## What is Health Sharing?

Health sharing is where individuals join together through a common bond or belief, and voluntarily share the cost of each members' medical expenses. The organization's membership guidelines spell out the rules. Most Health Sharing Organizations (HSOs) are nonprofit corporations sponsored by religious organizations.

**Health sharing is not insurance**. It is an alternative to insurance. It functions very much like insurance, but using insurance terms to describe it is taboo; maybe even illegal. And for the HSO, they don't want anything to do with insurance regulation. Most HSOs are careful about the terminology they use to explain their health care sharing operations. Some seem more concerned about this than others. You will notice varying degrees of similarity between their operations and those of an insurance company. They all use non-insurance terminology and all are very clear with disclaimers saying:

- Their services are not insurance.
- Their guidelines are not a contract.
- They aren't responsible for paying anything.

While they may sound a lot like an insurance company on the surface, the real differences are a little deeper.

Most HSOs only sell individual memberships, although Sedera Health and Aliera are two HSOs that offer group coverage for employers. This offers small companies alternatives to expensive small group insurance plans while still allowing their employees some level of coverage.

## How is Health Sharing Different from Insurance?

For starters, let's look at some of the terms HSOs use to describe their services. Below is a translation chart converting some of the HSO lingo into insurance terms.

| HSO Lingo | Insurance Term |
|---|---|
| Share, Contribution, Contribution Amount, Monthly Contribution Request, Monthly Share Amount, Monthly Membership Amount | Premium |
| Initial Unshareable Amount, Individual Sharing Amount, Member Responsibility Amounts, Annual Household Portion, Annual Unshareable Amount | Deductible |
| Need, Medical Need, Eligible Event, Eligible Sharing Need, Incident | Claim |

## Difference #1 – Transfer of Risk

Transfer of risk is the key difference between health sharing and health insurance. When you buy a policy of insurance you are transferring the risk of loss to the insurance company. They become responsible, by contract, for paying the benefits detailed in your policy.

HSOs, on the other hand, are not responsible for paying benefits, the members are. But members aren't contractually obligated to pay for anything. If your eligible expenses go unpaid, you have no legal recourse. Participation and payment are voluntary, but if you don't pay in your "contribution" you aren't eligible to have your "needs" shared among the community. So with HSOs, there's no transfer of risk. The HSO is not a risk taker. They're like a third-party administrator who manages enrollment, processes "medical needs", and runs the day to day operations.

While this idea may give you pause, and it should, there are a few HSOs that are well known for managing the members' money well and taking care or claims.

Christian Healthcare Ministries addresses this issue directly in their Member Guidelines:

Sometimes people question how we can be sure our members will honor their commitment to carry each other's burdens. We point to our history: Since 1981 CHM members have faithfully shared eligible medical needs.

### Difference #2 – Funds Administration

Some HSOs don't ever handle their member's money. In those cases, the HSO tells each member how much (up to their monthly contribution limit) to send, and to which member. In other words, members send money directly to other members to reimburse them for their covered expenses.

Other HSOs collect the monthly contributions, process the benefit requests and reimburse their members directly through an escrow account, more like a traditional Third Party Administrator (TPA). This is a much better way to manage the payments. Some HSOs even go as far as paying providers directly. While this may seem like a better option, these HSOs tend to have a poor reputation and are rarely accepted by providers due to their drawn out payment process (we will talk about reimbursement later)

### Difference #3 – Regulation

One of the reasons Insurance tends to cost more than an HSO is that insurance companies are strictly regulated and must maintain specific financial standards. There are several regulations insurance companies have to follow in order to protect their consumers. They're required to maintain a minimum amount of capital to support their risk-taking activities. This is called Risk Based Capital (RBC) and it's the way regulators measure the amount needed to support their overall operations. Each state also has guaranty association funds to pay claims if the insurance company becomes insolvent and is forced into liquidation. Insurance companies pay to help support these association funds.

Since neither state nor federal government regulates HSOs as insurers, they don't have to comply with state insurance laws. There's no financial oversight, and since they aren't responsible for paying the benefits, they have little financial risk. If the total membership contributions aren't enough to meet member needs, they can either increase the contribution amounts or simply not pay the full balance of claims for the year. Their members will have to make up the difference on their own. Again, certain HSOs manage this better than others and have a better reputation because of it.

If you choose to go with an HSO for your insurance needs, you need to understand the risks. There are no regulators you can go to if your "needs" go unpaid, despite the fact that you've paid your "share" to help others. The

operating history of the company, and the integrity and experience of their executives, is critical. Make sure the company you choose to go with has a good history of managing these things well on their own.

Staying out of insurance and insurance regulations helps keep costs low for HSOs. They have very low operating costs compared to insurance companies and, because they aren't assuming financial risk of medical needs, they are able to keep the monthly costs low for their members.

