



5 Things Christian Organizations Need to Know About Picking a Healthcare Plan



1 NETWORK

As a Christian organization, one of the foundational elements you'll want to explore when considering a healthcare program is if the corresponding network provides adequate access to care for your employees and their families. Navigating the web of health insurance networks can be challenging, but it's an important part of saving money on care. A provider network is a list of the doctors, healthcare facilities, and hospitals that an insurance plan has contracted with to provide medical care to its members. These providers are called "network providers" or "in-network providers." In-network providers are typically less expensive to utilize than out-of-network providers. Making sure you match your organization to the appropriate network will have a significant impact to the long-term success of your program.

Consider these components to optimize your healthcare investment:

- Does your organization have multiple locations in distinct geographic areas? If not, do you have plans to grow into other areas?
- Do you have overseas/expat staff such as missionaries? If not, is this part of your long-term vision as an organization?
- Do your staff prefer specific doctors, clinics or hospitals?
- Do your staff have strong vendor preferences?

The answer to these questions will guide your organization toward choosing the appropriate healthcare and reduce the amount of time you spend considering options that were not a great fit to begin with.

2 FUNDING MODEL

Once you identify the provider network that best suits your needs, another foundational component is determining the “funding model” for your healthcare program. Funding model refers to which party carries the risk (and potential reward) associated with paying medical and pharmacy claims. Generally, there are two basic funding models within which all healthcare programs in the United States are structured—each with their own pros and cons:

FULLY-INSURED (FI)

A fully-insured health plan is the most common/traditional way to structure an employer-sponsored health plan. If you currently offer healthcare to your staff, chances are that you are already in a fully-insured plan, given that most organizations are too small to take on the risk associated with other funding models. With a fully-insured health plan, your organization’s only responsibility is to pay monthly premiums to the insurance company for your plan. If your annual premiums are \$250k but you incur \$300k of annual claims, the insurance company is responsible for coming up with the extra \$50k (they carry 100% of the risk). On the other hand, in the same scenario, if your annual claims were only \$100k, the insurance company would keep the \$150k profit.

SELF-FUNDED (SF)

Self-funded health care, also known as Administrative Services Only (ASO), is a self-insurance arrangement whereby you provide medical and pharmacy benefits to your employees using your organization’s own funds. This model reduces fixed expenses such as admin cost and vendor profit and provides far greater control,

2

flexibility, and creativity when it comes to plan stewardship and overall long-term sustainability. Given these advantages, it is no surprise that nearly all large Christian organizations in the United States choose a self-funded model for the healthcare program they offer their employees. Additionally, most of these self-funded plans are structured as a “church plan,” which provides great flexibility to align benefits with Christian values.

Under a self-funded arrangement, a third-party administrator (TPA) processes claims, while your organization is responsible for paying claims. Therefore, there is generally more risk associated with choosing a self-funded healthcare program. Large organizations manage this risk in many ways, using data, predictive analytics, high-risk member intervention, wellness programs, etc. Additionally, many self-funded plans purchase a “stop-loss policy” which serves to limit the maximum exposure of each individual claim and/or sets a max aggregate financial liability. A self-funded plan that purchases a stop-loss policy is known as “partially self-funded,” as liability is only up to a predetermined point. For example, if a stop-loss policy was purchased with a \$250k “attachment point,” the most an organization would have to pay for any given claim is \$250k—even if a claim ended up costing \$1M.



3 PLAN TYPE

As you explore healthcare options, you will quickly come to find out that not all health insurance policies deliver the same model of care delivery. In fact, there are many different “types” of health insurance. Three of the most popular types include HMO, PPO and HSA plans. These plans all have features that make them unique, and understanding each model is very important:

PPO

PPO plans, or “Preferred Provider Organization” plans, are one of the most popular types of plans in the group healthcare market. PPO plans allow you to visit whatever doctor or healthcare facility you like without first requiring a referral from a primary care physician (PCP).

Here are a few key features of PPOs to be aware of:

- A PPO offers your staff the freedom to receive care from any provider in or out of your network. This means they can see any doctor or specialist or use any hospital.
- PPO plans do not require your staff to choose a Primary Care Physician (PCP) and do not require referrals. For example, if your staff already have a doctor they like, they can continue receiving care from that provider. If they need to see a specialist, they do not have to first consult with a PCP. No referrals are required for any doctor, specialist or hospital.
- Generally, traditional PPO plans are structured with “co-payments” for office visits such as primary care, urgent care or the emergency room. Co-payments are a flat dollar amount your staff pay to utilize these services.



HMO

HMO stands for Health Maintenance Organization. One of the most well-known HMO models in the United States is Kaiser Permanente. HMOs have their own network of doctors, hospitals and other healthcare providers who have agreed to accept payment at a certain level for any services they provide. In theory, this allows the HMO to keep costs in check for its members.

