ISSUE BRIEF
AUGUST 2018

Health Care Sharing Ministries: What Are the Risks to Consumers and Insurance Markets?

JoAnn Volk
Research Professor
Georgetown University Center on Health Insurance Reforms

Emily Curran
Research Fellow
Georgetown University Center on Health Insurance Reforms

Justin Giovannelli
Associate Research Professor
Georgetown University Center on Health Insurance Reforms

ABSTRACT

ISSUE: Health care sharing ministries (HCSMs) are a form of health coverage in which members — who typically share a religious belief — make monthly payments to cover expenses of other members. HCSMs do not have to comply with the consumer protections of the Affordable Care Act and may provide value for some individuals, but pose risks for others. Although HCSMs are not insurance and do not guarantee payment of claims, their features closely mimic traditional insurance products, possibly confusing consumers. Because they are largely unregulated and provide limited benefits, HCSMs may be disproportionately attractive to healthy individuals, causing the broader insurance market to become smaller, sicker, and more expensive.

GOAL: To understand state regulator perspectives on regulation of HCSMs and the impact of these arrangements on consumers and markets.

METHODS: Analysis of state laws governing HCSMs in all states; interviews with officials in 13 states; and review of the membership requirements and benefits of five HCSMs.

FINDINGS AND CONCLUSIONS: State regulators voiced concerns regarding the potential risks of HCSMs to consumers and their individual markets. However, in the absence of reliable data describing HCSM enrollment, regulators cannot adequately assess harm. Though limited resources and political constraints have made oversight difficult, all states, regardless of their regulatory approach to HCSMs, should obtain data to better understand the role of HCSMs in their markets.

KEY TAKEAWAYS

- Regulators lack data to assess health care sharing ministries' role in their states and may be constrained in their options for addressing regulatory concerns and consumer complaints.
- Many HCSMs use features that are very similar to insurance and may therefore mislead consumers into thinking they are enrolling in coverage that guarantees payment for a covered claim.
- If HCSMs draw healthier individuals out of the ACA-compliant market, it will help create smaller and sicker risk pools in that market, with higher premiums and fewer plan choices.

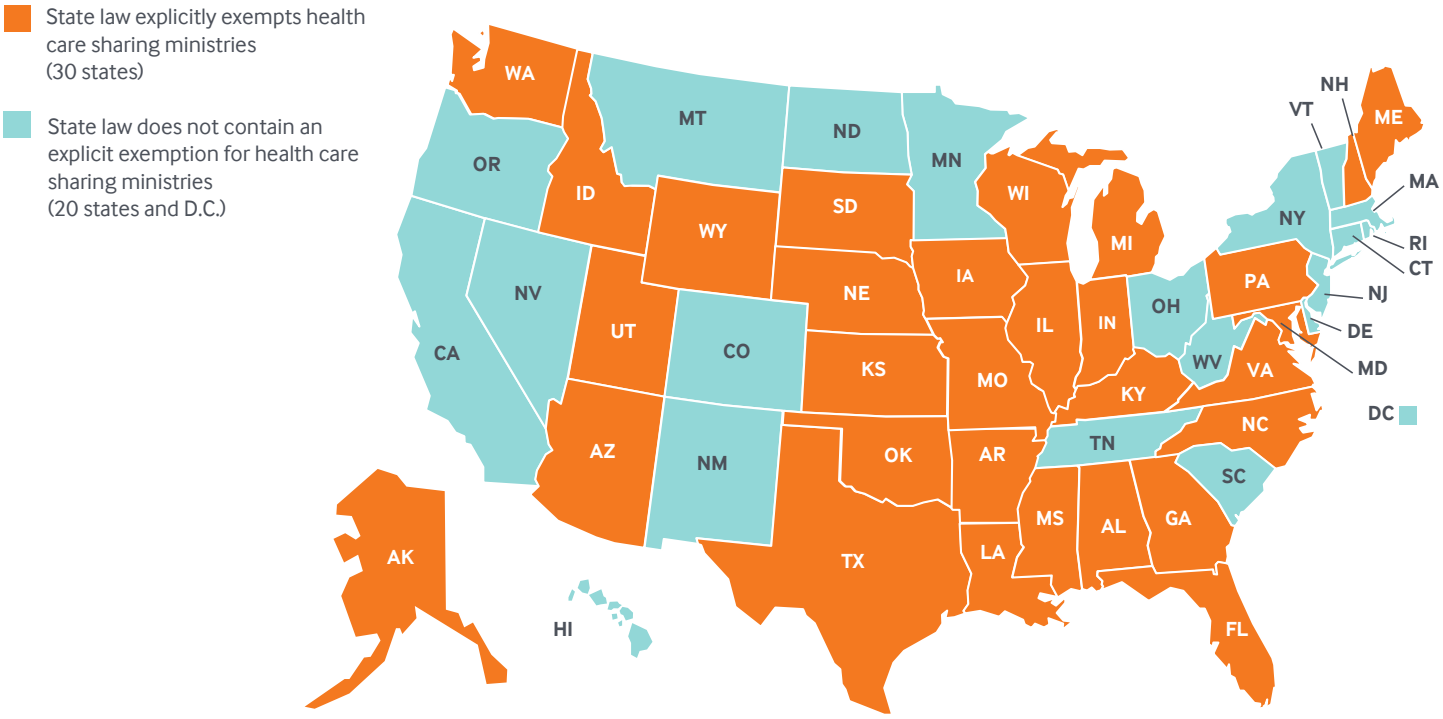
1918 2018 The Commonwealth Fund
A Century of Advancing Health Care for All

