The Affordable Care Act (ACA, i.e., federal health care reform) makes significant changes to health insurance practices nationwide. This document summarizes important features for employers within The United Methodist Church (UMC).

You will find more than 50 detailed articles on many topics, including:

- Reporting and notice requirements
- Employer Mandate (Employer Shared Responsibility Rule) and Individual Mandate
- Small Business Health Care Tax Credit
- Essential Health Benefits

You can read more about important features of the ACA for employees and other individuals [here](#).
Timeline for Key Provisions

Note: Provisions that directly impact employers (including churches and other salary-paying units (SPUs)) are highlighted in green.

October 1, 2013

Exchange Notice due from all employers.
All employers were required to send an Exchange Notice to all full-time and part-time employees. The Notice informs employees about the opportunity to enroll in health insurance through the new Health Insurance Marketplace, particularly if they don't have other affordable coverage through an employer or other source.

Ongoing obligation.
Employers are required to provide the Exchange Notice to newly hired employees on an ongoing basis. For employees hired between October 1 and December 31, 2013, employers should provide the Exchange Notice on the employee's date of hire (i.e., the first day of work). From January 1, 2014 forward, employers should provide the Exchange Notice to newly hired employees within 14 days of their hire date.

A summary of the requirement, Notice templates and sample cover letters are available at www.gbophb.org; select “Health Care Reform” and then Exchange Notice Toolkit materials.

SHOP Marketplace for small employers opens.
The Small Business Health Options Program (SHOP) Marketplace is an Internet-based “market” where small employers can compare, choose and enroll in health coverage for their employees. (Read more about SHOP on page 16 and at www.healthcare.gov).

October 1, 2013 – March 31, 2014

Open enrollment for Health Insurance Marketplace (also called “exchanges”) begins.
Individuals who do not have “affordable coverage” through an employer, government program (such as Medicaid or TRICARE) or other plan sponsor may enroll in a health plan through the Health Insurance Marketplace at www.healthcare.gov. Marketplace options are available to residents of every state and the District of Columbia. Residents in states that don't offer a state-run Marketplace may use the federal Marketplace (administered by the U.S. Department of Health and Human Services).

Although open enrollment for 2014 coverage is October 1, 2013 – March 31, 2014, one must enroll no later than December 23, 2013 for Marketplace coverage to be effective on January 1, 2014. Coverage for individuals who enroll through the Marketplace after December 23, 2013 will start a few weeks after enrollment.

Status of State Exchanges
August 2013

[Map showing state exchanges, with notes on state exchange statuses: State Exchange, No State Exchange (Federal Exchange), Partnership Exchange, Split Exchange]
Individual Mandate becomes effective.
Most American citizens (adults and children) and legal residents will be required to have health insurance coverage as of January 1, 2014*, or will pay a penalty through their income tax returns. Individuals and families have various options for health coverage, including:

- Employer-sponsored health plan
- Individual plan purchased through the new Health Insurance Marketplace or the private insurance market
- Government-sponsored programs [such as Medicaid, Medicare, Children’s Health Insurance Program (CHIP) or TRICARE]
- Spouse’s or parent’s health plan, if applicable

A few groups are exempted from the individual mandate or penalty. Exempted groups include:

- Individuals whose income is below $9,750 per year
- Individuals whose cost share (the amount they would pay for individual health insurance coverage) for the lowest-cost plan they can find (through an employer or a Marketplace) would be more than 8% of their modified adjusted gross income (MAGI)
- Religious objectors to public and private insurance (for example, the Amish)
- Undocumented aliens
- Native Americans

Health Insurance Marketplace plans—coverage begins.
The Marketplace (also called “exchanges”) is an Internet-based resource where individuals can compare health plans offered by different health insurance companies, including pricing, benefits, provider networks and other coverage details. Individuals and families also enroll in their selected health plan through the online Marketplace.

The Marketplace is designed primarily for individuals and families who don’t have affordable health coverage through an employer, including those who are self-employed or work for a small employer that does not offer health coverage.

Important:
The government is not providing insurance directly. Rather, the government-administered Marketplace enables people to enroll in insurance plans administered by regional and national insurance carriers such as Blue Cross and Blue Shield, Cigna, Kaiser Permanente, UnitedHealthcare and many others. Health Insurance Marketplaces will be administered by the federal government (through the Department of Health and Human Services) and many state governments.

* Individuals purchasing coverage through the Marketplace have until March 31 to secure coverage to avoid the mandate penalty.
Premium tax credit becomes effective for eligible individuals.

