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## Supporting Medicaid in Virginia

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## **Introduction**

Healthcare is on the minds of a lot of Americans today. According to a Reuters poll released November 18<sup>th</sup>, healthcare is the number 1 issue that voters want to see addressed first by president-elect Donald Trump and the 115<sup>th</sup> United States Congress (Kahn, 2016). Throughout his campaign, Trump made it clear of his plans to “repeal and replace Obamacare.” In the coming months, there will be a lot of discussion on what a “Trumpcare” replacement will look like and how best to minimize displacement of people affected by “repealing” the Affordable Care Act. During this period of transition, it is more important than ever to understand and support the nation’s healthcare “safety net” Medicaid for those most in need and those who may fall through the cracks during reform.

## **Background**

### *What is Medicaid?*

Medicaid is a public healthcare program for Americans with limited resources. It mostly covers low-income children, pregnant women, working parents, the elderly, and people with disabilities. It is the country’s largest health insurer covering about 73 million Americans and is jointly funded at the federal and state levels. Presently the federal government covers \$0.50 to \$0.75 of every dollar spent on Medicaid, covering more for states with lower average income and more beneficiaries (“Medicaid”, n.d.). Medicaid is a state run program that allows quite a bit of freedom for individual states to define how it will be run, who is eligible, and what benefits are covered.

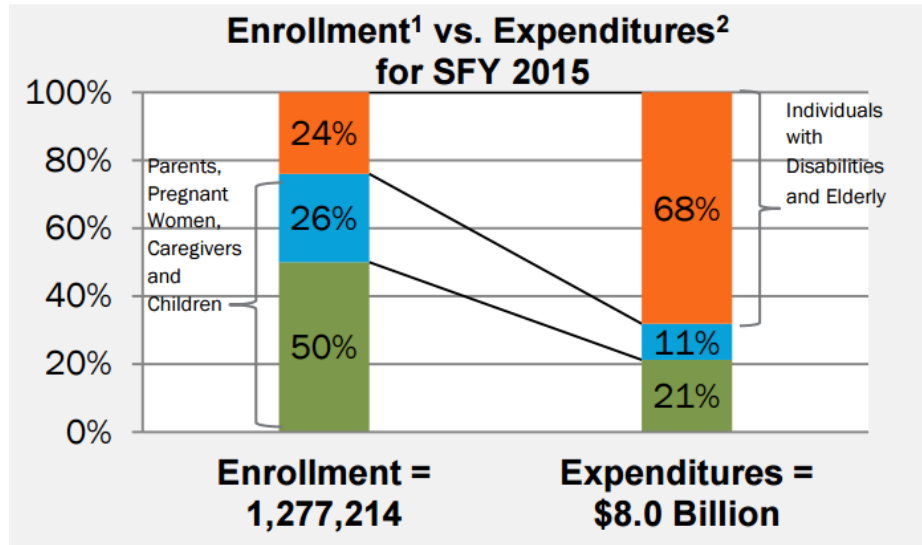
*How is Medicaid run in Virginia?*

Virginia has some of the strictest eligibility requirements for Medicaid in the United States. In order to be eligible for Medicaid in Virginia, children under the age of 18 or pregnant women must have a household income less than 148% of the federal poverty level, or \$29,748 for a family of three. Those over the age of 65 or those with a disability must have income less than 80% of the federal poverty level, or \$12,744 for an elderly couple. Parents are covered only if they make less than \$10,464 for a family of three. These numbers are state averages and can vary based upon locality. In Virginia Beach the maximum income for working parents to be eligible for health coverage under Medicaid is \$7,908 for two parents with one child. Adults without a disability preventing them from working and without children are not eligible for Medicaid regardless of their income (Whorley, 2015).

Financial eligibility restrictions can be waived for certain individuals to receive health care assistance from Medicaid. In order to qualify for these waivers, the individual must demonstrate functional needs, medical nursing needs and be at imminent health risk. These needs include things like needing assistance eating, dressing, and going to the bathroom. The goal of waiver programs is to allow those who need expensive long term care to avoid being institutionalized through community and home care programs without going bankrupt (Jones, 2016).

Medicaid covers about 1.3 million Virginians and costs about \$8.5 billion a year (Jones, 2016). Virginia ranks 48<sup>th</sup> in investment into its Medicaid program per enrollee. Only 2 states spend less per capita. As Figure 1 illustrates, the largest group of Medicaid enrollees, about half, are children and spending is heavily weighted towards the elderly and disabled, accounting for a little over two-thirds of expenditures due to their higher incidence of complicated conditions and long term care needs (Jones, 2016). Details like this are important for the public to know because

when informed of the lives that are in the balance and where tax dollars go, voters are much more likely to support funding of these programs (See: Survey in Appendix A for an example of this).



