Testimony of J. Michael Sharman
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Before the Colorado House Health and Insurance Committee
Regarding Colorado HB20-1008 "Health Care Cost-sharing Consumer Protections."
February 19, 2020

Thank you, Madame Chair and members of this committee for the opportunity to speak to you directly on this issue of personal importance to me. For the past thirty-plus years, I have been involved with healthcare sharing both as a member and as an attorney, and so I am very interested with any new legislation that impacts healthcare sharing.

The Health and Insurance Committee on February 4, 2020 held a meeting to consider HB20-1008 "Health Care Cost-sharing Consumer Protections." Sixty people signed up to testify at the meeting, and even though sixteen speakers did have that opportunity before the meeting had to be adjourned, it was clear the Committee members were not provided with a clear understanding of the distinction between insurance and Health Care Sharing, nor of the difference between a legitimate Health Care Sharing Ministry ("HCSM") and the illegal, counterfeit HCSMs.

The Committee members and the bill's sponsor voiced justifiable concerns on two categories of real or potential harm suffered by their constituents. The first was whether consumers understand the vast qualitative difference between an insurance company and a Health Care Sharing Ministry. Their second very real concern was the deceptive and fraudulent actions of the counterfeits that call themselves HCSMs but which are actually criminal enterprises.

Let's first look at some baseline explanations about HCSMs and then after that use the questions that were asked by the Health and Insurance Committee as a way to address the questions that those who are unfamiliar with HCSMs often ask.

Health Care Sharing Ministries and the Affordable Care Act.

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act ("Affordable Care Act" or "the ACA") into law. See Pub.L. No. 111–148, 124 Stat. 119 (2010). The concept of Health Care Sharing Ministries was not created by the Affordable Care Act, they pre-existed the ACA by a few centuries and were simply identified within the ACA as the vehicle to use to allow individuals to fulfill their ACA obligations without violating their conscientious objections.

And that is a very important legal point not to be hurried past. Historically, "Health Care Sharing Ministries" have been ministries whose focus is on the health needs of a religious community, caring for one another through the financial vehicle of voluntary sharing – not obligatory payments, but voluntary sharing.

In legislation that compels all Americans to take some affirmative act – such as with Social Security and registering for the military draft – there has been a conscientious objector clause within the legislation. The same is true for the Affordable Care Act, and the conscientious objector clause within the ACA is one that exempts from the ACA's individual mandate persons who are members of a Health Care Sharing Ministry that has applied for and received official recognition as a valid HCSM by the Centers for Medicare and Medicaid Services ("CMS").

There are only 104 HCSMs that have requested and received that CMS recognition. Only a half dozen of those are interdenominational HCSMs with a national reach, the remainder are HCSMs of the folks known as the Plain people, the Amish/Mennonites or the Old German Baptists. My firm assisted more than thirty of the Amish Beachy Mennonite groups to obtain their CMS recognition, and I am also occasionally consulted by some of the Old German Baptist Brethren groups.

The common thought is that the Individual Mandate has been repealed, but actually all that has happened is that the financial penalty has been zeroed out. All the rest of the language is still in the ACA. That is why the Affordable Care Act's "Health Care Sharing Ministry" definition is still an essential part of a Health Care Sharing Ministry's legal existence, and that means members of HCSMs are still exempt from all the other provisions of the ACA. The ACA definition of HCSMs also remains important not only because eight States have now adopted the ACA's definition of HCSMs as part of their laws governing HCSMs, but also because the individual mandate's financial penalty can be dropped back into the ACA whenever a majority of Congress chooses to do so.

For an entity to come within the ACA's rigid definition of a "Health care sharing ministry," it has to have all of the following eight criteria:

1. It must be a non-profit 501(c)(3) organization;
2. Its members must share a common set of ethical or religious beliefs;
3. Its members must share medical expenses in accordance with those shared beliefs;
4. Its members must share medical expenses without regard to a member's State of residency or employment;
5. Its members must be permitted to retain membership even after they develop a medical condition;
6. It must have been in existence at all times since December 31, 1999;
7. It must have shared the medical expenses of its members without interruption since at least December 31, 1999; and
8. It must conduct an annual audit by an independent certified public accounting firm and make it available to the public upon request.

Thirty-two States Currently Have Laws Expressly for HCSMs.

