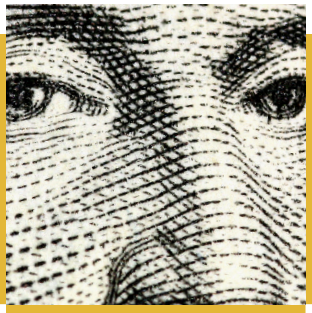
issue briefs
Family Financial Education



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FAMILY FINANCIAL ASPECTS OF HEALTH CARE

This brief provides a background on family *financial* aspects of health coverage, the basics of health insurance and dealing with uncovered medical expenses. With changing health care options offered by employers, states and the federal government, the need to understand how health care insurance works, as well as tax and other implications, is important. Yet, the majority of people do not understand how health insurance works, or how to deal with selecting and managing health coverage.[1] Even a basic understanding may help avoid high health care expenses and preserve family financial security.

How Does Health Insurance Work?

Health care costs can be expensive. It is hard to predict if a family will need major health care services in a given year, but most families incur basic health care costs associated with minor illnesses, well-visits and treatment of chronic conditions. These costs are often minor and could be paid for like any other service or product. But other costs can be extreme—for example coronary heart bypass surgery—a relatively common event for aging Americans, can cost $50,000-$100,000. This is where insurance is important; without insurance, critical care would be unaffordable. Insurance allows consumers to share those risks across large pools of people so that no one with insurance has to carry the full cost.

But health insurance markets are plagued with what economists call market failure. People do not usually search for health care based on price. Emergency services are not like shopping for groceries; people who need care get it and sort out the costs later. A related problem is people who are healthy may try to get by without insurance, but then sign up and enter an insurance pool after they are already sick. This is called adverse selection and instead of spreading the costs of insurance, it concentrates the costs and increases what health insurance pools have to charge for coverage. The ideal system from an economics perspective would allow maximum consumer choice but require most people, healthy or not, to

1 http://capsules.kaiserhealthnews.org/index.php/2013/08/survey-americans-have-low-health-insurance-literacy/

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pay into the pool. Then when consumers have time to "shop around" they do so, while emergency care is covered as an insured event. Getting this balance right is not easy, as evidenced by the complexity of the health care insurance market.

The Costs of Health Insurance

Getting coverage is complicated. Many people have health plans offered by their employer. Some use publically provided options like Medicaid (if they are low income) or Medicare (if they are older). Other people buy insurance independently, somewhat like buying property or auto insurance. Like these markets, firms charge premiums for coverage, but then also charge other fees. The costs of health insurance include:

- Premium Payments - the dollar amount that the insurance company charges for a specific health insurance contract for a set period of time. The total premium may include some portion paid by the consumer, employer or in some cases a federal subsidy.
- Co-insurance Costs – is a portion of the costs of a health care service that are paid for by the consumer, usually calculated as a percent of the final total bill (e.g. 20 percent). This is different from a deductible.
- Deductibles – this is the amount the consumer pays *before* health insurance begins to pay. For example, a deductible of $1000 means the insurance will not pay anything until at least $1000 of qualified expenses have been paid by the consumer. Deductibles may not apply to all kinds of expenses, or be categorized by type (e.g. kinds of treatments, etc.).
- Co-payments – this is a small, usually fixed amount (e.g., $5) for certain kinds of services, such as office visits or covered pharmaceuticals.

Most plans have an "Out-of-Pocket Limit" which creates a ceiling or maximum for total payments (typically for a calendar year). This limits the total costs of a large health care expense, but does not include premiums or uncovered care. These limits are often quite high so it takes a large number of co-insurance, deductible and co-payment charges to reach the limit.

