CHURCH PENSION FUND

# 2015 Denominational Health Plan Annual Report

## 2015 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 2015 we advanced a number of key DHP initiatives, including:

- Maintaining robust participation in the DHP with more than 95% of all eligible clergy and lay employees participating in or obtaining healthcare coverage through 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
- Implementing a two-year plan to help dioceses that have traditionally provided only the most expensive plans consider a broader array of plans representative of those that are more prevalent in the marketplace
- Maintaining a strong financial position with rates that are competitive and remain comparable to or lower than online health insurance exchange rates in most markets
- Advancing the issue of parity through our efforts in assisting dioceses establish the minimum required cost-sharing policy
- Remaining compliant with the Affordable Care Act (ACA), while reviewing and preparing for the impact of the Cadillac Tax, which will impose a 40% excise tax on high-cost employer-sponsored health plans, if it is implemented in 2020 as scheduled
- Absorbing an accumulated $2.3 million in required ACA fees rather than passing these fees along to participating dioceses and institutions
- Expanding eligibility rules, simplifying the application process and making other changes to increase usage of the Fund for Medical Assistance, and communicating these improvements to non-domestic dioceses to raise awareness of this program

## 2016 Outlook

As we look toward 2016, we expect continued rate fluctuations in the plans offered through the health insurance exchanges as some of the ACA financial safeguards expire. In addition, we expect health insurance companies offering insurance through the health insurance exchanges to experience continued pressure to increase rates to offset higher than expected claims and the impact of failing health insurance cooperatives. Our focus remains on continued cost containment while providing quality customer service and increased value to our clients. Looking ahead, The Episcopal Church Medical Trust (Medical Trust) will also 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.

## 2015 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, as well as its implementation schedules.

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, 50 other groups, schools, camps, conference centers and other Church agencies chose to participate in Medical Trust plans over other available options. We will continue to reach out to group administrators to encourage participation and discuss steps for enrolling any remaining clergy and lay employees who are not able to demonstrate they are covered under an approved source.

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, 65% of dioceses have an approved cost-sharing policy in place. We 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 non-domestic dioceses through the Fund for Medical Assistance, which is designed to offer financial assistance to individuals in need of certain healthcare expenses not otherwise covered by public or private insurance programs. We will continue our efforts of promoting the benefits of this program to non-domestic dioceses in 2016.

### III. A Continued Commitment To Cost Containment

The Medical Trust remains committed to containing cost increases as it seeks to provide a comprehensive healthcare benefits program coupled with excellent customer service. In order to provide the lowest possible rates while maintaining competitive levels of coverage for our members, the Medical Trust continues to:

- Evaluate its plan designs for quality and value
- Leverage its increasing purchasing power in negotiations with vendors to achieve maximum savings on plan administration fees
- Participate in group purchasing coalitions with other denominations, such as prescription drug contract negotiations with Express Scripts
- 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

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

- Introduced three new Anthem BlueCross BlueShield plan designs; the Gold High-Deductible Health Plan (HDHP), the Silver non-HDHP, which will also have a corresponding Medicare Secondary Payer Small Employer Exception plan, and the Bronze HDHP. These plans provide additional options and support our clients' cost containment strategies
- Implemented further enhancements to our Anthem BlueCross BlueShield prior authorization program that provides additional improvements to the overall member experience
- Eliminated three underutilized and redundant plan options

In 2015, the Medical Trust spent approximately 90% of every dollar collected to pay claims, with the remainder of every dollar spent on vendor administrative service fees and expenses to administer the DHP and provide related services such as billing and collections, member advocacy and education. Any remaining dollars are added to the member surplus account to absorb unexpected claims fluctuations. The current level of 90% is above the ACA's minimum legislative requirements of 85% for large group insurance and 80% for small group insurance (i.e., those with less than 50 employees), and has steadily improved since the beginning of the DHP implementation.

The Medical Trust used accumulated surplus to pay for approximately $2.3 million in required fees under the ACA, rather than passing these fees along to participating dioceses and institutions.

## Maintaining Compliance with Healthcare Reform Provisions

Compliance with healthcare regulations remains paramount. We continued to focus on full compliance with the ACA's healthcare reform provisions such as implementing solutions to comply with reporting requirements for the individual and employer mandates. To better assist them in their reporting and compliance efforts, and to help educate and inform them of the requirements and associated penalties, we provided employers with information to be shared with their related entities via the web, email, webinars and conferences. We also contracted with Sovos Compliance, a leading provider of regulatory compliance solutions, to ensure full compliance with our reporting obligations. In addition, we created a multi-unit project team consisting of our Benefits Policy, Tax, Communications/Web, Integrated Benefits Operations, Information Technology and Legal groups. This team developed various communications and education materials to alert Administrators that, beginning in 2016, we will complete the required individual mandate reporting for our self-insured plans, while Administrators will maintain responsibility for the employer mandate reporting.

## Preparing for the Potential Impact of the Cadillac Tax

Last December, Congress voted to postpone the implementation of the Cadillac Tax, which will impose a 40% excise tax on high-cost employer-sponsored health plans, until 2020. In advance of this decision we have contracted with Aon Hewitt Consulting, a leading global provider of risk management, insurance and reinsurance brokerage, and human resources solutions and outsourcing services, to better understand and quantify the potential impact the Cadillac Tax would have on our clients and our operations based on current guidance and plan selections. We have also worked with the Church Alliance, a coalition of the chief executive officers of 37 church benefit programs, to submit two comment letters to the Internal Revenue Service (IRS) with the goal of educating the IRS about the unique issues addressed by church plans and to request certain relief from the Cadillac Tax. While the future of the Cadillac Tax remains uncertain, we believe our advance preparation and the analysis that we conducted in 2015 positions us well for the future.

### IV. Equitable Sharing Of Healthcare Premium Costs

Each year, the Medical Trust deploys a two-step annual 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, we review cost disparities and local rate competitiveness when determining the annual contribution rate for each local and regional group. In 2015, we continued to make progress on reducing the cost disparities between the highest-priced and lowest-priced dioceses to allow for a more equitable sharing of healthcare contribution costs.

## Maintaining Our Competitiveness in the Marketplace

While we have been successful in reducing the disparity between those priced at the lowest and highest rate levels, it has created some tension as some rates are not competitive with the local market for certain dioceses. Although our overall average Medical Trust rate remains generally competitive and is approximately 2% below the 2015 average health insurance exchange rate, aggressive rate setting techniques on the health insurance exchange in certain markets contributed to local competitive rate issues for about 25 dioceses in 2015.

We shared this information at the 78th General Convention in an effort to provide a comparison of how competitive the Medical Trust is with the ACA health insurance exchanges. We also listened to the discussion and concerns regarding the geographically disproportionate financial burden that participation in the DHP has reportedly had on certain dioceses and have taken this into account with our 2016 renewal actions and decisions.

Accordingly, we expect to be more competitive on an overall basis and locally in 2016. We anticipate an overall rate increase of approximately 5% to 6%, which compares favorably to reports showing expected marketplace increases in the low double digits.

We remained balanced in addressing the cost disparities and local market pressures in our 2016 pricing actions and expect to largely address market competitive issues for most dioceses in 2016.

We will continue to monitor local market developments through 2016 and make any necessary adjustments in future renewals to address any remaining market competitiveness issues.