There are now more than thirty states that have explicit laws or regulations for HCSMs, including six of the seven states that border Colorado. (Arizona, ARS § 20-122; Kansas, § 40-202(j); Nebraska, Neb. Rev. Stat. § 44-311; Oklahoma, §36-110-11; Utah, § 31A-1-103; and Wyoming, § 26-1-104.)

The laws in these nearly three dozen States specifically define the criteria for the type of Health Care Sharing Ministries that the State will recognize as being exempt from its insurance laws and regulations. If an entity does not precisely fit each and every one of the State's criteria then it automatically is NOT exempt from the insurance commissioner's jurisdiction and it is in danger of civil and criminal prosecution.

Most of the States have criteria for exemption that either mirror the ACA definition or have these very similar elements:

- It must be a 501(c)(3) non-profit;
- It must be a faith-based or religious organization;
- It must limit its participants to those who are of a similar faith;
- It can only provide for the financial or medical needs of a participant through contributions from one participant to another;
- There can be no assumption of risk or promise to pay among the participants and no assumption of risk or promise to pay by the health care sharing ministry to the participants;
- The entity must provide a written disclaimer on all of its marketing materials and application that reads, in substance: "IMPORTANT NOTICE. This organization is not an insurance company, and its product should never be considered insurance. If you join this organization instead of purchasing health insurance, you will be considered uninsured. By the terms of this agreement, whether anyone chooses to assist you with your medical bills as a participant of this organization will be totally voluntary, and neither the organization nor any participant can be compelled by law to contribute toward your medical bills. Regardless of whether you receive payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills. This organization is not regulated by the Nebraska Department of Insurance. You should review this organization's guidelines carefully to be sure you understand any limitations that may affect your personal medical and financial needs.";
- It must allow its participants to retain participation even after they develop a medical condition; and
- It must have an independent certified public accounting firm conduct an annual audit in accordance with generally accepted accounting principles and make it available to the public upon request.

Perhaps the most important of those elements in terms of consumer protection is to have the medical costs shared directly from member to member, with no "pooling" of funds or "reserves" from which a member's medical bills are paid.

State Consumer Protection Acts.

Every State has a Consumer Protection Act. These laws are also sometimes labeled as a Consumer Sales Practices Act, Unfair and Deceptive Acts and Practices Act or Unfair Trade and Practices Act.

The State attorneys general are the ones who enforce their State's consumer protection laws.

State attorneys general often with work in tandem with the Department of Insurance against an entity they believe to be an unlicensed insurer. In the States in which there is a law governing Health Care Sharing Ministries, the Attorney General can take an enforcement action against an HCSM that is alleged to be deceptive. Even in the States which exempt HCSMs from that State's insurance laws, that exemption does not insulate an HCSM from the requirements of a State's consumer protection laws.

State AGs have very, very broad authority regarding "deceptive practices," and the statutes themselves typically have an extremely long list of specifically identified deceptive practices, as does the Colorado Consumer Protection Act. The Colorado Attorney General can enforce violations of the Consumer Protection Act with civil and criminal penalties. But§ 6-1-113 of the Colorado Consumer Protection Act also permits a private person to bring their own private civil against any person who has "engaged in or caused another to engage in any deceptive trade practice," and be awarded up to three times their actual damages, plus their attorney fees.

Answers for the Questions that were asked by the Health and Insurance Committee.

Q- Rep. Kyle Mullica: One question that I have.... the potential to deny a claim for immoral behavior. Is that something your organization participates in or is that something that you've heard of happens in the industry?

A: To be a CMS certified HCSM, the non-profit entity must be faith-based. And to remain compliant with the ACA's own definition of an HCSM, those entities must share their members' medical expenses only in accordance with the members' shared religious beliefs.
One of the speakers -- Kate Harris, Chief Deputy Insurance Commissioner for Life & Health Policy, Colorado Division of Insurance –told the Committee that her mother, who is gay, had asked for her advice about HCSMs. Ms. Harris told her mother that she would not be allowed to join them because she was gay.
That is correct for some, but not all, of the CMS-certified HCSMs. Just as the religious beliefs of some churches and denominations permit same-sex marriages and some do not, the same is true for these faith-based HCSMs.

