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Crafting Employee Health Plans for Catholic Institutions

by Dean Burri

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Dean Burri is the owner and CEO of Burri & Company, a national benefits insurance agency that provides services to Catholic employers and their employees. Established in 1988 to assist one small religious order, Burri & Company is today one of the nation's largest health insurance agencies exclusively serving the Catholic Church. The agency has offices near Charlotte, North Carolina, and Tampa, Florida. Burri has won numerous insurance industry and other business awards, including the Golden Eagle Award and leading producer awards. He has an insurance license in all 50 states and the U.S. territories and clients in all 50 states. He graduated in 1987 from Sacred Heart College in North Carolina (which later merged with Belmont Abbey College) with a B.A. in management.

Executive Summary

The Catholic Church and its institutions will inevitably and increasingly face legal battles over government-mandated health insurance coverage that conflicts with Catholic moral teachings, but Catholic employers can act now to make changes that help protect health plans. This paper offers recommendations for Catholic employers regarding self-funded plans that avoid state regulation. It also considers the wisdom of tactics including splitting off drug coverage from health plans and employer pools to reduce insurance costs. Ultimately, to properly construct a "Catholic" health plan, Catholic institutions need expert assistance to stay on top of changes to the law and to the health plan.

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The Center for the Study of Catholic Higher Education is the research division of The Cardinal Newman Society. Its mission is to promote the ongoing renewal of Catholic higher education by researching and analyzing critical issues facing Catholic colleges and universities, and sharing best practices. The Center's work is guided by the principles of *Ex corde Ecclesiae* and the Magisterium of the Catholic Church.

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Crafting Employee Health Plans for Catholic Institutions

In the last few years, the Catholic Church and its Catholic institutions have faced attacks through legislation and judicial activism, which are increasingly coming in the form of mandates for health insurance “benefits” that support immoral behavior but not medical necessities. The most recent instances in the news include the federal Equal Opportunity Employment Commission’s (EEOC) ruling against Belmont Abbey College and Wisconsin’s mandate forcing even Catholic employers to provide contraception coverage. Both are extremely troubling though not unexpected in today’s increasingly secular environment.

This paper is written from my experience building employee health plans for more than 50 Catholic employers, including several dioceses and religious orders. I do not write from a legal perspective. My concern is finding insurance solutions that avoid the problems of religious discrimination and violations of conscience—“real world” solutions that can be implemented today. Legal advice is also important, but it often only answers one question without examining the non-legal consequences of recommended actions. Health insurance experts like me who work every day with the Church must be concerned with reality and practicality, and not only what is permissible under the law.

The State of Affairs

Let us first consider the moral issues on which Catholic institutions are being attacked and which have a current or potential impact on medical insurance. These are many and growing: contraception, abortion, domestic partners, same-sex marriages, “gender reassignments,” sex-change operations, sterilization, stem cell research, in vitro fertilization and several other issues.

The attacks come primarily from two fronts, legislation and judicial activism. The activism is often coordinated and well-funded by Planned Parenthood, the American Civil Liberties Union and others who view the Church and its moral principles as dangerous obstacles that must be eliminated from public policy decisions.

In response to these attacks, the Church’s lawyers typically argue that the constitutional right of religious freedom should protect “religious” institutions from new laws and lawsuits. However, the reality is that it is very expensive to defend an institution in court, and there is significant risk of losing a court battle. The Supreme Courts of California and New York have issued rulings that are very troubling for Catholic institutions, and thus far the U.S. Supreme Court has not enforced First Amendment rights in these situations.

How “Catholic” must a college, hospital or other entity be to qualify for religious exemptions from health insurance mandates? Unfortunately several laws and rulings have denied a religious exclusion because of things like:

- 1) Too many employees are not Catholic.
- 2) Too many people served are not Catholic.
- 3) The institution takes federal funds.

This may be oversimplified, but it makes the point. Catholic charities, hospitals and colleges are going to be in great difficulty with these rulings, even in states that have

religious exemptions written into the laws. The courts are defining religious institutions so narrowly, it sometimes seems only a cloistered convent might qualify.

A particularly dangerous line of attack is employee complaints and “discrimination” lawsuits, alleging that by not providing morally offensive “benefits,” employers are discriminatory to women. This is the heart of the Belmont Abbey case. The argument is that by not covering contraception, an employer discriminates against women since they bear a higher burden and cost for birth control. There have been several rulings by the EEOC along these lines, and it is likely that in the current political climate there will be more of this, not less.

Additionally, Catholic institutions can anticipate great difficulties with regard to insuring legally married same-sex couples. While many have argued that the Defense of Marriage Act provides some protection, this law is being challenged on many levels, and Catholic employers should plan for the worst and expect lawsuits in this area.

