The Single Mom's Guide To Health Insurance

ARK INSURANCE SOLUTIONS

By Rebecca Yates
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Introduction

In 2004, I was navigating a large collection of life changes. I found myself facing a divorce, with a young child in tow, moving unexpectedly, and learning that my job was terminating. I could either move to another state or become unemployed. In my quest to find work that would allow me to stay near my support system, I was offered a job working in a small health insurance brokerage. It was July and I was very torn about taking the job. You see, I had been in sales for quite some time, but I was selling emergency medical supplies. Things that I knew for SURE were helping people in their lives and potentially even saving lives at the same time. My only exposure to insurance had been working for a short time in college for an agent who had some questionable morals. I tended to think that insurance people were dishonest and scummy, and truly, I didn't know if I believed in insurance.

Then I got a call from my mother-in-law. She told me that my soon-to-be ex-husband had rolled his four-wheeler and been life-flighted to the hospital. He was in the ICU and she asked me to bring our daughter up to see him. I remember standing there, unsure of my feelings, when the nurse asked "Are you the wife?"

At this point we had been separated for two years. I had just removed him from my health insurance on June 30. He had told me that he would be getting insurance from his dad's company, where he had just started working. I looked at the nurse and said, "Sort of, well technically yes, we've been separated for a long time, but aren't divorced yet." She replied, "Well welcome to Utah. He just informed us he doesn't have health insurance, and really doesn't have any income yet. Since you are still married, you are liable for the bill. We're at about $100,000 so far today and expect it to hit around $1,000,000 by the time he gets out. How do you want to pay for that?" I've had some nasty shocks in my life, but this one was up there. My jaw probably bounced off the floor when she said that. Then I knew I was staring bankruptcy in the face, with absolutely no alternative.

Except there was one. My father-in-law, standing near me, told the nurse we would figure something out. He called his health insurance broker. She had provided him with a quote for a plan from Regence Blue Cross/Blue Shield, that they had intended to be effective July 1.

This was before healthcare reform had passed and the group had received the highest rates, which they could not afford (understandably!) so they had decided not to get the insurance. Their agent informed them that the offer was valid for three more days. My father-in-law, being the amazing human that he is, paid the premium and started the policy. Regence paid the entire bill. I remember when he called me and told me as I sat on my floor sobbing while my daughter was asleep in her bed. Suddenly, I knew health insurance changed people's lives. That it kept people from losing everything. I accepted the job and have been working in the industry for 15 years now.

If you're a single, working mom like me, know that there are good health insurance options that are practical and affordable. It's my hope that you will find this guide to be useful in your journey to choose the best health insurance for you and your family. As always, if you have any questions, please reach out to us at Ark Insurance. We're here to help.

All the best,

Rebecca

Rebecca Yates

Rebecca is a published author, licensed insurance broker, consultant, and owner of Ark Insurance Solutions, LLC. She has been working in the health insurance industry since 2004. Before starting Ark in 2010, Rebecca worked for a diverse range of organizations including insurance brokerages, aerospace engineers, emergency medical suppliers, and technology consultants. She received a Bachelor of Arts degree from Westminster College. She is passionate about providing the best appropriate coverage for her clients, both taking time to assess their individual needs and create unique plans that offer the best value. Rebecca is the mother to two beautiful girls, loves to travel, garden, read, and is a DIY enthusiast.

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Make sure you know how you use your plan

Whenever you look into health insurance, you should always know how much care you and your kids use. Have the pharmacy run a report on medications you and your family have filled for the last year. If you currently have health insurance, the cost of these medications may surprise you!

Next, log into your insurance carrier's portal to pull the last year of claims. If you don't currently have insurance, collect all your medical bills and find the total.

Break these totals out by each person. Once you have that amount, estimate if the next year will be similar or different. For example, I know that one of my children will be incurring a VERY expensive medical experience next year, so I will change my plan to accommodate that.

If you have a special needs child, make sure you check with the providers and find out what needs they may have and how that might be covered. For example, children with Autism are often prescribed ABA Therapy. Not all plans cover this, and some have limits on it. If this is something that applies to your child, it is good to know how it is covered before you make a selection.

Take a look at your providers

Do you always go to the same pediatrician? Is your nearest hospital your favorite? Make a list of all the providers you have seen over the last year, and add in any others that you plan to see in the next year. Either you, or your agent, will want to run this list through any potential insurance carriers to make sure you can still access your favorite providers.

Look at your income and cash flow situation

There are two basic types of plans. Traditional plans, which often have low copayments for regular visits, and High Deductible health plans.

Traditional plans are what many people used before healthcare reform. They had copayments (a small amount due at the time of service) for regular Dr. visits and medications. They have a deductible and coinsurance for unusual things like MRI's, CT Scans, and hospital visits. These plans tend to be more expensive every month, but generally require a smaller portion to be paid by you when a claim happens.

High Deductible health plans are paired with a tax protected savings account called a Health Savings Account or HSA. These plans require that your deductible come first, unless it is a preventive service.

