CHURCH PENSION GROUP
Serving the Episcopal Church and Its People

Healthcare Coverage Feasibility Study and Recommendation to the 76th General Convention of the Episcopal Church

Executive Summary

In these challenging economic times, the continued accessibility and affordability of healthcare benefits for all those who serve the Church is one of the most pressing issues. In recognition of this, the 75th General Convention authorized the Church Pension Group (CPG) to conduct the Church-wide Healthcare Coverage Feasibility Study of the costs and issues surrounding the provision of healthcare benefits to all clergy and lay employees, including an analysis of and recommendation for a denominational healthcare benefits program, and to report back to the 76th General Convention this July.

The Episcopal Church is at a crossroads. The cost of providing healthcare benefits continues to increase, and congregational budgets are not able to keep pace. In 2010, the projected cost to The Episcopal Church for employee healthcare benefits is expected to increase by 9.5%. Total spending on employee healthcare benefits for 2010 by domestic congregations, dioceses, and official agencies, not including any dioceses in Province IX, is projected to be $161.2 million, or $12,343 per employee. The projected 9.5% increase is expected to be more than four times the rate of inflation and approximately four times the rate of average clergy salary increases.

Further, total annual spending on employee healthcare benefits in 2010 could represent more than 10% of Plate and Pledge income. Left unchecked, spending on employee healthcare benefits could increase at similar levels for the next two triennia, reaching $250.4 million in 2015 — potentially, 15% of the Plate and Pledge income as projected by the feasibility study.[1]

Over the past three years, we have conducted comprehensive research and analyses, financial modeling, focus groups, and plan comparisons. (See Sections 2 and 3 of this Report for details.) The study was conducted under the leadership of the Church Pension Fund (CPF) Board of Trustees' Healthcare Coverage Feasibility Study Advisory Group, headed by David R. Pitts. This Report, and the recommendation for a denominational health plan that will be presented at the 76th General Convention as Resolution A177, is the culmination of that exhaustive effort.

The denominational health plan, as recommended by the CPF Board and described below, is a socially and financially sustainable model for delivering employee healthcare benefits to eligible clergy and lay employees. Not only is it designed with fairness and equity in mind, but the savings it will generate, the benefits it will enhance, and the access it will provide, are unmatched by any available alternative.

At its core, it enables the Church to leverage its aggregate size for the large-scale purchase of employee healthcare benefits while dioceses and groups retain autonomy over key aspects such as plan choice and design and employee cost-sharing. Service to and savings for the Church are further enhanced by the centralization of administration, through the Episcopal Church Medical Trust (the Medical Trust), of employee healthcare benefits for The Episcopal Church.

At present, there is no binding General Convention resolution or canon requiring dioceses, congregations, or official agencies of the Church to provide healthcare benefits to their employees. Instead, healthcare benefits for clergy and lay employees working in the Church today are provided through a voluntary program of multiple and differing diocesan plans. Thus, each diocese functions separately and alone in the purchasing, administration, and delivery of health benefits. This results in an inefficient system that is unable to take advantage of economies of scale, and creates unequal costs and benefits across the Church.

[1] *Projected Plate and Pledge assumes a growth rate of 2.5% for the years 2009 to 2015 which may need future revision if the current economic conditions continue.*

In 2008, there were more than 100 different health plans being sponsored by domestic dioceses, not including the health plan options sponsored by congregations outside of their diocesan health program. Current data indicates that more than 13,000 clergy and lay employees are covered through congregation[2]- and diocesan-sponsored healthcare benefits programs. Of these, almost 9,000 are currently in plans administered and sponsored by the Medical Trust for active employees. The Medical Trust administers approximately 20 health plan options for 78 diocese, and there are almost 60 health plans administered locally by the remaining 20 dioceses not participating in the Medical Trust.

The economics of the U.S. healthcare environment require that purchasers strive for economies of scale, as larger groups yield lower unit costs. This is especially true today, with rising costs increasing the burden on employers and employees. According to the Kaiser Family Foundation, cumulative wage growth has risen 20% since 2000, while the cost of health insurance has risen 87%. The current multiplicity of separate diocesan healthcare programs is antithetical to the kind of model that results in lower costs.

For the Church, the cost of providing healthcare benefits are significant — typically, 7% to 9% of a median congregation budget. While this percentage does not vary significantly by the size of the budget, there are considerable differences in overall costs among individual congregations as well as dioceses. Congregations with smaller budgets and an average Sunday attendance below 100 may have costs of 14% or higher of the total operating budget. Moreover, the cost of providing health-care benefits are expected to continue to increase by 9.5% annually, while congregational operating revenues are only increasing at a rate of 2.5% per year.

Under the denominational health plan, however, conservative actuarial estimates demonstrate that the potential first-year savings[3] to the Church of the fully implemented plan are estimated to be least 10%, or approximately $17.7 million, for clergy and lay employees who are currently provided healthcare benefits, and a cumulative $64 million in the first four full years after approval. These numbers provide compelling support for the plan.

While the savings for an individual congregation will vary due to many factors — including congregational operating revenue and staffing levels — congregations and institutions currently offering healthcare benefits can expect a cost savings of 5% to 10% annually under the denominational health plan. In fact, the denominational health plan works for all five categories of congregations, from Family through Resource. (Impact analyses for all five categories appear in Section 5 of this Report.)

The situation in the non-domestic Episcopal dioceses is far more complex. Our completed in-depth research regarding healthcare in non-domestic diocese has made it clear that country-by-country solutions will be needed. The project team is actively engaged with the bishops and leadership of non-domestic dioceses to develop meaningful recommendations that can assist them.

[2] *In the context of this report, "congregations" includes cathedrals, parishes, missions, and chapels.*

[3] *Overall savings come from a variety of sources including elimination of most state premium taxes and brokerage fees, reduction in administrative service fees from product partners, and improvement in the underlying health risk of the employee population.*

Advantages of the Denominational Health Plan for the Church

The recommendation for a demominational health plan is based on significant advantages for Church employers and employees alike:

- **Sustainability of healthcare benefits:** In the light of increasing healthcare costs, the continuing ability of the Church to provide healthcare benefits becomes problematic. The denominational health plan contains costs, effects savings, and makes the continued provision of employee healthcare benefits sustainable.
- **Cost savings:** Conservative actuarial estimates indicate a cumulative savings of $64 million over first four years.
- **Economies of scale:** The ability to buy healthcare benefits collectively rather than per-diocese or per-congregation means savings for the Church since larger groups yield lower unit costs.
- **Diocesan autonomy and decision making:** Dioceses and groups will decide for themselves about employer cost-sharing, plan design options, the inclusion of schools and other diocesan institutions, and the offering of healthcare benefits to domestic partners.
- **Parity of eligible clergy and lay employees:** Each diocese or group will set its own cost-sharing level, and it must be the same for all eligible clergy and lay employees. Many clergy and lay employees have said this is an important social justice issue for the Church. Most congregations will find that their savings cover the additional cost of covering their eligible lay employees.
- **Portability of benefits:** Seamless transition of healthcare benefits when lay and clergy employees change jobs or residences, thanks to centralized administration and benefit plans
- **Centralized administration:** Currently, every diocese and institution manages its own plans, duplicating efforts and using time that could be better used for mission and ministry. Decreasing the administrative burden for employers by centralizing healthcare benefits administration saves time and money while freeing administrators to do more important work. It also allows the Church to take advantage of economies of scale, and equalizes costs and benefits across the Church.
- **Wide range of plan designs:** Dioceses will be able to offer employees a comparable range of plan choices as they do today. In fact, they may have even more plan designs available from which to choose.
- **Serving the Common Good:** Because the denominational health plan provides cost savings for the Church overall, and offers lay and clergy employees parity in healthcare benefits, it satisfies the imperative of the Church to do well by doing good and to serve the needs of all.

Report Contents

The comprehensive report that follows is divided into the following seven sections:

1. **Introduction and Background**
   The genesis, goals, scope, process, and governance of the feasibility study, and the text of Resolution A147 of the 75th General Convention
2. **The Church's Involvement in the Feasibility Study**
   The theology that informed the team's work, and the roles of myriad people across the Church — including bishops, diocesan administrators, clergy, and lay employees — in providing various perspectives and opinions throughout the study
3. **Data Collection and Analysis**
   A description of the exhaustive process used to capture and analyze data from across the Church, from other major denominations, and from the broader healthcare marketplace in the United States and elsewhere
4. **The Denominational Health Plan Recommendation**
   A detailed description of the denominational health plan that is being recommended to the 76th General Convention
5. **Impact Analysis by Church Size**
   A comprehensive analysis of the financial impact of today's various healthcare approaches and costs, as well as that of the proposed denominational health plan, on congregations in all church size categories
6. **Implementation Plan**
   A description and timeline of the transition process, and the inclusion and expansion of health and wellness programs
7. **Resolution A177 of the 76th General Convention and Proposed Canonical Change**

Section 1: Introduction and Background

This section provides an overview of the Church-wide healthcare feasibility study, including the genesis of General Convention Resolution A147, the overarching purpose and goal of the study, key objectives and parameters, scope and process, the formation of the project team, and the governance body that provided ongoing management and oversight.

During the past decade, the Church Pension Fund and the Medical Trust became increasingly aware that the high and rising cost of healthcare benefits for active clergy and lay employees was placing a progressively unsustainable financial burden on many dioceses and congregations. In light of the increasing severity of this problem, the Church Pension Fund Board of Trustees made a proposal to the General Convention that they would study the current situation in The Episcopal Church (TEC) and make recommendations to the 76th General Convention regarding new approaches to health-care benefits delivery that could restrain the growth of these costs.

Any such recommendations would need to address the following critical realities:

- The cost of healthcare benefits is high and rising rapidly toward levels that are unsustainable.
- Healthcare benefits costs are growing as a percentage of employee compensation.
- The percentage of a congregation budget that is devoted to the cost of employee healthcare benefits will continue to rise.

General Convention Resolution A147

In 2006, the 75th General Convention passed Resolution A147:

> *Resolved*, the House of _____ concurring, That the 75th General Convention endorse the Church Pension Group's proposal to conduct a church-wide study of the costs and issues surrounding the provision of healthcare benefits to all clergy and lay employees serving churches, diocese and other church institutions and to report their findings to the 76th General Convention; and be it further
>
> *Resolved*, That all diocese, congregations, and other church institutions are urged to cooperate with the conduct of this study by responding to requests for data regarding employee census and healthcare costs; and be it further
>
> *Resolved*, That this study will include an analysis of the potential for a mandated denominational healthcare benefits program and other viable alternatives, culminating in a recommended solution and an actionable implementation plan.

Feasibility Study Objectives

From the beginning, the feasibility study was intended to be a Church-wide effort over several years because of the complexity of the subject and the many constituencies whose voices would need to be heard.

The objectives were to conduct comprehensive research, data collection, and analysis, and, based on those findings, to propose a recommended course of action to the 76th General Convention. This work included exploring alternative solutions and their probable impact on individual Church employers, and building a consensus within The Episcopal Church as to the best long term strategy for both institutions and individuals.

The study examined two alternatives for The Episcopal Church:

- Retain the voluntary system of multiple and different diocesan programs currently in place, but with recommendations for new program features for dioceses participating in the Medical Trust to help them reduce and restrain future cost increases.
- Create a national denominational health plan for all eligible clergy and lay employees.

Early in the study, it became evident that a denominational health plan would have the most positive impact on employers and employees throughout the Church, and the greatest potential for cost savings. (See Section 5 for more details.)

It was determined that, to be effective, a Church-wide health plan would need to:

- Increase employer and employee participation in the Medical Trust, thereby reducing claim volatility, reducing operating unit costs, and improving bargaining leverage with vendors
- Increase the availability of more efficient plans, and optimize provider access while maintaining plan choice for members
- Reduce the administrative burden on participating groups
- Establish a uniform and coordinated wellness program designed to improve the health of the Church workforce, thereby positively impacting claims costs nationwide

Feasibility Study Parameters

To collect the relevant data needed for performing the analyses and developing a recommended solution, it was determined that the study would need to complete the following tasks:

- Define a current financial baseline (total cost, claims, retention, internal and external administration, etc.) against which the savings opportunities of new approaches would be measured against.
- Complete a census of employees working in The Episcopal Church.
- Review and assess the efficiency of available health plans and vendors (including network access, network size and capacity, provider discounts, access to centers of excellence, medical management features, eligibility, and available plan designs).

Specific to the analysis of establishing a denominational health plan for The Episcopal Church, the project team needed to:

- Determine a uniform eligibility rule for participation
- Review and assess the health plans of other denominations, including the Evangelical Lutheran Church in America (ELCA), the United Methodist Church, the Presbyterian Church (USA), and the Southern Baptist Convention
- Identify potential obstacles within The Episcopal Church that would need to be addressed in order to successfully implement a denominational health plan.
- Create standard plan designs from which to model cost
- Develop a funding model (employer/employer cost-sharing) that addresses the roles of
  - ~ the employer
  - ~ the employee

- Confirm that the provision of benefits conforms to relevant laws, regulations and Church canon
  - ~ Research and address potential canonical issues including the roles of General Convention, dioceses, and congregations
  - ~ Research and address diocesan concerns, including the required payment of employee healthcare premiums, as well as the required participation by Episcopal employers and employees
- Develop a model for plan administration and operations of the plan sponsor, including organizational capacity and capabilities, staffing requirements and skills, technology requirements, and service levels and performance standards
- Develop a model for the management and governance of the plan administration entity

Scope of the Feasibility Study

The following areas were determined to be within the scope of the study:

- Conducting of censuses and surveys in order to define the full universe of envisioned participants (e.g., active lay and clergy employees working at congregations, congregational schools, diocesan houses and offices, and other Episcopal organizations, such as stand-alone schools, camps, conference centers, healthcare facilities, and housing and social service agencies)
- Collection of data required to perform a thorough analysis of the present situation in the Church:
  - ~ Employee compensation and payroll contributions for healthcare benefits (medical and pharmacy)
  - ~ Current group rating methodology (self-funded, fully-insured, community-rated, experience-rated, etc.)
  - ~ Congregation budgets and amount spent on health insurance premiums
  - ~ Plan and benefit designs
  - ~ Underwriting and pricing (e.g., claim data, provider network discounts)
  - ~ Provider access, including negotiated fee information
- Development of recommended eligibility criteria and rules for clergy and lay employees, including part-time and full-time workers, hourly and salaried workers
- Development of recommended plan designs
- Development of goals (employee health and wellness, financial, organizational) for a denominational health plan
- Development of recommended legal and operating structure for the plan administration entity and the interface with The Episcopal Church, including legal structure of denominational health plan, staffing requirements, and service level benchmarks
- Analysis of funding mechanisms and alternatives (employer contribution and employee contributions)
- Development and analysis of the financial impact to the Medical Trust, CPF, and The Episcopal Church
- Analysis of impact on existing contractual obligations, canon, and Church custom and practice

It was also determined that the following areas were **not** in the scope of this study:

- Analysis relating to individuals not eligible to participate in the plan, including non-employee members of congregations and vestries, and employees of institutions that are not agencies of the Church
- Analysis of post-65 healthcare benefits (Medicare Supplement plans and dental benefits)
- Analysis of any other employee benefits, including dental coverage, life and accidental death and dismemberment insurance, long term care insurance, disability benefits, and pension plans

The Project Team

Once the full scope and parameters for the study were established, it was necessary to assemble a project team to work toward the delivery of the study's goals and objectives. First, team roles and responsibilities were defined and the skills and functions needed of each member were explicitly identified. Then, based on their experience, capacity, and the availability to participate, team members were mapped to those roles.

