Diocesan Health and Dental FAQs

- **Why do we have a Denominational Health Plan? Who administers it?**

  General Convention 2009 of The Episcopal Church (TEC) established a Denominational Health Plan (DHP) through Resolution A177 Acts of Convention: Resolution # 2009-A177 (episcopalarchives.org). General Convention 2012 reaffirmed the DHP Acts of Convention: Resolution # 2012-B026 (episcopalarchives.org). The Episcopal Church Medical Trust administers the DHP.

  The Goals of the DHP include: cost containment for the entire Church; reduced cost disparity among dioceses; and equal access to and parity of funding of healthcare benefits for eligible clergy, lay, and their eligible dependents.

  According to General Convention 2009 Resolution A177: The Denominational Health Plan shall provide benefits through the Episcopal Church Medical Trust, which shall be the sole plan sponsor for such benefits.

- **Who chooses the health plans? How are they selected?**

  The Episcopal Church Medical Trust (Medical Trust) creates and administers plans. The Medical Trust is an employee healthcare benefits organization and an affiliate of The Church Pension Fund (CPF). Most plans are self-funded and are not insurance. The Medical Trust works with national vendors to offer benefit plans to active employees and dependents, pre-65 retirees and dependents, post 65 retirees and dependents, and seminarians.

  Medical Trust Mission is to provide access to high-quality benefits and consistent service, balancing compassionate benefits with financial stewardship. 91% of The Episcopal Church Medical Trust contributions go to provide benefits.

  In accordance with General Convention 2009 Resolution A177: "The Denominational Health Plan shall provide that, subject to the rules of the plan administrator, each diocese has the right to make decisions as to plan design options offered by the plan administrator, minimum cost-sharing guidelines for parity between clergy and lay employees, domestic partner benefits in accordance with General Convention Resolution 1997-C024 and the participation of schools, day care facilities and other diocesan institutions (that is, other than the diocese itself and its parishes and missions) in the Denominational Health Plan."

- **How does the pricing process work?**

The Medical Trust maintains 10 plans – Seven National Plans (utilizing Anthem and Cigna Networks) and three Regional Plans (using the Kaiser Network).

Medical Trust plans are community rated. Every year during the renewal season, the Medical Trust engages with Aon Hewitt, its actuary, to understand overall healthcare trends in the United States and gauges the expectations for the rise in health care cost for the following year.

The Medical Trust, working with its actuary, utilizes the data on health care trends to establish the required amounts the Medical Trust will need in contributions from participating groups to pay claims on behalf of its members as well as cover administrative costs (vendor fees, regulatory fees, and its reserves). The Medical Trust is a Voluntary Beneficiary Association, is not for profit, and utilizes the majority of the contributions it collects (91%) to pay claims on behalf of its members.

The Medical Trust then analyzes its plans and also engages with its vendor partners to determine areas where cost can be managed (e.g. leveraging its size to negotiate lower fees) and efficiencies gained (by maximizing benefits under the plan on behalf of its members, e.g. cost-effective ways of delivering care to members such as virtual visits and telehealth).

After this broader analysis is completed, the Medical Trust then focuses on its individual participating groups. It reviews 3 years of a participating group's claims history, analyses each participating group's demographics, and takes into account regional cost of healthcare before setting rates for the next calendar year.

These rate increases also take into consideration the General Convention Resolution in 2012 BO26 to address disparity in rates among DHP groups and where possible bring participating groups closer to the average. This work remains ongoing. Additional information regarding the work around the DHP, and the Medical Trust is published annually as a DHP Report and available on CPG's website https://www.cpg.org/forms-and-publications/publications/dhp-annual-report/.

- **What role do state or other regulations play in determining our available plan options?**

The Episcopal Church Medical Trust is a Voluntary Employee Beneficiary Association (VEBA). A voluntary employees' beneficiary association under Internal Revenue Code section 501(c)(9) is an organization organized to pay life, sickness, accident, or similar benefits to members or their dependents, or designated beneficiaries. No part of the net earnings of the association may inure to the benefit of any private shareholder or individual. The organization must meet the following requirements:

1. It must be a voluntary association of employees;
2. The organization must provide for payment of life, sick, accident or other similar benefits to members or their dependents or designated beneficiaries and substantially all of its operations are for this purpose; and
3. Its earnings may not inure to the benefit of any private individual or shareholder other than through the payment of benefits described in (2) above.

