified small employers (those with 25 or fewer employees), including small nonprofit organizations, may be eligible for a tax credit for their contributions to purchase health insurance for employees. The credit for nonprofit employers will be up to 25% of the employer’s contribution. The credit is applied as an offset to the small nonprofit employer’s portion of payroll (FICA) taxes for its employees. Small churches that pay for coverage of their lay employees (or possibly clergy not covered through an annual conference plan) may benefit from this tax credit. However, the tax credit may be of limited benefit to small churches—often a small church’s payroll is primarily the salary of the clergyperson, and for payroll tax purposes (FICA/SECA), a clergyperson is considered self-employed. So, a small church may not owe enough in payroll taxes to fully benefit from this tax credit.

Lifetime Limits and Annual Limits

Group health plans are now prohibited from imposing lifetime limits on benefits and from using unreasonably restrictive annual limits. Annual conference health plans will need to remove lifetime benefit limits, and act in good faith to ensure annual limits are not unreasonable. We expect that the Department of Health and Human Services (HHS) will issue regulations to provide plan sponsors additional guidance about annual limits.

Dependent Coverage Extended

Group health plans that provide dependent coverage for children must continue to make that coverage available until children reach age 26 (regardless of student status), if they are not eligible for other coverage. Such coverage will be considered a tax-free benefit; employees will not be taxed on the imputed value of it, if the employer pays a portion of the premium. Annual conferences will need to ensure that their plans cover eligible children to age 26. In 2014, this extended dependent coverage will become available for any child under age 26, whether he or she is eligible for other coverage. We expect that HHS will issue additional guidance about this extended coverage.

Temporary Reinsurance Program

The federal government is establishing a temporary reinsurance program to help plans that provide early retiree health benefits for participants between the ages of 55 and 64 (pre-Medicare retirees). Group health plans will be able to request reimbursement from the reinsurance program to cover up to 80% of claims between \$15,000 and \$90,000 related to coverage of early retirees. The reinsurance can only be used to reduce costs under the plan. It will be available beginning 90 days after enactment (June 2010) and only until the \$5 billion fund is exhausted or December 31, 2013, whichever comes first. We expect HHS to issue regulations for the reinsurance program, and anticipate a process that resembles that for the current Medicare Part D Retiree Drug Subsidy (RDS). Annual conference plans that cover pre-Medicare retirees could benefit significantly from the reinsurance.

Rebates for the Part D “Donut Hole”

Effective immediately, the Medicare Part D initial coverage limit is increased by \$500 to reduce the donut hole (coverage gap)—all Medicare Part D enrollees who enter the donut hole will receive a \$250 rebate from the federal government. Currently, the donut hole falls between \$2,700 and \$6,154 in total drug costs. We expect HHS to issue guidance about whether this rebate will impact the actuarial calculations of employers in qualifying for the 2010 RDS. Annual conferences that participate in the RDS should review this with their vendors or actuaries.

Preventive Health Services Covered

All new group health plans must provide first dollar coverage for certain preventive services. We expect that HHS will issue regulatory guidance on this subject.

Insurance Company Reforms

The Acts make the following changes to individual insurance market practices, which may benefit Church workers who do not have coverage through their annual conference or employer.

Immediate Access to Insurance for Uninsured Individuals with a Pre-Existing Condition

Eligible individuals who do not have other coverage and cannot obtain individual coverage will have access to coverage through a federal high-risk pool that does not impose any coverage exclusions for pre-existing health conditions. This provision will end in 2014, when the exchanges (explained below) become operational.

Pre-Existing Condition Exclusions for Children Ends

Health insurance companies in the individual market will be prohibited from imposing pre-existing condition exclusions on coverage for children under age 19.

Rescissions

Health insurance companies will be prohibited from rescinding existing health insurance policies when a covered person becomes sick.

Medicaid Flexibility for States

States will be allowed to expand Medicaid programs—and receive federal assistance for the expanded coverage—to cover parents and childless adults with incomes up to 133% of the Federal Poverty Level (FPL) (approximately \$14,400 in 2010).