BACKGROUND

In a health care sharing ministry (HCSM), members follow a common set of religious or ethical beliefs and contribute — typically monthly — a payment, or share, to cover the qualifying medical expenses of other members.[1] An HCSM will then either match paying members with those who need funds for health care costs or pool all of the monthly shares and administer payments to members directly.[2] HCSMs have long maintained that they are not health insurance companies and do not guarantee payment for members' medical claims.[3] Since they do not meet the federal definition for health insurance, they are not subject to the consumer protections of the Affordable Care Act.

Under the ACA, members in HCSMs are exempted from the federal individual mandate, but the law does not dictate whether and how states may regulate them.[4] In particular cases, courts have concluded that HCSM practices constitute the business of insurance, but no state currently treats these entities as insurers.[5] Thirty states have enacted "safe-harbor" rules that exempt HCSMs from state insurance regulation (Exhibit 1, Appendix 1). Under the safe harbor, as long as an HCSM meets the requirements of the exemption, such as providing a written disclaimer and a monthly statement of member payment requests and contributions, it is, by definition, not engaged in the business of insurance and cannot be required to comply with standards and requirements otherwise applicable to health insurers.

Exhibit 1. State Laws Governing Whether Health Care Sharing Ministries Are Exempt from State Insurance Codes, 2018



Data: Authors' analysis of state laws governing health care sharing ministries.
Note that states that have not explicitly exempted health care sharing ministries from the state insurance code do not necessarily regulate them.

HCSMs have long been an alternative for certain religious communities that object to traditional insurance. The arrangement allows them to share health care cost burdens. Since the passage of the ACA, HCSMs have been marketed more broadly, reaching people who otherwise might not have considered membership.[6] While HCSMs may provide value for some people, they also have the potential to create confusion for others, as they closely mimic traditional insurance products, but do not provide the same consumer protections.[7] Most HCSMs require payments resembling deductibles, monthly premiums, and copayments, and define a benefits package. Many use provider networks, while some pay broker commissions for selling memberships or offer tiers of coverage similar to ACA-compliant products (i.e., gold, silver, and bronze plans).[8] At the same time, because HCSMs are not required to comply with the ACA's consumer protections, coverage for preexisting conditions may be limited or excluded, medical benefits are typically far more limited than in ACA-compliant plans, and members are never guaranteed payment, even for covered services.[9] As with other arrangements that pair low monthly payments with limited benefits, like short-term plans, HCSMs pose a risk of attracting a disproportionate share of currently healthy individuals. If HCSMs draw these consumers out of the ACA-compliant market, they help to create smaller and sicker risk pools in that market, with higher premiums and fewer plan choices (Exhibit 2).