The project team included representatives from the broader Church to ensure that those who might be impacted by the study's results would have a continuous voice and role, external healthcare and human resources consultants (including Aon, Hewitt Associates, and Solid Benefit Guidance), and representatives from CPG business units and support groups impacted by the study (including the Medical Trust, the Church Pension Fund, and Finance).

Many project team members were also responsible for leading specific working groups. These working groups consisted of specialist members, working together to produce well-defined study objectives or deliverables within a specified time frame. Working groups terminated at the delivery of their specific deliverables.

Permanent Members of the Project Team
Frank Armstrong, Actuary, Hewitt Associates
The Rev. Canon Keith Brown, Project Consultant, The Church Pension Fund
Paul Calio, Senior Vice President and General Manager, The Episcopal Church Medical Trust
Patrick Cheng, Senior Vice President and Deputy General Counsel, The Church Pension Fund
Nancy Fisher, Senior Vice President and Director of Communications, The Church Pension Fund
Jennifer Groh, Healthcare Consultant, Aon Corporation
The Rev. Robert Griffith, Data Analyst, The Church Pension Fund
Ann Hurst, Data and Research Analyst, The Church Pension Fund
Sally Johnson, Vice President, Risk Management and Education, The Church Pension Fund
Barton Jones, Senior Vice President and General Counsel, The Church Pension Fund
Alexandra Jung, Healthcare Consultant, Aon Corporation
Laurie Kazilionis, Vice President, Client Services, The Episcopal Church Medical Trust
Michael Lurski, Assistant Project Manager
Libby Miller, Assistant Vice President, Clinical Services, The Episcopal Church Medical Trust
Matthew Price, Ph.D., Vice President, Director of Analytical Research, The Church Pension Fund
William Resnick, Healthcare Consultant, Solid Benefit Guidance
Andrea Still, Vice President, Plan Administration, The Episcopal Church Medical Trust
Wesley Underwood, Vice President, Finance and Accounting, The Church Pension Fund
Timothy Vanover, Vice President and Project Manager, The Church Pension Fund
Eileen Weber, Communication Consultant, Hewitt Associates

Additional members participated in the temporary working groups described above.

Project Team Governance
The study was conducted under the leadership of the Church Pension Fund Board's Healthcare Coverage Feasibility Study Advisory Group, headed by David R. Pitts. The Advisory Group led the effort to set the strategic direction of the project and to build consensus within the project team and the Church. In addition to the responsibilities that most had as CPF Trustees, Advisory Group members also represented the diverse viewpoints of Church constituencies, and provided important feedback and insights as well as senior levels of expertise in the area of healthcare benefits.

Members of the Healthcare Coverage Feasibility Study Advisory Group
David R. Pitts, Chair
The Very Rev. George L.W. Werner, Vice Chair
The Rev. A. Thomas Blackmon
The Rev. Dr. Randall Chase, Jr.
Barbara B. Creed
Vincent C. Currie, Jr.
The Rev. Carlson Gerdau
Deborah Harmon Hines, Ph.D.
Robert E. Leamer
Diane Pollard
Edgar Starns, CPA
T. Dennis Sullivan
The Rt. Rev. Wayne P. Wright, D.D.

Section 2: The Church's Involvement in the Feasibility Study

The project team consistently sought guidance from the Church and its employers and employees throughout the study, actively inviting their perspectives and opinions. In addition, theological and ethical considerations have been integral themes.

Voices of Clergy and Lay Employees

In order to develop and recommend the best approach for providing healthcare benefits to The Episcopal Church, it was critical to understand the "mind of the Church." Multiple surveys (discussed in detail in Section 3 of this Report) were conducted, but the team felt the need to talk directly with people in the Church to better understand the feelings, perceptions, fears, concerns, and priorities of individual church employees. Specifically, the team knew that the overall approach to benefits delivery, plan design, and possible cost-sharing would be of primary concern to Church employees — clergy and lay alike.

Focus Groups

In partnership with communication consultants from Hewitt Associates, a human resources consulting and outsourcing firm, the project team created a focus group initiative that would allow clergy and lay employees to meet in separate groups to hear a 30-minute presentation about the feasibility study and initial findings, followed by a 90-minute open discussion guided by a set of professionally developed questions from Hewitt focus group specialists.

Focus Group Participants

Focus groups were conducted with employees from multiple dioceses in eight provinces as well as at collegial events such as the Consortium of Endowed Parishes, the Conference of Diocesan Executives (CODE), and the Episcopal Business Administrators Conference (EBAC).

Desired Outcomes as Voiced by Participants

Generally, the participants reached a consensus on the following preferred outcomes:

- Episcopal employers should be required to provide and fund healthcare benefits for clergy **and** lay employees.
- The goal should be coverage for all employees but, due to the cost, that is probably not possible.
- At a minimum, healthcare benefits should be provided to employees working 30 or more hours per week.
- The Church should fund coverage for clergy and lay employees and their dependents.
- The Church should fully fund the premiums for clergy and lay employees in the beginning but introduce premium cost-sharing in the future.

Common Issues and Concerns

Certain issues and concerns surfaced consistently during the discussions:

- "If the Church mandates benefits based on hours, lay employees will be paid for one hour less than necessary to qualify for paid benefits but will be expected to work more."
- "Vestries and wardens may be reluctant to fund additional benefits for lay employees. They will also be concerned about the cost of benefits for employees who currently opt out."
- "I'm concerned about the cost of a mandatory program and its impact on benefits and cost-sharing."
- "How will costs be distributed and rates be determined across the country, when costs of living are different?"

- "Cost will be the biggest barrier to getting a denominational health plan passed at General Convention."

Diocesan Meetings

Between 2008 and 2009, the project team also met individually with more than 90 bishops and diocesan administrators across the country. During these face-to-face and teleconference meetings, the project team shared and discussed with the dioceses the anticipated financial and social impacts of the proposed denominational health plan.

The meetings provided an opportunity for the project team to engage individual dioceses in open and forthright dialogue around the expected impact of the plan. It also provided the individual dioceses with the opportunity to review the draft health plan options. Lessons and findings from these individual meetings enabled the project team to incorporate the perspectives of the broader Church in the continued development and finalization of the action plans.

Theological Foundation: What We Are Called to Provide

Seeking guidance from The Episcopal Church is a complex and multifaceted task. The project team determined that yet another valuable method of "hearing" from the Church was to review and research prior Acts of General Convention. Using the materials available through the Archives, the project team reviewed multiple resolutions dating back to 1991.

Over the past two decades, through successive General Convention resolutions, the project team discovered that The Episcopal Church has repeatedly affirmed a number of principles in relation to healthcare that are relevant to a theology of healthcare benefits for employees of the Church. The project team believed that the four principles adopted in 1994 by the 71st General Convention in Resolution A057 reflect the goals the team itself hoped to achieve, as illustrated in the following excerpts from that resolution:

> *Resolved*, the House of Bishops concurring…
>
> That universal access to quality, cost effective, health care services be considered necessary for everyone in the population.
>
> That "quality health care" be defined so as to include programs in preventive medicine, where wellness is the first priority.
>
> That "quality health care" include interdisciplinary and interprofessional components to insure the care of the whole person — physiological, spiritual, psychological, social.
>
> That "quality health care" include the balanced distribution of resources so that no region of the country is underserved.

In recommending the denominational health plan, the project team's work was, in part, influenced by certain guiding principles:

First, as The Episcopal Church, our theology and ethics call us to use our resources responsibly (stewardship). Therefore, the art and technology of medicine should be used wisely and prudently to serve God's purpose in reconciliation and to support human dignity.

Second, when illness occurs, the health plan should provide benefits for medically necessary care. Moreover, the provision of healthcare benefits and the payment for healthcare services are not solely a financial transactions but an outward sign of love and respect for one another, and are symbolic of the community of saints and of living out our faith by "carrying each other's burdens" and by caring for our neighbors and ourselves.

Finally, healthcare benefits should be used to pay for medical care that returns a patient to a state of health that has meaning and dignity, enabling patients to live and "have life, and that they might have it more abundantly." Intentional ministries of health and wholeness have arisen in many places. For physicians, nurses, and healthcare professionals, there is an increasing interest in the importance of spirituality and the life of prayer in achieving and sustaining health. There is a growing recognition that genuine health depends on the interdependence and integration of mind, body, and spirit. Promoting this integration is the business of the whole Church and most certainly of the denominational health plan.

Section 3: Data Collection and Analysis

This section describes the exhaustive process used to capture and analyze data from across the Church — including the Church-wide census of lay employees in response to Resolution A125, the Healthcare Coverage Awareness and Opinion Survey — and additional online and in-person data collection efforts, the review of other denominations' approaches to healthcare coverage, and the evaluation of the broader healthcare marketplace in the United States and abroad.

The Lay Employee Census

In response to the authorization of the 75th General Convention, as expressed in Resolution A125, the Church Pension Group conducted a comprehensive Church-wide census of lay employees serving domestic dioceses, congregations, and institutions in February 2007. This census was necessary as neither the Church Pension Group nor the Episcopal Church Center had a current, complete record of all lay employees serving the Church.

To provide a complete picture of the lay employee population, congregations and institutions were asked to reply to the census even if they did not have any lay employees. The high response rate — approximately 95% of dioceses and 60% of congregations — exceeded expectations.

Through this census, data was collected about approximately 17,500 lay employees — by far the most extensive collection of Episcopal lay employee data since the Church's founding. This response rate, coupled with the demographics of the dioceses and congregations responding, allowed CPG to project that the total population of lay employees serving domestic dioceses and congregations is approximately 28,800, with approximately 1,300 serving on domestic diocesan staffs and approximately 27,500 serving in domestic congregations.

Census Data Tells a Compelling Story

The data revealed much about the lay employees serving the domestic dioceses and congregations of the Church. Approximately 72% of lay employees are female, with an average age of 49. The average age for all lay employees is 53. The majority of the lay employees (approximately 68%) are either married or partnered.

Not surprisingly, the majority of lay employees are responsible for some form of congregational administration. Lay employees occupying secretarial, administrative assistant, or clerical positions account for 33% of the total lay employee work force. 18% of the lay employees are church musicians, 7% work in parish pre-schools or parish schools, and 7% are Christian educators. Diocesan employees make up approximately 5% of the lay employee workforce. Social outreach employees, facilities workers, and "other" accounted for the remaining 30%.

Compensation averages $50,300 for all lay employees working 40 hours or more per week, $37,800 for those working 30 to 39 hours per week, and $17,600 for those working 20 to 29 hours per week.

In regard to the provision of employee healthcare benefits, the major findings were:

- Only 17% of lay employees working 20 to 29 hours per week have health benefits from their church employer.
- 50% of lay employees working 30 to 39 hours per week have health benefits from their church employer.
- 65% of lay employees working 40 hours or more per week, have coverage from their church employer.

Through data collection, research, and analysis, the project team determined that working 30 hours or more per week was the pivotal point at which healthcare benefits were provided to lay employees.

Healthcare Coverage Awareness and Opinion Survey

In April 2007, after the lay employee census was well underway, the project team launched an Awareness and Opinion Survey to learn what the Church knew about Resolution A147 of the 75th General Convention, and to gain a better understanding of the importance of healthcare benefits to the Church. The survey was conducted online in English and Spanish, and was available to all diocesan bishops and administrators, active and lay employees, seminarians, members of religious orders, and deputies to the 2006 General Convention. (The roster of deputies to the 2009 General Convention had not yet been determined.) The survey was also conducted by phone for diocesan bishops and administrators.

Over 3,000 participants responded. Respondents were evenly divided between clergy and lay employees, and included 334 General Convention deputies.

Survey Revealed Broad Consensus

Overall, the survey found that respondents agreed with the concept of the healthcare feasibility study and the relevance of its intentions. Specifically:

- Nearly all respondents agreed that
  - ~ The cost of healthcare benefits is high and rising rapidly toward levels that are unsustainable (96%).
  - ~ Controlling the rising cost of healthcare for each Church employer is an important issue for the Church to address (95%).
  - ~ The cost of healthcare benefits as a percentage of an employee's compensation package in The Episcopal Church is growing (85%).
  - ~ Purchasing healthcare benefits collectively rather than per-congregation or per-diocese could help slow the rising cost of healthcare coverage (79%).
- Respondents generally agreed that
  - ~ Collecting and analyzing information about employees' out-of-pocket healthcare costs was important to produce an objective report (90%).
  - ~ The Episcopal Church should offer a Church-wide healthcare program to all employees (88%), and doing so would send the message that the Church cares about protecting the interests of clergy and lay employees (86%).
  - ~ A Church-wide healthcare program could be a key driver to slowing the rising cost of healthcare for the Church overall (75%).
- Only half of all respondents realized that some Church employees are asked to fund the cost of healthcare benefits in whole or part themselves, which results in some employees going without coverage.

Employee Healthcare Benefits: Analysis of the Current Healthcare Marketplace

The project team did not set about the feasibility study in a vacuum. It was important to conduct an analysis of the current healthcare marketplace for all U.S. employers, as well as to better understand what is occurring in other denominations.

Healthcare Market Analysis

In 2008, employer-sponsored insurance was the leading source of health insurance, covering about 158 million non-elderly people in the United States. The average annual premiums for employer-sponsored health insurance were $4,704 for single coverage and $12,680 for family coverage, up

about 5% from the 2007 average premiums. Since 1999, average premiums for family coverage have increased 119%. Average premiums for high-deductible health plans (HDHPs) are lower than the overall average for all other plan types for both single and family coverage.

About 80% of workers with single coverage and 93% of workers with family coverage contribute to the total premium for their coverage. The average annual worker contributions for single and family coverage are $721 and $3,354, respectively. The average percentage of the premium paid by covered workers is 16% for single coverage and 27% for family coverage.

The majority (58%) of covered workers are enrolled in preferred provider organizations (PPOs). Health maintenance organizations (HMOs) cover 20%, followed by point-of-service (POS) plans (12%), HDHPs (8%), and other plans (2%).

