

## 2014 Denominational Health Plan Annual Report

In July 2009, the 76th General Convention passed Resolution A177 and its associated Canon, establishing the Denominational Health Plan (DHP). The resolution calls for The Church Pension Fund (CPF) to administer the DHP, with healthcare benefits to be provided through The Episcopal Church Medical Trust (Medical Trust), a CPF affiliate.

Under the provisions of Resolution A177, eligible clergy and lay employees are those scheduled to work a minimum of 1,500 hours annually for any domestic diocese, parish, mission or other ecclesiastical organization or body subject to the authority of the Church. Implementation was to be completed by January 1, 2013.

### **Resolution A177 has two distinct and separate goals, each of which can stand alone:**

1. Achieve cost containment for the Church in light of continually rising healthcare costs.
2. Provide equal access to and parity of funding for healthcare benefits for eligible clergy and lay employees in the domestic dioceses.

In July 2012, the 77th General Convention passed Resolution B026 and its associated Canon, affirming all of the requirements of Resolution A177 including the implementation date of January 1, 2013, but extends the period for achieving parity in cost-sharing between eligible clergy and lay employees until December 31, 2015.

Resolution B026 also urges the Medical Trust to continue to reduce the disparity in costs among dioceses and to continue exploring alternative strategies to arrive at a more equitable sharing of healthcare premium costs, including alternative means of achieving such equity by December 31, 2015. The resolution also calls for the Medical Trust to make an annual written report to the Executive Council, the House of Bishops and the CPF Board of Trustees, detailing progress in the containment of costs and achievement of such equity.

Although all domestic dioceses, congregations, and missions are required to participate in the DHP, each diocese decides whether its schools, daycare facilities, and other diocesan institutions are required to participate. Dioceses also decide what their diocesan-wide cost-sharing policy will be, whether or not to offer domestic partner healthcare benefits, and what Medical Trust health plans to offer. Individual employees may opt out of the DHP if they have coverage through approved sources such as a spouse or partner's coverage, Tricare, or individual coverage through the Health Insurance Marketplace (Marketplace) if verification of qualification for federal premium tax credits is provided. The Church Pension Group's (CPG) Integrated Benefits Account Management and Sales (IBAMS) relationship managers work with each diocese to help them understand their choices under the DHP, custom tailor an implementation plan to specific needs, and assist with compliance, while providing them and their employees with on-line resources, webinars and tools.

**As delineated in the sections of the report that follow, most dioceses and parishes have made material progress toward implementing this initiative which has contributed to the following realized benefits of the DHP:**

- **DHP Participation is largely complete:** Since January 1, 2014, all domestic dioceses have been participating in the DHP, with nearly full compliance of the eligible clergy and lay employee populations (excluding those who have coverage through other approved sources) receiving healthcare benefits through the Medical Trust.
- **The DHP continues to deliver cost containment:** The increased collective purchasing power due to the expanded participation in the Medical Trust allowed the DHP to drive cumulative cost containment leading to a savings of approximately 13%, or \$69 million, to the Church from 2012 through 2014. These savings have been passed directly to the Church through lower annual rate increases for participating dioceses and institutions.
- **The DHP is achieving equity in healthcare contribution costs:** These cumulative savings have enabled the Medical Trust to take meaningful steps in addressing cost disparities in levels of annual contributions by compressing the pricing structure from 14 to 6 bands from 2011 to 2014. Further action was taken during 2015 pricing, reducing the spread of highest to lowest rated groups from the pre-DHP ratio of 3:1 to a ratio of around 1.5:1. In other words, we cut the spread between the highest-priced and lowest-priced dioceses in half, bringing over 75% of dioceses to within 5% of the overall average Medical Trust contribution rate level.