Basically, the federal government decided that people were not very careful with the care in a Traditional plan. For example, if it only costs $10 to get an x-ray of an arm done, most people will x-ray arms, even if the probability is low that it is broken. However, if you have to pay $250 to get an x-ray done, you will most likely wait a day or two AND are more likely to compare prices. Back in 2003 when this was first created, the idea was that people would be better consumers if they knew how much things actually cost. In an attempt slow down the ever-increasing cost of care, the government agreed to create a tax incentive to get people to be more careful with their healthcare spending, and voilà! HSA's were born.

When you enroll in this type of medical plan, it allows you to open a tax protected savings account for your medical expenses. The money either goes in pre-tax or as a tax deduction (depending on if it is in a business or an individual policy), it grows tax-free, usually earning interest once you hit a certain amount in the account, and if you take it out for a medical expense it comes out tax-free. Unlike the FSA accounts of old, the money rolls over every single year. It is your personal savings account so even if you leave your job, the money in the account is still yours. Once you reach the age of retirement, you can take the money out for non-medical related expenses and pay your current tax bracket on it.

These plans tend to work well for people that like non-traditional care like chiropractic and acupuncture as well, as you can use your savings account money on them and receive the tax benefit.

Now here is where they get a little tricky.

1) Nothing is covered until you meet the deductible except preventive care. So getting immunizations and well-child checks are free! But picking up medications might feel expensive.

2) You have to pay your monthly premium for the plan AND fund your HSA account if you want to have the money to spend. It's like pre-funding your medical expenses, that you identified above, instead of paying after the fact. If you don't use it, COOL! You built a medical savings account for when you do need it!

3) For many carriers, they have a lower out of pocket maximum (we'll talk about that next).

Know your max liability

So many times, people get hung up on getting a lower deductible and having copays for something to be considered a "good" plan. However, most Americans miss the absolute most important thing in their health insurance documents: The Out-of-Pocket Maximum.

This is the most you would pay in one calendar year if everything went horribly wrong. If you have health insurance, this is the maximum of liability and it's a number you need to be aware of!

For example:

I often have clients tell me they want the "best" plan and are willing to pay for it! They want a $250 deductible. In my state, the $250 deductible plan has a $7,900 out-of-pocket maximum and is often 30% higher than an HSA plan for monthly premiums.

However, if they enroll in an HSA they can often get a lower out of pocket maximum. My plan is a $4,500 deductible, but that is also the out-of-pocket maximum. At 30% less expensive per month, it's an absolute bargain! But most people ignore this plan because all the see is the deductible.

Let's look at an example:

Johnny needs a $60,000 heart surgery.

Plan 1: He's paying $500 a month to get the lower deductible. That equates to $6,000 a year in insurance premiums. When he has his surgery, he will pay $7,900. So, in total he spent $13,900. Which beats the pants off $60,000 any day! But it's not the best he could have done.

Plan 2: He is now enrolled in the HSA plan. He is paying $350 a month. That equates to $4,200 a year in insurance premiums. BUT when he has his surgery, he pays $4,500. That means he spent $8,700 less than on the "best" plan. But wait! He also got to put that $4,500 through an HSA account and gained the additional tax savings.

Beware anything that looks too good to be true!

Yes, your parents were actually right on this one. Insurance is just math. If it's cheaper, there is a reason. I have found that most of the time those reasons look like limits on care. For example, many "cheaper" policies limit cancer coverage to $500,000. Sorry, but many forms of cancer can eat that up in a month or less. In those types of plans, you would be left holding the bag on the remaining cost of treatment, or WORSE, having the hospital or physician refuse to treat you.

If you are looking at insurance options and one is much cheaper than the others, find out why before you sign up! They often have clauses that lock you in for a year or may not be qualified coverage so you can't get in through the marketplace. It may be cheaper because it excludes something you don't care about (like maternity when you are done having kids), but you need to read the fine print. And I mean the 130+ page document that outlines everything. Or ask a knowledgeable local agent who has probably read the contract for fun, like the insurance nerds we often are.

This is the gold right here!

Your cost of premiums are directly related to your income and family size! Yup! You've probably heard the term "subsidy" in the news in direct relation to your health insurance. Well, what they really mean are Advanced Premium Tax Credits. That means the federal government uses the amount if income (modified adjusted gross) and the size of your family to estimate a tax credit for you. Rather than making you wait to access those funds until next April, they take that credit, divide it by 12 and pay it to the insurance carrier for you. That means it decreases the bill you get for your health insurance every single month.

Generally, if you make under 138% of the federal poverty level, you would be eligible for state-based Medicaid programs. If you fall under 250%, your kids may be eligible for a state-based program, and you would be eligible for a federal program. This free money, people! TAKE IT!! Single moms need all the lift they can get when it comes to cash flow!! To access any of this assistance you must apply either on the federal exchange or on your state exchange. You can go to www.healthcare.gov to see where you need to apply.

You may also qualify for a second type of subsidy called a Cost Sharing Reduction. The government realized that if you couldn't afford a high monthly premium, you also could not afford to pay for a crazy high deductible. Folks that fall into this category can qualify to get a $0 premium pre-month plan with a $0 deductible!