Exhibit 2. Consumer Protections in ACA Plans Compared to Health Care Sharing Ministries

Consumer protection	ACA plans	HCSM coverage
Includes coverage for preexisting conditions?	Yes	Not usually. Most HCSMs will share costs for preexisting conditions only if the condition was cured and a year or more has passed without symptoms or treatment (e.g., Samaritan Ministries: for heart conditions, enrollee must be symptom/treatment free for five years).
Bans charging higher rates based on health status?	Yes	No. HCSMs may charge a higher rate based on health status and some will deny membership to those who can't pass a medical screen (e.g., Medi-Share Christian Care Ministry: members are required to enroll in higher-cost membership level if they experience significant weight gain).
Covers essential health benefits?	Yes	No. HCSMs do not have to comply with any health benefit requirements and usually exclude treatment for mental and behavioral health and substance use disorders, and preventive and wellness services; and limit or exclude prescription drugs, in addition to other restrictions (e.g., Christian Healthcare Ministries: silver and bronze members cannot submit any prescriptions or doctors' bills, except doctors' bills incurred while a hospital inpatient or outpatient).
Covers benefits without dollar caps on health care services?	Yes	Not usually. Several HCSMs set monthly, annual, and lifetime limits on coverage (e.g., Altrua Ministries: members enrolled in bronze plans have a lifetime limit of $1,000,000 and a $50,000 limit per calendar year).
Caps out-of-pocket expenses for consumers?	Yes	No. HCSMs often limit the amount members can share and members are responsible for bills exceeding that limit; no HCSM guarantees payment for bills, even those eligible for sharing (e.g., Sedera Health: in months where needs exceed shares, members may only receive a prorated amount of funds needed).

Data: Review of the guidelines of five health care sharing ministries: Altrua HealthShare, Christian Healthcare Ministries, Medi-Share Christian Care Ministry, Samaritan Ministries, and Sedera Health. For more information, see Appendix 2.

Though HCSMs have grown in popularity and sophistication, consumers' experiences with them and HCSMs' effects on the traditional insurance markets are not well understood.[10] We gathered state regulators' perspectives on the regulation of HCSMs and data on the impact of these arrangements on consumers and insurance markets. We interviewed officials in 13 states and also examined membership requirements and coverage options offered by five HCSMs (Appendix 2).[11,12]

FINDINGS

Regulators Lack Data to Understand HCSM Operations and Impacts

None of the officials we interviewed could say for sure which HCSMs are active in their state or how many individuals are enrolled. Given that HCSMs are typically unregulated and unlicensed, officials have understandably found it difficult to gain even basic information about them. Often, officials become aware that an HCSM is operating through consumer, broker, or provider complaints. Respondents said that such complaints have been rare, but also said that few consumers are aware of the option to complain to state insurance regulators.[13] A few states learned of HCSMs when the groups started actively marketing following the implementation of the ACA. Others noted an uptick in marketing during the latest open-enrollment period. States found this to be particularly concerning and received an increase in consumer calls during this time, mostly from people who incorrectly believed they had purchased insurance. Aside from anecdotal evidence, states report that they have few avenues for identifying HCSMs in their areas; as one respondent lamented, "they operate [without oversight] until we find them."

Since enactment of the ACA, enrollment in HCSMs has reportedly spiked, growing from fewer than 200,000 before 2010 to perhaps 1 million today.[14] These estimates are self-reported; there are no independent data available to identify either national or state-level membership. Six states require HCSMs to issue annual audits to comply with their safe-harbor rules, but these reports are limited in scope and do not include enrollment numbers. Some states have attempted to gauge HCSM popularity by tracking local news reporting, combing through HCSM newsletters, or using an HCSM's total reported medical cost needs and expected member "shares" to infer potential enrollment. In one instance, a state obtained enrollment data directly from an HCSM that is cooperating with an investigation into deceptive broker practices. Aside from these ad hoc approaches, respondents said they have no mechanisms for soliciting information. Many suspected that enrollment is growing based on the number of consumer inquiries, prevalence of HCSM advertising, and sporadic news reports.[15] However, no state can pinpoint this trend definitively.