Employee Cost-Sharing
In addition to any premium contributions they may have, most covered workers face additional payments when they use healthcare services. Most (68%) workers in PPO plans have an annual deductible that must be met before all or most services are payable by the plan. Half of workers in POS plans and only 20% of workers in HMOs have an annual deductible. Many workers with no deductible have other forms of cost-sharing for office visits or other services.

The average annual deductible for workers with single coverage is $560 in PPOs, $503 in HMOs, $752 in POS plans, and $1,812 in HDHPs. Overall, the percentage of covered workers in a plan with a deductible of at least $1,000 for single coverage has grown from 10% to 18% over the last two years and, among small firms, the percentage of covered workers with a deductible of at least $1,000 has increased from 16% to 35%.

Outlook for the Future
Among companies that offer benefits, a large percentage report that, in the next year, they are very or somewhat likely to increase the amount workers contribute to premiums (40%), increase deductible amounts (41%), increase office visit cost-sharing (45%), or increase the amount that employees have to pay for prescription drugs (41%). About one in four firms offering health benefits — but not offering an HSA-qualified HDHP — say they are very likely (4%) or somewhat likely (21%) to do so. A similar share of firms not currently offering an HDHP report that they are very likely (5%) or somewhat likely (21%) to offer that plan type in 2009.

In January 2009, Hewitt Associates conducted a survey of more than 340 employers representing more than five million employees to understand their current and future approaches to healthcare benefits. While the number of companies focused solely on mitigating annual healthcare costs has more than doubled this year — from 15% in 2008 to 31% in 2009 — almost two-thirds (65%) said they are continuing to make significant investments in improving the health and productivity of their workforce despite the troubled economy.

Nevertheless, 4% of companies indicated they are taking steps today that will enable them to discontinue providing healthcare benefits altogether. This picture changes somewhat when employers describe their future approach to healthcare. While most companies (75%) plan to focus on improving employee health and productivity in the next three to five years, one-fifth (19%) said their strategy is to move away from directly providing healthcare benefits, up from 4% in 2008. Given that alternative healthcare offerings are being discussed in earnest by the Obama administration, these employers may see exiting healthcare as a more viable option than it was in the past.

Economic Impact on Employer Healthcare Programs in 2010
According to Hewitt's survey, the state of the economy has had little influence on healthcare programs in 2009. However, more than half (52%) of the companies surveyed said the economic downturn will have an impact on their 2010 healthcare programs. Overall, most employers are not planning to make drastic changes to their full-time and part-time healthcare benefits in 2010. Instead, they are focusing on both conventional and progressive approaches to address the costs related to their healthcare plans in light of the economic climate. Nearly two-thirds (65%) of companies plan to shift more costs to employees, and almost half (49%) plan to reduce the number of benefit plans. Conversely, a third (33%) plan to increase their focus on wellness programs, and almost 40% plan to increase the prevalence of consumer-driven healthcare plans, such as high-deductible health plans.

Employee Healthcare Benefits: Analysis of Church Health Plans

In addition to an analysis of the healthcare market in the United States, the project team evaluated the healthcare programs of other denominations to learn what was working successfully for other denominational employers.

Denominational Benchmarking Study
The denominational benchmarking study included elements such as guiding theology, eligibility, plan design, demographics, financial data, and organizational and administrative information. The information gathered from this benchmarking study provided a framework for the denominational health plan subsequently developed and proposed by the project team.

First, the project team partnered with Aon Consulting, Inc. (Aon) to develop an electronic questionnaire, as well as a live interview questionnaire to solicit more detailed information through one-on-one dialogue.

Next, potential participants were identified based on relationships within the Church Benefit Alliance (CBA) and other networks, as well as the size and scope of their current benefit programs. The project team contacted these participants, sharing the scope of Resolution A147 and an overview of the benchmarking objectives.

The following denominations participated in the study:

Presbyterian Church (USA)

The Lutheran Church - Missouri Synod

The Evangelical Lutheran Church in America

The United Methodist Church

The Southern Baptist Convention

As the survey and personal interviews were completed, responses were loaded into a database and a "scorecard" was developed to illustrate detailed responses.

Finally, the health plan administrator for each denomination was contacted. In all cases, the health plans were administered by the respective pension boards or agencies of the denominations.

Key Study Findings
The data from the participating denominations yielded a number of relevant findings, including:

- As of 2008, BlueCross BlueShield is the sole healthcare provider network for all of the denominations studied.
- The most prevalent health plan option offered by the other denominations was a Participating Provider Organization (PPO) program.

- All of the denominations are "self-insured" or "self-funded" and administered by their pension plan. This means the plans are underwritten by the pension plan and very few "fully-insured" (off-the-shelf) plans are made available.
- The Board of Pensions of the Presbyterian Church (USA) has the only plan with a provision for mandatory participation, and the mandate applies only to clergy — not to lay employees.
- Two out of five denominations [ELCA and the Presbyterian Church (USA)] offer only one plan option. In other words, employees do not have a choice of plan options from which to choose.
- The majority of the denominations have a higher medical plan deductible than those generally offered in The Episcopal Church.

Healthcare Benefits for Episcopal Employers
After reviewing the healthcare programs and policies of other denominations, the project team then turned its attention to the current state of healthcare in The Episcopal Church. After the census and survey, the project team began three additional online data collection efforts late in 2007:

- The first data collection effort focused on **dioceses of The Episcopal Church** and the policies and costs associated with diocesan requirements and practices for healthcare benefits among all congregations, diocesan institutions, and diocesan staff members. Ninety dioceses responded to the request for information — a 90% response rate.
- The second effort focused on **congregations of the Church and relevant Church institutions** (e.g., agencies, schools, and conference centers). The project team received 3,337 responses — a 37.5% response rate.
- The third effort centered on **individual lay and clergy employees** of the Church and of Church agencies and institutions. 8,166 employees responded to the survey — a 25.1% response rate.

The analysis of feasibility study data from employees presents a complex picture of healthcare benefits coverage. The cost of providing healthcare benefits for employees of The Episcopal Church continues to rise at an alarming rate. In 2010, the projected cost to The Episcopal Church for employee healthcare benefits is expected to increase by 9.5%. Total spending on employee healthcare benefits for 2010 by domestic congregations, dioceses, and official agencies, not including any dioceses in Province IX, is projected to be $161.2 million, or $12,343 per employee. The 9.5% increase is expected to be more than four times the rate of inflation and approximately four times the rate of average clergy salary increases.

Left unchecked, spending on employee healthcare benefits could increase at similar levels for the next two triennia, reaching $250.4 million in 2015, or potentially 15% of the Plate and Pledge income as projected by the feasibility study. (Projected Plate and Pledge assumes a growth rate of 2.5% for years 2009 to 2015 which may need future revision if the current economic conditions continue.)

This situation is not unique to The Episcopal Church. According to the Kaiser Family Foundation and the Health Research and Educational Trust, premiums for employer-sponsored health insurance in the U.S. have been rising four times faster, on average, than workers' earnings since 2000.

It is critical to understand the underlying demographics of The Episcopal Church as an employer to measure the impact of employee healthcare benefits on the Church. Approximately 44% of congregations do not have full-time staff. These congregations typically have a part-time or supply priest, and research indicates that the congregation contributes 50% or less of the cost of healthcare benefits for the priest.

Many of these congregations share a priest (e.g., yoked parishes or cluster ministries), and the cost of healthcare benefits is shared across the congregations or is paid for by the diocese. (It is important to

note here that while the congregation may employ a part-time priest, the priest serving these congregations may be working more than 30 hours per week by virtue of working in multiple congregations.)

Transitional-, program-, and resource-sized congregations account for only 25% of the total number of Episcopal congregations. (See page 34 for definitions.) However, 50% of full-time clergy and as much as 60% of full-time lay employees are working in these churches. It is no surprise that these larger congregations have large amounts in their budgets for employee healthcare benefits and are eager to find means of containing the rising cost of employee healthcare benefits.

The Church is the Primary Source of Healthcare Benefits for the Majority of Employees
87% of clergy are working full-time, and of those full-time clergy, approximately 83% receive their healthcare benefits through The Episcopal Church as their employer. The remaining 17% are covered by their spouses or a former employer, or through some government program. More than two-thirds of clergy have elected family coverage provided through their Episcopal employer. The vast majority of these clergy receive healthcare benefits at little to no cost to themselves.

The situation for the Church's lay employees is markedly different. Only one-third of lay employees are full-time,[4] and of those, only 65% receive their coverage through their Episcopal employer. A significant research finding was that 3% of full-time lay employees indicate that they are uninsured from any source. As compared to clergy, only one-third of lay employees have elected family coverage provided through their Episcopal employer. Furthermore, 50% of lay employees in our surveys reported paying more than half of the cost of their healthcare benefits coverage themselves. All of this data illustrates the disparity in the funding of healthcare benefits between clergy and lay employees.

The cost of healthcare benefits coverage is partly determined by the plan design itself. The project team collected information on the healthcare plans from more than 90 dioceses and multiple congregations. The collection process yielded more than 100 separate plan designs. Analysis of those plans demonstrated that 95% of all Episcopal employees were actually enrolled in a small number of unique plan options.

Designing Plan Options for a Denominational Health Plan
In developing an appropriate set of plans for The Episcopal Church, the project team set out several goals related to health plan design, including that the health plans offered under the denominational health plan must a) mitigate cost increases for the Church as an employer; b) provide financial protection from catastrophic healthcare expenses; c) include a comprehensive wellness program that will encourage member accountability; d) encourage the appropriate use of healthcare services; e) be competitive with the marketplace; and f) provide enough options to meet the individual needs of a diverse population.

At the conclusion of the plan design analysis, the team designed and recommended seven different plan options for the denominational health plan. These plan designs are shown on page 27 in Section 4.

Healthcare Benefits in Province IX

The diocese in Province IX — in Colombia, the Dominican Republic, Ecuador, Honduras, Puerto Rico, and Venezuela — are a highly integrated group focused on providing spiritual guidance, healthcare, and education services to some of the poorest communities in the world. Healthcare in Province IX is as much of an issue as in any other Province within the Church. The people in these countries suffer from the same chronic conditions and catastrophic events and they require the same level of services related to preventive care, diagnostic testing, and day-to-day treatment of minor ailments and illnesses. While dioceses and other institutions in Province IX will not be part of the first phase of implementation of

[4] *For the purposes of this report, full-time is defined as regularly scheduled to work 30 hours or more per week or 1,500 hours or more per year.*

the denominational health plan, the financial and cultural impacts of the denominational health plan in this region have been critical components of the project team's analysis.

And yet, the healthcare systems of each country range from barely sustainable to progressively improving. Accessing care through government-sponsored social security programs is challenging. But as part of an emerging region of the world, private healthcare services are expanding facilities, doctors, and services. The challenge is to leverage these new healthcare systems in the most cost-effective manner.

The following section outlines our research process and findings to date, and the future possibilities for this province of the Church.

Data Collection Process

Interviews with the Province IX bishops were conducted to better understand how each diocese is organized to serve its congregations and communities. These conversations revealed an impressive collection of congregations, schools, healthcare facilities, and well-structured community support groups, dedicated to serving the people of these countries.

In Venezuela, the diocese has created a consortium of organizations with the shared desire to purchase private healthcare insurance as a group. This consortium has used its collective strength to negotiate coverage levels that provide participants access to private healthcare facilities, doctors, and diagnostic services. In Puerto Rico, where the Church is responsible for more than 2,500 clergy, lay employees, hospital employees, school administrators and teachers, and home healthcare professionals, the entire organization is covered under insured healthcare coverage that includes dental and prescription drug coverage in addition to medical benefits. Further, the diocese has been subsidizing a significant portion of the cost of these benefits for several years, allowing for the provision of these benefits to all of these clergy and lay employees.

Other dioceses are exclusively reliant on the provision of care by government social security programs. In the Dominican Republic, while clergy and lay employees are all covered under a program required by local law, the limitations of the coverage and the difficulties in accessing care in a reasonable amount of time (some wait weeks or months for an appointment to see a specialist) are a stressful reality that the clergy and lay employees deal with on a daily basis. In Colombia, where the government has made efforts to coordinate care under the social security system through private healthcare facilities, the clergy and lay employees of the Church cannot always afford the services they need due to limitations in the amount covered by social security. Out-of-pocket expenses can be high and especially challenging for clergy who live off an annual stipend of less than USD 5,000. Bishops voiced a consistent need for supplemental insurance that would improve access to care and reduce out-of-pocket expenses of the clergy and lay employees. As with the domestic Church, a further study of the costs and issues surrounding healthcare benefits for all clergy and lay employees of Province IX will determine opportunities to enhance the provision of healthcare services in this region.

Province IX Census

A first important step in the discovery process was to understand the number of clergy and lay employees, as well as eligible dependents, in each diocese. The data showed that Province IX has a collection of dioceses with younger populations than the domestic Church and with average annual stipends that are significantly lower.

The project team prepared census files to share with insurance companies in each country, as well as companies that offer regional insurance options, so they could provide a quote for healthcare options for the dioceses. As of this writing, the project team has collected quotes for each country except Puerto Rico, which is being evaluated separately.

Funding of Healthcare Benefits
The challenges related to the funding of healthcare benefits for the Province IX dioceses are significant. Not only do most dioceses not have access to private insurance, they also face difficult situations when clergy or lay employees have critical medical issues. For example, a clergy or lay employee may need an expensive operation, which requires payment up front in order for the surgery to proceed. Neither the employees nor the dioceses are prepared to pay these out-of-pocket expenses. The bishops of Province IX discussed possible solutions, including researching private healthcare insurance options as well as creating and instituting an emergency medical fund.

Based on that input, the project team conducted research to determine the prevalence and structure of any emergency funds that other non-profit organizations might have established. It was learned that this type of fund is fairly prevalent, and a model for an emergency medical fund has been drafted and presented to the members of the Episcopal Church Medical Trust Strategy and Policy Committee of the CPF Board for consideration. However, the provision of an emergency fund would not preclude the need for private healthcare insurance. Such a fund would work in conjunction with local or regional insurance programs to cover excessive expenses in emergency situations as well as care excluded from a local plan due to pre-existing condition clauses in insurance contracts.

Market Analysis
There is a significant amount of growth in the countries of Latin America relative to healthcare services. Each country is growing at a different rate, and these differences are reflected in the availability of insurance and healthcare providers. Findings from the study were presented to the bishops in Province IX in October 2008. The data presented in this study was compiled in 2007 and early 2008 and does not reflect the situation after the fourth quarter of 2008 or current conditions.