A new premium tax credit (PTC) from the federal government will help reduce the cost of health insurance for eligible persons. One must meet all of these criteria to qualify for a premium tax credit:

- MAGI between 100% and 400% of the federal poverty level
- Lack of affordable coverage through employer, based on the ACA's definition of “affordable”
- Not covered in Medicare, Medicaid or other government-provided health coverage
- U.S. citizen or legal resident
- If married, file joint federal income tax returns

The premium tax credit amount is based on income (lower income = higher credit) and is intended to reduce the cost of health insurance coverage for those eligible. The PTC applies only for insurance purchased through a state or federal Health Insurance Marketplace. It can be paid in advance (usually beginning in January for the year ahead) or claimed on the individual’s income tax return for the prior year. It also can be assigned directly to the insurance company, which reduces the portion of the premium that the individual pays each month.

<table>
<thead>
<tr>
<th>% of Federal Poverty Level (2013)</th>
<th>Single</th>
<th>Family of 2</th>
<th>Family of 3</th>
<th>Family of 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>$11,490</td>
<td>$15,510</td>
<td>$19,530</td>
<td>$23,550</td>
</tr>
<tr>
<td>400%</td>
<td>$45,960</td>
<td>$62,040</td>
<td>$78,820</td>
<td>$94,200</td>
</tr>
</tbody>
</table>

Applicable large employers (i.e., employers with 50 or more full-time equivalent employees) that have even one employee who qualifies for and uses a PTC may be subject to a No Coverage Penalty or Inadequate Coverage Penalty. (See below for penalty details.)

Employer Mandate with enforcement penalties begins.

(Also called the Employer Shared Responsibility Rule)

Applicable large employers with at least 50 full-time equivalent employees (FTEEs) will be required to offer “affordable” health coverage that meets “minimum value” standards to all full-time employees (FTEs, i.e., employees working at least 30 hours per week) and their dependent children up to age 26. Applicable large employers are not required to offer coverage to spouses.

Applicable large employers that don't comply with the employer mandate will be subject to one of these penalties:

<table>
<thead>
<tr>
<th>No Coverage Penalty</th>
<th>Inadequate Coverage Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer does not offer coverage to full-time employees and dependent children</td>
<td>Employer offers coverage but at least one FTE qualifies for a PTC</td>
</tr>
<tr>
<td>Penalty*: $2,000 per FTE (minus first 30 FTEs)</td>
<td>Penalty* = $3,000 per FTE actually receiving a PTC (up to a maximum aggregate amount equal to the “no coverage” penalty)</td>
</tr>
</tbody>
</table>

Note: The ACA's employer mandate was initially scheduled for January 2014, but its enforcement penalties were later postponed until January 2015 to allow employers more time to comply.

* The penalty is assessed on a monthly basis, so technically it would be 1/12th of this amount for each applicable coverage month.
The Employer Mandate (also called the “Employer Shared Responsibility Rule”) requires applicable large employers to offer affordable health coverage that meets minimum value health coverage standards to all FTEs, or to pay a penalty. Here’s a closer look at how ACA defines these concepts.

**Applicable Large Employer:** Employers with 50 or more full-time equivalent employees.

Note that part-time workers are counted toward the full-time equivalent total on a prorated basis. Additionally, a small employer that is part of a “controlled group” may also be considered an applicable large employer under ACA rules. (See Employer Mandate, FTEEs and Controlled Groups on page 8 for more details.)

**Affordable Health Coverage:** Employee pays less than 9.5% of his or her modified adjusted gross income (MAGI) for insurance premiums (based on individual coverage).

**Important for Employers:** If the employee’s share of the premium* for individual (self-only) coverage costs more than 9.5% of the employee’s MAGI (“household income”), the coverage is not affordable under the ACA definition. If the same employee’s MAGI is between 100% and 400% of the federal poverty level, that individual could qualify for a premium tax credit (PTC) to purchase insurance through the Health Insurance Marketplace. In other words, if the employer makes the coverage too expensive for the employee, the employee can refuse the coverage and seek individual coverage with tax credit assistance (if applicable) through the Marketplace instead. Applicable large employers who offer a plan and have even one full-time employee who qualifies for a PTC due to this affordability rule are subject to the Inadequate Coverage Penalty, starting in 2015.

Click here for more about affordability under the ACA.

*Premium in this sense includes “required contributions” or “assessments” with regard to self-funded/self-insured plans.
**Minimum Value Health Coverage:** Plan design must provide at least 60% coverage.