Marketing and Insurance Features Contribute to Consumer Confusion

Nearly all respondents believed at least one HCSM was operating in their states. Most expressed concern that some appeared to be functioning in ways that differed from their original intent. Nearly all respondents who noted such concern said that many HCSMs use features that are very similar to insurance and may therefore mislead consumers into thinking they are enrolling in coverage that guarantees payment for a covered claim. Respondents noted that HCSMs have a defined monthly contribution and claims are reimbursed according to a schedule of payment for specific benefits, akin to an insurance contract that requires premiums and pays claims based on covered benefits. Features such as preferred provider networks and marketing during open enrollment — sometimes with the help of paid brokers — also contribute to consumer confusion. A few also noted that some HCSMs were marketing to employer groups — in one case, to a municipal government plan — an approach one respondent suggested was "antithetical to the concept" of the HCSM arrangement.

A Potential Driver of Market Segmentation

In states with active HCSMs, some respondents voiced concerns about the potential for the arrangements to draw healthy individuals from the ACA-regulated market.

Generally, respondents suggested there could be risk of market segmentation in the future. Most speculated that membership was too low to have much of an impact; others said that the HCSMs were likely attracting people who have already been priced out of marketplace coverage because they don't qualify for premium subsidies. Alaska stood out as an exception. Regulators said health care sharing ministry membership is significant (estimated at about 10,000) in the state relative to the individual market (20,000).[16] If affordability remains a problem, regulators said that membership in HCSMs could grow big enough to potentially adversely affect the individual market risk pool, particularly in conjunction with other non-ACA coverage options, such as short-term and association health plans, that are expected to draw greater enrollment.

States Can Perform Oversight, but Options Are Constrained

Whether or not a state has exempted HCSMs from insurance regulation, regulators may act under certain circumstances to safeguard consumers. Four respondents from states with safe-harbor rules said a threshold consideration was whether the HCSM was in compliance with their safe-harbor criteria. For example, if an HCSM fails to provide required notice to consumers or violates the condition to have a religious component, respondents said they would review the HCSM for activity indicating it was doing business as an unlicensed insurer. One state issued a cease-and-desist order for an HCSM that failed to comply with the religious component of their state's safe harbor, rendering membership marketing comparable to doing business as an unlicensed insurer. But short of finding an HCSM out of compliance with the safe harbor, regulators were reluctant to take action against it.

Regardless of a state's safe-harbor status, if a broker misrepresents that an HCSM is insurance or claims that it provides a guarantee of payment, states have the tools and authority to act. Respondents pointed to the state's authority under their unfair trade practices statutes or a broker suitability standard, which requires brokers to ensure a product is appropriate for a consumer's needs.

One state in this study is working with an HCSM to rein in deceptive broker activity, while others suggested they could refer fraudulent activity to the state attorney general for investigation and potential action.

But most respondents said their options for addressing regulatory concerns and consumer complaints are limited, even in states unconstrained by a safe harbor. One respondent, from a state without a safe harbor, investigates consumer complaints for unpaid claims, but lacks authority to compel an HCSM to respond unless there is evidence of fraud. Other respondents in safe-harbor states suggested it could be difficult for regulators to exercise oversight if legislatures have afforded HCSMs a wide berth. Political support for HCSMs and resource constraints have limited their options for intervening, respondents added.

Some regulators described a reluctance to pursue action without consumer complaints demonstrating harm and noted that even incremental or preliminary action can be met with strong opposition. Regulators in one state had begun taking action against an HCSM for doing business without obtaining a license, but the legislature responded by passing a safe harbor. Another respondent said that legislation to strengthen their safe harbor's notice requirement had been defeated, making regulators doubtful they could obtain even modest protections for consumers. Following regulatory scrutiny of an HCSM's operations, a third state's legislature expanded the definition of HCSMs exempt from state regulation, making the HCSM's operations legal under the revised safe harbor definition.

DISCUSSION

Some individuals may find value in HCSMs and view them as an alternative to ACA coverage. In particular, for consumers who do not receive marketplace subsidies, HCSM have lower up-front costs. Yet these arrangements carry risks. They may produce unforeseen consequences for members who do not understand what they are buying and who find coverage too skimpy to cover their costs. In addition, consumers in the ACA-compliant market will

experience rising premiums and fewer plan choices if HCSMs and other alternative coverage options undermine the risk pool. But it has been difficult to evaluate how these arrangements have worked in practice, given competing priorities, limited resources, and political constraints. In the absence of reliable data on HCSM enrollment, state regulators cannot adequately assess the potential effects on consumers or their individual markets.

