



January 28, 2013

Health Care Reform: What Annual Conferences Can Expect in 2013-2014

Enacted in March 2010, the federal Patient Protection and Affordable Care Act (PPACA or ACA) health care reform legislation contains consumer-friendly provisions intended to make health care coverage more accessible and affordable for most Americans. The ACA is implemented on a phased schedule through 2020, with the first wave of changes already implemented in 2010–12.

The PPACA will have its biggest impact in 2014, when the “individual mandate” begins, pre-existing condition exclusions for adults end, and federal subsidies in the form of premium-assistance tax credits (PTCs) help cover millions of uninsured Americans. The U.S. Supreme Court upheld the ACA in June 2012, and the outcome of the November 2012 presidential and congressional election removed the political uncertainty that remained about the ACA. Barring any changes to the ACA as part of a “grand bargain” in Congress to reduce the nation’s fiscal deficits, ACA provisions will be implemented as designed. This summary provides an overview of upcoming reforms and key events in 2013 and a preview of some of the changes in 2014.

December 2012–February 2013 States’ Decisions about Exchanges

Employers such as United Methodist Church annual conferences and local churches should have an understanding of the health insurance exchanges (Exchanges) because their employees may be able to choose to obtain coverage through an Exchange even if the employees have access to employer-sponsored group health plan coverage (depending on the cost of coverage). The Exchanges are required to provide information to prospective enrollees about their eligibility for PTCs (and are likely to request some information from employers to determine such eligibility). The Exchanges are scheduled to begin operation in January 2014, with open enrollment periods beginning October 1, 2013. As described below, employers also will be required to provide a notice explaining the Exchanges to all employees.

Under the ACA, states have the choice of: 1) running their own state-based Exchanges, 2) allowing the federal government to administer the Exchange (a federally-facilitated Exchange), or 3) forming a state-federal partnership Exchange. States had until December 14, 2012 to submit proposals for a state-based Exchange to the U.S. Department of Health and Human Services (HHS). HHS has given conditional approval to 18 states (California, Colorado, Connecticut, Hawaii, Idaho, Iowa, Kentucky, Maryland, Massachusetts, Minnesota, Mississippi, Nevada, New Mexico, New York, Oregon, Rhode Island, Vermont and Washington) and the District of Columbia to operate a state-based Exchange.

Two states—Arkansas and Delaware—have been approved for a state-federal partnership Exchange. Five states—Illinois, Iowa, Michigan, North Carolina and West Virginia—have applied to establish partnership Exchanges. States interested in a partnership exchange have until February 15, 2013 to submit applications to HHS. Any states not having a state-based or state-federal partnership Exchange will default to a federally-facilitated Exchange. At this time, it appears the federally-facilitated Exchange will operate in 25 states: Alabama, Alaska, Arizona, Florida, Georgia, Indiana, Kansas, Louisiana, Maine, Missouri, Montana, Nebraska, New Hampshire, New Jersey, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota,

Tennessee, Texas, Wisconsin, Wyoming and Virginia). A map of the states' Exchange decisions can be found in the Appendix at the end of this document.

There has been some confusion about whether individuals obtaining coverage through a federally-facilitated Exchange will be eligible for PTCs. Some legal scholars have argued that the text of the ACA regarding the PTCs precludes individuals purchasing coverage on federal Exchanges from qualifying for the PTCs. **However, the Internal Revenue Service (IRS) issued regulations governing the PTCs that expressly permit individuals purchasing coverage on federal Exchanges to receive PTCs.** As such, individuals in states with federally-facilitated or partnership Exchanges will be eligible for PTCs if they qualify otherwise. Currently, there is a lawsuit challenging the IRS interpretation of the law; however, it is unclear whether the case is yet ripe for review or whether the state has standing to sue.

January 1, 2013

The following changes took effect January 1, 2013.

Part D Donut Hole Continues Closing. On January 1, 2011, the Medicare Part D coverage gap or “donut hole” began closing through a combination of prescription drug discounts and subsidies from the pharmaceutical companies and federal government. Beginning January 1, 2013, Medicare beneficiaries in the donut hole receive a 50% point-of-service discount on brand-name drugs and now pay only 79% of the cost of generic drugs (down from 86% in 2012). Beneficiaries' cost-share for brand-name and generic drugs through the donut hole will decrease each year until it reaches only 25% in 2020.

Cap on Health FSAs. Starting on January 1, 2013, annual health flexible-spending account (FSA) contributions by employees will be limited to \$2,500. This limit will rise annually to reflect cost-of-living increases. Annual conferences and local churches should have amended their cafeteria plans' operations to limit participant salary-deferral contributions to health FSAs to no more than \$2,500. This \$2,500 limit does not apply to expenses incurred in 2013 but paid from amounts contributed in 2012 when the reimbursement is made pursuant to the IRS' special grace period provision for health FSAs (through March 15, 2013). Health FSAs must operate in accordance with the new \$2,500 limit beginning January 1, 2013, but plan sponsors have until December 31, 2014 to adopt the required written amendments to health FSA documents. You can read more about the FSA contribution limit [here](#).

