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Health Care
Sharing Ministries:
AN UNCOMMON BOND

SCOTT E. DANIELS, PH.D.

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Comments and information requests can be directed to:

Charlotte Lozier Institute

1200 New Hampshire Ave., NW, Suite 750

Washington, DC 20036

E-mail: info@lozierinstitute.org

Ph. 202-223-8073/www.lozierinstitute.org

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Abstract

Health care sharing ministries (HCSMs) occupy a unique and growing space in the health care market two years after the implementation of the Patient Protection and Affordable Health Care Act (ACA). HCSMs are national ministries that are alternatives to health care insurance. They avoid operations central to the business of insurance, involving the guarantee for payment of medical bills, assumption and distribution of health risk, and employment of actuarial methods. The ACA explicitly exempts HCSM members from the penalties imposed under the law's shared responsibility provisions. HCSM members are devoutly Christian. The sharing of medical bills is an expression of the biblical admonition "to bear one another's burdens," directly, member-to-member. This mission makes the bond of mutual aid and communal reliance uncommon compared with the secular social contract theory undergirding the ACA.

The members of the three largest HCSMs reviewed in this report do not live separate lives from the society at large, but work, play, pay taxes and raise their families in the society at large. Eligibility rules require a profession of genuine biblical faith, commitment to traditional religion, marriage, and the practice of moral and healthy lifestyles. The ministries do not offer comprehensive benefits; wellness is an expected objective under the control of individuals and families. The membership burden is affordable. The savings will vary depending on the specific sharing ministry. Overall, the savings can range from 45 percent to 60 percent below the cost of health insurance sold in the individual market, depending on the ministry plan selected. This translates into hundreds of dollars each month in the family budget and thousands each year. These monies can be redirected toward meeting the many other demands on the family pocketbook.

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HEALTH CARE SHARING MINISTRIES: AN UNCOMMON BOND

Introduction

Health care sharing ministries (HCSMs) are a legal alternative for subscribing individuals and families to pay medical bills without purchasing health insurance or paying penalties imposed by the ACA. The claim that HCSMs differ from health insurance has been contested (Eastman, K. 2010). Despite conceptual parallels in language to describe the financial arrangements designating and exchanging funds between members for purposes of paying medical expenses, HCSMs operate by avoiding key operations that are characteristic of the business of health insurance. They differ essentially from health insurance because they neither guarantee payment of medical bills, nor assume or distribute health risk, nor employ actuarial methods. This report will assess space for HCSMs as an alternative to insurance in the health care market.

It is the bond among their members and not the claim regarding insurance that is the hallmark of the HCSMs' model. Their form of social cooperation, which is understood theologically, distinguishes them from a world of secular contracts. The protection against financial loss attributable to poor health is for a group of like-minded and committed people who voluntarily share one another's burdensome medical bills. Insurance pools reflect risks typically linked to different social identities and demographics. Secular groups are quite heterogeneous in ways that Christian groups are predictably more homogenous. The bonds that hold the HCSM members responsible to one another are therefore distinctive. It is tempting to merely accept a secular perspective that translates the religious ties of spiritual covenants and moral duties into the secular contract of rights and legal enforcements. To yield to this secular temptation, however, reduces the essentials distinguishing this uncommon bond into one that is common.

The Patient Protection and Affordable Health Care Act (P.L. 114–148), or ACA, exempts individuals who are members of HCSMs from annual penalties for failing to purchase health coverage. Some consider this exemption a loophole (Jost, 41), others a concession to religious liberty, albeit a circumscribed liberty. The Center for Consumer Information and Insurance Oversight within the federal Centers for Medicare and Medicaid Services (CMS) reports that it has certified 53 HCSMs (PoliticoPro July 14, 2014)¹. Most of these communities have small rosters of approximately 100 members. The three largest HCSMs are Christian Care Ministry (CCM), Christian Healthcare Ministries (CHM), and Samaritan Ministries International (SMI), with each of these ministries having over 100,000 members. The Christ Medicus Foundation's CURO (meaning "to care for") recently joined with Samaritan as a "member representative" to offer health care sharing to primarily Catholic individuals and families. Together these organizations have shared the medical bills of more than 400,000 people, who reside in all 50 states (Alliance, 2015). The member share is over \$340 million each year (Alliance, 2015).

The ACA promised to achieve insurance coverage for all U.S. citizens, while lowering the cost of insurance (or at least not increasing the cost) and allowing everyone to keep their current

¹ The office with CMS has been non-responsive to requests for public information.

doctors, all the while improving quality of coverage. These promises have yet to become a reality. Documented inefficiencies in this new health care delivery system, however, are unlikely to lead to fundamental changes in this emerging institutional arrangement in the near term. Repairing and sustaining its existence in spite of the inefficiencies will require the support of a wider social ethos. This is because individual health involves more than biology or stopping the progression of disease. Health involves the well-being of individuals. For better or worse, communities and populations, too, affect the way individuals flourish. Health thus connects to social ideals.

Is This Uncommon Bond Distinctive?

Dr. Ezekiel Emanuel, a prominent advocate for the ACA, calls attention to the intimate conceptual connection between medical-ethical deliberation and socio-political philosophy by reference to the “political conception of medical ethics.”² He means by this that the moral ideals of medicine, most notable among them being the value of life, require a coherent “shared framework for resolving medical-ethical questions” that the political philosophy is to provide. For purposes of this report about the nature and social benefits of HCSMs, we can add the notions of “mutual aid” and “community” to this deliberation. These two moral concepts are central to the larger socio-political ethos that makes health care policy coherent and meaningful. Emanuel is not alone in making the linkage. A generation ago, Deborah Stone, Professor of Government at Dartmouth College, offered a pre-ACA critique of the private health insurance system based on “actuarial fairness” that assigned financing to individuals. “Mutual aid among a group who see themselves as sharing common interests is the essence of community,” which she said is true regardless of the specific community (Stone, 289 - 290). In her view, actuarial fairness that assigns the risk of sickness to individuals fragments a community, thereby destroying the bond of mutual aid. This shows the intimate connection between the two ethical concepts.

Social ideals are not ethically neutral. Specific ideals of community can express different and often conflicting ways of life. These ways of life in turn inform our basic ethical understanding of appropriate social arrangements that promote proper distributions of shared health care resources. Behind the draping of religious language about the duty to be one’s “brother’s keeper” used in the moral justification for the ACA lies a secular ideal of communal solidarity. In *The Ends of Human Life: Medical Ethics in a Liberal Polity*, Emanuel calls his ideal “liberal communitarianism” (Emanuel, 155ff). This ideal partially accounts for the coerced solidarity or “shared responsibility” concept underlying the individual mandate, especially among New Liberals with a collectivist communitarian vision for society. Timothy S. Jost, Family Professor of Law at Washington and Lee College, with careful discernment about the ACA, makes the critical observation that the secular conception of mutual aid requires state coercion while the religious conception allows participants to act on voluntary altruism.

“Except within families, and perhaps in small communities like the Amish, Hutterites, or religious orders, mutual aid as a means of sharing the cost of sickness rarely happens out of simple altruism. However, the health care financing systems of virtually all developed nations are, as

² Emanuel, E. J. (1991). *The Ends of Human Life: Medical Ethics in a Liberal Polity*. (Cambridge: Harvard University Press), p. 7.

Stone claims, based on the principle of “solidarity,” or mutual aid. But although this mutual aid is fundamentally based on a societal commitment to community in the face of sickness, in the end it is implemented through the coercive authority of the state.” (Jost, 2012)

Jost need not limit the “simple altruism” to small religious communities geographically situated. If “sharing common interests is the essence of community,” as Stone claims, then the same mutual aid can extend beyond to other larger communities not geographically-situated that have withdrawn from the larger organized social ethos. A softer pluralist version of national solidarity can accommodate religious communities such as those represented by the HCSMs’ non-insurance model. However, communitarian political philosophy also offers an ethical explanation for a statutory date-limitation of December 1999 set in the ACA as a criterion for certifying eligible HCSMs as an approved non-insurance alternative. The grandfathering of existing HCSMs treats them more as a time-limited accommodation than a viable alternative envisioned in a pluralistic universe of health care financing methods.

Thus, if a socio-political philosophy is required to inform ethical conceptions involved in health care policy, as Emanuel insists, then it is critically important to ask whether the Christian duty of mutual aid can have a distinct meaning, contrasting it with a secular understanding that requires a coercive community. It is also vital to discern how a divergent secular socio-political scheme might alter the understanding of mutual aid, as well as its practical ramifications for promoting community.

Is there a distinctive ethical nature to the duty that HCSM members feel toward each other? HCSMs’ leaders and members often make reference to Galatians 6:2 where St. Paul instructs the young Christian community to “bear one another’s burdens, and so fulfill the law of Christ.” Although different theological traditions give different commentary on the meaning of the “law of Christ,” it is clear in them all that God’s unmerited grace toward humankind is to be a model for relationships between fellow believing Christians. It is also true that “mutual aid” is a widespread, deeply held conviction outside the Christian tradition. Moreover, it can be justified in secular systems – at least up to a point. So, at first glance, St. Paul’s instruction and insistence on honoring the “law of Christ” appear to add nothing more than any other hegemonic cultural influence. Any acquiescence to the “law of Christ” could appear to be based on self-serving motives to gain material benefits, rather than on a genuine moral motive to share in mutual aid.

Some intellectuals go further. They are openly dismissive, labeling the religious bond as an irrational ideal. Molly Worthen, Assistant Professor of History at the University of North Carolina, is insistent on chastising the HCSMs’ uncommon bond for “fetishizing a romantic idea of community,” an idea closer to Marx’s than Hegel’s use of fetish (Worthen, 2015). But she writes sympathetically for the ACA’s quasi-religious New Deal communitarianism, which she acknowledges is compulsory. This religious bond, then, is acknowledged to be uncommon. But to the secularist, its distinctiveness is not a favorable attribute. It appears to be no better and perhaps worse than the expectations for a rights-based secular contract.

