Affordability of Health Insurance Options

Health Insurance Industry Basics: Part 2 of 3

BeWell
New Mexico's Health Insurance Marketplace

Introduction

Affording health insurance and health care can be stressful for some consumers. Understanding concepts related to the affordability of health insurance will enable you to help consumers in an efficient manner. The basic terms around affordability—such as deductible, cost-sharing, out-of-pocket limit, etc.—were covered in a previous lesson. This training will address affordability options for health insurance.

Main Topics

- Medical spending accounts
- Health insurance billing
- Utilization management

Medical Spending Accounts (1 of 5)

- Flexible Spending Account (FSA)
  - An FSA is a financial arrangement setup through the employer to pay tax-free dollars for many out-of-pocket medical, dental, and vision expenses.
  - These expenses include insurance copayments, deductibles, qualified prescription drugs, insulin, and medical devices. However, the FSA cannot be used to pay premiums.
  - The employee decides how much in pre-tax wages are taken out of their paycheck and put into an FSA. The maximum amount allowed is set by the IRS. No taxes are owed on this money.
  - There is no carry-over of FSA funds. This means that FSA funds not spent by the end of the plan year cannot be used for expenses in the next year.
  - FSA arrangements are only available through employer-sponsored insurance.
  - **Note**: Individuals should consult the plan administrator for details.
  - **Note**: An FSA cannot be used with a Marketplace plan.

Medical Spending Accounts (2 of 5)

- Health Savings Account (HSA)
  - An HSA is a medical savings account available to taxpayers who are enrolled in a qualified High Deductible Health Plan (HDHP).
    - An HDHP has a higher deductible than a traditional plan. The monthly premium is usually lower, but more health care costs are covered by the consumer before the insurance company starts to pay its share (the deductible). An HDHP can be combined with an HSA, allowing consumers to pay for certain medical expenses with money free from federal taxes.
  - All medical cost-sharing applies after the deductible is met for the HDHP.
  - The funds contributed to the account are exempt from federal income tax at the time of deposit. HSA are established through a financial institution.
  - **Note**: BeWell does not collect or hold the funds for an HSA.

Medical Spending Accounts (3 of 6)

- HSA (continued)
  - Funds must be used to pay for qualified medical expenses. Unlike an FSA, funds remain in the customer's account from year to year until withdrawn by the account holder.
  - HDHP/HSA can be associated with a Health Maintenance Organization (HMO), Exclusive Provider Organization (EPO), or Preferred Provider Organization (PPO) plan, and eligibility should be confirmed with the carrier.
  - The maximum annual HSA account contribution is based on Internal Revenue Service (IRS) limits. Employers can also contribute to their employees' HSA accounts, and the combined contributions cannot exceed the deductible level.

Medical Spending Accounts (4 of 6)

- HSA (Continued)
  - Funds from an HSA can be used to pay for covered and non-covered medical services.
  - There is a tax penalty for withdrawing funds from an HSA to pay for non-medical expenses before age 65.
  - After 65, the funds can be used for anything. However, if used for non-medical expenses, the funds will be subject to the current tax rate of the individual.
  - **Notes**:
    - HSA generally cannot be used to pay for health insurance premiums, except for COBRA coverage.
    - IRS-HSA medical expenses require a 1099-SA form.
    - To review a more detailed list of qualified medical expenses that can be paid for using an HSA, please visit the IRS website.

Medical Spending Accounts (5 of 6)

- HSA (Continued)
  - Mid-Year Qualification
    - Consumers seeking advice about their taxes should consult a tax professional. According to the IRS, when a consumer enrolls in a HDHP and opens an HSA on the first day of the last month of the tax year (December 1 for most taxpayers), they can contribute the total allowable amount for that year.
  - To take advantage of the tax savings, however, consumers must:
    - Stay enrolled in a qualified HDHP for the following 12 months
    - Not have other health care coverage that would make them ineligible to contribute to an HSA
  - **Note**: A Silver level HSA plan may or may not allow the consumer to contribute to an HSA if the CSR lowers the consumer's deductible too far. Deductibles must be at least $1,650 for an individual and $3,300 for a family to be allowed to contribute to an HSA for 2025.