2011

Filling the Part D “Donut Hole”

Medicare Part D beneficiaries will begin receiving a 50% discount on all brand-name drugs in the donut hole. Additional discounts on brand-name and generic drugs will be phased in from 2011 to 2020 to eventually close the donut hole completely by 2020 for all Part D enrollees. By 2020, seniors will pay only the standard 25% coinsurance through the entire coverage gap. As a result, each year it will become more difficult for employer plans that provide drug coverage to retirees to qualify for the RDS. Annual conferences should consult their actuaries and vendors to gauge when they might cease qualifying for the RDS and begin preparing for either increased costs to continue to provide drug coverage or migrating retirees to Part D plans.

Health Coverage Costs Reported on W-2 Forms

Employers will be required to disclose the value of providing employee health care coverage on each employee’s annual Form W-2 (the value of coverage remains tax-free). Annual conferences and all Church employers will have to begin providing this information to employees for whom they issue W-2s.

Definition of Qualified Medical Expenses Standardized

The definition of “qualified medical expenses” will be conformed for health savings accounts (HSAs), flexible spending accounts (FSAs), and health reimbursement arrangements (HRAs) to the definition used for the itemized deduction. This means that over-the-counter drugs will no longer be eligible for reimbursement from any of these accounts. An exception will remain so that amounts paid for over-the-counter medicine with a prescription would still qualify as “reimbursable medical expenses.”

Medicare Advantage Payments Changed

Payments to Medicare Advantage (MA) plans by the federal government will be frozen at 2010 levels. MA benchmarks will continue to be reduced in subsequent years relative to current levels. This may result in increased costs (higher premiums or out-of-pocket costs) for retirees in MA plans.

Cafeteria Plan Changes

A new Simple Cafeteria Plan will be established to provide a vehicle through which small employers can provide tax-free benefits to their employees. This may ease small employers' administrative burdens in sponsoring a cafeteria plan. Small churches may consider adopting Simple Cafeteria Plans that are easy to administer for the benefit of their employees.

2013

Limit on FSA Contributions

Contributions to health FSAs will be limited to \$2,500 per year, indexed to inflation for subsequent years. Annual conferences and other Church employers will need to amend their cafeteria plans to account for this limit. They will also need to communicate the changes to participants in 2012 before 2013 elections. Moreover, conferences may need to consider how this will impact their plan designs with respect to out-of-pocket costs for participants.

Uniform Summary of Benefits

HHS will provide the uniform standards for benefits by March 23, 2011; plans will have to provide a uniform summary of benefits to participants by March 23, 2012. Plans will have to notify participants of material modifications to plan benefits at least 60 days in advance.

Reporting Requirements

Employers will have to report to the Secretary of Treasury each year certifying whether coverage is offered to full-time employees, the waiting period for any such coverage, the number of full-time employees during each month, and the name, address and Social Security number of each full-time employee.

Employer Part D Subsidy Tax Deduction Ends

The tax deduction will be eliminated for the RDS subsidy for employers that maintain prescription drug plans for their Medicare Part D eligible retirees. Losing the tax-exempt benefit to the RDS may lead many corporate employers to terminate drug coverage for their retirees (sending their retirees to Part D). Though this will not directly impact the tax-exempt organizations in the Church, it may increase costs for prescription drug plans through medical vendors and pharmacy benefit managers (PBM), as their books of business shrink. It may also increase costs that PBMs charge for administration of the RDS.

Itemized Deduction for Medical Expenses Threshold Increases

The income threshold for claiming the itemized deduction for medical expenses will increase from 7.5% to 10% of adjusted gross income. Individuals over 65 will be able to claim the itemized deduction for medical expenses at 7.5% of adjusted gross income through 2016. This change may impact some clergy and retirees who pay for coverage out-of-pocket, or who pay for their own supplemental plan premiums.

Hospital Insurance Tax for High Earners

The hospital insurance (HI) tax rate (the Medicare portion of FICA; currently 1.45% of income) will increase by 0.9% (to 2.35%) for taxpayers earning over \$200,000 (\$250,000 for married couples filing jointly, on wages in excess of these thresholds). The HI tax rate will remain 1.45% for other taxpayers. Moreover, unearned income (e.g., dividends, interest, royalties, etc.) in the case of taxpayers earning over \$200,000 (\$250,000 for joint returns) will be subject to a 3.8% HI tax.

2014

New Health Insurance Regulations

Insurance companies in the individual market will be prohibited from refusing to sell or renew policies due to an individual's health status, or excluding coverage for pre-existing health conditions. Insurance companies will be restricted in the amount they can vary premium rates due to health status, gender or other factors. Premiums will be allowed to vary based only on age (by no more than 3 to 1), geography, family size and tobacco use.