**Figure 1. Virginia Medicaid: Enrollees vs. Expenditures. Source: “2016 Virginia Medicaid at a Glance”, by Virginia Department of Medical Assistance Services, 2016.**

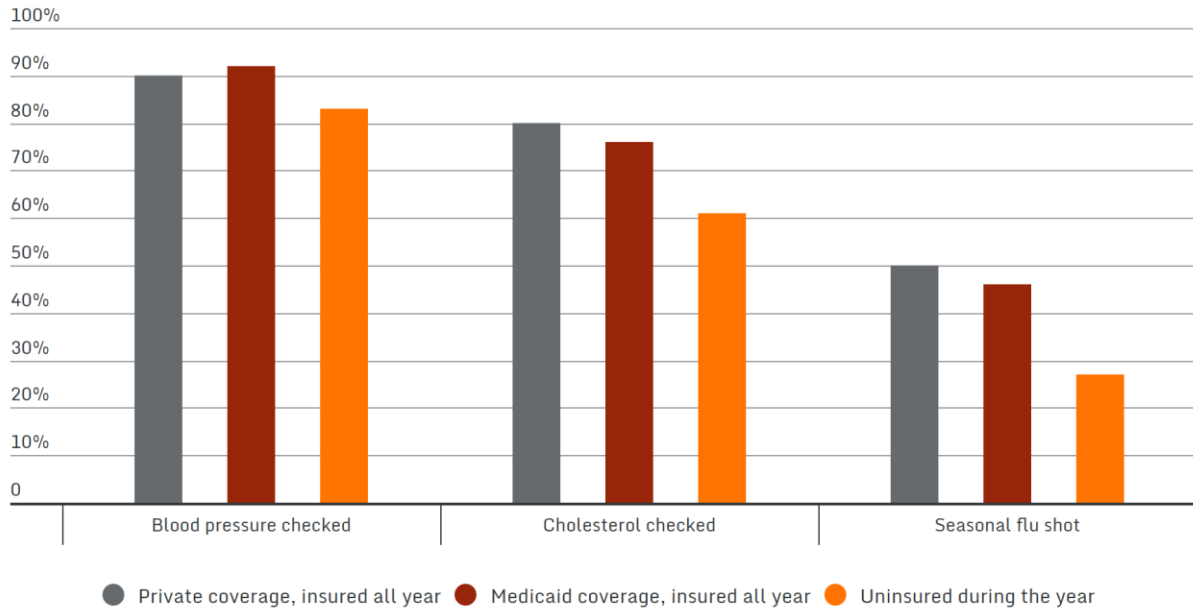
The Virginia Medicaid program covers medical services, nursing home services, and mental health services through two main delivery methods: managed care organizations (MCO’s) and fee for service. MCO’s are organizations that combine health insurance, delivery of care, and administration under one umbrella for greater efficiency. Often MCO’s negotiate with health care providers to create “provider networks” to make a referral network of specialists at a lower cost. Examples of MCO’s in Virginia are Optima Health, Kaiser Permanente, Humana, and Anthem Healthkeepers. Fee for service is simply directly reimbursing healthcare service providers for the cost of care. MCO’s are required to pass periodic reviews to ensure quality of care, efficiency, and cost standards to remain a part of Medicaid. 68% of Medicaid enrollees and rising get healthcare from managed care providers (Jones, 2016).

## **Analysis of Medicaid**

### *Is Medicaid a good investment?*

Medicaid is without question a huge expenditure across the nation. As noted previously, Virginia is one of the stingier states when it comes to Medicaid spending per capita, yet it still costs about 17% of its yearly state funds (Jones, 2016). In addition, costs have been rising more than ever. Spending increased nearly \$1 billion in the states latest 2-year budget plan (Martz, 2016). According to a Pew Research poll only 15% of Americans believe that Medicaid is in good financial standing (Paradise, 2015). Many of the 85% who don't are concerned that Medicaid costs are becoming unsustainable and will lead to cuts in education, transportation, other state spending or even lead to bankruptcy. Looking at the financial costs only looks at one side of the equation though. In order to determine whether Medicaid is worth the financial investment, it is important to understand the positives that having health coverage provides.

Individuals who have health insurance are much more likely to seek care for health concerns early. As can be seen in Figure 2, those without health insurance are more likely to put off preventative care due to fear of not being able to afford the bill. Delay in seeking care leads to worse and ultimately costlier health outcomes. One example was shown in a 2015 University of Michigan study that showed that those with prenatal care covered by Medicaid had lower rates of obesity and fewer hospitalizations from chronic conditions than those without coverage (Miller, 2015). Another paper by the National Bureau of Economics showed that for individuals who grew up in low income families the likelihood of an emergency room visit was negatively correlated with the amount of years they had healthcare coverage under Medicaid (Kaestner, 2015).

