Task Force to Advise the Church on Denominational Health Plans

Members

The Rev. David Sibley, *Chair*	Spokane, VIII	2024
The Rt. Rev. Susan Brown Snook, *Vice-Chair*	San Diego, VIII	2024
Mr. Luke Taylor, *Secretary*	Ohio, V	2024
Mr. Frank Armstrong	The Church Pension Group	2024
The Rt. Rev. Mark Hollingsworth	Ohio, V	2024
The Rev. Everett Lees	Oklahoma, VII	2024
Canon Kathryn McCormick	Mississippi, IV	2024
Ms. Joan Ogden	Utah, VIII	2024
Ms. Diane Pollard	New York, II	2024
The Rev. Phillip Shearin	Western Massachusetts, I	2024
Mr. Bill Thompson	Connecticut, II	2024
The Rev. Sandy Webb	West Tennessee, IV	2024
The Most Rev. Michael Bruce Curry, *Ex-Officio*	North Carolina, IV	2024
Ms. Julia Ayala Harris, *Ex-Officio*	Oklahoma, *VII*	2024

Changes in Membership

The Rev. Phillip Shearin resigned from the Task Force in April of 2023 and was not replaced.

Representation at General Convention

Deputy David Sibley and Bishop Susan Brown Snook are authorized to receive non-substantive amendments to this Report at the General Convention.

Acknowledgements

The Task Force wishes to offer its thanks to Bonnie Albritton and Ari Loiben of Lewis and Ellis Actuaries and Consultants for their thorough and outstanding review of the Denominational Health Plan within a condensed time frame, which provided the foundation for our recommendations to the church. The staff of the Church Pension Group, especially John Servais (SVP of Benefits Policy and Design), Laurie Kazilionis (SVP of Benefits Relationship Management), and Damon Tutein (Business Analyst & Vendor Management) worked hand in hand with the Task Force throughout our work, both educating us on the state of the Denominational Health Plan, enabling Task Force members to receive feedback and make presentations to Diocesan Administrators, receiving responses from vendors when soliciting

proposals for actuarial review, and for facilitating Lewis and Ellis' review . We finally offer our thanks to the Presiding Officers, to the Executive Council, and to the General Convention Office for the ongoing facilitation our work, most especially in securing resources to allow for meaningful study of the DHP, and data-driven recommendations for its future support of our church's ministry.

Mandate

2022–D034 Create a Task Force on the Denominational Health Plan

Resolved, that there shall be a Task Force to Advise the Church on the Denominational Health Plan…

The Task Force shall review the structure and offerings of the Denominational Health Plan, in consultation with the Church Pension Group staff, with special attention to the cost of premiums, and report back to the 81st General Convention a list of options to reduce health insurance costs across the church, including an examination of the impact of individual faith communities opting out of the Denominational Health Plan, with a full explanation of the reasoning for and costs and benefits of each option. The 81st General Convention shall consider the options in deciding whether to modify the mandate given to the Denominational Health Plan in Resolution 2009-A177.

The members of the Task Force shall be appointed by the Presiding Officers, and shall consist of: one member of the Church Pension Group Board of Trustees; one member of the Church Pension Group Client Council; one Church Pension Group staff member who is expert in the health care issues addressed by the Denominational Health Plan; two members of Executive Council; two Bishops who serve as at-large members of the Task Force; four Clergy or Lay People who serve as at-large members of the Task Force; and two members who are experts in health care and insurance finance issues."

Executive Summary

Among the most acute pressures faced by the domestic dioceses, congregations, and faith communities of The Episcopal Church is the precipitously rising cost of securing quality health insurance benefits for lay and clergy employees. For many communities in The Episcopal Church, the single most salient factor in choosing whether to offer employment on a basis of over 1,500 hours annually is the cost of securing mandatory health care coverage through the Denominational Health Plan (DHP) via its designated benefit structure, The Episcopal Church Medical Trust.

The Denominational Health Plan was established in 2009 as the mechanism by which health care and related benefits would be secured for eligible clergy and lay employees of this Church, together with their eligible dependents, at a more affordable price than either the small business insurance market, or the individual insurance market (which after the passage of the Affordable Care Act in 2010, would commonly become known as "exchanges"). Participation in DHP is mandatory for all parishes, missions, and other ecclesiastical organizations or bodies subject to the authority of this Church. Since its creation fifteen years ago, the General Convention has repeatedly considered concerns about the affordability and availability of DHP plan offerings through four separate resolutions, including the resolution establishing this Task Force.

The Denominational Health Plan covers participants located in the United States only; because health care systems vary widely from country to country, Church Pension Group has adopted a different strategy for non-US participants. The Fund for Medical Assistance (FMA) was created for eligible non-US dioceses and reimburses participants for qualified medical expenses not otherwise covered by public or private insurance. The non-US dioceses that are eligible to participate in the FMA currently include the Dioceses of Colombia, the Dominican Republic, Ecuador Central, Ecuador Litoral, Haiti, Honduras, Micronesia, Puerto Rico, Taiwan, Venezuela, and the British Virgin Islands. Because these non-US dioceses are not eligible to participate in the DHP, this report focuses on healthcare within the United States.

In the shortened biennium, The Denominational Health Plan Task Force undertook a careful, targeted, yet thorough review of the DHP, its structure, offered plans, and its status. We began with a thorough briefing on the DHP from the Church Pension Group, and on health insurance coverage at large from the Health Care Actuaries on the Task Force.

In considering the depth of analysis needed to make credible recommendations to the church, the Task Force requested that the Domestic and Foreign Missionary Society and Church Pension Group jointly fund a targeted independent study by an outside actuarial firm of DHP's current structure, funding, and plan offerings. Special attention was offered to any cross-subsidization of health insurance costs within the plan by benefit level, coverage tier, geography, mandatory vs. voluntary group participation, ordination status, and eligibility for Medicare benefits. After a multi-bidder request for proposal process, Lewis & Ellis Actuaries and Consultants were unanimously selected to undertake the review. Our conclusions are based in major part upon their excellent work.

We have found that The Church Pension Group has effectively implemented cost-saving strategies in line with the requests and mandates given to it by the General Convention. Despite these strategies, some inherent features of The Episcopal Church's group mean that overall costs of the plan are higher than plans intended for the general population. For instance, the higher average age of the TEC covered group as compared to the general population means that overall costs are inherently higher, since health care expenses on average increase as people age. In addition, plans currently offered by the DHP include some extremely generous benefit-rich plans that are not available to many people outside TEC. In fact, the DHP offers significantly richer coverage at its highest coverage levels than any of our denominational peers, including the Evangelical Lutheran Church in America (ELCA), the United Methodist Church (UMC), and the United Church of Christ (UCC). Our richest benefit levels offered at the PPO100 and PPO90 tiers through Anthem and Cigna (and richer even than most ACA exchange and small business market "platinum" level plans) - comprise 41% of members covered and are significantly subsidized by members receiving coverage at almost all other coverage levels. The rich benefits of these high-end plans increase the costs to all DHP participants that is not recouped by higher insurance rates charged to the participants in those benefit-rich plans.

However, past General Convention actions also have unintentionally raised costs. In a well-intentioned attempt to achieve equitable pricing, past Conventions adopted resolutions that asked the Church Pension Group to price DHP plans as much as possible to a national average. However, health care costs vary dramatically across the country, as does cost-of-living; a functional result of the Convention's action was to artificially subsidize the cost of health care in high-cost areas – areas that are usually (but not always) more resourced – with funds paid into the medical trust through insurance rates from lower-cost areas with lower cost of living. As a result of this subsidization, a church employing a young participant with a family in a relatively low-cost area pays a significantly higher health care insurance rate than would be available on the open-market healthcare exchanges. This imbalance results in inequity to the employing congregation and may even discourage churches from calling young clergy with families, because of the high health care costs that come with family coverage.

Some have asked why, in that case, a church should not be allowed to simply opt out of DHP coverage and buy their health insurance on the open market. The problem is that if all the employees who could get cheaper coverage elsewhere by virtue of their age, location, and other factors opt out of the plan, that leaves the plan with only more-expensive participants, driving up the cost per participant still further. As this cycle continues, with more participants opting out as prices increase, it becomes what is known as a "death spiral," resulting in financial unsustainability, and eventually in the loss of the whole plan. The ethical value underlying the DHP is that we care for each other by entering a health care pool together, sharing each other's burdens.

So what is to be done? A significant portion of our insured population is eligible for coverage through the Medicare Small Employer Exception, which allows Medicare to serve as the primary coverage for people 65 or older who work in institutions with fewer than 20 full and/or part-time employees. Given that many Episcopal communities meet the threshold for Medicare-primary coverage, greater efforts to encourage Medicare-eligible individuals to move to Medicare-primary coverage would provide a significant benefit to the whole church – both lowering the cost of supplemental coverage to the individual and/or institution, and creating a significant reduction of costs to the Denominational Health Plan.

Finally, past actions of the whole church have meant that some indigenous clergy have been priced out of the DHP. As discussed further below, our proposals are intended to provide just and equitable coverage for indigenous clergy and lay employees of The Episcopal Church. Our failure to provide the same benefits to our indigenous employees as we do to others is an injustice that violates our church's commitment to Becoming a Beloved Community and must be corrected.

In weighing the differing imperatives for coverage across the church and the church's moral obligations to its lay and clergy employees, the realities of the DHP as structured at present revealed by our actuarial study, extensive feedback from the whole church, and discussions in consultation with the Church Pension Group, we recommend the General Convention urge the following changes to the Denominational Health Plan:

- Make self-sufficient, to the extent possible, the coverage offered to employees and dependents at each benefit level – using the coverage offered by our denominational peers as a point of comparison to ensure that our employees receive appropriate coverage.
- Adopt additional markers to define "equitable" cost sharing across the church - including adding new rating factors in setting insurance rates that consider both the prevailing cost of health care in each region, and each community's resourcing and ability to pay.
- Change the rating structure to create a church-wide subsidy within the DHP to ensure that the Navajoland Area Mission, and the sponsored dioceses of Alaska, North Dakota, and South Dakota, can access affordable quality coverage outside of the Indian Health Service (IHS) for indigenous lay and clergy employees and dependents.
- Increase outreach efforts toward encouraging greater adoption of the Medicare Small Employer Exception among employees 65 and older by educating the church as to its benefits for both individuals and the whole church.
- Focus existing outreach efforts on the availability and use of Consumer Directed Health Plans (CDHPs) and Health Savings Accounts and providing resources by which covered communities can transition from more expensive PPO plans to less expensive CDHP plans in a way that works for employees.

Summary of Work

The DHP Task Force conducted its work over several meetings, projects, and presentations to the wider church throughout 2023:

- January 30, 2023 – Online
    - *Organizing Meeting and Development of Work Plan*
- February 24, 203 – Online
    - *CPG Presentation and Q&A on Denominational Health Plan History and Structure*
- April 27-29, 2023 – In Person
  Maritime Center, Linthicum Heights, MD
    - *Values for Work*
    - *Actuary Presentation on Actuarial Science, DHP Questions, Avenues of Inquiry*
    - *Group Deliberations and Beginning of Study Request for Proposal (RFP)*
    - *Meeting with Executive Council – CPG Memorandum of Understanding Committee*
- May-June 2023 – Asynchronous Work
    - *Microsoft Teams Collaboration on Study Request for Proposal*
- July 27, 2023 – Online
    - *Review of RFP Responses, Awarding of Study to Lewis and Ellis Actuaries*
- September 25-27, 2023 – In Person (Rev. David Sibley & Rev. Sandy Webb)
  Midtown Hilton, New York, NY
    - *Presentation to Episcopal Benefits Administrators' Conference*
    - *Feedback/Survey of Episcopal Benefits Administrators*
- November 2023 – Asynchronous Work
    - *Churchwide Survey on the Denominational Health Plan*
- November 13, 2023 – Online
    - *Actuarial Presentation and Q&A with Lewis & Ellis*
- November 14, 2023 – Online
    - *Churchwide Listening Session on the Denominational Health Plan*
- November 29, 2023 – Online
    - *Deliberation and Adoption of Recommendations to the Church*

In addition, the Chair and Vice-Chair of the Task Force collaborated with and presented to the Presidents of their respective Houses of the General Convention, to the Executive Council Joint Standing Committee on Finances for Mission, Church Pension Group Executives and Team Members, and Lewis & Ellis Actuaries and Consultants, the contracted firm for the Actuarial Study of DHP.

Values & Aims

The DHP Task Force sought to approach our work in ensuring affordability of health benefits for the church by expressing the values held by members of our Task Force and the church at large. This was to ensure that the recommendations made by the Task Force would be grounded in not only a zeal for pure efficiency and cost-cutting that is common in the secular world, but instead in our hopes and aspirations for providing health care to the church. The Task Force's expressed values were:

1. The Episcopal Church's witness matters, and we need to provide for long-term sustainability for our congregations and dioceses; health benefits are a major present challenge to sustainability for many communities.
2. We need to provide quality health and wellness for our employees and their dependents, and they need to be accessible within their contexts.
3. We need to support dioceses and congregations that have fewer resources in obtaining coverage that is priced appropriately to their context.

Similarly, we adopted aims for work to help shape our inquiry into the DHP and shape our deliberations and recommendations to the church:

1. Provide the 81st General Convention with a "menu" of recommendations that may provide meaningful and practical cost control in DHP.
2. Do our work with the depth of study, credibility, and explanation that the church needs to fully digest necessary changes to DHP.
3. Provide both input by and continuing education to church consumers about the costs and benefits of each recommendation we make.
4. Provide both input by and continuing education to administrators and those in a position now to make decisions that lower costs.

Background & Prior Action By General Convention on DHP

The Denominational Health Plan was established by the 76th General Convention in Resolution 2009-A177, which set the underlying principles for DHP and amended Canon I.8 of the *Canons of The Episcopal Church* to make participation in the DHP mandatory for all domestic dioceses, parishes, missions, and other ecclesiastical organizations or bodies subject to the authority of this church, and for all clergy and lay employees working a minimum of 1,500 hours per year.

Mandatory participation in the DHP ensures an adequate pool of insured to properly manage the risk and cost associated with operating a VEBA (a Voluntary Employees' Benefit Association), the legal and regulatory structure through which the DHP operates. The Denominational Health Plan is a self-insured entity – insurance coverage costs paid into the Medical Trust by covered communities in turn pay all member health claims and administrative costs with running the DHP. Re-insurance policies have historically been held by the Medical Trust to backstop the DHP against unanticipated shock claims and/or catastrophic losses. A prudent decision to end re-insurance coverage is scheduled to end in 2024, CPG will carefully monitor the potential need for resuming re-insurance.

By 2012 – only 3 years after the DHP was established – concerns arose as to the disparity of health care costs among the dioceses of the church. The 77th General Convention adopted resolution 2012-B026, which urged the Episcopal Church Medical Trust (and by extension, the Church Pension Group) to "explore alternative strategies to arrive at a more equitable sharing of health care premium costs, including alternative means of achieving such equity." Testimony in Legislative Committee at the 77th General Convention and debate on the floor of each house focused on a churchwide desire to achieving a single national rate in providing coverage at each benefit level.

While well intentioned, this approach was (and still remains) flawed as a means of providing equitable access to health care. Health care costs vary dramatically across domestic dioceses, and from state to state. While not universal across the country, locations with higher costs of living by and large have higher health care costs. As such, the General Convention's action created a *de facto* subsidy for high-cost areas with the coverage costs paid by low-cost areas.

As such, low-cost markets began to see the rates for their coverage in DHP rise above the rates in their markets. While resourcing and capability to pay higher rates for insurance in the church does not correspond 1:1 with cost of living – notable exceptions, such as South Dakota and Alaska do exist – in large part, it was the parts of the country with most access to institutional resources that benefited from the changes enacted in 2012-B026.

By 2015, the problems continued to be visible to the wider church, yet the solutions were not evident. The 78th General Convention considered 2015-D021 which noted the "disproportionate financial burden" on parishes in the Midwestern United States; however, it also sought to fix that problem with a contradictory resolve that would have made the situation worse - by instituting a "plan with minimal variance in premium costs from diocese to diocese, thereby reducing cost differences... between dioceses... of The Episcopal Church." As noted previously, while some exceptions exist, the net result of such approach would have been to create a subsidy of high-cost, high-resource areas at the expensive of lower-cost, lower resource areas. While the joint legislative committee honed the resolution to simply request further study , a floor debate in the House of Deputies restored a request for an opt out provision; floor debate in the House of Bishops removed it. The resolution ultimately died in non-concurrence upon adjournment.