Medical Spending Accounts (6 of 6)

- HSA (Continued)
  - Contribution penalties
    - For non-qualified expenses
      - Those under age 65 (unless totally and permanently disabled) who use HSA funds for non-qualified medical expenses face a penalty of 20% of the funds used for such expenses.
      - Funds spent for non-qualified purposes are also subject to income tax.
    - Excessive contributions
      - HSA contributions exceeding dollar limits are not tax deductible and are subject to a 6% excise tax.

Health Insurance Billing (1 of 4)

- Health insurance billing includes allowed amounts and balance billing.
  - Allowed Amount
    - Maximum amount a plan will pay for a covered health care service.
    - This amount may also be called eligible expense, payment allowance, or negotiated rate.
  - Balance Billing
    - The difference between what the provider charges and the allowed amount.
    - **Example**: If the provider's charge is $100 and the allowed amount is $70, the provider may charge the consumer for the remaining $30.

Health Insurance Billing (2 of 4)

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- When consumers see a doctor or other health care provider, they may owe certain out-of-pocket costs, such as copayments or coinsurances. They may also have additional costs or have to pay the entire bill if they see a provider that is out-of-network.
- Out-of-network providers may be allowed to bill consumers for the difference between what their plan pays, and the full amount charged for a service, or "balance billing."
    - This amount is likely more than in-network costs for the same service and might not count toward a health plan's deductible or annual out-of-pocket limit.
    - In-network providers cannot balance bill.

Health Insurance Billing (3 of 4)

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- "Surprise billing" is an unexpected balance bill. This can happen when consumers cannot control who is involved in their care.
    - **Example**: When consumers have an emergency or when they schedule a visit at an in-network facility then are unexpectedly treated by an out-of-network provider.
- Surprise medical bills could cost thousands of dollars depending on the procedure or service.

Health Insurance Billing (4 of 4)

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- New Mexicans are protected from surprise bills when:
  - They do not have a choice in where to get their care; or
  - They receive services from an out-of-network provider at an in-network facility, and:
    - They did not consent to the services from the out-of-network provider;
    - They were not offered the services from an in-network provider; or
    - The services were not available from an in-network provider.
- If consumers are protected from a surprise bill and pay an out-of-network provider more than their in-network cost-sharing amount, they may be entitled to a refund from the provider of any amount paid in excess of the in-network cost-sharing amount.

Utilization Management

- Utilization Management (UM)
  - A set of techniques used to manage health care costs by influencing patient care decision-making through case-by-case assessments of the appropriateness of care prior to its delivery.
  - UM often includes the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan.
  - The evaluation is also sometimes called a “utilization review.”

Utilization Management (Continued)

- Referral
  - A written order from the Primary Care Physician (PCP) to see a specialist or receive certain medical services.
  - If the referral is not obtained before the services, the plan may not pay for the services.
- Prior Review or Prior Authorization
  - A decision by the health plan that a certain service or treatment is medically necessary.
  - If prior authorization is not obtained before the service, the plan may not pay for the service.
  - There is never a requirement for prior authorization for emergency care.
  - To determine if a referral or prior authorization is needed, the consumer should review plan documents and/or consult with their PCP.

Key Points

- Understanding terms and concepts related to the affordability of health insurance will enable agents, brokers, and enrollment counselors to help consumers in an efficient manner.
- Individuals may choose to opt into an FSA or an HSA.
- Cost-sharing refers to the share of costs covered by the consumer's insurance that they pay and includes deductibles, coinsurances, and copayments, or similar charges.
- Consumers should refer to their plan documents to determine what their costs will be, if prior authorizations are needed, what their deductible is, if copayments/coinsurances are applicable before or after a deductible, etc.


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