Most conventional employer health plans, including plans offered by UMC annual conferences, currently meet this minimum value standard. However, plans with catastrophic-only coverage and very high deductibles may not meet the standard. Click [here](#) for more information about ACA minimum value.

The ACA provides that an employer group health plan fails to offer minimum value if “the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.” This is a determination made by actuaries, using U.S. Department of Health and Human Services (HHS) rules for determining actuarial value, explained [here](#). Minimum value for a group health plan can be calculated by determining its anticipated covered medical spending for 10 categories of essential health benefits (EHB) coverage that are required under the ACA (for example, office visits, hospital stays and prescription drug coverage).

HHS rules offer several options for employer plan sponsors to calculate minimum value:

- Plan sponsors may use the Minimum Value Calculator, which is explained [here](#)
- Plan sponsors may apply one of the safe harbor plan designs described below
- For plans with nonstandard designs or features, plan sponsors may provide an actuarial certification from a member of the American Academy of Actuaries
- Plan sponsors of plans in the fully insured small group market may also meet minimum value requirements if they provide a bronze level plan (60% coverage) or better.

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**Minimum Value—Safe Harbor Plan Designs**

<table>
<thead>
<tr>
<th>Safe Harbor 1</th>
<th>Safe Harbor 2</th>
<th>Safe Harbor 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3,500 integrated medical and prescription drug deductible</td>
<td>$4,500 integrated medical and prescription drug deductible</td>
<td>$3,500 medical deductible</td>
</tr>
<tr>
<td>80% cost-sharing</td>
<td>70% cost-sharing</td>
<td>$0 prescription drug deductible</td>
</tr>
<tr>
<td>$5,000 maximum out-of-pocket limit</td>
<td>$6,400 maximum out-of-pocket limit</td>
<td>$10/$20/$50 co-payment tiered prescription drug plan</td>
</tr>
<tr>
<td>$500 employer contribution to a health savings account</td>
<td>$500 employer contribution to a health savings account</td>
<td>75% co-insurance for specialty drugs</td>
</tr>
</tbody>
</table>

The 60% minimum value coverage is the minimum requirement. Plan sponsors may choose to provide more generous coverage. For example, HealthFlex plans offered through the General Board of Pension and Health Benefits generally provide at least 80% actuarial value coverage.

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**Does the employer mandate apply to your church or SPU?**

- **Large employer (50+ FTEEs):** Employer mandate
- **Small employer (<50 FTEEs):** No Employer mandate
**Employer Mandate**

Are you a large employer?
At least 50 FT equivalent workers
- Including FT (30+ hours/week) and PT workers (prorated)
- Excluding seasonal workers (up to 120 days per year)

Yes  
Are any of your FT employees receiving PTC for exchange coverage?  
No  
No Penalty

Yes  
Do you have more than 30 FT employees?  
No  
Pay monthly penalty, lesser of:
- $2,000 x (number of FT employees – 30)
- $3,000 x (number of FT employees receiving credits for exchange coverage)

Yes  
Do you provide health insurance?  
No  
Pay monthly penalty, lesser of:
- $2,000 x (number of FT employees – 30)
- $3,000 x (number of FT employees receiving credits for exchange coverage)
Is your organization a small employer or an applicable large employer?

The answer helps determine whether you are subject to the employer mandate for providing health coverage beginning in 2015. Yet the answer is more complicated than simply counting heads; it involves consideration of full-time equivalent employees (FTEEs) and controlled groups.

Full-Time Equivalent Employees

Full-time equivalent employees are counted by adding the number of full-time employees plus an aggregated count of part-time employees. An employer determines the number of full-time employees by counting employees who work on average 30 hours per week or 130 hours per month. An employer determines the number of full-time equivalent part-time employees by adding all part-time employees' hours (no more than 120 for any single part-time employee) worked in a month and dividing that sum by 120.

Example:

Employer UMC has 25 employees who each work 130 hours per month (full-time) and 75 employees who each work 80 hours per month.

Employer UMC has a total of 75 full-time equivalent employees (25 full-time employees plus 50 full-time equivalent part-time employees).

\[
75 \text{ part-time employees} \times 80 \text{ hours} = 6,000
\]

\[
6,000 \div 120 = 50 \text{ FTEEs}
\]

Employer UMC is considered an applicable large employer subject to the employer mandate.
**Controlled Group**

Includes related employers that have a common owner or share significant business operations. Thus, an organization with fewer than 50 full-time equivalent employees might actually be considered an “applicable large employer” if it is part of a controlled group that, in total, has 50 or more FTEEs.