Designing Catholic Health Plans

The Catholic Church and its institutions will inevitably and increasingly face legal battles, but must act now to make changes that help protect health plans. At the risk of oversimplifying a complex task that requires professional advice, what follows are a few recommendations for Catholic employers.

Plan ahead and stop being reactionary with regard to health insurance. Assume that your institution’s Catholic principles will be challenged eventually; it is not a matter of “if” but “when” in today’s increasingly secular society. To be safe your institution must have a specifically Catholic health plan in place, not an off-the-shelf product.

Commit today to take a few hours up front dealing correctly with health insurance, first by reading and understanding what your existing policy actually covers. Many Catholic institutions will be surprised by what they find. It helps to have professional assistance, because often the offensive benefits are hidden in vague language and technical insurance terms.

Consider the Belmont Abbey situation. Their health insurer reportedly added contraception coverage without their knowledge, which was readily apparent when officials read the plan documents. However, to be honest, officials and even human resources staff often fail to read such documents in their entirety. The documents are dry and boring and have paragraph after paragraph of highly technical insurance contract language. Unfortunately the consequence of a mistake could be spending hundreds of hours playing defense in a legal system that is not always friendly to Catholic concerns.

When designing or revising your employee health plan, ensure that it is regulated by federal law and not state law, by “self-funding” if at all possible. Almost all state-regulated, fully insured plans are deficient in protecting Catholic institutions. Currently 23 states have mandated contraception coverage. When provisions for abortion, sterilization, in vitro fertilization and same-sex couples are considered, more than half of the states have morally objectionable mandates. The remaining states are constantly moving in the same secular direction. Even in states that do not have these morally objectionable mandates, Catholic institutions are not likely to be safe for the long term in state-regulated insurance plans.

Federal regulation of medical insurance began in 1974 with the Employment Retirement Income Security Act (ERISA), which covers “self-funded” insurance. A section of ERISA specifically provides for “church plans” that generally do not have to pay for morally objectionable “benefits.”

To avoid state regulation, the real-world answer is to “self fund.” That means that instead of paying a fixed premium every month to an insurance company that accepts all the risk of claims, the employer agrees to share the risk. The employer financially “participates” in the cost of the employees’ medical claims. Does this mean that a self-funded plan is riskier than the alternative? Not necessarily. Any insurance plan can have zero risk or a large amount of risk—the latter can include a fully insured plan with a high deductible that the employer reimburses. But many Catholic institutions do not have the resources to gamble on high-risk plans.

In layman’s terms, here is how self-funding works. A plan document is written specifying what the plan pays for. The employee has a plastic card that looks and works just like a fully insured plan. A hired third-party administrator receives and pays claims from the doctors and other health care providers. In a “pure” self funded plan, the administrator would simply bill the employer for the cost of claims plus administrative costs, but few have a plan like that.

More commonly, an employer will purchase an insurance contract to limit the risk per insured on the plan. The employer is now responsible for only the first “X” dollars in claims per person, called the “stop loss” deductible. A large conglomerate might have a \$100,000 stop loss deductible; but a smaller organization may have a risk as low as \$25,000 a person. Even then, an institution of 100 employees cannot afford \$2.5 million in risk, so they buy another type of stop loss insurance called “aggregate stop loss” to limit the maximum claims of the entire group. Aggregate allows the institution to budget, since it now has a firm cap and maximum risk if claims go out of control. If claims are less than the maximum, the employer keeps the funds instead of the insurer.

The bottom line is that self funded does not have to mean unlimited risk. With careful planning many if not most Catholic organizations should be able to find a way to do this.

Getting It Right

Even though I recommend getting out from under state regulation if possible, Catholic employers should not run out and self-fund unless they do it correctly. Many dioceses have had very bad experiences with self-funding, because their advisors were not sufficiently knowledgeable about “church plans,” how to use appropriate language and structure, and other practical details. Self-funding is not bad by itself, but every detail must be considered to avoid serious difficulties.

For instance, consider cash flow: many Catholic institutions are not wealthy, but most stop loss insurance requires them to pay the costs up front and get reimbursed at a later date. For institutions in this position, a third type of insurance, “cash flow protection,” is available to limit employer up-front costs to an annual cap divided by 12 months. It is added protection that many insurance advisors are not always aware of, because their experience with self-funded plans may have been primarily with larger corporations where cash flow is not a primary consideration.