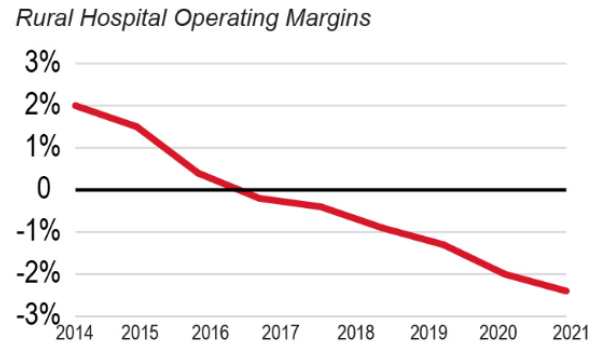


**Figure 2. Adults with Medicaid reported getting recommended preventative care services at higher rates than those who were uninsured. Source: “Why the U.S. needs Medicaid”, by the Commonwealth Fund, 2016.**

When uninsured, low income families develop chronic, costly health conditions and only seek out medical care in emergency departments they are very unlikely to have the means to pay. Hospitals absorb this cost of uncompensated care and in order to remain solvent increase the price of care to everyone else. In 2013 uncompensated care accounted for 7% of hospital costs in Virginia, approximately \$1.2 billion (Whorley, 2015). Figure 3 shows that hospitals in rural areas of Virginia are those hardest hit. Without the financial support of Medicaid covering much of these uncompensated costs, many of these hospitals, which act as the only convenient source of medical care for many Virginians, are at risk of being shut down. High uncompensated care means less high quality healthcare jobs are created and less state tax revenue is generated. By supporting Medicaid, benefits are transferred to the growth of the healthcare sector which



employs 124,000 Virginians and generates \$585 million in local and state taxes every year (Stewart, 2016).

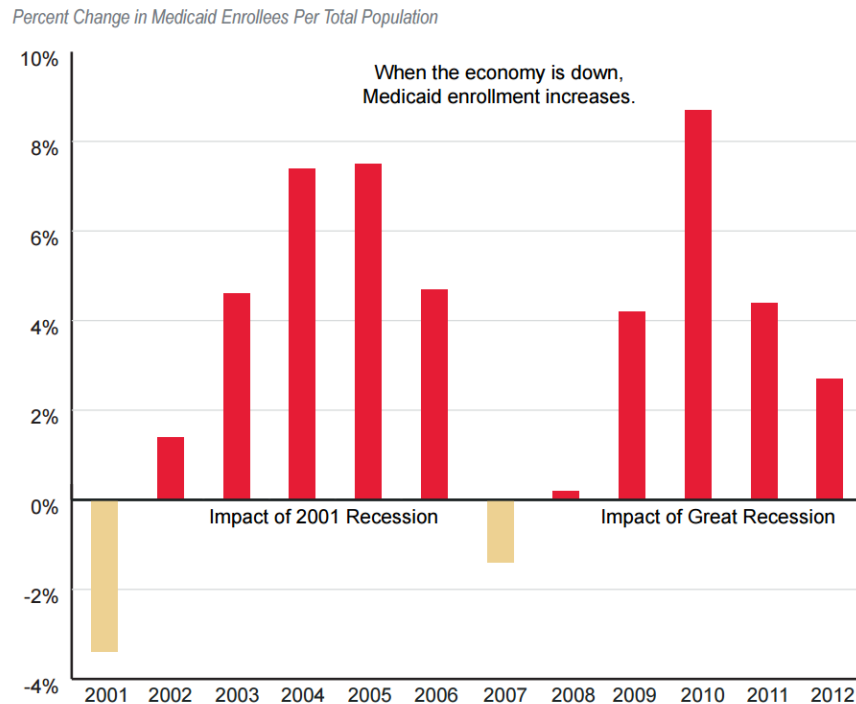


**Figure 3. Operating margins for rural hospitals in Virginia are slated to turn negative in 2017. “Critical Care, Critical Contributions”, by the Commonwealth Institute, 2016.**

Medicaid provides financial stability to families that otherwise would be at risk of medical bankruptcy. This has several positive societal impacts. A 2016 paper by the National Bureau of Economic Research showed that children who received healthcare coverage due to the expansion of Medicaid in the 1980’s and 1990’s were more likely to go to college, earn higher wages and pay more taxes in their lifetimes. They estimated that the increased tax revenues alone equated to the government recouping \$0.56 on every dollar spent on Medicaid during this group’s childhood (Brown, 2016). Other studies showed that children who have health insurance coverage due to Medicaid are more likely to finish high school and less likely to commit crime (Carroll, 2015).