**Example:**

A UMC local church with 25 FTEEs is related to a UMC day care center with 20 FTEEs and UMC soup kitchen with 10 FTEEs. The three organizations share an employer identification number and have one common board of trustees. Combined, they have 55 FTEEs.

\[25 + 20 + 10 = 55 \text{ FTEEs}\]

In this scenario, the local church, day care center and soup kitchen are each subject to the employer mandate to provide health insurance to their full-time employees or pay a penalty.

Your organization may be part of a controlled group if any of the following apply:

- The Employer Identification Number (EIN) or federal Tax Identification Number (TIN) is shared among several organizations
- At least 80% of one employer’s operating funds are provided by a different organization, and the organizations share common management/supervision
- At least 80% of the members of the organization's governing (managing) body are either representatives of another organization or controlled by another organization

**Note:** Multiple documents about the Employer Shared Responsibility Rule will soon be available on the General Board website (www.gbophb.org). Under “Health Care Reform,” search through the **Employer Shared Responsibility Rule Toolkit**.

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**Coverage for Spouse/Dependents**

The employer mandate requires applicable large employers to offer health insurance coverage for the dependent children of full-time employees up to age 26 (or else pay the Inadequate Coverage Penalty for any dependent children who receive a PTC). However, the employer mandate does not require employers to offer coverage for spouses.

Further, the ACA's definition of “affordable” coverage is based on individual (self-only) coverage (i.e., coverage for the employee) even when employer coverage is offered to family members.
The ACA enacted three separate information reporting provisions under Sections 6051, 6055 and 6056 of the Internal Revenue Code. Although there is some overlap in information employers and health insurance carriers must report, the three reporting provisions described here have unique purposes and requirements.

**Section 6051 Reporting**

- Reports employees' wages and related information, including health benefits
- Employer submits data to IRS

Section 6051 requires employers to report annually all wages and wage-related information on employees' Form W-2. Beginning with the Form W-2 provided to employees in January 2013 for the 2012 tax year, employers who filed 250 or more Forms W-2 were required to report the aggregate cost of employer-sponsored health care coverage for employees. Section 6051 was enacted to give employees a transparent view of the value (i.e., the employer’s cost) of employer-sponsored health care coverage that is provided on a pre-tax basis. This information may also assist the IRS in enforcing the Cadillac Plan Tax that begins in 2018.

**Church employers and small employers are temporarily exempt from Section 6051 reporting.** Employers that issued fewer than 250 Forms W-2 for a 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 (including self-funded church plans like HealthFlex or typical annual conference plans) are temporarily exempt from this requirement. The earliest that small employers 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 2015 (for the 2014 tax year). The IRS will issue advanced notice of the end of this exemption when it is finalized.

The Form W-2 reporting requirement is discussed in greater detail [here](#).
Section 6055 Reporting

- Identifies participants with minimum essential coverage through health plan
- Health plan or annual conference board of pensions submits data to IRS

Section 6055 requires employers sponsoring self-insured group health plans and health insurance issuers for fully-insured health plans to report to the IRS information regarding the employees, participants and covered dependents who are provided “minimum essential coverage” under the plan. The employer, plan administrator or health insurance issuer must also provide a statement to covered individuals with information regarding minimum essential coverage. Employers and health insurance issuers report the information only if the individual is actually enrolled in the plan. Section 6055 reporting is designed to assist the IRS with administering the ACA’s individual mandate (requiring most Americans to have minimum essential coverage).

Section 6055 reporting applies to all health plans, including those provided by health insurance companies, self-insured employers including UMC general agencies, self-insured annual conference health plans, and the HealthFlex plan administered by the General Board. These plans will need to report the minimal essential health coverage, as defined under the ACA, provided to employees, participants and covered dependents to the IRS beginning in 2016 (related to 2015 coverage). For most UMC local churches, Section 6055 reporting will be completed by the annual conference board of pensions, the General Board (for HealthFlex) or the health insurance company providing the plan coverage.

Section 6056 Reporting

- Verifies employees’ offer and acceptance of employer-provided coverage
- Applicable large employers submit data to IRS

Section 6056 requires applicable large employers (employers with 50 or more full-time equivalent employees) to report to the IRS information about employer-provided coverage, i.e., whether coverage was offered to full-time employees and whether or not the offer of coverage was accepted. Applicable large employers will also submit a statement of coverage to all full-time employees. Section 6056 reporting is designed to assist the IRS with administering the employer mandate. It also provides information necessary to administer the premium tax credit for Marketplace coverage by identifying individuals with an offer of affordable employer coverage, who are therefore ineligible for premium tax credits.