### Difference #4 – Payment to Providers

Members of an HSO are self-pay customers. They are uninsured. For the members, this is a good thing. Why? Because it forces them to be actively involved in the treatment they receive and how much those services cost. Research has proven that getting individuals involved in the utilization and cost improves medical care and lowers the expense.

For the health care providers this can be a double-edged sword. On the one hand, they don't have to deal with the paperwork, payment delays, and post-payment audits required by their contracts with insurance companies. Many health care providers like dentists and chiropractors have actually quit accepting insurance due to the expenses of working with insurance companies. This gives consumers power of negotiating cash-pay rates for their medical expenses. On the other hand, providers have collection issues because they are dealing with individuals who typically don't have the money to cover the costs up front. They then have to manage payment plans and additional billing themselves. Some consumers on HSOs may even choose to do something else with their reimbursement than make final payment with the providers. This has led many providers to not accept HSOs.

Most HSOs don't use provider networks. As a self-pay customer, members are able to use whichever providers they want. However, some HSOs will review and negotiate the medical bills for their members.

Some HSOs do utilize a provider network in order to help reduce out-of-pocket costs to their members. These HSOs issue ID cards to their members in order to give them access to network providers.

Here is the explanation for how benefits get paid from the Altrua 2019 Membership Guidelines

Members do not file claims, nor does Altrua HealthShare handle claims. A "claim" suggests there exists an entitlement to other's money. Altrua HealthShare processes medical needs for sharing among the membership. Your medical provider may submit your medical need by using the instructions on the back of the member ID card. Once the medical need is received and deter- mined eligible for sharing, the medical need is adjudicated, and MRAs are applied. The membership will send your provider a check for the shareable amount. These funds are issued from the members' monthly contributions held in the membership escrow account.

This set-up allows providers to submit bills directly to the HSO. However, as explained before, some members may choose to use the reimbursement funds for other purposes instead of paying the medical bill. This has caused some providers to shy away from these types of HSOs. But just because HSOs don't have networks doesn't mean they don't work to control medical costs. They help their members navigate the health care system by finding the best provider, negotiating the cost ahead of time and avoiding unnecessary procedures. If services are received before contacting the HSO they will work with the provider to get the self-pay cash rates.

### Difference #5 – Reimbursement and Up Front Cost

With Insurance, when you provide your ID card to a medical provider, they are contacted with your insurance company to collect payment (minus co-pays, deductibles, and coinsurance) from the insurance company. They are paid directly by the insurance company and any remaining balance is billed to you after the fact.

HSOs work differently. Because they are not an insurance company and are not assuming any financial risk on your behalf, HSOs deal directly with you, not the medical provider (Although we already discussed how some HSOs will help negotiate prices for you). Once a claim is submitted, instead of paying the provider directly, they send a reimbursement directly to the member for the amount that was successfully shared.

This process takes time. Reimbursement can sometimes take upwards of 6 months before the full amount is received by the member. This means both the member and the provider are waiting this entire time. This is another reason some providers are turned off to HSOs. As a result, many providers will require the member to go on a payment plan which contacts them to pay a certain amount monthly until the bill is paid in full. This can sometimes be used to your advantage, however, as many medical providers will give an additional discount if you pay your bill in full after being on a payment plan for a while in order to close out the bill quicker, leaving funds in excess of the reimbursed amount. Most will put these excess funds into a savings account to pay for future medical expenses while waiting for reimbursement from their HSO.

As a cash pay patient, many providers will require an upfront cost. For simple medical expenses such as doctor visits, many providers offer a cash-pay rate comparable to an insurance co-pay. With more major medical expenses such as surgeries, most medical providers will require anywhere from 10%-25% of the total procedure cost up front before even scheduling the procedure. This means, working with an HSO, you will need to have money set aside for these upfront costs. Some people use a credit card or even have a savings account set aside for these expenses.

## How do Healthshare Benefits Compare to Health Insurance Benefits?

HSOs, in a certain respect, provide more coverage than health insurance when it comes to the things they actually cover, but health insurance covers a lot more situations. In addition, most health insurance has no maximum payable amount since the ACA. This means, once your max out-of-pocket is met, all remaining expenses for the year are 100% covered. Most HSOs have a maximum annual amount they will cover (usually between $150,000-$200,000), although there are a few that offer options to make this amount unlimited (CHMs Brother’s Keepers Program paired with their Gold level plan). Even if you have an HSO that gives unlimited coverage, you should still consider their guideline that states,

“There is no guarantee of payment” as well as the regulations in place with insurance companies requiring them to maintain accounts to make payments. Even with unlimited coverage on an HSO, share amounts can be limited by how much is contributed by its members.