Q- Rep. Mark Baisley: The description [that one panelist testified about], with the Spina Bifida surgery in utero, would that [willingness of a health care sharing ministry to pay for that experimental surgery] be a differentiator between a health care ministry, a health care sharing and traditional insurance? I don't know but I'm just wondering what the likelihood of something like that being covered and I wonder if that might kind of draw a distinction of what this industry is or this ministry is.

A: Freedom of conscience and healthcare freedom are primary distinctives for HCSMs. Most HCSMs permit a member to go to any health care provider of their choice, anywhere in the world, and obtain the care chosen for them by their doctor, even if that care is still considered experimental.

Q- Rep. Kerry Tipper: If you could, kind of in plain English tell me what's the difference between your associations and insurance? Draw that distinction clearly for me, on the record.

A: For the 104 HCSMs that have received CMS recognition, each one of them had to be faith-based in order to get that recognition, and so Healthcare Sharing is simply passing the plate among persons who share a similar faith and doing so in an orderly fashion.
This statement from one of the applications to CMS is typical for the approximately 98 small Amish/Mennonite or Old German Baptist Brethren CMS-recognized HCSMs: "The church has a long tradition of supporting their members with medical costs. Assurance

plans are administrated by the members of the Church on a regional basis." The administrators of those small plans are typically unpaid volunteers.

Essentially all of the legitimate HCSMs, large or small, have the persons who are joining their group sign an application similar to this one from a national sharing ministry that says: "I have read and understand any disclaimers to this effect and understand that there are no representations, promises or guarantees that my medical expenses will be paid. I also understand that any funds that I may receive for medical expenses do not come from an insurance plan, but are voluntary donations by the members."

Health Care Sharing Ministries can only function properly within a faith-based environment because the entire concept works on faith alone – faith in each other and, ultimately, faith in God.

Insurance, on the other hand, is completely and totally contractual.

Colorado's definition for insurance is very similar to most States' definition: "'Insurance' means a contract whereby one, for consideration, undertakes to indemnify another or to pay a specified or ascertainable amount or benefit upon determinable risk contingencies, and includes annuities." (Colo. Rev. Stat. § 10-1-102 (12).)

In plain terms, that means that an insurer is one who accepts money from someone in exchange for a promise them if a certain risk occurs, such as an auto accident, a death or a medical cost. In other words, for an insurance contract to exist, there has to be a risk, an assumption of the risk by another, and a promise to pay if the risk occurs. A person who purchases an insurance policy has bought an enforceable contract.

Q – Rep. Dominique Jackson: I need clarification. Describe to me how decisions are made to cover somebody's medical procedure or something that insurance would cover. Describe to me how that process works.

A: In essentially all of the legitimate HCSMs, the original membership of the sharing group had decided on the agreed upon items that would regularly be shared or not shared and those items are published in what is typically referred to as their Guidelines.

For the occasional items that crop up that were not originally contemplated or that fall outside of regular sharing, the Guidelines typically provide for how the frontline staff decide whether to permit sharing for a medical expense that falls outside of the clear language of the Guidelines.

If there is a disagreement as to whether or not a medical expense can be shared under the Guidelines, each of the HCSMs have an appeals process that usually involves first going up the staff chain of command, then having binding arbitration done by either randomly selected members or by the nationally known and well-regarded conciliation group, Peacemaker Ministries.

If it becomes apparent that the Guidelines need to be amended, the members and Board of Directors will vote upon those amendments. (See Q&A immediately below.)

Q – Rep. Dominique Jackson: I heard you say you vote on membership guidelines. So, if members are slow in putting together, you know, the bills that they would like the entire membership to consider and then does it take a majority rule to vote to change the membership guidelines?

A: When done, the vote to amend the Guidelines is prospective in nature. For a medical need which began before the change was adopted, the sharing of bills related to that need will be determined by the Guidelines as they existed on the date the bills were incurred. A Guideline change cannot adversely impact a member's ability to share needs that were in existence before the amendment.

Q – Rep. Dominique Jackson: How are those membership guidelines changes explained to people?

A: Sharing Members are notified of changes to the Guidelines in the normal course of communication with members, normally in the next monthly newsletter.

Q – Rep. Dominique Jackson: Can that happen while somebody is submitting a bill?

