MARSH & McLENNAN AGENCY
Known locally as McGraw Wentworth

THE VIEWSLETTER

Volume Nineteen, Issue Four **November 2016**

THE STATE OF THE MARKETPLACES

The fourth annual Affordable Care Act (ACA) Marketplace open enrollment is underway. This year, enrollees will see significant changes. Because of a number of factors, several Consumer Operated and Oriented Plans (CO-OPs) as well as many carriers and health plans will no longer be available. Premiums may increase, some substantially. In fact, there is now concern that the Marketplaces will not be sustainable over time.

Why so much change in the Marketplace? At the 2014 launch, carriers were unsure of the risk that the new market would bring. Many factors were unknown:

- Would enrollees be healthy?
- How many enrollees would have significant pre-existing medical conditions? How long had these conditions gone untreated?
- How should rates be set to accommodate all the new rules? (Rates can vary only based on age, geographic region and tobacco use.)
- How much financial assistance would the rate stabilization programs (risk corridor program and the reinsurance program) provide?
- How much market share would each carrier capture? What type of risks would be included in that market share?
- How well would the Marketplace manage mid-year special enrollment rights to mitigate adverse selection?

Because they did not have an experience pool on which to base their rates, carriers rated blindly in year one. Many were very aggressive in their rate setting in an attempt to secure market share. What's more, government's rate stabilization programs did not help carriers as much as anticipated. The Marketplace has not tightly managed mid-year enrollment and it looks like adverse selection is influencing claim pools.

Continued on Page 2

We welcome your comments and suggestions regarding this issue of our Viewsletter. For more information, please contact your Account Manager or visit our website at www.mma-mi.com.

As a result, carriers are leaving Marketplaces where the losses have been substantial. Twenty-three CO-OP plans were established as of the first enrollment under the Marketplace. Twelve have now shut down. More CO-OPs are expected to follow their lead. Insurance carriers still offering Marketplace plans have increased their rates. In many states, these increases are quite substantial. The increased rates will not affect members receiving federal subsidies to help pay the premiums. Their premiums under the ACA are capped based on household income and household members. The federal government funds the substantial premium increases for members that qualify for premium assistance. The full premium increase will apply for members who do not qualify for assistance.

The Marketplace for 2017 is markedly different from the Marketplace of 2014. Consumers are likely to see fewer carriers, fewer plan options and higher premiums. Carriers want to attract young, healthy members to balance out their risk pools. Unfortunately, this group tends not to purchase coverage when the premiums are too high. The individual mandate penalty is not substantial enough to force them to pay high premiums for coverage they can't conceivably imagine using.

Some aspects of these Marketplaces and the ACA may have to change just to survive. As carriers pull out of Marketplaces, competition is diminished. If the risk pools don't improve, some state Marketplaces may not have any carriers willing to offer coverage. As a result, some people will not be able to obtain coverage at all. The individual market a few years into ACA changes is pretty unstable.

DID YOU KNOW

- 78% of employers offer employees short-term disability benefits
- 63% of employers offer employees long-term disability benefits
- For short-term disability benefits - 37% of employers fully insure benefits; 56% self-fund and 7% self-fund with some form of stop loss protection
- For long-term disability benefits - 81% of employers fully insure benefits; 15% self-fund and 4% self-fund with some form of stop loss protection
- 56% of employers offer a short-term 26-week disability benefit period; 16% have a 13-week benefit period
- 75% of employers that offer long-term disability benefits will pay benefits until age 65 or retirement age if an individual remains disabled

Source: 2016 Employee Benefits Survey, International Foundation of Employee Benefit Plans

With a Republican Congress and President in 2017, it will be interesting to see how they address these issues. The Republicans tend to support solutions with less government involvement. President-elect Trump supports the expansion of Medicaid. Republicans may eliminate some of ACA rules that dictate coverage. They may also eliminate the Federal rules that dictate how health insurance is rated. President-elect Trump would encourage greater use of Health Savings Accounts (HSAs). They also plan to allow insurance policies to be sold across state lines. Finally, they hope to allow some individual tax deductions on individual policy premiums.

