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The Financial and Tax Implications of the Affordable Care Act on Lower and Middle Class U.S. Residents

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THE FINANCIAL AND TAX IMPLICATIONS OF THE AFFORDABLE CARE ACT ON LOWER AND MIDDLE CLASS U.S. RESIDENTS

by

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1. Abstract

U.S. residents have historically struggled to obtain affordable, accessible, and high quality health insurance, the ACA has given residents the belief that this situation will change. I examine whether the Affordable Care Act (ACA) fulfills its predicted benefits for United States' lower and middle class residents, through analysis of both quantitative and qualitative information. The intent of the Affordable Care Act was to make health care more affordable, accessible and of higher quality than previously available (Assistant Secretary for Public Affairs (ASPA), 2014). The ACA set a single person insurance health plan premium limit of 9.66 percent of household income for that individual to meet essential coverage. The insurance companies could adjust premiums for any non-single person insurance plan without a limit. I suggest that there were significant cost increases to lower and middle class residents[1] that had health insurance coverage when the ACA went into effect. I used a survey of 100 people to evaluate the financial impacts of the ACA for the different income classes in the period from 2010 through 2014. The results of my survey showed that there were reported increases in costs for the lower and middle classes. There were no reported increases to the upper class participant in the survey.

2. Introduction

President Barack Obama signed the Affordable Care Act into law on March 23, 2010 (eHealth, 2016). The intent of the ACA was to allow people to make their preferred choices regarding their health care and to assist in making health care more accessible, affordable and more beneficial for those paying for healthcare (Assistant Secretary for Public Affairs (ASPA), 2014). The complete Affordable Care Act is a 2409-page pdf file that covers every conceivable aspect of this health care law; I am only going to focus on the financial and tax implications for lower and middle class U.S. residents who may, or may not, have realized the predicted benefits associated with the ACA. My concern is that when the ACA

[1] Defined as $0 to $150,000 annual income for a family of four (Francis, 2012).

went into effect, one portion of U.S. residents may have realized some increased benefits but another portion of the U.S. population suffered by negative financial effects.

This study addresses whether the Affordable Care Act has generated the benefit of residents increased ability to pay for necessary healthcare, based on changes in health insurance premiums, deductibles, and co-insurance payments since the implementation of the ACA.

According to HealthCare.gov, those who are eligible to purchase insurance through the marketplaces must be U.S. citizens, nationals, or lawful immigrants living in the United States, and not incarcerated. People who have or are eligible to have Medicare coverage cannot buy health or dental insurance from marketplaces. I will refer to those listed above who are eligible to purchase insurance from the marketplaces as participants (U.S. Centers for Medicare & Medicaid Services).

According to the Internal Revenue Service, the Department of Treasury (Treasury) and the IRS have issued final regulations requiring large employers, those who have 50 or more full-time employees or equivalents, to report health insurance coverage of their employees to both the IRS and their employees. The ACA also requires that the employers report the cost of coverage under an employer-sponsored group health plan on an employee's Form W-2, Wage and Tax Statement. These requirements show the employees the value of their health care benefits (IRS, 2016).

According to the information on the HealthCare.gov website, an individual can find the requirements that an individual/family have to meet under the requirements of the ACA. Such as, if an individual/family has a health insurance policy that meets the criteria of minimum essential coverage, then that individual/family is not required to pay the individual shared responsibility payment (penalty). Minimum essential coverage is any health insurance that meets the requirements of the ACA. Examples of plans that meet minimum essential coverage would be health insurance marketplace plans, job-based plans, Medicare, Medicaid, etc. Some individuals/families may be eligible for health cover exemptions for situations such as certain life events, financial status, etc., exemptions have to be preapproved and an individual/family cannot claim it without proof of approval (U.S. Centers for Medicare & Medicaid Services).