### Non-Domestic Dioceses

Although non-domestic dioceses and institutions are not part of the DHP as defined by Resolution A177, the resolution directed CPF to “continue to work with the Dioceses of Colombia, Convocation of American Churches in Europe, Dominican Republic, Ecuador Central, Ecuador Litoral, Haiti, Honduras, Micronesia, Taiwan, and Venezuela to make recommendations with respect to the provision and funding of healthcare benefits of such dioceses under the DHP.” In response to varying economic and healthcare access constraints in these countries, the CPF Trustees established the Fund for Medical Assistance (FMA) in 2010 for a five-year pilot period. The FMA provides reimbursement to eligible full-time clergy and lay employees in non-domestic dioceses for certain healthcare expenses not otherwise covered by public or private insurance programs. In 2014, the CPF Trustees approved a three-year extension of the FMA, and expanded eligibility, simplified the application process, and allowed for greater flexibility in accessing available funds in order to promote increased use.

## I. Participation

The intent of the DHP’s mandatory participation is cost containment, with the objective of driving scale and savings through an Episcopal purchasing coalition for health benefits. According to Resolution B026, the “all in” nature of the DHP was affirmed as was the original implementation date of January 1, 2013, when all domestic dioceses, parishes, missions and other ecclesiastical organizations and bodies subject to the authority of the Church must offer Medical Trust health plans to their clergy and lay employees who are scheduled to work at least 1,500 per year. The exception to this requirement is that dioceses must determine if their schools, day care facilities and other diocesan institutions are required to participate in the DHP or if these organizations will participate on a voluntary basis.

Since January 2014, all domestic dioceses and 48 additional groups have been participating in the DHP (see Exhibits A and B for growth in participating groups from 2004 through 2014). The additional groups consist of several large mandated institutions and various schools, camps, conference centers and other Church agencies. The current enrollment in Medical Trust plans offered under the DHP represents a total of 13,900 households (26,000 total members, including covered dependents). Current participation levels have recently exceeded the DHP Feasibility

Study estimate of 13,061 households for a fully implemented DHP.

Based on available data, the current DHP enrolled population represents nearly all of the eligible population of the Church (excluding those who have coverage through other approved sources). CPG's IBAMS relationship managers will continue to reach out to group administrators to validate participation data and discuss next steps for enrolling any remaining clergy and lay employees in non-participating congregations who are not able to demonstrate they are covered under an approved source.

Exhibit A

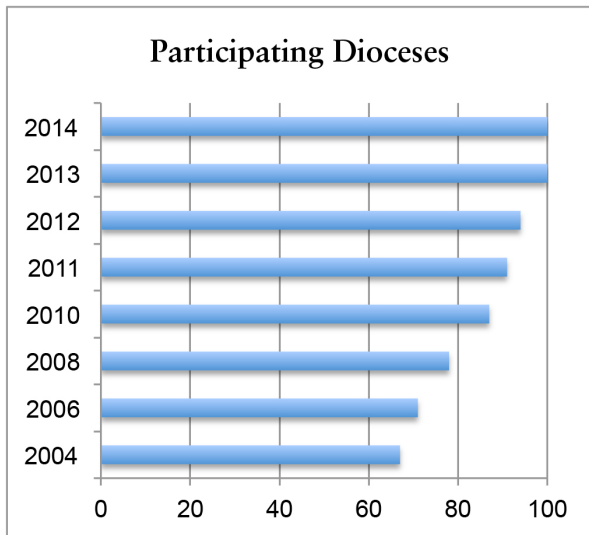
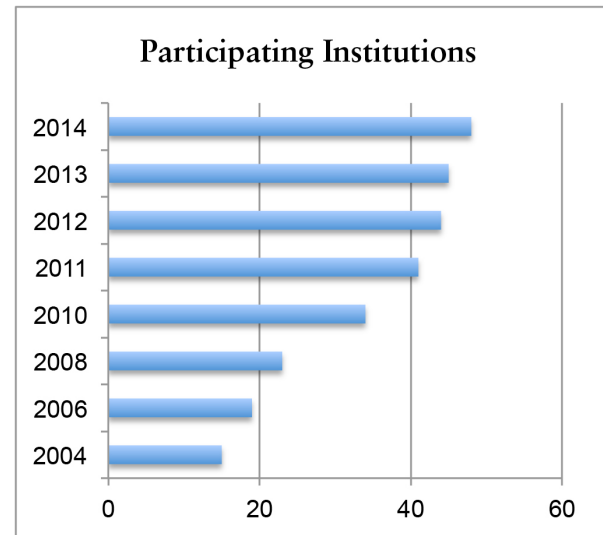