These solutions would need approval of Congress. At a minimum, Congress should consider compromise measures to allow insurance carriers to protect against adverse selection and significant utilization. For example, they can revisit the complete elimination of pre-existing condition limitations. Instead they could apply a process that was part of HIPAA before the ACA became law. HIPAA's creditable coverage provisions allowed people to apply previous coverage to new pre-existing condition limitations as long as there was not a significant break in coverage. This would induce people to maintain coverage to avoid a pre-existing condition limitation with a new carrier. Another option would be to maintain the limitation exclusion and establish state high risk pools for high amount claimants.

If the individual market continues to be unstable, the government will likely need to act. The form of that action will be interesting to see. MMA

Continued on Page 3

TREND TIDBITS

- $ PPO plan cost is projected to increase 7.6% in 2017 (down slightly from 7.8% in 2016)
- $ HMO plan cost is projected to increase 6.7% in 2017 (down slightly from 6.8% in 2016)
- $ High Deductible Health Plan (HDHP) cost is projected to increase 7.7% in 2017 (down slightly from 8.0% in 2016)
- $ Rx cost is projected to increase 11.6% in 2017 (up slightly from 11.3% in 2016)

DAZED AND CONFUSED: MARIJUANA LAWS AND THE IMPACT ON THE WORKPLACE

Marijuana initiatives for both medical and recreational use were on a number of ballets this election season. Twenty-six states and the District of Columbia (DC) allow medical marijuana use. Michigan has allowed it since 2008. Some states have even legalized recreational use of marijuana. These states and jurisdictions include Colorado, Washington, Oregon, Alaska and DC. In the 2016 elections, three more states legalized recreational marijuana use. The three were California, Massachusetts and Nevada. Marijuana use, medical or otherwise, is still illegal under federal law.

Marijuana is considered a Schedule I controlled substance under federal drug laws. Schedule I controlled substances do not currently have an accepted medical use in the United States and they have a high potential for abuse. Other Schedule I controlled substances include heroin, LSD and Ecstasy. The FDA requires carefully conducted clinical trials in order to approve a substance for medical use.
So far, researchers have not conducted enough large-scale clinical trials that show that the benefits of marijuana outweigh its risks.

Does the fact so many states have approved marijuana for certain medical conditions validate its accepted medical use? It certainly is implied. Some small-scale pre-clinical and clinical trials with marijuana and its extracts have been used to treat numerous diseases and conditions including:

- Autoimmune Diseases (diseases that weaken the immune system) like HIV/AIDS
- Multiple Sclerosis (MS), which causes gradual loss of muscle control
- Alzheimer's disease, which causes loss of brain function, affecting memory, thinking, and behavior
- Inflammation
- Pain
- Seizures
- Cancer

Some of these trials have shown marijuana can be an effective treatment. The FDA has approved two marijuana drugs (Dronabinol and Nabilone), both used to treat nausea and boost appetite particularly in cancer treatment. However, the federal government has not approved marijuana in plant-based form to treat any medical condition.

The legal differences between how marijuana is treated at the state level and how it is treated at the federal level may confuse employers. Can employers still test for marijuana use under mandatory or new hire drug testing program? Federal law will pre-empt state law when it comes to federal drug testing programs including testing done to comply with:

- Department of Transportation requirements
- Occupational Safety and Health Administration (OSHA) requirements
- Drug Free Workplace Act
- Americans with Disabilities Act (ADA)

Under the ADA, even if a state has legalized medical marijuana, employers do not need to allow an employee to use medical marijuana at work.

Employers need to be careful in drug testing. They should clearly communicate drug testing requirements, regular or random testing rights, and drug testing required on a return to work from disability. Employers need to monitor state law in states where they have employees. Some state laws may require accommodations or prohibit discrimination for medical marijuana use at the state level. Understand whether you can take

Continued on Page 4

action on a failed drug test or deny an accommodation based on the medical use of marijuana. Consider the circumstances if the employee fails a drug test:

- Is the employee a qualifying patient or registered card-holder?
- What are the employee's duties and is drug testing a necessity for that job?
- Is the employee's position one that would cause safety concerns with medical use of marijuana?