Medicaid is not just for those who are presently poor. One of its largest values is its role as a safety net during economic downturns. In the United States, approximately 50% of people have health insurance through their jobs. When the economy underperforms many people lose their jobs and in turn their employer-sponsored health insurance. This causes people to fall into a

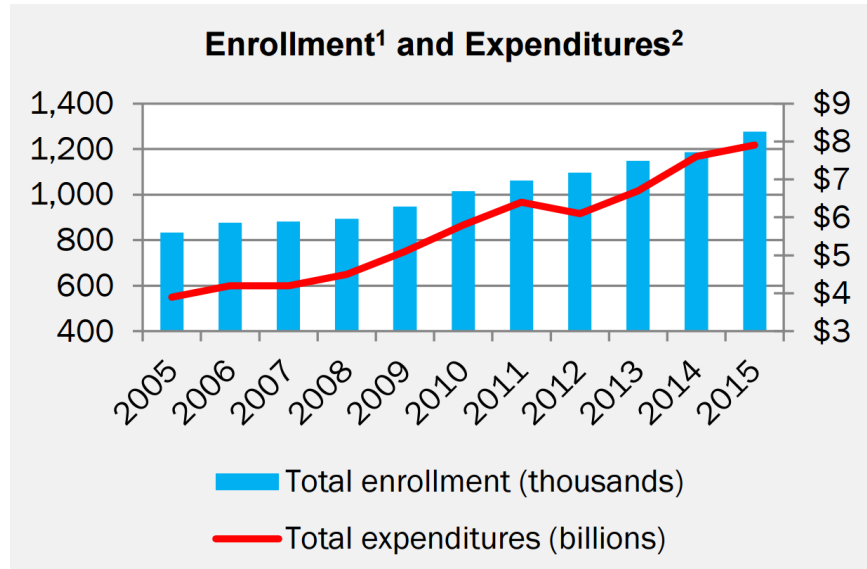
situation where they can no longer afford health coverage and rely on Medicaid. As Figure 4 illustrates, the effects of a recession on the demand for Medicaid often last several years as job growth rebounds (Whorley, 2015).



**Figure 4. Medicaid protects Virginians during Economic downturns. “How Medicaid Works”, by the Commonwealth Institute, 2016.**

*Why is the cost of Medicaid rising so rapidly?*

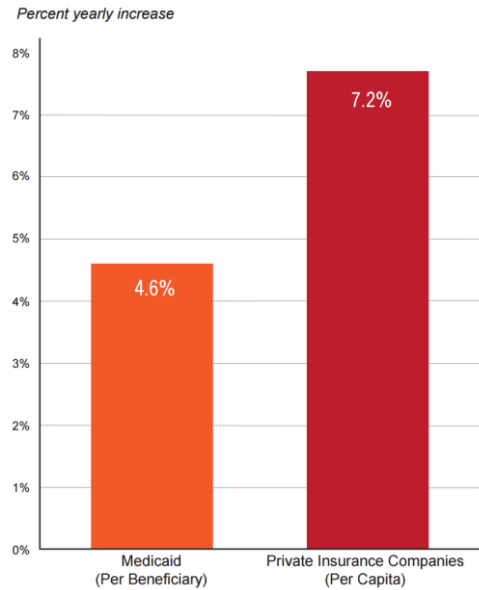
The majority of people agree that supporting the health of underprivileged youth, pregnant women, the disabled and elderly is good for the country but at the same time are concerned about the financial condition of supporting these programs (Paradise, 2015). The primary reason for growth in spending on Medicaid in Virginia is due to increased enrollment as can be seen in Figure 5. In addition to increased enrollment, rising healthcare costs nationally play a huge role.



**Figure 5. Virginia Medicaid: Growth in Enrollment and Expenditures over the last 10 years. “2016 Virginia Medicaid at a Glance”, by Virginia Department of Medical Assistance Services, 2016.**

Health care costs have been on the rise across the United States for many years. This is due to many factors. One factor is that people are living longer translating to an increase in lifetime healthcare costs. This rise is accompanied by the aging of the “Baby Boomer” generation which has led to a 27% increase in the over 65 population in the past decade (Arias, 2013). Another factor is that more people are seeking out the use of new procedures, new drugs, and new technologies that cost more money. Since health insurance works by pooling the risks of large groups of people, the costs are also pooled meaning that everyone pays more when any one group’s spending rises significantly. The baby boomer generation’s increased demand for end-of-life and long term care will likely cause further increase in medical costs in the coming years. These factors are somewhat outside of the control of Medicaid, but Medicaid actually does a better job at controlling these cost increases compared to private insurance as shown in Figure 6. One of the reasons for this is that Medicaid has lower administrative costs than private insurance.

In Virginia, only 2.5% of Medicaid expenditures go towards administrative costs (Whorley, 2015).