Health Insurance Exchanges

Each state (or states together) will open a Health Insurance Exchange where individuals (who do not have employer or government coverage) and small employers can comparison shop among an array of standardized health plans. The Exchanges will facilitate enrollment and administer tax credits (affordability subsidies) so that people of all incomes can obtain affordable coverage. Depending upon application of certain tax regulations and possibly decisions by the denomination and annual conferences, clergy and local church employees might begin seeking coverage on the Exchanges.

Individual Mandate

All individuals will be required to obtain acceptable health insurance coverage (from an employer, an Exchange, Medicare or Medicaid) or else pay an excise tax equal to the greater of \$95 or 1% of income in 2014; \$325 or 2% of income in 2015; \$695 or 2.5% of income in 2016. Families will pay half the amount for uncovered children, up to a maximum of \$2,250 per family. After 2016, dollar amounts are indexed to inflation. A few exceptions will be made for religious objection and hardship.

Health Care Affordability Tax Credits

Premium tax credits will become available through the Exchange to ensure individuals can obtain affordable coverage. Credits will be available on a sliding scale for people with incomes below 400% of FPL (approximately \$43,000 for an individual; \$88,000 for a family of four) who are not eligible for employer or government coverage. (The 2010 Denominational Average Compensation (DAC) is roughly \$60,000.) The credits apply to both premiums and cost-sharing (deductibles and coinsurance) to ensure that out-of-pocket expenses are capped for low-and middle-income families. If clergypersons become eligible for the Exchanges, the health care tax credits would likely be available to a significant number of them. However, this may make annual conference plans appear expensive in comparison.

Employer Penalties

Employers with 50 or more employees that do not provide coverage will be required to pay \$2,000 annually (indexed to inflation) for each full-time employee (employers may subtract the first 30 employees) if even one of their employees receives a health care tax credit. This is called a "free-rider penalty." Employers that offer coverage, but whose employees receive tax credits because the coverage is unaffordable to the employees (i.e., the portion the employee pays exceeds 9.8% of household income) must pay \$3,000 for each worker receiving a tax credit (limited to an amount equal to \$2,000 times the total number of full-time employees, i.e., what the employer would pay for not offering coverage at all).

Small employers (those with fewer than 50 employees) are exempt from these penalties. Whether small local churches will be exempt from these penalties, and whether they will apply to the annual conference, is unclear and could affect annual conference coverage. If these penalties were applied to the denomination or annual conferences based on the actions of local churches, it could have a significant impact on the Church.

Free Choice Vouchers

If an employer plan requires an employee to pay a share of the coverage that exceeds 8% of household income but is not greater than 9.8%, and the employee's household income is no greater than 400% of FPL, the employer must offer the employee a "free-choice voucher." This is a tax-free voucher equal to the employer contribution for coverage under its health plan; the employee can use this money to purchase coverage on an Exchange (and keep the remainder if a less expensive plan is purchased). The employer will not incur a free-rider penalty for employees receiving free-choice vouchers. This provision could have an impact on annual conference plans, given the income thresholds for free choice voucher eligibility.

Wellness Incentives

The limit on wellness program incentives under HIPAA will increase from 20% to 30% of total cost of coverage.

Medicaid Eligibility Increases

Medicaid eligibility will expand to 133% of FPL in all states for all non-elderly individuals. States will receive increased federal funding to cover these new populations.

Small Business Tax Credit

The small business tax credit for qualified small employers will continue, but only for small employers that provide coverage to their employees through the Exchanges.

2018

Excise Tax on High-Cost Plans Begins—Cadillac Plan Tax

Health coverage that exceeds a certain value (based on the total premium), \$10,200 for an individual or \$27,500 for a family will be subject to an excise tax, frequently called the "Cadillac Plan Tax." These amounts are increased to \$11,850 (individual) and \$30,950 (family) for retirees and certain employees in high-risk professions. The dollar thresholds are indexed to inflation. Vision and dental coverage is excluded from the cost calculation. And, importantly for annual conference plans, plans with higher-than-average costs, because of the age or gender demographics of their participants, may adjust the value of their coverage using the age and gender demographics of a national risk pool. Though the Cadillac Plan Tax remains a concern for annual conference plans, the adjustments made to the tax in the Reconciliation Act substantially postpone and partially alleviate the adverse impact of the tax on church health plans.

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