A: For a medical need which began before the change was adopted, the sharing of bills related to that need will be determined by the Guidelines as they existed on the date the bills were incurred. A Guideline change cannot adversely impact a member's ability to share needs that were in existence before the amendment.

Q- Rep. Perry Will: How do you get potential people involved? I'm looking at a letter here that says they talked to a representative. How does that work? So how do you get people? Is it just in your church and in your community? Is that how you get them or is there recruitment for these people?

A: For the approximately 98 small Amish/Mennonite or Old German Baptist Brethren CMS-recognized HCSMs, all the members of those churches are, by virtue of being members of one of those churches, also members of its sharing ministry. For generations and generations, this is how they have dealt with their medical costs.

Among the half dozen larger interdenominational HCSMs, the main source of new members is word of mouth and standard advertising. A few of those use actual insurance agents, which is an extremely poor idea and likely puts them in the definition of "doing the business of insurance" in at least the 18 States that do not have laws specifically exempting HCSMs.

Voluntary sharing should be encouraged but it should not be a product that is sold.

HB20-1008 puts "producers" (defined by Colo. 10-2-103(6) to include an insurance producer) on a par with legitimate HCSMs, and appears to permit them to do everything an HCSM could do in Colorado.

There are thousands of insurance agents in Colorado. Passing the HB20-1008 legislation not only permits them to sell HCSM memberships as if they were just another insurance product, but it would also allow every one of those insurance agents to start up their own HCSM whenever they felt like it.

Q- Rep. Perry Will: These payments that people make. They go where?

A: For most HCSMs, the payments go directly from one member to another. That is the safest method to Health Care Sharing, which is why twenty of the 32 States with HCSM laws have provisions expressly requiring direct sharing among the members. The States'

laws on direct sharing are very similar, with these slight differences in their phrasing of that requirement:

- "gifts directly from one member or subscriber to another"
- "contributions from one participant to another"
- "payments directly from one participant to another participant"
- "payments made directly from one participant to another"
- "direct payments from one subscriber to another"

Q-Rep. Kyle Mullica: I have heard conflicting reports. Do you know if any of these organizations or businesses that are currently under investigation by the FBI or any other organization for anything?

A: On July 10, 2019 the Houston Chronicle reported that the Georgia Attorney General's office turned over to the FBI 10 consumer complaints about Atlanta-based insurance producer Aliera.

Each State that has looked at Aliera has charged it and Trinity HealthShare, its spuriously created non-profit, to be an illegal operation: Colorado, Connecticut, Maryland; New Hampshire; Rhode Island; Texas; and Washington.

Aliera and Trinity HealthShare are perhaps the best reason why only the 104 HCSMs that have received CMS recognition should be permitted to operate. The successful challenges against Aliera and Trinity by the appropriate agencies also show that no new legislation is needed to defeat the illegal actions of those who claim to be HCSMs with no intention of staying within a legitimate HCSM's very narrow legal boundaries.

Q- Rep. Janet P. Buckner: I hope this question doesn't sound flip, but … how do you prove that you are a person of faith? Because I'm a woman of faith, but how do you prove that you're a person of faith in order to be able to accepted, your application to be approved?

A: For legitimate HCSMs, the legal issue is not whether someone generally is a "person of faith," but whether the HCSM itself is:

- According to the ACA: an entity "which is described in section 501(c)(3) and is exempt from taxation under section 501(a), (II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs;" and
- According to the majority of the States: using Nebraska's law as an example, an entity which is "a faith-based, nonprofit organization that is tax-exempt under the Internal Revenue Code which: (a) Limits its participants to those who are of a similar faith."

The application questions for each HCSM then become very simple to determine whether a potential member shares that HCSM's "common set of ethical or religious beliefs," and is "of a similar faith" to the others in the HCSM.

Q-Rep. Kyle Mullica: My question is, your testimony [is] that your company, your business is a good actor, then I'm wondering what is the hesitancy to support this bill because when I look at

this bill we are not eliminating being able to participate in these programs, we're trying to set parameters around them to make sure that information is being shared with those that participate to make sure that if there are bad actors that there is the ability to deal with those bad actors. And so if you are already doing all of those things then what would be the issue in actually participating or having these systems put in place?

A: HB20-1008 does vastly more than merely require certain disclosures to be made.