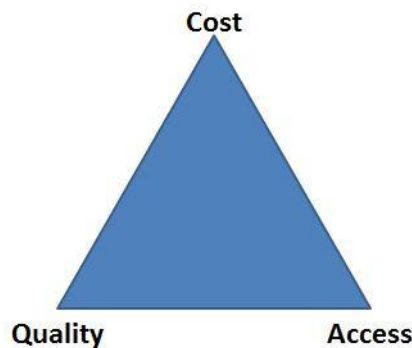
**Figure 6. Virginia Medicaid growth vs. Private insurance companies 2000-2009. “How Medicaid Works”, by the Commonwealth Institute, 2016.**

One of the benefits of Medicaid being a state run program is that the state legislature can implement reforms to Medicaid to control costs in a way that best suits Virginia’s residents. Medicaid is not static and there are several reforms already being implemented to try to slow the growth of cost without hurting beneficiaries in the state. Improvements include increased oversight of provider networks (saving \$57 million) and implementing a program to better manage individuals who qualify for both Medicare and Medicaid (saving \$21 million) (Whorley, 2016). With that being said, the policy decisions on the federal level still have a huge impact on the healthcare system, health insurance, and Medicaid, so it is important to take a closer look at how politics may affect things going forward.

## Analysis of Healthcare Policy

*How did the Affordable Care Act change healthcare?*

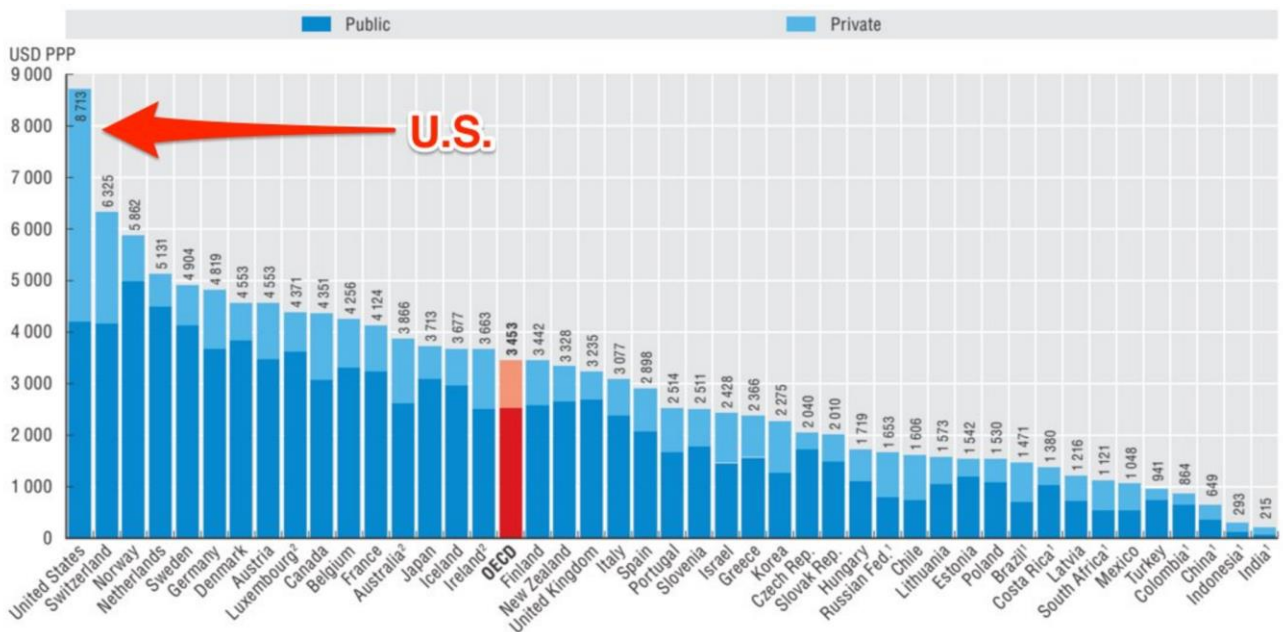
The Patient Protection and Affordable Care Act (ACA), often called Obamacare, had a goal of increasing access, improving quality, and reducing the cost of healthcare in the United States. According to William Kissick, professor of healthcare economics at Yale, this is easier said than done. He describes an “Iron Triangle of Healthcare,” shown in Figure 7, where these issues compete and improving one often means negatively affecting the other two.



