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THE VIEWSLETTER

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THE 115TH CONGRESS

The 115th Congress was sworn in at the beginning of January. President Trump took the oath of office on January 20th. Within hours of taking the oath of office, President Trump issued an executive order directing the Treasury, Health and Human Services and Labor Departments to "take all actions consistent with law to minimize the unwarranted economic and regulatory burdens of the Act". The order does not repeal any part of the Affordable Care Act (ACA) but directs the heads of those Departments to "minimize the economic burden" of the ACA where possible. Many of the heads of these respective Departments have been confirmed. It will be at their discretion to interpret and effectuate the order.

The Republicans have long vowed to repeal the Affordable Care Act (ACA). They certainly are not wasting time. The process started even before President Trump was sworn into office. The Senate Budget Chairman introduced a resolution that includes fast-track instructions to repeal parts of the ACA through the reconciliation process. This is important because only specific elements of the law can be repealed through reconciliation and Senate reconciliation measures require only 51 votes.

Legislation to repeal the Cadillac Tax has already been introduced. Slated to take effect in 2020, this tax is a 40 percent excise tax on applicable health care costs that exceed specific thresholds. Both Republicans and Democrats support the repeal of this tax.

It is absolutely clear that while Republicans aim to repeal some parts of the ACA, they support other more popular aspects of this health reform legislation. Specifically, they support continuing health plan coverage to age 26 for dependent children and eliminating annual and lifetime maximums.

What is not clear; however, is what replacement legislation will look like. Republicans do not

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appear to agree on the details in a potential replacement law. Following are some options Republican stakeholders have mentioned:

- Eliminate the individual mandate to purchase health coverage.
- Eliminate employer mandate to cover employees working 30 or more hours a week.
- Limit the tax-favored status of employer-sponsored health coverage to specific thresholds.
- Extend tax-favored status to coverage purchased in the individual market.
- Eliminate subsidies to pay for Marketplace coverage that are determined by capping individual contributions at a percent of household income.
- Offer tax credits based on age to help pay for individual coverage.
- Expand the benefits associated with Health Savings Accounts (HSAs).
- Reinstate the Health Insurance Portability and Accountability Act's (HIPAA's) pre-existing condition rules and have them apply to the individual and group market.
- Establish state high-risk pools to shift risk to pools for high amount claimants who can't obtain coverage if medical underwriting is reinstated.
- Allow the sale of insurance across state lines.
- Allow employer incentives for wellness program participation up to 50 percent of the cost of employer coverage.
- Block the federal government from denying coverage for health services based on lack of effectiveness.
- Repeal the Medicaid expansion, offer Medicaid block grants and return control of Medicaid programs to their respective states.
- Make it more difficult for patients claiming to be injured by medical negligence to sue their doctors.

DID YOU KNOW

- In 2016, 70% of survey respondents offered tele-health services to employees.
- In 2017, 90% of survey respondents offered tele-health services to employees.
- By 2020, virtually all employers are expected to offer tele-health services to employees.
- Just because it is offered, does not mean employees will use:
  - In 2015, survey respondents report just 1% of employees used tele-health services.
  - In 2016, survey respondents report 3% of employees used tele-health services.
- Tele-health visits are cost effective. According to United HealthCare (UHC):
  - Average tele-health visits cost just less than $50.
  - A visit to a primary care doctor averages $80.
  - A visit to an urgent care center averages $160.
  - A visit to an emergency room averages $650.

Source: 2017 Health Plan Design Survey, National Business Group on Health

No one is certain what the replacement legislation will look like. Republicans may exercise some caution in the contents or timing of the replacement. The ACA is an extremely complicated piece of legislation. Think of it as a game of Jenga. Pulling out certain provisions could have significant impact on different aspects of the health care market. For example, eliminating the individual mandate will have a significant impact on insurers still offering coverage in the individual market. The individual mandate was significant

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because it encouraged healthy folks to obtain coverage to avoid tax penalties. If carriers were still forced to cover pre-existing conditions without the individual mandate and without medical underwriting, they would find it difficult to stay in the individual market. Premiums would likely increase rapidly.