In addition, a “church plan” under federal law must have some very specific language to avoid future challenges. The insurer most likely will not be an expert on Catholic-sensitive language and will offer a boilerplate contract. Do not assume that the Church’s definition of something is the same as the insurer’s. For instance, the contract must define “family” and other things that may have very different meanings for a Catholic institution and a secular insurer. Every word of the contract must be read and understood, and every exclusion must be examined. You cannot trust that a contract is operating the way your agent, lawyer or other professional claims, unless you read and understand it yourself and consult with a true expert on the very unique needs of Catholic institutions.

The contract needs language controlling when an insurer can add benefits. Several dioceses were recently surprised when they learned the hard way that their insurer had the contractual right to add benefits without their approval. Although the dioceses’ lawyers believed they had a contract that could only be changed on renewal, the insurer had the unilateral right to impose changes—in this case covering contraception in response to a new state law. Thus in the middle of the year the dioceses have a major problem.

Eligibility is also an area where Catholic institutions may run into problems. In the U.S., health insurance is governed by an employer-employee relationship, and insurers expect to see a wage and tax statement showing earnings for each employee. Insurers do not want to cover volunteers who might only be volunteering to gain health insurance because they are ill. But how do we deal with Religious with a vow of poverty? Even if full-time employees, they are not paid; instead their order is often paid for their services. Thus, many Religious and even entire orders have been denied or removed from coverage because they receive no wages. Worse, insurers often do not ask for proof of wages until after the insured has an expensive claim—a terrible time to lose coverage. Again, this is a contractual issue that should be addressed up front.

There are also Catholic Church-specific laws, such as the Downey Amendment, that deal with Medicare for Catholic Religious. It is a very complex law, and most insurers are not even aware of its existence, let alone the application. There has been much confusion that required a ruling by the Center for Medicare Services three years ago, as many dioceses were interpreting the law incorrectly.

There are many more considerations involved in constructing a health plan for Catholic employers. This generally must be done with a custom product, not an off-the-shelf “normal” design. A custom plan often requires the cooperation of the insurer, filing with regulatory agencies and complex legal issues.

Split Off Drugs?

It is sometimes recommended that Catholic institutions should split off drugs—that is, have a fully insured health plan and self fund prescription drug claims—in order to avoid government mandates for contraceptives. It is suggested that such a scheme also produces cost savings, sometimes leading to rebates from the insurance companies that offer such standalone drug programs. My experience has shown this not to be the case, and I would advise against it.

Let us look how drugs are purchased by insurance plans. An insurance company will often subcontract portions of an employer's health plan including drugs, transplants and networks of doctors and hospitals. All these are normal subcontracted functions under the health plan. With regard to prescription drugs, most health plans use the same four pharmacy benefit managers.

Separating out drugs does not generate any cost savings by itself. There are actually several possible negative economic consequences. Many times drugs are not covered under the stop loss agreements if an employer self funds, but this is especially likely if drugs are covered through a separate plan. If the institution has a fully insured medical plan and then self funds the drugs, it could have unlimited drug cost liability. How would the institution budget? What if it has a terrible year? Will it have adequate reserves?

As for avoiding state mandates, self-funding a drug plan alone may not help. Regulators could simply decide that drugs are part of the major medical plan, regardless of the setup. For instance, when a patient is in the hospital, some drugs are covered under the medical plan; when he leaves the hospital and takes the same drugs, they may be covered by the self-funded pharmacy plan. How does the institution explain that inconsistency? The opportunity for misinterpretation by state regulators is great, and a legal fight to argue otherwise could be costly.

My best advice: do not do it. Leave the pharmacy plan to the insurer and take the huge discounts.

Pool Together?

It is also often recommended that Catholic institutions "pool" together for health insurance benefits, but there are many reasons why a pooled plan could be a disaster waiting to happen.

If the goal is to avoid mandates as a religious employer, the courts have indicated that the pooled entity itself must be "Catholic." Would that new entity qualify for inclusion in the Official Catholic Directory?

And what about linking an institution's finances with another entity? My firm has several clients that have struggled through the huge time, effort and cost of fighting sexual abuse lawsuits. One has filed for bankruptcy, and the lawyers aggressively sought to "find" money. Does another institution want to intertwine finances with such a troubled entity at this time? What kind of risk does that add? I know that this is a terrible question, but it is an honest, real-world question. Pools have set up separate corporations to try to limit the risk to individual employers, but the more that the pool or self-funded plan is walled off, the less likely that it will be considered "Catholic" by regulators or the courts. The two goals are somewhat at odds with each other.

Another argument for a pool is the opportunity for a volume discount, which in itself is a good idea. However, a good firm can help employers create groups that are financially separate, with different premium levels, yet receive a volume discount. Think about going to the car dealership and pooling with 10 entities for a fleet discount, but writing separate checks. It is the same concept, provides the same net result and risks much less liability, since you do not in fact pool assets together.