If an individual/family did not have, or cannot prove that they had, insurance coverage, they will be required to pay the penalty. If they qualify for the short gap exemption (less than three consecutive months) when they file their tax return, they will not be penalized. The listed penalty amounts are on the IRS website. This penalty is the greater of the percentage of the individual's income or a flat dollar amount. The percentage method uses the amount of income over the year's tax threshold for the individual/couples filing joint status. An individual/family will be required to pay 1/12 of the annual payment for every month they are not covered or exempt. The penalty amounts greatly increased between the 2014 and 2016 tax years. The requirements for that time span are as follows:

	2014	2015	2016
Percent of household income	1%	2%	2.5%
Flat dollar amount[2]:			
Per adult	$95.00	$325.00	$695.00
Per child under age 18	$47.50	$162.50	$347.50
Or maximum per family	$285.00	$975.00	$2,085.00

The following comparison is of the insurance coverage, premiums, and deductibles that my husband and I have had to meet both pre-ACA and post-ACA, with the comprehensive comparison attached as appendix A and B[3]. We are a middle-income family in the United States. Since the enactment of the ACA, we financially struggle to meet the expense of any medical care that we might need, except for the one free annual physical that our insurance provider covers without consideration of our deductible. The one free physical does not include the fully comprehensive physicals and significantly reduces blood draws that doctors would normally perform, such as cholesterol testing.

In 2013, we paid an annual premium amount of $4,897.10, after January 1, 2014 this amount increased to $6,251.96 with a much higher deductible and per visit payment requirements. Pre-ACA we could require a primary care visit and only have to pay a $20 copay, whether our deductible of $325 per individual was met or not. Under the new policy, in the same situation, we would be required to have met our $1,800 per individual deductible before the insurance will pay any amount. If we had met our deductible, our appointment would be 80 percent covered by our insurance. We would be charged $98 for the office visit if we were with the doctor for less than 20 minutes, depending on our medical complaint. There would be an additional medical fee of $59.00, totaling $157.00, if we were with the doctor for more than 20 minutes. Our 20 percent payment would be a minimum of $19.60 to a maximum $31.40. When compared to the previous copay of $20, this does not seem like a drastic difference until the amount of the deductible is considered. If we had not yet paid our deductible amount, we would have to pay the full amount of the office visit. Therefore, if the doctor visit happened on January 15 under the old coverage we would pay $20, but under the new coverage, we would pay $98. Another comparison is what I pay for premiums and family deductibles each year before I am at maximum benefit coverage. The pre-ACA plan amount increased from $5,547.10 to the post-ACA amount of $9851.96, for a significant increase of $4,304.86 annually.

[2] The flat dollar amounts increased by more than a multiple of seven in just two years, the maximum amount is capped at the premium amount for the bronze level health plan (detailed in Appendix C) through the marketplace (IRS, 2016).

[3] Employer sponsored insurance policy information for Robert Orton through BlueCross BlueShield of Alabama.

I researched what benefits are available through Coventry One, a company listed on the marketplace for coverage in Iowa and Nebraska. I found an offering of insurance for Des Moines county residents and then compiled that information into a spreadsheet, which I have attached as Appendix C. I am using this information to show what type of coverage is available through the marketplaces. I could not receive a premium dollar amount without applying for a policy.

Through this offering, there are four levels of insurance to choose from; Bronze with a $15 copay, Bronze/HAS eligible, Silver with a $10 copay, and Gold with a $10 copay. Information that I found in the Coventry One pamphlet (pdf file) shows a simplistic correlation between premiums and out-of-pocket costs. To realize a lower premium payment, the resident will have to incur higher out-of-pocket costs. If they choose to pay a higher premium, they will incur lower out-of-pocket costs. The table in Appendix C details the four available plans and what costs a participant can expect to see for a few specific medical benefits (Coventry Health Care, 2016).

People who have insurance offered by their employer could still be eligible to purchase insurance from the marketplaces. This option may not be beneficial if they have "affordable" insurance available. HealthCare.gov defines "affordable" insurance as insurance with a premium that meets the 9.66 percent standard. This means that the insurance provided by an employer costs the employee less than 9.66 percent of their total household income for employee-only coverage. The "affordability" standard does not have a designated maximum cost if the employee is paying for insurance for a plus spouse or plus family policy. Employees would not be able to realize the premium tax credit if they have employer offered insurance that meets the "affordability" standard, even in a situation where their income would normally qualify them for marketplace insurance. They will also not receive an employer contribution towards their insurance plan. (U.S. Centers for Medicare & Medicaid Services).