In 2018, the 79th General Convention acted to ensure each diocese had access to multiple networks for insurance care ("health insurance providers"), and provided an opt-out for any diocese in which only one health insurance provider is available under the Denominational Health Plan when "the availability of only one provider would have a material negative impact on the diocese's employees, congregations, new recruitment, or overall well-being, that diocese will be permitted to seek other insurance options outside of the Denominational Health Plan" in 2018-C023. A challenge in the interpretation of the resolution exists in the gap that exists between the mere existence of a network's presence in a given area with the lived reality of finding an available network provider. While a network may be able to take clients within a given area on paper, the number of providers may be limited or extremely distant. At this time, the Cigna and Anthem networks are offered throughout the DHP; Kaiser Permanente's network is also offered in certain locations in the West.

By 2022, pressure on the DHP from local congregations had grown acute – and ultimately led to the formation of this Task Force. The 80th General Convention considered 2022-D034, which as submitted would have revised the principles associated with the DHP to allow for an opt-out from the DHP when premiums for similar coverage on local markets were 20% less than DHP rates. The resolution was amended in committee to create this task force, and carried both Houses, resulting in the creation of this Task Force and its attendant report and resolutions.

Actuarial Review of the Current State of the Denominational Health Plan

To undertake a review of the current function of the Denominational Health Plan and offer recommendations to the General Convention in lines with the values of the church, the Task Force quickly recognized the importance of having highly qualified "fresh eyes" review the DHP. With equal joint support from DFMS and CPG, the Task Force presented a Request for Proposal to actuarial firms with no prior engagement with the Denominational Health Plan, and asked for review of the following components of DHP:

1. *Plan Benefit and Design*
    - How do plan offerings align with the broader market for health care in the United States?
    - How do plan offerings align with benefit plans offered by other peer denominations?
2. *Benefit Pricing and Pricing Structure*
    - How is risk actually shared among participants in the Denominational Health Plan?
    - What is the relative value of each dollar paid to obtain coverage, and does subsidization occur within the plan by:
        - Network Choice (i.e. Anthem, Cigna, or Kaiser)
        - Benefit Option (i.e. PPO100, PPO90, CDHP-15, Kaiser)

- Coverage Tier (ie. Employee, Employee+1, Employee+Family)
- Region and Geography
- Mandatory vs. Voluntary Participation in DHP
- Clergy or Lay Status
- Pre-65 and Post-65 Employees

3. *Cost Management*
    - What specific steps may be taken to help contain costs without compromising care?
4. *Reserves and Surplus Levels*
    - Does the DHP's balance sheet reflect broadly accepted understandings of appropriate levels of reserves held to pay claims?

Six total responses were received to the Request for Proposal, and the Task Force unanimously selected the proposal presented by Lewis & Ellis Actuaries and Consultants as the proposal that most properly responded to our allotted budget and the scope of review needed, in addition to the time-pressure of a shortened biennium between conventions.

Central to the healthy function of the DHP is sharing risk. By paying insurance premiums into a common pool, members share their financial resources to create a large enough umbrella to weather and bear the costs of any storm that may occur when they need health care.

When functioning well, the umbrella is both wide enough to cover the costs that may be incurred by a pool's members for their health care costs, while also narrow enough to assure that the rates paid to underwrite each member are affordable. Maintenance of a proper balance between these two risk imperatives – holding sufficient funds to cover all costs while not charging rates so high that members seek to leave the plan - requires actuarial expertise, a deep knowledge of the needs of the client base, and a careful evaluation of the risk each participant and group brings, and how they affect the whole.

In insuring a group, common rating characteristics for a group include:

- Age
- Gender
- Health Status (i.e. experience in prior claims)
- Tiers of Coverage
- Geography
- Group Size

Inherent in any group plan is the reality of designed vs. unintended subsidization of health costs across its membership. While it might seem the larger the covered group, the lower the cost, a truism holds that about 15% of members generally drive about 80% of costs regardless of group size. Simply adding more members doesn't change the overall actuarial equation of risk management. All participants will choose the benefit richness they think is best for their risk. Participants who believe their personal medical risk is higher will choose the richest benefit plans; this choice drives up costs for everyone as payouts are correspondingly high. This "adverse selection" effect is well known in the insurance industry. To be clear, no insurance plan exists without some necessary subsidy. But countering unintended subsidization through benefit design and rate-setting can help ensure that the plans offered are as affordable as possible.

In this report, we present our findings specifically on key drivers of higher insurance rates, and meaningful options for General Convention action to reduce costs without compromising care. In the review of DHP, Lewis and Ellis found, and the Task Force agreed, that unintended subsidization is occurring with the DHP across three key categories: by benefit option, by region and geography, and between Pre-65 and Post-65 Employees.

The report presented to the Task Force by Lewis & Ellis is provided in its entirety as an appendix to this report and reprinted with their permission for the use of the Convention in its deliberations.

Countering Unintended Subsidization by Benefit Offering

Over 40% of DHP participants have coverage through a PPO100 or PPO90 plan in the Anthem and Cigna networks. PPO100 and PPO90 plans are considered "platinum plus" level coverage, with very few out of pocket costs. None of our denominational peers, and indeed none of the denominations researched by Lewis and Ellis, offer plans of comparative richness to the Anthem/Cigna PPO100 plan; a few, but not all, offer coverage akin to the Anthem/Cigna PPO90. These plans are all significantly more generous than the counterparts that provide coverage in the secular world through the small business and individual markets

Figure 1: Comparison of Plans offered Across Sibling Denominations

Denomination	TEC / ECMT PPO100	ELCA / Portico Platinum+	UCC Plan A	UMC / Wespath B1000
Richest Plan Deductible (Individual / Family)	$0 / $0	$550 / $1,100	$300 / $600	$1,000 / $2,000
Richest Plan Out of Pocket Max (Individual / Family)	$2,000 / $4,000	$3,400 / $6,800	$2,000 / $4,000	$5,000 / $10,000
Richest Plan Coinsurance	0%	20%	20%	20%

The PPO100 and PPO90 plans are carrying combined claim and administrative loss ratios of 111% and 102% respectively – meaning that the costs incurred by each plan exceed the income from rates paid to obtain coverage by 11% and 2%, and those holding other plans through the medical trust subsidize the true cost of coverage at this level. Our actuarial study calculated what change in rate would be required to remove the subsidy from other plans. Assuming no change to the overall income, the calculation showed that to remove the subsidy from participants in other plans, rates of the PPO100 plan would need to increase by 18.2%; rates of the PPO90 plan would need to increase by 9.6%. In pure dollar amounts, these subsidies may amount to as much as $18 million in costs subsidized by the rates paid by those who *are not* insured in a PPO100 or PPO90 plan.

Figure 2: DHP PPO 100 and PPO 90 Plans & Subsidy

Plan	Anthem/Cigna PPO100	Anthem/Cigna PPO90
Deductible/Coinsurance/Out of Pocket Maximum	$0 / 0% / $2,000	$500 / 10% / $2,500
Claim & ASO Fees Loss Ratio	111%	102%
Rate % Subsidy from Other Plans	**18.2%**	**9.6%**

We recommend that General Convention urge the Church Pension Group to take steps to make each benefit level self-sufficient and self-funding to the extent that is possible and appropriate, using the plan offerings of our denominational peers as a guide to set appropriate benefit richness. Consistent with our ethical and moral convictions, we can use the benefit offerings of our sibling denominations to ensure our plans are rich enough to ensure productive ministry (especially in areas where benefits are among the primary means of compensation owing to low salaries) while not so over-rich as to result in shifting of claim costs from the richest plans to those enrolled in other plans within church. Very often, lay and clergy employees in less-rich benefit tiers are enrolled in these benefits precisely because they cannot afford the PPO100 or PPO90 plans – so it is critical to ensure that these members are not over-subsidizing medical costs in richer benefit options that they cannot afford themselves.

Countering Unintended Subsidization by Region

Medical costs vary dramatically by location across the country, as becomes readily evident when considering Health Care Spending Per Capita in 2020, as presented by the KFF's *State Health Facts.*

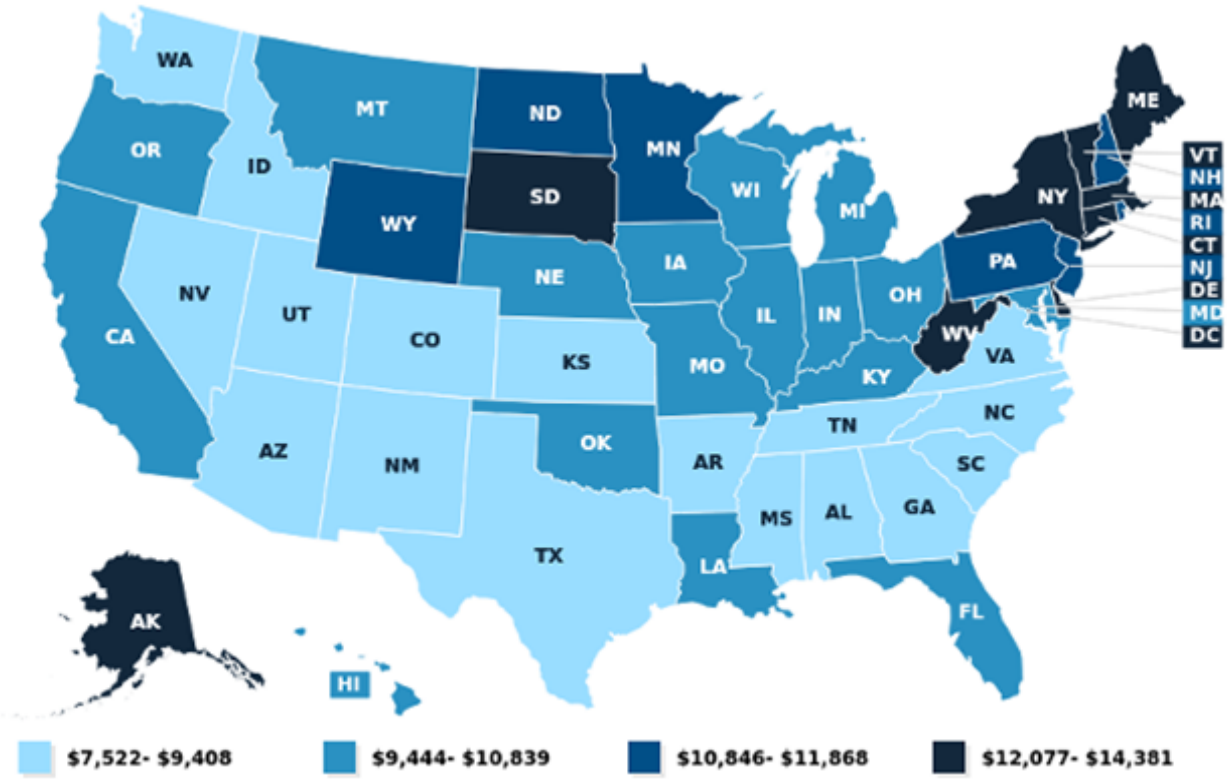

Figure 3: Health Care Spending Per Capita, 2020

Prior General Convention action asked CPG to try to achieve equitable rate costs across the country, without regard to the actual market cost of health care in each area. Even before actuarial analysis, the Task Force was aware that regional subsidization was likely occurring within the DHP.

Lewis & Ellis analyzed the extent of subsidy in the church under the following broad categories of geography:

- Northeast: Provinces I, II, and III
- Midwest: Province V
- South: Provinces IV and VII
- West: Provinces VI and VIII
- Other: Episcopal Service Corps and Episcopal Camps and Conference Centers

Figure 3: Contribution & Claim Relative Value by Geography

	Northeast	Midwest	South	West	Other
Contribution Relative Value	1.00	0.96	0.88	0.94	0.90
Claim & ASO Fees Relative Value	1.00	0.97	0.86	0.84	0.79
Rate Change to Remove Subsidy	**2.5%**	**3.7%**	**0.4%**	**-8.2%**	**-9.5%**

The result observed is a functional subsidy of health care by Provinces VI and VIII, Episcopal Service Corps (ESC) programs, and Episcopal Camps and Conference Centers (ECCC) to the rest of the country. Were geographic subsidy removed from the plan, Provinces VI and VIII would have rates drop by 8.2%; ESC and ECCC groups would have rates drop by 9.5%.

Yet the most acute challenge in addressing regional subsidization in the DHP is the uneven distribution of resources across The Episcopal Church. The cost of health care is acutely high as many would expect in places of comparatively high resourcing such as the Dioceses of New York and Long Island – but also in under-resourced dioceses such as South Dakota, West Virginia, and Alaska. Meanwhile, other highly resourced dioceses – such as Texas – benefit from lower health care costs than the national median. Strictly setting insurance rates based on geography and the prevailing cost in each area does not foster the mutual interdependence intended to be created through the DHP.

The Task Force recommends that the General Convention urge CPG to add two new factors, in addition to existing factors, to make rates more equitable across the church. This would take the form of adopting of a counter-balancing "dual mandate" to consider two additional factors when setting health insurance rates:

- the relative ability of each covered community to pay a given rate
- the prevailing cost of comparable coverage within the area covered by each group

Such an added rating mechanism will allow the DHP to generally key the cost of health insurance to cost of living and cost of health care in each location, while also recognizing that the resourcing to pay for health coverage is unequally distributed across our church.

Countering Unintended Subsidization by Age

A simple reality is that as age increases, health care costs increase. Try as we might, there is no action the General Convention can take to reverse the realities of the passage of time, and the reality that older individuals will always have higher claim costs. The DHP is no exception: claims for DHP Primary 65+ members are more than double those of the pre-65 members, but contributions to the plan are only 24% higher.

Figure 4: Effect of Age on DHP Claims and Associated Subsidy

	Pre-65	DHP Primary 65+	Medicare Primary 65+	Total
Member Count	21,178	1,574	442	23,194
Member Distribution	91%	7%	2%	100%
Claim & ASO Loss Ratio	88%	145%	133%	94%
Rate Change to Remove Subsidy	**-6.0%**	**+55.4%**	**+40.7%**	**-**

Similarly, post-65 employees insured by the DHP overwhelmingly choose the options with the richest benefits. One reason is likely the sheer generosity of our richest plans; another is the relatively recent introduction of Consumer Directed Health Plans (CDHPs) and Portable Health Savings Accounts (HSA) means that those 65 and older have had less time to build a HSA "nest-egg" by contributions, whether made by the employer or the employee.

Figure 5: Plan Selections of Employees by Age

	Pre-65	DHP Primary 65+	Medicare Primary 65+
PPO100/PPO90	40%	56%	73%
PPO80/PPO70	26%	20%	27%
CDHP Plans	26%	17%	0%
Kaiser EPO Plans	8%	7%	0%

The Task Force expressly does not recommend further adjustments to rating mechanisms to remove functional subsidy within DHP by age. We do, however, recommend that the General Convention urge CPG to make intentional efforts to encourage greater adoption of the Medicare Small Employee Exception (SEE). The Medicare Small Employer Exception allows Medicare to serve as the *primary* payer of medical claims for people 65 or older when they work in an institution with fewer than 20 full and/or part-time employees.

The vast majority of Episcopal communities have fewer than 20 employees, and therefore meet the threshold for Medicare-primary coverage. While CPG cannot mandate, price, or force any 65+ employee to avail themselves of the Medicare Small Employee Exception, new efforts to help employees opt for Medicare-primary coverage would shift the principal cost burden of their care from the DHP to Medicare. In doing so, they would both lower the cost of their Medicare supplemental coverage provided through DHP, and the total cost of claims incurred by the DHP. In so doing, less subsidy would be required from the population under 65 to pay the plan's total claims.

Providing Affordable DHP Coverage to Indigenous Lay and Clergy Employees of our Church

Past actions of General Convention have had the unintended result of pricing some indigenous clergy and lay employees of the church out of the DHP, particularly in the Navajoland Area Mission.