Here are a few other key features of HMO's to be aware of:

- Because of the agreed-upon payment level, an HMO usually offers lower monthly premiums than other types of insurance plans.
- HMO's don't cover any out-of-network care, except in a true emergency.
- With an HMO, your staff must choose a Primary Care Physician (PCP) from a network of local healthcare providers when they join. This is the doctor your staff will see whenever they need medical care.
- If your staff were to need the care of a specialist, they would first see their PCP. Then, if needed, he or she would provide a referral to a specialist within the HMO's network.
- HMO's are generally regional solutions, so if you have multiple locations or overseas staff, an HMO may not be a great option.

HSA

A health savings account, also known as an HSA, is a tax-exempt savings account that, when paired with a qualified high-deductible health plan (HDHP), can be used to pay for certain medical



expenses. HSA's are one of the fastest growing plan types in the United States, increasing from about 5% of plans in 2008 to roughly 20% of plans in 2018.

The increasing popularity of these types of plans is due to several factors:

- An HSA plan can provide the broad access to care associated with a PPO while also costing less, like an HMO.
- Unlike many PPO or HMO plans, HSA's are uniquely able to encourage consumerism and shared responsibilities due to the fact that thoughtful plan utilization results in decreased expenses for your staff. In other words, your staff has "skin in the game." This type of behavior change can help with long-term sustainability of your healthcare plan.
- The HSA itself has many other benefits, listed below.

To use an HSA with a health insurance plan, your staff need to have access to, and enroll in, a qualified HDHP (HSA-compatible health plan). It's important to know that not all high-deductible health plans are qualified. The Internal Revenue Service (IRS) defines what makes a plan qualified. These requirements can change, so be sure to check that your high-deductible plan is a qualified high-deductible plan.



HSAs have many benefits for your staff, like:

- **TRIPLE TAX ADVANTAGED**

1. Money goes in tax-free. HSA contributions are made on a pre-tax basis and are tax deductible.
2. Money comes out tax-free. Qualified medical expenses can be made tax-free when an HSA is used. Purchases can be made directly from the HSA account, either by using a healthcare debit card (if included with your HSA), ACH, online bill-pay or check; or, your staff can pay out of pocket and reimburse themselves from their HSA.
3. Earn interest, tax-free. The interest on HSA funds grows on a tax-free basis. Unlike most savings accounts, interest earned on an HSA is not considered taxable income when funds are used for eligible medical expenses.

- **HSA BALANCES CAN BE CARRIED OVER YEAR AFTER YEAR**

Unlike a flexible spending account (FSA), an HSA is not a use-it-or-lose-it account. This is because an HSA is an account in your staff member's name (it's a personal bank account). As such, employer contributions into your staff's HSA accounts are a funded liability, unlike an FSA which is an unfunded liability. Because the money belongs to your staff and sits in a bank account in their name, the account balance continues to grow year after year until utilized.



- **AN HSA BALANCE CAN BE INVESTED**

Depending on the HSA your organization selects, staff may be eligible to invest HSA funds into mutual funds, stocks, or bonds similar to a 401(k) or 403(b). Any gains from this investment are tax-free.

- **YOUR STAFF CAN USE AN HSA TO HELP ADD TO RETIREMENT FUNDS**

After your staff turns 65, they can withdraw funds from their HSA for any reason without penalty.

4 PLAN DESIGN

This is one of the most variable considerations to keep in mind when it comes to choosing a healthcare plan. Each plan offers different benefits, and with the right amount of research you can find one that best suits your organization's health needs, budget, and risk tolerance. That said, it is critical to make sure you understand the core components of healthcare programs and how modifications to these components impact both you and your employees:

COINSURANCE

The percentage of costs of a covered health care service your staff pay (20%, for example) after they have paid their deductible. Let's say your health insurance plan's rate for an office visit is \$100 and your coinsurance is 20%. If a staff member has already paid their deductible due to previous claims, they would only pay 20% of the \$100 office visit, or \$20 and the plan pays the rest. If a staff member hasn't met their deductible, they pay the full allowed amount of \$100. Coinsurance levels are generally higher for in-network claims and lower for out-of-network claims. Additionally, coinsurance levels can vary from plan to plan, from about 50% to 100%.

DEDUCTIBLE

The amount your staff pays for covered health care services before your insurance plan starts to pay via coinsurance. With a \$2,000 deductible, for example, your staff pays the first \$2,000 of covered services. After someone reaches their deductible, they usually pay only a copayment or coinsurance for covered services.



All ACA compliant plans pay the full cost of certain preventive benefits even before your staff meet their deductible. Some plans have separate deductibles for certain services, like prescription drugs. Family plans often have both an individual deductible, which applies to each person, and a family deductible, which applies to all family members. Generally, plans with lower monthly premiums have higher deductibles. Plans with higher monthly premiums usually have lower deductibles.

OUT-OF-POCKET MAXIMUM (OOP MAX)

This is the most your staff will ever have to pay for covered services in a plan year. After your staff spend this amount on deductibles, copayments, and coinsurance, the health plan pays 100% of the costs of covered benefits. Think of the OOP Max as the “worst case scenario” for an individual or family over a 12-month period. It’s important to note that the OOP Max doesn’t include monthly premiums or anything your staff spend for services the plan doesn’t cover.

BENEFIT ADMINISTRATION

Once you select the network, funding type, plan type, and plan design that best fits your organization’s needs, the next step is figuring out how you’re going to administer everything you just selected.

