

PCA Healthcare Options

PCA Retirement & Benefits, Inc. (RBI) understands the circumstances our ministry partners face regarding the excessive cost of medical insurance. Almost on a daily basis we hear the stories of families who are financially overwhelmed by the cost associated with health coverage. Please know that RBI continues to search for answers to assist families from a denominational perspective, but in the short term there is no satisfactory solution to a problem that has become a national crisis.

As some may be aware, the PCA Health Plan was discontinued in 2005 due to a challenging phenomenon called "adverse selection" (or 'anti selection') wherein insured participants in the plan who are not obligated to be in a plan, choose other coverage. These choices are typically driven by factors like age, health and insurability. Those who remain in the plan are typically older and sicker (and more expensive to cover). Due to adverse selection the PCA Health Plan was ultimately dominated by higher risk individuals resulting in spiraling premium increases. The Health Plan had to be closed and PCA Retirement & Benefits, Inc. (RBI) has no plans to offer one. Why?

RBI believes that if a denominational health plan is resumed it must have every chance to succeed. For this to happen, we believe the PCA constitution must be modified to (a) require or mandate participation in a group health plan; and (b) have enforcement authority to discipline a church or presbytery if they fail to participate in the plan. If those two positions are crafted into the BCO, we believe a nationwide, viable census to craft a health plan for all churches and pastors could be provided.

A recommendation to require full denomination participation was recommended by RBI at the 2002 General Assembly. That recommendation was defeated and determined to be unconstitutional. We believe advancing a similar recommendation would not pass and we do not advocate doing so, for a few reasons. First, creating the constitutional framework that would allow such a recommendation would require a formidable effort that has little chance of success. Second, it should not be assumed that a newly crafted PCA group health plan would result in significant premium savings relative to other group health plans (indeed, it could be worse than many already experience). At the end of the day, only a thorough census of all PCA employees provided to health insurance companies would determine this outcome. For those who have experience in the PCA, you know how difficult it is to gather detailed information from every church employer. Third, achieving group status may well be possible through PCA Presbyteries rather than through a national effort. If a presbytery could come together and require all pastors within the geographic bounds of that presbytery to be in the same plan, then that presbytery could effectively mandate coverage. One of the larger churches in that presbytery would then go to their group agent and say, "we have XX employees who will participate in a plan and they are required to participate what plans do you have for us?" Then that group agent could then craft a local, presbytery-wide plan with an insurance carrier who is active in that presbytery's geographic area. We believe that **this** would be more effective initially than a national plan as it would be (a) local: those making the decisions (the presbytery) 'see' each other several times a year; (b) enforced: the presbytery can determine rules for participation; and (c) the local plan (with local doctors, hospitals, networks, etc.) is more easily crafted than a national plan.

RBI is 'hearing' of similar challenges with other denominational group health plans. Some of the larger church plans are beginning to experience anti-selection in favor of cheaper ACA plans (yes, this can occur assuming individual tax credits) or in favor of sharing ministries. Those larger denominational plans who have no enforcement power (even though benefits are mandated by their denominations), are beginning

to experience adverse selection. While they are bigger and have more reserves than what the PCA had at the time of our health plan closure, their experience cannot continue.

Presently, we have resources on our website: <https://pcarbi.org/healthcare/> that provide guidance. We understand this is not what many are seeking. We also continue to have discussions with members of the Church Benefits Association and other potential providers.

Currently, the best solutions available include:

- ACA plans or sharing ministries for very small (one or two employee) organizations
- QSEHRAs for small churches with more than one or two employees
- Group plans for larger churches and organizations
- Self-funded or partially self-funded group medical arrangements for very large organizations

Note: The Affordable Care Act (ACA) requires all employers with 50 or more full-time equivalent employees (FTEs) to provide minimum essential coverage (which would be met by a group medical plan).