How to treat medical marijuana use under state and federal employment laws is a dynamic topic. State laws differ and frequently change. Before you take drastic action because of a positive drug test in a state where medical and even recreational use is permitted, check with your legal department. You may be able to terminate an employee for drug use under federal law, but you need be aware of potential state law implications. MMA

YOUR QUESTIONS

Q: Our HR team is working on finalizing all of our open enrollment materials. Our new manager recommended we add a process to identify anyone dropping coverage at open enrollment (employee, spouse or child) so that we can send out COBRA notices. I did not think COBRA notices were needed if someone dropped coverage at open enrollment.

A: For the most part, you are right. In order for COBRA to apply, a qualified beneficiary has to lose coverage as a result of a qualifying event. Qualified beneficiaries can be employees, spouses or children as long as they were covered the day before the qualifying event. Qualifying events for employees include termination of employment or a reduction in work hours making the employee ineligible for the health plan. For spouses and dependents, qualifying events include divorce, death of employee, and loss of eligibility for benefits (for example, a dependent child aging out of plan eligibility).

One situation at open enrollment may generate COBRA rights. If an employee stops spousal coverage at open enrollment in anticipation of a pending divorce, you need to offer COBRA to the former spouse when the divorce is final. You need to be aware in these situations. A former spouse or even an employee may notify you of the divorce. If you see the spouse was not covered as of the divorce date, investigate further. If coverage was cancelled at open enrollment and the divorce occurred within a reasonable time period, then COBRA will apply. The employer would look at this situation and assume the employee dropped coverage because of the impending divorce. If the former spouse elects COBRA, coverage should be reinstated as the day of the divorce.

Continued on Page 5

TECHNICAL CORNER

ELECTRONIC MEDICAL RECORDS

An electronic medical record (EMR) is an electronic record of a person's health-related information that authorized clinicians and staff within one health care organization can create, gather, manage, and consult. These records provide substantial benefits to physicians, clinic practices, and health care organizations. They facilitate workflow and improve the quality of patient care and patient safety. They also help avoid repeating a diagnostic test because all health care providers within a health care system share the medical record.

Health care systems were initially slow to adopt electronic medical record systems. Keeping electronic medical records was not simply a matter of purchasing a software product for formatting and storing the data. Health care organizations needed to change the entire treatment process and patient management protocols to incorporate electronic data entry.

Implementing this technology was expensive. The added cost for redesigning the clinical process and workflow was unexpected.

Because medical facilities were slow to adopt automated systems, the government started offering substantial incentives in 2011. They seem to be working. Today almost every hospital and about 75 percent of physicians have implemented EMRs. While adoption rates are up, making the best use of electronic medical records still takes a lot of work.

Electronic medical record systems need to simplify the lives of health care providers not make them more complex. The systems also need to bring patients into the process. Patients would benefit from improved access to their medical information and the ability to communicate electronically with their doctors.

Electronic medical record systems will continue to evolve. The information available and patient access is being improved. Mobile friendly EMR capabilities are being developed. Systems to accommodate telehealth capabilities are also improving. Security remains a top priority as the electronic record system vendors expand with mobile options and telehealth.

Electronic medical records have become more common in the last five years. Hopefully, the result will be less waste and better quality care. MMA

Copyright Marsh & McLennan Agency LLC company. This document is not intended to be taken as advice regarding any individual situation and should not be relied upon as such. Marsh & McLennan Agency LLC shall have no obligation to update this publication and shall have no liability to you or any other party arising out of this publication or any matter contained herein. Any statements concerning actuarial, tax, accounting or legal matters are based solely on our experience as consultants and are not to be relied upon as actuarial, accounting, tax or legal advice, for which you should consult your own professional advisors. Any modeling analytics or projections are subject to inherent uncertainty and the analysis could be materially affective if any underlying assumptions, conditions, information or factors are inaccurate or incomplete or should change.

Marsh & McLennan Agency LLC

3331 West Big Beaver Road, Suite 200
Troy, MI 48084
Telephone: 248-822-8000 Fax: 248-822-4131
www.mma-mi.com

250 Monroe Ave. NW, Suite 400
Grand Rapids, MI 49503
Telephone: 616-717-5647 Fax: 248-822-1278
www.mma-mi.com