HOW TO CHOOSE THE RIGHT **HEALTH CARE STRATEGY** FOR YOUR **CHURCH OR MINISTRY**

EXAMINING THE BENEFITS AND RISKS OF **SIX POPULAR STRATEGIES**

When it comes to finding a benefit strategy that fits your ministry, you have more choices than at any other time in history. This means employers across all industries are looking outside the traditional insurance box for alternative strategies to provide health benefits to their employees.

But there's a lot at stake when making decisions about your employees' health care. According to the Kaiser Family Foundation, the cost for a typical employer-provided group health plan for a family of four is $22,221 per year — including both employee and employer spending.[1]

To offset these increased costs, employers are looking for relief in many different ways. For example, those who choose to stick with the traditional group health insurance model might pass costs on to their employees in the form of higher out-of pocket costs. They could also offer an HSA-qualified High Deductible Health Plan alongside traditional PPO plans or use Health Reimbursement Accounts (HRAs) to help offset passing along higher out-of-pocket costs to employees.

As a result of this changing marketplace, many churches, ministries and other Christian employers are turning to new strategies to provide health care coverage. **To help you determine the right one for your church, ministry or school, we've outlined the six most common modern health care strategies we've encountered — including both the benefits and risks.**

[1] https://www.kff.org/health-costs/report/2021-employer-health-benefits-survey/

STRATEGY 1: THE MARKETPLACE

It's no secret that the insurance open marketplace took a dramatic turn with the introduction of the Affordable Care Act (ACA) in 2010. As part of the legislation, the ACA introduced both an expanded open marketplace for individuals and the Small Business Health Options Program (SHOP) for small group employers.

THE MARKETPLACE

Many churches and other Christian employers have turned to the Marketplace for individuals (also called the exchange) to find coverage for their teams. There are three types of exchanges for individuals:

- **State-based exchange:** Some states create and operate their own exchanges.
- **Federally facilitated exchange:** Some states choose to allow the federal government to create and operate their exchange.
- **Partnership exchange:** A state and the federal government create and operate the exchange together.

Individuals who are not offered coverage by their employer that is either affordable or of minimum value as defined by the ACA and who meet state and federal residency requirements may purchase coverage through one of these exchanges. They are then able to choose from four levels of available coverage:

- **Platinum:** Benefits on these plans cover at least 90% of the participant's eligible medical expenses.
- **Gold:** Benefits on these plans cover 80% to 89% of the participant's eligible medical expenses.
- **Silver:** Benefits on these plans cover 70% to 79% of the participant's eligible medical expenses.
- **Bronze:** Benefits on these plans cover 60% to 69% of the participant's eligible medical expenses.

Many ministry employees who purchase their health insurance through an exchange also qualify for federal subsidies, which help offset a portion of the cost. The subsidies are calculated using a formula based on your income, ZIP code and family size. In 2021, of the 12 million people enrolled in exchange plans, 88% received premium subsidies — with the average after-subsidy premium paid by those on the exchange plan totaling only $92 per month.[2]

[2] https://www.cms.gov/files/document/health-insurance-exchanges-2021-open-enrollment-report-final.pdf

BENEFITS OF THE MARKETPLACE:

The individual Marketplace can be an important resource for those who do not have access to a group medical plan through their employer.

- Individuals who purchase coverage through the exchange have the option to choose the level of coverage that's right for them.
- Subsidies may be available to those who qualify

RISKS OF THE MARKETPLACE:

The individual Marketplace does have its drawbacks.

- It is a massive resource that can be overwhelming to navigate.
- There is no central source from which to shop for coverage, and it can be challenging to know what to choose.
- Provider networks are typically narrow, making it challenging for individuals to see their preferred provider.
- The enrollment period is limited to October through early December of each year.
- Coverage varies from state to state, so it is difficult to carry a plan from one state to another if you move.

THE SHOP MARKETPLACE FOR SMALL EMPLOYERS

The **SHOP Marketplace** was created for small businesses and nonprofit employers — generally those with one to 50 employees. Some states even allow employers with up to 100 employees to purchase coverage through SHOP. One of the major advantages of SHOP is the ease with which rates are calculated, using a simple formula that analyzes ZIP code and age to determine risk and assign rates.

BENEFITS OF THE SHOP MARKETPLACE:

For employers looking for affordable ways to offer group coverage, the SHOP Marketplace offers many distinct benefits.

- There is no need to wait for open enrollment. Employers can begin offering SHOP coverage to employees at any time of the year.
- Employers can choose to offer multiple plans to their employee group.
- Dental coverage is also available.
- The employer sets the employee eligibility waiting period.
- Churches and ministries could qualify for the small business health care tax credit and premium assistance program and/or receive a tax credit by offering coverage through SHOP.

