



Updated April 30, 2010

## Health Care Reform 2010—An Overview

The health care reform legislation signed into law March 23, 2010 contains significant changes that will affect clergy, churches, annual conferences and lay employees of The United Methodist Church. The General Board of Pension and Health Benefits (General Board) prepared this overview of the key features of the legislation, summarized below.

### The Legislation (the “Acts”)

There are two “Acts” under health care reform legislation:

- Patient Protection and Affordable Care Act (PPACA)
- Health Care and Education Affordability Reconciliation Act of 2010 (the “sidecar reconciliation bill”)

### Health Care Reform Legislation—Overall Objectives

- Expand health care coverage to more Americans, including 30 million currently uninsured adults and children.
- Ban insurers from denying insurance for people with pre-existing conditions or from dropping coverage for people who become ill.
- Make health care services more affordable for most Americans.
- Improve the overall quality of health care services.
- Require most Americans to have health insurance.
- Require employers with 50 or more employees to provide coverage.

### Timeline

The Acts’ provisions will be implemented through a *phased timeline*, 2010 through 2018.

### Health Care Reform Legislation—Key Provisions

#### Early Changes—2010-2011

- **Lifetime Limits and Annual Limits**—Prohibits lifetime limits and unreasonably restrictive annual limits on health insurance benefits.
- **Extension of Dependent Care Coverage**—Extends dependent coverage for children until age 26, for individuals not eligible for other coverage. (In 2014, extended dependent coverage becomes available for any child younger than age 26, even if he or she is eligible for other coverage.)
- **Pre-Existing Conditions Limits**—Prohibits denying coverage for children with pre-existing medical conditions.
- **Rebates for Part D “Donut Hole” in 2010 and 2011**—Begins to address gap in current Medicare Part D coverage for drug costs and discounts brand-name drugs for people covered by Medicare Part D.
- **Over-the-Counter Drugs Excluded from Flexible Spending Accounts**—Excludes non-prescribed over-the-counter drug reimbursement from flexible spending accounts (FSAs), health savings accounts (HSAs) and health reimbursement arrangements (HRAs).

**Small Business Tax Credit**—Provides a tax credit for qualified small employers (25 or fewer employees). May benefit small churches that pay for health insurance coverage of clergy and lay employees.

- **Temporary Reinsurance Program**—Establishes a new program to help employer plans providing health benefits for pre-Medicare retirees (ages 55 to 64).
- **Reporting Health Coverage Costs**—Requires employers (including annual conferences and other church employers) to disclose the dollar value of health coverage on employee W-2 statements.
- **Medicare Advantage Payment Changes**—Freezes the federal government’s payments to Medicare Advantage (MA) plans at 2010 levels. Retirees in MA plans may face higher out-of-pocket or premium costs.

### **Later Impacts—2013-2018**

- **Reduces the amount individuals can contribute to health FSAs** (\$2,500 limit).
- **Raises the threshold for itemized tax deductions for medical expenses** (from 7.5% to 10%).
- **Increases the Medicare tax rate for taxpayers earning more than \$200,000** (or \$250,000 for those married, filing jointly).
- **Bans insurance companies from refusing coverage or charging higher premiums** based on a person’s health status or pre-existing condition.
- **Establishes state-level health insurance exchanges** to make health coverage more affordable for individuals and small employers. Some clergy and local church employees may eventually seek coverage through exchanges.
- **Mandates individuals to obtain health insurance coverage** through an employer, exchange, Medicare or Medicaid—or pay an excise tax.
- **Offers tax credits** aimed at making coverage affordable for individuals with incomes below 400% of the federal poverty level (approximately \$43,000 for an individual or \$88,000 for a family of four).
- **Penalizes employers**, if they have 50 or more employees, that don’t provide health coverage at all or that offer health coverage that is unaffordable to employees.
- **Imposes excise tax** on high-cost “Cadillac” health plans.

### **General Board Involvement**

The General Board closely monitors government activities related to health care legislation and will continue to update participants and plan sponsors on any new developments.

Additionally, the General Board is working with other church benefit plans through the regulatory process to reduce the new legislation’s uncertainty for plan sponsors and participants in church health plans.

**Read more** about the health care reform legislation, provisions, timeline, and the potential impact on clergy and employees of The United Methodist Church.

### **Questions?**

Contact the General Board at [healthcarereform@gbophb.org](mailto: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 health insurance coverage of their lay employees (or possibly clergy not covered through an annual conference plan) may benefit from this tax credit. Only premiums paid for health insurance from a state-licensed insurer are eligible for this 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. This tax credit is of limited duration; from 2010 to 2013 for health insurance coverage, and from 2014 to 2016 for exchange coverage.

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#### **Lifetime Limits and Annual Limits**

Group health plans are now prohibited from imposing lifetime limits on essential health insurance 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.

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#### **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. Moreover, many plans are taking interim steps to prevent young adults from losing coverage in 2010.

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#### **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 23, 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.

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### **Rebates for the Part D “Donut Hole”**

Effective immediately, 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.

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### **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.

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### **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 later in this document) become operational.

#### ***Pre-Existing Condition Exclusions for Children Ends***

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

#### ***Rescissions***

Health insurance companies and group health plans 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).

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## **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 the Part D benefit will become more valuable. Employer plans that provide drug coverage to retirees and qualify for the RDS may consider shifting retirees to Part D plans. Annual conferences should consult their actuaries and vendors to gauge when they might cease qualifying for the RDS.

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### **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.

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### **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.”

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### **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.

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### **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.

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## **2012**

### **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.

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## **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.

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### **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.

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### **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 (PBMs), as their books of business shrink. It may also increase costs that PBMs charge for administration of the RDS.

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### **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.

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### **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.

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## **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.

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### **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.

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### **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.

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### **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.

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## **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.

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## ***The New Paradigm***

Combining the effects of the Health Insurance Exchanges, Individual Mandate, Health Care Affordability Tax Credits and Employer Penalties (each explained above), after 2014 local churches in The United Methodist Church will be facing an uncertain environment relating to health care coverage for clergy and lay employees. Most local churches would be considered small employers (depending on application of certain provisions of the tax code), exempt from penalties for not providing employer coverage. If the clergy and employees of those local churches instead seek coverage on the Exchanges, many of them will be eligible for significant federal subsidies and tax credits (given the generally modest pay of church employees and the fact that the income thresholds appear to be tied to modified adjusted gross income, which would exclude housing allowance for clergy). Churches could then offer to cover the small difference in cost between Exchange coverage and the federal subsidies, potentially substantially reducing the burden of health care coverage costs in the denomination.

## **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.

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## **Wellness Incentives**

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

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## **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.

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## **Small Business Tax Credit**

The small business tax credit for qualified small employers will continue until 2016, but only for small employers that provide coverage to their employees through the Exchanges.

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**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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*This update is provided by the General Board of Pension and Health Benefits as a general informational and educational service to its plan sponsors, the annual conferences, plan participants and friends across The United Methodist Church. It should not be construed as, and does not constitute, legal advice nor accounting, tax, or other professional advice or services on any specific matter, nor does this message create an attorney-client relationship. Readers should consult with their counsel or other professional advisor before acting on any information contained in this publication.*

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