The comparison, however, is superficial. It is true that secular and Christian responses can be given to the question, “Why should an individual share the burdens of others?” in terms of the social function of morality. The secular answer correctly points out that individuals cannot achieve their purposes and indeed cultivate their individuality at all³ outside of a community. No society can survive without some system of shared values. Clearly “mutual aid” is among these fundamental moral intuitions. Individuals have an interest in continuing the system built on those shared beliefs. They can be expected to contribute to its maintenance. This is correct for the health care system, or for that matter the morality of the society at large, so far as it goes. Yet in secular ethics it remains open to individuals to be a “free rider” on the system that benefits them, while discharging their duties only when it is prudent or convenient for them. (Mitchell, 138–144). Providing a coherent answer to the question “Why be moral?” has been a recognized problem for Western societies since Plato’s *Republic*.⁴ It is even widely recognized as a shortfall for secular ethics (albeit implicitly) in standard college textbooks used in introductory ethics courses today (Landau, 206–210).

For Christians, however, the answer is different. First, they understand the law of Christ as God’s purposes for human beings whereby they can achieve final blessedness only in the love of God and of their neighbors. In the end, a precept of self-interest offers no hope of that satisfaction. Moreover, this personal pursuit of blessedness is not an objectionable form of self-seeking. What they desire for themselves is at the same moment what they desire for others. If this genuine motive is lacking, it is because they have yet to experience genuine repentance. Finally, the individual mandate’s role in coercing compliance adds nothing to the Christian’s duty. Its external pressure is no substitute for the Christian’s inner conviction to respond in gratitude to the grace of God. The mandate’s coercive appeal to self-interest is contrary to the sentiment of the Christian’s sincerely felt duty.

Although the ACA embraces a splintered vision of the liberal society, it tolerates rival ideals reflecting different understandings of human community informed by distinctively different conceptions of mutual aid. At the same time, it construes the bonds of mutual aid as enforced contractual rights and conscripted sympathy. This report presents the Christian vision as an alternative notion that sees community life as connected by the invisible chains of trust and gratitude. This understanding of duty creates the uncommon bonds formed in the process of “sharing one another burdens.” It arguably creates a superior form of community to that which the liberal society hopes to create. HCSMs allow a community of Christians to share in the costs of medical bills as an alternative to distributing financial risk through insurance. Members are bound together by spiritual relationships and religious duties rather than mandate- and penalty-laden contracts.

Legal Authorities for Health Care Sharing Ministries

Shared responsibility was a foundational value justifying the burdens imposed by the Patient Protection and Affordable Care Act (ACA). The law prescribes at Title I, Subtitle F an individual

³ Cultivating individuality refers to the dispute among liberals about the role of community in the relationship between individual personality and sociability. See Avital Simhony and Weinstein (2001), especially pp. 16 – 20.

⁴ A general version of this argument was worked out by Basil Mitchell in his Gifford Lectures (1974–76).

responsibility clause requiring all Americans to maintain minimal essential coverage as an expression of shared responsibility applied to families and individuals. This is one of the sections to which policy analysts point when debating the coercive powers of government that violate individual liberty. The so-called “individual mandate” began on December 31, 2013, requiring that Americans purchase insurance approved to cover minimum essential benefits or pay a penalty to the Internal Revenue Service (IRC §5000A(a), (b)).

The initial penalty for the first year was modest relative to the purchase price of insurance, but it will increase substantially in future years. Each year the ACA penalties are the greater of two quantities:

- In 2014, a household owed 1% of taxable income, or \$95 per adult and \$47.50 per child with a maximum fee of \$285 if the per-adult and per-child method is used.⁵ Put another way, there is no fee for more than two children (or dependents) in a two-parent household.
- In 2015, the ACA penalty will be 2% of your household’s annual income, or \$325 per adult and \$162.50 per child, whichever total amount is greater. The maximum penalty for a household, however, cannot exceed \$975 if the second method is the one used. Again, put another way, there is no fee for more than two children (or dependents) in a two-parent household.
- By 2016 the penalty will climb to 2.5% of annual income or \$695 for an adult and \$347.50 for a child. The maximum penalty is \$2,085 per family if the second method is used.
- In 2017 and the following years, the fee amounts will be adjusted each year for inflation.

The Individual Mandate and Its Penalties and Exemptions. This same title and subtitle of the ACA, however, exempts nine classes of people from the penalty for not purchasing approved coverage. There are exclusions that apply to two classes of religious persons:⁶ those who certify their objections to having public or private insurance on the grounds of “religious conscience” and those who are members of a “health care sharing ministry.” Here is the language from Section 1402(g)(1) of the Internal Revenue Code:

MEMBERS OF CERTAIN RELIGIOUS FAITHS

(1) Exemption

Any individual may file an application (in such form and manner, and with such official, as may be prescribed by regulations under this chapter) for an exemption from the tax imposed by this chapter if he is a member of a recognized religious sect or division thereof and is an adherent of established tenets or teachings of such sect or division by reason of which he is conscientiously opposed to acceptance of the benefits of any private or public insurance which makes

⁵ The Individual Shared Responsibility Payment: An Overview,” March 20, 2014; at <http://www.irs.gov/Affordable-Care-Act/The-Individual-Shared-Responsibility-Payment-An-Overview> (July 13, 2015). The calculation based on a percentage of income (1, 2, or 2.5%) is based on taxable income above the taxable threshold for the appropriate filing status on IRS Form 1040.

⁶ With respect to members of health care sharing ministries, however, the language in the ACA says “share a common set of ethical or religious beliefs.”

payments in the event of death, disability, old-age, or retirement or makes payments toward the cost of, or provides services for, medical care (including the benefits of any insurance system established by the Social Security Act).

This provision is quite narrow in practice, excluding different religious sects. In addition to having to certify that foregoing insurance is a longstanding practice in a particular religious sect, the petitioner must sign a waiver that he or she is foregoing social security benefits, both disability and, perhaps more importantly, retirement benefits.

(B) his waiver of all benefits and other payments under titles II and XVIII of the Social Security Act on the basis of his wages and self-employment income as well as all such benefits and other payments to him on the basis of the wages and self-employment income of any other person...⁷

Thus, the religious exemption limits the practitioner to a life of health, insurance-related and welfare benefits within their faith community. The religious exemption is not narrowly focused on public or private health insurance, but instead views the faith practitioner as reclusive from all forms of government and non-government public assistance and insurance.

The ACA recognizes the long-standing practice of faith-based sharing as a non-insurance practice through a grandfathering clause. The law offers several different types of exemptions to its requirement of shared responsibility. Members of an HCSM need not live their lives separate from society at large. It is common that members still pay into and receive other forms of social assistance, such as social security. The provision in the ACA legally defining an HCSM follows:

(B) HEALTH CARE SHARING MINISTRY

(i) IN GENERAL.—Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

(ii) HEALTH CARE SHARING MINISTRY.—The term “health care sharing ministry” means an organization—

(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

(III) members of which retain membership even after they develop a medical condition,

(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

⁷ 26 U.S.C. § 1402 (g)(1)(B)

(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.⁸

In brief, the law says that HCSMs must maintain a lawful charitable non-profit status with the Internal Revenue Service and consist of a membership devoted to sharing the same ethical or religious beliefs, who do indeed share one another's medical burdens after an illness occurs. The organization's origins must pre-date December 31, 1999 with a continuous and uninterrupted membership. This "grandfathering" clause reflects an asserted hesitancy by at least some in the U.S. Congress to open the door to the establishment of new "ministries" by charlatans, and those who might be motivated for non-religious reasons to escape the mandates of the ACA. The final criterion for the HCSM is an independent audit to prevent, or make more difficult, a misuse of funds shared within the ministry.

Federal/State Oversight of HCSMs. There are two avenues for state oversight of HCSMs, as will be explained further below. The ACA makes clear that individual subscribers to HCSMs are exempt from the federal individual mandate. But exemption from the individual mandate to purchase health insurance is a separate issue from regulating or overseeing the operations of the HCSMs as they engage in practices that affect the citizens of states. The McCarran-Ferguson Act⁹ (1945) leaves the states with the authority to oversee insurance practices by exempting the business of insurance from federal regulation. State Commissioners of Insurance have a responsibility to examine the practices if the activity of an organization constitutes the business of insurance. If not, then responsibility to protect the consumer falls to the State Attorneys General. Their authority also includes not-for-profit organizations, which the ACA requires HCSMs to be. The determining factor of which state agency should be employed to protect citizens in their relationship with an HCSM rests on whether or not the agreements between the HCSMs and their members constitute the business of insurance. If they do, then the various state insurance laws apply to the organizations.

Applying Three Criteria to HCSMs from U.S. Supreme Court Rulings on the Business of Insurance. There are three U.S. Supreme Court rulings that provide guidelines for assessing the business of insurance. *Securities and Exchange Commission v. Variable Annuity Life Insurance Company* (Variable Annuity Life, 1959) laid the early groundwork with the element of insurance being a "guarantee for a fixed return." The key feature of a variable annuity is that the benefit is based on the performance of the investment that fluctuates with the market. The annuitant is guaranteed certain unit shares, but the company makes no promise to policyholders regarding set values for each share. The Court considered whether variable annuities agreements were insurance. It concluded that variable life products are not insurance because the annuitant "cannot look forward to a fixed monthly or annual value" (Variable Annuity Life, 310).

Group Life & Health Company v. Royal Drug Company (Group Life, 1979)¹⁰ established a

⁸ 26 U.S.C. 1402

⁹ The McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, also known as Public Law 15.

¹⁰ *Group Life & Health Co. v. Royal Drug Co.*, 440 U.S. 205, 211 (1979) (quoting G. Richards, *The Law of Insurance* §2 (W. Freedman 5th

“primary” element involved with the business of insurance where there is “spreading and underwriting of the policyholder’s risk” (Group Life, 210).

*Metropolitan Life Ins. Co. v. Massachusetts*¹¹ (Metropolitan Life, 1985) affirmed and built on these previous criteria. It presents three criteria to assess the business of insurance. This key criterion of shared risk is combined with two additional criteria for identifying the business of insurance (Metropolitan Life, 743):

- a) whether the practice has the effect of transferring or spreading a policyholder’s risk;
- b) whether the practice is an integral part of the insurer and policyholder relationship; and
- c) whether the practice is limited to entities within the insurance industry.

