ULTIMATE GUIDE TO HEALTH COVERAGE

for Churches and Ministries

GuideStone®

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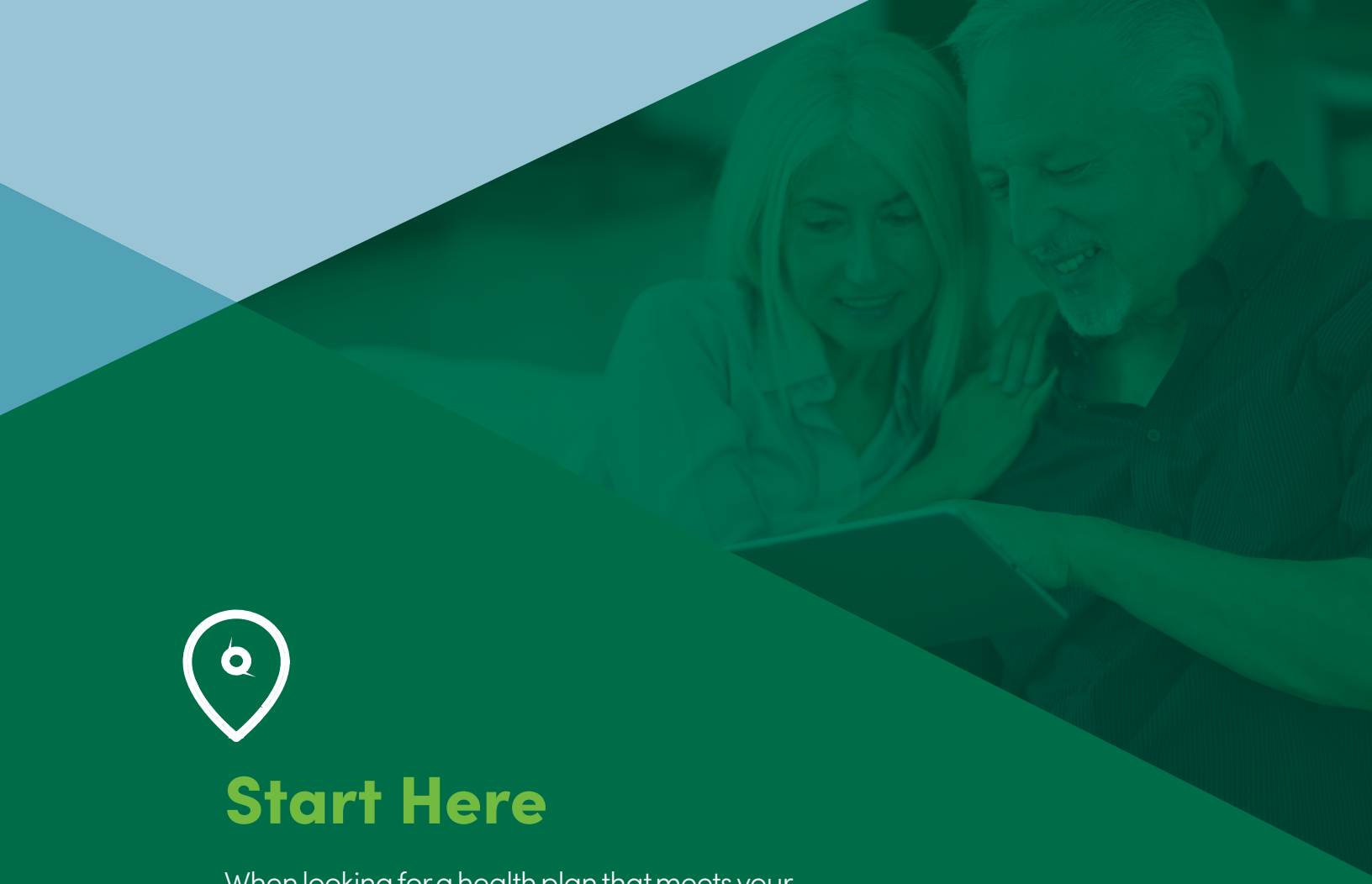

Start Here

When looking for a health plan that meets your ministry needs, you will face a multitude of plan details, terms and numbers, and it's often hard to keep them straight. At GuideStone, our goal is to equip you with the information you need to make the best decisions for your ministry. So, we put together a comprehensive guide of your health care options that is simple and easy to understand.

Taking care of your team doesn't have to be stressful or complicated. You can provide your team medical coverage that has **value and values.**

THE BASICS

Health care can be confusing. So, let's start with the basics. Whether you're an HR coordinator or an executive pastor, here is a quick overview of key health care terms everyone needs to know. Understanding each of these terms will help you make a more informed decision on what your ministry needs.

Health Plan 500*

PLAN FEATURES	
Deductible for Individual	$500
Deductible for a family	$1,000
Teladoc® co-pay	$0
Maximum out-of-pocket (medical and prescription)	$4,750/$7,500
Outpatient Surgery	20% After deductable
Urgent **co-pay**	$50
Plan pays/individual pays **(co-insurance)**	80%/20%
Wellness & **Preventive Care**	100% No Co-Pay

Deductible: The amount you pay out-of-pocket for a covered health care service before the co-insurance takes effect. The lower the deductible, the faster you get covered at the co-insurance level.