3. Literature Review

As of November 2014, the claim is that the ACA is working because health care is "more affordable, accessible and of a higher quality, for families, seniors, businesses, and taxpayers alike." I found this quote on the U.S. Department of Health & Human Services website, where they state this information includes those residents who had no insurance and those who had insurance that was not sufficient (Assistant Secretary for Public Affairs (ASPA), 2014). The U.S. Department of Health & Human Services website contains a page that lists and describes the benefits of the ACA for Americans, but does not give any supporting information to verify their claim that the ACA is working. One topic addressed is implementing a state-by-state approval system for insurance company rate increases. Any insurance company trying to increase their premiums by more than 10 percent would have to justify the increase to state regulators before implementing the proposed rate. Any state that is participating in this insurance regulation plan will be eligible for additional federal grants. The purpose of this is to allow

states to regulate premium increases, which would help control the negative financial implications for the insured. Any insurance company deemed to be implementing unjustified or unwarranted increases will be restricted from providing services in the marketplaces (Assistant Secretary for Public Affairs (ASPA), 2013).

According to information found on ehealthinsurance.com, there are grandfathered health insurance plans. This term means that the insured can continue with an individual health plan they enrolled in before the ACA went into effect as long as the plan stays active. Once the insurer no longer offers that plan, the insured must enroll in a plan that meets all of the requirements of the ACA (eHealth, 2016). Therefore, a grandfathered plan may or may not be beneficial depending on the premiums the individual is paying. They may be able to purchase insurance for a lesser amount.

A Huffington Post article contained the most comprehensive information on how the ACA has affected U.S. residents. The article reports both positive and negative results and possible future outcomes. The article states that the ACA law has reigned in some inappropriate practices by the insurance industry, and improved the way in which Americans receive care. The article states that since insurance companies can no longer deny coverage due to pre-existing conditions, they had to raise premiums to cover claims. There are still millions of residents without insurance and some who have insurance still have financial difficulty in paying medical bills. Some states seem to be able to work within the restraints with a few insurers actually making money.

The biggest piece of evidence from the article demonstrates that there have been improvements for the country. Gallup poll results reported in October 2016 state that the number of people without health insurance had decreased between 2008 and now. In 2008, the reported percent of American people without insurance was 14.8. In 2016, the report stated that the percentage is 10.8, for a total decrease of four percent. It also reported that the percent of adults who struggled to pay for medicine or health care in the past year had decreased from 19.7 to 15.5, for a difference of 4.2 percent from 2008 to 2016 (Cohn, 2016).

The graph below is the Gallup poll information, which was included in this article to show the changes in adults who struggled to pay for medicine and health care from 2008 to 2016 (Cohn, 2016). As you can see, the greatest decreases occurred between 2014 and 2016, which is when the ACA began prohibiting the discrimination of residents who had pre-existing conditions or due to gender and established the health insurance marketplaces (Assistant Secretary for Public Affairs (ASPA), 2013). When these two areas of the ACA law went into effect in 2014, there appears to be an improvement in medicine and health care affordability.

Many large insurers claim to be losing money due to the policies they sell on the marketplaces. The insurance providers attribute the high financial losses to the fact that the healthier uninsured residents have not enrolled in the marketplace at the pace that was expected, but unhealthy residents have, which causes the insurance companies to pay more in claims than they are receiving in premiums. These losses have triggered the insurance companies to either increase premiums or remove themselves from the marketplaces. Because insurance providers are leaving the marketplace, there is a prediction that over 19 percent of residents who use the marketplace will only have one insurance provider available to them in 2017 compared to two percent the year before. The article did not explain the reason(s) behind the millions that still do not have insurance coverage. An explanation for the residents who now have insurance, but struggle to pay their medical bills, could be the increasing premiums the insurance companies have been implementing. The premium increases may cause more of the residents' money to go to premiums and reduce the amount available to pay medical bills (Cohn, 2016).