The court’s second criterion has importance for pooling resources. It holds that spreading risk is critical to the business of insurance only when it is an integral relationship between the insurer and the insured. The third condition looks for the use of analytical tools employed uniquely by insurance carriers to maintain the solvency of their product, i.e., the actuarial methodologies. Thus, transferring risk, as an integral part of the relationship between insurer and policyholder, and using distinct methodologies to guarantee fixed return are among the three critical components that states must demonstrate if they are to declare HCSMs as businesses of insurance for purposes of regulation.

Before reviewing specific state court rulings applying the U.S. Supreme Court’s conditions to HCSMs, it is useful to summarize a legal scholar’s analysis of their application. Benjamin Boyd, a staff attorney for the Chief Justice of the Alabama Supreme Court, recently wrote a study applying to HCSMs the criteria from the Supreme Court’s decisions discussed above. The study assesses whether the HCSMs’ business of sharing meets these legal guidelines for the business of insurance (Boyd, 2013). This is a summary of his conclusions.

- 1) Applying the criteria developed under *Group Life*, the HCSMs lack the primary element of insurance involving underwriting of policyholders. The members rather than the HCSMs themselves voluntarily share the risk.
- 2) Extrapolating the conditions from *Met Life*, the HCSMs’ contracts have the effect of spreading the members’ risk, but the relationship is between members (“insured”) not the organization (“insurer”) and the members (“insured”). The members “indemnify” or pay one another. Therefore, the spreading of risk is not an integral part of the policy relationship between the organization (“insurer”) and the members (“insured”).
- 3) Extending the guideline from *Variable Annuity Life*, HCSMs’ voluntary agreements do not obligate the organization to secure a “fixed return” to its participating members.

There are two relatively recent reviews discussing the judicial decisions regarding state oversight of HCSMs. Each analysis seems to reach different conclusions. The National Association

ed. 1952). Cited by Boyd, B. Health Care Sharing Ministries: Scam or Solution?. *Journal of Law & Health*. 26, 2, 219-283, July 2013. ISSN: 10446419.

¹¹ Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 743 (1985).

of Insurance Commissioners conducted an earlier study (Eastman, *et al.*, 2010). In this study, the authors compare the operational language of the HCSM programs with the vernacular of conventional health insurance. They argue by way of analogy: If a bird “looks, walks and swims like a duck, then it is a duck.” Although subtle details suggest the authors believe that HCSMs are engaged in the business of insurance, the conclusion is more circumspect:

“Hence if subscribers’ shares, or premiums, are based on underwriting and risk assessment, and such premiums are pooled together for purposes of paying losses, then the activity should be considered an insurance business, regardless of any written disclaimers to the contrary. If subscribers’ shares, or premiums, are the same for all subscribers, regardless of health conditions or risk, or if claims are paid directly from one subscriber to another without pooling of funds, then the activity may not be considered insurance for regulatory purposes.” (Eastman, *et al.*, 204).

Boyd’s argument is more direct. He concludes that the central functions of the HCSMs do not fit the U.S. Supreme Court’s general paradigm for the business of insurance. In particular, he specifically points out that the similarities in programmatic concepts do not constitute rigorous grounds for proponents to employ analogical reasoning in order to conclude that the HCSMs are insurance.¹² The analogy breaks down on each and every crucial criterion. The HCSMs do not underwrite risk. The members share the risk voluntarily and directly among themselves. The HCSMs specifically declare that there is no guaranteed fixed return to meet medical needs. HCSMs guarantee only “the provision of certain services as a clearing house for information on medical need.”¹³ They connect members with medical needs to members willing to make voluntary gifts.

However, the informed opinion of a legal analyst does not mean that state insurance agencies and courts will similarly apply the criteria to the factual circumstances. We now turn to the two cases where the courts have applied the U.S. Supreme Court criteria to HCSMs.

State Actions Pertaining to Regulating HCSMs as Health Insurance. HCSMs have sought, and continue to seek, to clarify to the state that they are ministries, not health insurance. After two decades of government relations, a majority consensus has emerged among the states to the effect that HCSMs are not health insurance. The three HCSMs currently conduct ministries in all 50 states (with the singular exception that Christian Healthcare Ministries does not operate in Montana). Their approach is generally to assume that state governments will recognize their operations and practices as ministries. However, they have proactively sought official recognition (e.g., Washington) from the state prior to accepting sharing memberships. Nevertheless, HCSMs have effectively responded to the states’ department of insurance challenges to the charitable operations of the HCSMs, seeking to regulate them as health insurance.

States have an interest in protecting their citizens from fraudulent activities in health insur-

¹² The Iowa Insurance Division employed this argument from analogy to assert that HCSMs are in the business of insurance. See *Barberton Rescue Missions, Inc. v. Insurance Division of Iowa Department of Commerce*, 586 N.W. 2d 355 (Iowa 1998). Also see Boyd, B. (2013). *Health Care Sharing Ministries: Scam or Solution?* *Journal of Law & Health*, 26(2), 240.

¹³ Boyd, B. (2013). *Health Care Sharing Ministries: Scam or Solution?* *Journal of Law & Health*, 26(2), 256.

ance. State oversight occurs in one of two ways. Following the general precedents set forth by the U.S. Supreme Court, state insurance commissioners provide consumer protections through state health insurance laws and regulations. Their assessment regarding the business of insurance follows the general paradigm set forth by the U.S. Supreme Court. Alternatively, the attorneys general of each state offer oversight of non-profit organizations through their investigation and prosecution authorities. HCSMs functioning as registered charities under the Internal Revenue Code 501(c)(3) fall under the oversight of the attorneys general.

Some state departments of insurance have questioned the voluntary dimension of the HCSM sharing operations. They initiate their challenge through a commissioner's judgment, which is subject to administrative appeal in most states. Further remedy is then pursued through the court system (typically constituted of three levels: circuit, appellate, and supreme court). Regulations under state health insurance laws can be particularly burdensome, and they could be arguably inimical to the existence of HCSMs. This is because they typically require more administrative oversight in the forms of actuarial models, financial reserves, and prohibitions against religious and other forms of discrimination. Consumers feel the effect of this protection through added cost to the price of the product or service. Moreover, participating members can view the interventions as altering the nature of the relationships in ways contrary to the values and purposes of the free association.

A safe harbor provision mitigates the effect of a rendered judgment of insurance. It is a specific exemption from an existing statute or regulation involving supervision of the entity's business as health insurance. To receive an exemption from state insurance laws is to say that the insurance code does not apply to the practices of the organization. It is not to presuppose that the organization is in the business of insurance, but merely that it receives special treatment. Safe harbor legislation is pursued through the state general assembly, which upon passage is written into a state's insurance code. HCSMs have pursued these as a remedy to a court ruling (as in the case of the Kentucky Supreme Court), or proactively as a preventive measure. There are 29 states with safe-harbor laws that recognize that HCSMs operating in those states are not subject to the oversight of the state department of insurance (Alliance, July 2014).

Whether or not HCSMs constitute health insurance is the dominant policy issue. Although this report does not review the legal argument, it is obvious that variant normative commitments are intertwined with differing jurisprudential philosophies (e.g., the majority opinion and dissent in Kentucky)¹⁴. State insurance departments, court systems, and general assemblies have all played a role in determining oversight of HCSMs. The HCSMs' non-insurance disclaimers promoting informed consent among its applicants are central to judicial deliberations regarding insurance status. As an example of a liability disclaimer and statement of responsibility, consider the following statement in the "Testimony and Commitment" form, which Christian Care Ministry requires each

¹⁴ Although Boyd does comment on jurisprudential philosophy, his analysis of the majority's reasoning in *Commonwealth v. Reinhold* (2010) also shows that it involves a positivist jurisprudence combined with an instrumentalist social theory, and a consequentialist normative theory. By contrast, the dissent's reasoning in the Kentucky case and the Court ruling in *Barberton Rescue Missions, Inc. v. Insurance Division of the Iowa Department of Commerce* (1998) do not. See Boyd (2013, 233-241).

applicant to sign as part of his or her application to Medi-Share:

I understand that Medi-Share, like all health care sharing ministries under the Affordable Care Act, is not insurance or an insurance policy nor is it offered through an insurance company. Neither is Medi-Share a discount health care or discount health card program. Whether anyone chooses to assist me with my medical bills will be totally voluntary, as neither CCM nor any other member can or will be compelled to make the payment of my medical bill. As such, I understand that whether I receive any amounts for medical bills and whether or not Medi-Share continues to operate, I am always personally responsible for the payment of my own medical bills. I understand that Medi-Share is not subject to the regulatory requirements or consumer protections of my state's insurance code/statutes.¹⁵

In addition to this liability disclaimer, CCM clearly states in its program guidelines that “each member is solely responsible for his or her own medical bills” (Program Guidelines, 11).

According to J. Brian Heller, General Counsel, Samaritan Ministries International, in making assessments regarding HCSMs' status as health insurance, administrative judgments or the court rulings either “ignore or discount” the member attestation in this commitment.¹⁶ With respect to the court rulings, significance is either attached to the “plain” meaning of the language or it is not. In either case the grounds for this assessment is based on other jurisprudential commitments. These commitments betray the reasons for the disagreement. He also observes that “[t]he Iowa Supreme Court decision was the only full published appellate decision on the question of insurance, making it the most persuasive court decision that this form of sharing does not constitute “insurance.”

Chart 1 is a global illustration of the state activity across the country. The columns list a mix of the public authorities making the decision. These authorities include (from right to left): the state legislature, agency judgments and administrative appeals, and the courts. The columns are marked with an “X” to indicate which public authority is responsible for the current ruling. The point of the chart is to provide the reader with a simple panorama of the status of public policy activity in 33 states. The HCSMs, however, remain active in all 50 states. Their involvement in some states, however, has not triggered policy activity.