Our failure to provide the same benefits to our indigenous employees as we do to others is an injustice that violates our church's commitment to Becoming the Beloved Community and must be corrected immediately. Past block-granting by the General Convention rested on the assumption that coverage available to indigenous employees and their dependents through the Indian Health Service (IHS) would be sufficient for their health care needs, and thus funds were not provided to purchase DHP coverage. Simultaneously, the General Convention's actions attempting to equalize the cost of health coverage in all regions of the church has caused the price of health insurance to be too high for such less-resourced areas to afford. No action was taken – on either churchwide budget or DHP plan design sides of the coverage funding equation – to be sure DHP plans were accessible to these employees and their dependents.

Government-provided health care through IHS available to indigenous people was indeed once considered to be adequate – but it no longer is. Reliance on such care has resulted in substandard health outcomes for our Episcopal employees. The task force heard impassioned testimony at our open forum asking us to correct this injustice and letting us know that Navajo people have been praying for this plea to be heard for years. Our failure to hear and respond to this request would be a moral stain on our church's witness as God's Beloved Community. This egregious injustice to our colleagues in ministry is an indictment of our own ability to care for our people and must be corrected immediately.

The resolutions we are proposing will allow the DHP to consider the relative resourcing of employers in determining DHP prices, particularly in the case of Navajoland and the other three dioceses with many indigenous employees which are supported by block grants from TEC: Alaska, North Dakota, and South Dakota. Spreading the cost of affordable coverage for indigenous employees across all DHP participants would result in a relatively small added cost to participants, while providing a life changing (and literally lifesaving) benefit to indigenous employees who labor in the same fields and for the same Lord.

Additional Education Efforts to Relieve Pressures on the Denominational Health Plan

In addition to the previously mentioned need for greater education concerning adoptions of the Medicare Small Employer Exception, we recommend efforts be focused in two other areas that may have the potential to help relieve pressures on DHP:

- Better education of Group Administrator on the importance of selectivity in selecting the plans which will be offered to employees
- Better education across the church on the use and benefits of Consumer Directed Health Plans

At the Episcopal Benefit Administrators Conference for 2023, a majority of diocesan administrators present (55%) indicated that a single staff member is responsible for choosing the plan offerings for each group. Additionally, 49% of administrators present indicated their group offered 5 or more plan options to participants.

As more plans are offered at Open Enrollment to a given group, the greater the likelihood that high-cost participants will be centralized in the most generous plans, while lower-cost participants are distributed across all offered plans – which will inevitably result in rising costs for all plans offered. Exercising discretion in offering as few plans as possible to meet the needs of the group may have a salutary effect in controlling costs.

One prudent practice for each group administrator might be to offer a limited number of plans – perhaps a single PPO, a single CDHP, and their Medicare supplement counterparts – ideally within a single provider network that fits the care profile of the group. While the needs of each group (e.g. a diocese) will differ – and many groups may not be able to conform to a single "best practice" – CPG's expertise in the DHP's plan offerings and established client relationships with group administrators provides a meaningful conduit for aiding administrators in offering plan selections that balance employee needs while not overextending and exacerbating adverse selection phenomena.

Similarly, the DHP has lower rates of usage for Consumer Directed Health Plans (CDHPs) than among secular employers. These plans – which pair a high deductible and fixed coinsurance together with an employee-owned Health Savings Account (HSA) into which employees and employers make tax-advantaged contributions to meet health care costs – require significant education for both group administrators and employees alike. "Sticker shock" at a high deductible often keeps administrators and employees from opting for these plans; in many cases, however, the cost of CDHP rates paired with employer HSA funding of a substantial amount of the higher deductible may end up providing lower costs to employees *without* increasing that employee's overall out-of-pocket cost exposure.

At the same time, Consumer Directed Health Plans (CDHPs) most benefit more informed health care consumers – especially those who are on a peer relationship to their providers. As such, the "on ramp" to CDHP adoption among the entire insured population may be longer than that associated with more traditional PPO plans. Employers must carefully plan in setting the proper rate of HSA funding to

incentivize plan adoption; plan for the proper long-term adjusting of those contributions as HSA balances of employees increase through continued contributions and investment. Employees need to understand fully how their plans work, think about how to manage their health care by readily and consistently availing themselves of free preventative care (annual physicals, for example) built into the plan, while also being sure not to defer necessary care out of fear of "sticker shock." The fundamental difference between CDHP/HSA plans and PPOs require extensive education, but when well educated, can produce great results for employees and employers without compromising care.

Final Note on Proposed Resolutions

The canonical, legal, and regulatory structure of the Denominational Health Plan is awkwardly shared between The Episcopal Church and the Church Pension Group. The Canons of the church create the DHP mandate for employees over 1,500 hours annually and provide authority to CPG to implement and manage the Denominational Health Plan by setting insurance rates and paying insurance claims. A past resolution of General Convention, 2009-A177, by canon sets the underlying principles and intent for the DHP. Yet it is the responsibility of the Board of the Church Pension Group to ensure the proper operation of DHP, its legal and regulatory compliance, and to manage its finances to sustain DHP as a going concern.

As such, these resolutions urge the Church Pension Group to make specific changes to DHP and the Medical Trust in keeping with this report and are understood by the Task Force as an addition to the underlying principles for the DHP first expressed in 2009-177 – in line with the way resolutions previously adopted by General Convention on DHP after its founding in 2009 (2012-B026, 2018-C023) have been interpreted by the church and CPG.

We very intentionally do not offer explicit actuarial mechanisms, formulas, or specific instructions for their implementation beyond that which is explicitly stated within the resolutions and explanations themselves – such responsibility ultimately will rest with the Board of the Church Pension Group, and CPG's staff.

Proposed Resolutions

A100 Adopt Cost Controls in Denominational Health Plan

Resolved, That the 81st General Convention urge the Church Pension Group to take actions to make the health insurance plans offered by the Episcopal Church Medical Trust self-sufficient and self-funding at each offered benefit level to the extent possible and appropriate; and be it further

Resolved, That the Church Pension Group be urged to offer health insurance benefit offerings in the Episcopal Church Medical Trust comparable to those offered by the benefit agencies of similar denominations including, but not limited to, the Evangelical Lutheran Church in America, the United Methodist Church, the Presbyterian Church USA, and the United Church of Christ, and to continue collaborating with them when feasible for achieving greater purchasing power in the provision of prescription drug benefit offerings.

EXPLANATION

The rising cost of health insurance presents a continuing challenge to communities within The Episcopal Church seeking to provide quality benefits for health care to their employees at an affordable cost. While the Church Pension Group has moved to control costs to the fullest extent of their ability, the church itself needs to recommend specific changes to keep costs affordable.

At present, not all benefit levels within the Episcopal Church Medical Trust are self-supporting, which leads to rising costs across all plans offered to employees and dependents. Many of our benefit offerings are also out of step with those offered to lay and clergy employees in our peer denominations.

This resolution expresses the desire of the church for CPG to take steps to contain costs within the Denominational Health Plan by taking steps to make each benefit level self-sustaining to the extent possible, and by seeking to keep benefit offerings in line with those offered by our sibling denominations.

A101 Revise DHP Pricing Structures for Equitable Access

Resolved, That the 81st General Convention reaffirms The Episcopal Church's commitment to maintaining parity in health benefits offered to clergy and lay employees of The Episcopal Church and its dioceses, congregations, institutions and communities; and be it further

Resolved, That the 81st General Convention urge the Church Pension Group to adopt methods to provide equitable churchwide pricing of plans offered by the Episcopal Church Medical Trust, including by taking into account additional factors that may increase equity such as (a) the relative ability of each covered community to pay for needed benefits, and (b) the prevailing cost of comparable coverage within the area covered by each group; and be it further

Resolved, That the 81st General Convention urge the Church Pension Group to adopt a pricing structure that will ensure the ability of the Navajoland Area Mission and the Dioceses of Alaska, North Dakota, and South Dakota to provide plans through the Episcopal Church Medical Trust to their qualifying lay and clergy employees and their dependents, most especially to those who presently only receive coverage through the Indian Health Service (IHS) of the United States Department of Health and Human Services (HHS).

EXPLANATION

At present, lay employees make up a majority of those covered by the Denominational Health Plan. As such, the continued requirement of parity in benefit offerings between clergy and lay employees is paramount to the affordability and financial sustainability of the plan.

However, based on a prior resolution of the General Convention, CPG has been asked to strive to price health insurance offerings at a universal price without regard to location. This prior resolve, while well intended, did not consider a critical factor of health care in the United States – that the cost of health care varies dramatically across the country, just as cost of living varies from place to place. This has led to insurance rates that are often out-of-sync with a church community's local insurance market.

This resolution reaffirms the necessity of lay/clergy parity in benefits, while asking CPG to consider two factors when it sets insurance rates for health plans – the ability of a covered community to pay, and the prevailing cost of comparable health care within the area covered by each group.

Finally, we seek to correct an injustice that has created a disparity in health care access between indigenous and white employees of the church – some indigenous lay and clergy employees do not receive Denominational Health Plan coverage, instead relying on coverage provided by the Indian Health Service (IHS) of the United States Department of Health and Human Services that does not meet their present need. Our failure as a church to provide equal offerings must be rectified.

This resolution asks CPG to set a rating structure that would provide extra support to the Navajoland Area Mission, and to those US dioceses who receive block grants from the DFMS budget, to ensure that all employees of the church have access to quality health care.

A102 Churchwide Education Efforts to Control Healthcare Costs

Resolved, That the 81st General Convention urge the Church Pension Group to continue its education efforts around health insurance benefit selection, with more purposeful attention given to the benefits offered to employees, covered communities, and the whole church through greater use of the Medicare Small Employer Exception by employees age 65 or older in eligible communities; the need for group administrators to exercise discretion in the number of benefit levels offered within a group; and the benefits to employees and covered communities through the adoption and use of Consumer Directed Health Plans (CDHPs) and associated Health Savings Accounts, and methods by which institutions may transition their employees to such plan offerings.

EXPLANATION

This resolution asks CPG to undertake purposeful education efforts around the Medical Small Employer Exception (SEE) for employees over age 65, the benefits of targeted selection of plan offerings by benefit administrators in order to combat adverse selection, and to administrators and consumers alike around the use of Consumer Directed Health Plans (CDHPs) and Health Savings Accounts (HSAs) as a cost effective way of providing quality medical care.

Wider uptake of best practices in all three areas could result in significant savings to DHP while not constraining or restricting access to care.

Supplementary Materials

Actuarial Review of the Denominational Health Plan of The Episcopal Church,
prepared by Lewis and Ellis Actuaries and Consultants for the Task Force.

Actuarial Review of the Denominational Health Plan

The Episcopal Church

DECEMBER 4, 2023

LEWIS & ELLIS

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December 4, 2023

The Task Force to Advise the Church on the Denominational Health Plan
The Reverend David C. Sibley
Task Force Chair
815 2nd Avenue
New York, NY 10017

Re: The Episcopal Church
Actuarial Review of the Denominational Health Plan

Dear Reverend Sibley:

We are pleased to present our report documenting our review of the Episcopal Church's Denominational Health Plan.

We appreciate the opportunity to be of service. If you have any questions, please call.

Sincerely,

Bonnie S. Albritton, FSA, MAAA
Vice President & Principal

Ari T. Loiben, ASA, MAAA, MS
Vice President & Principal

Enclosures

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EXECUTIVE SUMMARY

The 80th General Convention of The Episcopal Church ("the Church") created a task force ("the Task Force") to advise the Church on the Denominational Health Plan ("DHP"), with emphasis on the cost of benefits. The Task Force was asked to *"review the structure and offerings of the Denominational Health Plan with special attention to the cost of premiums and to report back to the 81st Convention a list of options to reduce health insurance costs across the church, including an examination of the impact of individual faith communities opting out of the Denominational Health Plan, with a full explanation of the reasoning for and costs and benefits of each option."*

Lewis & Ellis ("L&E") was asked to provide an independent review of the DHP to assist the Task Force in completing this charge. This report documents our review, findings, and recommendations for the Task Force.

Some of the past and current objectives of the DHP include working to manage overall healthcare costs, achieving parity in cost sharing between clergy and lay employes and reducing premium disparities among dioceses. While working to achieve these objectives, the DHP also tries to balance high-quality benefits with financial stewardship for the Church. Sometimes these objectives can be difficult to achieve because they can be competing and improvement in one area may negatively impact another area.

The Church Pension Group ("CPG") has implemented several cost-saving strategies over the past several years and continues to do so. However, at a certain point, it becomes difficult to continue squeezing out savings in the areas where members are minimally impacted. The Task Force has the difficult job of considering certain changes that may be challenging to implement because they will have more impact on the members.

We separated our review into several broad categories to address the requests from the Task Force which are outlined in the report. The scope of our analysis only includes the self-funded benefits for active employees. It does not include fully insured plans or benefits for retirees.

Observations and Recommendations

- **Carriers:** Resolution 2018-C023 from the General Convention requested at least two national health insurance carriers in each diocese. The DHP has Anthem and Cigna as the two national health carriers and Kaiser in several regions. Kaiser has a different business model, so we included the fees associated with carriers in our comparisons. Based on our analysis, the Anthem and Cigna benefit options are performing well, and average claims are consistent with each other. There is some subsidization of costs by the Kaiser benefit options.

- **Meaningful Differences:** While the DHP offers 17 benefit options between Anthem, Cigna, and Kaiser, there are 7 benefit options nationwide and 3 Kaiser plans. It is our opinion that the options provide meaningful differences in benefits and there is enough of a difference that we do not recommend eliminating a benefit option for this reason.

- **Anthem/Cigna PPO 100**: This benefit option has no deductible, no coinsurance, limited copayments, and a $2,000 out-of-pocket maximum. None of the benefit plans offered by the other religious organizations we researched have comparable benefits. Based on the Employer Health Benefits

2023 Annual Survey published by Kaiser Family Foundation, only 10% of employees are covered by a plan with no deductible. In addition, none of the other researched denominations provide benefits that are as rich as this plan. The PPO 100 option has 21% of the membership and a one-year loss ratio[1] of 111%. The cost of this benefit option is being heavily subsidized by other lower-cost benefit options. ***We recommend that the Task Force consider removing this option, adjusting some of the benefits (such as adding coinsurance), or starting to increase the premium rates to remove some of the subsidization by the other plan options. Eliminating the plan could result in savings up to approximately $6 million or 2.8% of contributions.***

- **Anthem/Cigna PPO 90**: This benefit option is in a similar situation as the Anthem/Cigna PPO 90 has a $500 deductible, 10% coinsurance, and $2,500 out-of-pocket maximum. The benefit option has 20% of the membership with a 102% one-year loss ratio. The cost of this benefit option is also being heavily subsidized by other lower-cost benefit options. While there are some religious organizations that provide similar benefit options, based on the overall employer marketplace, the cost-sharing is still very low.
  - ***We recommend that the Task Force consider removing this option, adjusting some of the benefits (such as increasing coinsurance amounts), or starting to increase the premium rates to remove some of the subsidization by the other plan options. Eliminating this plan, in addition to the PPO 100 option could result in savings up to approximately $18 million of 8.4% of contributions.***
  - ***As an alternative to removing the plan, we recommend changing some of the benefits. We estimate that changing the in-network coinsurance from 10% to 20% and the out-of-pocket maximum from $2,500 to $3,000 can reduce the per employee cost of the PPO 90 benefit option by approximately 8%[2].***

- **Coverage Tiers[3]:** The DHP allows each diocese to select the number of coverage tiers for their rates. The 3-tier employer groups account for 45% of membership with a one-year loss ratio of 100%. Within the 3-tier groups, the Employee+1 rates are being significantly subsidized by the employee only and family tiers. ***While we do not recommend significant adjustment at one time, the Task Force may want to consider adjusting the 3-tier Employee +1 rates over several years.***

- **Post-65 Employees:** There is significant subsidization by pre-65 members for the post-65 members. The post-65-member benefit cost is almost double the pre-65 members, but average contributions are only 20% higher than pre-65. Even among the Medicare-primary members, the costs are 69% higher but contributions are only 5% higher than pre-65. While higher costs are expected for older members, the impact is exacerbated because the older employees are electing the richer benefit options at a higher rate. Over 70% of Medicare-primary employees and 56% of DHP-primary employees have selected one of the two highest-cost plans. In contrast, only 40% of pre-65 employees have selected these plans. ***This analysis reinforces our recommendation that the Task Force consider making changes to the PPO 100 and PPO 90 plans.***

[1] The loss ratio is claims divided by premiums and does not include administrative expenses.
[2] Based on modeling the plan changes in the L&E Group Medical Manual.
[3] 2-Tier: Employee/Family; 3-Tier: Employee/Employee+1/Family; 4-Tier: Employee/Employee+Spouse/ Employee+Childr(ren)/Family

- **Mandatory Coverage Opt-Out:** We caution the Task Force against allowing employer groups to opt out of the DHP. Currently, 80% of the membership originates from Mandatory groups, and removing the mandate could drive a significant portion of the healthier groups away towards lower-cost solutions. This could cause the future experience to deteriorate exponentially. ***We recommend making some of the other adjustments discussed above in order to bring down the cost for the mandatory groups.***

SCOPE OF SERVICES

The Church Pension Group and the Domestic and Foreign Missionary Society of the Episcopal Church have engaged Lewis & Ellis, Inc., to perform an actuarial analysis of the Denominational Health Plan.

