

2016 Denominational Health Plan Annual Report

Prepared January 2017

2016 Highlights

The Denominational Health Plan (DHP), established in July 2009 by General Convention Resolution 2009-A177 and its associated canon, continues to help domestic dioceses, parishes and other institutions subject to the authority of the Episcopal Church control the rising costs of healthcare. This Annual Report, published pursuant to General Convention Resolution 2012-B026, summarizes more recent developments with the DHP.

In 2016 The Episcopal Church Medical Trust (Medical Trust) advanced a number of key DHP initiatives, including:

- Maintaining robust participation in the DHP, with approximately 95% of all eligible clergy and lay employees participating in a Medical Trust plan or obtaining healthcare coverage through other approved sources.
- Delivering cost containment that continues to be passed on to the Church; since 2009, most dioceses have received annual rate reductions or low single-digit annual increases.
- Ongoing support of dioceses in determining the most optimal array of plans to meet the needs of their groups.
- Maintaining a strong financial position with rates that are competitive in most markets.
- Continuing to advance the issue of parity.
- Remaining compliant with the Affordable Care Act (ACA) by implementing required tax reporting and plan design changes, while continuing to assess and plan for solutions should the “Cadillac Tax” be implemented in 2020.
- Absorbing \$626,000 in required ACA fees rather than passing these fees along to participating dioceses and institutions.

2017 Outlook

The future of the ACA is uncertain following the 2016 election results. President Donald J. Trump and congressional leadership have indicated repealing and replacing the law is a top priority. The ACA also faces instability in the state exchanges due to high premium increases and lower participation than expected. While it is too early to tell what will ultimately happen, the ACA is likely to undergo significant changes over the next few years. The Medical Trust will continue to monitor these developments and how the DHP is impacted.

We estimate that Medical Trust rates in 2017 will be more competitive than the local exchanges in 90% of the groups we cover. With respect to the remaining groups, we expect Medical Trust rates to be no more than 10% above the average local exchange rate. We will continue to explore additional opportunities to provide greater equity in healthcare contribution costs without materially impacting the competitiveness of the DHP at local and regional levels.

2016 Year in Review

I. DHP Participation Remains High

The intent of the DHP’s mandatory participation provision is cost containment, with the objective of using volume to drive savings through an Episcopal Church purchasing coalition for health benefits. General Convention Resolution 2012-B026 affirmed the “all in” nature of the DHP.

Participation remains high, with nearly all of the eligible population of the Church (excluding those who have coverage through other approved sources) enrolled in the DHP. All domestic dioceses have been participating in the DHP since January 2014. In addition, 52 other groups (schools, camps, conference centers, and other Church agencies) chose to participate in Medical Trust plans over other available options. The Medical Trust continued to reach out to administrators in all dioceses to gather information, encourage participation, and discuss steps for enrolling any remaining clergy and lay employees who should be enrolled. While all domestic dioceses have been participating, only 82% have confirmed they have implemented specific policies or canons that address the requirement for parishes and other institutions in the diocese to participate in Medical Trust sponsored plans.

As detailed in General Convention Resolution 2009-A177, each diocese was required to set a minimum cost-sharing policy that applies equally to eligible clergy and lay employees by December 31, 2015. Based on information available to us in 2016, 75% of dioceses have an approved cost-sharing policy in place. The Medical Trust will continue to work closely with the remaining dioceses to assist them in their efforts to establish, on a diocesan-wide basis, the minimum required employer cost-sharing policy for healthcare benefits.

II. Promoting the Fund for Medical Assistance

We also continue to support our clients in the nondomestic dioceses through the Fund for Medical Assistance, which offers financial assistance to individuals facing healthcare expenses that are not otherwise covered by public or private insurance programs. In 2016, we granted \$32,000 from the Fund for Medical Assistance. We will continue our efforts to promote the benefits of this program to non-domestic dioceses in 2017.