Colombia
With 43 million people, Colombia is the third-most-populous country in Latin America, after Brazil and Mexico. The country is undergoing significant economic reforms under the leadership of President Uribe (reelected in 2006). The annual economic growth has been 6.5 to 7% since 2006, and unemployment was reported at 9.4% in November 2007 compared to 15.1% in December 2002. In 2007, Colombia reportedly received USD 8 billion in foreign direct investment as more companies saw this country as an important emerging market for their goods and services. Colombia currently ranks 29th in the world as a trading partner for U.S. goods, and there are efforts underway to improve the trading relationship. Colombia wants to move beyond trade preferences with the U.S. and establish a permanent reciprocal economic partnership. Legislation has been introduced in the U.S. Congress (April 2008) and is pending approval. Improved security has led to the *New York Times* designating Bogotá as one of the top 50 cities in the world to visit.

In Colombia, Church employees live primarily in the two geographic areas where most of the 42 million Colombians live and where health coverage is better. The in-country staff, which serves in 37 congregations, is made up of six full-time clergy, 20 worker priests, and five full-time lay employees. Currently, these employees participate in the national health coverage (contributory public system). Some concerns were expressed about this coverage, and it is the desire of the clergy and lay employees to have a private insurance plan which will allow access to different providers. The diocese does not pay for health insurance due to financial limitations. The expectation is that the cost of private insurance could exceed monthly income levels of some clergy and staff.

There are two potential solutions for providing healthcare insurance to clergy and lay employees in Colombia. A local insurance company and reputable regional insurance firm have submitted proposals to provide coverage locally in Colombia as part of a multi-country plan that also includes Honduras. The advantage of this regional plan is that Colombia is able to take advantage of economies of scale by being included with the population in Honduras which is considerably larger.

It is important to analyze the financial aspects of these options, as well as verify that the regional coverage truly works locally in Colombia, to ensure the clergy and lay employees will be able to effectively use the plans.

The Dominican Republic

The Dominican Republic is one of the most popular tourist destinations in Latin America, and many of its nine million residents are dedicated to this service industry. The economy in the Dominican Republic boomed in the 1990s, expanding at an average rate of 7.7% per year from 1996 to 2000. The country enjoys a strong trading relationship with the U.S. (75% of export revenues), Canada, Western Europe, and South Korea. The Dominican Republic is the 31st-largest commercial partner of the U.S. The Central Bank estimates that the economy grew at 7.9% during the first six months of 2007 with an inflation rate of 5.9%, and the projected rate of inflation for 2008 is 8.0%; the increase is due, in part, to higher oil prices. The unemployment rate is expected to increase marginally from 15.6% to 15.8%. Foreign direct investment reached USD 7.423 billion in 2007. In September 2005, the country ratified a free trade agreement with the U.S. and five Central American countries, known as CAFTA-DR.

Since 1991, the Church has doubled the number of missions and clergy, and significantly reduced its dependence upon funds from The Episcopal Church. There are 65 congregations with 22 clergy and 11 lay employees, as well as 24 Episcopal schools with around 290 employees. The diocese helps to deliver health services to the general population with three clinics equipped with ten field medical teams which include dentists as well as clinics that provide general, specialty, and pharmacy care. There is also the HIV/AIDS program funded by the Bill Clinton Foundation.

Currently, the diocese does not provide private healthcare insurance to its clergy or lay employees, but the group is registered in a local HMO-type plan that the government put into place in 2007. Through this HMO, clergy and lay employees have access to a local network of providers, and services are covered through a standard plan design. This type of coverage is available to all employees in the Dominican Republic and paid for through employee payroll taxes. The coverage is limited, and out-of-pocket expenses are an issue for the diocese. The access to care is also an issue as the providers in this HMO are serving the entire public system which is plagued by poor service and poor quality.

Similar to Colombia, there are two possible options for the Diocese of the Dominican Republic. The local solution is significantly less expensive than the regional option because it is designed to work in conjunction with the local HMO coverage employees have access to now. Supplemental insurance would provide coverage for services not adequately covered by the HMO plan. They would also have the opportunity to access providers that operate independently of the public system, improving the access to quality care. The regional option would consolidate the coverage for the Dominican Republic with Ecuador, Honduras, and Venezuela. The advantages of the regional option may outweigh the significant difference in cost to the local option, and the Diocese of the Dominican Republic is evaluating the options with the project team.

Ecuador

As the second-smallest country in South America, Ecuador is home to an amazing contrast of tropical forests, mountainous regions and, of course, the Galapagos Islands. With just over 13 million inhabitants, and as much as 70% of Ecuadorians living below the poverty line, the country faces many challenges. Ecuador's economy is highly dependent on the price of oil; in the early 1990s, the country experienced strong growth. But with a number of factors in the late 1990s, including El Niño weather patterns, a steep drop in oil prices, and instability in an emerging market, the country experienced a 6.3% contraction in GDP. Annual economic growth has been 1.7% to 2.6% since 2007, and unemployment was estimated at 9.3% for 2007. The rate is expected to remain the same for 2009. Recently, President Correa has been involved in negotiations to increase the government's role

in the energy industry, which could lead to economic recovery. Ecuador's oil production accounted for approximately 60% of exports earnings (2006), and it is the world's largest banana exporter.

There are two dioceses in Ecuador: Ecuador Central and Ecuador Litoral. In Ecuador Central, there are 30 congregations with 16 clergy, seven lay missioners, seven diocesan staff, and two schools with 20 employees. In Ecuador Litoral, there are 34 congregations with 11 clergy, two lay missioners, four diocesan staff, and four schools. Ecuador Central has financial problems as a result of previous leadership and is now under budget constraints. The diocese would need significant additional outside financial assistance. The diocese currently delivers healthcare services for two small, poorly funded medical clinics serving the indigenous population in Ecuador Central. In Litoral, there is one general clinic with ten specialties which includes a staff of 16 volunteer medical doctors and dentists, as well as visiting mission teams from the Diocese of Tennessee which include many doctors and nurses from Vanderbilt University.

The diocese does not provide healthcare to its clergy and employees, and relies on the public health-care system. The program is plagued by poor access and poor quality. Care provided by the public health hospitals is minimal, and they require payment up front. Appointments are difficult to schedule, and long waits of one to two months or more for doctor visits are typical.

However, private healthcare systems and insurance programs are developing. There are two local options, as well as the regional option noted earlier that includes the Dominican Republic. The local options are more expensive than the regional plan, demonstrating the opportunity for smaller dioceses to take advantage of the economies of scale by joining other dioceses in other countries.

Honduras

Honduras has faced a number of obstacles in developing and maintaining economic growth since the 1980s. The devastation from Hurricane Mitch in 1998 — 5,000 deaths and USD 3 billion in damages — left the country feeling the economic aftermath. Since then, Honduras has relied heavily on foreign aid and debt relief programs in an effort to reduce poverty and stimulate the economy. Of an estimated 7.48 million people in Honduras, two thirds are living below poverty level, and the average unemployment level has hovered around 28% since 2002. Annual economic growth has averaged 7% for the past few years. The U.S. is Honduras' primary trading partner, supplying more than one half of all imports and approximately 65% of Honduran exports.

The Episcopal Diocese of Honduras has been described as one of the most dynamic and rapidly growing dioceses of The Episcopal Church. The diocese works primarily in poor and marginalized communities, and balances a strong emphasis on church plants and congregational development with great emphasis on evangelism, stewardship, and financial self-sufficiency, with an equally strong focus on economic development, food security, education, and healthcare. It is made up of ten deaneries and 153 congregations, with 60 clergy and 14 lay pastors on ordination tracks, six diocesan lay employees working in traditional areas and 25 employed by Anglidesh, the diocesan-level development agency. In addition, there are ten schools with 500 employees, and eight "cooperativas" (cooperative financial institutions). The diocesan offices are located in San Pedro Sula, a city in the most developed part of the country.

52% of the population relies on the public healthcare system. Only approximately 10% of the population has private insurance and access to privately funded services. There are three possible options for Honduras; one local and two regional. The costs of the options vary quite significantly. This diocese is the second-largest in Province IX, and providing for private healthcare insurance for this group will result in a significant financial burden to the Church. In addition to evaluating the

options, the coverages, and the needs of the diocese, a financial solution that would allow for the provision of this benefit in a way that is sustainable must be designed.

Puerto Rico
Puerto Rico enjoys a unique relationship with the United States. A Commonwealth of the U.S., Puerto Rico is a semi-autonomous territory. However, many organizations, including The Episcopal Church, consider Puerto Rico an international location, and for that reason, Puerto Rico is the largest diocese outside of the U.S. The island is considered to have the strongest and most diversified industrial economy and highest per capita income in the Caribbean. For the past three years, however, Puerto Rico has been in a recession as annual economic growth is negative 1.2% and is continuing to decline. Unemployment is currently at 13.5% compared to 7.2% in the U.S. (December 2008), and inflation has recently hit 11.7%, slightly higher than 2007.

The diocese has 48 congregations; 40 of the congregations are missions. Currently, 60 active clergy and 17 lay employees are serving the diocese. Under the Iglesia Episcopal is the Episcopal schools network which consists of four schools with approximately 45 employees; Servicios Sociales Episcopales (Social Services) with approximately 80 employees; Servicios de Salud Episcopales (SSE) which is made up of the Servicios Generales Episcopales (SGE); 60 employees made up of executives and administration located in Ponce, PR; and three hospitals and one home health agency which are involved with delivering health services to the general population.

- Hospital Episcopal San Lucas I — currently closed, however, will reopen as a hospice (home health agency) and employs approximately 1,000 employees
- Hospital Episcopal San Lucas II — approximately 1,165 employees (does not include physicians or per diem workers)
- Hospital Episcopal Cristo Redentor — approximately 400 plus employees and subsidizes healthcare through Triple–S, International Health Care and Preferred Medical Care; all plans are fully-insured
- Naval Hospital, Roosevelt Roads — tentative opening soon; 900 beds

The Diocese of Puerto Rico provides employee healthcare benefits through First Medical Plan, Preferred Health, and Triple–S, an affiliate of BCBS. Health plan contracts are renewed every January. The health plans are fully-insured and cover clergy, lay employees, and dependents.

Given the system in place, the project team is focused on maximizing the effectiveness of the current benefit programs in Puerto Rico. It may be possible to leverage U.S.-based programs on the island. For example, there is an opportunity to extend the prescription drug coverage contemplated for the U.S. under the denominational health plan to Puerto Rico, which should significantly reduce costs while potentially improving the benefit. The team is also evaluating the financial structure of the medical plan to determine further cost-saving opportunities. There is also a proposal to include the Puerto Rico benefits under the Medical Trust, which will allow for additional services directed to participants to be extended to the Puerto Rico population.

Venezuela
Recognized globally as one of the most controversial countries in the world, Venezuela, with President Hugo Chávez at the helm, has been pursuing several nationalist and populist policies. Currently, the role of government in the economy remains ambiguous. The recent constitution calls for a limited role in the private sector, while the government is being pressured to pursue market reforms. The Venezuelan economy is based in large part on oil, which accounts for 80% of all export earnings and more than half of government operating revenues. The economic growth

rate is 8.3% due to the success in petroleum sales, and the unemployment rate dropped to 9.1% due to high economic growth. Inflation is around 20%, one of the highest in Latin America.

The Episcopal Diocese of Venezuela currently has 22 congregations, 11 full-time clergy and one lay employee. A few years ago, the diocese led efforts to create a consortium of companies with the sole purpose of leveraging the consolidated populations of these companies to more effectively purchase healthcare coverage (total census in the consortium is 504 employees, 182 spouses, and 389 children and other dependents). The diocese pays for private healthcare coverage for the clergy and lay employees. However, the long term sustainability of present coverage would require continued sacrifices in other parts of the diocesan budget, rapid stewardship growth, or additional outside support.

Benchmarking the current healthcare plan relative to other market options reveals that the plan is comprehensive in its coverage and the pricing is very competitive (particularly as a result of the leverage the diocese is able to realize through the consortium). The project team is now working with the diocese to determine how to sustain the current benefits given the financial constraints the plan puts on the Church.

Plan Design Analysis
While there are evident differences in plan design from country to country, there are components of medical plan designs that can be consistently applied. The project team is working with each diocese to determine overall guiding principles that will influence the plan designs of each healthcare solution for each country. These include:

- Costs based on Reasonable and Customary charges
- Hospital coverage
- Outpatient coverage
- Diagnostic tests coverage (lab and x-ray)
- Prescription drug coverage
- Emergency care
- Maternity benefits

There are certain elements that could be considered optional and certainly have a significant influence on the cost of healthcare benefits. The project team is working with each diocese to measure the importance of various design options, including international coverage, dental and vision benefits, and coverage for catastrophic conditions.

A key challenge remains in the negotiation of pre-existing condition exclusions. In Latin America, many insurance companies exclude the coverage of pre-existing conditions, sometimes indefinitely and sometimes for a finite period (e.g., not within the first 3 to 12 months of the effective date of the plan). It is possible to negotiate (the Diocese of Venezuela has been successful), but it remains an important point of negotiation as the dioceses move forward on plan design details.

Future Cost Analysis
In addition to striving for the best solutions for Province IX, the project team is mindful of cost issues. The expense of providing private healthcare benefits for the diocese of Province IX is an additional expense to a region that is already challenged every day to meet their financial obligations. Most of these dioceses also prefer to be self-sufficient. The project team continues to analyze different scenarios and develop creative options for consideration.

Section 4: The Denominational Health Plan Recommendation

At the start of the feasibility study, two alternative approaches to improving the healthcare benefits program across the Church were to be evaluated: retaining the current voluntary system of multiple diocesan programs but with recommendations for reducing and restraining future cost increases, and creating a denominational health plan for all eligible clergy and lay employees. As the study progressed, however, it became evident that a denominational health plan would have the most positive impact on employers and employees throughout the Church and the greatest potential for cost savings. This section describes in detail the denominational health plan that is being recommended to the 76th General Convention.

Evaluating the Retention of the Current Voluntary System with Enhancements

The feasibility study examined two alternate approaches to the system currently in place: retaining the voluntary system with the addition of recommended enhancements, and the creation of a denominational health plan. Although it became evident early in the study that a denominational health plan would result in the most positive impact for the Church, the viability of the current system, with enhancements to drive new cost reduction and growth restraints, was thoroughly examined as well.

In its evaluation of the viability of an enhanced version of the Church's current healthcare benefits model, the project team first studied its inherent benefits and disadvantages.

Benefits include:
Flexibility to explore alternatives to control premiums in the short term: local market forces, alternative funding arrangements, and plan design changes

Suitable to meet unique needs of individual diocesan and congregational employees

Allows for local control and influence in areas such as healthcare management, administrative service, choice management, equity definition, and contract tailoring

Ability to resolve issues quickly

Disadvantages included:
Limited ability to constrain overall healthcare costs for The Episcopal Church:
Fragmented risk pool, added cost/margin to account for inherent claims volatility, sub-optimal large scale purchasing and administrative efficiencies, and an inconsistent and uncoordinated approach to utilization and care management.