The 80th General Convention of The Episcopal Church created a task force to advise the Church on the DHP, with emphasis on the cost of benefits. The Task Force was asked to *"Review the structure and offerings of the Denominational Health Plan with special attention to the cost of premiums and to report back to the 81st Convention a list of options to reduce health insurance costs across the church, including an examination of the impact of individual faith communities opting out of the Denominational Health Plan, with a full explanation of the reasoning for and costs and benefits of each option."*

More specifically, we were asked to:

- Review the current state of the DHP and make recommendations for improvements, most notably, that will reduce overall costs, while providing meaningful levels of benefits and cost sharing for clergy and lay employees participating in the DHP.
- Evaluate the distribution of risk and cross-diocese subsidy.
- Assess the impact of groups beyond those under a mandate for coverage through the DHP.
- Evaluate appropriate levels of reserves and surplus held by the DHP.

BACKGROUND

The Episcopal Church Medical Trust ("Medical Trust") is an employee healthcare benefits organization and an affiliate of The Church Pension Fund ("CPF"). The Medical Trust sponsors health plans that have served The Episcopal Church since 1978.

The Medical Trust administers the Denominational Health Plan, established in 2009 by the 76th General Convention's passage of Resolution A177 and reaffirmed in 2012 by Resolution B026 passed by the 77th General Convention. The resolutions requested that the Medical Trust administer a national healthcare plan and provide an annual status report.

These resolutions:

- Established the DHP for all domestic dioceses, parishes, missions, and other ecclesiastical organizations or bodies subject to the authority of the Church,
- Covered clergy and lay employees who are scheduled to work a minimum of 1,500 hours annually,
- Required dioceses to ensure parity in cost sharing between clergy and lay employees, and
- Requested that the Medical Trust continue to reduce the disparity of health care premiums among dioceses.

In addition, Resolution 2018-C023 requested that the Medical Trust strive to make available at least two national health insurance carriers in each diocese.

The DHP has two categories of employer groups.

- **Mandatory**: Institutions under the authority of the Episcopal Church are required to provide and subsize coverage for clergy and lay employees working at least 1,500 hours per year. Employees working between 1,000 and 1,500 hours are eligible for benefits, but employer subsidization is not required.
- **Voluntary:** Employees of institutions affiliated with the Episcopal Church which are normally scheduled to work at least 1,000 compensated hours per year are eligible.

The mandatory groups make up 103 of the employers participating in the Medical Trust and approximately 78% of the enrolled employees and 80% of the members.

DATA RELIANCE

CPG staff provided the data upon which we relied, including the enrollment, contribution rates, claims data and other information. We have reviewed the data for reasonableness but have not audited it. To the extent that there are material inaccuracies in the data, our results may be accordingly affected.

LIMITATIONS

The analysis included in this report involves the Episcopal Church's Denominational Health Plan. Our services were provided on behalf of the Church Pension Group and the Domestic and Foreign Missionary Society of the Episcopal Church. The information included in this report is for the use of the General Convention's Task Force in their review of the benefits, pricing, and recommendations to report back to the General Convention. These communications should not be relied upon for any other purpose.

The date through which data or other information has been considered in developing the findings included in this report is July 31, 2023. We are not aware of any subsequent events that may have a material effect on the actuarial findings.

We understand that this report will be provided to the General Convention which may result in it becoming publicly available. However, the report may only be distributed to other parties in its entirety. In addition, any third party with access to this report acknowledges, as a condition of receipt, that L&E does not make any representations or warranty as to the accuracy or completeness of the material. Any third party with access to these materials cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.

CPG and the Domestic and Foreign Missionary Society of the Episcopal Church agreed to pay Lewis & Ellis, Inc., a fee for preparing this report. Other than regarding that contract, we are financially and organizationally independent from the Episcopal Church and any entity or individual related to the Church. There is nothing in our relationship with the Church that would impair or seem to impair the objectivity of our work.

There are no assumptions or method prescribed by law with respect to the scope of this report. The actuary does not disclaim responsibility for any material assumption(s) or method(s).

SECTION I
PLAN BENEFIT DESIGN

OVERVIEW OF CURRENT PLANS

The scope of our analysis only includes the self-funded benefits for active employees. It does not include fully insured plans or plans for retirees.

Summary of Benefits

The DHP currently offers four PPO and three high deductible plans through Anthem and Cigna. There are three regional Kaiser plans. The following table provides a brief summary of the medical benefits by plan. More details are included in Appendix A for reference.

Plan	In-Network Deductible[4]	Out-of-Pocket Maximum[5]	Coinsurance	PCP / Specialty Visit
Anthem/Cigna PPO 100	$0 / $0	$2,000 / $4,000	0%	$30 / $45
Anthem/Cigna PPO 90	$500 / $1,000	$2,500 / $5,000	10%	$30 / $45
Anthem/Cigna PPO 80	$1,000 / $2,000	$3,500 / $7,000	20%	$30 / $45
Anthem/Cigna PPO 70	$3,500 / $7,000	$5,000 / $10,000	30%	$30 / $45
Anthem/Cigna CDHP-15/HSA	$1,600 / $3,200	$2,400 / $4,800	15%	15%
Anthem/Cigna CDHP-20/HSA	$3,000 / $5,450	$4,200 / $8,450	20%	20%
Anthem/Cigna CDHP-40/HSA	$3,500 / $7,000	$6,000 / $12,000	40%	40%
Kaiser EPO High	$0 / $0	$1,750 / $3,500	0%	$25
Kaiser EPO 80	$500 / $1,000	$3,400 / $7,000	20%	$25
Kaiser CDP-20/HSA	$3,000 / $5,450	$4,200 / $8,450	20%	20%

The prescription drug benefits are summarized below. For each of the Anthem/Cigna PPO plans, there is a choice between Standard and Premium drug coverage.

Prescription Drugs	Generic	Preferred Brand	Non-Preferred Brand	Specialty
Anthem/Cigna Standard PPO	$10 Copay	25% up to $40	40% up to $80	40% up to $100
Anthem/Cigna Premium PPO	$5 Copay	$35 Copay	$70 Copay	$90 Copay
Anthem/Cigna CDHP	Coinsurance	Coinsurance	Coinsurance	Coinsurance
Kaiser EPO	$5 Copay	$30 Copay	$70 Copay	$90 Copay
Kaiser CDHP	Coinsurance	Coinsurance	Coinsurance	Coinsurance

[4] Individual/Family
[5] Individual/Family

Benefit Selection

The DHP was initially structured and continues to allow each diocese to determine which plans will be offered to parishes within the diocese. A few dioceses have allowed their larger parishes to select their own benefit options. Administratively, they are set up as separate "groups" within the plan.

Employee Contributions

Each diocese determines the employee contributions for each plan option. The DHP does not have a minimum level; the only requirement is parity between clergy and lay employees. Most dioceses allow individual parishes the latitude to set their own level to meet their financial needs.

CPG does not have the authority to make any requirements about the employee contribution strategy and/or level. However, there are discussions between CPG and the diocesan and large parish administrators to help inform their employer-subsidy decision making.

CPG does not have access to the actual employee contributions, but their research indicates that there is an even mix across dioceses using percentage-based employee contribution strategies and diocese using a core plus buy-up/buy-down employee contribution strategy[6].

CURRENT MARKETPLACE OFFERING

For a comparison to the current marketplace, we considered two primary sources: the Employer Health Benefits 2023 Annual Survey published by Kaiser Family Foundation ("KFF Survey")[7] and publicly available information for health plan options offered by other religious organizations. The KFF Survey provides a current snapshot of employer-sponsored health benefits based on its annual survey of private and non-federal public employers with three or more workers.

The following sections provide summaries based on our research. In addition, we have provided comparisons to current DHP offerings when applicable.

Plan Type

The KFF Survey provides a high-level summary of the distribution of plan types offered by employers as well as the distribution of employers that offer varying types of plans. See the summary tables below.

Plan Type[8]	Distribution
HMO	13%
PPO	47%
POS	10%
HDHP	29%
Indemnity	1%

[6] Core plus buy-up/buy down: The diocese selects a core plan for which the employer subsidy amount is set. The employee has the option to buy-up to a higher-cost plan or buy-down to a lower-cost plan at the employee's own cost.
[7] https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2023-Annual-Survey.pdf.
[8] HMO: Health Maintenance Organization; PPO: Preferred Provider Organization; POS: Point-of-Service plan; HDHP: High Deductible Health Plan; Indemnity: No provider networks and same cost sharing for all services.

As is the case with the DHP, the majority of those considered in the study are enrolled in either a PPO or HDHP plan.

Number of Plan Types	Distribution
1	77%
2	18%
3+	5%

While more than three-quarters of the total employers only offer a single plan type, over half of the large employers (200 or more workers) offer more than one plan type. The DHP is competitive from this standpoint, typically offering at least two plan types to each group.

Employee Cost Sharing (Medical)

DEDUCTIBLES

Based on the KFF Survey, 10% of employees are enrolled in a plan with no deductible. The DHP plans have 24% of employees with no deductible.

For employees with a deductible, the average deductible for employee only coverage[9] is $1,281 and $2,611 for PPO and HDHP plans, respectively. The average DHP deductible for employees with a deductible is $951 for PPO and $2,763 for HDHP plans.

The DHP's offerings are in line with these industry results; however, the up-take in low deductible plans is greater for the DHP vs. the industry. Additionally, the distribution by plan type and deductible amount is provided in the following table.

Deductibles	HMO	PPO	POS	HDHP	All Plans	DHP Plans
$0[10]	N/A	N/A	N/A	0%	10%	24%
$1 - $499	16%	15%	11%	0%	7%	0%
$500 - $999	30%	32%	15%	0%	18%	26%
$1,000 - $1,999	35%	33%	41%	36%	37%	26%
$2,000 - $2,999	12%	9%	14%	32%	14%	0%
$3,000 or More	7%	10%	19%	33%	14%	24%

OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum is the amount that an enrollee must pay before all additional costs are covered by the health plan. The average employee-only out-of-pocket maximum is $4,346, and the distribution by plan type is provided in the following table. For the DHP plan, the average out-of-pocket maximum is $3,072.

[9] In this section of the report, our focus is on the employee deductible/out-of-pocket maximum, but family deductibles/out-of-pocket maximums are typically 2- to 3-times the employee amount.

[10] The KFF Study only disclosed the percentage of all plans with zero deductible and did not distinguish between plan types.

Out-of-Pocket Max	HMO	PPO	POS	HDHP	All Plans	DHP Plans
$2,000 or Less	28%	15%	15%	1%	13%	24%
$2,001 - $3,000	20%	22%	14%	13%	19%	25%
$3,001 - $4,000	11%	24%	14%	34%	24%	25%
$4,001 - $5,000	18%	10%	13%	22%	14%	24%
$5,001 - $6,000	6%	8%	7%	11%	8%	1%
$6,000 or More	18%	22%	38%	19%	21%	0%

The DHP offerings do not exceed $6,000, but they provide covered groups with competitive options that allow enrollees to balance benefit richness vs. cost. In addition, as evidenced in the table above, employees are taking advantage of these offerings by enrolling in richer plans compared to the industry.

PHYSICIAN OFFICE VISITS

Regarding primary care and specialist visits, the KFF Survey discloses the average copay and coinsurance amounts for each service are as follows. Approximately 70% of these visits have a copay structure while 20% require a coinsurance payment. The DHP copay/coinsurance amounts for these services are very consistent with these averages.

Visit Type	Copay	Coinsurance	DHP Copay	DHP Coinsurance
Primary Care	$26	19%	$30	20%
Specialist	$44	20%	$45	20%

Employee Cost Sharing (Prescription Drugs)

More than 80% of prescription drug plans offered by employers have three or more tiers per the KFF Survey. Regarding these plans, the following table provides the average cost sharing to enrollees depending on whether the plan applies copays or a coinsurance structure. The first four tiers exclude specialty drugs completely.

Rx Tier	Copay	Coinsurance	DHP Copay[11]	DHP Coinsurance
First Tier (Generics)	$11	20%	$9	20%
Second Tier (Preferred)	$36	26%	$38	20%
Third Tier (Non-Preferred)	$66	38%	$77	20%
Fourth Tier (Other)	$125	28%	N/A	20%
Specialty	$110	26%	$97	20%

The distribution of employees by the cost-sharing structure and tier from the KFF Survey is as follows. In this case, "Other" represents some other cost sharing form or no cost sharing at all.

[11] The DHP's Standard Plan cost sharing for tiers other than generic is a percentage of the cost, up to a dollar amount. We assumed that cost sharing will be at the maximum for comparison purposes.

Rx Tier	Copay	Coinsurance	Other	DHP Copay	DHP Coinsurance
First Tier (Generics)	82%	13%	5%	73%	27%
Second Tier (Preferred)	73%	23%	4%	73%	27%
Third Tier (Non-Preferred)	69%	27%	4%	73%	27%
Fourth Tier (Other)	56%	41%	3%	73%	27%
Specialty	42%	50%	8%	73%	27%

The various DHP offerings for prescription drug coverage are competitive with the results of the KFF Survey.

Health Promotion & Wellness Programs

Health promotion and wellness programs are designed to be utilized by enrollees to better their overall health and manage/prevent disease. While there is initial investment, with enough participation and successful implementation, these types of programs can benefit not only the enrollees but provide cost savings to the plan by limiting and preventing further healthcare needs. It is our understanding that the DHP does not currently implement these programs apart from what may be included in case management, maternity, and autism solutions through the different carriers.

The KFF Survey summarizes the percentage of employers participating in various health promotion and wellness programs. The following table provides this detail bifurcated by size of employer (i.e., large firm employees 200 or more workers).

Description	Small Firms	Large Firms	All Firms
Health Risk Assessment	36%	54%	36%
Biometric Screenings	15%	42%	16%
Health & Wellness Promotion Programs[12]	62%	80%	63%
Disease Management Programs	36%	64%	37%

In addition, 59% of large firms that employ Health Risk Assessments use incentives/penalties to ensure assessment completion whereas 67% of such large firms take a similar approach when implementing Biometric Screenings. Of those performing biometric screenings, 20% also institute incentives/penalties based on whether enrollees meet specified biometric outcomes (e.g., maintaining cholesterol levels, body weight, etc.).

HSA Employer Contributions

Based on the KFF Survey, approximately 40% of employers do not contribute to their employees' HSA accounts. However, for those contributing employers, the average annual contribution for employee-only and family coverage is $791 and $1,471, respectively.

There is not a requirement for employers to contribute to their employees' qualified HSA accounts and CPG does not have any information regarding any employer contributions.

[12] These programs include smoking cessation, weight management and behavioral or lifestyle coaching.

Premiums and Employee Contributions

PREMIUMS

The following tables compare the average annual premiums by region for single vs. family[13] coverage from the KFF Survey and the DHP offerings for employees in-force as of July 2023. The premiums are shown on a per employee basis.