As mentioned above, voluntary sharing should be encouraged and it should not be a product that is sold, but HB20-1008 puts "producers" (defined by Colo. 10-2-103(6) to include an insurance producer) on a par with legitimate HCSMs, and the plain language of the bill permits them to do everything an HCSM could do in Colorado. There are thousands of insurance agents in Colorado. Passing the HB20-1008 legislation not only permits them to sell HCSM memberships as if an HCSM membership were just another insurance product, but it would also allow every one of those insurance agents to start up their own HCSM whenever they felt like it. Rather than reduce consumer problems, HB20-1008 would create infinitely more.

Q-Rep. Kyle Mullica: Why would we not want disclosures? Why would we not want the ability to handle bad actors out there taking advantage of the residents of Colorado?

A: Colorado already has the ability to handle bad actors. This bill would not affect the bad actors, who would just ignore its requirements until they are caught. This bill would already encumber the law-abiding valid HCSMs. It would be particularly burdensome to the small Amish/Mennonite or Old German Baptist BrethrenCMS-recognized HCSMs, whose administrators are simply church volunteers doing the "book work" in their spare time.

If an entity is not a valid HCSM, there is absolutely no reason why Colorado does not now have the ability to hold them accountable for each and every one of their violations of civil, criminal and regulatory law.

As an example, as was mentioned above, every State that has chosen to challenge Aliera and its spuriously created non-profit, Trinity HealthShare, have found it to be an illegal operation and have shut it down in their State: Colorado; Connecticut; Maryland; New Hampshire; Rhode Island; Texas; and Washington.

Q- Rep. Dominique Jackson: Are people told up front what their financial responsibility is going to be?

A: Yes, the valid HCSMs make sure their prospective members are told over and over that this health care sharing is simply that -- voluntary sharing, and the financial responsibility always remains with them. The HCSM does not assume their risk and the other members do not assume the risks of each other.

Q- Rep. Dominique Jackson: So, you mentioned that there's a 7-member board to appeal the process [if a bill is determined to be outside the ministry's Guidelines]. If people are made aware on the upfront what their financial responsibility is and what kinds of things are going to be covered, why then would there be an appeal process and how do you appeal that appeal process and why are those claims, why would those be denied?

A: The Guidelines of one of the HCSMs explains it by saying it "is a voluntary association of like-minded people who come together to assist each other by sharing medical expenses. Such a sharing and caring association does not lend itself well to the mentality of legally enforceable rights. However, it is recognized that differences of opinion will occur, and that a methodology for resolving disputes must be available."

Another HCSM's Guidelines says, "[The HCSM] is a community of Christians—and its members, as followers of Christ, believe that the Bible commands them to make every effort to live at peace and to resolve disputes with each other in private or within the Christian church (see MATT 18:15-20; 1 COR 6:1-8)."

Q-Rep. Kerry Tipper: So right now, who holds, who would be holding those companies accountable?

A: The legitimate, CM- approved HCSMs are constrained within the box of these four legal boundaries:

1. the Affordable Care Act;
2. the definitions of insurance and the business of insurance set by case law and statutory law;
3. State exemptions for Health Care Sharing Ministries; and
4. State Consumer Protection Acts.

Q-Rep. Kerry Tipper: I'm just asking who would hold those bad actors accountable without this bill. Who would you believe to be holding those bad actors accountable?

A: An invalid, non-CMS-recognized HCSM has NO legal protection. Therefore, an invalid, non-CMS-recognized HCSM is by definition operating illegally and is accountable to:

1. The Colorado Insurance Commissioner;
2. The Colorado Attorney General;
3. Each county prosecutor;
4. The United States Postal Inspector;
5. The Federal Bureau of Investigation; and
6. Every person who is harmed by them who can take them to civil court for damages.

Q-Rep. Dominique Jackson: What are insurance companies… how much of the premiums that people pay are the insurance companies actually required to spend on care?

A: The Insurance Commissioner can speak to the insurance companies' percentages, but as to the valid HCSMs: The small Amish/Mennonite or Old German Baptist BrethrenCMS-recognized HCSMs use 100% of their monies on their members' health care. The administration of those small HCSMs is done by volunteers. Occasionally, they may appeal for the folks to send in some money for postage.