Influences on plan rates may include plan design changes; direct vendor negotiations; consolidated risk pool; and economies of scale purchasing, including ESI coalition of denominations.

- **How do Medical Trust plans compare to health insurance plans?**

  Medical Trust plans and benefits include Health Plan, Pharmacy, Dental, Vision, Hearing, Employee Assistance Program, Health Advocate Services, Behavioral Health and Substance Use Disorder Services, and Travel Protection.

  The DHP covers a population whose median age is 10 years older than the broader population in the United States.

  Adult children can remain on Medical Trust health plans until the age of 30, versus a limit of 26 on most plans as required by the Affordable Health Care Act. Children with disabilities are eligible for lifetime benefits if the disability occurred prior to age 25 and it is certified by our disability vendor Aflac.

  The Medical Plan has provisions for COBRA like benefits. The Extension of Benefits that are extended to former employees and eligible dependents for up to 36 months.

- How do the DHP costs and cost increases compare to those of other employers?

  Since the DHP's inception, annual average cost increases have ranged from 4% to 6%, versus 7% to 9% for other large employers during the same period.

  The Medical Trust delivered an average annual increase of 6.4% ECMT and ~~4.4%~~ 5.99% for the Diocese of Rhode Island for 2023, which means that the increase for the Diocese is -10.20% below national average, compared to an estimated national trend of 5.6% to 8%. This is especially noteworthy because DHP claim costs have historically been about 20% higher than the average US employer. These higher claim costs are driven by three main factors:

  Older population – The median age of participants covered by the DHP is 52, compared to 42 across the broader US population. Older members are more likely to utilize healthcare services, including treatment for chronic conditions, leading to higher claims costs.

  More generous plans – As US employers generally shift to coverage with higher member out-of-pocket costs, 94% of DHP members are enrolled in our most generous plans, which feature the lowest member out-of-pocket cost share.

Meaningful benefits and financial stewardship

Higher specialty prescription cost – The specialty percent of pharmacy plan costs for the DHP is 64.5% compared to 59.4% for peers in the Church Benefits Association health_dhp_annual-report_july-2023.pdf (cpg.org)

In 2022, overall Medical Trust contributions were about 8% lower than average premiums for similar plans (i.e., broad network access and out-of-network benefit option) available on the exchanges for a similar demographic and geographic profile. It is important to note that most plans offered on the exchanges have narrow networks and in-network only options, which reduces costs by restricting access to a select number of physicians and hospitals. Medical Trust health plans also offer additional benefits not offered by exchange plans such as vision, hearing aid coverage, and advocacy services.

- **The Diocese currently offers individual and family plan options. Is it possible to offer an individual plus one option?**

The Episcopal Medical Trust offers 3 Tiers.

- 2 Tiers - **Single** and **Dependents** (which could be Single plus child(ren), Spouse, or Family)
- 3 Tiers - **Single**, **Plus One** (Spouse or child), **Family**
- 4 Tiers - **Single**, **Single Plus Child(ren)**, **Single Plus Spouse**, **Family**

Tier Level	**Single**	**Single Plus Child(ren)**	**Single Plus One/Spouse**	**Family**
2 Tiers	1 X Single			2.3 X Single
3 Tiers	1 X Single		1.8 X Single	2.8 X Single
4 Tiers	1 X Single	1.8 X Single	2 X Single	3 X Single

As shown in the chart above, the cost with 3 tiers the Single Plus One rate decreases by .2 from two Single plans, and the cost for a Family increases .5. The Committee did not recommend the change of tiers due to the increase of .5 for the larger number of employees utilizing the Family plan compared to a modest savings for a smaller number of employees who would use the Single Plus One plan.

- **The Medical Trust offers a Health Savings Account (HSA) for the high deductible plan. Is there a reason we do not offer a Flexible Savings Account (FSA) for the standard Preferred Provider Organization (PPO) plan?**

Medical Trust does not offer an FSA. A separate outside broker would be required. For a plan with fewer than 50 employees in a group, the administrative costs outweigh the benefits.