4. Research Method

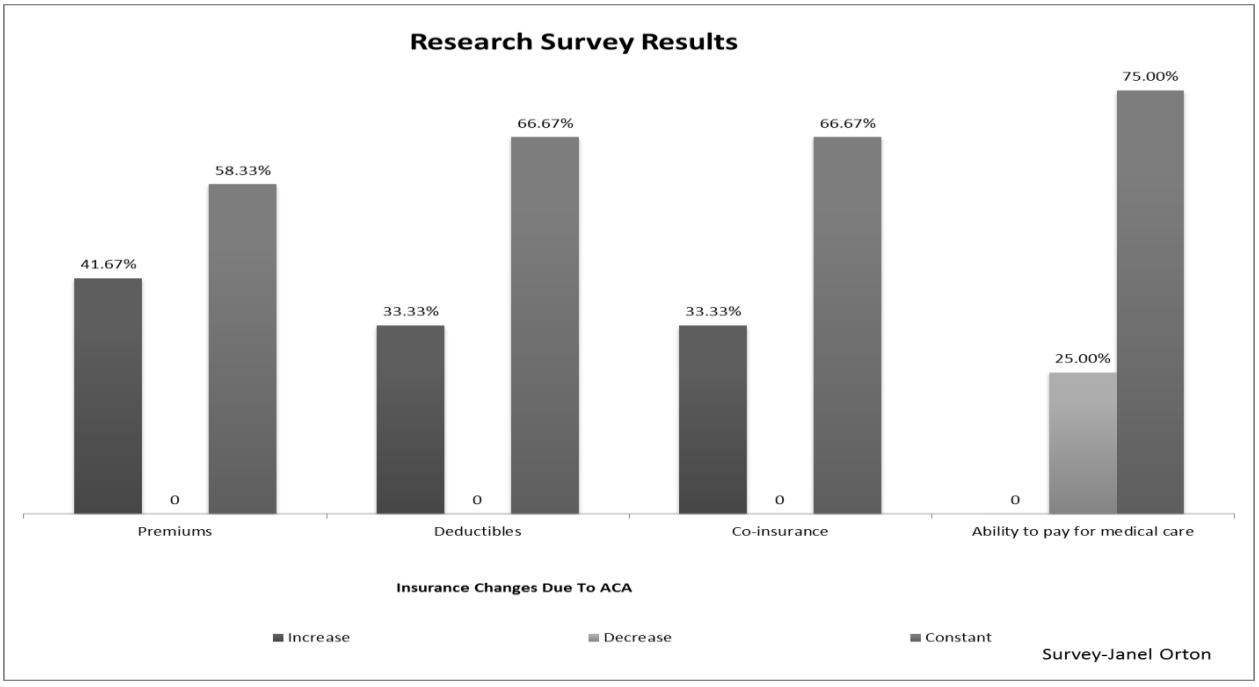
For the research information collected, I used mail/e-mail surveys in a questionnaire design with closed-ended questions. The purpose of using mail surveys was for participants who wanted to remain anonymous, but still wanted to be able to help me complete my research. If participants wanted to save time and was not concerned about me knowing whom the survey came from, they could send their survey results to me through e-mail. I gave my personal guarantee that I would not use any names in my thesis, but gave both options to the participants to try to increase participation. Mail surveys tend to receive honest responses due to participant anonymity, but there is typically a lower response rate from possible participants. I used the questionnaire design because I wanted answers to very specific questions that are

comparable to information found in the articles I have already referenced. The use of closed-ended questions is because I needed simple yes, no, or not applicable answers.

5. Survey Results

"A common response rate for a survey is 10-20%." (Knowledge Base), the survey I conducted had a typical response rate, 15 percnet. I mailed/e-mailed 100 surveys and received submissions from 15 people, but three of them cannot be considered in the sample for different reasons. One is on Medicare and also has retirement medical coverage from his past employer and is not responsible for any medical premiums, deductibles, copays, or co-insurance. Another is in the upper middle class income category, $100,000 to $150,000 yearly income for a family of four, but the participant and participant's family does not have any health insurance at this time. Medicaid covers the last participant and participant's family and the participant stated that they are not financially responsible for any portion of their current health coverage. The results from the remaining 12 participants showed that 41.67 percent had premium increases due to the ACA, 33.33 percent experienced deductible increases, 33.33 percent now have to pay a larger co-insurance amount, and 25 percent are less able to pay for health care visits.

According to the information obtained from the Unite for Sight website, a sample size would be considered a reasonable starting point if it consisted of 30 respondents but it also gives the formula, $1\sqrt{n}$, where n represents the number of participants, which can be used to determine the margin of error at a 95 percent confidence. This would mean that within that particular margin of error there is only a 5 percent chance that the results would not represent the true population (Unite for Sight). Therefore, there is a 25.82 percent margin of error at a 95 percent confidence level, for the results of my survey.



None of the participants reported a decrease in premiums, deductible, or co-insurance payments, but a large percent for each payment type reported that their health insurance remained constant before and after implementation of the ACA. After calculating the overall survey results, I then broke the information down by income class. It became apparent that the participants in the poverty class and upper class did not experience premium or deductible increases, and the upper class did not experience co-insurance increases or a decreased ability to pay for healthcare. The working class and all categories of the middle classes experienced at least some premium increases, while the increases for deductibles, co-insurance and a decrease in ability to pay was varied throughout these classes.