Summaries of Benefits and Coverage (SBC). A summary of benefits and coverage (SBC) based on a federally provided template must be provided by group health plans, including grandfathered plans, to health plan participants before enrollment and at re-enrollment. While the first SBC should have been provided to participants during open enrollment periods in fall 2012, plan sponsors should be aware that distributing the SBC is not a one-time-only requirement. SBCs need to be distributed annually, whenever material changes are made to coverage, and upon request from covered individuals. By now, annual conferences and local churches with calendar-year plans should have distributed their SBCs as part of the open enrollment process for 2013 (in fall of 2012). You can read more about the SBC requirements [here](#) and [here](#).

Women's Preventive Services. Beginning January 1, 2013 (for calendar-year plans), non-grandfathered plans must cover 100% of in-network women's preventive services. Preventive care services include well-woman visits, screening for gestational diabetes, human papillomavirus (HPV) testing, counseling for sexually transmitted infections and HIV, contraception and sterilization, breastfeeding support and supplies, as well as screening and counseling for interpersonal and domestic violence. The coverage requirement means the plan must pay for the services without subjecting the participant to cost-sharing provisions, e.g., co-payments, deductibles and co-insurance. Plans may impose cost-sharing requirements for services rendered by out-of-network providers. Some of these requirements are subject to delays or exceptions for certain religious employers that have a theological objection to the services, and are also the subject of many ongoing lawsuits. Annual conference plans that are not grandfathered should be covering these services without cost-sharing or other restrictions in 2013. You can read more information about these services [here](#).

Higher Medicare Taxes on Certain High Earners. The ACA established a new “Additional Medicare Tax” of 0.9% effective January 1, 2013. The Additional Medicare Tax applies to single individuals earning over \$200,000 and married couples filing jointly who earn over \$250,000. However, employers must withhold the Additional Medicare Tax from all workers on wages exceeding \$200,000, regardless of marital status. Thus, the employee Medicare tax rate (normally 1.45%) will rise to 2.35% on earnings exceeding \$200,000. The employer share of the Medicare tax remains 1.45%. In addition to the 0.9% increase to the existing Medicare payroll tax discussed above, there is a new, non-payroll Medicare tax effective January 1, 2013. This new Medicare tax of 3.8% applies to the lesser of: 1) net investment income, or 2) the excess of modified adjusted gross income (MAGI) over \$200,000 (\$250,000 for joint filers). Net investment income does not include, for example, tax-exempt interest or distributions from tax qualified plans. Questions and answers from the IRS about these taxes can be found [here](#) and [here](#).

January 31, 2013

W-2 Reporting. The ACA requires employers to report the cost of employer-provided group health plan coverage on employees’ *Forms W-2*, starting with the *Forms W-2* issued for calendar year 2012 (generally provided to employees on or before January 31, 2013). This information reporting is intended to help employees understand the value of their employer-provided health coverage.

However, based on IRS guidance in *Notice 2012-9*, employers that issued fewer than 250 *Forms W-2* for the 2011 calendar year (i.e., small employers) and employers providing coverage through a self-insured (self-funded) health plan that is not subject to federal COBRA continuation coverage requirements (i.e., self-funded church plans like HealthFlex or a typical annual conference plan) **are currently temporarily exempt** from the requirement to report the cost of group health plan coverage on the 2012 tax year *Forms W-2* furnished to employees in January 2013. Although this exemption is temporary, the earliest that small employers in general and employers in self-funded church plans could be required to begin reporting the value of employees’ health coverage on *Forms W-2* is January 2014 (for the 2013 tax year). The IRS will issue advanced notice of the end of this exemption. The *Form W-2* reporting requirement is discussed in greater detail [here](#).

March 1, 2013

Notice of Exchange Eligibility. The ACA amended the Fair Labor Standards Act (FLSA) to require that employers provide all current employees and subsequent new hires with a written notice of the existence of the Exchange in their state (“Exchange Notice”). The Exchange Notice must provide certain details regarding the Exchange, including:

- Description of the services provided by the state or federal Exchange
- How an employee may be eligible for a PTC if his or her employer’s group health plan does not meet certain requirements (i.e., covering minimum value and being affordable)
- Tax and financial consequences that an employee may experience if he or she purchases a qualified health plan (QHP) through the Exchange
- Contact information for customer service resources within the Exchange

The Department of Labor (DOL) is expected to issue a model Exchange Notice. Once guidance (likely including a model notice) is issued, annual conferences and local churches will need to determine the best way to distribute the notice. On January 23, 2013, the Department of Labor, HHS and the IRS officially **postponed the March 1 deadline**. You can read more about this [here](#).