HSO unshareable amounts (deductibles) and the contributions (premiums) tend to be much lower than health insurance. Unshareable amounts are based on a need, not visits. When compared to co-pays, deductibles and coinsurance, a minor health event will cost you less out of pocket than a high deductible health plan. Here’s an example from Sedera Health.

**Example:** *The McMahon family has a one year old child suffering from persistent ear infections. Their health plan had a deductible of $5,000 per family member. Care for their child required a series of antibiotics & booster injections and a visit with an ENT specialist who inserted tubes in the child’s ear at a local hospital. Here’s how that need looks in their Health Insurance plan vs. Sedera’s Medical Cost Sharing model:*


The McMahon’s experienced **over $2,000 in savings** for their child’s illness!

In this example, the overall out-of-pocket would be less than traditional insurance. Remember, however, that the shared expenses could take up to 6 months to be shared and will likely require an up front payment from the family. Also, the cash-pay rate for the surgery will be higher than the rate negotiated by the insurance company. Although, the cost of the surgery will

eventually be shared, the family can expect to see an initial out-of-pocket of $1000-$3000 with all but $500 being reimbursed.

Another way HSOs reduce the risk of paying claims is to ask health questions as part of their underwriting. They either exclude or significantly limit the coverage for applicants with certain serious medical issues, like cancer and diabetes. Some apply surcharges for being overweight and for smoking, and they all limit coverage on pre-existing conditions. HSOs also have an extensive list of exclusions which will not be covered regardless of when they occur. With most health insurance today, pre-existing conditions are covered regardless and exclusions to coverage are less extensive.

HSOs have varying annual limits, lifetime maximums and sub-limits for certain procedures like organ transplants, and conditions like pregnancy. Kingdom Healthshare limits maternity coverage to $5,000 on their best plan, with no coverage on their other two plans. Christian Healthcare Ministries (CHM) has a max benefit of $125,000 as long as you joined 300 days before the doctor's estimated due date. Another exception is Sedera Health. They don't have either an annual limit or lifetime maximum – other than a rule that a need can't take up more than one third of the total funds available for sharing. This means anything above ⅓ of all membership contributions will be out-of-pocket for members on their plan

CHM also has a "catastrophic bills program" called Brother's Keeper. If you enroll in their Gold Program and sign up for this deal, then the sky's the limit – actually there's no limit – you get unlimited sharing. Again, this is limited by the amount of funds available.

One great feature you can find in some HSOs is the non-resetting unshareable amount. It resets based on a need, not the calendar. In other words, if you have a need that crosses calendar years (Such as cancer), you don't have to come up with the unshareable amount for expenses related to that need just because it's a new year. That's a big deal, since a late in the year emergency could cost you twice your deductible with

traditional insurance. With a health share plan there's no reason to rush into a last-minute knee surgery and ruin your holiday.

## What are the Risks?

The overriding risk of an HSO is their financial viability. They might not have enough money, at any given point, to pay everyone's eligible expenses. The HSO could go out of business leaving you to pay costs that would otherwise be covered, even though you've paid all of your contributions on time.

To illustrate, let's look at Liberty HealthShare's annual audited financial statements.

These numbers are from their 2017 statements. Member dues were $58.5 million – these are not the member's sharing funds. Dues are the non-profit's operating income. Member contributions are not part of the assets of the non-profit, so those figures are not carried on Liberty's financial statements. The member sharing funds are accounted for at a very high level in the Notes to Financial Statements.

At the end of the year, the non-profit entity had $1,574,771 in assets, which is comprised of cash and accounts receivable (AR) – the AR being $172,138 of that. But that's not the member's money and Liberty has no obligation to the members for paying shareable expenses with those assets.

Funds contributed by members totaled $167.2 million and amounts shared were $168.3 million. Yes, they paid out more in shareable expenses than the members paid in contributions. Luckily, they had a cash balance of $2.7 million in member's contributions at the beginning of the year. That leaves a cash balance to start 2018 of $1.6 million. Another year like 2017 and Liberty will have to increase member contributions just to break even.

Another risk with HSOs is the risk of up front cost and financial liability of the member. As discussed, as a cash-pay patient, all medical expenses are your responsibility in entirety. Any up front costs required by the provider will be out-of-pocket until the HSO reimburses any shareable portion of it. In the event the HSO does not reimburse the expense, there is no recourse and the member remains the responsible party to pay the expense.

## So is it worth Sharing?

In the end, the choice is up to you. HSOs provide a very inexpensive alternative to health insurance. As long as you understand the risk involved and are willing to assume that risk, Health Sharing can be a great option for you. Do your research to understand the company you are partnering with and understand that, many of the protections in place for consumers in the health insurance industry simply do not exist with HSOs, so choose a company that has a good track record for handling those things that aren't being regulated.