	KFF Survey		DHP Plans	
Region[14]	Single	Family	Single	Family
Northeast	$9,167	$26,146	$11,630	$28,575
Midwest	$8,353	$23,861	$11,709	$26,660
South	$8,050	$23,330	$11,007	$25,224
West	$8,474	$22,896	$11,314	$25,375
All Regions	$8,435	$23,968	$11,328	$26,886

As seen above, the Northeast is among the highest premium regions for both the KFF Survey and the DHP plans. However, the relationships among the regions are not as consistent when comparing the KFF Survey and the DHP average contributions. This is partially due to inconsistencies in how states are assigned to the KFF Survey regions vs. the Provinces of the DHP.

Overall, this summary indicates that DHP contribution rates are significantly higher than average employer-based coverage (i.e., 34% greater for employee-only coverage). A reasonable explanation for this is likely the concentration of the DHP membership in very rich benefit plans (e.g., approximately 70% of the DHP membership is enrolled in plans with a deductible of $1,000 or less with more than 24% enrolled in a $0 deductible plan) compared with the KFF Survey. In addition, the average age of the DHP employees is higher than the nationwide average.

EMPLOYEE CONTRIBUTIONS

In terms of employee contributions, the KFF Survey reports that employees contribute 17% and 29%, on average, towards single and family coverage premiums, respectively. The following table shows the average employee and employer contributions by plan type.

	Employee		Employer	
Plan Type	Single	Family	Single	Family
HMO	$1,420	$7,158	$6,783	$16,600
PPO	$1,507	$7,108	$7,399	$18,120
POS	$1,456	$6,938	$6,940	$15,917
HDHP	$1,193	$5,302	$6,561	$17,041
All Plans	$1,401	$7,034	$7,034	$17,393

CPG does not have enough data to provide a comparison to the DHP contributions.

[13] In this case, family coverage refers to all tiers excluding employee-only (e.g., EE+SP, EE+CH(N), EE+FAM).

[14] Province assignments by region are as follows: Northeast – Province I, II, III; Midwest – Province V; South – Province IV, VII; West – Province VI, VIII. There are a small portion of DHP policies that were excluded here due to not having an associated Province (Episcopal Services Corps and the Episcopal Camp and Conference Centers groups).

Religious Organizations - Benefit Plan Comparison

We have performed expansive research in order to provide a summary of benefit plan offerings currently being made by other religious organizations to their employer groups. We accumulated data on ten organizations, including:

- Baptist Health
- Concordia Plan
- Evangelical Covenant Church
- Evangelical Lutheran Church of America (Portico)
- Evangelical Presbyterian Church
- GuideStone
- Pension Boards of United Church of Christ
- Reta Smaller Trustor (Catholic)
- The Reformed Church in America
- United Methodist Church (Wespath)

From this information, we summarized deductibles, out-of-pocket maximums, primary care/specialty office visits, prescription drug cost sharing by tier, administrator/carrier, plan types (e.g., PPO, HDHP, etc.) offered and number of plans offered. The summary table is included in Appendix B.

We also included benefit option specific information for the highest-cost and lowest-cost plans for five of the organizations compared to the highest/lowest Anthem/Cigna DHP plan in Appendix C.

As can be seen in the appendices, with the exception of the PPO 100 plan, the DHP plan offerings are within the ranges for these key plan characteristics for the various organizations as was similarly discussed when comparing to the KFF Survey. Eight out of the ten organizations offer more than one plan type (e.g., POS, PPO, HDHP, EPO). Moreover, while eight out of the ten organizations offer between three and six plans, Concordia Plans offers 15 plans and GuideStone offers 41 plans. The increase in these plan offerings is partially driven by geography and very minor differences within multiple plan options as well as the size of the plans.

We note that there are only two organizations that offer a plan with no deductible. They both have at least 10% coinsurance and larger out-of-pocket maximums than the DHP's no deductible plan (PPO 100).

SECTION II
BENEFIT PRICING AND PRICING STRUCTURE

PRICING OVERVIEW

One of the primary concepts with insurance is sharing risk. Everyone pays into the plan with the goal of being able to pay medical expenses – at some points, certain members have higher claims than others, so the expense balances out. An individual may have a year where they pay more in premiums than they receive in benefits, but in other years, that person may have medical costs that exceed the premiums they pay. As an example, there is generally, but not always, subsidization of the costs by younger employees for the benefit of older employees.

As health insurance has evolved, different risk classifications have been considered so that there is more equity, and the healthier groups of employees are paying an amount that is closer to their risk.

When employers offer multiple benefit options and employees have the choice of which option to select, they will generally select the plan that is most advantageous. If an individual typically has high medical costs, they will usually select the plan with the most generous benefits. However, there are ways to attempt to steer employees based on, for example, the contribution amount required by the employee.

One other important consideration in plan design – when a member does not have to pay for medical services, their utilization will be higher. While some medical costs are unexpected and out of the control of the members, there are others that are elective and discretionary. Utilization tends to increase with benefit options that have very little cost sharing or once the member reaches the out-of-pocket maximum.

In the group health insurance industry, common rating characteristics include age, gender, health status (e.g., risk adjustment), rating tiers, geographic factors, industry factors, and group size.

Other pricing factors may include:

- participation levels, meaning the percentage of eligible employees who elect coverage, and
- the level of the employee's contribution to the premiums.

Within a group, there can be subsidization that is intentional or unintentional. For example, the General Convention's request to reduce disparities in health care contributions among dioceses is intended subsidization. Unintentional subsidization could be the higher-cost individuals selecting benefit options with richer benefits, causing the contributions for all benefit options to increase.

DHP RATE-SETTING PROCESS

There is a two-step process in developing rates for the year. As a Voluntary Employees' Beneficiary Association ("VEBA"), all contributions collected from participating groups go directly to paying claims, to cover annual expenses and vendor fees, and to maintain adequate reserves and capital position to meet the financial commitments.

CPG's first step is to determine the total annual contributions required to pay projected claims and expenses for the plan year. The most recent 24 months of claims experience are pooled for the combined DHP and voluntary groups, adjusting for known and expected changes, adjusting for large claims and stop-loss reinsurance, and reviewing the current and forecasted capital position. Additionally, experience is analyzed and monitored separately for the DHP and voluntary populations to maintain each pool as self-supporting.

The second step of the rate-setting process is to distribute the total annual required contributions across the participating groups. Generally, the overall percentage increase is applied to all participating groups with certain adjustments made to maintain the DHP objective of reducing cost disparities, considering the demographic profile of each group, local healthcare costs, and group experience to the degree it is credible.

OVERVIEW OF ANALYSIS

We reviewed the DHP's benefits, looking at several different segments of employees and from several different perspectives. Within each segment, we compared the claims and carrier fees to the contributions, which is the loss ratio. This measures the extent to which the contributions are adequate to cover the claims and ASO-specific fees independent of the other categories. There are other administrative costs associated with the DHP, which increase the loss ratios by approximately 4%-5%.

Second, we analyzed the relative value of the average contributions to the relative value of the claims for each component of the segment to highlight areas where subsidization is occurring between each segment component.

We reviewed the following segments.

- Carrier – Anthem, Cigna, Kaiser
- Benefit Option
- Coverage Tier
- Region
- Mandatory and Voluntary
- Clergy and Lay
- Pre-65 and Post-65 Employees

We used claims incurred from May 1, 2022 to April 30, 2023, with claim runout through July 31, 2023. We defined this timeframe as our Experience Period. Since we used three months of runout, we did not make any adjustments for claims incurred but unpaid as of April 30, 2023. In addition, current membership counts are based on in-force data as of July 2023.

To provide a complete picture of the costs, we added the administrative fees associated with each carrier and plan type (e.g., PPO, EPO, CDHP) from the Profit & Loss statement ("P&L") provided by CPG. The fees included stop-loss premiums, vendor administrative fees, health advocate, EAP, and vision. The fees were offset by stop-loss recoveries and pharmacy rebates received. In our report, we refer to these expenses and offsets collectively as "ASO Fees." In some situations, the pharmacy rebates exceed the other administrative fees. We note that the fees do not include General & Administrative ("G&A") expenses as reported in the P&L.

Under normal circumstances, we would apply trend factors to the claims to bring them to the current date. However, since the review was primarily limited to claims and contributions over the same period of time, we did not feel it necessary.

Impact of Benefit Levels on Health Status

With benefit changes, there may be concerns about the impact on health status. There is more available research on the impact of increased cost-sharing on health care utilization than there is on health outcomes. However, there are several factors related to cost-sharing that influence both utilization and health outcomes, including income level and existence of chronic disease in the population.

It is well-established from research that lower cost-sharing increases utilization, especially with middle- to high-income individuals. In addition, there is an increase in utilization of more high-cost but low-value procedures.

In general, individuals with lower income and more chronic disease are more significantly impacted by increased cost-sharing.

One area that has received significant attention, especially with the passage of the Affordable Care Act ("ACA"), is value-based insurance design ("VBID") which is discussed further in Section III. Limited or no cost-sharing for preventive care is an example, which is designed to promote more efficient spending by catching problems early.

As the Task Force considers changes, it will be important to consider the impact on health outcomes through thoughtful benefit changes.

REVIEW OF CARRIERS

Overview

The DHP provides health benefits through three main carriers – Anthem BlueCross Blue Shield, Cigna Healthcare, and Kaiser Permanente.

Anthem and Cigna provide nationwide coverage. The DHP provides the same benefit options through both carriers. Anthem has better network coverage and/or network discounts in some areas and Cigna is better in other areas. However, the DHP offers both carriers.

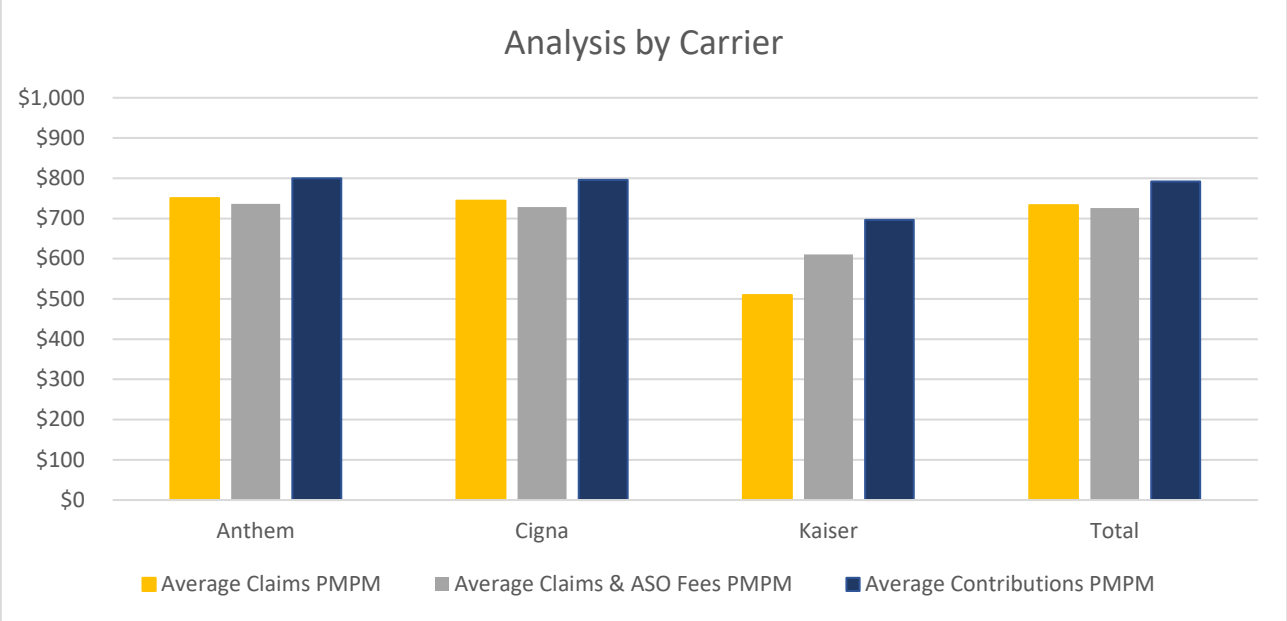
Kaiser has a different business model with tighter controls and a more limited network. Kaiser's plans are only available in California, Colorado, the District of Columbia, Georgia, Maryland, Oregon, Virginia, and Washington.

Analysis of Carriers

The following table includes the current employee count and percentage in each plan. It also includes the loss ratios over the experience period. We have included the loss ratios two ways – (1) only including the claims and (2) claims and ASO fees – because Kaiser has significantly higher administrative costs.

	Anthem	Cigna	Kaiser	Total
Current Employee Count	9,826	1,610	985	12,421
Employee Distribution	79%	13%	8%	100%
Claim Loss Ratio	**96%**	**96%**	**74%**	**95%**
Claim & ASO Fee Loss Ratio	**94%**	**94%**	**89%**	**94%**

The chart below shows the average claims, the average claims and ASO fees, with a comparison to the average contributions on a per member per month basis. Because of the pharmacy rebates, the Anthem and Cigna costs are lower with the ASO fees included.



Using Anthem as the base, we compared the relative value of the average contribution rates and the relative value of the claims. We could have used any of the three carriers as the base, but we chose Anthem since it has most of the DHP enrollment.

The average Cigna contributions are 99% of Anthem and the benefits are 99% of Anthem, which is consistent and indicates no subsidization. However, Kaiser's average contributions are 87% of Anthem's but claims and ASO fees are 83%. This indicates that the Anthem and Cigna benefits are subsidized by Kaiser.

With no change in the overall contribution levels, Anthem rates would need to increase 0.4%, Cigna's rates would need to decrease 0.1%, and Kaiser's rates would need to decrease by 4.3% to remove the subsidies occurring within the rates.

	Anthem	Cigna	Kaiser
Contribution Relative Value	1.00	0.99	0.87
Claim & ASO Fees Relative Value	1.00	0.99	0.83
Rate Change to Remove Subsidy	**0.4%**	**-0.1%**	**-4.3%**

For each of the segments reviewed, we are not recommending significant rate changes, but they illustrate the extent of subsidization that is occurring.

REVIEW OF CURRENT BENEFIT OPTIONS

Overview

There are four PPO plans and three high-deductible ("CDHP") plans offered by Anthem and Cigna. For the regions where Kaiser is offered, there are two Exclusive Provider Organization ("EPO") plans and one CDHP plan.

Analysis of Benefit Options

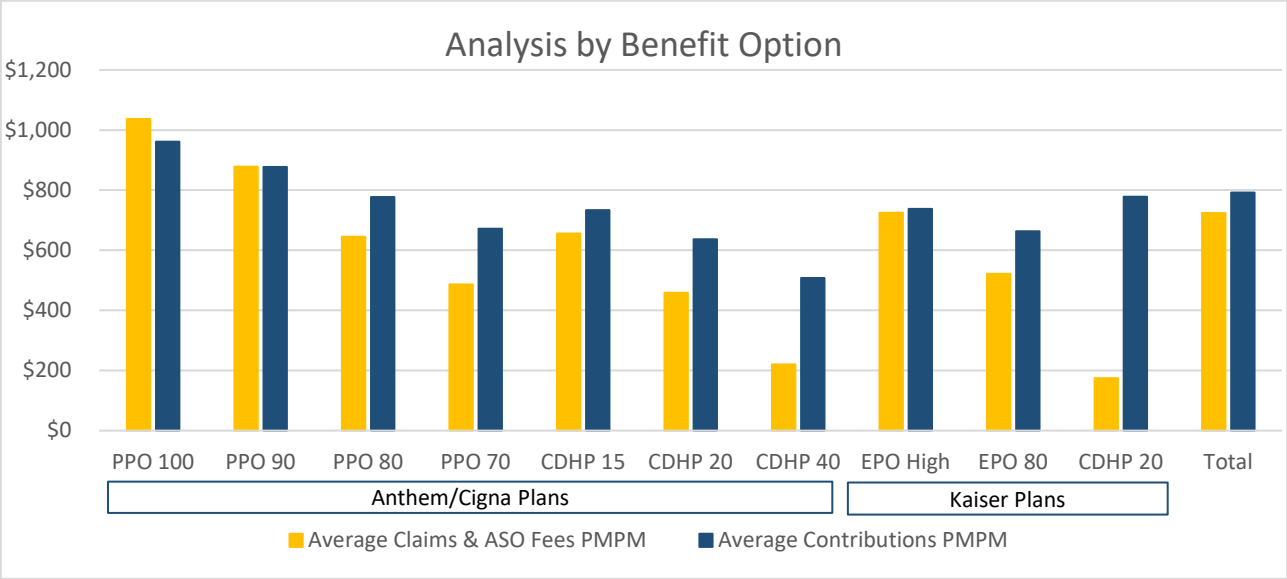
The current member counts, percentage of the members, and loss ratios for each plan option are included in the following table.

