UMC Plan Sponsor ACA Impact Model—A Primer

On June 28, 2012 the U.S. Supreme Court ruled that the Affordable Care Act (ACA, also called the Patient Protection and Affordable Care Act) is constitutional—upholding the law nearly entirely. The ACA will fundamentally change the individual health insurance market in 2014 and will have profound impact on employer health plans, including United Methodist annual conference health plans. This ACA impact primer summarizes—in narrative form—the complex set of rules through which the ACA attempts to create near-universal coverage for all Americans. This Primer also helps explain the companion quantitative model (Model) created by Mercer (Todd Swim and Akira Matsuo) with the aid of and plan data from the General Board of Pension and Health Benefits (General Board). HealthFlex plan sponsors and other annual conferences may use these informational and illustrative tools to help assess the ACA’s impact on their health plans and participants.

I. Mercer Model Assumptions

The Model is based on the ACA provisions as enacted and the regulations issued by the federal agencies (U.S. Department of Health and Human Services, Department of Labor and internal Revenue Service, i.e., the Departments) through July 2012. Some of the regulations are in proposed or interim form. In other cases, the Departments have issued informal guidance to date about certain ACA provisions or requested public comment.

The Model uses compensation information from the General Board, supplemented by some assumptions about spousal income (used to determine household income) established by Mercer and adjusted to sync with household income data resulting from a few Center for Health surveys of segments within the denomination.

*Caveat 1:* For purposes of the employer responsibility provision and determination of access to an affordable employer health plan, the Model assumes that the local church—i.e., the common-law employer—is the “employer” of UMC clergy under the ACA. This assumption is based on reasonable interpretations of current law, regulations, applicable court cases, and the nature of the UMC structure and appointment system.

*Caveat 2:* The applicability of certain portions of the Model will depend on eventual guidance from the Departments about the viability after 2014 of health reimbursement arrangements (HRAs, also called health reimbursement accounts) as stand-alone defined contribution mechanisms or as coupled with individual (Exchange) policies. HRA viability will be determined by the final ACA rules regarding the prohibition on annual limits, definitions of minimum value and minimum essential coverage, and nondiscrimination rules.

*Caveat 3:* Challenges to the ACA will continue on political and legal fronts. Even after the U.S. Supreme Court’s ruling, several legal challenges remain active in lower courts. Although these cases will not directly affect annual conference health plans, the courts’ rulings could affect the ACA’s efficacy. Depending on the outcome of the 2012 presidential and congressional elections, Republican lawmakers, a Romney administration, or both would be expected to move aggressively to eliminate or modify some central provisions of the ACA.
II. New Paradigm in 2014
The ACA includes provisions under which certain low-income individuals may qualify for premium tax credits (PTCs) that assist them with purchasing qualified health plans (QHPs) being offered through state-based health insurance exchanges (Exchanges). PTCs serve two purposes under the ACA:

1. PTCs enable low-income individuals to afford health insurance and comply with the individual mandate; and,
2. PTCs influence employer shared responsibility payments imposed on certain large employers (50 or more employees). Such payments may depend on the number of full-time employees who receive a PTC.

Three complex variables in the ACA impact this Model:

1. PTCs are available to individuals earning more than 100% but less than 400% of the federal poverty level (FPL, approximately $98,000 for a family of four in 2014) who do not have government or employer coverage.
2. Exchanges function as connectors or aggregators of a menu of health insurance plans for individuals and small employers.
3. Employer shared responsibility payments, i.e., the “pay or play” penalties, affect large employers that do not provide affordable health coverage to full-time employees.

Because many UMC clergy and employees have incomes below 400% of the FPL, the Exchange coverage and PTCs may be a cost-effective way for clergy and lay employees at local churches to obtain health coverage.

III. Exchanges
The ACA encourages states to establish health benefit Exchanges by January 1, 2014. Each Exchange must set up a website through which an individual or small business can purchase QHP coverage. QHPs are insured health plans that meet minimum federal standards (covering “essential health benefits”) established under the ACA, as well as the certification standards established by each separate state Exchange. QHPs must provide benefits at various actuarial levels—called bronze (60%), silver (70%), gold (80%) and platinum (90%). Through the Exchanges, individuals will be able to determine whether they are eligible for PTCs, Medicaid\(^1\) or the Children’s Health Insurance Program (CHIP).