The key point is that anyone in the market for health insurance needs to look at more than just the premium. Co-insurance, deductibles and co-payments can make a bigger dent in the typical family's budget than a premium if someone needs critical health care. In general, higher premiums will result in lower payments for care, and lower premiums will result in more costs for deductibles, co-insurance and co-payments. Under the Affordable Care Act (ACA) there are four "tiers" of health plans. These are categorized to help people select a combination of premiums and services covered. Bronze plans have the lowest premiums but the highest out-of-pocket costs, covering just about 60 percent of the actual costs of care. Silver plans cover about 70 percent of the costs of care, but have higher premiums. Gold plans cover 80 percent of costs but have even higher premiums. Finally, Platinum cover 90 percent of costs and have the highest premiums, but the lowest out-of-pocket costs. Under ACA, all health insurance plans must cover 10 essential benefits, including: emergency services, hospitalization, laboratory tests, maternity and newborn care, mental health/substance-abuse treatment, outpatient care, pediatric services, prescription drugs and preventive and rehabilitation services.)

The Federal government's Centers for Medicare and Medicaid Services (CMS) has developed some useful materials for helping people understand how health insurance works, including graphics, brochures and a glossary of terms. These health insurance literacy materials are on the CMS.gov website at http://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library-Items/Health-Insurance-Literacy.html

How Has the Affordable Care Act (ACA) Changed Family Financial Aspects of Health Care Coverage?

ACA expanded coverage and standardized what should be covered. It also sets up a way to lower the costs of premiums for lower-income families based on their "modified adjusted gross income" in federal income tax returns. Health insurance subsidies are available if this calculation of income is less than 400% of the federal poverty level (about $46,000 for an individual and $94,000 for a family of four). The tax subsidies for insurance are largest for people earning close to the federal poverty level, gradually phasing out as income increases.[2]

2 See https://www.healthcare.gov/what-if-i-dont-have-health-coverage/

What are the Tax Implications of Having Subsidized Health Care Premiums?

In November of each year, people estimate their income for the next year. On that basis, they participate in Open Enrollment for the following year's health care coverage. If someone underestimates their income and their actual income is higher than estimated at the time of application for health insurance, then the tax subsidy may be reduced and refunds the following year will be reduced or even taxes could be owed.

Anyone who works on commission or took a new job or got a raise may need to be concerned about tax implications. More than 7 million taxpayers are eligible for health insurance tax credits each year and should monitor their income for this risk. People can contact HealthCare.gov to update their estimated income, which if increased, will lead to higher health insurance premiums, but they can avoid tax implications later. In some cases, people will have to write a check to the IRS to make up for premiums owed, although the amounts are capped for lower-income earners. People who have a large increase in income may need to work with an advisor to minimize tax liabilities including making contributions to retirement accounts. Conversely, anyone who overestimates their income may actually be eligible for a larger tax credit for health premiums and, therefore, get a larger refund.

What are the Tax Implications of Being Uninsured?

The "penalty" for being uninsured is levied through tax filing. The amount changes from 2014 to 2016, increasing significantly. For tax year 2014, the penalty is typically $95 to $285 for lower income families, or 1% of income up to the lowest annual "bronze" plan premium. In tax year 2015, the penalty is $325 per person or 2% of income for higher-income families. In 2016, the penalty increases to $695 per person or 2.5% of income. The penalty is levied by month, so being uninsured for 6 months means paying 1/2 of the annual penalty. Being uninsured for 2 months or less does not trigger a penalty payment. Any penalties are paid through the federal income tax return, typically due April 15th of the following year. But underpayments of taxes can actually trigger other penalties.[3]

What About Costs that Are Not Covered?

When someone suffers a serious illness or injury, the bills can start stacking up fast. Not paying these bills can result in accounts being sent to collections, which can be referred to as medical debt (although there was no real borrowing—just accounts turned over to a collection agency). Medical "debt" may be reported in credit reports for up to 7 years after being settled. Obviously, this could be detrimental to credit histories and scores, lowering credit worthiness.

How To Save Costs?