There are no exceptions for tax-exempt employers or churches, so applicable large employers in the UMC, including large local churches, certain general agencies, large UMC-affiliated employers and large conference offices, must comply with Section 6056 reporting requirements.

An applicable large employer must report:
- Name, address and employer identification number (EIN) of the applicable large employer
- Name and telephone number of a contact person for the employer
- Calendar reporting year
- Certification as to whether the applicable large employer offered its FTEs and their dependent children the opportunity to enroll in coverage (by calendar month)
- Number of full-time employees for each month in the calendar year
- For each FTE:
  - Months for which coverage was made available and months for which the FTE was actually covered under the employer-sponsored health plan
  - Employee’s share of the lowest-cost monthly premium for individual (self-only) coverage providing minimum value, by calendar month
  - Name, address and taxpayer identification number (TIN, usually Social Security number)

Applicable large employers may contract with third parties such as a payroll management company for Section 6056 reporting, but remain liable for failure to report. Employers who fail to report are subject to penalties under the Tax Code.

As with reporting wages with Forms W-2 (Section 6051 reporting), this Section 6056 reporting requires a separate return for each FTE (using a yet-to-be-designed Form 1095-C). These new forms would be submitted to the IRS accompanied by a single transmittal Form 1094-C.

You can read more about Section 6055 reporting and Section 6056 reporting requirements here.
Several new fees and taxes on certain health plans may affect the group plans offered by local churches and other UMC employers to their clergy and lay employees.

### PCORI Fee

- **HealthFlex, conference board of pensions or health insurer pays**
- **Temporary (2012 – 2019)**

This temporary annual fee will help finance comparative effectiveness research conducted through the Patient-Centered Outcomes Research Institute (PCORI). PCORI is a private, nonprofit corporation established under the ACA to fund research on the clinical effectiveness of medical treatments, procedures and drugs. PCORI aims to expand access to evidence-based medical information for patients, clinicians and payers.

The PCORI Fee applies to fully-insured and self-funded plans for each plan year that ends between October 1, 2012 and October 1, 2019. The PCORI expires after October 2019. For calendar-year plans including HealthFlex, the first PCORI Fee covered the plan year ended December 31, 2012 and was paid by July 31, 2013.

### PCORI Fee Structure

Based on calendar-year plans ending:

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<tbody>
<tr>
<td><strong>Fee Structure</strong></td>
<td>$1 x plan's average number of covered lives (employees and covered dependents)</td>
<td>$2 x plan's average number of covered lives</td>
<td>Rises with health care inflation rate</td>
</tr>
</tbody>
</table>
For most local UMC churches and other UMC employers, the PCORI Fee will be paid by the health insurance company, annual conference board of pensions or the General Board (for HealthFlex). Plan sponsors must submit IRS Form 720 — Quarterly Federal Excise Tax Return to report the PCORI Fee and make annual payments.

Although it is uncommon for a local church to maintain its own self-insured medical plan, a local church that maintains its own self-insured health reimbursement arrangement (HRA; e.g., as a supplement to an annual conference’s medical plan) or health flexible spending accounts (FSAs) for employees may be subject to the PCORI fee as a plan sponsor.

You can read more about the PCORI Fee here.

Health insurance companies (issuers) will be assessed an annual fee to fund some of the ACA provisions, such as premium tax credits and cost-sharing reductions for some individuals who purchase coverage through the Health Insurance Marketplace (exchanges).

The total amount collected through this fee on health insurance companies will be $8 billion in 2014 and will increase to $14.3 billion by 2018. After 2018, the amount will be determined by the annual rate of health insurance premium growth. The fee will be divided proportionately between all health insurance issuers, although for-profit insurers will pay twice the amount as not-for-profit insurers. This fee is not applicable to self-funded/self-insured health plans (including many annual conference plans and HealthFlex).

However, this fee increases overall costs for health insurance companies. As a result, the fee could increase premiums for fully-insured health plans, including those purchased by churches and other small UMC employers in the small group market by an estimated 2-2.5% in 2014 and 3-4% in later years.