Sub-optimal access to healthcare:
Inconsistent approach to offering most efficient and effective provider networks, evidence of insurability, rating requirements, and pre-existing condition limitations

Inconsistent and uncoordinated approach to offering the most efficient plans, improving underlying health of clergy and lay employees, and defining equity:
Fragmented dependent eligibility rules, perpetual change driven by short term cost pressures borne by participants, and mobility challenges due to lack of and/or difficulty in portability of coverage

Somewhat limited ability to react and capitalize on changes in the healthcare system and healthcare reform:
Longer term sustainability shifts to individual participants

In addition to the examination of the benefits and disadvantages of maintaining the current voluntary system, the study also quantified the expected savings that recommended enhancements to the current voluntary system could bring. The study focused on the same core savings components that were identified by examining the denominational health plan model. Although certain advantages of the denominational health plan (e.g., cost management/improvement initiatives, optimal plan and network selection, economies-of-scale purchasing) could be replicated under the voluntary model, the order of magnitude of savings would be expected to be lower since they would impact a smaller proportion of the overall population. Other components of savings (e.g., removal of state premium tax, commissions, excess margin inherent in local fully-insured plans) would be limited and more volatile under the voluntary model since short term cost pressures could continue to drive short term local savings while sacrificing larger and longer term savings for The Episcopal Church.

Similar to the financial analysis under the proposed denominational health plan model, the study determined a range of savings for each core savings component for the enhanced voluntary model, and applied them to the baseline costs that were established under the current voluntary model. The level of savings varied across components, and was applied separately to the different cohorts that exist under the current model. The financial modeling produced results that showed expected savings under the enhanced voluntary model to be only approximately 30% to 40% of the potential savings under the denominational health plan model. The expected results equated to an approximate 3.5% reduction in healthcare spending and accumulated savings of $21 million over the first full four years after approval. As detailed benefit offerings, cost data, and demographic data was not available for the entire Church-covered population, sensitivity analysis was also conducted to determine the likely range of savings based on varying sets of assumptions that impacted the magnitude of savings for each core component. The sensitivity analysis produced a range of savings of 2% to 8% for the full implementation of the recommendations under the voluntary model for new cost reduction and growth constraints.

The Denominational Health Plan: A Healthcare Benefits Model for the Church's Future

The reality is that many congregations across the Church are having difficulty providing affordable health insurance for their employees. Further, current research indicates that more and more congregations are experiencing financial difficulties and may be forced to make budget changes for 2010. In a matter of a few years, the number of congregations unable to provide employee healthcare benefits could increase significantly.

So what is the denominational health plan, and how does it address the financial problems facing Episcopal employers? At its core, it is a model for central administration of employee healthcare benefits for The Episcopal Church. While administration is centralized, the plan provides dioceses and groups with autonomy over key aspects of their healthcare programs — including plan choice and design — while lowering costs to employers and employees.

Centralized Administration Brings Better Choices

The words "denominational health plan" may stir images of rigidity, requirements, and restrictions. This is simply not true. Dioceses will have control and choice. The denominational health plan is really about leveraging the Church's aggregate size for the large-scale purchasing of employee healthcare benefits. This aggregation will be accomplished by the Medical Trust, which will serve the Church as the central point, plan administrator, and sole plan sponsor for the purchasing and administration of employee healthcare benefits for dioceses, congregations, and official agencies of The Episcopal Church.

All domestic U.S. dioceses (including their cathedrals, congregations, parishes, missions, and chapels), Puerto Rico, and the Virgin Islands, along with official ecclesiastical organizations or bodies subject to the authority of the General Convention, will be required to participate in the denominational health plan. Any other societies, organizations, or bodies in the Church may participate on a voluntary basis.

Centralized Administration Balanced with Autonomy
Each diocese or group will have autonomy over benefit plan options and designs, cost-sharing between employer and employee, the participation of schools, day care facilities, and other institutions, and eligibility, including whether or not to cover domestic partners. In fact, the denominational health plan may enable dioceses and groups to offer more plan choices for their employees than they do today.

Plan Design Options
The breadth of healthcare plan types currently available to clergy and lay employees today will remain largely intact. This is possible because the Medical Trust already offers a variety of plan designs (including HMOs, PPOs, and HDHP/HSAs), with a variety of deductibles, coinsurances, and copayments. Plans will be offered through a number of healthcare vendors that will include BlueCross BlueShield, Aetna, United Healthcare, CIGNA, Kaiser, Group Health, and other regional plans that are best in market or are required to ensure adequate access to healthcare providers. Each diocese and group chooses the plans that are offered to employees and may change plans and vendors on an annual basis, based upon changing local preferences and needs.

Proposed Denominational Health Plan Design Options – Effective 1/1/2010

Plan Provisions	**PPO 100/70**	**PPO 100/70**	**PPO 90/70**	**PPO 80/60**	**EPO 90**	**HMO**	**HDHP II**
DHP Plan Type	PPO	PPO	PPO	PPO	EPO	HMO	PPO
Vendor	BCBS/United	BCBS/United	BCBS/United	BCBS/United	Aetna/BCBS	Aetna/Kaiser	BCBS/CIGNA
PCP Required	No	No	No	No	No	No	No
Network Deductible	$0	$200	$250	$500	$200	$0	$2,700
Network OOP Max (incl. Deductibles)	$0	$200	$1,250	$2,000	$1,200	N/A	$4,200
Network Coinsurance	100%	100%	90%	80%	90%	100%	80%
Routine/Preventive Care	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Office Visit	$25	$25	$25	$25	$25	$20	N/A
Non-Network Deductible	$500	$500	$500	$1,000	N/A	N/A	$3,000
Non-Network OOP Max (incl. Deductibles)	$3,500	$3,500	$3,500	$5,500	N/A	N/A	$7,000
Non-Network Coinsurance	70%	70%	70%	60%	N/A	N/A	55%

Prescription Drug	**Standard**	**Premier**	**HDHP**
Deductible – Retail	$50	$50	Comb. w/Medical
Retail – Generic Copay	$10	$5	15%
Retail – Brand Formulary Copay	$30	$20	25%
Retail – Brand Non-Formulary Copay	$50	$35	50%
Mail – Generic Copay	$25	$12	15%
Mail – Brand Formulary Copay	$70	$50	25%
Mail – Brand Non-Formulary Copay	$120	$80	50%

Cost-Sharing
Each diocese will need to establish its own policy for congregations regarding the required employer cost-sharing. That means that a diocese can choose to cover 100% of the premium cost for employees and families, or only a portion. The diocesan policy regarding employer cost-sharing must be the same for both clergy and lay employees working 1,500 hours or more per year (full-time). This will eliminate the disparity that exists today between full-time clergy and lay employees. The policy regarding employer cost-sharing must be implemented no later than December 31, 2012 in preparation for the 2013 plan year.

Domestic Partner Benefits
Dioceses and groups also will determine whether or not they wish to offer domestic partner benefits to employees. If they choose to do so, they will be administered in accordance with the 1997 General Convention Resolution C024.[5]

Congregational Schools, Day Care Facilities, and Diocesan Agencies
Each diocese will decide annually whether or not schools, day care facilities, and other diocesan institutions participate in the denominational health plan. If a diocese does not require participation by these institutions, voluntary access will be available but participation will not be required.

Freedom of Choice for Employees
Full-time clergy and lay employees who have health benefits through an approved outside source may waive their coverage (opt out) under the denominational health plan and choose to maintain their healthcare benefits through a spouse's or partner's employment, military service benefits, governmental program, or coverage from a previous employer. However, employees may choose to enroll in a plan offered under the denominational health plan during the next annual open enrollment or at the beginning of any month in which a significant life event occurs.

Required Participation Versus Freedom of Choice
If all of a congregation's employees have their healthcare benefits through an approved non-denominational health plan source, is the congregation expected to contribute towards the cost of administering the denominational health plan? The answer is no. However, in the event that a new employee without healthcare benefits is hired, or an existing employee loses his/her non-denominational health plan coverage and desires the congregation to provide him/her with healthcare benefits, the congregation will be required to offer and fund those healthcare benefits through the denominational health plan and in accordance with the employer cost-sharing policy as established by the diocese.

Centralized Administration for the Common Good
Research shows that the denominational health plan will result in a variety of benefits for dioceses, along with financial stability and cost savings for the entire Church. But approving the denominational health plan isn't simply about administrative and fiscal responsibility — it's also about fairness and equity. It offers individual dioceses the opportunity to make a choice for the benefit of the whole. It is, in a sense, a symbol of what can be done for the common good when we work together as one Church, striving for a positive outcome for all.

[5] ***Resolution C024: Request the Medical Trust to Cover Domestic Partnerships in Health Plans***
Resolved, That the Episcopal Church Clergy and Employees' Medical Trust be authorized to offer to dioceses which desire such coverage provision for the inclusion of domestic partners in its health insurance plans. The extension of such coverage shall not constitute an opinion as to what constitutes an ecclesiastically sanctioned domestic unit.

Section 5. Impact Analysis by Church Size

An important part of the feasibility study was a comprehensive analysis of the financial impact of today's various healthcare approaches and costs, as well as that of the proposed denominational health plan, on Episcopal congregations in all church size categories, to determine the potential for savings and efficiencies. This section provides a brief overview of healthcare costs across the Church, followed by financial impact analyses for congregations, dioceses, and institutions within the five church size categories: Family (1 to 75 average Sunday attendance[ASA]), Pastoral (76 to 140 ASA), Transitional (141 to 225 ASA), Program (226 to 400 ASA), and Resource (401+ ASA).

The Costliness of the Current Model

The current cost of providing healthcare benefits is typically 7% to 9% of a median congregation budget. In the minority of congregations that offer full parity of healthcare benefits to clergy and lay employees with family coverage, the cost of providing those benefits takes an additional 2% to 3% of the total operating budget.

While this percentage does not vary significantly by size of budget, there are considerable differences in overall costs among individual congregations as well as dioceses. Congregations with smaller budgets and an ASA below 100 may have costs of 14% or higher of the total operating budget. Moreover, the cost of providing healthcare benefits is expected to continue to increase at a rate of 9.5% per annum while congregational operating revenues are increasing at a rate of only 2.5% per year.

The Denominational Health Plan: Savings Opportunity for the Church

Collectively, congregations and institutions currently offering healthcare benefits with parity for both clergy and lay employees, including any of their eligible family member dependents, can expect an annual cost savings of 8% to 10% under the denominational health plan. Additional savings will result from minimizing the time and hidden costs associated with dioceses and congregations individually procuring and administering a multiplicity of separate healthcare benefits plans.

The impact on an individual congregation may vary due to many factors, including congregational operating revenue and staffing levels, plan coverage currently offered, and the health plans and eligibility provisions chosen by the diocese under the denominational health plan. In addition, the family status of clergy and lay employees (whether they are married and/or have dependent children whom they choose to cover under the plan), the number of employees who currently receive healthcare benefits from another source but subsequently choose to enroll in coverage through the denominational health plan, and the costs for employees working fewer than 30 hours who may be offered healthcare benefits, may also impact the costs and savings of an individual congregation.

Savings for Congregations with Full Parity

Congregations that have already achieved healthcare benefits parity between their eligible clergy and lay employees will realize the greatest cost savings under the denominational health plan.

Savings for Congregations without Full Parity

Assessing the financial impact on individual congregations or institutions that have not already achieved parity requires a detailed review of multiple factors, including the number of lay employees and their dependents, and the types of health plans to be offered. In congregations where lack of numerical and financial growth is already creating financial stress, the requirement for healthcare benefits parity for clergy and lay employees scheduled to work 30 or more hours per week could

conceivably be a factor in future staffing decisions. However, as the following analysis illustrates, in most cases, a congregation will find that the cost savings realized through the denominational health plan will cover the additional costs associated with offering parity between clergy and lay employees.

Church Employees and Dependents Covered Today

As of December 31, 2008, about 13,060 individuals were covered by healthcare benefits plans provided by dioceses, congregations, and official agencies of the Church. Of that number, 5,310 were clergy (40.7%) and 7,750 were lay employees (59.3%). The Medical Trust covered 8,312 employees (3,128 active clergy and 5,184 lay employees) or 64% of all employees.

97% of all lay employees working 30 or more hours per week or 1,500 hours per year (full-time) currently have healthcare benefits. Of those 97%, 64% receive their healthcare benefits from their Church employer, 17.8% receive benefits from their spouse or partner, and 15.1% receive their healthcare benefits from other sources. That means that only 3% of lay employees working full-time today have no healthcare coverage.

The data reported by congregations suggest that at least 67.5% of congregations offer multiple tier coverage (Single, Employee plus 1, Employee plus Child, Family) to lay employees. However, lay employees typically are enrolled in single coverage. This may be explained by the fact that most or all of the additional costs for family coverage would be borne by the lay employee rather than the employer. Of the 67.5% of congregations that report offering multi-tiered coverage to lay employees, 21% report paying 100% of the premium across all tiers, suggesting that many congregations have already deemed parity of healthcare benefits to be important and have already been able to attain parity.

The percentage of lay employees receiving coverage for additional family members improves somewhat by church size, ranging from 11.1% in Family size congregations (1 to 75 ASA) to 36.8% in Resource size congregations (401+ ASA). By contrast, 53.0% of full-time clergy in Family size congregations utilize additional family member coverage; this rises to 74.7% in Resource size congregations. Those working on a diocesan staff are closer to parity, with 55.1% of lay employees and 68.6% of clergy utilizing coverage that includes additional family members.

In the case of full-time clergy, most diocesan compensation guidelines specify that full-time clergy be offered church-provided healthcare benefits. Indeed, of the more than 2,000 full-time clergy who responded to the Healthcare Feasibility Study, 100% report that they currently receive a healthcare benefit. 82% receive their healthcare coverage from the church, 13.5% from their spouse/partner, and 4.5% from other sources. Even among those clergy working fewer than 30 hours per week, only 2.6% report receiving no healthcare benefits and being uninsured.

The Cost to Cover Today's Church Employees

Clergy Employees

In 2007, the average annual cost of healthcare benefits from a variety of vendors including the Medical Trust was $12,300 per cleric. The benefit offered to a cleric typically includes a spouse/partner or family benefit as appropriate, thus explaining much of the $5,000 average cost difference between clergy and lay employee benefits. In addition, the higher median age of the clergy and their utilization of benefits are additional factors in the cost disparity.

As with lay employees, the cost to the congregation per individual cleric did not vary significantly by church size. With the same expectations of 9.5% healthcare cost increases per year, the cost of providing a comparable benefit will have risen to $16,100 by 2010. And again, by contrast, with

the implementation of a denominational health plan, the expected average cost in the year 2010 for providing healthcare benefits to a cleric would be $14,500.