Sometimes people may think that healthcare coverage makes the costs of health care "free." In reality, costs are a factor to consider in almost all, but the most dire situations. Using the emergency room is really the most expensive, last resort option for care only for life-threatening situations. High medical bills often stem from overuse of the emergency room. Urgent care centers can handle many issues that are less than life threatening, but beyond the times doctor offices are open. Most providers have afterhours care and last minute appointments, so seeing a regular health care professional may be an option, and at far lower cost. In-office visits may also help with continuity of care and support improved treatment overall. Many providers have no-cost ask-a-nurse advice telephone numbers, with such services available at all hours and over weekends, too. Each treatment proposed by a health care provider will have a cost, and providers generally know what will be covered under most insurance plans. Consumers need to remember to ask about the costs and coverage of any proposed procedure, and then ask about alternatives if the costs are higher than expected or unaffordable. Some procedures can be deferred, or even performed at a lower cost in another facility.

Shopping around is not an easy task, even with web-based tools like the cost comparison tool in Wisconsin: http://www.wipricepoint.org/. The larger barrier is just getting patients/consumers to ask questions and pay attention to costs at all. One strategy to encourage is for people to develop a budget or spending plan, based on expected health care usage and costs, for each year. The ideal is to set aside enough in savings to cover deductibles and other anticipated payments.

3 There are a number of "calculators" to estimate penalties. See one example at: https://www.healthcareact.com/calculators-penalty.asp . These sites will ask for income, family size and filing status to show projected penalties.

Attention to Prescription Costs

More and more plans offer prescription-drug programs with a specific formulary—that is a list of drugs that are covered, or not, and then any co-pays. Trips to the pharmacy can be a significant cost for some families, so paying attention to which drugs are listed is important, especially since the formulary changes from year to year.

Explanation of Benefits Forms (EOB) Need Scrutiny

The EOB shows how much the doctor charged the insurer, the amount insurance is covering (which may include more than one plan or insurer), and then the balance due from the consumer that a doctor may then proceed to bill directly. Many health care providers will start collecting payments soon after the EOB, and sometimes the EOB is revised so the amount owed can change. The process can take months. Consumers should not submit payments based on the EOB (it even says "this is not a bill"), and should look closely to make sure charges are accurate. Any mistakes can be disputed by calling the number on the EOB, and in some cases, also with the insurer and the provider directly. Common EOB mistakes include errors in service dates, duplicate charges, and costs of medications or tests that may have been ordered or discussed but never actually delivered.

What About Missed Premiums?

For people who take their tax credits for health care insurance in advance of tax time, insurers must provide a 90-day grace period during which consumers can bring their premium payments up to date without losing coverage. The insurer will continue to process and pay claims for the first 30 days, but after that, the insured consumer may be held responsible for any new services received. Health care providers may actually deny care if the policy is in delinquent payment status. People not receiving advanced tax credits also will have a 30-day grace period, although the rules will vary by plan and across states.

If a consumer is able to catch up on premium payments before the end of the 90-day grace period, the insurer will pay claims for expenses incurred. After the fourth premium is missed, coverage may be canceled and all charges deflected back to the consumer. The insurer may also have to return funds it received from the federal government for premium subsidies.[4]

Conclusion

Health insurance is a complicated market. Each fall people have to select a plan, navigate payment and subsidy alternatives, and predict future income and health care expenses. This requires a knowledge of how insurance works, the role of tax credits, and attention to household budgeting and planning. But over the course of the year, families also need to monitor health care spending and use of services; even small decisions can add significantly to overall costs if they are taken too lightly. Families need to begin learning about their options in the fall of each year, but focus attention on the finances of health care year around.

Resources:

To find coverage outside of employer-provided care and to sign up for reminders for enrollment periods see the Federal Healthcare.gov website: https://www.healthcare.gov/how-do-i-get-help-enrolling-in-the-marketplace/

There is also a database of community-based advisors online at https://localhelp.healthcare.gov/

To estimate tax credit subsidies for premiums see the Kaiser Family Foundation: http://kff.org/interactive/subsidy-calculator/

An interactive tool to help budget for out-of-pocket healthcare spending: http://www.puttingpatientsfirst.net/

Covering Kids and Families website with links and information on BadgerCare+ health insurance coverage: http://www.ckfwi.org/index.html

Additional links to resources for Cooperative Extension Educators: http://fyi.uwex.edu/healthteam/?page_id=468

4 marketplace.cms.gov/technical-assistance-resources/helping-consumers-grace-period.pdf

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