**Figure 7. The Iron Triangle of Healthcare. Source: “Medicine’s Dilemmas: Infinite needs versus Finite Resources”, by William Kissick, 1994.**

While it is undoubtedly difficult to improve cost, quality, and access all in one fell swoop, the United States was in a position in 2010 where there was plenty of room for improvement. In terms of access, 49.9 million Americans, 16.3% of the population, were uninsured according to the 2010 census. Studies have indicated that this uninsured rate contributed to roughly 18,000 unnecessary deaths and 62.1% of personal bankruptcies every year in the United States (“Healthcare in the United States”, n.d.). Of the 35 democratic market-based countries in the Organization for Economic Cooperation and Development (OECD), all but the

United States, Turkey, Mexico, and Chile had health coverage above 98.4%. Despite this, healthcare costs in the United States have been higher than anywhere else. The U.S. spent over two and a half times more than the average OECD country on healthcare as seen in Figure 8. Additionally, all this spending did not translate into much better quality. Our health outcomes were generally towards the lower end of most developed nations. For example, 68% of the elderly in the U.S. had at least two chronic conditions. Other OECD countries ranged from 33% to 56% in this measure (“Healthcare in the United States”, n.d.).



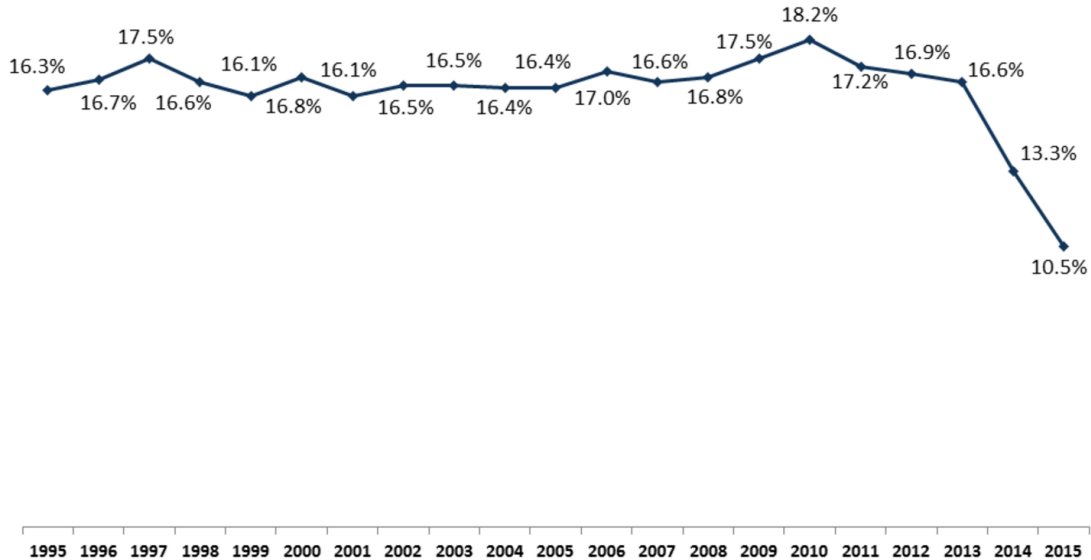
**Figure 8. Health expenditure per capita of OECD countries. “OECD Health Statistics 2011”, by World Health Organization, 2012.**

The architects of Obamacare primarily addressed the issue of access in the American healthcare system. Prior to the ACA, in the individual market if you got sick you could be denied health insurance or have your rates increase dramatically if you developed a costly, chronic condition. The Affordable Care Act changed this through “guaranteed issue” and “community

ratings.” These required health insurance companies to offer plans to people with pre-existing conditions and charge rates independent of a person’s health status (Carroll, 2013).

These regulations have a downside. They create an environment where healthy people have no reason to buy health insurance. They can just wait until they get sick and then sign up for coverage for the same rate they would have gotten before they got sick. In addition, with unhealthier individuals with greater health costs entering the insurance market the average cost per person would rise. In order to control costs more healthy people needed to sign up. This was addressed by charging a penalty for those who do not have health insurance called the “individual mandate” and by subsidizing the health insurance costs for those who would have trouble affording buying it on their own (Carroll, 2013).

The subsidies for the health insurance marketplace gave discounts to those making less than 400% of the federal poverty line, or \$94,000 for a family of 4. Even with this help many Americans fell into a coverage gap, making too much money to qualify for Medicaid but not enough to be able to buy health insurance on their own. To address this, the ACA offered to cover an expansion of Medicaid to those making less than 138% of the federal poverty line. 31 states and the District of Columbia accepted this expansion that was 100% covered by the federal government for the first 4 years then reduced to 90% in later years. This expansion led to 15 million Americans gaining health care coverage under Medicaid and helped the United States reach its lowest uninsured rate among nonelderly Americans in its history as seen in Figure 9 (Garfield, 2016).