Lay Employees
Over 1,600 congregations responded to the detailed financial survey conducted as part of the feasibility study. In 2007, the average annual cost of healthcare benefits from a variety of vendors including the Medical Trust was $7,300 per lay employee, and did not vary significantly by congregation size. Given the projected cost increase of 9.5% per year, the cost of providing a comparable benefit will rise to $9,600 per lay employee by 2010.

These average costs are not an average premium of church-provided health benefits for clergy but rather the national average (mean) value that is essentially a weighted value that reflects different carriers, health insurance plans, family situations, and those who are not covered by a Church plan today. It is important to note that current healthcare benefits costs per individual covered differ considerably by region, diocese, and the specific benefits provided under the variety of plans now offered throughout The Episcopal Church.

The Financial Impact to an Individual Congregation, Diocese, or Institution

Church Size Categories
The 7,145 domestic congregations of The Episcopal Church can be classified into five categories as measured by average Sunday attendance (ASA). These congregation size categories have been widely adopted throughout the Church as a useful way to understand the cultural and financial differences of these various congregational models. The categories were developed by the Diocese of Texas through the work and teaching of Kevin Martin. Martin extended the pioneering work of Alan Routhage, which postulated four church sizes. Under the five category system, congregations are classified as Family (1 to 75 ASA), Pastoral (76 to 140 ASA), Transitional (141 to 225 ASA), Program (226 to 400 ASA), and Resource (401+ ASA).

The five church size categories are helpful in evaluating the differing potential financial impacts of the denominational health plan, particularly as levels of revenue, per capita giving, staffing, and benefits correlate closely with church size. Plate and Pledge income, or current member giving, typically grows at a more rapid rate than average Sunday attendance. By contrast, although clergy compensation also correlates well with church size, it grows more slowly than operating revenue.

That said, healthcare costs for an individual clergy or lay employee with comparable benefits are independent of congregation size. This makes it easier for a larger congregation not only to add additional paid staff but also to fund their ministries at a higher level. In financial terms, congregation costs are highly leveraged, with small gains in giving and attendance significantly enhancing the ability of a congregation to do ministry and mission as additional revenues are available over and above the costs of staff and benefits. Cost reductions through the implementation of a denominational health plan would enhance the leveraging of growth in a congregation's giving and attendance.

As previously mentioned, the impact on an individual congregation may vary due to many factors, including congregational operating revenue and staffing levels, plan coverage currently offered, and the actual health plan(s) chosen by the diocese in which the congregation is located, family status of clergy and lay employees, and the number of employees currently receiving healthcare benefits from another source who choose to enroll in the denominational health plan. Healthcare benefits costs of an individual congregation will also be affected by the extent to which employees working less than 30 hours may be offered healthcare benefits now or in the future, and to what extent cost-sharing is involved for individuals who are below the mandated healthcare benefits threshold.

Data from the feasibility study has been compared with parochial report data and CPF compensation report data. They generally correlate quite well by church size categories. However, it is important to note that while a minimum of 30 scheduled hours per week is generally the minimum threshold at which healthcare benefits are offered, many congregations and institutions offer full or partial healthcare benefits to those who work fewer than 30 hours per week. Additionally, many who are offered healthcare benefits choose to waive coverage (opt out) because of the high costs of the employee share. Under a denominational health plan, some of those who currently waive coverage may choose to enroll.

The examples that follow were selected to be as representative as possible for each church size category, including operating revenues and staffing. Data was taken from a variety of sources, including the annual Parochial Reports and annual Compensation Reports.

Impact of Denominational Health Plan on Family Size Congregations (1 to 75 ASA)

Family Size Congregations (1 to 75 ASA)	
3,640 congregations	50.9% of all domestic TEC congregations
Mean ASA	38
Median ASA	36
Median Operating Revenue	$ 50,500
Total number of full-time clergy (est.)	1,115
All full-time clergy, median compensation (stipend, housing, SSA offset)	$ 51,996
Total number of full-time lay employees (est.)	225
All full-time lay employees, median compensation (salary/wages)	$ 31,209
Average annual giving (annual per capita ASA giving)	$ 1,290

The 3,640 Family size congregations represent 51% of all domestic TEC congregations, with 17.6% of the total TEC average Sunday attendance and 15.7% of the total operating revenue, and are served by 21% of the full-time parochial clergy and 4% of the full-time congregational lay employees. In most diocese, particularly in dioceses away from the coasts and outside of the southeastern United States, this type of congregation is the most prevalent.

Much of the leadership and decision-making functions are typically vested in a few lay individuals and couples who often are described as “matriarchs and patriarchs” and congregational “pillars.” In the smaller 70% of the Family size congregations, clergy are generally part-time, often scheduled just for Sunday and perhaps one additional day or so, and tend to function primarily as chaplains. These clergy generally work below the scheduled 30 hours per week threshold and would not receive healthcare benefits unless they serve in yoked ministry arrangements with one or several other congregation(s) that results in a combined weekly total of 30 scheduled hours or more.

Nevertheless, in about 30% of Family size congregations, some combination of factors, such as high rates of member per capita giving, diocesan financial support, endowment income, or outside sources of income, including yoking with another congregation, yield an operating budget adequate to support a full-time cleric, and occasionally an associate or lay employee as well. Where use of endowment funds are involved, questions of long term sustainability arise where the corpus of the endowment (as well as income) is being used to support the operating budget.

Since the denominational health plan threshold for mandated coverage for either a cleric or lay employee would be at least 1,500 regularly scheduled hours per year or 30 or more hours per week

with annual earnings documented by the issuance of a W-2, the subsequent remarks for Family size congregations are divided into those without a full-time cleric (less than 30 hours per week) and those that do have a full-time cleric (30 or more hours per week) and in some cases additional clergy and lay employees. In approximately a quarter of these congregations that report having a full-time cleric, the cleric is involved in yoked and shared ministries.

However, it is important to note that while a minimum of 30 scheduled hours per week is generally the minimum threshold at which healthcare benefits are offered, many congregations and institutions offer full or partial healthcare benefits to those who work less than 30 hours per week. In many of these cases, the employee shares part of the cost of the healthcare benefits. Additionally, many who do work 30 or more hours per week and are offered healthcare benefits choose to opt out of either individual coverage or additional spouse/partner/dependent coverage, often because of the high costs of the employee share.

Family Size Congregations Without Full-Time Clergy or Lay Employees

2,526 congregations	35.4% of all domestic congregations
Mean ASA	27.5
Median ASA	28.0
Median operating revenue	$ 39,355
Average annual giving (annual per capita ASA giving)	$ 1,202

This sub-category of the 2,526 Family size congregations without a full-time cleric or a full-time lay employee represents more than a third (35.4%) of all of the 7,145 congregations in domestic TEC dioceses and about 70% of all Family size congregations. These 2,526 smaller congregations have median operating revenues of $39,355 and median ASA of 28. The average annual giving of the members is $1,202, about 60% of the average level of all domestic TEC congregations. Thus, currently, these congregations do not by themselves have the resources necessary to call a full-time cleric or lay employee and pay pension and medical coverage.

The member and funding limitations inherent to a congregation with a median ASA of 28, median operating revenue of about $40,000, and minimal income from other sources, impose severe restraints. Nevertheless, resiliency and ingenuity are reflected in the variety of ways by which these congregations are able to recruit and retain a full-time cleric.

Clergy and staffing coverage are characterized by a variety of creative solutions. This may frequently involve a cleric who is retired for pension purposes and who receives healthcare benefits through Medicare and pension supplements, a non-stipendiary cleric who receives an income or pension from non-TEC sources, or a cleric who may serve multiple congregations or a congregation in another denomination such as The Evangelical Lutheran Church in America. A few of these congregations have a part-time paid lay employee who may be a "lay missioner" on an ordination track. The part-time cleric often serves only on Sunday and serves more as chaplain and sacramentalist. The cleric may travel significant distances in order to provide sacerdotal ministry. Terms of agreement may thus provide for a mileage and travel reimbursement.

A rectory or vicarage, perhaps including utilities, may be provided in lieu of a cash stipend. Partial healthcare benefits are often part of the agreement and may be provided in a variety of ways. For example, healthcare benefits may be in the form of a Health Savings Account (HSA) nested within a small cash stipend or an additional supplement to the stipend which is, in fact, considered a partial, de facto contribution to allow the individual cleric to purchase healthcare benefits from a non-TEC vendor. In some yoked congregation arrangements, one location may provide a rectory or housing

allowance, while another provides a stipend which is implicitly understood to provide an allowance for partial or even full healthcare benefits or substitute.

A retired cleric over the age of 65 will most likely rely on Medicare and, if having served sufficient years, receive some Medicare supplemental benefits or a portion thereof as part of his/her CPF retirement benefits. In situations involving yoked congregations, one congregation may provide partial or even full healthcare benefits while the other(s) provide housing, etc.

Thus, very few of these 2,526 or so smaller Family size congregations would be impacted by the passage and implementation of a denominational health plan as they simply would not have employees, clerical or lay, who would reach the 30 hours per week coverage threshold unless they serve in yoked or shared ministries with other congregations. However, for those congregations desiring a full-time cleric for whom health benefits would be an integral part of the total compensation package, and for which future gains in congregational income and attendance makes this a realistic goal, the 8% to 10% cost savings achievable through the denominational health plan could result in future savings and reduce the total compensation package for a full-time cleric at such time as adequate funding is available.

Family Size Congregations With Full-Time Clergy
(Family size congregations typically do not have full-time lay employees.)

1,114 congregations	15.6% of all domestic TEC congregations
Mean ASA	62
Median ASA	62
Median operating revenue	$111,698
Median clergy compensation	$ 50,500
Average annual giving (annual per capita ASA giving)	$ 1,380

About 30% or 1,100 Family size congregations have a full-time cleric. Less commonly, they may also have a full-time lay employee. These congregations typically have an ASA of 60 or more, a per capita giving rate of $1,380, or 15% higher than the smaller family congregations, and generally supplement the budget through other income such as endowment, diocesan support, or a yoked arrangement with another congregation.

Many of these clerics, while classified as full-time by virtue of exceeding the CPF 2006 threshold of $28,080 annually or who are scheduled for 30 or more hours a week, are, in fact, part-time as measured by the clergy compensation guidelines of minimum compensation in the diocese in which they serve. For example, a cleric could earn a $30,000 stipend and housing and be full-time for purposes of published clergy compensation, work 30 or more hours a week and receive healthcare benefits, but be three-quarter-time by the standards of a diocese where the minimum is $40,000. These clergy would typically receive healthcare benefits; however, the wide range of creative solutions used by the smaller Family size congregations are not uncommon here.

Example of a Typical Larger Family Size Congregation with a Full-Time Cleric
About 30% of Family size congregations have a full-time priest who receives some form of health-care benefits. There may also be a part-time lay administrator or secretary who works 20 hours or less per week and generally does not receive healthcare benefits. Assuming healthcare benefits for the cleric are comparable to those in larger congregations and include coverage for a spouse/partner or family as appropriate, the average annual premium of $16,100 in 2010 represents 12.8% of a $126,000 annual budget. Thus, annual increases in the cost of providing health coverage will be an extraordinary challenge to vestries of congregations of this size. The estimated national average

of a premium in the year 2010 under a denominational health plan would be $14,500, freeing $1,600 for additional ministry and mission.

Because of factors previously noted, this is a representative example only, and the impact on any individual congregation may vary.

Impact of Denominational Health Plan on Pastoral Size Congregations (76 to 140 ASA)

Pastoral Size Congregations (76 to 140 ASA)	
1,737 congregations	24.3% of all domestic TEC congregations
Mean ASA	103.9
Median ASA	102.0
Median Operating Revenue	$180,000
Total number of full-time clergy (est.)	1,442
All full-time clergy, median compensation (stipend, housing, SSA offset)	$ 61,462
Total number of full-time lay employees (est.)	620
All full-time lay employees, median lay compensation (salary/wages)	$ 31,652
Average annual giving (annual per capita ASA giving)	$ 1,481

The 1,737 Pastoral size congregations represent 24.3% of all domestic U.S. congregations in TEC, have 22.9% of the total ASA and 21.1% of total operating revenue, and are served by 27% of the full-time parochial clergy and 11% of the full-time lay employees. These congregations are typically the traditional "one priest, one roof" congregation where leadership and pastoral care are centered around the priest.

The priest's compensation, including benefits, is usually about half of the annual congregational budget. The cost of family healthcare benefits alone is often at least 8%, and frequently 14% or more, of the total congregational budget. Accordingly, increases in the cost of providing healthcare benefits severely impact the congregation's budget. This is particularly true in those congregations where additional clergy or lay employees are employed and healthcare benefits are provided.

Within the Pastoral size category, there are considerable differences between smaller and larger congregations with respect to operating revenues and the funds available for payroll and benefits. For example, the difference between a congregation of 80 ASA and 120 ASA for Plate and Pledge income alone is likely to be at least $60,000.

Example of a Typical Pastoral Size Congregation
(A) In a typical Pastoral size congregation, there is one full-time priest who receives healthcare benefits which include spouse/partner or family coverage as appropriate. There is also a part-time administrator or secretary, scheduled to work less than 30 hours per week, who does not receive health benefits. The average annual premium of $16,100 represents 7.9% of a $204,000 annual budget. The estimated average annual premium under the denominational health plan would be $14,500, freeing $1,600 for additional ministry and mission.

(B) In a significant minority of Pastoral size congregations, particularly the larger ones, a lay employee in an administrator position is typically scheduled to work more than 30 hours per week and receives healthcare benefits, single coverage being the most common choice (which may or may not represent parity between a cleric and a lay employee). In this case, the Pastoral size congregation

without a denominational health plan will pay an average annual premium of $25,600. The estimated premium under a denominational health plan, with parity achieved for the cleric and lay employee maintaining the same overall percentage of cost-sharing, would be $25,200, resulting in a net decrease in healthcare costs for the congregation of $400.

Because of factors previously noted, this is a representative example only, and the impact on any individual congregation may vary.

Impact of Denominational Health Plan on Transitional Size Congregations (141 to 225 ASA)

Transitional Size Congregations (141 to 225 ASA)	
1,011 congregations	14.1% of all domestic TEC congregations
Mean ASA	177.4
Median ASA	175.0
Median Operating Revenue	$329,880
Total number of full-time clergy (est.)	1,195
All full-time clergy, median compensation (stipend, housing, SSA offset)	$ 69,017
Total number of full-time lay employees (est., 30 or more hours)	1,175
All full-time lay employees, median compensation (salary/wages)	$ 34,660
Average annual giving (annual per capita ASA giving)	$ 1,623

The 1,011 Transitional size congregations represent 14.1% of all domestic TEC U.S. congregations, have 22.8 % of the total ASA and 22.0% of total TEC operating revenue, and are served by 23% of the full-time parochial clergy and 21% of full-time congregation lay employees. Typically, Transitional congregations, at 141 ASA, have reached the level of attendance where additional clergy and lay employees are essential to sustain mission and ministry. Generally, however, the breakeven point for additional full-time staff can be reached only at the attendance level of a Program size congregation (226 ASA or above). Accordingly, Transitional congregations typically struggle to bring the additional lay and clergy staff to the level of full-time status. The high cost of providing healthcare benefits exacerbates the problem.

