The 1971 Louisville General Assembly called for the creation of a churchwide healthcare program with the Pension Fund of the Christian Church serving as Trustee. The program was initially open to pastors in 17 regions that did not offer group healthcare. Additionally, the resolution was seeking a churchwide plan that would exclude pre-existing conditions for pastors moving across state lines, create equity in the cost of premiums and provide for consistent coverage.

In 1972, Pension Fund, on behalf of the church, launched churchwide healthcare. Over the next five years, other regions joined the program. Churchwide healthcare benefited from stable premiums through June 1975. In 1975, healthcare costs began to increase and thus, premiums increased. In 1979, increases in healthcare claims threatened the financial viability of the program. By 1988, the Insurer was requesting premium increases as high as 20% and in 1989 the premiums were raised 30% as medical inflation continued to escalate. By 1993, claims were $1.2 million in excess of premiums.

In 1996, churchwide healthcare became self-funded. As a self-funded health care plan, Christian Church Healthcare Benefit Trust (CCHCBT) assumed the direct risk for payment of the claims for benefits. The terms of eligibility and covered benefits were set forth in a plan document which included provisions similar to those found in a typical group health insurance policy. But again medical inflation and declining enrollment began to threaten the program. In 1999, premiums had risen by 20% and by 2000 claims exceeded premiums by $1.5 million.

In 2005, Pension Fund, as trustee for churchwide healthcare, notified the Portland General Assembly that the program was at risk and Pension Fund assets could not legally be (and had not been) used to cover the cost of the program, nor the loss. If the church failed to rally behind churchwide healthcare, Pension Fund stated its intention to resign as the Trustee, leaving the church with $5.4MM in debt plus runout costs. A re-pricing strategy was employed that included an age and area banded rate structure to
draw younger members with lower claims risk into the program. By 2007, the $5.4 million deficit reduced to $1.9 million and active participation increased by 24%. In 2009, the deficit reduced to $123,705 but participation began declining as premiums began rising.

In 2016, faced with a rapidly declining participation, and having back to back years of financial losses within the plan due to increasing medical inflation and with a projected deficit of $3-$3.5MM, the Trustees of CCHCBT voted to close the active plan, providing resources to assist with the transition of active members. At its peak, churchwide healthcare had more than 11,000 members. At plan’s closing, there were fewer than 1,100 members. The deficit for the plan is funded by loans from Church Extension and Ministerial Relief. The line of credit with Church Extension will not exceed the value of the Heartbeats of Faith Reserves.

It is important to note that the reasons churchwide healthcare was created were resolved by the Affordable Care Act (ACA). Even with the concern that ACA will be repealed, it is a widely held belief that the reasons churchwide healthcare came into existence will no longer be of concern. Current legislative proposals to repeal and/or replace ACA retain the elimination of pre-existing conditions, seek to control costs and ensure access to healthcare.

In closing the active plan, the Trustees did vote to continue offering the Medicare supplemental plans. Until 2016, the Medicare Supplement program had enjoyed years of solvency. In 2016, due to rising pharmaceutical costs, the Medicare plan was placed on a watch list for fiscal vulnerability. For 2017, Medicare rates were increased 7% in an effort to stabilize the plan. The primary advantage of the Medicare supplement is convenience for Pension Fund members who have the premium deducted from pension payments. CCHCBT recognizes the vulnerability of the Medicare plan is exacerbated without an active healthcare plan serving as a pipeline for new members and the recognition that local supplement options have similar benefits at a lower cost. At the April 2017 board meeting, the Trustees of CCHCBT will consider several options related to the Medicare supplemental program. An update on the Trustee’s decision will be provided as part of the verbal report to the General Assembly.

It has been Pension Fund’s privilege to serve as the Trustee of CCHCBT and bring significant resources to the Church. Please know we will continue to be an advocate and resource for the Church, as together, we face the ever-changing landscape of healthcare in the United States.

The General Board has reviewed GA-1716 from the Christian Church Healthcare Benefit Trust. The report is submitted to the General Assembly for presentation and discussion. No action is required. (Discussion time: 12 minutes)