Family Deductible: The amount your family needs to pay out-of-pocket for a covered health care service before co-insurance takes effect for the whole family. This amount needs to be met by a combination of two or more people on the plan.

Maximum Out-Of-Pocket (MOOP): The absolute maximum you will pay under a plan, including your deductible, co-pays and prescription costs. Once you reach this limit, the plan pays 100% of claims.

Co-Pay: The fixed amount you pay for certain in-network expenses like a primary care visit and urgent care.

Preventive Care: This includes routine procedures such as check-ups, screenings and immunizations. Here, with the PPO Plan 500, preventive care is covered at 100%.

Co-Insurance: The split cost between what you and the plan pay for eligible claim expenses. Here, the plan pays 80% of the claim, and you pay 20%.

*Health Plan 500 is a fictional plan for illustrative purposes.

Top 6 Health Coverage Acronyms to Know

Preferred Provider Organization (PPO) Plan: A type of health plan that contracts with medical providers — such as hospitals and doctors — to create a network of participating providers. You pay less if you useproviders that belong to the plan's network; however, you can use doctors, hospitals, and providers outside of the network at an additional cost.

Exclusive Provider Organization (EPO) Plan: A managed care plan where services are covered only if you go to doctors, specialists or hospitals in the plan's network (except in an emergency).

High Deductible Health Plan (HDHP): A plan with a higher deductible than a traditional insurance plan because it is designed to be used with a health savings account (HSA) allowing you to pay for certain medicalexpenses with tax-advantaged dollars.

High Performance Network (HPN) Plan: An in-network only access plan with a refined network of providers chosen based on their commitment to enhancing care quality and lowering costs.

Health Maintenance Organization (HMO) Plan: A plan that only covers care within a smaller network of providers (except in case of emergency) and requires a designated Primary Care Provider (PCP) to coordinate your health care and provide referrals to specialists.

Point of Service (POS) Plan: A type of plan where your level of coverage depends on whether your "point of service" — your chosen provider — is in or out of network and whether you've obtained required referrals. POS plans are a blend of HMO and PPO plans where you have the ability to go to an out-of-network provider, but it may come with greater limitations —– such as required referrals — and less coverage.

For a full list of common coverage acronyms, check out ***Insurance Alphabet Soup Decoded***.

Questions to Ask When Selecting Coverage

3 Key Questions to Ask When Selecting Coverage

Health coverage is a crucial aspect of ensuring the well-being of any ministry team.

Churches and ministries have diverse employment types, budget constraints and ministry-specific considerations that set them apart from for-profit organizations.

Tailoring your health plan options to meet the unique needs of your organization is essential to provide comprehensive and cost-effective coverage. Here are some key things churches and ministries need to consider when choosing a health plan:

1. What size is your ministry?

To determine the most suitable health care coverage, it is essential to consider your ministry's size. Larger ministries may benefit from group health plans, which offer cost-effective options due to higher enrollment numbers. Smaller ministries, on the other hand, may look into personal coverage.

2. What is your ministry's health plan budget?

- Creating a realistic budget for your coverage is also a crucial step. It ensures that the plan you select aligns with your financial capacity while still providing adequate protection for your team.
- Finding cost-effective options doesn't automatically mean compromising on quality. At GuideStone, we work diligently to explore various options and identify those that best fit your budgetary constraints without sacrificing the benefits you need.

3. What are the specific needs of your ministry?

Diversity
Understanding the diverse health care needs of your employees is critical to getting the right coverage for you. When selecting plans, consider factors such as:

- Age demographics
- Family size
- Potential pre-existing conditions

Missionaries
In addition to employees, ministries often include volunteers and missionaries involved in various activities. If you send missionaries overseas as part of your ministry, keep that in mind when considering health care coverage options.

Full-Time. Part-Time. Independent Contractors.
Ministry roles may vary, with some individuals serving in full-time positions, part-time roles or even as independent contractors. Keep employee status in mind when evaluating eligibility for health plans.

By understanding your organization's unique needs and finding coverage options designed with ministries and churches in mind, you can help ensure everyone receives the care they deserve without stretching your financial resources.

GuideStone health plans save churches and ministries an average of 32%* on monthly rates. Our members can rest easy knowing that rates start low and stay low.

*Compared to 2022 Texas, Blue Cross Blue Shield PPO, small group community-rated exchange products.

How to Choose the Right Health Care Option for Your Church

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]

For a church, those expenses can really stack up, and many churches find themselves stuck between **taking care of their staff** and **growing their ministry.**

There are **seven common strategies** that most churches use to try and find that balance. To help you walk through which may be the best for you, we've outlined their benefits and risks below:

1. THE EXCHANGE

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 a part of that, a marketplace exchange was introduced, allowing individuals to directly find insurance coverage for themselves, without having to go through an employer.