RISKS OF THE SHOP MARKETPLACE:

The SHOP Marketplace is a valuable resource. However, there are some risks to consider.

- There are minimum employee participation rates for SHOP plans. View this report to learn your state's minimum participation rate.[3]
- There is no centralized place to shop for a plan. Employers looking for a plan must work with a broker or find the plans directly from the individual providers.[4]
- Employers are required to submit a SHOP eligibility determination form to enroll in their plan each year.
- The plans have low participation rates.[5]
- The simplistic rate calculation formula forces younger and/or healthier groups to pay more than their risk level warrants.

FINAL THOUGHTS ON THE MARKETPLACE/SHOP MARKETPLACE

The individual Marketplace is a good option for individuals who are comfortable with the limitations of a narrow network and fewer options. The SHOP Marketplace is a valid choice for ministries who have the time and patience to wade through the options and find a plan that fits their needs.

[3] https://marketplace.cms.gov/outreach-and-education/shop-minimum-participation-rates.pdf
[4] https://healthpayerintelligence.com/news/pros-and-cons-of-small-business-health-options-program-health-plans
[5] https://thebenefitsguide.com/small-business-health-insurance-off-exchange-right/

STRATEGY 2: FULLY INSURED GROUP COVERAGE

The traditional, fully insured group market is dominated by carriers Blue Cross Blue Shield, UnitedHealthcare, Cigna and Aetna. These four carriers provide coverage to 185 million Americans, which allows them to leverage both their size and the strength of their membership to set the standards for much of today's health care. Because of the high number of individuals covered by their plans and the massive amount of premiums collected, any of these four carriers can handle even the unhealthiest group and still turn a profit.

BENEFITS OF FULLY INSURED GROUP COVERAGE:

Enrolling your employees in a fully insured medical plan has many advantages.

- Fully insured plans are available in every state. While the four large carriers are dominant, there are also dozens of regional carrier choices.
- They are the most common form of group coverage in the U.S. Your employees and their medical professionals understand how the plans work.
- There are a multitude of plans from which to choose.
- The carrier assumes all risk and responsibility to pay claims — meaning your group is free of any worry about catastrophic claims.

RISKS OF FULLY INSURED GROUP COVERAGE:

These plans are popular, but they do have some drawbacks, especially for small and nonprofit employers.

- Groups of 50 or fewer employees are subject to community rating, no matter what their individual health experience might be. This could cause some ministry groups, especially those with a healthy employee population, to pay a higher rate.
- Plans are designed for businesses and may not meet the unique needs of ministries.
- The sheer size of the providers prevents smaller group clients from receiving personalized service.
- All plans provide coverage for procedures church and ministry employers find objectionable, such as abortion.

FINAL THOUGHTS ON FULLY INSURED GROUP COVERAGE

Purchasing coverage through a fully insured carrier is safe and easy. The companies have a favorable record of providing solid group medical benefits to large, secular employers. However, ministries and employers with fewer than 50 covered employees may find higher rates, impersonal service and plans that are not a good fit for their specific needs.

STRATEGY 3: SELF-FUNDING

Some ministries have determined the best way to handle the increasing cost of providing health care to their employees is to become a self-funded plan. In this arrangement, the employer assumes responsibility to pay the employees' claims for health care expenses rather than paying those costs through premiums paid to a private insurer.

BENEFITS OF OF SELF-FUNDING:

Employers are drawn to self-funding for a number of valid reasons.

- The employer retains control of every aspect of the plan from design to administration.
- Employers with healthy groups can realize cost savings.
- By not having to prepay for coverage, the employer can see improved cash flow.
- Self-funding gives your ministry the flexibility to build a plan that's customized to meet your needs.
- The employer no longer pays state health insurance taxes. [6]

RISKS OF OF SELF-FUNDING:

The financial benefits of self-funding must be weighed against numerous inherent risks.

- Your benefits staff assumes a heavy workload that includes funding, administration, federal reporting and claims management.
- Employers with self-funded plans are required to set aside reserves to pay claims. The employer generally has to hire actuarial experts to calculate the needed size of the reserve fund and an investment adviser to manage it.
- Employers are required to create their own provider network or pay to participate in an existing network in order to obtain discounts. Those without a network will be forcing their employees to pay full price for health services
- Most self-funded employers must purchase stop-loss insurance coverage to protect themselves from larger claims in excess of their reserves.
- Because managing claims requires a deep level of knowledge of both the medical care and insurance worlds, most employers engage a third-party payer to administer their claims.