April 2013

Counting Full-Time Employees. The IRS has issued a proposed rule about the employer shared responsibility rule (the “pay or play” rule or Employer Mandate) under the ACA that describes a number of safe harbors related to determining when employees are treated as full-time employees (FTEs). The proposed rule allows employers to use up to a 12-month initial measurement period to determine whether a new variable-hour or seasonal employee completes an average of 30 hours of service per week or more (and, as a result, is treated as a full-time employee under the ACA). The measurement period then applies for a follow-up stability period of the same length of time (up to 12 months). The proposed rule allows a shorter measurement period, e.g., six months, to be used only in 2013 to determine full-time employees for up to a 12-month stability period in 2014. As a result, employers may want to begin tracking and measuring hours for variable hour (i.e., part-time) and seasonal employees as early as April 2013. The General Board of Pension and Health Benefits (General Board) will publish more information about the Employer Mandate soon on its [health care reform web page](#).

May 15, 2013

Small Business Health Care Tax Credit. May 15, 2013 is the deadline for eligible United Methodist small employers to submit the applicable tax forms for the Small Business Health Care Tax Credit (Tax Credit) for the 2012 Tax Year. The Tax Credit will continue to be available for eligible small employers, including those in self-funded and fully-insured church plans like many local United Methodist churches, through December 31, 2013 (the 2013 Tax Credit would be claimed on tax forms before May 15, 2014). The Tax Credit provides a credit worth up to 25% of a tax-exempt employer’s contribution to the employees’ health insurance. For more information about the Tax Credit in 2013 (for the 2012 Tax Year), please review the series of **Small Business Health Care Tax Credit articles** on the General Board [health care reform web page](#).

July 31, 2013

Comparative Effectiveness Fee. For plan years that end after September 30, 2012 (December 31, 2013 for calendar-year plans), insured and self-insured group health plans will have to pay fees to fund the federal Patient-Centered Outcomes Research Institute (PCORI). The PCORI is tasked with conducting research to evaluate and compare health outcomes, as well as clinical effectiveness, risk and benefits of medical strategies that treat, manage, diagnose or prevent illness or injury. This outcomes research is intended to assist patients, clinicians, plans and policymakers in making informed health decisions. The first year’s PCORI Fee (paid in 2013 for the 2012 plan year) will be \$1 multiplied by the average number of covered lives under a health plan. The fee amount will increase each year thereafter until the PCORI Fee ceases in 2019. The IRS recently issued a **final rule** regarding the PCORI Fee, including how plans should calculate and pay the fee.

For calendar-year self-insured plans, the first payment will be due by July 31, 2013. Self-funded plans will need to pay the PCORI Fee for 2012 using IRS *Form 720* by July 31, 2013. The General Board will publish more information about the PCORI Fee soon on its [health care reform web page](#).

October 1, 2013

Open Enrollment Begins for Exchanges. The initial open enrollment period for Exchanges will be October 1, 2013 through February 28, 2014. Thereafter, the Exchanges must provide an annual open enrollment period from October 15 through December 7. Individuals would be able to enroll outside of this annual opportunity only if they qualify for special enrollment under circumstances similar to HIPAA (e.g., loss of other coverage, marriage, birth, becoming eligible for a PTC, or becoming a citizen or legal resident).

January 1, 2014

Individual Mandate. Individuals will be required to obtain health insurance coverage (“minimum essential coverage”) through an employer plan, Medicare, Medicaid or an Exchange. Those who choose to not obtain health insurance coverage will pay a penalty to help offset the costs of caring for the uninsured. The penalty associated with the individual mandate was challenged through high-profile litigation, yet was upheld by the Supreme Court as a tax. Read more about the ruling [here](#).

Insurance Market Reforms. New rules end discrimination in health insurance coverage (Exchange coverage and non-Exchange individual market coverage) due to pre-existing conditions, health claims, health status or gender. This means that insurers will no longer be allowed to deny or cancel health coverage to individuals due to pre-existing conditions, previous health claims, health status or gender. Further, insurers in the Exchanges and the non-Exchange individual and small group markets may only vary premiums with respect to age (at most by 3 to 1), tobacco use (1.5 to 1), geography (to account for regional medical cost differences) and family size. Beyond these defined limits, insurers will not be allowed to charge extensively higher premiums for “higher-risk” individuals than they charge their general insured population. Insurers would be required to maintain a single statewide risk pool for each of the individual and small-group markets, reflecting a drive toward pricing standardization. Insurers would also be required to report and justify premium increases to HHS.