At least one reason people consider HCSMs for coverage — lower up-front costs than ACA plans — will likely persist, and increasingly broader marketing of these arrangements can capitalize on that to drive even greater enrollment. In light of the expansion of non-ACA-compliant plans available to individuals buying coverage,[17] all states, regardless of whether they have a safe harbor for HCSMs, should collect data — for example, by using audits to obtain membership numbers or monitoring the use of brokers — to better understand the scope and magnitude of HCSMs in their states. States without an exemption may want to go further and review the regulatory framework under which HCSMs operate.

While HCSMs may have previously served a niche market — providing some financial assistance for people who share religious beliefs — many have transformed to give the appearance of traditional insurance. As these entities grow, so too do the risks of consumer confusion, financial exposure, and market segmentation. States should more closely scrutinize whether these arrangements are hewing to their original purpose and the role HCSMs play in a regulated market.

NOTES

1. Defined in 26 U.S.C. § 5000A(d)(2)(B) (2012). The information and examples provided in this report are based on a review of the guidelines of five health care sharing ministries. Four ministries attest that they meet the ACA exemption: Altrua HealthShare, Christian Healthcare Ministries, Medi-Share Christian Care Ministry, and Samaritan Ministries. The fifth, Sedera Health, specifically markets to small employers. The Alliance of Health Care Sharing Ministries, a trade group representing Samaritan Ministries, Medi-Share Christian Care Ministry and Christian Healthcare Ministries, reports that these three ministries represent the largest enrollment in the United States. See Altrua HealthShare, *Membership Guidelines* (Altrua, Jan. 2018); Christian Healthcare Ministries, *Guidelines Version 1, 2018* (CHM, 2018); Medi-Share, *Program Guidelines and Frequently Asked Questions* (MediShare, Nov. 2017); Samaritan Ministries, *Guidelines for Health Care Sharing* (Samaritan, July 2018); and Sedera Health, *Select Membership Guidelines* (Sedera, Mar. 2018).

2. See note 1.

3. See note 1.

4. Defined in 26 U.S.C. § 5000A(d)(2)(B) (2012).

5. See, e.g., Rowden v. American Evangelical Association and its Division of Christian Care Ministry d/b/a Medi-Share, Montana First Judicial District Court, Order on Various Motions, Cause No. BDV-2006-109, Jan. 2007; Commonwealth of Kentucky, Appellant v. E. John Reinhold (d/b/a American Evangelistic Association), Medi-Share, and Christian Care Ministry, Appellees, No. 2008-SC-000839-DG.

6. Kimberly Leonard, "Christians Find Their Own Way to Replace Obamacare," *U.S. News & World Report,* Feb. 23, 2016.

7. See note 1.

8. We use the term "broker" to include licensed insurance agents and producers. See Tony Leys, "More Iowans Opting for 'Health Sharing Ministries' as Alternative to Increasingly Pricey Insurance," *Des Moines Register,* updated Dec. 10, 2017.

9. See note 1.

10. Laura Santhanam, "1 Million Americans Pool Money in Religious Ministries to Pay for Health Care," *PBS News Hour,* Jan. 16, 2018; Laura Turner, "There's a Christian Alternative to Health Insurance, But It's Not for Everyone," *BuzzFeed News,* June 1, 2017; and Leonard, "Christians Find," 2016.

11. See note 1.

12. We interviewed nine states with safe harbor laws — Alaska, Florida, Maine, Nebraska, New Hampshire, Pennsylvania, Texas, Utah, and Washington — and four states that do not have a safe harbor law — Massachusetts, Minnesota, Rhode Island, and West Virginia. Our study states draw more heavily from those with a safe harbor since they represent the majority of states and were chosen to represent geographic diversity.

13. A 2015 survey by *Consumer Reports* found that 87 percent of privately insured Americans were unaware of what agency or department in their state is tasked with handling complaints about health insurance and 83 percent have never complained to a government agency about any issue ever. See Consumer Reports National Research Center, "Surprise Medical Bills Survey," *Consumer Reports,* May 5, 2015.