This fee will first be assessed in January 2014.
This temporary annual fee on most health plans will help fund a transitional reinsurance program for the health plans participating in the federal and state Marketplaces. The Reinsurance Fee is designed to stabilize individual health insurance premiums in 2014, 2015 and 2016—the first three years that the ACA's Health Insurance Marketplaces (exchanges) will be operational. The Reinsurance Fee will help mitigate premium increases in the individual market that could result from individuals with high health care costs (who previously may have been "uninsurable") purchasing insurance through the Marketplaces and dramatically changing actuarial risk pools.

The Reinsurance Fee applies to all health insurance companies (issuers) and third-party administrators (TPAs) on behalf of self-insured group health plans. Therefore, plans offered by UMC churches and other employers to clergy and lay employees are affected by the Reinsurance Fee.

HHS has determined that it needs to collect $12.02 billion in 2014, $8.02 billion in 2015 and $5.02 billion in 2016 to sufficiently fund the reinsurance program. HHS determines the Reinsurance Fee by dividing these annual aggregate amounts by the number of enrollees in health plans nationwide. For 2014, HHS estimates that the national per capita rate for the Reinsurance Fee will be $5.25 monthly ($63 annually). This means that a plan (the health insurance issuer or TPA) will pay an estimated $63 multiplied by the average number of covered lives (employees and covered dependents) during the first year of the Reinsurance Fee. This per capita dollar amount will change for 2015 and 2016. The Reinsurance Fee is scheduled to end after calendar year 2016.

HHS will require health plans to submit enrollment counts by November 15, 2014, and will return assessment invoices to plans by December 15, 2014. Payments will be due 30 days later (i.e., January 15, 2015).

You can read more about the Reinsurance Fee here.
The ACA requires health insurance issuers and self-funded/self-insured plans to pay a 40% excise tax on annual health insurance plan premiums that exceed defined thresholds. The tax will generate revenue to help finance health care reform. Many observers view the Cadillac Plan Tax as an incentive to health plans to control the cost of health insurance, and an incentive for individuals and employers to avoid purchasing expensive plans.

Beginning in 2018, the Cadillac Tax thresholds are:

- **$10,200** for single coverage
- **$27,500** for family coverage
- Special groups: **$11,850** (individual coverage) and **$30,950** (family coverage) for early retirees over age 55 and individuals employed in certain high-risk professions

The tax applies to premiums above these thresholds. For example, if an individual plan's annual premiums in 2018 are $12,200—or $2,000 over the $10,200 threshold—the Cadillac Plan Tax would be **40% of $2,000 = $800** for the year. The tax is assessed to the plan (thereby increasing plan costs in the following year).

The thresholds may be increased upon implementation in 2018, depending on actual medical inflation between 2010 and 2018 using a measure that is linked to the Federal Employees Health Benefits (FEHB) Program.

For fully insured plans, the health insurance issuer is responsible for paying this fee. For self-funded plans, the employer plan sponsor of the plan administrator (i.e., the General Board for the HealthFlex plan, or the annual conference board of pensions for non-HealthFlex plans) would be responsible for paying the tax.
If your organization is considered a small employer (fewer than 50 FTEEs and not part of a controlled group), you are not subject to the ACA's employer mandate. That means as a small employer you are not required to offer health coverage to your full-time employees (or pay the No Penalty or Inadequate Coverage penalty).

Nonetheless, you may want to offer insurance to your employees. The ACA created new insurance opportunities through the Small Business Health Options Program (SHOP) Marketplace for smaller employers, including local churches, nonprofits and small businesses. Small employers that choose to offer health coverage may select a plan for employees through SHOP or through the traditional insurance market.

The SHOP Marketplace (also called the SHOP exchange) provides an online environment where eligible small employers can “shop for” employee health coverage by comparing plans from multiple insurance carriers in terms of premium cost, coverage and other features.

Premiums for SHOP plans are based on community rating rules for sample population groups (“risk pools”) from many small businesses—not on the risk or claims history from your own employee group. This is true also for renewal rates in subsequent years, even if someone in the small employer’s plan incurs large medical claims. Community rating helps protect small employers from dramatic rate increases that traditionally would result from a very high medical claim within its small population of covered lives.

Keep in mind that many UMC annual conferences require local churches to cover full-time clergy in the annual conference plan, such as HealthFlex or another plan adopted by the annual conference. If that is the case in your annual conference, be sure to talk to your conference benefits office before your church adopts a SHOP plan to assess the consequences.

