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Health Care Reform and HealthFlex

Introduction

The recently enacted federal health care reform legislation will affect HealthFlex, and the clergy and lay employees it covers. On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA), and on March 30, 2010, he signed the Health Care and Education Affordability Reconciliation Act of 2010 (“Reconciliation Act”), which amends certain provisions of PPACA (referred to together as the “Acts”).

On March 30, 2010, the General Board of Pension and Health Benefits (General Board) released an *On Board Express*, which contained a Health Care Reform Highlights and Summary document (www.gbophb.org/health_welfare/healthcarereform/index.asp) highlighting the potential impacts of the Acts on the denomination’s health plans and providing a timeline and analysis of the major provisions. Although this document contains some of the same information, it will inform you of what the General Board is doing to adapt HealthFlex (the “Plan”) to the early changes under the Acts, and to prepare for the Acts’ broader impact over time.

How the Acts Apply to HealthFlex

The General Board is reviewing the Acts to determine their full impact on HealthFlex; however, based on our preliminary review, some of the primary changes are highlighted below.

I. 2010 Changes

A. Temporary Reinsurance Program

The federal government has established 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 (up to \$60,000 per retiree). The program is effective June 1, 2010 and the application is expected to become available in mid- to late June. The program has only \$5 billion in funding, which—once exhausted—will end the program. Read more about the [temporary reinsurance program](#).

HealthFlex: The U.S. Department of Health and Human Services (HHS) has issued interim final regulations about the temporary reinsurance program. The application process is similar to the process used for the current Medicare Part D Retiree Drug Subsidy (RDS). The General Board intends to submit an application under the program seeking reinsurance funds on behalf of the Plan and eligible plan sponsors.

B. Rebates for the Part D “Donut Hole”

Effective immediately, Medicare Part D enrollees who enter the donut hole will receive a \$250 rebate from the federal government.

HealthFlex: It does not appear that this rebate will impact HealthFlex or the 2010 RDS.

C. Small Business Tax Credit

Qualified small, nonprofit employers with 25 or fewer employees, like many local churches, may be eligible for a tax credit for up to 25% of their contributions to purchase health insurance for employees. The credit is applied as an offset to the small, nonprofit employer’s portion of payroll (FICA) taxes for its employees. Without regulatory guidance to the contrary, it appears that only premiums paid for health insurance from a state-licensed insurer are eligible for the credit—not coverage in a self-funded plan. The tax credit may be of limited benefit to small churches; often a small church’s payroll is primarily the salary of the clergy person and, for payroll tax purposes (FICA/SECA), a clergy person is considered self-employed. This tax credit is of limited duration; from 2010 to 2013 for health insurance coverage, and from 2014 to 2016 for exchange coverage.

HealthFlex: We have created a **preliminary analysis** to help United Methodist annual conferences better understand this tax credit.

II. 2011 Changes

The Acts will require HealthFlex to make several changes effective January 1, 2011. Those changes include:

A. Extended Dependent Coverage

Plans that cover dependent children will make that coverage available for children of participants until those children reach age 26 (regardless of student status, tax-dependent status, marital status, and whether or not the older children reside with the participant), if those older children are not eligible for other coverage. In addition, even if the older child/young adult is no longer a tax dependent, such coverage will be considered a tax-free benefit. In 2014, this extended dependent coverage will become available for any child younger than age 26, whether or not he or she is eligible for other employer-provided coverage. HHS has issued **regulatory guidance** about this provision.

HealthFlex: We will implement the change and update necessary processes and communications. HealthFlex has implemented a **bridge policy** in the interim to prevent young adults covered in the Plan from losing coverage in 2010.

B. Pre-Existing Condition Exclusions for Children

HealthFlex will no longer impose any pre-existing condition exclusions on coverage for children younger than age 19. In 2014, HealthFlex will no longer impose pre-existing condition exclusions on anyone enrolled in the Plan.

HealthFlex: We will implement this change and update necessary processes and communications.