Exhibit B



## II. Cost Containment

The healthcare landscape is in a persistent state of change, and these changes will continue to impact costs for 2015 and beyond. Many factors impact the overall healthcare cost trend: some continue to apply upward pressure, while others are moderating influences. The combined impact of these factors is expected to continue to keep annual increases in the cost of healthcare greater than the overall U.S. inflation rate, as well as workers' wage increases and economic growth. For large U.S. employers in 2015, leading consultancies and the National Business Group on Health have forecasted average cost increases for health benefits ranging from 6.5% to 8.0%. As in 2014, a wider range of increases is forecasted for both smaller U.S. employers and for qualified health plans on the Marketplace.

The Medical Trust strives to contain cost increases on an ongoing basis, while continuing to provide robust and high-quality healthcare benefits and consistent service. In order to achieve the lowest possible rates for our members, the Medical Trust:

- Continually evaluates our plan designs for quality and value
- Leverages our increasing purchasing power in our negotiations with our vendors to achieve maximum savings on plan administration
- Participates in group purchasing coalitions with other denominations, such as prescription drug contract negotiations with Express Scripts
- Proactively manages our internal operations to drive continued cost efficiencies
- Explores additional cost savings opportunities that develop in the emerging healthcare marketplace

- Encourages members to take active responsibility for their own health and wellness by engaging them through educational programs and other resources in collaboration with our participating groups.

**Cost containment continues to drive savings for the Church.** Cost containment is a key goal of the DHP and a continual focus of the Medical Trust. The DHP has been able to drive cumulative cost containment leading to a savings of approximately 13%, or \$69 million, to the Church from 2012 through 2014. This compares favorably with the DHP Feasibility Study's estimated cumulative total of expected savings of 10% for a fully implemented DHP. These savings have been passed directly to the Church through lower annual rate increases for participating dioceses and institutions from 2009 through 2014. To put this in perspective, from 2010 to 2014, U.S. employers' health insurance premiums increased an average of 5% to 11% annually (assuming individuals remained in the same plans), while the Medical Trust's increases averaged 4.3% to 6.0% on an annual basis (assuming individuals remained in the same plans).

**About 90% of every dollar collected will go to pay participant benefits in 2014.** The Medical Trust strives to contain cost increases on an ongoing basis by addressing the factors within our control while continuing to provide robust and high quality healthcare benefits and consistent service to clergy, lay employees and their covered dependents. Key Medical Trust objectives continue to focus on containing and stabilizing costs, providing savings to the Church, and making the continued provision of healthcare benefits by the Church sustainable.

In 2014, the Medical Trust will spend about 90% of every dollar collected to pay claims, with the remainder of every dollar going towards vendor administrative service fees and Medical Trust expenses to administer the DHP and provide related services such as billing and collections, member advocacy, and client and member education. Any remaining dollars are returned to member surplus to assist with financial sustainability and to absorb future unexpected claims fluctuations. The current level of 90% is well above the minimum legislative requirements of 85% for large group insurance and 80% for small group insurance (typically defined as groups with less than 50 employees), and has steadily improved since the beginning of the DHP implementation. The Medical Trust has experienced a significant increase in the number and size of large claims paid in 2014 and has used accumulated surpluses to absorb the resulting higher-than-expected claims levels. The Medical Trust has also used accumulated surpluses to pay for approximately \$1.6 million in required fees under the Affordable Care Act (ACA), such as the Transitional Reinsurance Fee and the Patient-Centered Outcomes Research Trust Fund Fee, rather than passing these fees along to participating dioceses and institutions.