SHOP plans may be a viable option for small churches that want to cover lay employees and part-time clergy.
If you choose a plan for your employees through the SHOP Marketplace, the following details apply:

- Your business must offer coverage to all full-time employees (clergy and lay employees).
- Your employees can enroll in a SHOP plan online—either through the federally facilitated* SHOP exchange or through a state-based SHOP exchange where available.
- In 2014, employers adopting SHOP in most states will be limited to offering a single plan to its employees; only a few states will allow employees a choice among several SHOP plans. In future years, all states will allow employees to choose from multiple SHOP plan options.
- You can share the cost of premiums with your employees, just like you can with a health plan selected through the traditional small group market or through a broker.
- Your tax-exempt church or business organization might qualify for a Small Business Health Care Tax Credit worth up to 35% of your premium cost. This Tax Credit is refundable for tax-exempt employers even though they do not generally pay corporate taxes. (Read more about the Small Business Health Care Tax Credit here.)
- You can select a plan any time after October 1, 2013.

Find more information about the SHOP Marketplace here and at www.healthcare.gov or by calling 1-800-706-7893.

*Online enrollment through the federally facilitated SHOP has been delayed until fall 2014.

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**What Color Is Your Plan?**

<table>
<thead>
<tr>
<th>60%</th>
<th>70%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze</td>
<td>Silver</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>80%</th>
<th>90%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gold</td>
<td>Platinum</td>
</tr>
</tbody>
</table>

Plans offered through the Marketplace are grouped into coverage categories described as “platinum, gold, silver or bronze.” In general, platinum plans charge the highest costs for monthly premiums but charge members lower deductibles, co-payments and other out-of-pocket costs for services received, while bronze plans generally charge lower monthly premiums but have higher deductibles and co-payments. All plans cover the same essential health benefits and services.

The ACA’s minimum value requirement for employer plans is 60% coverage, which equates to a bronze plan in the Marketplace. HealthFlex plans offered through the General Board equate to gold-level coverage. Individuals and employers have flexibility to choose any level plan that best fits their budget and coverage needs.
Determining the clergyperson’s employer is not as easy as it seems. Yet the answer—to be decided by the federal government for purposes of the ACA—could have significant impact on United Methodist Church pastors, churches and annual conferences.

Clergy are considered self-employed for employment tax (SECA) purposes, but are not considered self-employed for health care and other tax-related benefits. So it is unclear if their employer for purposes of the employer mandate is: 1) the annual conference (which typically maintains or sponsors the group health plan); or 2) the local church, ministry or other salary-paying unit (SPU), where the clergyperson works day-to-day.

If the Annual Conference Is the Employer
Most annual conferences would have 50+ full-time equivalent employees (counting clergy), so they would be subject to the employer mandate. Full-time clergy would continue to receive health coverage through the annual conference (HealthFlex or another annual conference-sponsored plan).

If the Local Church, Ministry or other SPU Is the Employer
Most local churches, ministries and other SPUs have fewer than 50 full-time equivalent employees, so they would be exempt from the employer mandate. As small employers, churches would have more flexibility to explore options such as allowing clergy and lay employees to seek individual coverage (with tax credits based on income) through the Marketplace or offering a plan through SHOP. In either case, the churches would have to work with annual conferences, which can still require churches to participate in a conference plan under The Book of Discipline.

However, even in this case, local churches that have day care centers, camps, after-school programs, and retreats or other affiliated “businesses” might—when counted together—have a total of 50 or more full-time equivalent employees. In this case, the local church and the affiliated “businesses” are considered a controlled group and would be subject to the employer mandate.

Note: It is important to understand that UMC clergy are not considered employees of the annual conference, local church or denomination under The Book of Discipline (¶143). However, for certain purposes such as taxation and employee benefits, federal agencies classify clergy as “self-employed” or “in an employment relationship.” Health benefits and the ACA’s employer mandate are such circumstances. Moreover, even if the IRS classifies the local church as the “common law employer” for the ACA’s employer mandate, that classification will not affect the clergy relationship with the annual conference, nor the appointment process.
As of January 1, 2014, the ACA terminates several popular arrangements for employers to assist employees in purchasing individual health insurance policies with nontaxable or pre-tax employer dollars:

- **Stand-alone HRAs** can no longer be used to provide employer-sponsored health coverage to active employees.
- **Employer payment plans** can no longer be used (i.e., the employer cannot pay the employee's health premiums directly or reimburse the employee for premium payments with dollars that are not subject to income taxes).