It seems difficult not to conclude that there is a kind of rough consensus that HCSMs are neither insurance nor should they be treated as insurance. Some rows display two notations to represent a state's present policy. For these states the general assembly passed a safe harbor law making moot an administrative or court judgment about the status of HCSMs regarding insurance. In most but not all cases the administrative or court position triggered general assembly action.

¹⁵ Medi-Share, Testimony and Commitment Form 02.As.06.1114, p.2.

¹⁶ Personal communication August 31, 2015.

Chart 1: State Policy and Authority						
State	State Supreme Court Held HCSM is Insurance	State Supreme Court Ruling Held HCSM is NOT Insurance	Circuit Court Decision	Administrative Decision	DOI Judgment	Legislation (Safe Harbor)
IA, ID		X				X
WA						
DE	X					
MN, NV				X		
IA, KS, MD, PA, UT, WI					X	X
OK, IL			X			X
MT			X			
KY	X					X
AL, AR, AZ, FL, FL, GA, IN, LA, ME, MO, MS, NE, NH, NC, SD, TX, VA, WY						X

Data Source: J. Brian Heller, (August, 2015). "Summary of the History of Health Care Sharing Ministries' Legal Interaction with State Insurance Regulations." (Unpublished).

The Three Largest Health Care Sharing Ministries: Profiles and Ministry Models¹⁷

Christian Healthcare Ministries (“CHM”). CHM was founded in 1981.¹⁸ Its offices are located in Barberton, Ohio. The Centers for Medicare and Medicaid Services (CMS) has certified that CHM meets the definition of an HCSM in the ACA, so its members are exempt from the individual mandate to purchase insurance.

Looking at the decade of participation surrounding the build-up to, passage, and implementation of the ACA and individual mandate, growth in this ministry is evident. In 2005, CHM had 16,690 members in 8,015 household across the U.S. In 2010 at the point of passage of the ACA, there were 19,407 members in 9,200 households. At the point of implementing the individual mandate in 2013, CHM had enrolled 53,517 members in 15,471 households. The current enrollment stands at 104,014 members in 24,938 households. Membership increase over the decade is 523 percent. The largest growth followed the implementation of the individual mandate.

Moreover, this increase in membership increases responsibility for the dollars shared over the same period. In 2002 the CHM shared \$12,746,165. That amount grew slightly more than 400 percent to \$64,654,943 in 2015. During this decade the ministry shared a total of \$223,129,743.

¹⁷ The three ministries in connection with the Alliance of Healthcare Sharing Ministries have supplied the administrative data on membership, households, and shared data for this section.

¹⁸ The Christian Healthcare Ministries assumed its current name in 2007. Between July 2001 and 2007 the organization was called The Christian Brotherhood Newsletter. In July 2001 The Christian Brotherhood News Letter legally separated from the Barberton Recuse Mission, which dates back to 1981, after the IRS instructed the organization to operate its health care ministry as a separate 501(c)(3).

Christian Care Ministry/Medi-Share (“Medi-Share”). Christian Care Ministry (CCM) began administering the Medi-Share program in 1993. Its offices are located in Melbourne, Florida. CMS has certified that Medi-Share meets the definition of an HCSM in the ACA. Thus its members are exempt from the shared responsibility provision under the ACA.

Looking at the decade of participation surrounding the build-up to, passage, and implementation of the ACA and individual mandate, growth in this ministry is evident. In 2005 Medi-Share had 52,793 members in 18,808 households across the U.S. In 2010 at the point of passage of the ACA, there were 36,411 members in 12,429 households. At the point of implementing the individual mandate in 2013, Medi-Share enrolled 58,911 members in 20,375 households. Its current enrollment stands at 90,901 lives in 31,713 households. Membership increase over the decade is 72 percent. The largest growth followed the implementation of the individual mandate.

Moreover, this growth in membership increases responsibility for the dollars shared over the same period. In 2005 Medi-Share shared \$36,052,097. That amount grew about 111 percent to \$76,249,867 in 2015. During this decade the ministry shared a total of \$506,535,523.

Samaritan Ministries International (“SMI”). SMI was founded in 1991. Its offices are located in Peoria, Illinois. CMS has certified that SMI meets the definition of an HCSM in the ACA, so its members are exempt from the individual mandate.

During the past decade, participation surrounding the build-up to, passage, and implementation of the ACA and individual mandate showed growth in this ministry. In 2005 SMI had 32,614 members in 11,267 households across the U.S. In 2010 at the point of passage of the ACA there were 47,586 members in 14,623 households. At the point of implementing the individual mandate in 2013, SMI enrolled 82,508 members in 24,625 households. Its current enrollment stands at 117,038 lives in 35,159 households. Membership increase over this decade is 259 percent. The largest growth followed the implementation of the individual mandate.

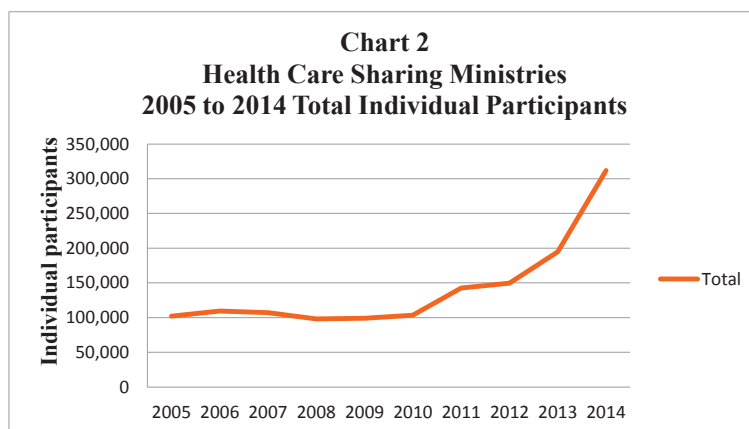
Moreover, this growth in membership increases responsibility for the dollars shared over the same period. In 2005 the SMI shared \$20,148,617. That amount grew 458 percent to \$112,371,512 in 2015. During the decade the ministry shared a total of \$498,907,376.

Christ Medicus Foundation CURO (hereafter CURO). CURO launched its health care sharing ministry on January 1, 2015. CURO is a ministry extension of Christ Medicus Foundation (CMF), a Catholic 501(c)(3) nonprofit.¹⁹ CURO strategically allied itself with SMI because the ACA date restriction precluded the formation of new HCSMs after December 31, 1999. The controversy surrounding provision of abortion and other reproductive services in the new health law ignited the

¹⁹ As of December 31, 1999, there were no Catholic health care sharing ministries in the United States. Seeking to bring health sharing to the Catholic community in America, the Christ Medicus Foundation realized that a new Catholic health care sharing option should partner with a recognized health care sharing ministry. Working with SMI, CMF CURO was announced in October 2014 and fully launched in 2015. It is the fruit of ecumenical collaboration between Catholics and Protestants seeking to empower Catholics to live their Christian faith in health care.

CMF to create a non-insurance, health care sharing ministry where Christians could freely exercise their conscience. CURO operates as an ancillary partner or “member representative” within Samaritan Ministries International. There are 400 members currently participating. CURO provides a health care sharing option consistent with the medical-ethical principles of Catholic teaching. However, the CURO ministry does not impose a religious test on members and is an ecumenical option for both Catholic and non-Catholic Christians. Members of CMF CURO either enroll in health care sharing through Samaritan’s standard application process, at which point they learn about the specifically Catholic option, or directly through the CURO website, CMFCURO.com.

Looking at the Big Trend. The following three charts illustrate data for the total number of members, households, and dollars for the three HCSMs combined. These measures correspond to significant moments in the passage and implementation of the ACA, especially the individual mandate. Chart 2 summarizes the pattern of total sharing individuals among the three ministries between 2005 and 2015. This decade straddles the build-up to, passage, and implementation of the ACA.



In this period, enrollment was dynamic with members participating in sharing medical needs and costs. Brian Heller estimates that the annual attrition rate is about 10 percent.²⁰ The net growth for the three ministries increased from an annual enrollment of 102,097 to 311,953 lives. This is a 200 percent growth rate over the decade. During the period of 2005 to 2010 enrollment fluctuated in modest swings up and down. The jump in enrollment corresponds to the uncertainties of the ACA being debated in Congress and at its enactment. There was an early surge of about 39,000 enrollees between 2010 and 2011. A surge of 30 percent continued in the next year. But after the implementation of the individual mandate in 2013 when membership was about 195,000, the enrollment swelled by 117,000 in 2014, or 60 percent over 2013 levels. This was the largest annual increase over the decade. Its growth is reasonably interpreted as a response to the values represented by the ACA and the coercive implementation of the individual mandate.

²⁰ Personal communication, September 4, 2015.

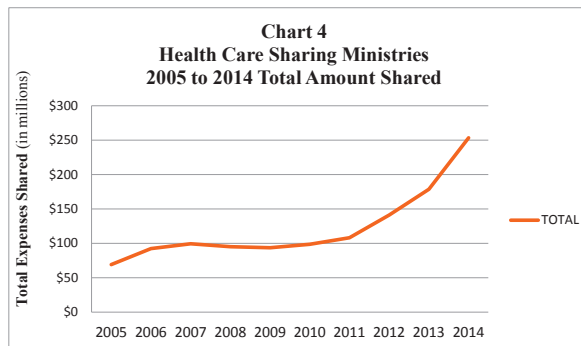
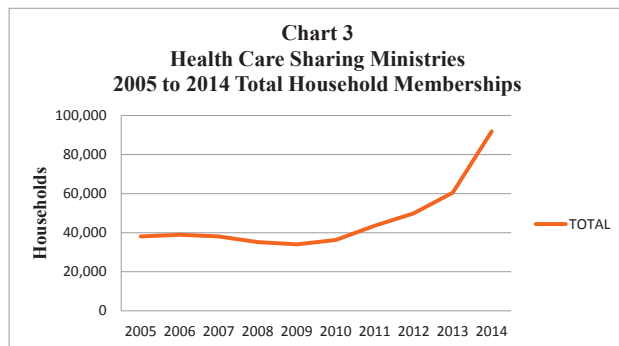


Chart 3 tells a story of growth in terms of families. In 2005 there were 38,000 families enrolled within the three ministries. Today there are 92,000. This increase reflects a 142 percent climb. After 2013 the number of families climbed 52 percent.