Example of a Typical Transitional Size Congregation
In a typical Transitional size congregation, there is one full-time priest who receives healthcare benefits including spouse/partner or family coverage as appropriate. There is one full-time administrator or secretary who receives healthcare benefits, single coverage being the most common choice. There are typically additional part-time clergy and lay employees working below the 30 hour a week threshold for healthcare benefits.

In a congregation that offers parity of benefits between clergy and lay employees, the combined average annual premium without a denominational health plan will be $27,900 in 2010, representing 6.7% of a $373,000 annual budget. The estimated premium under a denominational health plan would be $25,200, freeing $2,700 for additional ministry and mission.

In a congregation that does not currently offer parity of benefits for clergy and lay employees, the combined average annual premium without a denominational health plan will be $25,000, representing 6.2% of the $373,000 annual budget for 2010. The estimated premium under a denominational health plan, with parity achieved for the cleric and lay employee maintaining the same overall percentage of cost-sharing, would be $25,200, resulting in a net decrease in healthcare benefits costs for the congregation of $400.

Because of factors previously noted, this is a representative example only, and the impact on any individual congregation may vary.

Impact of Denominational Health Plan on Program Size Congregations (226 to 400 ASA)

Program Size Congregations (226 to 400 ASA)	
552 congregations	7.7% of all domestic TEC congregations
Mean ASA	291.3
Median ASA	283.0
Median Operating Revenue	$535,052
Total number of full-time clergy (est.)	915
All full-time clergy, median compensation (stipend, housing, SSA offset)	$ 73,054
Total number of full-time lay employees (est.)	1,790
All full-time lay employees, median lay compensation (salary/wages)	$ 45,061
Average annual giving (annual per capita ASA giving)	$ 1,649

The 552 Program size congregations represent 7.7% of all domestic TEC U.S. congregations but have 20.4% of the total ASA and 20.5% of the total TEC operating revenue, and are served by 17% of the full-time parochial clergy and 32% of the full-time congregation lay employees. Program congregations generally have a variety of adequately funded programs and ministries with multiple paid and volunteer staff. Congregations of this size tend to be concentrated in the larger dioceses and in urban areas, particularly in the southeast and Texas. Many TEC diocese have no congregations of this size or larger.

Congregations with similar ASAs and budgets may staff very differently; differences are likely to reflect the way vestries decide to allocate the available personnel funds between benefits and compensation, particularly with respect to the compensation package of the senior cleric.

Example of a Typical Program Size Congregation
In a typical Program size congregation, there are full-time priests who receive healthcare benefits which include spouse/partner or family coverage as appropriate. There are two full-time lay employees who receive healthcare benefits and typically choose single coverage. There are usually additional part-time clergy and lay employees working below the 30 hour a week threshold for mandated healthcare benefits.

In a congregation that offers parity of healthcare benefits for clergy and lay employees, the combined average annual premium in 2010 without a denominational health plan will be $55,800, representing 8.3% of a $605,000 annual budget. The estimated premium under a denominational health plan will be $50,400, freeing $5,400 for additional ministry and mission.

In a congregation that does not currently offer parity of benefits between clergy and lay employees, the combined average annual premium without a denominational health plan will be $51,200 in 2010, representing 7.7% of the $605,000 annual budget. The estimated premium under a denominational health plan, with parity achieved for the cleric and lay employee maintaining the same overall percentage of cost-sharing, will be $50,400, resulting in a net decrease of $800 in healthcare costs for the congregation.

Because of factors previously noted, this is a representative example only, and the impact on any individual congregation may vary.

Impact of Denominational Health Plan on Resource Size Congregations (400+ ASA)

Impact of Denominational Health Plan on Resource Size Congregations (400+ ASA)	
205 congregations	2.9% of all domestic TEC congregations
Mean ASA	625.3
Median ASA	532.0
Median Operating Revenues	$1,304,437
Total number of full-time clergy (est.)	610
All full-time clergy, median compensation (stipend, housing, SSA offset)	$ 74,810
Total number of full-time lay employees (est.)	1,735
All full-time lay employees, median compensation (salary/wages)	$ 59,048
Average annual giving (annual per capita ASA giving)	$ 2,086

The 205 Resource size congregations represent only 2.9% of all domestic TEC U.S. congregations but have 17.6% of the total average ASA and 20.9% of the total TEC congregational operating revenue, and are served by 12% of the full-time parochial clergy and 31% of the full-time congregational lay employees. The number of ministries, programs, and outreaches define a congregation that has effectively become a "federation" of smaller churches under the leadership of a strong charismatic rector and experienced vestry. Some of the largest resource churches approach an ASA of 2,000 and thus have attendance and revenues larger than some of the smaller dioceses.

Benefits including healthcare as well as compensation for both clergy and lay employees are generally significantly higher than in smaller congregations. This is not only because of more congregational members but also because the per capita or average annual giving rate of $2,086 is 28% higher than Program size congregations and some 62% higher than in the typical Family size congregation. Lay employees are more likely to receive healthcare benefits that are comparable to those offered to the clergy. In the median Resource size congregation, with an ASA of 532 and operating revenues of $1,304,437, the rector's total compensation package, including healthcare and pension benefits, is only 11% of the total budget.

Example of a Typical Resource Size Congregation
In a typical Resource size congregation, there are three full-time priests who receive healthcare benefits which include spouse/partner or family coverage as appropriate. There are seven full-time lay employees who receive healthcare benefits and typically choose single coverage. There are usually additional part-time clergy and lay employees working below the 30 hour per week threshold for a mandated benefit.

In a congregation that offers parity of benefits for clergy and lay employees, the combined average annual premium without a denominational health plan would be $130,900 in 2010, representing 8.7% of a $1,475,000 annual budget. The estimated premium under the denominational health plan would be $118,400, freeing $12,500 for additional ministry and mission.

In a congregation that does not currently offer parity of benefits for clergy and lay employees, the combined average annual premium in 2010 would be $114,80, representing 6.7% of the $1,475,000 annual budget. The estimated premium under the denominational health plan, with parity achieved for the cleric and lay employee maintaining the same overall percentage of cost-sharing, would be $118,400, resulting in a net increase in $3,600 in healthcare costs for the congregation.

Because of factors previously noted, this is a representative example only, and the impact on any individual congregation may vary.

Impact of Denominational Health Plan on Diocesan Offices

The dioceses of The Episcopal Church vary considerably with respect to the number of congregations, attendance, giving, endowment, and revenues. Accordingly, diocesan budgets and staffs vary as well, and may range from a diocesan bishop with an assistant to a diocesan bischop with several bishops and a staff of dozens.

Most dioceses offer healthcare benefits to full-time staff, and many offer parity between clergy and lay employees, including family coverage when eligible. Those working on a diocesan staff are closer to parity than those in congregations, with 55.1% of lay employees and 68.6% of clergy receiving healthcare coverage that includes additional family members. In most cases, there will be direct net savings of 8% to 10% to the line item for healthcare benefits in a diocesan budget with the denominational health plan.

Since the majority of all dioceses are comprised predominantly of smaller congregations, a nationally administered denominational health plan will not only provide estimated cost savings of at least 8% to 10%, but also provide intangible but important time savings to a diocese with respect to plan selection and administration. Many diocesan staff members spend significant amounts of time explaining plan design and benefits to clergy and lay employees. The denominational health plan would centralize such functions, freeing staff from interruptions and allowing them to redirect and to invest the time saved on ministry and mission. The reductions of hidden costs of plan administration for an individual diocese are thus likely to be substantial.

Impact of Denominational Health Plan on Province IX, Haiti, and the Virgin Islands

The denominational health plan design for the domestic dioceses could not be implemented in non-domestic TEC dioceses due to differences in vendors and national law and healthcare systems. Nevertheless, alternative ways are being explored by which healthcare benefits for clergy and lay employees in these dioceses may be improved.

As with income and standard of living, there is considerable variation with respect to healthcare and healthcare benefits among the dioceses of Puerto Rico, the Dominican Republic, Honduras, Venezuela, Colombia, Ecuador Central, Ecuador Litoral, Haiti, and the Virgin Islands.

Iglesia Episcopal Puertorriqueña (IEP) rejoined The Episcopal Church and returned to the Church Pension Fund effective April 1, 2007. Puerto Rico is a commonwealth of the United States and has its own tax code and regulations. As a result, technically, clergy in IEP receive benefits under a separate pension plan that mirrors the benefits provided by the Clergy Pension Plan. They are eligible to participate in Medicare after reaching the age of 65. Active clergy and lay employees not only have healthcare benefits through Triple-S, an affiliate of BlueCross/BlueShield, but for needs such as surgery, they have access to the Diocese of Puerto Rico's hospital and health system which employs 9,000 people in state-of-the-art hospitals. When teachers and employees of the diocesan parochial school system are added, the diocese is the third-largest non-governmental employer on the island.

The non-domestic diocese of TEC have a strong desire to improve healthcare and healthcare benefits available to clergy and lay employees who currently have access only to the national healthcare systems. These systems typically have three tiers: one system for the large indigenous populations; a healthcare system for employees that is part of the social security system; and private clinics and healthcare insurance. However, the latter are expensive, with premiums often well above a median salary.

The national healthcare systems are typically underfunded, with access that is not only limited, but characterized by delays of weeks to months and time-consuming and burdensome procedures for

making appointments. Once a doctor is seen, prescription medications are often not available, and surgery, if required, may require an additional wait time. Healthcare coverage for employees enrolled in the national social security health systems is generally only for the individual employee with no spousal or family coverage available. In virtually all cases, healthcare costs are high and unmanageable relative to disposable income.

When provided, diocesan healthcare benefits represent a high percentage of the diocesan budget. The legitimate desire to simultaneously plant churches and improve compensation and benefits puts tremendous strains on available diocesan funds. Although many dioceses have made heroic progress towards financial self-sufficiency, most are still dependant on outside support. Devolution while progressing will nevertheless be a multi-year process. Most of these diocese also use their limited funds, often with mission support from domestic dioceses, to address healthcare needs of the general population though clinics and medical missions.

Some non-domestic dioceses have worked hard to improve healthcare benefits by adopting a variety of creative and innovative solutions. In Venezuela, for example, the diocese took the lead in forming a mini insurance cooperative with employees from other non-profits as well as for-profit firms in order to create a pool big enough to secure healthcare insurance from a major vendor at more favorable rates. This includes full parity of benefits for clergy and lay employees, and AIDS coverage for all employees in the cooperative, a type of coverage that is unusual in Venezuela. However, compensation for some individuals employed by the diocese has suffered in order to make this possible.

In most of these dioceses, relatively small additional monies, if available, could significantly improve access to healthcare for clergy and lay employees. Due to the national differences in standard of living, and healthcare and legal systems, healthcare benefit improvements would need to be tailored to each country.

Section 6: Implementation Plan

The project team has created a comprehensive, multi-year transition plan encompassing benefits administration, staffing and personnel, communications, and member education. The goal is to transition those not currently with the Medical Trust in the most expedient and pastoral fashion and with the least amount of disruption to their constituents. This section describes the elements and timeline of the transition process as well as the inclusion and expansion of new health and wellness programs.

The implementation plan has been designed to ensure that dioceses, congregations, and groups, including congregations in rural areas, will be transitioned effectively and pastorally, and in such a way as to reduce the administrative burden on individual employers. In addition, transitioning to the denominational health plan will improve access to expanded health and wellness programs for all eligible employees.

The implementation program will take a simultaneous four-pronged approach:

1. Transitioning of those dioceses, congregations, and groups that do not currently participate in the Medical Trust ("non-participants")
2. Inclusion and expansion of health and wellness programs that may not have been available to non-participants
3. Assisting dioceses to develop policies to implement parity in the funding of healthcare benefits for clergy and lay employees
4. Ensuring a seamless, pastoral, and efficient transition to the denominational health plan

A Phased Transition

The project team considered a number of ways of implementing the denominational health plan, and ultimately determined that a phased transition process would be the most supportive, effective, and efficient. Therefore, if Resolution A177 is passed, the implementation plan will begin in the fall of 2009 and be completed by December 31, 2012. "Waves" of dioceses and groups will be transitioned to healthcare administration through the Medical Trust during each calendar year.

The process of adding new dioceses and enrolling new members will be managed by a Quality Assurance program to ensure that internal and external expectations are met. This phased process allows adequate time to enroll new participants while maintaining high levels of customer service.

Implementation of Non-Participating Dioceses and Congregations: A Multi-Year Phased Approach

At the beginning of the implementation program, the Medical Trust will work closely with diocesan and group administrators to develop an implementation schedule that reflects local timing preferences. Working with diocesan administrators, the Medical Trust will notify congregations in a timely manner of upcoming transition activities. All dioceses and other groups will be slotted into a transition wave that permits a steady and manageable transition, year by year. Dioceses and groups will be selected for a given wave based on several factors, including their existing contracts with health plans or other vendors, group size, and geographic location.

The implementation plan also allows for flexibility for dioceses and groups to move from one designated wave to another as circumstances warrant. For example, a diocese who signed a three-year contract with a health plan vendor in 2008 would certainly not be asked to transition to the Medical Trust prior to the contract's effective termination date. Alternatively, if a group implemented significant health plan design changes for 2009 (e.g., the introduction of a consumer-driven health plan), the project team would recognize that for employers and employees to have to deal with two concurrent years of significant change would not provide the type of member experience appropriate for Church employees.

The phased transition process is designed to produce a membership increase rate that maximizes the discounts and economies of scale inherent in the modeling of the denominational health plan while maintaining the highest levels of quality control and customer service for both current and onboarding Medical Trust clients. In this way, phased implementation of the denominational health plan will be as expedient as administratively possible without negatively impacting the quality of service and administrative support offered to diocesan and group administrators and their members.

Staffing Expansion

Of the more than 13,000 clergy and lay employees currently covered through congregation- and diocesan-sponsored healthcare benefit programs, 8,300 are in plans administered by the Medical Trust. In this regard, the Medical Trust currently serves 78 dioceses, as well as a number of Church institutions and agencies, with active healthcare benefits. As the number of participating dioceses has increased over the years, the Medical Trust has expanded its capacity in administration and management systems to ensure its ability to provide quality support for participating Church employers and employees.

Analysis of Medical Trust staffing levels has determined that resources — including customer service, member education and communication, and enrollment administration employees — are currently sufficient to accommodate the increased demand for support from administrators and covered individuals during the first implementation wave. And new staff will be added and trained during later waves, as required. The Medical Trust is confident of being prepared to meet the additional needs of transitioning dioceses and their employees throughout the coming years of transition.