**DHP plan designs continue to provide high levels of benefits and services.** The addition of dioceses that were not previously participating in the Medical Trust, national trends in the healthcare industry, the changing economy and the passage of healthcare reform have resulted in the need for a wider array of plan designs than the initial DHP model offering. Over the past several years, the Medical Trust has continued to be flexible regarding needed changes in our product array while being mindful of the administrative complexity of managing the plans.

For 2015, no changes were made to the product array of medical plans offered by the Medical Trust. Areas of focus for 2015 were benchmarking eligible covered services and compliance with the ACA and medical management programs. As a result, beginning in 2015, covered benefits will be expanded to include the following: (1) infertility treatment with separate medical and prescription drug lifetime maximums, (2) applied behavioral analysis (ABA Therapy) for children with autism spectrum disorder, and (3) medical transition benefits for transgender individuals, including gender

reassignment surgeries and hormone replacement therapies. Also in 2015, medical management programs will be implemented with all vendors to support stronger medical necessity and outcomes-based criteria.

Leading up to and during 2014, the Medical Trust closely monitored the launch of the Marketplace created by the ACA. As expected, the vast majority of Marketplace participants (over 80%) enrolled in Silver or Bronze Plans (plan pays 70% or 60%, respectively of costs on average). Prevailing offerings for the Episcopal Church continue to be at more generous benefit levels with about 87% of Medical Trust participants enrolled in Platinum Plans (plan pays 90% of costs on average) even when Gold and Silver level plans are offered. Recent research conducted by the management consulting firm McKinsey & Company suggests that about 50% of plans on the Marketplace use narrow networks (defined as networks that include only 30% to 70% of the hospitals that are in the broadest networks). All Medical Trust plans continue to use broad, national networks of providers in order to provide clergy and lay employees greater access to hospitals and doctors and to facilitate their mobility.

The Medical Trust also conducted an extensive review of the 2014 premium rates on the Marketplace. By accessing Aon Hewitt Consulting's database, we were able to match current Medical Trust contribution plan rates with the Marketplace rates at the individual participant level. A rollup at the national level showed that the average Medical Trust rates were approximately 2% below the average Marketplace rates. We also compared the least and most expensive plans in each market to the Medical Trust rates and found that rates ranged +/-30% within most markets, demonstrating that materially lower and higher rated plans exist in almost all markets, depending on the penetration of narrow network plans, local hospital and doctor competition, and number of health plans offering plans on the Marketplace.

The Medical Trust will continue to review and evaluate these and other emerging market trends and their potential fit with the available DHP plan design options, incorporating those that add value and working collaboratively with our clients to ensure that the array of plan designs properly balances a breadth of offerings with financial stewardship. As the expected changes in the healthcare market evolve, the Medical Trust will be reassessing the overall array of plan design and vendor offerings to make sure that the needs of our clients and members continue to be met, while seizing opportunities for enhanced value and cost efficiencies and remaining competitive with local market offerings and premium rate levels.

### **III. Equitable Sharing of Healthcare Premium Costs**

Resolution B026 urges the Medical Trust to continue to reduce the disparity in costs among dioceses and to continue exploring alternative strategies to arrive at a more equitable sharing of healthcare premium costs, including alternative means of achieving such equity by December 31, 2015.