**Figure 9. Uninsured rate among the nonelderly population, 1995-2015. Source: “Key facts about the Uninsured Population”, by Kaiser Family Foundation, 2016.**

Many opponents to Obamacare have argued, as the “Iron Triangle” suggests, that any improvement in healthcare access under the law has been at the sacrifice of reasonable costs. Speaker of the House Paul Ryan, Senator John McCain and others have pointed to states with the largest premium hikes, such as Arizona with 50-75% increases, as evidence of this (Carroll, 2016). Though it is undoubtedly true that healthcare costs have continued to rise since the ACA was passed, an argument could be made that the rate of increase in healthcare costs has been slower than it would have been the way things were and that long-term benefits have not yet had the time to fully develop (Whorley, 2015). Regardless, many Americans felt unsatisfied with the way things were, came out to vote on November 8<sup>th</sup> and elected representatives promising something better so it is important to now look forward.

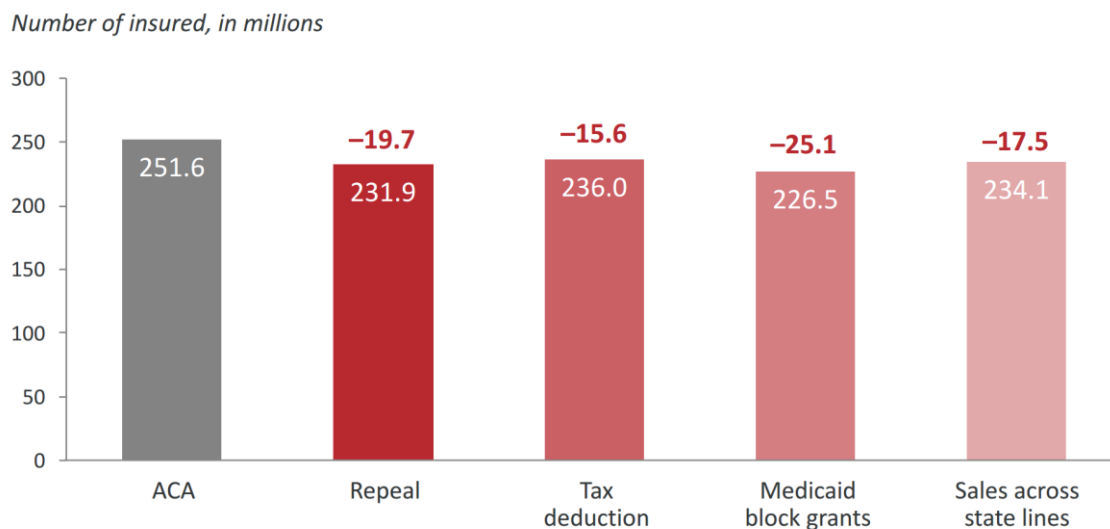


*What effect will Donald Trump's healthcare proposals have?*

Donald Trump campaigned on the promise to “repeal and replace Obamacare” on his first day in office. His healthcare plan titled “Healthcare Reform to Make America Great Again” includes full repeal of the Affordable Care Act, making health insurance premiums tax deductible, allowing insurers to sell plans across state lines, and converting Medicaid funding to a block-grant program (Trump, 2016). A full repeal of the healthcare law would require 60 votes in the Senate which seems unlikely with 52 Republican senators elected. The Senate could defund Obamacare through “reconciliation,” which changes things affecting the U.S. budget with just 51 votes though. Reconciliation could remove the individual mandate, healthcare marketplace subsidies, and the Medicaid expansion. In doing so as many as 20 million people could lose insurance coverage and with healthy people dropping out of the market, costs would dramatically rise for those with pre-existing conditions unless a more comprehensive replacement was implemented concurrently (Saltzman, 2016).

“Removing the lines around the states” to sell health insurance was a favorite mantra during Trump’s campaign but it will likely not lead to much change. Insurance companies tend to sell plans regionally because they need to negotiate rates with local healthcare providers and abide by local regulations. “Removing the lines” would not necessarily change anything other than creating national “bare-bones” plans based in the locality with the least regulations. This would lead to more people being underinsured or having an insurance plan with inadequate coverage, leading to a higher risk of crippling medical debt and higher likelihood of avoiding important preventative care due to cost. Additionally, this would cause more healthy people to buy plans outside of their state leaving those remaining and state governments with higher costs (Eibner, 2016).

Under the Affordable Care Act, subsidies gave discounts in the form of a tax credit to individuals making below 400% of the federal poverty line to purchase insurance. Trump’s plan would replace these tax credits with tax deductions for those buying health insurance in the individual market like the deductions that those who get their health insurance through their job currently get. This means that income that is put towards healthcare premiums would not be taxed. The issue with this is that it disproportionately helps those who pay a lot of taxes and does nothing for the about half of Americans who do not make enough money to pay income tax. Removing these subsidies will increase the uninsured by as much as 15.6 million people according to the Commonwealth fund as can be seen in Figure 10 (Saltzman, 2016).