Survey-Janel Orton	**Increases by Income Class**					
Number of Participants	1	1	1	6	1	2
Income Class	Poverty	Working Class	Lower Middle Class	Middle Middle Class	Upper Middle Class	Upper Class
Premiums	0.00%	100.00%	100.00%	33.33%	100.00%	0.00%
Deductibles	0.00%	100.00%	0.00%	33.33%	100.00%	0.00%
Co-insurance	100.00%	100.00%	0.00%	33.33%	0.00%	0.00%
Less Ability to pay for medical care	100.00%	100.00%	0.00%	16.67%	0.00%	0.00%

6. Discussion

By using the information received from the surveys, I am able to determine from the sample that the upper class income level respondent reported no negative financial effects due to increased premiums or deductibles, therefore I will consider them unaffected. A large number of the participants, ranging from poverty level to upper middle class, reported adverse financial effects due to the implementation of the ACA. These results agree with the information from the Huffington Post article, stating that insurance companies are claiming financial losses and in response, some have raised premiums, and in some cases, the increases have been dramatic (Cohn, 2016). If insurance companies are drastically raising their premiums, that information leads to the conclusion that at least some states are not participating in the proposed justification program that would help regulate how much insurance companies could increase premium prices and allow states to be eligible for grant funds (Assistant Secretary for Public Affairs (ASPA), 2013). Insurance companies need to be able to have a financial inflow that can cover their claims outflow and their cost of doing business. By increasing premiums, deductibles, and co-insurance payments to help cover the losses they have experienced since the implementation of the ACA, there is a

definite possibility that more residents have faced negative financial effects, than those who have experienced positive benefits.

Those negatively affected by one or more of the premium, deductible, or co-insurance increases then have to decide which financial decision to make for their own benefit:

- Forego paying for insurance at all as one of my survey respondents did, or
- Pay the increased amounts charged by the insurance companies, which could make it more difficult to afford medical care?

The survey participant who reported not having insurance would have to consider both their tax consequences, the cost of paying for insurance, and the possible amounts they would have to pay for medical care throughout the year to determine which they feel will be more beneficial to them. This participant is from the upper middle class, married, and has two children. To calculate the approximate tax penalty, I will calculate based on the low- ($100,000) and high-income ($150,000) dollar amounts for this class. The penalty needs to be calculated both by the percent of household income and by the flat dollar amount, then the tax payer has to pay whichever is higher but no more than the average for the national marketplace Bronze plan. When calculating the percent of household income, a taxpayer would first reduce their income by either $10,150 for an individual or $20,300 for a couple filing jointly, which is the tax thresholds for 2016. To calculate the annual flat rate there is a fee of $695.00 per adult without insurance and $347.50 per child without insurance, but cannot exceed $2,085.00. Calculation amounts below would indicate that if the taxpayer's household income were $100,000, they would have to pay the penalty based on the flat fee. If their household income were closer to $150,000, they would pay the penalty based on the percentage calculation. Either calculation could be limited if the national marketplace average for the Bronze plan was less than the fee calculated. Calculations are as follows:

Comparison of penalty	Percent of household income method		Flat fee method
Household Income	$100,000 annual	$150,000 annual	2 adults, 2 children
Less: tax threshold	(20,300)	(20,300)	N/A
Subtotal	79,700	129,700	N/A
Multiplied by fee	*2.5%	*2.5%	
Total Fee	$1,993	$3,243	$2,085[4]

A taxpayer would have to determine if it is financially beneficial to pay the tax penalty instead of paying the insurance company's premiums and medical care required through the year. The taxpayer I used in this example has obviously decided it was better for them to pay the penalty. Insurance companies are blaming residents such as this participant for the premium increases that insurance companies have

[4] Calculation is 2 * 695.00 for the adults plus 2 * 347.50 for the children, equals $2,085.00.

implemented. The insurers are claiming that the healthier residents are opting not to enroll in the marketplaces, which mean that those who are enrolling are less healthy, and have numerous medical claims and this is the reasoning insurers used for increasing premiums. They are claiming that if the healthier residents would have also enrolled in the marketplaces that the premiums for those residents would help to cover the claims for the medical claims of the less healthy residents, and they would not have had to increase premiums to continue to operate (Cohn, 2016). I know from personal experience that my husband's insurance premiums increased on January 1, 2014, the day the marketplaces began to operate and before the insurance companies would have started to lose money which leads to the conclusion that the insurance companies were possibly raising premiums before they had experienced losses.