	Anthem/Cigna PPO				Anthem/Cigna CDHP			Kaiser Plans		
	PPO 100	PPO 90	PPO 80	PPO 70	CDHP 15	CDHP 20	CDHP 40	EPO High	EPO 80	CDHP 20
Current Employee Count	2,577	2,662	2,670	512	575	2,262	178	461	515	9
Employee Distribution	21%	21%	21%	4%	5%	18%	1%	4%	4%	0%
Claim & ASO Fee Loss Ratio	**111%**	**102%**	**86%**	**74%**	**92%**	**74%**	**44%**	**99%**	**80%**	**23%**

The loss ratios are highest in the richest plans – the PPO 100 and PPO 90. There are some plans with low enrollment, so the loss ratios and analysis are not as reliable. For example, while the loss ratio for the Kaiser CDHP 20 plan is only 23%, there are only 9 employees in the plan.

The PPO 100 and PPO 90 plans account for 42% of the current employee enrollment. The loss ratios for both plans exceed 100%, meaning the premiums are not adequate for the benefits provided even before accounting for G&A expenses.

The following chart shows the average claims and contributions per member per month for each plan and highlights the richness of the PPO 100 and PPO 90 plans.



For each benefit option, the table below shows the relative value of the benefits and contributions by plan. In addition, we have included our estimate of the expected relative value of the claims, based on the DHP's relative values, adjusted for L&E's estimates of demographic differences between the plans.

Finally, we calculated the rate adjustments that would be necessary to bring the premiums in line with the claims assuming no change to the overall aggregate premium income.

	Anthem/Cigna PPO				Anthem/Cigna CDHP			Kaiser Plans		
	PPO 100	PPO 90	PPO 80	PPO 70	CDHP 40	CDHP 20	CDHP 15	EPO High	EPO 80	CDHP 20
Contribution Relative Value	1.00	0.91	0.81	0.70	0.76	0.66	0.53	0.77	0.69	0.81
Claim & ASO Fee Relative Value	1.00	0.85	0.62	0.47	0.63	0.44	0.21	0.70	0.50	0.17
Expected Claim Relative Value[15]	1.00	0.92	0.75	0.60	0.59	0.61	0.50	1.07	0.83	0.71
Rate Change to Remove Subsidy	**18.2%**	**9.6%**	**-9.1%**	**-20.7%**	**-2.0%**	**-21.0%**	**-52.5%**	**7.7%**	**-13.9%**	**-75.5%**

Using the Anthem/Cigna CHDP 20 plan as an example, the current average contributions are 66% of the Anthem PPO 100. We would expect claims to be 61% of the PPO 100 plan, but over the experience period, they were only 44% of the PPO plan.

Cost-Impact of Removing the PPO 100 Plan

We estimated the cost impact of removing the PPO 100 Plan. We assumed that all current members would migrate from the PPO 100 Plan to the PPO 90 Plan. In order to measure the impact, we adjusted the claims for the current PPO 100 Plan members to be equivalent to the PPO 90 Plan claims on a per capita basis while adjusting for age/gender/area differences. In addition, we revised the contributions based on the nationwide relative values provided by Aon. We estimate savings of approximately $6 million, or a 4% reduction to the Claim & ASO Fee Loss Ratio.

Cost-Impact of Removing the PPO 100 and PPO 90 Plans

Using the same methodology described above, but assuming all current members in the PPO 100 and PPO 10 Plans will move to the PPO 80 plan. We estimate that savings could be as high as $18 million or a 9.5% reduction in the loss ratio.

REVIEW OF COVERAGE TIERS

Overview

Each employer groups can choose to offer 2-tier, 3-tier, or 4-tier contribution rates.

- Two Tier: Employee Only, Family
- Three Tier: Employee Only, Employee+1, Family
- Four Tier: Employee Only, Employee & Spouse, Employee & Child(ren), Family

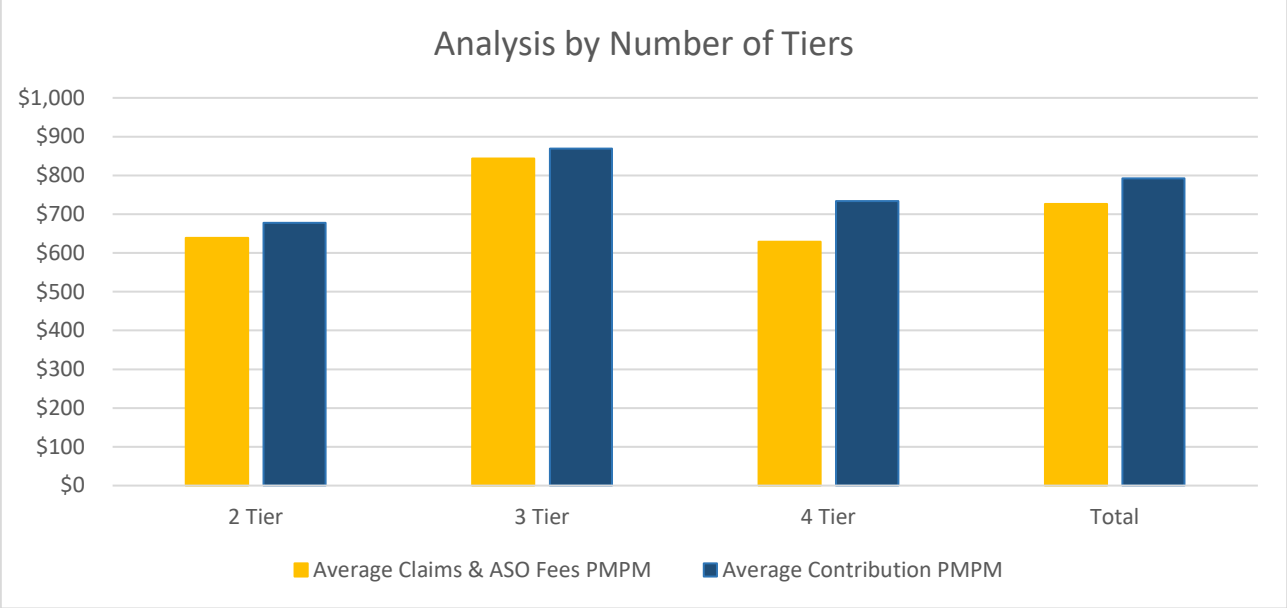
[15] Based on DHP's 2023 Relative Values with utilization adjustments. Relative values are adjusted to account for area and demographics of the members in each plan option using L&E's area factors and age/gender factors.

Analysis by Number of Tiers

Most employers have chosen 3- or 4-tier rates. We note that the loss ratios are highest for the 3-tier employers.

	2 Tier	3 Tier	4 Tier	Total
Current Employee Count	456	5,523	6,442	12,421
Employee Distribution	4%	44%	52%	100%
Claim & ASO Fee Loss Ratio	**96%**	**100%**	**88%**	**94%**

The average claims per member per month are highest for 3-tier groups.



As the table below shows, there is some subsidization in the contribution rates by the 4-tier rate groups.

	2 Tier	3 Tier	4 Tier
Contribution Relative Value	1.00	1.28	1.08
Claim & ASO Fees Relative Value	1.00	1.32	0.98
Rate Change to Remove Subsidy	**2.9%**	**5.9%**	**-6.5%**

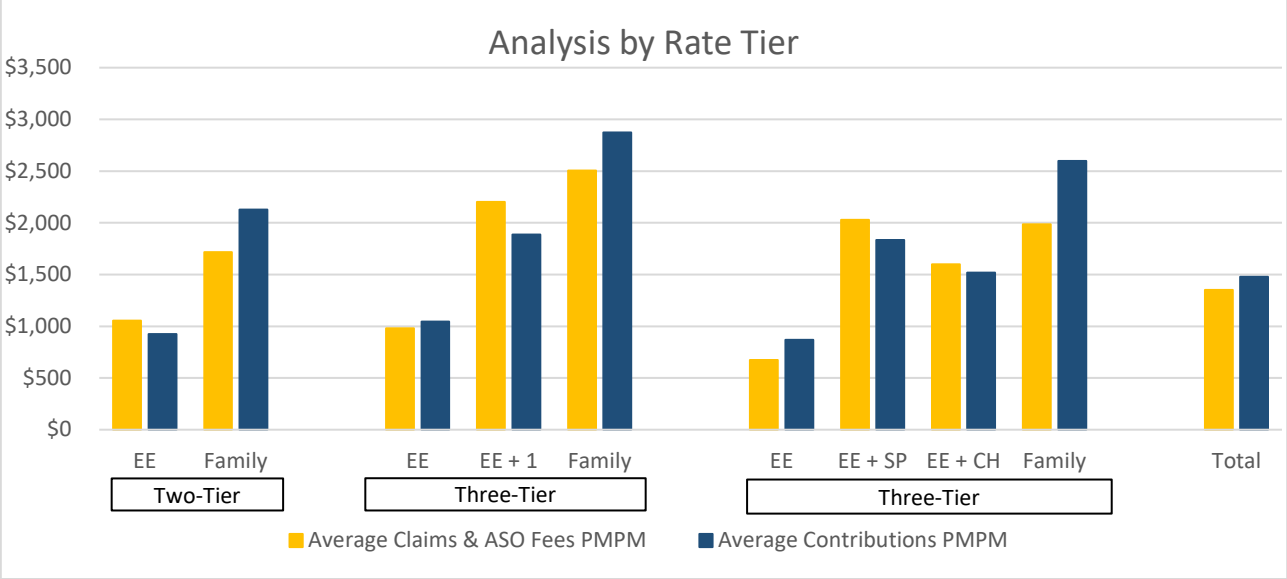
Analysis by Coverage Tier

We also reviewed the individual tiers within the 2-tier, 3-tier, and 4-tier groupings. For this analysis we used a per employee per month basis, as opposed to a per member per month basis. For the two-tier groups, the employee-only loss ratio is the highest. For the three-tier and four-tier groups, the EE + 1 and the EE + SP/EE + CH rate tiers have the highest loss ratios.

Two-Tier Groups		
	EE	Family
Current Subscriber Count	257	199
Subscriber Distribution	2%	2%
Claim & ASO Fee Loss Ratio	**117%**	**83%**

Three-Tier Groups			
	EE	EE + 1	Family
Current Subscriber Count	3,073	1,172	1,278
Subscriber Distribution	25%	9%	10%
Claim & ASO Fee Loss Ratio	**97%**	**120%**	**90%**

Four-Tier Groups				
	EE	EE + SP	EE + CH	Family
Current Subscriber Count	3,962	704	667	1,109
Subscriber Distribution	32%	6%	5%	9%
Claim & ASO Fee Loss Ratio	**80%**	**113%**	**108%**	**78%**



For each tier, we reviewed the subsidization *within* the tier grouping since the prior section looked at the subsidization *between* the tier groupings.

Two-Tier Groups		
	EE	Family
Contribution Relative Value	1.00	2.30
Claim & ASO Fees Relative Value	1.00	1.63
Rate Change to Remove Subsidy	**23.0%**	**-12.9%**

Three-Tier Groups			
	EE	EE + 1	Family
Contribution Relative Value	1.00	1.81	2.75
Claim Relative Value	1.00	2.25	2.56
Rate Change to Remove Subsidy	**-3.0%**	**20.8%**	**-9.9%**

Four-Tier Groups				
	EE	EE + SP	EE + CH	Family
Contribution Relative Value	1.00	2.11	1.75	2.99
Claim Relative Value	1.00	3.01	2.37	2.95
Rate Change to Remove Subsidy	**-9.1%**	**29.4%**	**23.2%**	**-10.5%**

REVIEW OF REGIONS

Overview

Medical costs can vary significantly by region. We summarized the employer groups by the following general regions, even though the costs can vary within each broad region.

- Northeast – Provinces I, II and III
- Midwest – Province V
- South – Provinces IV and VII
- West – Provinces VI and VIII
- Other – Episcopal Services Corps and the Episcopal Camp and Conference Centers

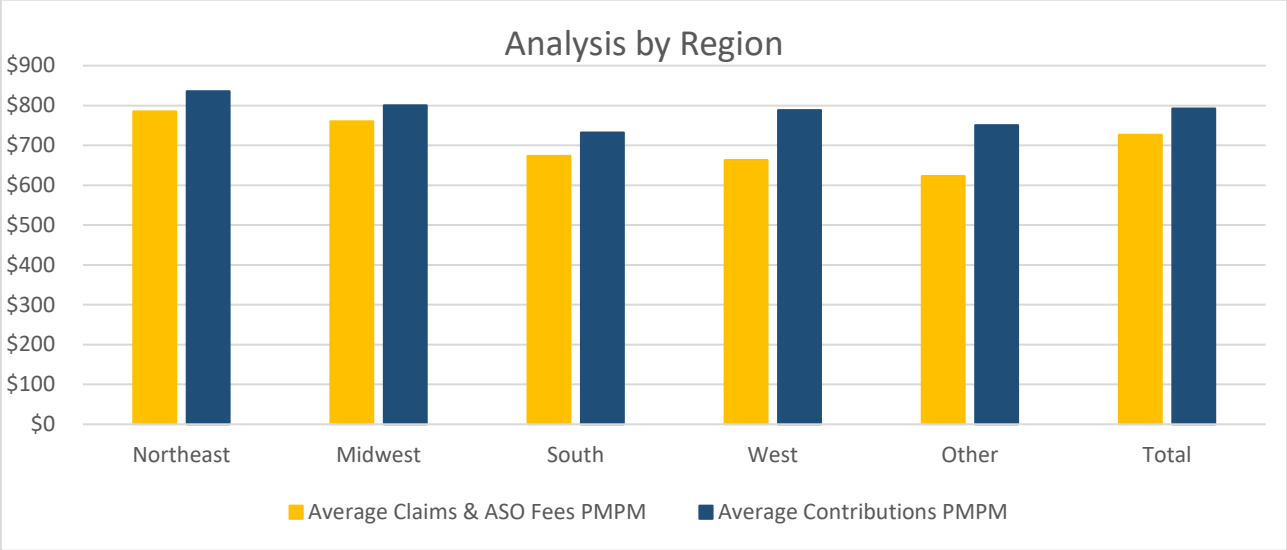
Analysis by Region

The current employee counts, percentage of the employees, and loss ratios for each plan option are included in the following table.

The enrollment is concentrated in the northeast and the south. The loss ratios are lowest in the western part of the country, likely due to the Kaiser plans in that area.

	Northeast	Midwest	South	West	Other	Total
Current Employee Count	5,370	872	3,785	2,085	309	12,421
Employee Distribution	43%	7%	30%	17%	2%	100%
Claim & ASO Fee Loss Ratio	**97%**	**97%**	**94%**	**86%**	**88%**	**94%**

Costs are highest in the Northeast, followed by the Midwest and South.



As shown in the table below, the relative values of the contributions and claims are fairly well aligned in the Northeast, Midwest, and South. However, there is subsidization between those three regions and the West and Other regions.

	Northeast	Midwest	South	West	Other
Contribution Relative Value	1.00	0.96	0.88	0.94	0.90
Claim & ASO Fees Relative Value	1.00	0.97	0.86	0.84	0.79
Rate Change to Remove Subsidy	**2.5%**	**3.7%**	**0.4%**	**-8.2%**	**-9.5%**

REVIEW OF VOLUNTARY VS. MANDATORY COVERAGE

Overview

The Episcopal Church requires institutions under their authority to provide coverage through the DHP and subsize coverage for clergy and lay employees working at least 1,500 hours per year. Employees working between 1,000 and 1,500 hours are eligible for benefits, but employer subsidization is not required.

Institutions affiliated with the Episcopal Church but not under the mandate can provide coverage through the DHP for employees normally scheduled to work at least 1,000 compensated hours per year.