The dollars shared illustrated in Chart 4 is the most striking feature of growth. These ministries have shared nearly \$1.3 billion in this decade. Beginning in 2005 the amount was shy of \$70 million. In the most recent annual reporting period, the dollars shared accelerated to more than \$253 million. That amount reflects overall growth of 261 percent and an average annual growth rate of 29 percent. The biggest annual spike for the decade of \$74 million, or 47 percent, occurred immediately after the implementation of the individual mandate.

Ministry Sharing Models

The sharing models employed by the HCSMs hold in common the member-to-member exchange (MME). Members are responsible to fellow members, not to the administrative organization. This MME creates an opportunity to personalize giving and enrich that giving through answering prayer requests. But there are nuanced differences among the groups in implementing the MME. This report tries to capture the nuances with a descriptive name.

The CHM sharing model involves the *organization as a ministry fiduciary*. Members send their monthly financial gifts of a predetermined amount to CHM, which then uses the shared funds to pay medical bills eligible under the ministry’s guidelines. CHM acts as a fiduciary holding the collected funds in an escrow account while medical bills are reviewed for accuracy and completeness, and while discount negotiations take place with providers. When those tasks are completed, the shared funds are sent to members for the purpose of paying their providers. CHM’s accounting practices are subject to independent financial audits, internal controls, and transparent financial policies, including making the ministry’s finances available via the Internet.

Medi-Share employs a *patented member share exchange* model. Member households deposit a pre-arranged monthly contribution into their personal bank account at a designated financial institution called America’s Christian Credit Union. On behalf of the contributing members, funds are automatically transferred through the member share exchange from the contributing mem-

bers' accounts to accounts of members with eligible medical needs. In this sense, the transaction remains member to member. The contribution includes a monthly transaction fee for administrative expenses. Medi-Share has developed a software technology to match member shares to member bills electronically, and in real time it publishes where the dollars are going, transfers the required dollars between accounts, and then makes payment to providers. Members receive notification electronically, ahead of sharing, whom their shares are assisting each month, and they can view all published bills daily on the webpage.

SMI uses a member-to-member *direct sharing* model. The organization distributes a monthly newsletter to all members. Specific members receive inserts in their newsletter. The notice includes their monthly bill for their contribution to the ministry and a listing of fellow members' medical bills. Members directly send cards and letters to fellow members along with the suggested contribution. Once a year members send their monthly share to the administrative office to help cover expenses. If medical bills for a month exceed the amount of shares available, each household with a medical need that month receives a prorated portion of their medical expenses. The balance is raised from voluntary contributions to cover the difference.

CURO's sharing model is structured similarly to Samaritan's member-to-member *direct sharing* model. However, CURO members use a designated, member-owned VISA debit card.²¹ It can be used for identification and pricing at the point of care, as well as payment of medical bills, and for online health and wellness tools such as health assessments, online health courses, and goal tracking. After a service-pricing administrator (SPA) examines the medical charges, a bill is sent for review to SMI and to the member in need. The member having a need and SMI approve the bill. SMI assigns fellow subscribers to share with the member in need. Louis Brown, Director of CURO, describes how the VISA card alters the transactional operations of the ministry: "Instead of sending checks and prayer letters to the member-in-need's home address, the member funds (both shared and received) are deposited into a bank account using a CURO membership debit card. The members own and supervise their own bank accounts. There is no third-party fiduciary involved directing the electronic transaction. The member in need can then use their CURO card to seamlessly pay for their eligible medical expenses. Prayer letters are also scanned and made available for the member in need to view online." CURO members contribute an additional \$84 per month to support the Catholic spiritual life fostered by the ministry's gospel of life service to society.

Comparing Conventional Health Insurance with Health Care Sharing Ministries

Health care is expensive. An average three-day stay in the hospital can approach \$30,000. Hospital costs for maternity are similar. This report looks at three key structural reforms related to benefits central to making comparisons. These key issues for understanding health care sharing in relation to health insurance include benefit coverage, affordability, and provider choice. The benchmark for making product comparisons is the second-lowest-cost Silver Plan in the ACA. It will be used here for comparison with ministry programs.

²¹ Personal communication with Louis Brown, June 12, 2015. The implementation of the VISA debit card will replace the need for paper transmission in the form of checks. The VISA debit card was not operational as of the date of the interview.

Benefit Coverage. The first reform for comparison concerns benefit coverage. This section makes proximal comparisons with three benefit reforms that are the hallmark of the ACA. These include the ACA’s minimum benefits, pre-existing condition, and catastrophic protections. Title I of the ACA requires that all plans sold in the individual and small-group markets cover “essential health benefits” (EHB). The law directed the Secretary of Health and Human Services to identify a specific roster of services. The Secretary announced 10 general categories for medical services in an online bulletin. All plans sold in the individual and small group markets must offer these services. Individuals must purchase plans containing such benefits under penalty of law, unless otherwise exempted.

The HCSMs do not present their listing of medical services eligible for sharing as a comprehensive catalogue, unlike the ACA. The ministries, no doubt, think that the services and conditions eligible for sharing are essential, but they do not attempt to be comprehensive. In this respect, they are “non-wellness” programs. Indeed a narrower set of benefits is attractive to their members. The “burdens” that members carry are those primarily beyond the control of moral agency. The eligibility criteria for the HCSMs require that all members practice biblical lifestyles. They are non-smokers, practice moderate consumption of alcohol, and are faithful in marriage.

Table I Benefit Comparison – 10 Essential ACA Benefit Package vs. HCSM				
ACA EHB “metal tiers”	CHM (Gold)	Medi-Share	SMI	CURO
Emergency services	Y	Y	Y	Y
Hospitalization	Y	Y	Y	Y
Laboratory tests	Y	Y	Y	Y
Maternity & newborn	Y	Y	Y	Y
Mental health & substance abuse	N	N	N	N
Outpatient care (doctors & other services – may include abortion)	Y (but no abortion)	Y (but no abortion)	Y (but no abortion)	Y (but no abortion)
Pediatric service (including dental & vision)	Y, but excludes dental & vision	Y, but excludes dental & vision	Y, but excludes dental & vision	Y, but excludes dental & vision
Preventive services (e.g., contraception, immunization & mammograms)	N (e.g., contraception, immunization, mammograms)	N (e.g., contraception, immunization, mammograms)	N (e.g., contraception, immunization, mammograms)	N (e.g., contraception, immunization, mammograms)
Prescription drugs	Y	Y	Y	Y

Table I illustrates some of the differences in eligible benefits. In order to make proximate comparisons, this section attempts to match the pooling arrangement from the different programs

within the HCSMs with the ACA benchmark plan. For example, the Gold program offered by Christian Healthcare Ministry provides the more expansive sharing option for that ministry. The programs from the other ministries may offer opportunities for additional benefits to enrich the standard sharing option.

A second reform under the ACA involves pre-existing conditions, which protects the enrollee from exclusion of coverage or higher premiums resulting from a medical condition. As long as one enrolls during the open enrollment period, insurance companies are required under the ACA to insure all applicants. Outside of the open enrollment period, however, some insurance plans in the individual market, particularly those being “grandfathered,” may base eligibility and price decisions on health status.

HCSMs typically do *not* share medical bills for pre-existing conditions. If a person enrolls while being treated for diabetes, cancer or a heart condition, the medical bills associated with those treatments will *not* be published. There are, however, procedures within the different ministries for handling exceptions. For example, SMI and CURO will publish these needs as “Special Prayer Needs” so that members can voluntarily contribute over and above their pledges made to other members. Medi-Share mentions that there are exceptions to the time limits and limits to eligible amounts for sharing (Alliance, Comparison Chart 2015).

Christian Healthcare Ministries (CHM) does make accommodation for sharing medical bills attributed to pre-existing conditions, unlike the other HCSMs. In the first year needs are published *up to* \$15,000. In the second year CHM publishes an *additional* \$10,000 (or up to \$25,000 in the first two years). The third year *adds* \$25,000 (or up to \$50,000 for the first three years). Thus, over three years the opportunity for sharing is possible up to \$50,000. Conditions are no longer deemed pre-existing after the third year. Combined with CHM’s Prayer Page portion (i.e., the listing of medical bills for pre-existing conditions), the total cost of the pre-existing condition is shared or paid.

The third notable change to the insurance market is with respect to limits for maximum out-of-pocket costs or catastrophic coverage. The ACA restricts insurers from structuring plans with “lifetime” caps and unreasonable annual limits on the essential health benefits (EHB) (ACA §2711). Prior to January 1, 2014 these insurance coverage limits could leave an insured person with severe, chronic and life-threatening illnesses facing sizeable financial burdens. The new federal rule set the maximum amount that the insured will pay out-of-pocket in 2015 at \$6,600 for single coverage and up to \$13,200 for a family.

Out-of-pocket refers to the portion of the actual medical bills that remains the responsibility of the insured. Sometimes insurance calls “out-of-pocket” (OOP) expenses “cost-sharing.” In the context of insurance, these expenses refer to co-pays (a fixed dollar amount for certain services), co-insurance (a percentage of the cost for a service) and deductibles (the front-end dollars the subscriber pays before the insurance pays). Typically the OOP costs do not include the insured’s share of the premium, even though the insured’s portion of the premium is a very real cost also.

The HCSMs offer opportunities to share in the catastrophic burdens of their community. The CHM standard Gold program allows members to publish medical bills up to \$125,000 per illness. Brother's Keeper, however, allows for an additional sharing in annual increments of \$100,000 up to a \$1 million lifetime maximum. Contributions to this program are made quarterly at \$25 per unit and an application fee, and they range annually from \$100 for an individual to \$450 for a family.