You may have heard that XYZ Diocese pools together and it works great. Pools do often work great, right up to the day they do not! Consider a real example:

A large Catholic pool run by a secular broker struggled with passing on necessary rate increases, and the trustees did not fund the plan to the level it needed. The plan nearly ran out of money. The dioceses participating in the plan were surprised by a mid-year assessment. Now how do you budget for that?

Ultimately, when an institution is in a pool, it owns all the risk of the whole pool. It is like owning a condo and having the pool leak. Every unit gets assessed money. It does not matter if a participating institution was excellent and had low claims. Pools generally must have the ability to assess or they run the risk of not having funds to pay unexpected or higher-than-expected costs.

Now here is the real mess: How should the pool assess, or make any similar decision? Should it divide the total amount of the assessment by the number of entities in the pool? The larger entities would favor that, but a smaller entity would want the assessment to be apportioned by the number of insureds for each participant.

So assume that everything is pro-rated according to each entity's number of insureds—then turn the tables. What happens when the pool needs to pick a network of doctors? Back to my real example: The pool decided on a network that was not great for small rural dioceses but excellent for large dioceses. What could the little guys do? They only had 100 votes, while the big member had 50,000.

At some point the pool will not work for a member institution. Typically it is when the institution is very healthy and the pool is sick. The institution's rates go up, and its trustees want to leave. It cannot afford the huge premiums, and it can go locally for much less. The institution leaves the pool, thus the remaining participants have fewer people to spread the risk of claims. Rates go up, and more participants leave. This drives the rates way up, and eventually the plan collapses. This is classic "adverse selection" as we call it in the insurance industry.

Now there are rare occasions when adverse selection is tempered. There is a state-specific Catholic pool where one health insurer virtually owns the state, due to restrictive laws; this seems to function well.

But that is the exception. The insurance industry tried for years to form pools through "associations." They almost all lost money and blew up the pools with huge claims. Remember chamber of commerce pools?

Yet another problem with pools is how to get out. They tend to be thrown together for the sake of what often turns out to be short-term cost savings. Rarely do the pool members ask going in, "What are the rules to leave?" The example I have been using had two small entities leave. One had a surplus and its employees were very healthy; it was not allowed to take their surplus with them when they left. Another entity that left had a deficit of several hundred thousand dollars; it was forced to pay the debt to the pool. This institution had not budgeted for that, believing that the premiums they paid were the maximum required.

Let us say that one entity in a pool is knowingly incurring non-eligible expenses or is poor at controlling eligibility. How do other institutions control a pool participant? One bishop or entity cannot tell another what to do. What is the enforcement action? What if the problem participant is costing other institutions money that they really

should not be paying? This is real and happens often. The other institutions cannot do much except maybe leave the pool, but under what terms?

Another example: Many dioceses and even some larger independent Catholic institutions do not have centralized payroll. Their sub-units hire and fire, and the master entity has difficulty controlling and keeping track of who should be on the health plan. In such cases there are often people not on the plan who should be, and others who are on the health plan but should not be.

Consider this also: what if the pool fails or too many groups suddenly pull out? A sick group could have a world of problems. Do groups that leave take pending claims with them? Let us say their insured receive one million dollars of health care on December 31, and the group leaves on January 1. Does the group that left “own” the claim legally, or are the remaining groups “stuck” with it? It is typical for many pools to not fully educate, disclose or address these issues, and so many of their member entities do not fully understand their liabilities.

Conclusion

For many institutions, employee health insurance is the second largest expense after payroll. Yet most will spend less time on their health plan than mundane purchases such as computers or telephone plans. Given the increasing dangers to Catholic institutions because of federal and state regulation of employee benefits, it is critical for Catholic institutions to take a fresh look at their health insurance decisions.

This applies especially to the choice of broker. Most institutions consult only with local general practitioner agents. These may be friends, donors or other honest, hard-working people. The problem is they are not experts in this unique and specialized field, lacking the skill sets, abilities and relationships of Catholic-only agencies. They do not devote all or even a substantial part of their time to Catholic institutions and their particular requirements.

Ultimately, to properly construct a “Catholic” health plan, Catholic institutions need an expert. Think of it this way: if your child becomes ill and needs brain surgery, you would never ask a pediatrician to be the surgeon. In situation after situation, problems could have been avoided if a Catholic institution had hired a Catholic-specific firm to stay on top of changes to the law and to the health plan, avoiding future lawsuits.

The bottom line is that today’s legal and policy environment makes it difficult for Catholic institutions to buy “off the shelf” health insurance that is morally sound. The good news is that there are ways to craft Catholic health plans. To help navigate the complex issues, there are at least three major firms that work only with the Catholic Church and others with particular expertise in designing plans for Catholic institutions.