C. Lifetime Limits and Annual Limits

HealthFlex will eliminate lifetime limits on essential health insurance benefits. In addition, the Plan will modify annual limits as required under the Acts, after reviewing regulatory guidance expected from HHS that will set standards for annual limits on benefits.

HealthFlex: We will implement this change and update necessary processes and communications.

We do not anticipate that these changes in 2011 will affect 2012 premium rates; however, we are fully evaluating their potential impact.

III. 2011 Changes

A. Over-the-Counter Drugs No Longer FSA-Qualified

Health flexible spending accounts (FSA) will no longer reimburse participants for over-the-counter drugs. An exception will remain so that amounts paid for over-the-counter medicine with a prescription will still qualify for reimbursement.

HealthFlex: We will implement this change to the HealthFlex health FSA—the medical reimbursement account (MRA)—and update necessary processes and communications.

IV. 2012 Changes

A. Uniform Summary of Benefits

Based on the uniform standards HHS issues by March 23, 2011, plans must begin providing participants a *uniform summary of benefits* on or before March 23, 2012. Plans will have to begin notifying participants of material modifications to benefits at least 60 days in advance.

HealthFlex: We will implement this change and update necessary processes and communications.

V. 2013 Changes

A. Limit on FSA Contributions

Contributions to health FSAs will be limited to \$2,500 per year, indexed to inflation for subsequent years.

HealthFlex: We will implement this change and update necessary processes and communications. We will communicate this change to participants in 2012 before 2013 annual elections. At this time, HealthFlex does not anticipate this being a prohibitive change to its consumer-driven health plan (CDHP) designs, but we will analyze it further as this deadline approaches. The change does not affect the annual limit on the dependent care flexible spending account (DCA), which will remain \$5,000.

V. Other Considerations (Intermediate and Long-Term)

A. The Acts Fill the Part D Donut Hole

Part D beneficiaries will begin receiving a 50% discount on all brand-name drugs while 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. By 2020, seniors will pay only the standard 25% coinsurance through the entire coverage gap. This will increase the value of the Part D benefit over time.

HealthFlex: 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. We will work closely with Mercer to determine the point at which the Plan might cease to qualify for the RDS. We also will investigate possible strategies to account for this impact on retiree drug coverage.

B. New System of Insurance

The more system-changing provisions of the Acts come into effect in 2014, such as the establishment of the state insurance exchanges (Exchanges), individual affordability subsidies and employer penalties. Combining the effects of the Exchanges, the individual mandate to be covered, individual affordability credits and subsidies, and employer penalties (**each explained here**) after 2014 local churches in The United Methodist Church will face an uncertain environment relating to health care coverage for clergy and lay employees. Many local churches would be considered small employers (depending on application of certain provisions of the tax code), exempt from penalties for not providing employer health 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 the housing allowance for clergy.) Churches could then offer to cover the small difference in cost between the Exchange coverage and the federal subsidies, potentially reducing the burden of health care coverage costs in the denomination substantially.

HealthFlex: We will begin working with plan sponsors to prepare for the potential consequences of these major changes.

General Conference 2012 may have to consider legislation that either clarifies the nature of health plans in the denomination or allows each annual conference to make certain determinations with respect to its health plan as a result of the Acts.

C. Consumer-Driven Health Plans

The Acts do not eliminate consumer-driven health plans (CDHP). They permit high-deductible health plans (HDHP), health reimbursement arrangements (HRA) and health savings accounts (HSA) to continue (subject to some limits).

HealthFlex: We intend to continue efforts to administer a CDHP with an HRA as a plan option for plan sponsors. We will carefully assess the potential impacts of the Acts on these plans as HHS and the Internal Revenue Service issue regulations and guidance under the Acts.

VI. Participant Communications

We will begin communicating directly with participants about the meaning and effects of the Acts. We will post some educational materials on the General Board Web site. Additionally, we plan to create educational documents and tools for plan sponsors to use to help their participants understand the impact of health care reform legislation.

If you have questions regarding the impact of health care reform on HealthFlex, please contact us at healthcarereform@gbophb.org.

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