The following questions often begin to surface:



- How will we handle benefits enrollment?
- Who will be responsible for enrolling/administering our new hires, terminations, and life event changes?
- How will we have time to deal with billing, premium reconciliation, and payroll deductions?
- Who will be handling employee questions and concerns about our benefits program?
- How will we stay on top of benefits compliance and ongoing regulatory changes?
- Who/how will we administer COBRA?
- Who/how will we administer our health savings or health reimbursement accounts?
- How will we stay on top of ACA reporting and filing requirements?

Given that most Christian organizations have limited resources, the aforementioned items often have the potential to take up a lot of time, and fall to staff that are already stretched thin in other initiatives. The fruit of this unfortunate reality is a focus on “benefits stuff” (day-to-day remedial tasks) vs. “benefits strategy” (long-term vision and stewardship plan) as the burden of administration takes hold.

That’s why it’s very important to evaluate what administrative efficiencies can be gained for your organization as you make decisions regarding your benefits program. For example, some programs may offer fully-integrated benefit administration platforms that allow for a meaningful shift back to “benefits strategy” and away from the grind of “benefits stuff.”



These integrated, cloud-based solutions for benefits administration and human capital management can be affordable, intuitive, and highly configurable to support your unique benefits strategy. To add to this, these platforms can be integrated with a wide range of complementary benefit services outside of year-round enrollment—such as COBRA admin, ACA reporting/filing, HSA admin, billing reconciliation, and employee contact center—that provide your organization with a single and complete source for human resources software.

5

CHRISTIAN HEALTHCARE SHARING PROGRAMS VS. TRADITIONAL HEALTHCARE

If you are a Christian employer, you have likely heard of, or perhaps even strongly considered, a Christian Healthcare Sharing program. While these programs have many attractive features such as lower cost and general alignment with Christian values, it is critically important to objectively understand what these programs offer (and what they don't), and how these differences from traditional healthcare programs impact your staff before making a decision.

Here is a quick list of some of the provisions/structures you should be aware of that exist in a Christian Healthcare Sharing program:

- Membership is not a guarantee of reimbursement for medical expenses (not a contract).
- Morality Clause: Medical expenses resulting from the use of illegal drugs or unlawful activities will not be shared.
- Dependent Morality Clause: Dependent medical expenses resulting from illegal drugs, alcohol, or unlawful activities will not be shared. Parents are responsible to hold children to adherence with guidelines.
- Lifetime maximum sharing thresholds
- Annual maximum sharing thresholds
- Medical condition and/or medical services sharing limitations
- Pre-existing condition limitations
- Tobacco product use limitations
- Tax-Treatment of Premiums: Generally, payments for Christian Healthcare Sharing programs are not pre-tax like in traditional healthcare plans. A staff member considering a Christian Healthcare sharing program may want to consider the impact of paying for these types of programs with post-tax dollars.

5

- “Good health measures” or “Balanced Lifestyle” language requirements
- Reckless driving exclusions (employees & dependents)
- Helmet and/or seatbelt requirements for sharing eligibility
- Pregnancy: Pregnancy complications and/or birth defects subject to pre-existing condition limitations
- Genetic defect limitations
- Sexually Transmitted Disease (STD) limitations/exclusions
- No coverage for routine care, preventative care or well-visits

In the right situation, Christian Healthcare Sharing programs can be a wonderful option. That said, as a Christian employer, it is very important to objectively evaluate all options for your employees. For example, cost may be able to be reduced by coming together with other like-minded Christian employers in a traditional healthcare aggregation model such as an association health plan (AHP), healthcare cooperative, or professional employer organization (PEO). Additionally, aggregation models can be self-funded and/or structured as a church plan, potentially providing you with greatly enhanced stewardship options that can serve to unite the Body of Christ and align benefits and programs with Christian values. While Christian Healthcare Sharing programs will likely always be the lowest cost option, aggregation may provide your organization with a new middle ground that allows you to take advantage of the best of both worlds.



AUTHOR

**LOUIS GALLUCCI
LEAD CONSULTANT,
MISSIO BENEFITS**

Louis has spent over a decade helping employers steward their Health & Welfare programs. Knowing that creating meaningful solutions in the health & welfare space means challenging and redefining traditional marketing constructs, Louis joined a handful of partners in 2014 to start Enterprise Risk Strategies, LLC (ERS)—a benefits consulting firm rooted in paradigm-change. He studied agricultural business at California Polytechnic University, San Luis Obispo. In his free time, Louis enjoys spending time with his wife and three children, advancing the unity of non-profit organizations and serving the local church.

ABOUT MISSIO BENEFITS

At the foundation of the Missio Benefits program are like-minded ministries who seek to work together to enhance the ability of their organizations to procure competitive, objective, and transparent employee benefits programs that exemplify quality, stewardship, integrity and unity. The participating members will benefit from meaningful financial savings derived from great lifestyle decisions and innovative solutions through global aggregation and unity.

LEARN MORE

Visit missiobenefits.com or download our podcast:

People First: HR Podcast for Churches and Ministries.