Medi-Share reports no maximum limits on sharing. SMI and CURO rely on the Save to Share program. The standard program allows sharing up to \$250,000 for each incident. The Save to Share "add-on" involves an additional annual household sharing commitment and \$15 administration fee. The members pledge to set aside sums each year ranging from \$133 for singles to \$399 for two-parent families. The respective annual commitment continues over three years only. In this program members can publish medical bills that exceed \$250,000 for each medical incident once they meet their personal responsibility level (Samaritan Guideline, 36).

Affordability. HCSMs maintain that the central value of a sharing ministry is its voluntary spiritual participation in a divinely sanctioned duty one to another. The awareness of costs, however, does not weaken that basic commitment for participating in the ministry. Costs simply reveal that the burdens are manageable. It is common to read that HCSMs promote their affordability as an alternative to health insurance. Tony Meggs, President and CEO of Christian Care Ministry, provided Hiran Ratnayake from *The News Journal* (Delaware) with his estimate a few years ago. "You compare us against the average premium and we're about 50 percent less expensive and that drives people to us" (*The News Journal*, September 4, 2011). This could translate into a savings of a few thousand dollars a year for a family. The Citizens' Council on Health Care is one source that looked into the affordability claim of HCSMs. Using the sharing plans offered by the oldest and largest HCSMs for comparison, the Citizens' Council concluded that these "costs are affordable when compared to traditional health insurance" (Brase, January 2010).

The implementation of the ACA has introduced significant changes to the health care market since the Citizens' Council study in 2010. As a general rule the lower the premiums, the higher the deductible. Alternatively, a higher premium means a lower deductible. This report takes a fresh look at the claim using the Citizens' Council's basic methodology. This methodology only establishes a *presumption* of affordability. It is not intended as a definitive analysis in deciding to forego insurance for sharing. Individuals should compare family needs with representative ministry programs and insurance before making a final decision. The finding contained here is only approximate. It is offered only to give a sense of the actual costs. It is not intended to be a precise comparison. The insurance plans as well as the sharing ministries offer variations that would make a comparison for participation more complicated. However, the methodology can illustrate why the health sharing plans might be attractive on grounds of affordability alone.

Premiums vs. Sharing Contributions. The ACA is in its third year of implementation. Federal and state exchanges are up and running for the individual market. The following tables (II-VII) attempt to illustrate a contrast between the price of insurance and the contributions made via shar-

ing ministries. The data used for health insurance comes from The Kaiser Foundation’s 2014 health insurance survey. The data for the sharing ministries is from the respective organizational web-pages as of May 2015. Table II (below) presents average premiums for employer-sponsored health plans collected annually by the Kaiser Family Foundation 2014 Employer Health Benefits Survey.

Table II: Employer-Sponsored Health Insurance								
Average annual premium (2014)	Health Maintenance Organization (HMO) plans		Preferred Provider Organization (PPO) plans		Point of Service (POS)		Overall Health care inflation Individual = 2%> Family = 3%>	
	Individual	Family	Individual	Family	Individual	Family	Individual	Family
	\$6,223	\$17,383	\$6,217	\$17,333	\$6,166	\$16,037	\$6,025	\$16,434

Source: Employer Health Benefits 2014 Summary of Findings Kaiser Foundation and Health Research & Education

Table II(b) compares average premiums for employer-sponsored health insurance in small firms with the annualized monthly sharing contributions. Although comparing premiums is interesting, judgments of affordability must be based on the fuller impact of an insurance policy, combining premiums and cost-sharing. The table illustrates that the HCSM contributions are comparable to the average premium for a single plan. However, HCSM contributions for family members can be considerably less than the average premium for ESHI family coverage.

Table II(b) Average Annual Premium ESHI compared to HCSM		
Plan	Individual	Family
ESHI	\$6,217 (\$518/month)	\$16,434 (\$1,369/month)
Christian Health Care Ministries (Gold)	\$2,440	\$7,240
Medi-Share	\$3,564 (\$297/month*; will likely reduce by participating in the Health Monthly program with \$161/month)	\$4,920 (\$410/month)
SMI	\$3,474	\$6,174
CMF CURO	\$4,482	\$7,182

*Medi-Share pricing data as of May 2015.

In addition, we illustrate the prices in the individual market using Kaiser’s Analysis of 2015 Premium Changes in the Affordable Care Act’s Health Insurance Marketplaces shown in Table III (below). This report uses the Anthem HealthKeepers Silver X sold in Central Virginia as a representative for the benchmark plan for comparison. Finally, this section explores 2015 premiums and deductibles for a benchmark plan using the Obama Administration’s HealthCare.gov. This report uses that benchmark tier with the HMO being the representative plan type as it is priced in the individual marketplace. The average annual (weighted) premium in 2014 for a single (male or female) non-smoker, age 40, is \$3,276 before applying the possibility for tax subsidy. Premiums for family coverage can vary among the states. The best way to compare the sharing ministries with regular insurance will be to pick a representative plan and estimate the premium prices for different coverage using the Healthcare.Gov estimator. Several illustrations follow in the tables below using this method of comparison.

Table III: Anthem HealthKeepers Silver X				
Plan Coverage	Premium (Annual)	Deductible (Annual)	Maximum out-of-pocket (Annual)	Total (Annual)
Single	\$3,163 (\$264/month)	\$3,350	\$5,150	\$6,450 <i>(plus out of pocket)</i>
Couple	\$6,324 (\$527/month)	\$6,700	\$10,300	\$13,024 <i>(plus out of pocket)</i>
Single Parent	\$3,372 (\$281/month)	\$4,700	\$8,400	\$8,072 <i>(plus out of pocket)</i>
Family	\$8,736 (\$728/month)	\$6,700	\$10,300	\$15,436 <i>(plus out of pocket)</i>

Deductibles vs. First Dollar Personal Responsibility Cost. In addition, conventional insurance involves cost-sharing. These expenses are always “out-of-pocket,” making actual health care costs higher than just the monthly premium. A person trying to decide between health insurance and an HCSM will want to consider cost-sharing in addition to premiums. Although out-of-pocket costs can be significant to a family budget, the ACA limits them for the individual or family. One typical kind of cost-sharing is co-payment. This is a dollar amount set for each visit that can vary depending upon whether the visit is to a primary care doctor, specialty physician, hospital, lab, or pharmacy. Another form is co-insurance, which assigns the insured responsibility for a percentage of the allowable medical bill.

Deductibles, of course, get the most attention when examining the impact of cost-sharing on the overall cost of insurance. The fluctuation in deductibles has been a popular media story since the implementation of the ACA. Assessing the value of deductibles, however, is more complex than

what media sound bites might lead us to otherwise think. The deductible is the amount paid toward a medical bill before the insurance begins to pay its portion of the bill. Some plan types may combine the other forms of cost-sharing with a deductible, while other plans may require no deductible. In family plans, the deductibles can be considered for individual members or in aggregate. Deductibles can combine medical services with prescription drugs, or there can be separate deductibles for each. It should also be noted that a significant percentage of plans do not use deductibles as a means of cost-sharing.

The Kaiser Family Foundation (KFF) analysis concludes that the average annual deductible for single coverage across employer-sponsored Silver plans in 2014 is about \$1,276. The annual deductible in employer-sponsored family plans with an *aggregated* deductible ranges from \$1,947 to \$2,470 (KFF, §7). The average aggregated deductible of an HMO is \$2,328. The separate per-person deductibles will be lower, ranging from \$821 to \$1,153 (KFF, §7). The separate per-person annual deductible for the HMO is \$821. The average deductible for a high-deductible health plan (HDHP) is \$2,235. In a family covered in a plan where the deductible is separate per-person, the total deductible will be a multiple of the values listed here.

In the individual market an estimated 45 percent of the Silver plans offer separate per-person deductibles, and 55 percent offer combined deductibles. The average annual dollar amount devoted to a medical deductible in Silver plans offering a combined medical and prescription deductible is about \$2,556 for both single and family coverage. The average annual medical deductible for plans with separate deductibles is \$3,453. The benchmark Silver plan separates the average medical deductible in the family, assigning an individual deductible level to each family member.

Making proximate comparisons. The scenarios below assume the second-lowest Silver plan sold in the individual marketplace, which covers 70 percent of insurance. The plan type is an HMO. The estimates are built on non-smokers, age 40, earning about \$45,000 per year. The income level is doubled for couple and family coverage. Single-parent plans assume two teenage children. Similarly, two-parent family coverage also assumes two teenage children. Central Virginia is the presumed residence. This report continues to use the Anthem HealthKeepers Silver X sold in Central Virginia as a representative benchmark plan to make comparisons. It is difficult to compare the benefits perfectly. The obvious differences on some medical and preventive services previously mentioned apply. Finally, ACA tax credits are applied when appropriate to reduce the premium.

Medi-Share ministry contribution. Table IV illustrates four hypothetical household arrangements participating in the highest level of Medi-Share (single, couple, single parent with one child, and two parents with one or more children). The illustration assumes the regular or standard program for individuals 40 years of age. Unlike the other HCSMs, Medi-Share factors age into its price calculator. Age elevates the pricing for contributions. However, the Medi-Share contribution already includes catastrophic coverage, unlike the other plans. The Annual Household Portion (AHP) is that amount out-of-pocket that members must pay toward their eligible medical bills during a 12-month period before their bills can be published for sharing. The AHP is \$2,500

for married couples, single-parent and two-parent family households. However, the AHP is assumed to be lower for individuals. The assumption is that these households in accepting an annual household portion are seeking an optimum balance between fulfilling their duty to bear other members' burdens while minimizing overall cost to the household budget. The illustration also assumes the participants are living biblical lifestyles. To simplify the illustration, the Health Monthly Sharing discount (20 percent) is not factored in. Therefore, the annual contribution could be significantly less.