Mandatory coverage has advantages.

- Provides quality medical coverage for the Episcopal Church's clergy and lay employees.
- Ensures that the DHP has a large membership base, providing economies of scale for purchasing power and lower administrative fees.
- Helps spread the cost of individuals with higher medical needs over a larger risk pool with more individuals with lower medical needs.

There are some benefits to allowing groups to opt out of mandatory coverage.

- Individual dioceses or employer groups may be able to find health coverage outside of the DHP at a lower cost. This can be compounded by reducing the disparity of healthcare premiums among dioceses.
- Mandatory coverage may cause financial strain on employer groups that are struggling to pay the required contributions.

With the current contribution strategy, allowing mandatory groups to opt-out of the DHP coverage would likely cause some of the lower-cost groups to exit the plan. This could lead to an anti-selection spiral where healthier groups leave, increasing contribution rates for the remaining groups and perpetuating the spiral.

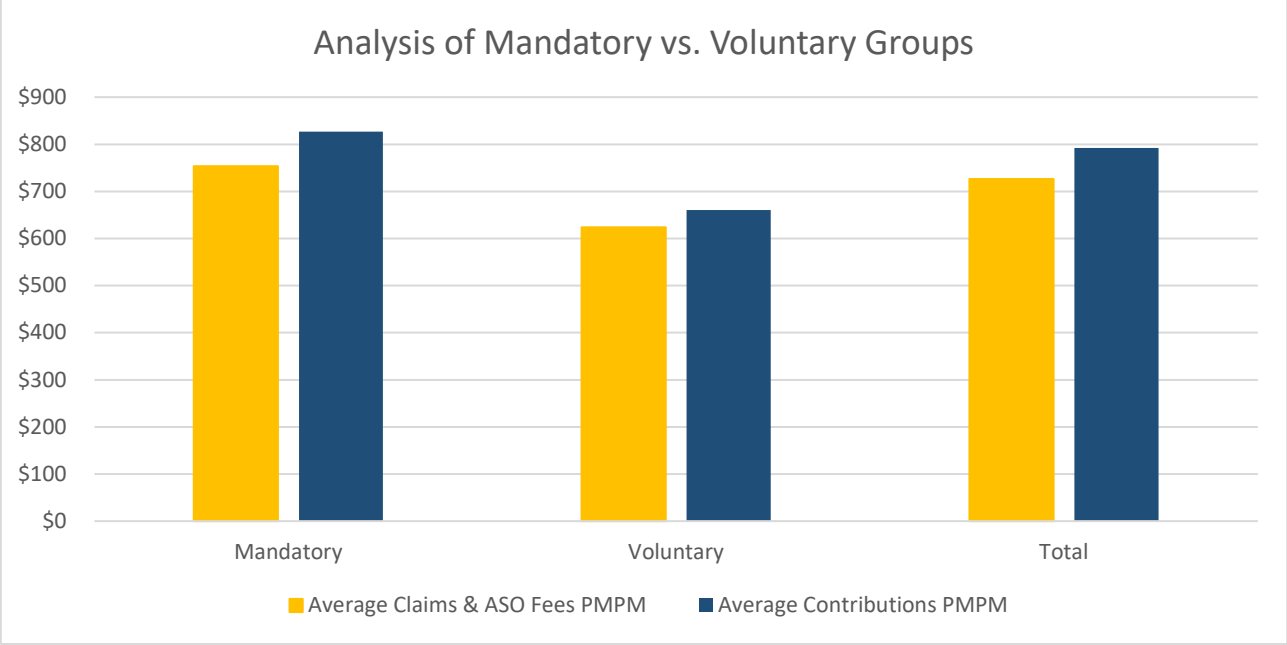
There is a delicate balance between spreading the costs over the entire DHP and making sure the contribution rates are reasonable compared to the outside market.

Analysis of Voluntary and Mandatory Groups

The following table shows that mandatory groups make up almost 80% of the employees. The loss ratio for the mandatory group is slightly lower than the voluntary group.

	Mandatory	Voluntary	Total
Current Employee Count	9,697	2,724	12,421
Employee Distribution	78%	22%	100%
Claim & ASO Fee Loss Ratio	**93%**	**99%**	**94%**

The mandatory groups have higher average claims and contributions per member per month than the voluntary groups. Part of this difference is because the mandatory group has a higher average age.



Looking at the relative value of the contributions and claims, there is no significant subsidization between the mandatory and voluntary groups.

	Mandatory	Voluntary
Contribution Relative Value	1.00	0.80
Claim & ASO Fees Relative Value	1.00	0.83
Rate Change to Remove Subsidy	**-0.6%**	**3.0%**

REVIEW OF CLERGY AND LAY EMPLOYEES

Overview

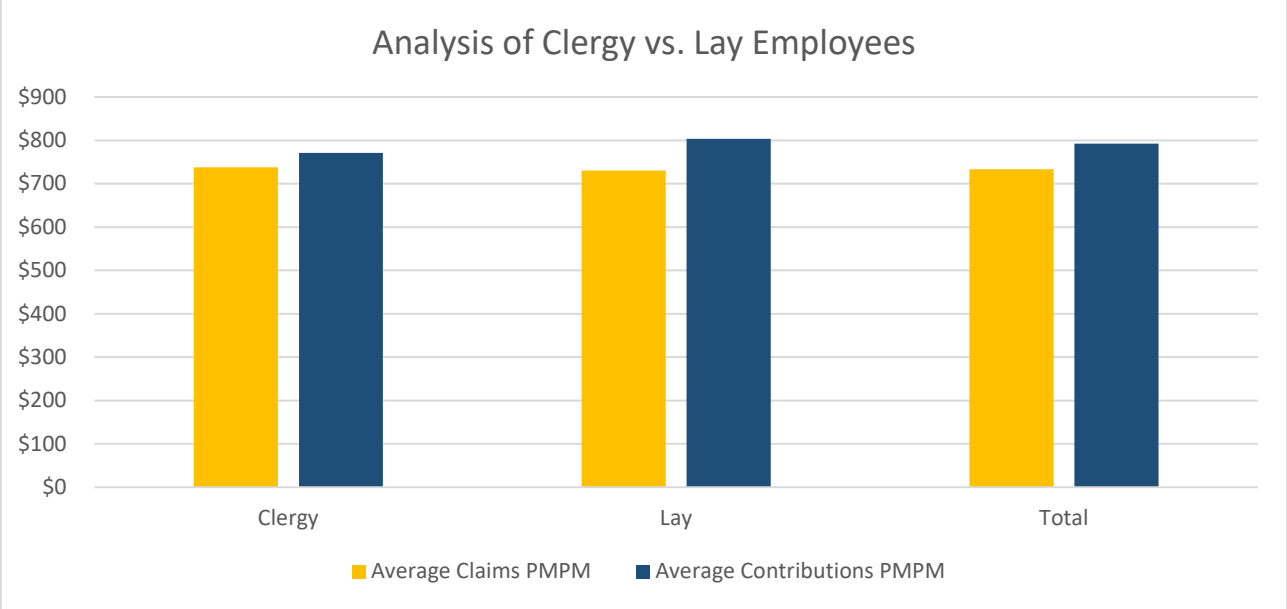
One of the directives from the General Convention was to ensure parity in cost sharing between clergy and lay employees.

Analysis by Clergy and Lay Employees

The lay employees are a large portion of the enrollment, but the loss ratio for clergy is slightly higher.

	Clergy	Lay	Total
Current Employee Count	8,062	15,132	23,194
Employee Distribution	35%	65%	100%
Claim & ASO Fee Loss Ratio	**96%**	**93%**	**94%**

The claims and contributions per member per month are very similar between the two groups.



Looking at the relative value of the contributions and claims, there is a small amount of subsidization between the clergy and lay employees.

	Clergy	Lay
Contribution Relative Value	1.00	1.04
Claim & ASO Fees Relative Value	1.00	1.00
Rate Change to Remove Subsidy	**2.8%**	**-1.4%**

REVIEW OF PRE-65 AND POST-65 EMPLOYEES

Overview

Medical costs generally increase with age, and often with significant differences for pre-65 and post-65 employees. As discussed in more detail later in the report, most employees become Medicare eligible at age 65. For most employees, the DHP coverage is primary and pays before Medicare. However, there is an exemption for small employers that Medicare will be primary, with the DHP paying secondary. We are using "DHP primary" to refer to the DHP paying first, then Medicare and "Medicare Primary" where Medicare plays first and then the DHP.

Analysis by Pre-65 and Post-65 Employees

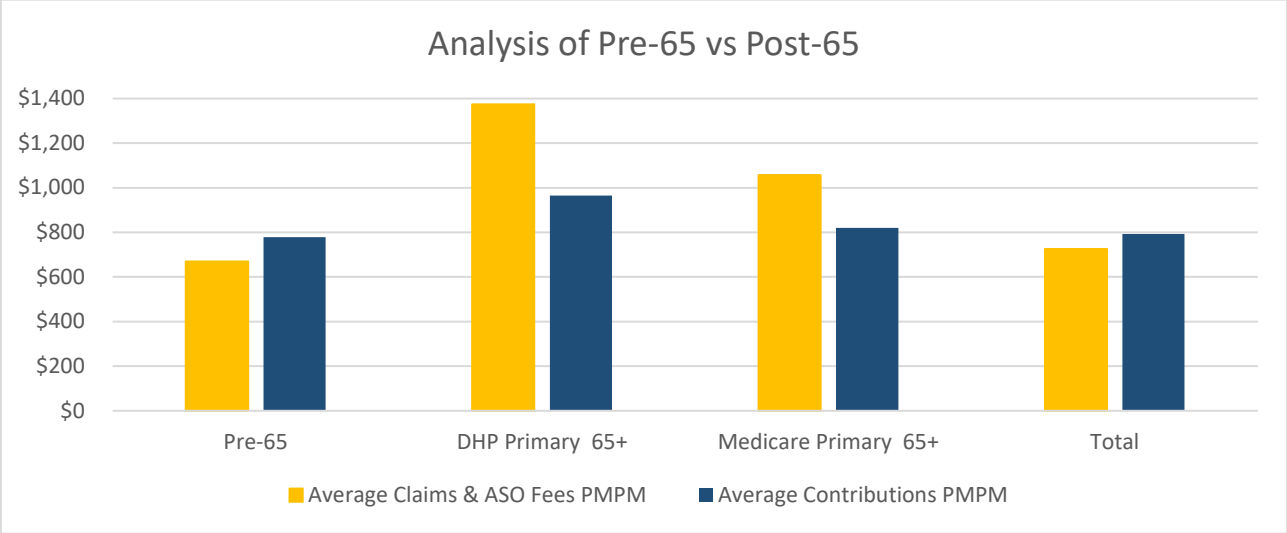
We looked at the premiums and claims for pre-65 employees and post-65 employees split between members where the DHP pays primary and where the DHP pays secondary to Medicare.

The loss ratio for post-65 members is significantly higher than for pre-65 members.

	Pre-65	DHP Primary 65+	Medicare Primary 65+	Total
Current Member Count	21,178	1,574	442	23,194
Member Distribution	91%	7%	2%	100%
Claim & ASO Fee Loss Ratio	**88%**	**145%**	**133%**	**94%**

In addition to significant differences between pre-65 and post-65 employees, the average claims for post-65, DHP primary members are significantly higher than pre-65 retirees and post-65 Medicare primary members. When Medicare is primary, employer plans typically save between 60% and 70% on claims. The DHP is seeing a savings of approximately 15% for Medicare primary members.

We note that there is a significantly higher proportion of post-65 employees in the two plans with the highest benefits (e.g., PPO 100 and PPO 90): approximately 60% of post-65 employees compared to 40% of pre-65 employees.



A significant increase in the post-65 rates would be necessary to reduce the subsidization between pre-65 and post-65 members.

	Pre-65	DHP Primary 65+	Medicare Primary 65+
Contribution Relative Value	1.00	1.24	1.05
Claim & ASO Fees Relative Value	1.00	2.05	1.58
Rate Change to Remove Subsidy	**-6.0%**	**55.4%**	**40.7%**

There is significant subsidization between pre-65 and post-65 members. For example, claims for DHP primary members are more than double the pre-65 members, but contributions are only 24% higher.

Because of the significant impact of age, it is important to delve deeper into the plan election of employees. The following table shows the benefit option election of employees.

	Pre-65	DHP Primary 65+	Medicare Primary 65+
PPO 100/PPO 90	40%	**56%**	**73%**
PPO 80/PPO 70	26%	20%	27%
CDHP Plans	26%	17%	0%
Kaiser EPO Plans	8%	7%	0%

The post-65 employees are overwhelmingly choosing the options with richer benefits. One reason may be because the contribution rates for post-65 employees are too low.

REVIEW OF EMPLOYEE CONTRIBUTIONS AND/OR HSA FUNDING

Each employer group determines the contributions that employees are required to pay for their insurance coverage and any HSA funding for the CDHP plans. The employer groups are not required to share the employee contribution levels with the DHP.

Employee cost-sharing, whether through premium contributions or benefit cost sharing impacts claim utilization. We previously discussed increased utilization when there is very limited benefit cost-sharing. The level of employee premium contributions will impact the employees' choice between benefit options. Low employee contributions combined with low cost-sharing benefit plans can significantly increase the cost of coverage.

The same situation arises when considering HSA funding. The level of employer contributions towards employee HSA accounts impacts whether employees may elect a lower cost high deductible plan vs. a higher cost/low benefit cost-sharing plan.

SECTION III
COST MANAGEMENT

VALUE-BASED INSURANCE DESIGN

One option is to consider value-based insurance designs ("VBID"). The goal of VBID is to decrease the cost of health care while increasing the effectiveness of health services by removing financial and social barriers to essential, high-value services.

The National Pharmaceutical Council and the University of Michigan Center for Value-Based Insurance Design highlight four fundamental approaches in their 2009 Value-Based Insurance Design Landscape Digest[16]. Most VBIDs incorporate one or more of these approaches:

- **Design by service**—eliminating or lowering co-payments for certain health care services or medications (e.g., cholesterol tests, asthma drugs), regardless of who uses them.

- **Design by condition**—eliminating or lowering co-payments for patients with specific clinical diagnoses (e.g., hypertension, prediabetes) for related services or medications.

- **Design by condition severity**—eliminating or lowering co-payments for patients who are at high risk of disease (or costly complications) and could benefit from participating in disease management programs.

- **Design by disease management condition**—eliminating or lowering co-payments for high-risk patients who actively participate in disease management programs.

VBID is bigger than just cost sharing. VBID requires coordination between the subscriber, the payer, and provider. For example, consider colon cancer screening. Screenings provide exceptionally high value for subscribers with a first-degree family member diagnosed with colon cancer. Screenings also provide high value for 50-year-olds with average risk; however, they provide low value to a 30-year-old with no family history of colon cancer. Who provides the screening is important as well – a high-performing provider vs. a poor-performing provider. In addition, where the screening is provided significantly impacts the cost of the screening – an ambulatory care center vs. a hospital.

While Kaiser typically does a good job with providers, the DHP may be able to push Anthem and Cigna for more evidence-based, high-quality patient outcomes. Another area is bundled payment approaches, which is contracting that combines pre-and post-procedural care into one negotiated price that can deliver savings and simplify billing for organizations and employers.

The DHP may want to look further into VBID and may be able to leverage the information that will be available through the introduction of the Quantum Health Navigator to determine areas that might be most impactful.

If the Task Force recommends eliminating either the PPO 100 or PPO 90, one idea is to consider enhancing benefits on the remaining plans with a focus on VBID.

One suggestion that is relatively easy to implement is to waive the deductible for maintenance medications where consistency is important such as asthma/COPD, diabetes, blood pressure, cholesterol,

[16] https://www.cdc.gov/nccdphp/dch/pdfs/value_based_ins_design.pdf

emotional/mental disorders, osteoporosis and/or prenatal vitamins. This benefit is allowed for qualified HDHPs where normally the deductible must be met in order to remain qualified under IRS rules. We note that this is not an exhaustive list of conditions allowed under IRS rules.

ACTIVE EMPLOYEES ELIGIBLE FOR MEDICARE

Medicare-Eligible Active Employees

Employees who are eligible for Medicare but still working and receiving health insurance coverage through their employer have several options.