14. See note 1.

15. See, e.g., Stephanie Armour, "More People Turn to Faith-Based Groups for Health Coverage," *Wall Street Journal,* Jan. 4, 2016.

16. Figure reflects state-reported data. See also Annie Feidt, "Alaskans Opt Out of Insurance, Turn to Health Care Sharing Ministries," *Alaska Public Media,* Nov. 9, 2015.

17. Kevin Lucia et al., *State Regulation of Coverage Options Outside of the Affordable Care Act: Limiting the Risk to the Individual Market* (Commonwealth Fund, Mar. 2018).

ABOUT THE AUTHORS

JoAnn Volk, M.A., is a research professor at the Center on Health Insurance Reforms, Health Policy Institute, McCourt School of Public Policy at Georgetown University. Her work is focused on regulation of private health insurance under the Affordable Care Act and the effect of health coverage reform on access, affordability, and adequacy of coverage for consumers. Ms. Volk holds a master's degree in public policy from Johns Hopkins University, with a concentration in health policy.

Emily Curran, M.P.H., is a research fellow at the Georgetown University Health Policy Institute's Center on Health Insurance Reforms. Her research focuses on private health insurance and the effects of the Affordable Care Act, with emphasis on the implementation of the federal and state health insurance marketplaces. Curran received her M.P.H. in health policy from George Washington University's Milken Institute School of Public Health.

Justin Giovannelli, J.D., M.P.P., is an associate research professor at the Georgetown University Health Policy Institute's Center on Health Insurance Reforms. His research focuses primarily on the implementation of the Affordable Care Act's market reforms and health insurance exchanges at the federal and state levels. Giovannelli received his law degree from the New York University School of Law and his master's degree in public policy from Georgetown's Public Policy Institute.

Editorial support was provided by Deborah Lorber.

ACKNOWLEDGMENTS

The authors thank the state officials who shared their time and valuable insights with us. We are also grateful to Tim Jost for his thoughtful review, and to Christina Goe and Kevin Lucia for their review and contributions throughout the research for this brief.

For more information about this brief, please contact:
JoAnn Volk, M.A.
Research Professor
Center on Health Insurance Reforms
Georgetown University Health Policy Institute
JoAnn.Volk@georgetown.edu

About the Commonwealth Fund
The mission of the Commonwealth Fund is to promote a high-performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, and people of color. Support for this research was provided by the Commonwealth Fund. The views presented here are those of the authors and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.

APPENDIX 1. STATE SAFE HARBOR STATUTES APPLICABLE TO HEALTH CARE SHARING MINISTRIES

		Health care sharing ministry (HCSM) defined as providing:		
State	HCSMs exempt from state insurance code?	A written disclaimer that the organization is not an insurance company	A written monthly statement to participants listing: (a) the total dollar amount of qualified needs submitted to the HCSM; and (b) the amount assigned to participants for their contribution	An annual audit
Alabama	Yes	X	X	
Alaska	Yes	X	X	X
Arizona	Yes	X	X	
Arkansas	Yes	X	X	
California	No			
Colorado	No			
Connecticut	No			
Delaware	No			
District of Columbia	No			
Florida	Yes	X		
Georgia	Yes	X	X	
Hawaii	No			
Idaho	Yes	X	X	
Illinois	Yes	X	X	X
Indiana	Yes	X	X	
Iowa	Yes			
Kansas	Yes			
Kentucky	Yes	X		
Louisiana	Yes	X	X	
Maine	Yes	X	X	X
Maryland	Yes	X	X	
Massachusetts	No			
Michigan	Yes	X	X	
Minnesota	No			
Mississippi	Yes	X	X	
Missouri	Yes	X	X	
Montana	No			
Nebraska	Yes	X	X	X
Nevada	No			
New Hampshire	Yes	X	X	X
New Jersey	No			
New Mexico	No			
New York	No			
North Carolina	Yes	X	X	
North Dakota	No			
Ohio	No			
Oklahoma	Yes			
Oregon	No			
Pennsylvania	Yes	X	X	
Rhode Island	No			
South Carolina	No			
South Dakota	Yes	X	X	
Tennessee	No			
Texas	Yes	X	X	
Utah	Yes			
Vermont	No			
Virginia	Yes	X	X	
Washington	Yes			
West Virginia	No			
Wisconsin	Yes	X	X	
Wyoming	Yes	X		X

Data: Authors' analysis of state laws governing health care sharing ministries.