Table IV: Medi-Share (Standard Option)				
Annualized Average Monthly Contribution	Individual 40 yrs	Married Couple 40 yrs	Single Parent 1 child 40 yrs	Family 40 yrs
	\$3,564 (\$297)	\$4,488 (\$374)	\$4,488 (\$374)	\$6,648 (\$554)
Catastrophic	No limit	No limit	No limit	No limit
Annual Household Portion	\$1,250 (plus non-sharable provider fee \$35/visit & \$135/ER)*	\$1,250 (plus non-sharable provider fee \$35/visit & \$135/ER)*	\$1,250 (plus non-sharable provider fee \$35/visit & \$135/ER)*	\$2,500 (plus non-sharable provider fee \$35/visit & \$135/ER)*
<i>Estimated annual total</i>	<i>\$4,814</i>	<i>\$6,988</i>	<i>\$6,988</i>	<i>\$9,148</i>
Source: Christian Care Ministry Website. Tab Medi-Share Subtab: Share Calculator. (Note: Additional options and discounts based on health promotion programs are not factored into the annual values.) https://mychristiancare.org/medi-share-pricing-tool.aspx *The per visit provider fee is not included in the annual household portion.				

Christian HealthCare Ministry (CHM/Gold) contribution. Table V (next page) illustrates four hypothetical household arrangements participating in the Gold level in the CHM program (single, couple, single parent with one child, and two parents with one or more children). CHM prices by unit in a household. Each unit is \$150 monthly. A unit is a participating individual within a membership (i.e., single = 1 unit; couple = 2 units; single parent with children = 2 units; family = 3 units). The illustration assumes the regular or standard program for individuals 40 years of age. CHM, unlike Medi-Share, *excludes* age as a factor in its price calculator. However, Brother's Keeper, or catastrophic coverage, is an add-on to the monthly contribution. Personal responsibility is \$500 per participating unit in the household. The personal responsibility is the amount paid toward eligible medical bills by the member in a 12-month period before their bills can be published for sharing. (However, active member negotiations with providers to reduce medical bills can lower the personal responsibility amount.)

Table V: CHM (Gold)				
Average Annual Contribution	Individual 40 yrs>	Single Parent 40 yrs>	Married Couple 40 yrs>	Family 40 yrs>
	\$1,800	\$3,600	\$3,600	\$5,400
Brother's Keeper* Catastrophic Addition <i>quarterly</i> gift amount is \$25 per unit plus annual fee per unit = \$40	\$140	\$240	\$240	\$340
Personal Responsibility**	\$500	\$1,000	\$1,000	\$1,500
Estimated Annual Total	\$2,440	\$4,840	\$4,840	\$7,240
*Brother's Keeper provides <i>unlimited</i> cost support per illness (diagnosis). Source: CHM Website Tab "How it works" Sub-tab: "Program & Costs" http://www.chministries.org/programs.aspx **If members assist in negotiating with providers, CHM waives their personal responsibility.				

Samaritan Ministries International (SMI) contributions. Table VI illustrates four hypothetical household arrangements participating in the SMI program. According to their guidelines, the current monthly share contribution is \$180 for a single, \$360 for a married couple, \$250 for a single-parent family of any size, and \$405 for a two-parent family of any size. The illustration assumes the regular or standard program for individuals 40 years of age. SMI, unlike Medi-Share, *excludes* age as a factor in its price calculator. The personal responsibility is the amount paid toward eligible medical bills by the member or household in a 12-month period before their bills can be published for sharing. (However, active member negotiations with providers to reduce medical bills can lower the personal responsibility amount.) Personal responsibility is assigned to the medical incident rather than the member or household. It is \$300 for each of three medical incidents during

Table VI: SMI				
Average Annual Contribution	Individual 40 yrs>	Single Parent 40 yrs>	Married Couple 40 yrs>	Family 40 yrs>
	\$2,160	\$3,000	\$4,320	\$4,860
Save to Share Catastrophic (\$133 single; \$266 married couple & single parent \$399/year for 3 years & \$15 administration fee)	\$148	\$281	\$281	\$414
Personal Responsibility (\$300/incident up to 3 total in a 12- month period)	\$900	\$900	\$900	\$900
Estimated Annual Total	\$3,208	\$4,181	\$5,501	\$6,174
Source: http://samaritanministries.org/how-it-works/guidelines/				

a 12-month period for participating households. Catastrophic coverage is through the Save to Share program. Members pledge to set aside \$399 each year for three years *only* (and are charged an administrative fee of \$15 per year).

CMF CURO contributions. CURO builds on top of SMI offering a sharing ministry that is distinctive to the Catholic spiritual experience and belief system. Table VII uses the same assumption as Table VI except it adds costs distinctive to the CURO participants. These costs include an additional \$55 per month directed to a special CURO fund designated for pro-life education and charitable care services to non-CURO organizations. There is also a \$29 per month administration fee. Personal responsibility is \$300 for each of three medical incidents during a 12-month period for participating households.

Table VII: SMI/CMF CURO				
Average Annual Contribution	Individual 40 yrs>	Single Parent 40 yrs>	Married Couple 40 yrs>	Family 40 yrs>
SMI Estimated Annual (from Table VI)	\$3,208	\$4,181	\$5,501	\$6,174
Administration Fee (\$29 monthly)	\$348	\$348	\$348	\$348
CMF CURO Fund (\$55 monthly)	\$660	\$660	\$660	\$660
CURO Estimated Total	\$4,216	\$5,189	\$6,509	\$7,182
Source: CMF/CURO Website Tab: Ministry Costs Sub-tab: Ministry Costs & Details, http://www.cmfcuro.com - http://www.cmfcuro.com/details.php				

Doctors and Hospitals. “If you like your doctors, you can keep them!” was the bold promise of President Obama in the summer of 2009 as the ACA was being fashioned and debated. Patients cherish their relationships with their *particular* doctors. The conventional understanding of network medicine is that care is likely to be more costly when patients use a provider out-of-network than within network. Similarly, plans with networks having a wider selection of providers will be more costly than plans with a narrower range. Under the ACA, however, a narrowing of networks by certain plans frustrates patients’ desires to choose their doctors and hospitals. Given the cost of premiums following the passage of the ACA, insurers respond rationally by narrowing their network of providers in order to hold costs down. This containment strategy has not escaped the eye of regulators and legislators who are developing standards to assess the quality and adequacy of provider networks. Yet despite attempts to deter a “narrowing” of networks, the economic incentive for insurers is toward more limited rather than wider provider networks. This structural issue is a

persistent economic challenge with network medicine (Appleby, 2014) as a result of the ACA. The ordinary person assesses the loss of this liberty in one's health care as a negative quality of a health care system. However, some influential health policy experts, for instance, Ezekiel Emanuel, argue that choice of doctors is overrated (Emanuel, March 2014).

Members in HCSMs, in contrast, generally do not need to worry about service disruptions. The typical HCSM does not have this type of restriction or penalty. With the exception of Medi-Share's PPO plan, a hallmark of the HCSMs is that they impose no limits on member choice of a doctor, hospital, or pharmacist and do not require any pre-authorization for medical services or medications. But sharing members are "self-pay" patients. Providers may have limited experience with this type of payment system. Moreover, the members are asked to negotiate reduced charges with their providers before publishing a medical bill for sharing. Concerns about disruption in the service/payment cycle might adversely affect providers' willingness to care for members.

First, CHM and SMI/CURO make available negotiation coaching and advocacy resources through their websites and advisors. Medi-Share conducts the negotiation for their members. All the ministries make available a point of contact with the ministry for providers. Second, the service/payment cycle is very similar to what medical offices are already exposed to in their dealings with insured patients. Sharing members present a member visit card. The members pay a provider a fee upfront just like a copay. Billing offices often provide reduced charges similar to negotiation with insured rates for services. The interaction between sharing member and provider billing offices is similar to the interactions with insurance companies. In general, the only difference is that the member rather than the insurance company represents the patient.²² (SMI and CHM allow members to offset the personal responsibility amounts by the amount of discount when the member conducts the negotiation.) Finally, the complete service/billing cycle is similar to the timeframe involved with insured patients. Ralph Weber, president of the innovative website Medibid.com, told Fox Business News' Melissa Francis that insurance collections for doctors' offices can take up to 120 days (Money with Melissa Francis).

Testing Member Satisfaction: Samaritan Ministries International vs. Conventional Health Insurance

The comparisons being made with conventional health insurance use proximate measures. There are always trade-offs, even with conventional health insurance. Checking the impact of HCSMs' benefit structures, affordability, and provider networks on a specific family participating in a particular sharing ministry is more telling.

Each of the HCSMs asserts that it has not received complaints from its members in more than a decade. They point to inclusion of impartial review panels to evaluate the appeals about benefit payments as a reason for their success. SMI, for instance, has been sharing needs since 1995, now with over 47,000 households and 157,000 individuals sharing in hundreds of thousands, perhaps over a million, medical bills, with several hundred million dollars in total sharing. To the HCSMs'

²² The PPO options with a predetermined discount are an exception.

knowledge there hasn't been a single complaint by one of its members to any local, state or federal government agency or elected official, nor to any private consumer agency like the Better Business Bureau.²³

Mr. Joseph Guarino and his family live in Central Virginia. By most measurements they are middle-class. Their income is above the median for that region. He and his wife are approximately 50 years of age. They are all in excellent health. Their lifestyle conforms to "biblical" standards, according to Mr. Guarino. They do not smoke and have moderate, if any, alcohol consumption. They are industrious and faithful to marriage and parenting. The family has participated in the Samaritan Ministries International (SMI) health care sharing program for about a decade. This period spans an experience both before and following implementation of the ACA. Mr. Guarino is very knowledgeable about the HCSMs' operations, public policies, and political affairs during the development of the new health care law. He served as an adviser and reviewer for this report. He also has earlier (pre-ACA) experiences with health insurance policy analysis. His impression of sharing ministry operations is very favorable, and so is his view of the spiritual life and benefits that accompany participation. To personalize this report, he was invited to present his particular experiences.