Although I have not been able to prove that the negative tax and financial implications for the lower and middle classes have outweighed the benefits realized by those using the marketplaces, I have proven that there have been negative implications for those classes.

7. Conclusion

With the election of 2016 electing a Republican president and Republicans having majority of both the house and senate, there is concern that the ACA will not be a going concern. The Republicans have declared they will repeal the ACA, but they have also suggested replacing it but without a specific plan described. The Huffington Post article is predicting that if the ACA is replaced it will revert back to a similar structure to what it was before the ACA, with less regulation for insurance companies, cheaper premiums for being in good health, and less healthy residents having problems obtaining insurance (Cohn, 2016). If the Republicans repeal the ACA, some of the concerns in this thesis may become mute but other consequences would need addressing. Such as, now that the insurers are collecting higher premiums and deductibles would they revert to the previously charged premiums and deductible levels? As any business that has risen prices and continued to maintain their customer base, they most likely will not be willing to reduce their premiums back to pre-ACA amounts.

With this knowledge, repealing the ACA or leaving it structured exactly as it is now will most likely continue to have negative financial and tax implications for lower and middle class residents. As stated in the Huffington Post article, our elected politicians will need to find a way to work in a bipartisan manner to find resolutions to what is not working within the ACA (Cohn, 2016).

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Appendix A

Employer offered insurance--personal experience		
Base salary of $50,000 but less than $70,000	Before Affordable Care Act implementation	
Yearly Premium	$4,897.10	
Monthly Premium	$408.09	
Member benefits	In network	Out of network
Deductible (ded) individual/family[1] (applies to out-of-pocket maximum)	$325/$650	$700/$1,400
Insurance Provider coinsurance	85%	65%
Out-of-pocket maximum individual/family[1] (maximum you will pay for all covered services)	$1,500/$3,000 (not including copays)	$2,500/$5,000 (not including copays)
Primary care visit	100% after $20 copay	65% after ded.
Specialist visit	100% after $20 copay	65% after ded.
Outpatient surgery (ambulatory surgical center/hospital)	85% after ded.	65% after ded.
Emergency Room (non-emergency additional copay)	85% after ded. ($100)	65% after ded. ($100)
Hospital stay--facility fee (e.g. hospital room) (If not precertified $500 copay)	85% after ded.	65% after ded.
Preventive care/screening/immunization (1st in-network routine colonoscopy and mammogram of the year 100%)	100% after $20 copay, limit $280/ year per person	100% after $20 copay, limit $280/ year per person
Diagnostic lab	85% after ded.	65% after ded.
Diagnostic X-ray	85% after ded.	65% after ded.
Imaging (CT/PET scans, MRIs)	85% after ded.	65% after ded.
Urgent care	No information	No information
Other practictioner (chiropractor) $1,000/year max	85% after ded	65% after ded
Physician/surgeon fees	85% after ded.	65% after ded.
Emergency medical transportation	No information	No information
Hospital stay--physician/surgeon fee	85% after ded.	65% after ded.
Mental/Behavorial health outpatient services	85% after ded.	65% after ded.
Mental/Behavorial health inpatient services (If not precertified $500 copay)	85% after ded.	65% after ded.
Substance use disorder outpatient services	85% after ded.	65% after ded.
Substance use disorder inpatient services (If not precertified $500 copay)	85% after ded.	65% after ded.
Prenatal and postnatal care	85% after ded.	65% after ded.
Delivery and all inpatient services	85% after ded.	65% after ded.
Home health care (If not precertified $500 copay)	100% no ded.	65% after ded.
Rehabilitation services (60 visits per member/year)	85% after ded.	65% after ded.
Habilitation services (60 visits per member/year)	85% after ded.	65% after ded.
Skilled nursing care (60 visits per member/year)	85% after ded.	65% after ded.
Durable medical equipment	85% after ded.	65% after ded.
Hospice service (If not precertified $500 copay)	100%, no ded or copay	65% after ded.