III. A Continued Commitment to Cost Containment

The Medical Trust remains committed to containing cost increases while continuing to provide comprehensive healthcare benefits and compassionate service. In order to provide the lowest possible rates while maintaining competitive levels of coverage for its members, the Medical Trust continues to:

- Evaluate its plan designs for quality and value.
- Leverage purchasing power in negotiations with key vendors to achieve maximum savings on plan administration fees.
- Participate in the Express Scripts group purchasing coalition for pharmacy benefits. Contract negotiations in 2016 will reduce future prescription drug costs by approximately \$37 million over the next three years.
- Manage its internal operations to drive continued cost efficiencies.
- Explore additional cost-saving opportunities that develop in the emerging healthcare marketplace.
- Encourage its members to take active responsibility for their own health and wellness by engaging them through educational programs and other resources in collaboration with participating groups.
- Encourage small employers (those with fewer than 20 employees) with active employees over age 65 to participate in our Medicare Secondary Payer Small Employer Exception plans to defray costs for the employee, group, and Plan.
- Seek out opportunities to eliminate unnecessary costs through management programs that encourage appropriate use of healthcare services.

This past year the Medical Trust continued to implement a multiyear strategy to provide a comprehensive healthcare benefits program that not only meets clients' unique needs, but also remains affordable when compared with similar options in the broader marketplace. In doing so, it successfully:

- Modified the Kaiser plan array, merging two benefit-rich options into a consolidated design and implementing a new consumer-directed option to provide meaningful choice and support for client cost containment strategies.
- Implemented further enhancements to prior authorization programs that provide additional improvements to the overall member experience.
- Reduced the plan array by eliminating two underutilized and redundant plan options.
- Consolidated three plan options as part of a continued strategic plan for simplification.
- Eliminated Aetna as an offered vendor at year-end 2016, which enables the Medical Trust to align individuals to more cost-efficient networks.

The Medical Trust spends approximately 90% of every dollar collected to pay claims, which is higher than the 85% required by the ACA for large-group insurance. The remaining dollars are budgeted for third-party fees and other expenses associated with administering the DHP. When expenses run lower than contributions, any remaining dollars are added to the member surplus account to absorb unexpected claims fluctuations.

In 2016, the Medical Trust used its accumulated surplus to pay for approximately \$626,000 in fees required by the ACA. This brings the inception to date total to \$3.03 million in costs that have been absorbed and not passed along as an expense to participating groups.

IV. Maintaining Compliance with Healthcare Reform Provisions

Compliance with healthcare regulations remains paramount. The Medical Trust continued to focus on full compliance with the ACA's healthcare reform provisions throughout the year, including filing required tax reporting for Minimum Essential Coverage (MEC). The Medical Trust issued Forms 1095-B to participants and the IRS, and also completed the required Form 1094-B for submission to the IRS. In addition, the Medical Trust continues to evaluate benefits and makes ongoing modifications to remain in compliance, such as the notice of nondiscrimination and accessibility requirements under the ACA, and any related benefit changes.

V. Equitable Sharing Of Healthcare Premium Costs

Each year, the Medical Trust deploys a two-step pricing process. In the first step, it pools all participating groups to leverage the purchasing power of the larger group to achieve the best financial terms from vendors. It then establishes the overall contribution that must be paid by all DHP participants in the aggregate to cover expected costs.

In the second step, the Medical Trust reviews cost disparities and local rate competitiveness when determining the annual contribution rate for each local and regional group. In 2016, the Medical Trust continued to make progress reducing the cost disparities between the highest-priced and lowest-priced dioceses to allow for a more even sharing of healthcare contribution costs.

VI. Maintaining Our Competitiveness in the Marketplace

As of April 2016, average Medical Trust rates were approximately 4% below the average health insurance exchange rate, and we expect the DHP's position to improve for 2017. The Medical Trust estimates that over 90% of the groups participating in the DHP will be in a more competitive position than their local exchanges in 2017.

The Medical Trust was able to deliver a single-digit average rate increase of 5.5% for the 2017 plan year, a favorable result as compared to exchange rate increases that averaged 24%. The ongoing process of monitoring local market developments enables the Medical Trust to make necessary adjustments in future renewals to address market competitiveness issues that may continue or arise due to volatility in the exchanges.