The larger interdenominational HCSMs segregate the monies sent for medical costs from those paid for the administrative fees. Those fees rarely are more than 12% of the total amount given by a member.

Q-Rep. Dominique Jackson: I'm trying to figure out growth in this particular marketplace, these cost sharing entities, do they offer other products, are they spending to your knowledge and I know you are looking for data but do you have any ideas as to how much of those premiums is it 80-85% that they're actually spending on care or how much of it is going for administration? I'm on the website of one of them and they have all kinds of jobs. So, tell me about how this industry is growing and tell me where you believe the money is going.

A: The ACA did not exempt HCSMs in order for them to create an "Industry." Before and after the ACA, the only proper function for Health Care Sharing is for it to be a ministerial function, which is why only non-profits can legally operate as HCSMs.

Prior to the ACA, the HCSMs were not well known to the general public, but as their exemption within the ACA became known, they became more and more popular. Even as their popularity increase, though, they should remain ministerial and not commercial.

Q-Rep. Kerry Tipper: I wondered if Ms. Harris could talk to me. Are there differences in terms of what this bill would require cost sharing to report versus what traditional health plans have to report?

A: These valid CMS-recognized HCSMs are all non-profit ministries. They are not AIG or Travelers Insurance.

The small Amish/Mennonite or Old German Baptist Brethren CMS-recognized HCSMs operate out of and as a part of their individual churches, yet because of the dictates of the ACA they were compelled to apply for and become CMS-recognized HCSMs. As a CMS-recognized HCSM, each one of them must have an annual audit performed by a certified public accountant.

The larger HCSMs also have that same annual audit requirement, but as one might expect, their audits are much lengthier and more involved.

The audits of all HCSMs, small and large, are required by the ACA to be publicly available to any one who asks for them.

There is no realistic need for these valid CMS-recognized HCSMs to report anything else.

Q-Rep. Mark Baisley: Ms. Harris [of the Department of Insurance], do you foresee a time then in the future based upon your personal story when the DOI would establish a rule or some other requirement that would direct the health sharing ministries to not discriminate based on sexual preference?

A: On this and any future question about the possible expansion of government influence over HCSMs, please keep in mind this example of the incremental expansion of government: When the income tax on individuals was first passed by Congress and implemented in 1913, the original United States "Return of Annual Net Income Tax of Individuals" was a single page and the instruction for calculation of an individual's tax was very simple: it was one percent (yes, 1%) of the person's net income.

Q-Rep. Matt Soper: What I'm still trying to figure out is, actually the question is ... the premium. It's my understanding just from listening that premiums aren't paid per month but that you have a pooling of funds whenever there is a medical emergency so is just that when a member of the cost sharing has a medical emergency that they can't cover is that when the members also chip in to help cover those expenses?

A: It is important to remember that in order to distinguish HCSMs from insurance, as well as to create a consumer protection tool, twenty of the 32 States with HCSM laws do not permit HCSMs to pool funds or create reserves but rather these States have provisions expressly requiring HCSMs to only use direct member-to-member sharing.

As to the amounts shared, the principle is that everyone ought to carry their own load but the burdens that cannot easily be budgeted for should be shared amongst the group. The various HCSMs all incorporate that same principle but implement and express it in different ways.

Q-Rep. Kerry Tipper: I think I misunderstood something, I think you said Riley's premature birth was about 1 million dollars in bills and that you received cost sharing in roughly half a million, is that what I understood you to say?

A: Basically, no one pays the retail price that is shown on a hospital's bill. In an unpleasant irony, the people who typically are given the worst discount and are asked to pay the most are self-pay patients, and HCSM members are self-pay patients. As a result all of the HCSMs, even the small church-based ones, have someone who tries to help the member negotiate the bill down to an amount that would be more in line with what the hospital usually receives from other payors.

That is what likely happened with Riley.

Q-Rep. Brianna Titone: I belong to a HOA, is this sort of like that? If you're in a HOA and the roof has got to be repaired and everybody chips in to pay for the roof because we're all kind of responsible for the roof? If somebody has a catastrophic illness everybody is on the hook to pay for that person who has that illness?

A: No. In an HOA, each member is obligated to pay their share of the collective costs of the homeowners group, and by their covenants each HOA member and the HOA itself have an enforceable right against a non-compliant member to compel them to pay. In an HCSM, no member is obligated to pay anything, and neither the members nor the HCSM have any enforceable right against a member who chooses not to share.