Expanded Medicaid. Individuals who earn less than 133% of the federal poverty level (FPL)—approximately \$15,300 for an individual or \$31,200 for a family of four in 2013—will be eligible for Medicaid in states that opt to expand Medicaid under the ACA. Some states have indicated that they will not expand Medicaid but will retain their traditional Medicaid eligibility rules set by each state. State-based eligibility rules tend to be significantly more modest than 133% of FPL and sometimes exclude childless adults. In states that opt not to expand Medicaid, individuals with household incomes that are greater than the state’s Medicaid eligibility threshold but below 100% of FPL (the minimum threshold for PTC eligibility) could be without access to affordable health coverage.

Affordable Insurance Exchanges. Exchanges are new transparent and competitive insurance marketplaces where individuals can purchase qualified health plans (QHPs). Certain individuals purchasing QHP coverage through an Exchange, i.e., those whose household income is between 100% and 400% of FPL, will receive PTCs to make the QHP coverage more affordable. Eligible small businesses will also be able to purchase coverage for their employees through the Exchanges, through what are called the Small Business Health Options Program (SHOP) Exchanges within each state or federal Exchange. Notably, employees covered in an Exchange plan through a SHOP are not eligible for PTCs, yet the small business may be eligible for the Small Business Health Care Tax Credit.

Affordability Premium Assistance Tax Credits. PTCs will make it easier for the middle class to afford insurance. PTCs will become available for people with household income between 100% and 400% of FPL who are not eligible for other forms of “affordable coverage” (such as employer-provided coverage, Medicare or Medicaid). In 2014, 400% of FPL is estimated at \$46,000 for an individual or \$95,000 for a family of four. PTCs may be paid in advance through the Exchange (or claimed later on an individual’s tax return) and assigned (paid directly to the chosen Exchange plan) to reduce the individual’s monthly out-of-pocket premium payments. PTCs are also fully refundable, meaning a PTC can exceed an individual’s owed federal income tax, so even lower-income families can receive the full credit. Household income used to determine this is modified adjusted gross income (MAGI), calculated basically by adding tax-exempt interest income, certain foreign income, and tax-free Social Security benefits to adjusted gross income (AGI), which is usually found on the last line of the first page of an individual’s tax return. For clergy, the housing exclusion or allowance reduces the individual’s MAGI; for all employees, certain pre-tax salary reductions [for example, deferrals to a 401(k) or 403(b) retirement plan] can effectively reduce individuals’ MAGI.

Increased Small Business Health Care Tax Credit. The second phase of the Tax Credit pays up to 35% of a tax-exempt employer’s contribution to employees’ health insurance. The Tax Credit will apply only to Exchange-purchased coverage through the SHOP Exchanges. See the General Board’s [health care reform web page](#) for several articles about the Small Business Health Care Tax Credit.

Employer Mandate (“Pay or Play” Rule). Employers with 50 or more full-time equivalent employees that do not provide adequate (minimum value) and affordable health coverage will face “shared responsibility” penalties (\$2,000 per employee if no coverage is provided, or \$3,000 per employee receiving a PTC for inadequate or unaffordable coverage). Recent regulatory guidance included clarification on the Employer Mandate’s definition of “full-time employee,” rules about variable hour and seasonal employees, rules for determining compliance with the mandate’s “minimum value” requirement, and the application of the “controlled group rules” (employer aggregating rules) to tax-exempt employers. The General Board will publish more information for United Methodist plan sponsors about the Employer Mandate soon.

Transitional Reinsurance Program. HHS issued a proposed rule that includes additional details regarding the transitional reinsurance program—a program to help stabilize premiums for Exchange coverage 2014–2016. Funding for the program comes from contributions from insured and self-insured health plans, such as HealthFlex and other annual conference plans. The fee is calculated on a per capita (per covered life) basis, in a manner similar to the PCORI fee described above, and is expected to be approximately \$63 per year per person. The General Board will publish more information about the reinsurance fee soon on its [health care reform web page](#).

Other Provisions in 2014:

- New maximum on eligibility waiting periods in employer health plans—limited to 90-day waiting period
- Complete prohibition on annual dollar limits for “essential health benefits” in insurance plans and employer health plans
- Complete prohibition on pre-existing condition exclusions for all individuals in health insurance plans and employer health plans (pre-existing exclusions for children eliminated in 2011; for adults in 2014)
- Increase in permitted outcome-based wellness incentives for employer health plans—increases from 20% to 30% of total premium or cost
- Employer certification to HHS regarding whether its group health plan provides “minimum value” for purposes of the Employer Mandate

Questions and Information

If you have questions or would like additional information, please send your inquiries to healthcarereform@gbophb.org. General information about health care reform is available from the federal government at www.healthcare.gov.

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