APPENDIX 2. KEY FEATURES OF HEALTH CARE SHARING MINISTRIES

Features	Altrua Ministries/ Altrua HealthShare	Christian Healthcare Ministries	Medi-Share Christian Care Ministry (CCM)	Samaritan Ministries	Sedera Health
Payments to cover ministry's administrative costs	Part of members' monthly contributions are used to run membership and support qualified charities Other fees include: $100 annual membership fee and a requested $25 annual donation to Altura Ministries	None indicated	Members pay a monthly administrative portion from each monthly share for CCM's administrative expenses	One month share from each member annually supports administrative services	Each month, 9.9% of medical cost-sharing dollars are retained for administrative costs; Sedera may retain up to the first 90 days of new members' monthly shares to cover program expenses and costs related to expanding the community
Monthly contributions	Based on age, number of members in the household, plan metal level and type: standard or advantage	Based on sharing (metal) level and number of members in household	Based on age and number of members in the household; additional monthly charge for Health Partners, a program for those at higher risk for disease or who have significant weight gain	Based on age, number of members in the household, and membership level	Based on each member in the household's dependent status, age, and employer contribution, if any Households with one or more tobacco users are subject to higher monthly share rate
Coverage levels	Gold, silver, bronze levels, with option to enroll in standard or advantage program for each	Gold, silver, bronze levels, with option to enroll in Plus program for each to obtain additional coverage	Members select an annual household portion (AHP) level for the amount that must be paid toward eligible medical bills before any bill may be shared among members	Classic and basic membership levels	Vary by initial unshareable amount (IUA)
Payments that act as deductibles	Member responsibility amounts (MRA) range from $500–$4,000 per "need" (i.e., expenses related to the same medical condition), depending on membership level	Personal responsibility payments range from $500 (gold) to $1,000 (silver) to $5,000 (bronze) per "need" (i.e., expenses related to the same medical condition)	AHPs range from $1,000–$10,500 and are reset annually*	Initial unshareable amounts range from $300 for classic to $1,500 for basic per "need" (i.e., expenses related to the same medical condition)	IUA of $500–$1,000 per "need" (i.e., expenses related to the same medical condition) Members with multiple needs in a year pay no more than 3 IUAs; households with 2 or more members pay a maximum of 5 IUAs per year
Sharing limits	Gold/silver: Lifetime limit of $1,000,000; Bronze: Lifetime limit of $1,000,000, with a $50,000 limit per calendar year** Service-specific limits include: 6 office or urgent care visits per year; no more than a combined 20 visits per year for occupational, speech, or physical therapy, home health care, and chiropractic care; $4,000 for "normal" delivery of baby, $6,000 for medically necessary cesarean section	Gold, silver, bronze: $125,000 per illness (can be increased with participation in "Brother's Keeper" program) Gold Plus: Unlimited per illness Silver/bronze Plus: An additional $100,000 per illness up to $1,000,000	Limited to $50,000 in first month of membership, but then no annual or lifetime limit for shareable expenses Service-specific limits include: up to 36 sessions for cardiac rehabilitation; up to 20 visits combined for physical therapy or occupational therapy per referral	$250,000 for each medical need in classic, $236,500 in basic Other service-specific limits apply, including $4,950 for medical equipment or more with preapproval***	Prior medical conditions (with 36-month look-back), if shareable, are subject to limits of $25,000 or $50,000 depending on membership tenure (and fully shareable with 37-month tenure or longer) Limit of $25,000 applies, regardless of tenure, for tobacco users age 50 or older for cancer, heart condition, COPD, and stroke

* Christian Care Ministry, *What Is Medi-Share?* (CCM, n.d.).