Many states (primarily in the south and south-central U.S.) will not have Exchanges ready by 2014. The federal government will administer similar federally-facilitated Exchanges in states that elect not to establish their own Exchange. (See Appendix C for map and status of Exchanges by state.)

The initial open enrollment period for Exchanges will run from **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.

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\(^1\) The ACA expands Medicaid from its current form to cover all individuals with income below 138% of FPL (approximately $16,000 for an individual in 2014). In the pre-ACA structure, certain low-income individuals (including disabled persons, pregnant women and parents of dependent children in most states, as well as other categories of individuals in several more expansive states) can obtain Medicaid coverage when their income is below certain FPL thresholds (roughly 20-70% of FPL, depending on the state). The ACA encouraged states to agree to this expanded Medicaid eligibility (138% of FPL) by penalizing states that did not agree with a loss of all federal Medicaid funding (not just for the expanded coverage but also for basic Medicaid). However, the Supreme Court determined this provision was unconstitutionally coercive on states. States now may refuse this expanded Medicaid program and retain their basic Medicaid funding. Several states have indicated preliminarily that they will decline to expand Medicaid (e.g., Florida, Louisiana and Texas). Several other states are studying the impact before deciding whether to embrace the expansion (e.g., Arkansas, Pennsylvania, Wisconsin and Missouri). This may create regional gaps in ACA coverage, as the PTCs are not available to any individuals with income below 100% of FPL.
[e.g., loss of other minimum essential coverage (MEC); marriage, birth, adoption; becoming eligible for a PTC; or becoming a citizen or legal resident].

QHPs cannot discriminate among consumers based on health status, meaning Exchange coverage is “guaranteed issue” and cannot exclude pre-existing conditions. QHPs can only vary individual rates based upon geographic area, individual or family, age (by no more than 3 to 1) and tobacco use (by no more than 1.5 to 1). QHPs also can have no more than four different types of family composition tiers: individuals, two-adult families, one-adult families with a child or children, and all other families.

IV. Premium Tax Credits

The ACA provides federal subsidies (PTCs) to assist lower and middle income taxpayers to purchase coverage through the Exchanges. To be eligible for a PTC, an individual must have a household income for the taxable year between 100% and 400% of FPL for the individual’s family size. Household income is modified adjusted gross income (MAGI, i.e., total earnings or “adjusted gross income” increased by certain foreign income and tax-exempt interest). Clergy housing allowance is excluded from MAGI. Individuals who are incarcerated or who are not lawfully present in the United States may not enroll in a QHP through an Exchange. These individuals may, however, have family members who are eligible for Exchange coverage.

To qualify for the PTC, an individual also must be enrolled in a QHP through an Exchange and must not be eligible for MEC. MEC includes government-sponsored coverage (e.g., Medicare, Medicaid, CHIP, TRICARE and veterans’ health care). Employer plans also may be MEC, provided that the employee’s share of the premiums is “affordable” and the coverage provides “minimum value” (discussed below). An individual is treated as eligible for MEC if the individual enrolls in an employer plan, even if the coverage does not meet the affordability and minimum value requirements.

Individuals may calculate the PTC when submitting their federal income tax returns, i.e., pay the premium out of pocket and wait for reimbursement through a PTC the following April. Alternatively, individuals can apply for advance payment of PTCs through an Exchange. Exchanges will make advanced determinations of eligibility for individuals seeking PTCs based on information submitted at the time of enrollment. Once an individual qualifies, advanced payments are made monthly to the health insurance issuer of the QHP. Advanced payments must be reconciled at year-end, and individuals will have to repay at least a portion of any premium credit overpayments.

The monthly premium for the second-lowest-cost silver plan offered through an Exchange is the benchmark for computing an individual’s PTC. To determine the PTC amount, an individual must compute the difference between the premium for the benchmark plan and the applicable percentage of the individual’s household income. An individual’s applicable percentage is designated by the ACA as reflected in the table below:

<table>
<thead>
<tr>
<th>Household Income as % of FPL</th>
<th>Applicable PTC Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 133%</td>
<td>2.0%</td>
</tr>
<tr>
<td>At least 133% but less than 150%</td>
<td>3.0% - 4.0%</td>
</tr>
<tr>
<td>At least 150% but less than 200%</td>
<td>4.0% - 6.3%</td>
</tr>
<tr>
<td>At least 200% but less than 250%</td>
<td>6.3% - 8.05%</td>
</tr>
<tr>
<td>At least 250% but less than 300%</td>
<td>8.05% - 9.5%</td>
</tr>
<tr>
<td>At least 300% but less than 400%</td>
<td>9.5%</td>
</tr>
</tbody>
</table>
The applicable percentages may be adjusted after 2014. Individuals are required to pay the difference between the PTC and the premium for the plan they choose (e.g., a gold plan). Individuals choosing gold or platinum plans will also pay out of pocket the premium difference between the silver benchmark plan and their chosen plan.

**Example:**
Assume Jane Doe has household income of $50,353 (275% of the FPL); that she has a family of three; that the second-lowest-cost silver plan has a premium of $12,000 for family coverage; and that Jane qualifies for and enrolls in family coverage.

Jane’s initial applicable percentage is 8.78% (since 275% is halfway between 250% and 300%, Jane’s applicable percentage is halfway between 8.05% and 9.5%). Her PTC is $7,579.01—i.e., the lesser of $12,000 (annual premium for the QHP or $12,000 minus $4,420.99 ($50,353 x 8.78%).

Individuals seeking advanced PTCs will need to provide the necessary information to the Exchange so it can determine eligibility. To determine whether the individual has access to an employer plan MEC, the individual will need to provide to the Exchange:

- Employer contact and identification information, and
- Notice on whether the individual’s employer provides coverage.

**Minimum Value and Affordability**
An individual who is eligible for employer plan coverage may still qualify for the PTC if the plan fails to provide “minimum value.” A plan provides minimum value if the plan’s share of the total allowed costs of benefits provided under the plan is at least 60%.

An individual who is eligible for employer plan coverage may still qualify for the PTC if the plan is not “affordable.” An employer plan is defined as not “affordable” if the employee’s required contribution exceeds 9.5% of his or her household income for the taxable year. (This percentage may be adjusted after 2014.) The “required contribution” for this purpose is the portion of the annual premium that would be paid by the individual for self-only coverage (participant-only).

Earlier proposed PTC regulations would have treated employer coverage as affordable for all family members if the cost of participant-only coverage did not exceed 9.5% of the employee’s household income. This scenario would have disqualified an employee’s family members from receiving PTCs whenever the employee’s contribution for participant-only coverage—regardless of the cost for spouse or dependent coverage—met the “affordable” criteria. However, the final PTC rules eliminate this provision and indicate that future guidance will address how to determine affordability for family members seeking PTCs. Many plan sponsors have reduced costs by keeping participant-only costs relatively low, while pricing family coverage more aggressively. Plan sponsors may need to review this strategy, depending on the final guidance on the PTC.

**Reconciling the Credit and Advanced Credit Payments**
An individual who qualifies for the PTC must reconcile the actual credit for the year with the amount of advanced PTC payments made on his or her behalf. If an individual’s PTC exceeds the amount of the advanced payments for the taxable year, the individual may be eligible for an income tax refund. Conversely, if an individual’s advanced payments exceed the PTC, the individual must repay the overpayment as an additional income tax liability. To help relieve this financial burden, the ACA establishes graduated caps on the additional tax liability for individuals with household income under 400% of the FPL.
V. Employer Responsibility

The ACA’s employer responsibility provisions generally require employers with 50 or more full-time equivalent employees (FTEEs) to pay a penalty if any of the employer’s full-time employees (FTEs) is certified to receive a PTC through an Exchange. The penalty varies depending on whether the employer offers to its FTEs an eligible employer-sponsored plan and, if so, whether that coverage provides *minimum value* and is *affordable*.

A large employer is subject to a penalty under two circumstances:

1. **An employer fails to offer coverage to its FTEs and at least one employee receives a PTC.**
   A penalty is imposed monthly in an amount equal to $166.67 multiplied by the number of the employer’s FTEs, excluding the first 30 ($2,000 annually per employee).

2. **An employer makes an offer of coverage, but at least one of its employees receives a PTC from an Exchange (e.g., if the coverage is not affordable).** The penalty is equal to $250 per month multiplied by the number of FTEs receiving a PTC. The penalty is capped at the amount that would be charged if the employer offered no coverage (described above in 1).