Appendix B

	Employer offered continued	
Base salary of $50,000 but less than $70,000	After Affordable Care Act implementation	
Yearly Premium	$6,251.96	
Monthly Premium	$521.00	
Member benefits	In network	Out of network
Deductible (ded) individual/family[1] (applies to out-of-pocket maximum)	$1,800/$3,600	$4,000/$8,000
Member coinsurance	80%	50%
Out-of-pocket maximum individual/family[1] (maximum you will pay for all covered services)	$6,350/$12,700	$15,000/$30,000
Primary care visit	80% after ded	50% after ded
Specialist visit	80% after ded	50% after ded
Outpatient surgery (ambulatory surgical center/hospital)	80% after ded	50% after ded
Emergency Room (non-emergency additional copay)	80% after ded. ($250)	50% after ded, ($250)
Hospital stay--facility fee (e.g. hospital room) (If not precertified $500 copay)	80% after ded	50% after ded
Preventive care/screening/immunization (1st in-network routine colonoscopy and mammogram of the year 100%)	Covered in full; ded waived	Not covered
Diagnostic lab	80% after ded	50% after ded
Diagnostic X-ray	80% after ded	50% after ded
Imaging (CT/PET scans, MRIs)	80% after ded	50% after ded
Urgent care	80% after ded	50% after ded
Other practictioner (chiropractor) $1,000/year max	80% after ded	50% after ded.
Physician/surgeon fees	80% after ded	50% after ded
Emergency medical transportation	80% after ded	50% after ded
Hospital stay--physician/surgeon fee	80% after ded	50% after ded
Mental/Behavorial health outpatient services	80% after ded	50% after ded
Mental/Behavorial health inpatient services (If not precertified $500 copay)	80% after ded	50% after ded
Substance use disorder outpatient services	80% after ded	50% after ded
Substance use disorder inpatient services (If not precertified $500 copay)	80% after ded	50% after ded
Prenatal and postnatal care	80% after ded	50% after ded
Delivery and all inpatient services	80% after ded	50% after ded
Home health care (If not precertified $500 copay)	80% after ded	50% after ded
Rehabilitation services (60 visits per member/year)	80% after ded	50% after ded
Habilitation services (60 visits per member/year)	80% after ded	50% after ded
Skilled nursing care (60 visits per member/year)	80% after ded	50% after ded
Durable medical equipment	80% after ded	50% after ded
Hospice service (If not precertified $500 copay)	80% after ded	50% after ded

Appendix C

On & Off Exchange Coventry One Health Plan options, Iowa & Nebraska				
	Coventry Bronze $15 Copay	Coventry Bronze HAS Eligible	Coventry Silver $10 Copay	Coventry Gold $10 Copay
Yearly Premium				
Monthly Premium				
Member benefits	In Network Coverage			
Deductible (ded) individual/family[1] (applies to out-of-pocket maximum)	$6,850/$13,700	$6,450/$12,900	$3,500/$7,000	$1,400/$2,800
Insurance Provider coinsurance	100%	100%	70%	80%
Out-of-pocket maximum individual/family[1] (maximum you will pay for all covered services)	$6,850/$13,700	$6,450/$12,900	$6,250/$12,500	$5,000/$10,000
Primary care visit	$15 copay; ded waived	Covered in full after ded	$10 copay, ded waived	$10 copay, ded waived
Specialist visit	Covered in full after ded	Covered in full after ded	$75 copay, ded waived	$40 copay; ded waived
Outpatient surgery (ambulatory surgical center/hospital)	Covered in full after ded	Covered in full after ded	$250 copay after ded, then 70%	80% after ded
Emergency room (copay waived if admitted)	Covered in full after ded	Covered in full after ded	$500 copay after ded	$250 copay after ded
Hospital stay	Covered in full after ded	Covered in full after ded	$500 copay/admission, after ded, then 70%	80% after ded
Preventive care/screening/immunization (age and visit limits apply)	Covered in full; ded waived	Covered in full; ded waived	Covered in full; ded waived	Covered in full; ded waived
Annual routine gyn exam (annual pap/mammogram)	Covered in full; ded waived	Covered in full; ded waived	Covered in full; ded waived	Covered in full; ded waived
Diagnostic lab	Covered in full after ded	Covered in full after ded	70% after ded	80% after ded
Diagnostic X-ray	Covered in full after ded	Covered in full after ded	70% after ded	80% after ded
Imaging (CT/PET scans, MRIs)	Covered in full after ded	Covered in full after ded	$250 copay after ded, then 70%	80% after ded
Urgent care	$100 copay; ded waived	Covered in full after ded	$75 copay, ded waived	$75 copay, ded waived