Republicans do recognize a substantial number of Americans obtained coverage through various ACA programs. A large number gained coverage under Medicaid with the expansion of eligibility. Many gained coverage in the individual market. Some were able to afford coverage due to substantial federal government subsidies. Others gained coverage because medical underwriting was prohibited as of January 1, 2014. If Republicans gut the ACA reforms immediately without offering thoughtful replacement options, many of these people could lose coverage. This would play out poorly in the media and could affect Republicans in mid-term elections.

The Republicans intend to keep their promise to repeal the ACA. It may happen very early in the Trump presidency. With the directives in the Executive Order, we may likely see multiple actions on many fronts to lessen the burdens the ACA has placed on individuals, employers and industries. ■

Condition	Spend (in billions)
1. Diabetes	$101.4
2. Ischemic heart disease	$88.1
3. Low back and neck pain	$87.6
4. Hypertension	$83.9
5. Injuries from falls	$76.3
6. Depressive disorders	$71.1
7. Oral-related problems	$66.4
8. Vision and hearing problems	$59.0
9. Skin-related problems	$55.7
10. Pregnancy and post-partnum care	$55.6

A CLOSER LOOK AT CONDITIONS DRIVING HEALTH PLAN COST

Health plan cost increases continue to challenge employers. According to the Kaiser Family Foundation's *2016 Annual Survey*, the average cost for employee-only coverage was $6,435. The average cost for family coverage was $18,142.

Most employers need to deal with projected cost increases that may exceed their budgets every year. They use various tactics to meet budget targets including:

- Increasing employee contributions
- Carving back benefits and increasing employee cost sharing when they use the plan
- Limiting spousal eligibility by requiring surcharges
- Adding a low cost Consumer Drive Health Plan (CDHP)

Shifting cost to employees is a concern. Some employers are looking more closely at the conditions driving health plan cost so they can take a more focused approach to controlling their health plan spend.

A recent study in the *Journal of American Medical Association (JAMA)* analyzed 2013 medical cost. It identified 20 conditions that account for half of all medical spending in the United States.

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The top 10 medical conditions and their associated expense in 2013 are shown in the table at the top of page 3.

Employers could use this list as a reference. It is likely many of these conditions are driving up plan costs. Some employers are willing to invest in data warehousing and population health management services to understand the medical conditions in their population.

If your organization will not invest in population health management, take time to look at the programs your health insurance carrier offers. Some carriers offer programs to manage conditions such as diabetes, heart disease and hypertension. Learn how your carrier identifies and contacts potential enrollees. Inform employees that these programs are intended to help them be their healthiest, despite a chronic condition. Identify resources that can help employees better understand and manage their conditions. For example, your EAP could offer a lunch and learn on combatting depression.

Population health management programs provide much more information and intervention. With the data they receive from health plan vendors, they can identify when patients stop taking a critical medication. Outreach, in some cases by the patient's physician, can make sure patients resume taking that medication. Population health management programs can also identify when a plan member is not getting recommended preventive care. The population health management vendors can send notices reminding members that they are due for recommended preventive services.

Many of the conditions driving medical cost are chronic. When managed well, costs for these conditions can be reasonable. When not managed well, cost for treatment can be significant. The number of emergency room visits and even inpatient hospitalizations rises when chronic conditions are not managed properly.

It is in your plan's best interest to make sure your employees are managing chronic conditions responsibly. Although many health plans have tools to help manage health, employees are not always aware these tools exist. Your organization could use the JAMA top 10 conditions as a guideline for focused efforts to help employees effective manage conditions. Your organization could take an additional step and hire population health management vendor. Population health management takes a much more personalized and comprehensive approach to managing chronic conditions. The result should be healthier employees and lower health plan cost increases. ■

TREND TIDBITS

- $ The average cost increase of all types of health plans in 2016 was 2.4% after plan changes. Across all plans, gross cost averaged $11,920 per employee.
- $ Small employers (10-499 employees) reported an average gross cost for health benefits at $11,271 per employee in 2016.
- $ Large employers (500+ employees) reported a higher average gross cost for health benefits at $12,288 per employee in 2016.
- $ On average, costs for Consumer Driven Health Plans (CDHPs) are 22% less than PPO plans in the large employer segment. The cost differential includes employer funding to a Health Savings Account (HSA).

Source: 2016 National Survey of Employer-Sponsored Health Plans, Mercer

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TECHNICAL CORNER

ELECTRONIC ENROLLMENT

Most employers just completed their annual open enrollment. Open enrollment is typically chaotic in many organizations. Every year, HR departments resolve that next year's open enrollment will run better. The only way to make that happen is to analyze which activities contributed to the chaos.