FINAL THOUGHTS ON SELF-FUNDING

Because of the financial risks and extra administration involved, only very large employers are successful at self-funding. Groups who choose self-funding and have trained staff to manage the extra administrative duties are often pleased with their coverage. Others who choose this option find they are spending more on plan administration, which is eating away at their overall savings. The self-funded approach makes sense for larger employers because, generally, more employees — especially more healthy employees — spread out the risk and lessen the impact of extremely high claims.

[6]https://www.bbgbroker.com/self-funding-insurance-switch-4-reasons/

STRATEGY 4: LEVEL-FUNDING

Level-funding is a hybrid of self-funding and traditional, fully insured plans. Employers in level-funded plans contract with insurance providers but take on more of the financial risk. Level- funded plans are built on four main components:

- Administrative costs are fixed and charged per employee.
- Individual stop-loss coverage is required to protect the employer from high claims from individuals in the plan.
- Aggregate stop-loss coverage is required to protect the employer from overall high claims against the plan.
- Claims are estimated by the carrier, and that cost is used to calculate the employer's overall premium. If claims are lower than expected, the carrier will generally refund some of the unused funds back to the employer.

BENEFITS OF LEVEL-FUNDING:

Level-funding is a less-common type of group plan that has several distinct advantages.

- Level-funded plans are generally less costly than fully insured plans.
- These plans are less risky to individual employers than self-funded plans.
- Employers have greater flexibility in plan design options.
- Level-funded plans are exempt from some ACA regulations, which lessens the administrative burden.

RISKS OF LEVEL-FUNDING:

However, employers choosing level-funded plans assume several unique risks.

- Carriers can manipulate the definition of claims expenses to benefit their bottom line due to an exemption for these plans from the ACA's medical loss ratio rule, which stipulates that carriers must spend at least 80% of collected premiums on medical care and efforts to improve quality of care.
- Level-funded plans are not subject to ACA minimum coverage rules, which allows them to offer fewer benefits than traditional insurance offerings or self-funded arrangements.[7]
- If the carrier underestimates claims and collects too little premium to cover the costs, the employer will be on the hook to pay back the difference.

FINAL THOUGHTS ON LEVEL-FUNDING

Level-funding is an attractive option for organizations looking for a solution that balances costs and risks. It can work for larger organizations that have a healthy employee group and the financial flexibility to manage this unique hybrid plan.

[7] https://www.griffinbenefits.com/employeebenefitsblog/why-level-funded-health-plans-are-increasingly-popular-among-small-businesses

STRATEGY 5: HEALTH SHARING

Health sharing plans, sometimes referred to as Christian health sharing plans, are organizations that connect like-minded Christians to share the cost of all members' medical bills. Health sharing plans have always been available to individuals, but some churches have recently started offering health sharing plans in lieu of group insurance.

BENEFITS OF HEALTH SHARING:

Health sharing plans have found a market in the Christian world by providing a product that resembles pre-ACA health insurance while also framing themselves as a ministry.

- Monthly shares in a health sharing plan are typically much less than monthly premiums for medical insurance.
- Health sharing plans are legally recognized by the ACA. However, the plans are exempt from many ACA regulations.
- Applicants can join anytime. There is no enrollment period.
- The plans do not include coverage for services that Christians find objectionable, such as abortion

RISKS OF HEALTH SHARING:

Individuals and groups enrolling in health sharing plans must take time to understand the risks associated with them.

- Health sharing plans are not real insurance, and there is no guarantee of payment.
- There is no discounted network of providers. Members are expected to negotiate their own discounts.
- Members must pay their medical bills up front and then request payment from the plan. Reimbursements can take three to six months.
- There is no coverage for pre-existing conditions.
- Membership requirements are restrictive and are limited to those who are professing Christians
- Prescription drugs are not covered by most health sharing plans.
- The cost of monthly shares and, in some cases, the payment of personal medical bills are not tax-deductible.
- There is substantial financial risk for employers who choose to offer health sharing plans in lieu of group coverage.[8,9]

Health sharing plan benefits vary. This is for informational purposes only

FINAL THOUGHTS ON HEALTH SHARING

Health sharing plans should never be mistaken for real insurance. The plans may be an adequate short-term option for those who are healthy and have no other affordable option. There are a few larger churches and ministries who offer these plans in lieu of traditional group plans, but it is a tricky and expensive proposition that is not yet legally tested. Churches and ministries who are pioneering the health sharing plan as group coverage have been surprised by the large financial commitment required to set up reserve accounts and hire additional staff to manage the plan. Additionally, the unregulated nature of these plans makes it impossible to offer side-by-side comparisons of benefits and costs, which can both vary widely among plans.