- Keep employer plan and not sign up for Medicare.
- Keep employer plan and sign up for Medicare Part A. There are no premiums for Part A if the individual paid enough Medicare taxes while working.
- Keep employer plan, sign up for Medicare Part A, and sign up for Parts B, D, and/or a Medigap Plan. However, there is a monthly premium for Parts B, D and MediGap.
- Keep employer plan and sign up for Medicare coverage through a Part C plan, which also has a monthly premium.
- Drop employer coverage and sign up for Medicare.

Coordination Between Medicare and Employer Plan

When an individual is covered by more than one medical plan, coordination of benefits rules determine which plan pays first. The "primary payer" pays claims first, based on the primary payer benefits. Then the "secondary payer" will pay if there are costs that the primary payer did not cover.

For active employees in an employer-sponsored plan where the employer has at least 20 full and/or part-time employees, the employer-sponsor plan is the primary payer and Medicare is secondary [17].

If an employer has fewer than 20 full and/or part-time employees, sponsors or contributes to a single-employer group health plan, the Medicare Secondary Payer ("MSP") rules applicable to individuals entitled to Medicare on the basis of age do not apply to such individuals.

If such an employer participates in a multiple employer or multi-employer plan, such as the DHP, and at least one participating employer has at least 20 full and/or part-time employees, these MSP rules apply to all individuals entitled to Medicare on the basis of age, including those associated with the employer having fewer than 20 employees.

CMS allows multi-employer group health plans to be granted a Small Employer Exception ("SEE") for participating small employers (less than 20 full and/or part-time employees). Each employer group may apply for the SEE by submitting the required information via an Employee Certification Form for each eligible participant to the Medical Trust. If CMS approves the SEE, eligible employees may choose to participate in the Small Employer Exception Plan (the "SEE Plan") as administered through the Medical Trust.

[17] For retired employees, Medicare becomes primary, regardless of the employers' size. However, retirees are not included in our analysis.

Cost-Savings Through Small Employer Exception for Medicare

The SEE Plan can provide significant cost savings for both employers and participating individuals. We typically see savings between 60% and 70% when Medicare is primary. As we noted in the previous section of the report, the DHP savings has only been approximately 15%. In addition, the contributions have not been high enough to cover the losses. The problem is exacerbated by the high enrollment of post-65 employees in the PPO 100 and PPO 90 plans.

Based on discussions with CPG, it is difficult to determine how many employers are eligible for the SEE but have not taken advantage of it. Therefore, it is difficult to quantify the potential savings with more participation. However, the DHP savings could be much higher with changes to benefits and/or contributions.

Cost-Savings Through Education of Larger Employers

As mentioned above, an actively employed, Medicare-eligible employee has several options for health coverage. Depending on the required contributions by the employer, it may be more cost-effective for an employee to drop the employer coverage and elect coverage through Medicare with a MediGap plan or a Medicare Advantage plan.

One important note: an employer ***may not*** encourage or incentivize an employee to move to Medicare, but there are consultants who work with employees to review and perform a cost-benefit analysis of the options available to Medicare-eligible employees. Not only can this type of service assist employees in making informed decisions but can also result in savings to the employee, the employer, and the DHP.

SPECIALTY DRUGS AND GENE THERAPY

Specialty Drugs

Specialty drugs are high-cost medications that treat rare, complex, and chronic health conditions. The drugs themselves may require special handling, and patients who use them may need to work closely with doctors, pharmacists, and other health care providers who can monitor their progress.

Gene Therapy

Gene therapy is a new generation of medicine where a functioning gene is delivered to a targeted tissue in the body to produce missing or nonfunctioning protein.

Gene therapy targets the underlying cause of genetic diseases, which are caused by alterations in a person's DNA. This type of treatment has the potential to provide clinical benefits that transform and dramatically improve a patient's quality of life. Our focus is on therapies that are administered on a one-time basis and are potentially curative.

While the impact to patient health can be life-changing, it comes at a significant price tab. Two examples are Luxturna which treats a rare form of inherited vision loss and Zolgensma which treats certain forms of spinal muscular atrophy. When Luxturna launched it had a cost of $425,000 per eye and Zolgensmqa launched at $2.125 million. In late November 2022, the FDA approved Hemgenix, the first gene therapy for hemophilia B and has a record-setting price tag of $3.5 million.

While these new therapies can provide life-preserving and life-saving benefits, they can cause financial strain. Members, health plans, pharmacy benefit managers, plan sponsors and reinsurers are wrestling with how to provide these therapies in a way that is affordable and ensures the best outcomes.

CVS Health publishes a quarterly report[18] for the projected treatments and approval timelines for the gene therapy pipeline. New gene therapies are expected to treat conditions that affect larger populations starting in mid-2024 and beyond, including,

- Diabetic peripheral neuropathy (impacting between 5 and 11 million adults in the US),
- Neovascular age-related macular degeneration (impacting approximately 1 million US adults), and
- Knee osteoarthritis (affecting 16 million US adults).

Tracking the gene therapy pipeline is increasingly critical as the potential for gene therapy grows, so that the DHP can be proactive in developing strategies to manage access and cost.

Some stop-loss carriers are lasering[19] individuals who may be candidates for the gene therapy drugs which exposes self-funded plans to significant risk.

Specialty and Gene Therapy Solutions

The DHP is utilizing SaveOnSP program through Express Scripts to save on certain specialty drugs by maximizing copay assistance programs that are available from drug manufacturers. However, only certain drugs are covered. If the DHP decides to forgo stop-loss insurance, this type of coverage will not be available through most channels. However, Express Scripts has a program called Embarq Benefit Protection which is a solution for gene therapy which may be an option for the DHP.

Innovative payment approaches will play an important role in making gene therapy treatments more accessible and more affordable. Two potential approaches consider:

- Evolving the role of a specialty pharmacy: Having specialty pharmacies purchase gene therapies directly from the manufacturer is an opportunity to reduce the cost impact and avoid the risks of markup.
- Value-based contracting (previously discussed as VBID): Gene therapies are good candidates for value-based contracting, where reimbursement is tied to expected durable outcomes.

Some drug manufacturers are considering warranties. For example, Roctavian was approved by the FDA in June 2023 and is the first gene therapy approved in the U.S. for certain patients with hemophilia A. The list price is $2.9 million per single-use. The manufacturer, BioMarin, plans to offer a warranty in the U.S. and refund the payer if the patient must revert to prophylaxis treatment within a certain period of time.

[18] https://payorsolutions.cvshealth.com/sites/default/files/Q2%202023%20REPORT%20Gene%20Therapies%20-%20CVS%20Health.pdf

[19] A laser assigns a higher specific deductible to plan members with a higher predisposition for illness or healthcare costs, rather than raising the deductible for all.

NETWORK CONFIGURATIONS

There are several changes that can be considered with provider networks.

Tiered Networks

In a tiered network, the plan divides the providers in its network into two or more distinct groups, typically based on the cost effectiveness and/or quality of the care they provide. Tiering may be used for all types of providers or may be limited to select categories such as hospitals or specialists. Most employers electing to contract with a plan with a tiered network say the selection of providers into tiers is based on both costs and quality.

Narrow Networks

Another, more aggressive strategy that health plans use to direct enrollees to more cost-effective providers is to create a network that is restricted only to a limited number of providers that agree to meet relatively stringent cost and/or quality objectives. These plans, often referred to as narrow network plans, have been found to significantly lower premiums and overall spending without necessarily harming access to care, even though fewer providers are covered.

Centers of Excellence

Health plans can designate specific facilities as Centers of Excellence if they provide very high quality or low-cost care, often times for a particular service. The plan will then encourage workers to receive care for select procedures, such as transplants, at these facilities by offering significantly lower cost sharing than is otherwise available at their in-network hospitals. Some employers, particularly very large ones, have seen drastic reductions in unnecessary care and expenses after adopting Centers of Excellence.

Employer Direct Contracting with Health Care Providers

Some employers look beyond the network established by their health plan or administrator and contract directly with hospitals, health systems, or clinics to provide services for certain conditions. These arrangements are available to self-funded firms and are negotiated independent of their health plan. An employer may choose to contract directly with a provider or system of providers if it can negotiate a better deal or get better service than it would through its health plan network. An employer with a substantial number of employees may be able to negotiate for favorable prices, shared-risk arrangements, or may gain access to additional services or data.

Direct contracting might be difficult, given that the members are spread across the country, but focusing on some key areas with larger membership might be an option.

ALTERNATIVE PAYMENT MODELS

Innovative approaches like membership-based primary care models aim to address the costly waste in healthcare by realigning provider incentives toward quality outcomes and delivering value-based care. The two types of membership models are concierge medicine and direct primary care.

Concierge medicine was developed as an alternative to volume-based care models to give physicians more time with patients. However, it can be cost-prohibitive for some populations, though, since a patient generally pays a membership fee to the practice as well as insurance copays.

With direct primary care, physicians are paid directly by the patient or their employer, eliminating the need for using insurance for primary care services.

Both models increase the time a patient has with their provider, putting more focus on disease prevention. Each model also often includes a virtual care element that enables higher-touch patient care.

STOP-LOSS COVERAGE

Unlike an employer who purchases a fully insured plan from an insurance company, an employer who self-funds takes on all the responsibility and risk that a fully insured employer has transferred to the insurance company, as is the case with the DHP. Self-funding leaves the employer at significant risk for "shock claims" (i.e., high dollar but low frequency claims, such as an organ transplant) and high utilization claims (i.e., low dollar but unusually high frequency claims). A self-funded employer may transfer some of its risk of loss to a stop-loss insurer by purchasing a stop-loss insurance policy.

A stop loss insurance policy usually contains two components: 1) a specific "attachment point" (or "retention level") that protects against claim severity; and 2) an aggregate attachment point that protects against claim frequency. The policy's specific coverage provides protection in the case of a single covered individual with a high dollar claim or series of claims. Any costs exceeding the specific attachment point are covered by the stop loss policy. The aggregate coverage provides protection against the cumulative impact of smaller claims that may never meet the threshold of a specific attachment point. Once the employer's total claims payments (not counting any claims paid by the specific coverage) reach the aggregate attachment point, the stop loss policy covers all remaining costs for the year (up to the policy limit, if any).

The DHP's current stop-loss policy includes a $1 million specific attachment point with no aggregate stop-loss coverage; however, it is our understanding that the DHP does not plan to renew this coverage for 2024. While there will be immediate savings from the lack of stop-loss premiums, the DHP will bear the entire risk of the previously discussed shock claims that have the potential to have a significant impact on the Plan. This should be meticulously monitored during the upcoming plan year with consideration given as to whether stop-loss coverage should be re-instituted in future years based on emerging claims experience.

SECTION IV
RESERVES AND SURPLUS LEVELS

RISK BASED CAPITAL OVERVIEW

Risk Based Capital ("RBC") is a method developed by the National Association of Insurance Commissioners ("NAIC") to measure the minimum amount of capital that an insurance company needs to support its overall business operations. RBC is used to set capital requirements considering the size and degree of risk taken by the insurer. As the current measurement stands, there are four major categories of risk that must be measured to arrive at an overall RBC amount.

- Asset risk: This is a measure of an asset's default of principal or interest or fluctuation in market value as a result of changes in the market.
- Credit risk: This is a measure of the default risk on amounts that are due from policyholders, reinsurers, or creditors.
- Underwriting risk: This is a measure of the risk that arises from underestimating the liabilities from business already written or inadequate pricing on current or prospective business.
- Off-balance sheet risk: This is a measure of risk due to excessive rates of growth, contingent liabilities, or other items not reflected on the balance sheet.

The RBC formula establishes a hypothetical minimum capital level that is compared to a company's actual capital level. The formula is used to derive a measure of "minimum capital" that an insurer would be expected to hold based on the types of risk to which the company is exposed. Recognizing these risks will differ, sometimes significantly, based on the type of insurance that the NAIC has adopted. There is a specific formula for health companies.

The RBC model generates required capital levels for each of these risk categories. These capital requirements are then aggregated, and the minimum capital level that a company must maintain to avoid regulatory action is produced.

It is common for self-insured programs that are not subject to the RBC test to consult with their actuaries, auditors, brokers, or managers to run the test for them and report on the results.

OVERVIEW OF DHP PROCESS

As a non-regulated entity, the DHP does not have to adhere to the RBC requirements promulgated by the NAIC; however, the DHP does set its target capital position in the range of 125% to 175% of its calculated RBC using industry standard methods. As mentioned in the previous section, the DHP will discontinue individual stop-loss reinsurance coverage effective 1/1/2024, as its capital position has stabilized at the upper end of the target range and will be used to handle large claims volatility.

The following table (reported in $1,000's) provides a comparison of targeted vs. reported capital for 2019 through 6/30/2023.

	2019	2020	2021	2022	2Q2023
Targeted Capital	$35,342	33,500	40,242	35,280	43,295
Reported Capital	35,139	68,546	53,777	37,986	42,200
% of Targeted	99%	205%	134%	108%	97%

The increase in capital in 2020 and 2021 was primarily due to the pandemic which dampened claims utilization (i.e., fewer claims). This enabled the DHP to soften rate increases in 2022 and 2023. In addition, the 2023 increase in reported capital was due to operating income and unrealized gains in the investment portfolio, as the market recovered during the first six months of 2023.

As has continued to be the case for the DHP, the most significant risks to capital moving forward are pricing, claim costs (especially now with the termination of the stop-loss arrangement), and the volatility in the investment portfolio.

APPENDICES

APPENDIX A
SUMMARY OF DHP BENEFITS

From Excel

APPENDIX B
RELIGIOUS ORGANIZATION BENEFIT COMPARISON

The following table provides a very brief overview of the benefit ranges for each organization based on publicly available information. The cost-sharing varies, depending on the plan.

Organization	Employee Only In-Network Deductible	In-Network Coinsurance	Employee Only Out-of-Pocket Maximum	Primary Care	Specialist	Prescription Drugs[20]	Plan Types	Plans Offered
Baptist Health	$300 - $1,000	Copay Only	$2,000 / $4,000	$0	$15 - $40	$15 - $75	POS, PPO	3
Concordia Plans	$0 - $6,000	20%	$1,500 - $8,550	$20 - $35 or Ded & Coins	$20 - $65 or Ded & Coins	$10 - $100 or Ded & Coins	HDHP, HMO	15
Evangelical Covenant Church	$400 - $6,250	10% - 42%	$2,750 - $6,250	$20 - $35 or Ded & Coins	$20 - $45 or Ded & Coins	$8 - $125	PPO	3
Evangelical Lutheran Church of America (Portico)	$550 - $5,000	20%	$3,400 - $6,800	Ded & Coins	Ded & Coins	$12 - $180 or Ded & Coins	HDHP, POS	6
Evangelical Presbyterian Church	$450 - $6,200	10% - 40%	$2,800 - $6,750	$25 - $60 or Ded & Coins	$20 - $50 or Ded & Coins	$10 - $500 or Ded & Coins	HDHP, PPO	5
GuideStone	$0 - $18,000	0% - 30%	$3,000 - $40,000	$0 - $25 or Ded & Coins	$45 - $70 or Ded & Coins	$15 - $150 or Ded & Coins	HDHP, EPO, PPO	41
Pension Boards of United Church of Christ	$300 - $1,000	20% - 30%	$2,000 - $6,000	$25 or Ded & Coins	$25 or Ded & Coins	$17 - $45 or Ded & Coins	PPO	4
The Reformed Church in America	$500 - 3,000	0% - 20%	$5,000	$20 - $75 or Ded & Coins	$20 - $75 or Ded & Coins	$10 - $150	PPO, HDHP	3
Reta Smaller Trustor (Catholic)	$500 - $2,500	10% - 20%	$2,500 - $14,000	$25 or Ded & Coins	$40 or Ded & Coins	$10 - $40	PPO, EPO, HDHP	4
United Methodist Church (Wespath)	$500 - 3,000	0% - 50%	$5,000	$20 - $75 or Ded & Coins	$20 - $75 or Ded & Coins	$10 - $150 or Ded & Coins	PPO, HDHP	6

[20] Retail 30-day supply

APPENDIX C
RELIGIOUS ORGANIZATION BENEFIT EXAMPLES