Since then, many churches and other Christian employers have turned directly to the Exchange to help each team member find coverage. 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.

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]

BENEFITS OF THE EXCHANGE

- 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 EXCHANGE

- It is a massive system 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 Exchange is a good option for individuals who are comfortable with the limitations of a narrow network and fewer options. While churches can help guide their employees in decision-making, knowing the ins and outs of the plans is incredibly time-consuming, and they may find themselves stuck with a subpar provider who might not be there when they need it most.

THE SHOP

2. THE SHOP

As part of the legislation, the ACA also introduced a Small Business Health Options Program (SHOP) for small group employers. SHOP 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

- 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

- 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.

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.

GROUP COVERAGE

3. GROUP COVERAGE

The traditional, fully insured group market is dominated by carriers Blue Cross Blue Shield (BCBS), 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.

BENEFITS OF GROUP COVERAGE

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

RISKS OF GROUP COVERAGE

- Groups of 50 or fewer employees can get a "community" rating. This could cause some ministry groups to pay a higher rate, no matter how healthy they might be.
- Plans are designed for traditional 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 could disagree with.

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, poor customer support and plans that are not a good fit for their specific needs.

SELF-FUNDING

4. 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 SELF-FUNDING

- 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 SELF-FUNDING

- 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 accounting 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.

Because of the financial risks and extra administration involved, only very large ministries are successful at self-funding. Self-funded groups that have trained staff to manage the extra administrative duties are often pleased with their coverage. Others find a large portion of their savings goes toward plan administration instead of actual coverage. 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.

LEVEL-FUNDING

5. LEVEL-FUNDING

Level-funding is a hybrid of self-funding and traditional insurance plans. In level-funded plans, employers contract with insurance providers and pay them a set monthly premium to cover the estimated cost for expected claims. That monthly premium goes towards three things:

- **Administrative costs**
- **Stop-loss coverage** to protect employers from high claims incurred by individuals in the plan.
- **Expected claim amounts.** Claims are estimated by the carrier, and that cost is used to calculate the employer's overall premium. If total claims each year are higher or lower than expected, the provider makes adjustments at the end of the plan year in the form of a refund to the employer for lower claims or a premium increase for higher claims.

BENEFITS OF LEVEL-FUNDING

- Level-funded plans are generally less costly than fully insured plans.
- These plans are less risky to 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

- 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.

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.

HEALTH SHARING MINISTRY

6. HEALTH SHARING MINISTRY

Health sharing plans, sometimes referred to as Christian health sharing plans, are organizations that connect like-minded Christians to share the cost of members' medical bills. Health sharing plans have always been available to individuals, but some health care sharing ministries now have options for ministry staff.

BENEFITS OF HEALTH SHARING

- 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.

RISKS OF HEALTH SHARING

- Health sharing plans are not actual insurance, and there is no guarantee of payment toward a medical bill.
- 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 can be restrictive
- 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 a substantial financial risk for employers who choose to offer health sharing plans in lieu of group coverage.[8,9]

Health sharing plans should never be mistaken for real insurance. There are a few larger churches and ministries that 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, benefits and costs vary widely among these plans due to being unregulated.

CHURCH HEALTH PLAN

7. CHURCH HEALTH PLAN

A church health plan is actual insurance that offers coverage to employers who meet certain parameters. It is established and maintained by a church, a convention or an association of churches. GuideStone is a church health plan that was originally chartered by the Southern Baptist Convention (SBC) and has since expanded to offer coverage to the wider evangelical community.

BENEFITS OF CHURCH HEALTH PLANS

- Church health plans bring together benefits from a number of providers to create their plans, allowing them to offer the best of the best.
- Church health plans can be a lower-cost option than most other options.
- Smaller churches may be able to obtain group rates that are unavailable to them in the Exchange or the Shop.
- 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 while still not 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.

RISKS OF CHURCH HEALTH PLANS

- Nonprofits 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 than in the Exchange or Shop.
- 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.

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]

[1]https://www.kff.org/health-costs/report/2021-employer-health-benefits-survey/
[2]https://www.cms.gov/files/document/health-insurance-exchanges-2021-open-enrollment-report-final.pdf
[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/
[6]https://www.bbgbroker.com/self-funding-insurance-switch-4-reasons/
[7]https://www.griffinbenefits.com/employeebenefitsblog/why-level-funded-health-plans-are-increasingly-popular-among-small-businesses
[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
[10]http://chirblog.org/church-plans-and-health-care-sharing-ministries/

How to know which strategy is right for your church.

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. This guide will at least get you started as you decode the complicated world of health care and equip you to support your staff in a way that aligns with your values.

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 right strategy for you, visit our website to learn more and request a consultation with a GuideStone expert.

Start today at ***GuideStone.org/HealthPlans***

For more information, contact Customer Solutions at **1-844-INS-GUIDE** (1-844-467-4843), Monday through Friday, from 7 a.m. to 6 p.m. CT.

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