Health care sharing is a voluntary act and an expression of faith. It does not involve a contractual act or promise to pay.

Q-Rep. Kerry Tipper: So, the cost sharing members aren't just individuals or families, they can be organizations as well?

A: An HCSM member can only be an individual. Employers, churches, and other organizations can not be an HCSM member. It is not unusual, though, especially in the Plain communities of the Amish/Mennonite or Old German Baptist Brethren, for all the employees of a business to be members of the same church and belong to the same HCSM.

Even outside of the Plain communities, many for-profit and non-profit organizations will be made up of like-minded people who want to use an HCSM and the employer assists as the various applicable laws permit them to do so.

Q-Rep. Brianna Titone: How many members do you have roughly in the organization right now?

A: Some of my Amish/Mennonite or Old German Baptist Brethren HCSM clients may have only a dozen or so families and as few as 40 individuals. The larger interdenominational HCSMs can have more than a hundred thousand members.

Q-Rep. Matt Soper: One question I have for you guys is would you ever have a health insurance plan and a health cost sharing at the same time?

A: It is not common, but I have had business clients who have done exactly that, simply because they liked their health insurance for themselves but they wanted to have an HCSM membership simply so they could assist the HCSM's members.

Q-Rep. Kyle Mullica: Mr. Noble [a staff person with Samaritan Ministries], … I don't see that the bill is necessarily trying to stop organizations from being in business but you had mentioned and we had heard that there may be some outliers and we talked about there may be some outliers being investigated and being shut down in Colorado. We've heard that maybe there's some outliers that aren't necessarily putting as much money back into the system as they should. That's not necessarily your company and I understand that. But when we do have those outliers, when we do have an organization that is not operating in good faith, that is potentially trying to harm some of our community members. Why would we not want the ability to deal with them? Why would we not want the ability? To me those outliers actually harm your business, they harm the reputation of the entire system as a whole so I would think we would want to try to deal with those that are not operating in good faith so that the whole system doesn't get a bad reputation or doesn't go down.

A: Absolutely, the counterfeit HCSMs such as Aliera and Trinity do harm the reputation of the valid CMS-recognized HCSMs and should be investigated and shut down, as they have been in Colorado, Connecticut, Maryland, New Hampshire, Rhode Island, Texas, and Washington. The fact that they have been successfully shut down in each of those States shows Colorado and those other States clearly did have the ability to deal with them.

Think about this -- every store wants to be able to successfully identify counterfeit money, but it would never consider ripping up all the bills in the drawer when it finds a counterfeit one. Identifying a counterfeit bill is easily done by a cashier at the register. The Federal Reserve gives these identifying features for a $20 bill: "The current design $20 note features subtle background colors of green and peach. The $20 note includes an embedded security thread that glows green when illuminated by UV light. When held to light, a portrait watermark of President Jackson is visible from both sides of the note. In addition, the note includes a color-shifting numeral 20 in the lower right corner of the note."

Identifying a counterfeit HCSM is not much more difficult: Is it able to produce a letter from CMS stating that it is recognized as fitting the ACA definition of a valid HCSM? If not, it is a counterfeit HCSM and it should be shut down. The religious expression of the

people who joined the 104 valid CMS-recognized HCSMs should not be restricted because of the illegal actions of the few counterfeits that can easily be identified and quickly shut down.

Q-Rep. Mark Baisley: Mr. Stone, the purpose of this bill is for the government to call out the bad actors. Those who are not operating in good faith. As I recall, related to your story, the President of the United States guaranteed you, all of us, if you liked your insurance plan that you could keep your insurance plan and you are telling us that didn't happen, twice. So, is it your assertion that the government is not operating in good faith?

A: Under President Obama, the ACA specifically exempted members of valid CMS-recognized HCSMs from having to participate in the ACA. We applaud him for doing so in conformity with the First Amendment and much case law. People acted upon that exemption and joined these HCSMs in good faith. We are simply asking that they be allowed to continue to operate as long as they do so within the limitations of the ACA's definition of a valid HCSM.

Thank you, and I would be glad to entertain any comments or questions that you may have.

J. Michael Sharman
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