[8] https://www.healthmarkets.com/resources/supplemental-health-insurance/Christian-healthcare/
[9] https://www.guidestoneinsurance.org/-/media/Insurance/LifeConversionForms/Christian_Sharing_Ministry_Comparison_Group.pdf

STRATEGY 6: CHURCH HEALTH PLAN

A church health plan is established and maintained for its employers by a church, a convention or an association of churches. These plans offer true group medical coverage to employers who meet certain parameters. GuideStone® is a church health plan that was originally chartered by the Southern Baptist Convention and has since expanded to offer coverage to the wider evangelical community.

BENEFITS OF HEALTH SHARING:

Church health plans take the unique needs of ministry into consideration.

- Church health plans can be a lower-cost option.
- Smaller churches may be able to obtain group rates that are unavailable to them in the larger market.
- These plans are created specifically for churches and ministries by organizations that understand their unique structure.
- Most church health plans are self-funded, which allows ministries associated with them to have the opportunity to reap the benefits of self-funding without assuming the risks of individual self-funding.
- Church health plans have greater flexibility in calculating rates, which will benefit healthy groups.
- The plans are created to reflect biblical values, so a Christian organization's benefit dollars do not go toward funding abortions.
- Church health plans bring together benefits from a number of providers to create their plans, allowing them to offer the best of the best.

RISKS OF HEALTH SHARING:

Church health plans are a unique product with a few minor risks.

- Organizations that are used to dealing directly with their benefits provider may feel that the church health plan is an unnecessary middleman.
- There may be fewer plan options from which to choose.
- Church health plans offer less flexibility than self-funding.
- Not all churches, ministries and Christian organizations will meet the eligibility requirements for church health plans. For example, GuideStone plans are open only to evangelical churches and ministries.

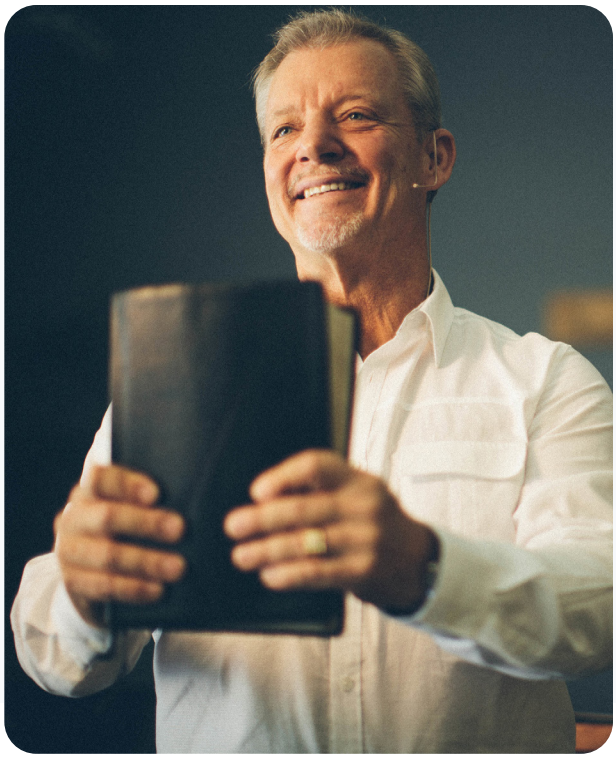
FINAL THOUGHTS ON CHURCH HEALTH PLAN

Church health plans are a unique niche in the overall employee benefits market. These plans harness the power of multiple organizations to create a group plan for churches and ministries of all sizes. This allows larger church and ministry groups to offer health plans that limit coverage for biblically unsound practices, such as abortion. Through a church health plan, smaller employee groups will have access to group health plans unavailable to them in the greater marketplace. While church health plans are not right for every organization, they can be a good fit for many churches, ministries and Christian organizations.[10]

[10] http://chirblog.org/church-plans-and-health-care-sharing-ministries/

WHICH STRATEGY IS RIGHT FOR YOUR CHURCH OR MINISTRY?

No matter your ministry's makeup and budget, one of these strategies ticks off all the checkboxes on your medical plan checklist. The most important thing is to investigate all the options and truly understand the benefits and risks associated with each strategy — then choose the one that most closely aligns with the needs of your organization. Of course, this is a high-level overview of some of the most common benefit strategies for churches and ministries. Given the fluctuating nature of the modern health care market, new strategies are sure to emerge as innovative organizations try to balance the cost and delivery of health care benefits.



A WORD FROM GUIDESTONE

At GuideStone, we are committed to providing churches, ministries and organizations quality health plans and related employee benefits that are cost-effective and allow you to honor your biblical convictions regarding the sanctity of life. We monitor trends and actively seek out options that will make our health plans stronger. If you have questions about your existing plan or would like to know more about the strategies outlined here, visit us at GuideStone.org to learn more and request a consultation with a GuideStone expert.

GuideStone.org/HealthPlans

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