If you make more than 400% of the federal poverty level, then you now longer qualify for a tax subsidy and you will want to talk to your local agent about finding alternatives.

Check out the current chart on our blog by **clicking here**.

Know your plan

Most plans have benefits inside of them that the average consumer does not know exist. For example, in our local market we have a carrier that will pay you $20 a month if you hit 8,000 steps a day. $240 a year per person over the age of 18, and all you have to do is walk? Sign me up!! Plan benefits often include Lasik discount, vision exams, even dental exams. One of my favorites though is the telehealth benefit. Many of the plans now offer the ability to do a virtual call with a Dr. who can prescribe meds over an app in your phone, and they charge WAY less to do it. So, let me get this straight, I don't have to get dressed. I don't have to dress my kids and haul them to the swarming germ fest that all Dr. waiting rooms are AND It's going to cost me less time and MONEY! SIGN ME UP!! Some plans even include extra benefits for international travel.

Health insurance and travel

Most plans will provide coverage for you in the US if you have an urgent or emergent event. That means if you need to be seen or treated within 48 hours. BUT they often fail to tell you that if you don't call and find out where they have a contract, you can get nailed with what they call a Balance Bill. So let's say you are in Disneyland and little Suzy trips on the sidewalk and breaks her arm. If you run to the closest urgent care, they will most likely take your card and get her in a cast. But the thing is, EVERYTHING in California is more expensive. So, at home, your insurance would pay $700 for a broken arm. But in Cali they charge $2,000. If you failed to call and go to a contracted provider, YOU are responsible for the difference. If at all possible, call your provider and find out where they have a contract.

If you are traveling out of the US, buy a travel medical policy. Your policy MAY include coverage, but the process is torturous and does not provide things like child care and translation services. Travel medical policies are pretty cheap, you only buy them for the time you are gone, and they provide a lot of very specific coverages like flying in a babysitter to help watch your kids while you are in the hospital. I actually buy these now when I travel more than 500 miles from home because I am usually the only adult traveling, and I want to know my kids won't be stuck sitting in the ER alone.

If your income changes, MAKE SURE you update your agent and/or healthcare.gov

If you got one of those subsidies we talked about earlier, remember, it is an estimate of a tax credit. That means if you suddenly win the lottery tomorrow, you are no longer eligible for that tax credit because your tax bracket just skyrocketed. You would have to pay back any of those funds when your taxes come due. If you lost your job and your income suddenly dropped so that your estimate was too high, the federal government may actually give you a refund if you should have gotten a higher subsidy. Just remember, it gets reconciled at tax time both ways and be sure to update your application with any changes!

Now for the glossary of overly confusing insurance terms!

1) Copay. A small amount that you pay that is set in your plan for things like office visits and medications.

2) Deductible. Just like your auto insurance, if you hit another car you pay your $500 or $1,000 deductible. Health insurance has the same thing. This is the amount you pay up front before the insurance kicks in. Be sure to never pay your deductible at the time of service! Let them know you need to see what your explanation of benefit shows you are responsible for. MANY people pay more than they should because they pay at the time of service.

3) Coinsurance. This is the percentage that you and the insurance company split after the deductible. It is typically 20 to 30% that you are responsible for until you meet your out-of-pocket maximum.

4) Out-of-pocket maximum. This is the amount you pay if everything goes horribly wrong. Everything you do that is covered under your plan goes toward this number (if it's an ACA-qualified plan) so your medications, hospital stays, even visits to the Dr. add up. Make sure this is a number you a comfortable with paying in one year!

5) Premium: The amount you pay the insurance company each month to ensure you have insurance coverage.

6) HSA: Health Savings Account. This is the tax-protected savings account that must be paired with a qualified high deductible health plan.

You do not have to navigate this alone

Health insurance agents exist in every state. They get paid by the insurance carrier to help you navigate all of these pieces. This is a complex choice and one that impacts you and your family's health for at least the next 12 months. Do not try to figure this out on your own. Find an experienced broker in your area and let them help you. In most areas, this help is totally free to you! Here is a handy dandy link to help you find agents registered with healthcare.gov. Try to work with one that has at least five years of service.

If I can help you in any way, or if you have any questions, please feel free to reach me by clicking **here**.

About Ark Insurance

In 2010, Rebecca Yates launched Ark Insurance Solutions, LLC based on her desire to focus not solely on the dollar, but to put individuals and clients first. It is this founding principle that has helped make Ark Insurance Solutions LLC the most trusted resource for affordable health insurance in the greater Salt Lake City, Utah area.

As an independent broker, Ark works with a number of the nation's top health and life insurance companies to find the best policies to protect your family and finances in times of trouble. As the company has grown, we've built a dedicated team of experts in each niche in the health insurance industry. We can help you compare health plans to make the best decision based on your unique circumstances and budget.

At Ark, we love our community and believe in fully immersing ourselves in the causes, people, and places that we care deeply about. We invest time in our team, fellow business owners, and our clients to create lasting relationships and a true sense of community.

We can help you navigate the complex world of health insurance. Give us a call or request a health insurance quote now.

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