To begin with, we asked him to compare his existing sharing ministry with a popular HMO in Central Virginia called Anthem HealthKeepers Silver X. He used the www.healthcare.gov research

Table VIII: HealthKeepers, Inc. Anthem HealthKeepers Silver X (Silver HMO)		
Estimated monthly/annual premium \$765/\$9,180 Number of people covered: 7 Monthly premium before tax credit: \$1,619 <i>(His tax credit saves him \$10,248 annually or \$854/month)</i>	Estimated deductible \$3,350 person/\$6,700 family for in-network providers. <i>(Does not apply to preventive care and primary care visits.)</i>	Estimated out-of-pocket maximum \$10,300 Estimated family total
Total Annual Expenses for HealthKeepers: \$9,180 + \$6,700 = \$15,880 + any out-of-pocket costs		
Samaritan International Ministries		
Monthly/annual share \$405/\$4,860	Personal Responsibility \$300 per medical event (max of per 12 months, or \$900)	Save to Share (unlimited) \$399/year for three years <i>(Administrative fee \$15/yr)+</i>
Total Annual Expenses for the Guarino family: \$4,860 + \$900 = \$5,760 Note: The Guarinos do not participate in Save to Share. Personal responsibility is usually negotiated down to zero.		

²³ It is noteworthy that from 2005-2007 Medi-Share had problems with several members filing complaints. They subsequently adopted a similar member appeals panel and have had no members file legal complaints against them since. Likewise, since July 2001, after coming out of receivership, CHM has never had a single member filing a complaint. (Personal conversation with Alliance for Healthcare Sharing Ministries and Dr. Rev. Howard Russell, President and CEO of Christian Health Care Ministries on June 19, 2015.)

portal to obtain information about this plan as it relates to his family. Table VIII (see next page) presents the following findings:

The Guarino family’s sharing plan is presumably affordable. Of course, Mr. Guarino confidently asserts that this is not a “presumption”; an estimated savings of \$10,120 is a reality. To bolster his confidence, he presented his 2013 analysis comparing the average premium for eight of the lowest Silver plans. His illustration showed an average premium of \$803.48/month compared to his monthly sharing at that time of \$370. Traditional HMO insurance plans would be about two and a half times more than what he currently contributes in his faith community. His sharing plan appears to be 60 percent less expensive than if he purchased insurance. He was then asked several questions about his practical experiences with health care sharing:

(1) Does it matter to your family that your sharing program does not publish the cost of preventive services? He responded saying, “With five children the demands on my family budget are not restricted to health care. I also have to think about housing, home education, and the children’s sports programs. With health care sharing, we have sufficient health care protection. Our payment arrangement for health care works. Participating in a health care sharing ministry, we have learned the meaning of ‘bear ye one another’s burdens, and so fulfill the law of Christ’ found in the book of Galatians. We can juggle the cost of preventive services as we need them.”

(2) How has your experience been with developing a relationship with doctors and hospitals? “Fine. No access challenges. We can see whomever we would like.”

(3) Have you experienced any large medical bills? “Our largest medical occurred in 2014 when one of my sons had his ACL reconstructed. So far, it has cost \$22,000. And, because I negotiated with my doctors, we recovered enough to cover our personal responsibility contribution through the saving from the reduced medical fees.”

(4) About how much do you spend on health care each year as a family? “HCSM is \$4,860/year. Additional care not shared? Less than \$500/year.”

(5) How has your experience been with negotiation? “Great. Eighty percent of providers have given me a discount. It’s usually been 20-25% of the full retail price. The 20 percent that haven’t discounted is because I haven’t asked because the bill is too small, such as \$17 for a lab test.”

(6) Does the process seem to add considerable administrative burden to your life managing your health care? “It definitely adds to my life. But I do not consider an hour or so once a month per medical event to be burdensome, especially when juxtaposed with the savings I accrue.”

Conclusion to Comparisons between Health Insurance and HCSMs

The task in this section has been to assess the relative difference in affordability between

HCSM programs when compared with health insurance. There is no perfect measurement of comparison given the difference in the benefits available. Although the benefits available under health insurance and sharing ministries significantly differ, the question for the consumer is, “Are the benefits in the sharing ministries more than adequate to meet personal or family medical needs?” Health insurance is not the only pressure on the family budget. Except in extraordinary circumstances, it should not be disproportionate to other pressing demands like education, a home mortgage, meals, and transportation. When these demands compete for dollars in a fixed family budget, it is not unreasonable for individuals and families to benefit from healthy lifestyles and to seek opportunities that allow them to be economically as self-reliant as possible while caring for each other at the same time.

Table IX (next page) supports the general statement that HCSMs provide a viable alternative that supports the integrity of the family budget. It illustrates the extent of saving in simple dollars and cents. The approximate savings vary among ministry plans.

Nuanced differences among the ministry plans offer strategic choices that may fit some individual and family needs better than others. Table IX presents a summary comparison of prices between the ministries and the benchmark insurance plan sold in Central Virginia. One can reasonably expect that there will be differences in insurance pricing across the regions of the U.S. This will alter the amount of savings for these national ministries. In general, however, the sharing plans of all ministries will be significantly less pricey than a comparable benchmark health insurance plan for those regions. Thus, individuals considering a sharing ministry rather than an ESHI plan might see a savings in sharing ministries between \$2,000 and \$5,000 dollars each year. Depending on the ministry, two-parent families might benefit between \$10,000 and \$13,000 annually.

The rough comparison with the benchmark plan sold in the individual market shows similar promise for the sharing ministries. For singles the annual savings might range between \$1,600 and \$4,000. Married couples might see a benefit between \$6,000 and \$7,500 per year.

Single-parent families, who may need the extra cash in the family budget, might see savings opportunities similar to those enjoyed by married couples. Two-parent families might be able to reallocate savings of between \$6,200 and \$9,200 each year. These are sizeable saving whose benefit would be felt monthly to the tune of several hundred dollars.

Table IX Summary Comparison				
Average Annual Premiums & Deductibles for Insurance and HCSMs				
Insurance Plan or Sharing Program	Single	Married Couple	Single Parent with One Child	Two Parents with Children
<i>ESHI (HMO)</i> Total Premium Deductible	\$7,499	<i>(Unavailable)</i>	<i>(Unavailable)</i>	\$19,711
	\$6,223	<i>(Unavailable)</i>	<i>(Unavailable)</i>	\$17,383
	\$1,276	<i>(Unavailable)</i>	<i>(Unavailable)</i>	\$2,328
<i>Anthem Health- Keepers Silver</i> Total Premium Deductible	\$6,450	\$13,024	\$8,072	\$15,436
	\$3,163	\$6,324	\$3,372	\$8,372
	\$3,350	\$6,700	\$4,700	\$6,700
<i>CHM (Gold)</i> Total Contribution Personal Responsibility	\$2,440	\$4,840	\$4,840	\$7,240
	\$1,940	\$3,840	\$3,840	\$5,740
	\$500	\$1,000	\$1,000	\$1,500
<i>Medi-Share</i> Total Contribution AHP	\$4,814	\$6,988	\$6,988	\$9,148
	\$3,564	\$4,488	\$4,488	\$6,648
	\$1,250	\$2,500	\$2,500	\$2,500
<i>SMI</i> Total Contribution Personal Responsibility	\$3,208	\$5,501	\$4,181	\$6,174
	\$2,308	\$4,601	\$3,281	\$5,274
	\$900	\$900	\$900	\$900
<i>CURO</i> Total Contribution Personal Responsibility	\$4,216	\$6,509	\$5,189	\$7,122
	\$3,316	\$5,609	\$4,289	\$6,222
	\$900	\$900	\$900	\$900

Overall, the range of savings appears to be from 45 percent to 60 percent below the cost of health insurance sold in the individual market, depending on the ministry plan selected. The comparisons in Table X (next page) illustrate the savings from HCSMs as a *percentage of the market insurance benchmark*²⁴ for either the ESHI or individual markets. Medi-Share's health ministry

²⁴ The reader can calculate the percentage of savings by subtracting from 100 percent the percentage shown for the insurance rows under each ministry.

Table X: Cost of HCSM to Conventional Health Insurance by Percentage				
	Single	Married Couple	Single Parent with Child	Two Parents with Child
ESHI	\$7,499	Unavailable	Unavailable	\$19,711
Anthem Health Keepers Silver (HMO)	\$6,450	\$13,024	\$8,072	\$15,436
CHM (Gold)	\$2,440	\$4,840	\$4,840	\$7,240
CHM cost as % of ESHI	33%			33%
CHM cost as % of Health Keepers	38%	37%	60%	47%
Medi-Share	\$4,814	\$6,988	\$6,988	\$9,148
Medi-Share cost as % of ESHI	64%			44%
Medi-Share cost as % of Health Keepers	75%	37%	86%	59%
SMI	\$3,208	\$5,501	\$4,181	\$6,174
SMI cost as % of ESHI	43%			31%
SMI cost as % of Health Keepers	50%	42%	52%	52%
CURO	\$4,216	\$6,509	\$5,189	\$7,122
CURO cost as % of ESHI	56%			36%
CURO cost as % of Health Keepers	65%	50%	64%	46%

program for two-parent families, for instance, is 44 percent of the cost of the ESHI benchmark (slightly under half the price) and 59 percent of the cost of the benchmark, Anthem Health Keepers Silver (HMO), sold in the individual market. Two-parent family sharing plans range from 50 percent to 60 percent less than health insurance in the individual market. Single plans fall between 35 percent and 75 percent of the price of the individual market benchmark. Overall, regardless of plan type, health care sharing ministries appear to cost approximately 50% less than the insurance benchmark in the individual market. The caveat is, of course, the underlying assumptions and the trade-off with HCSMs' non-comprehensive, but adequate benefit package.

The sharing ministry's programs for the married couple, single parent, and two parents with children fit this pattern. The single-parent programs are even less expensive, ranging in some cases from 60 to 80 percent less than the benchmark. The exception is the Medi-Share single program. It is about 10 percent less expensive whether compared with the average valued HMO in the ESHI market or the actual priced HMO sold in the individual market. Data for married and single plans in the ESHI market was not available at the time of writing this report.

One question that comes up is why is the difference so significant? An answer to this question is beyond the scope of this report. Suffice it to say that the differential likely rests with the variations in benefit packages, the shift from actuarial rating to community rating, and the distribution effects necessary to expand coverage universally to a U.S. population with very divergent health care needs, all of which are now imposed on the insured populace. It thus remains a real question as to whether the ACA overinsures the vast majority of covered individuals and families.

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