The Medical Trust Service Model

The mission of the Medical Trust is to "balance compassionate Christian benefits with financial stewardship." This is a unique mission in the world of healthcare, and it is reflected in all aspects of its operations.

Each diocese and group participating in the Medical Trust will immediately benefit from a high level of customer service, a broad array of plan design options, access to several partners in health-care delivery, comprehensive member communications, and decision support resources. Nevertheless, the project team understands that even positive change can be difficult and confusing at times. To that end, a detailed activity and event schedule was developed for each wave of the transition. The following schedule for the first year of implementation is designed to simplify the process for both diocesan administrators and employees, and provide the best possible experience during the transition.

Activity and Event Schedule for First Year of Implementation

Timing	Activity/Event
June – July 2009	• The Medical Trust confirms adequate staffing in customer service, member education and communication, and enrollment administration employees to support annual benefits enrollment in the fall • If needed, conduct additional hiring
July – August 2009	• Identify transitioning groups for this year's wave; determine single administration point of contact for each new diocese • Share transition communication plan and calendar with onboarding dioceses and groups • Diocesan plan pricing and cost-sharing determined for each group • Identify eligible employees and covered dependents for each group, including census data for transitioning groups to facilitate the enrollment process • Customize benefits enrollment education and communication materials for each transitioning group
September – October 2009	• Diocesan plan selection for following year (may include maintaining current plans if those are also offered through the Medical Trust and/or adding new plan options) • Conduct train-the-trainer workshops for diocesan and other group administrators • Schedule employee benefits meetings • Distribute benefits enrollment education and communication materials
November 2009	• Continue employee benefits meetings • Annual benefits enrollment window
December 2009	• The Medical Trust transfers enrollment files to health plans • The Medical Trust welcome packages are sent to new enrollees • New ID cards mailed by health plans
January – February 2010	• "Transition Lessons Learned" communication shared with all participating and non-participating dioceses (and applied to improve process in subsequent years) • Updated plan handbooks available on ***www.cpg.org*** • The Medical Trust begins to include new employees and family members in ongoing communications about wellness, preventive care, and using health plans most effectively

The Medical Trust and the project team will solicit feedback throughout the process from group administrators, plan members, staff, board members, and other constituencies, and adjust the Activity and Event Schedule appropriately. Due to the timing of General Convention, the first year's schedule begins in June; in subsequent years, the schedule will begin in January.

As shown in the schedule, the Medical Trust intends to provide comprehensive communication and education materials to assist participants in understanding the process and to facilitate the transition. Dioceses and employees will receive the following support:

Diocesan Transition Support

- **Train-the-Trainer Benefits Workshops**
- **MLPS/Web Self-Service Training:** An online real-time enrollment system for benefit administrators.
- **Church Pension Group website training:** The CPG website offers a convenient access point for administrators to access important documents and forms.

Employee and Family Member Transition Support

- **Introduction to the denominational health plan:** The Medical Trust will develop a user-friendly overview of the denominational health plan to share with employees and family members ahead of annual enrollment. This way, they will be familiar with the provisions of the resolution and understand and be prepared for the transition they will be experiencing.
- **Healthcare Benefits Enrollment Guide:** This booklet provides an overview of all available health plan options, including medical, prescription drug, dental, vision, mental health and substance abuse, employee assistance and health advocacy programs, and travel assistance benefits. It also provides detailed instructions for enrolling online, offers important considerations for choosing the right coverage, and outlines costs.
- **Schedules of Benefits (Plan Highlights):** These abbreviated, easy-to-digest summaries provide high-level overviews of the covered benefits and services of individual health plans.
- **Plan Handbooks:** These detailed guides provide complete coverage provisions for the individual plans, including covered services and exclusions, claims filing, and appeals information.
- **Employee Meetings:** It is the practice of the Medical Trust to conduct employee meetings for newly-participating dioceses and groups in order to provide an in-person, high-touch opportunity for employees and family members to learn about their available healthcare options and to get answers to any questions they may have.
- **The Church Pension Group website:** The CPG website offers a convenient access point for employees and family members to access important documents and forms, including the guides, summaries, and handbooks mentioned above.

Implementation of Local Health Plans and/or Regional Carriers

Through the course of the healthcare coverage feasibility study, the project team has reviewed the plans and carriers used by each diocese. In certain geographic areas, a diocese may be using a local health plan/regional carrier that may be categorized as "best-in-market" for reasons of provider access or advantageous rates. For this reason, careful analysis must be given to the possibility of maintaining the relationship with the local carrier. The Medical Trust is committed to conducting further analysis of these local plans and carriers. Provider access and advantageous rates may change quickly in a volatile healthcare marketplace such as exists today.

The Medical Trust will partner with each new diocesan/group administrator to determine which carriers and plan designs are best suited to local budgets and participant needs. In determining the scope of plans to offer, the implementation team will seek to balance national plan options with local plans so as not to erode the benefits of economies of scale achieved by the denominational health plan. There is no minimum or maximum number of health plans that must be selected to offer employees, and there is no mandate to select one health plan provider over another. During 2009, the Medical Trust has partnered with Aetna, CIGNA, Empire BlueCross/BlueShield, and United Healthcare to offer 16 medical plan options.

In addition, efforts continue to address the employee healthcare benefit needs in Province IX. As mentioned earlier in this report, Province IX dioceses present unique challenges as they are separate nations, for the most part, having some form of national or governmental healthcare program. The project team has worked closely with Province IX leadership to identify its employee healthcare benefits needs and to start the process of finding local and regional carriers that may have the potential to serve multiple dioceses. The implementation of health plans in Province IX, to the extent feasible, will be done in consultation with diocesan leadership.

Inclusion and Expansion of Health and Wellness Programs

As a healthcare benefits provider, enhancing health and wellness wherever possible is a logical extension of the Medical Trust's mission of balancing the delivery of compassionate Christian healthcare benefits with financial stewardship. The Medical Trust has been committed to improving and sustaining the health of Church employees since 1978. The Medical Trust currently provides an employee assistance program, health promotion programs, including affordable preventive routine care, and other wellness services. Through the denominational health plan, the Medical Trust is committed to expanding these programs to all domestic dioceses and Province IX over the next several years, with the goal of creating a "Global Culture of Wellness" for Episcopal Church employees.

In order to significantly impact the health of members, the denominational health plan will have health and wellness programs that are robust enough to engage members at all levels along the healthcare continuum (well, acute, and chronic). The goal of the wellness program is to maintain or restore, to the best possible quality, the health of the Church's clergy and lay employees. The denominational health plan will offer a comprehensive wellness program to address the lifestyles and enhance the well-being of employees and their families. Dioceses and groups currently participating in the Medical Trust already take advantage of these wellness programs, and the Medical Trust looks forward to bringing them to the whole Church.

An integral component of the wellness program is a Personal Health Assessment — a confidential questionnaire that enables employees and their adult family members to assess their current health and identify health risks. Health promotion programs will be targeted to risks such as smoking, obesity, stress, depression, elevated cholesterol levels, and pre-diabetes. Every effort will be made to engage Church leadership since executive support has been proven to have a significant positive impact on the impact of these types of programs.

Restoring health and preventing the onset of illness brings benefits both to the individual and the Church as a whole. A membership engaged in taking care of its health can significantly enhance Church wellness and has the potential to positively impact the cost of healthcare for the Church.

Employee Assistance Program

The Medical Trust understands that employees' personal challenges are inextricably linked to their work lives. Issues related to relationships, child rearing, substance abuse, or other sources of stress can have an impact on the health, happiness, and quality of lives of clergy and lay employees and their families. Therefore, the Medical Trust has arranged for members to have access to Employee Assistance (EAP), an exceptional support program that is currently managed by CIGNA Behavioral Health Services.

The EAP program offers an array of family and personal services, including counseling, assessment, intervention, and training. To ensure that all employees interested in using the program feel comfortable doing so, services can be accessed electronically, via a toll-free phone number, or by visiting an offsite counselor.

The Medical Trust continuously evaluates the services provided and identifies areas for future development. The EAP program will evolve as new issues surface and programs are needed. By the end of 2012, the goal is to expand the EAP program to all domestic dioceses and Puerto Rico. During that same time, the EAP programs will be reviewed carefully in order to customize EAP services in culturally sensitive ways for Church employees in non-domestic dioceses.

Health Promotion Services
The Medical Trust is keenly interested in helping employees and their dependents make informed choices about their health. Through its health promotion services, the Medical Trust provides employees with access to credible information about how to stay healthy and prevent disease and injury, offers user-friendly health promotion resources, and, through its product partners, offers all employees access to information about multiple health topics and preventable diseases.

As part of the implementation program, all health benefits plans offered through the denominational health plan will provide employees and their dependents with the ability to have routine and preventive healthcare services at no out-of-pocket cost. By 2010, all participating employees and their dependents will have this benefit available.

Implementation of Parity in the Funding of Healthcare Benefits for Clergy and Lay Employees

Each diocese will need to establish its own policy for congregations regarding the minimum required employer cost-sharing. That means that a diocese can decide to cover 100% of the premium cost for employees and families, or only a portion. The diocesan policy regarding employer cost-sharing must be the same for both clergy and lay employees working 1,500 hours or more per year (full-time), thus eliminating the disparity that exists today between full-time clergy and lay employees. Resolution A177 requires that the policy regarding employer cost-sharing must be implemented no later than December 31, 2012.

The Medical Trust will assist dioceses to develop policies to implement parity in the funding of healthcare benefits for clergy and lay employees by providing access to sample policy documents and by aiding in the modeling of funding options. Each diocese will formulate its own policy based on local polity and preferences.

Ensuring a Seamless, Pastoral, and Efficient Transition to the Denominational Health Plan

The Medical Trust will form an implementation team to organize and coordinate the overall implementation and transition process. Other related departments within the Church Pension Group are prepared to assist in formulating supportive education and informational materials. The implementation team will work with administrators at the diocesan and congregational levels to strengthen the overall implementation program, and will ensure the involvement of diocesan and parish administrators, wardens and vestry meetings, and other local resources, in the implementation process.

The denominational health plan implementation involves a wide range of complex situations, so the implementation team will work closely with diocesan and group administrators before interacting with local congregations and employees. The implementation team understands that conditions vary from place to place. Dioceses will be encouraged to work with the implementation team to formulate specific plans to accommodate actual local conditions and make changes as required. The implementation team will be responsible for the overall coordination and guidance of the transition in the various dioceses and geographic locations. Serious attention will be given to examining the implementation experience as it proceeds and to improving the transition experience progressively through continuous process improvement.

From the beginning of the implementation process, efforts will be made to:

- Provide accurate and timely information to employees and members
- Formulate written enrollment guides that offer step-by-step guidance

- Use comprehensive and understandable communication materials to announce and explain the implementation process

These communication activities are intended to effectively resolve any concerns of employees and employers about "What comes next?" By announcing and explaining the implementation process in a timely and clear manner, the team is confident of achieving a high level of customer satisfaction and comfort during and after the transition experience.

Section 7: Resolution A177 and Proposed Canonical Change

Resolution A177: Denominational Health Plan

Resolved, the House of _____ concurring, That this church establish The Denominational Health Plan of this church for all domestic dioceses, parishes, missions, and other ecclesiastical organizations or bodies subject to the authority of this church, for clergy and lay employees who are scheduled to work a minimum of 1,500 hours annually, in accordance with the following principles:

1. The Denominational Health Plan shall be designed and administered by the Trustees and officers of The Church Pension Fund, following best industry practices for comparable plans;
2. The Denominational Health Plan shall provide that, subject to the rules of the plan administrator, each diocese has the right to make decisions as to plan design options offered by the plan administrator, minimum cost-sharing guidelines for parity between clergy and lay employees, domestic partner benefits in accordance with General Convention Resolution 1997-C024 and the participation of schools, day care facilities and other diocesan institutions (that is, other than the diocese itself and its parishes and missions) in The Denominational Health Plan;
3. The Denominational Health Plan shall provide benefits that are comparable in coverage to those benefits currently provided by the domestic dioceses and parishes of this church;
4. The Denominational Health Plan shall provide equal access to health care benefits for eligible clergy and eligible lay employees;
5. The Denominational Health Plan shall provide benefits through The Episcopal Church Medical Trust, which shall be the sole plan sponsor for such benefits and continue to be operated on a financially sound basis;
6. The Denominational Health Plan shall have a church-wide advisory committee that is representative of the broader church and appointed by The Church Pension Fund, and such church-wide advisory committee shall receive an annual report about the status of The Denominational Health Plan;
7. For purposes of this Resolution, the term "domestic" shall mean ecclesiastical organizations and bodies located in the United States, including the Dioceses of Puerto Rico and Virgin Islands;
8. The Church Pension Fund shall 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 Denominational Health Plan; and
9. The implementation of The Denominational Health Plan shall be completed as soon as practicable, but in no event later than by the end of 2012; and be it further

Resolved, That Canon I.8 shall be amended as follows:

Sec. 1. The Church Pension Fund, a corporation created by Chapter 97 of the Laws of 1914 of the State of New York as subsequently amended, is hereby authorized to establish and administer the clergy pension system, including life, accident and health benefits, of this Church, substantially in accordance with the principles adopted by the General Convention of 1913 and approved thereafter by the several Dioceses, with the view to providing pensions and related benefits for the Clergy who reach normal age of retirement, for the Clergy disabled by age or infirmity, and for the surviving spouses and minor children of deceased Clergy. *The Church Pension Fund is also authorized to establish and administer the denominational*

health plan of this Church, substantially in accordance with the principles adopted by the General Convention of 2009, with the view to providing health care and related benefits for the eligible Clergy and eligible lay employees of this Church, as well as their eligible dependents.

Sec. 3. For the purpose of administering the pension system, The Church Pension Fund shall be entitled to receive and to use all net royalties from publications authorized by the General Convention, and to levy upon and to collect from all Parishes, Missions, and other ecclesiastical organizations or bodies subject to the authority of this Church, and any other societies, organizations, or bodies in the Church which under the regulations of The Church Pension Fund shall elect to come into the pension system, assessments based upon the salaries and other compensation paid to Clergy by such Parishes, Missions, and other ecclesiastical organizations or bodies for services rendered currently or in the past, prior to their becoming beneficiaries of the Fund. *For the purpose of administering the denominational health plan, The Church Pension Fund shall determine the eligibility of all Clergy and lay employees to participate in the denominational health plan through a formal benefits enrollment process, and The Church Pension Fund shall be entitled to levy upon and collect contributions for health care and related benefits under the denominational health plan from all Parishes, Missions, and other ecclesiastical organizations or bodies subject to the authority of this Church with respect to their Clergy and lay employees.*