Coverage is deemed to provide *minimum value* if it pays for at least 60% all plan benefits, without regard to co-payments, deductibles, co-insurance and employee premium contributions; i.e., comparable to a *bronze* Exchange plan. Coverage under an employer-sponsored plan is *affordable* to a particular employee if the employee’s required contribution (the employee’s share of premium) for participant-only coverage does not exceed 9.5% of the employee’s household (MAGI) income for the taxable year.

In *Notice 2011-73*, the Internal Revenue Service proposed and solicited comments on a safe harbor under which an employee’s household income is presumed to equal his or her wages as listed in Box 1 on the income tax Form W-2, solely for purposes of determining the employer penalty amount. To qualify for this proposed safe harbor, an employer must meet the following requirements:

- The employer must offer its FTEs (*and their dependents*) the opportunity to enroll in MEC under an eligible employer-sponsored plan; and
- The employee’s portion of the participant-only premium for the employer’s lowest-cost coverage must not exceed 9.5% of the employee’s W-2 wages.

Where the employer satisfies both of these requirements for a particular employee, the employer is not subject to a penalty, even if that employee receives a PTC. As proposed, the safe harbor would be determined after the end of the calendar year and on an employee-by-employee basis, taking into account the W-2 wages and the employee contribution. In *Notice 2012-58*, the IRS announced that employers could rely on this safe harbor approach through the end of 2014.

Resolving this issue of affordability for both eligibility for the PTC and the employer shared responsibility provision involves competing policy considerations, such as the federal budget impact of extending premium credits to a much larger group (if family contributions are used) versus the reform law’s goal of maximizing individuals’ access to affordable coverage. Future regulations may have differing safe harbors and inconsistent provisions with respect to the definition of affordability for PTCs versus that for shared-responsibility penalties.
More Information
More about health care reform is available on the General Board’s health care reform webpage. Please send your questions to healthcarereform@gbophb.org. General information about health care reform is available from the federal government at www.healthcare.gov.

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Appendix A—Premium Tax Credits

The following flow chart summarizes the rules governing the ACA federal premium support subsidies (the premium tax credits, PTCs):
Appendix B—Employer Responsibility

The following flow chart summarizes the rules governing the ACA employer penalties under Internal Revenue Code §4980H:

**Start:** Employer responsibility under §4980H

- Is the employer a large employer (LE, 50 or more full-time equivalent employees)?
  - No → **Stop:** No penalty.
  - Yes → Does any full-time employee (FTE) qualify for a PTC?
    - No → **Stop:** No penalty.
    - Yes → Does LE offer health plan to all FTEs?
      - No → **Penalty:** §4980H(a) (No Coverage Penalty) → $2,000 per FTE (minus first 30 FTEs) annually
      - Yes → Is LE plan **affordable and minimum value**?
        - No → **Penalty:** §4980H(b) → lesser of (i) $3,000 per year per FTE receiving PTC, or (ii) No Coverage Penalty.
        - Yes → **Stop:** No penalty.
Appendix C

Status of State Exchanges

Notes: Data as of July 11, 2012

Sources: Data compiled through review of state legislation and other exchange documents by the Kaiser Family Foundation. For more detailed descriptions of states’ health insurance exchange planning and implementation efforts, visit State Exchange Profiles: http://healthreform.kff.org/State-Exchange-Profiles-Page.aspx.

Fifteen states have established or will establish a state Exchange: California, Colorado, Connecticut, District of Columbia, Hawaii, Maryland, Massachusetts, Nevada, New York, Oregon, Rhode Island, Utah, Washington and West Virginia.

Sixteen states are actively studying a state Exchange: Alabama, Arizona, Delaware, Illinois, Indiana, Iowa, Kentucky, Michigan, Minnesota, Mississippi, Montana, Nebraska, New Jersey, New Mexico, North Carolina, Pennsylvania, Tennessee and Virginia.

Ten states have made no indication of establishing a state Exchange: Georgia, Idaho, Kansas, Missouri, North Dakota, Ohio, Oklahoma, South Dakota, Wisconsin and Wyoming.

Seven states have declined to establish a state Exchange: Alaska (announced July 18, 2012), Florida, Louisiana, Maine, New Hampshire, South Carolina and Texas.

Arkansas previously has announced its partnership with the Department of Health and Human Services for a federally-facilitated Exchange.