** Altrua HealthShare, *What Our Members Give to the Membership* (Altrua HealthShare, May 2018).

*** Samaritan Ministries, *Guidelines for Health Care Sharing* (Samaritan, July 2018).

APPENDIX 2. KEY FEATURES OF HEALTH CARE SHARING MINISTRIES (CONTINUED)

Features	Altrua Ministries/ Altrua HealthShare	Christian Healthcare Ministries	Medi-Share Christian Care Ministry (CCM)	Samaritan Ministries	Sedera Health
Provider agreements	Uses an affiliated network of providers that agree to discount their services for members	Members can use the provider of their choice, but are encouraged to use recommended providers from CHM's list	Uses network of providers that agree to discount member fees; if member uses a nonnetwork provider, bills eligible for sharing are limited to usual and customary charges	Members are not required to use approved providers, but Samaritan will help negotiate rates on behalf of members	Members are not required to use approved providers, but Sedera will help negotiate rates on behalf of members
Preexisting condition policy	Preexisting conditions will be considered in determining eligibility for sharing. A preexisting condition is an illness or medical condition for which a member has received medical advice or treatment in the 24 months prior to membership; a 2- to 5-year limit on sharing may apply if not disclosed during application process Maternity services are eligible for sharing if the woman is married and has been on a gold or silver membership plan for 10 consecutive months prior to conception	Preexisting condition bills can only be shared under a gold level membership, up to $50,000 total for the first 3 years. After 3 years, the condition is no longer considered preexisting A condition is no longer preexisting if there have been no documented signs/symptoms for one year; cancer is no longer preexisting when a doctor has declared a member to be cancer-free or the member has gone 5 years without signs or symptoms Maternity services are eligible if a member's due date is at least 300 days after joining	Preexisting condition bills will be eligible for sharing up to $100,000 per member per calendar year if condition has gone 36 consecutive months without symptoms or member has been sharing for 36 consecutive months; or up to $500,000 per member per calendar year if condition has gone 60 consecutive months without symptoms or member has been sharing faithfully for 60 consecutive months	Preexisting condition bills are only shareable if the condition appears to be cured and 12 months have passed without any symptoms; needs resulting from Type 1 diabetes that existed prior to membership will not be shared, even if a member was without treatment or symptoms for 12 months For genetic defects, hereditary diseases, cases of related cancers, and for heart conditions, the symptom/treatment-free period is 5 years	Needs that arise from a condition that existed prior to membership are only shareable if the condition is fully cured and 36 months have passed without any symptoms, treatment, or medication Restrictions do not apply for high blood pressure, as long as the member has not been hospitalized for high blood pressure in the 36 months prior to membership and the condition is controlled through medication or diet
General exclusions	Ineligible needs include: – Illnesses arising from tobacco use or obesity – Counseling, testing, treatment, medication, and hospitalization for mental or psychiatric health, learning disabilities, developmental delays, autism, behavioral disorders – Cancer testing or treatment in the first 12 months of membership; failure to obtain biennial cancer screenings for certain types of cancer may render ineligible future related costs	Ineligible needs include: – Routine and preventive care, including well-patient care and screening tests – Psychological treatment, tests or counseling – Prescriptions after 6 months per condition (exceptions may be made for cancer and transplant recipients)	Ineligible needs include expenses related to: – Non-Biblical lifestyles and choices (e.g., alcohol and drug-related injuries, maternity out of wedlock) – Behavioral and mental health care – Durable medical equipment – Routine preventive care, including physicals, vaccinations, mammograms, colonoscopy (with an exception for well-child care to age 6)	Ineligible needs include: – Donations of tissues or organs, unless used for another Samaritan member – Routine medical care including physicals, checkups, flu shots, long-term maintenance prescriptions – Expenses resulting from alcohol, drug, or armed conflict-related injuries – Prescriptions after 120 days for qualifying medical condition; exceptions apply (chemotherapy, medications to treat pain and other side effects, and anti-rejection medications are not subject to the limit)	Ineligible needs include: – Medical expenses resulting from illegal drug use or unlawful activities – Medication for treatment of chronic or recurring conditions (diabetes, high blood pressure) are not shareable beyond 120 days – Therapy for developmental issues or psychological care – Routine physicals, checkups, vaccinations, and other routine medical expenses

Data: Authors' analysis of the guidelines of five health care sharing ministries: Altrua HealthShare, Christian Healthcare Ministries, Medi-Share Christian Care Ministry, Samaritan Ministries, and Sedera Health.


1918
2018
The
Commonwealth
Fund
A Century of Advancing Health Care for All