Employer payment plans and stand-alone HRAs are common health plan arrangements in local churches in The United Methodist Church and other denominations, particularly for coverage of lay employees. These are arrangements where the lay employees (and some local pastors and deacons) purchase coverage on the private market for individual health insurance policies and the local church then either: 1) reimburses the employee for all or part of the premium cost; or 2) directly pays all or part of the individual policy premium to the insurance company, with non-taxed employer dollars (money not reported as taxable income to the employees). These plans and arrangements will no longer be permitted as of January 1, 2014.

**UMC local churches should terminate such plans as of December 31, 2013** and explore other options for providing health coverage to lay employees and select local pastors and deacons. Alternative options include:

- adopting a small group market plan through the SHOP Marketplace for small employers
- paying directly for individual policies for employees using taxable dollars (dollars reported as taxable wages and subject to employment taxes and income tax withholding)
- reimbursing employees for premiums paid for individual policies with taxable dollars

You can read more about these new restrictions on employer payments plans and stand-alone HRAs [here](#).
The ACA rules are complicated, yet must be considered by all UMC employers: small and large churches, annual conferences, hospitals, colleges, senior centers and more. You can find more than 50 articles with detailed information about ACA provisions and how they affect UMC employers and employees on the General Board of Pension and Health Benefits “health care reform” Web page at www.gbophb.org.

The federal government’s website www.healthcare.gov also provides helpful information.

Learn More about Health Care Reform

Information for United Methodist Church annual conferences, churches and other employers

www.gbophb.org
Select “Health Care Reform”

General information for employers and individuals
www.healthcare.gov

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Glossary

ACA—Affordable Care Act, i.e., federal health care reform legislation. Also called “Obamacare” in the media.

Affordable Care Act—The Patient Protection and Affordable Care Act of 2010, also known as health care reform legislation and sometimes called “Obamacare.” The act was passed in two parts: the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010.

Bronze plan—Describes a health plan design that provides at 60-69% coverage (based on actuarial value). Bronze plans meet the ACA’s minimum value coverage threshold.

Cost share—Amount the participant pays for coverage in health insurance premiums or required contributions to a self-insured plan. Typically, an employer (a local church, UMC agency, annual conference, other ministry or other UMC-related organization) pays a portion of the premium (“the employer share”) and the plan participant (the employee) pays a portion (the “member or participant share”).

Employer mandate—Requirement that employers with at least 50 full-time equivalent employees offer affordable health coverage that meets minimum value standards. Also called the Employer Shared Responsibility Rule or “pay or play” rule. Enforcement of this mandate is postponed until January 2015.

Exchanges—Statutory name for the Health Insurance Marketplace; some states also are using the term “connectors.”

Federal poverty level (FPL)—Defined each year by the U.S. Census Bureau and Department of Health and Human Services. Updated information is available at http://aspe.hhs.gov/poverty/13poverty.cfm. Individuals and families with household income between 100% and 400% of the federal poverty level may be eligible for a premium tax credit under the ACA.

Gold plan—Describes a health plan design that provides 80-89% coverage (based on actuarial value).

Health Insurance Marketplace—Online resource (www.healthcare.gov) for comparing health plans offered by different insurance carriers, including pricing, benefits and other coverage features. Marketplace options are available for residents of all 50 states and the District of Columbia, through either a state-based program or the federal Marketplace.
**Individual coverage**—Health insurance for the primary participant or employee only (i.e., individual coverage); does not include coverage for a spouse or dependent children. Also called “self-only” coverage.

**Individual mandate**—Requirement that adults, children and legal residents maintain health coverage (health insurance) or pay a tax penalty.

**Modified adjusted gross income (MAGI)**—Taxable income as reported on federal income tax return. Does not include clergy housing allowance, pre-tax contributions to the United Methodist Personal Investment Plan and certain other income sources.

**Platinum plan**—Describes a health plan design that provides more than 90% coverage (based on actuarial value).

**Pre-existing condition**—Chronic illness or other health issue that was diagnosed under an earlier health plan or prior to obtaining current health coverage. Under the ACA, adults and children with a pre-existing condition cannot be denied health insurance or charged higher premiums because of their current or prior health status.

**Premium tax credit (PTC)**—Income-based financial assistance from the federal government for individuals or families who purchase health insurance through the Marketplace. Eligibility is based on modified adjusted gross income and other factors.

**Self-only coverage**—Health insurance for the primary participant only (i.e., individual coverage); does not include coverage for spouse or dependent children.

**Silver plan**—Describes a health plan design that provides 70-79% coverage (based on actuarial value).