Every organization manages open enrollment differently. Some organizations, for example, are highly automated. Their employees make elections online and election data is transmitted electronically to all carriers, payroll systems and so on. Some even use video explanations or interactive communication technology. However, even highly automated organizations can improve. They should first identify the issues. For example, the organization may have fielded a substantial number of questions on how to manage the online enrollment process. If this case, the organization should distribute a tutorial when they notify employees of open enrollment changes. Perhaps, the organization had difficulty getting employees to complete evidence of insurability on voluntary life insurance. In this case, the organization should review the election process to make sure the evidence of insurability requirement and process are clearly stated.

Surprisingly, many organizations still manage open enrollment on paper. This labor-intensive system requires entering election data manually into several carrier eligibility systems, payroll systems, HRIS and so on. Multiple system data entry typically results in some level of errors. If your organization still manages open enrollment on paper, 2017 may be the year to consider electronic enrollment.

Electronic enrollment systems have improved significantly over the last several years and prices for these systems have dropped. They are now affordable for even smaller employers. It does take time to review the options. It also is a good idea to launch these systems before your next open enrollment. That way new hires have a chance to enroll electronically during the year. It will give HR experience with the system, and the HR team can learn how to use the system effectively. It also provides time to work through any potential programming issues before all employees are online, ready to re-enroll at open enrollment.

The time to think about open enrollment issues and improvements to your enrollment process is now while the challenges are still fresh in your mind. If you work through the challenges now, next year's open enrollment process will be less chaotic. ■

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YOUR QUESTIONS

Q: We have an employee getting ready to retire. He also will become Medicare eligible shortly thereafter. He has asked about COBRA coverage and how Medicare eligibility will affect his coverage and his wife's coverage. His wife is three years younger. Can you explain how COBRA and Medicare interact?

A: The interaction between COBRA and Medicare is complicated. The rules depend on the relationship between the COBRA election date and the Medicare entitlement date. First, the maximum COBRA coverage period for retirement is 18 months for both the employee and his wife. COBRA ends when the employee becomes eligible for Medicare. COBRA can continue for the employee's wife for the 18-month coverage period (so long as the wife remains eligible). In this case, assume the COBRA election date occurs prior to the employee's Medicare entitlement date. The employee would have COBRA up to his Medicare entitlement date. His spouse would have COBRA for 18 months, measured from the retirement date.

Special rules apply if the employee becomes eligible for Medicare before the COBRA coverage election date. In that case, the employee can elect 18 months of COBRA. The wife's maximum coverage period will be the greater of 18 months measured from retirement date or 36 months from the employee's Medicare entitlement date.

LIABILITY LESSONS

Did you know that you are pledging your personal assets as a guarantee of proper management of your organization's employee benefit plans? Under the Employee Retirement Income Security Act (ERISA), plan fiduciaries may be personally liable to reimburse the plan and compensate any participants for losses sustained as a result of a breach of the fiduciary's management responsibilities.

It is important to understand who your plan's fiduciaries are. Under ERISA, any individual who exercises discretion over the employee benefit or pension plan is considered a fiduciary. A fiduciary's status is based upon the functions performed, not just the person's title. If a plan participant brings a lawsuit against a fiduciary for a breach of their duties that fiduciary may be personally liable.

ERISA requires fiduciaries:

- Act solely in the interest of plan participants and beneficiaries
- Carry out their responsibilities as a prudent person
- Follow plan documents
- Hold plan assets in trust

The duty to act prudently is one of a fiduciary's central responsibilities. This means that the fiduciary's actions will be compared against those of a hypothetical prudent person. A fiduciary must give appropriate consideration to the facts and circumstances that the fiduciary knows or should know relevant to the particular plan or investment. This may require expertise in a number of different areas. In some cases, it may be necessary to hire a third party expert with sufficient knowledge to carry out those duties and protect plan fiduciaries from the financial consequences of ERISA-related claims. In addition to a fiduciary's personal liability for plan assets, the Department of Labor has the right to assess penalties and in some circumstances could pursue criminal liability.

Fiduciary liability insurance is an essential part of an organization's overall risk management plan. Without the proper insurance policy, fiduciaries could be left on their own to pay for their defense and any resulting judgment. ■

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