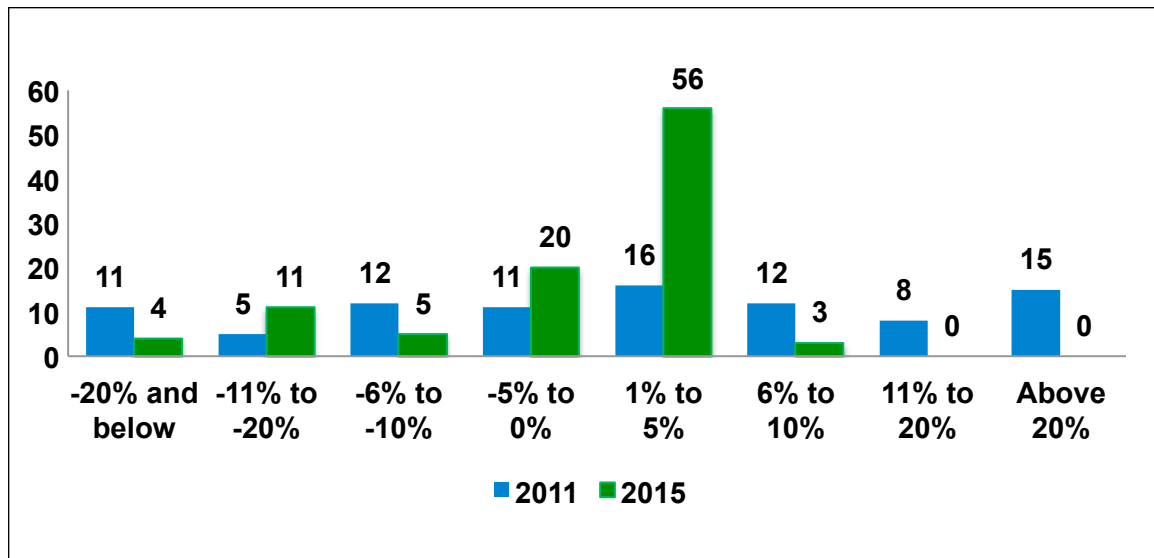
The Medical Trust deploys a two-step annual pricing process. The pooling of all Medical Trust participants is the first step of the process. In that step, the Medical Trust uses the DHP larger group purchasing power in order to achieve the best financial terms from vendors and then establishes the overall contribution that must be paid by all DHP participants in the aggregate to cover expected costs.

Determining annual contribution rates for each local and regional group occurs in the second part of the pricing process. The Medical Trust's standard pricing methodology takes into consideration

each group’s demographic characteristics (age, gender, family composition) and the cost of healthcare services in the group’s geographic location. Before the passage of the DHP, the Medical Trust operated with 14 pricing bands (where band 14 rates were approximately three times the level of band 1 rates). The implementation of band compression lowered the number of bands from 14 to 10 in 2012, and down to 6 in 2014. Further progress was made for 2015 renewals by passing along lower-than-average increases to the remaining higher rated groups. These actions have resulted in a compression of the spread of highest to lowest rated groups from the pre-DHP ratio of 3:1 to a ratio of around 1.5:1. In other words, we cut the spread between the highest-priced and lowest-priced dioceses in half, bringing over 75% of groups to within 5% of the average Medical Trust book of business rate (See Exhibit C). In order to achieve these results, the Medical Trust altered its standard methodology to allow for a more equitable sharing of healthcare contribution costs while applying gradual increases to the lower-priced groups.

The Medical Trust’s band compression strategy has provided flexibility to reduce the disparity between those priced at the lowest and highest rate levels but has also resulted in rates that are not as competitive (up to 25% or higher) with the local market for certain dioceses. We anticipate further migration to be less significant as we look to balance equitable cost sharing with local market competition. That said, the Medical Trust will continue to explore additional opportunities to provide greater equity in healthcare contribution costs without materially deteriorating the competitiveness of the DHP at local and regional levels.

Exhibit C - Diocesan Rates Versus Average Medical Trust Rate



**Note:** Exhibit C illustrates the impact of the Medical Trust pricing band compression from 2011 (blue bars) to 2015 (green bars) comparing the distribution of diocesan contribution rates versus the Medical Trust average book of business rate level from current to pre-band compression levels. Most notably, the number of dioceses that are within 5% of the average Medical Trust rate level has increased from 27 to 76 from 2011 to 2015.





**CHURCH  
PENSION FUND**

19 East 34th Street  
New York, NY 10016  
(800) 223-6602  
[www.cpg.org](http://www.cpg.org)