**Figure 10. Impact of Trump’s proposed reforms on the number of people with insurance coverage, 2018. Source: “Donald Trump’s Health Care Reform Proposals: Anticipated Effects on Insurance Coverage, Out-of-Pocket Costs, and the Federal Deficit”, by the Commonwealth Fund, 2016.**

Medicaid is currently classified as an entitlement, which means that those who meet eligibility requirements have a right to health coverage under the program. State spending on

Medicaid is automatically matched by the federal government to help cover this right. A block grant is an alternative way of funding government programs that allocates a set amount of money to each state with limited provisions on how it is spent. In theory this could mean that the government could provide the same people with Medicaid while giving more freedom to the states to choose how to best serve their population. The issue is that block-granting has a history of funding falling short on its program's initial goals. An example is the "Temporary assistance for needy families" (TANF) program. TANF converted to a block grant in 1996 and has seen its original goal of providing cash-assistance to families cut from 70% of the block grant to 25% on average (Park, 2016). If Medicaid block grants do not keep up with costs this could mean states would have to kick people off of the program, reduce the care that is covered, or reduce reimbursements leading to less choice in providers if they did not have a surplus of revenues to cover the difference (Park, 2016).

A block grant of Medicaid was proposed by Speaker of the House Paul Ryan in 2014 and as Table 1 shows it would have led to larger and larger cuts in funding to Medicaid over time. When the programs costs exceed expectations, such as when a new procedure or drug emerges that would improve the health of beneficiaries or when an unanticipated health crisis such as a particularly bad flu season hits a state, the federal block-grant will fall short and state's will have to absorb these unexpected costs (Park, 2016).

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2015-2024
Federal Medicaid and CHIP Baseline Spending *	302	313	329	343	363	384	406	429	451	477	3,797
Medicaid Spending Cuts Under Ryan Block Grant **	n/a	-31	-47	-62	-71	-80	-93	-106	-118	-124	-732
Percentage Cut	n/a	-10%	-14%	-18%	-20%	-21%	-23%	-25%	-26%	-26%	-19%

**Table 1. Federal Medicaid and CHIP (Children’s Health Insurance Program) spending cuts required by Ryan block grant in billions of dollars, 2014. Source: “Ryan Block Grant Proposal Would Cut Medicaid by More Than One-Quarter by 2024 and More After That”, by Center on Budget and Policy Priorities, 2015.**

Republicans in Congress have several other proposals for how the replacement to Obamacare will look, but there is still a long way to any sort of consensus. Common ideas in proposed plans include high risk pools, continuous coverage mandates, narrowing health benefits and increasing the age band (See: Appendix B for a discussion on these topics). Like Trump’s proposals, each of these targets cost and would likely lead to cheaper plans for young, healthy Americans, but would put the poor, sick and elderly at greater risk of decreased healthcare access or decreased quality of healthcare coverage and put more financial stress on state and local economies (Carroll, 2016).

### Conclusion

Healthcare is complex. There is no single solution that will reduce costs, increase access, and improve quality overnight. Improving one area often means trade-offs in others. The repercussions of policy changes are not always apparent the day a law is enacted. For these reasons, it is of the utmost importance that precautions are made to protect those who are at most

risk of major catastrophe in the face of major change. Decisions in this realm can often mean the difference between life and death.

Medicaid is a program that can act as a safety net to catch those who fall through the cracks during this period new policies are being implemented. Medicaid has a proven track record of improving the lives of beneficiaries through better health, less economic hardship, and more opportunities to pay back the investment society has made in them. Beyond this, Medicaid reduces the strain on the healthcare system by reducing long term uncompensated costs from segments of the population that cannot pay. Without this, these costs are passed along to everyone else in larger hospital bills and less job growth in this important sector.

The Affordable Care Act was far from perfect but it did improve access to health coverage to more Americans than ever before. Going forward, Republicans' plans to replace Obamacare have promise in reducing cost but in doing so extra focus needs to be placed on the possibility of leaving segments of the population in need of additional help. Medicaid offers this help to many poor children, pregnant women, working parents, the disabled and elderly.

Policies that put Medicaid at risk of reduced funding in the future pass the bill, previously shared with the federal government, solely to Virginians. Virginia's representatives will have the burden of cutting funding to other state spending or taking away health coverage from their constituents who are most at risk. When Virginians are informed about Medicaid and the healthcare system, they overwhelmingly oppose these cuts. Federal decisions around this program will therefore have huge implications going forward and legislation that puts Medicaid at risk should be opposed.

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## Appendix A: Survey

This was a non-scientific poll conducted at a civic league meeting in Sandbridge, Virginia on November 14, 2016. Respondents were generally over 40 years old, white, upper-middle class, and college educated. Of the 40 respondents: 21 were Republican, 14 were Democrat, and 5 were independent voters. Survey Question A was given to half of the respondents and Survey Question B was given to the other half.

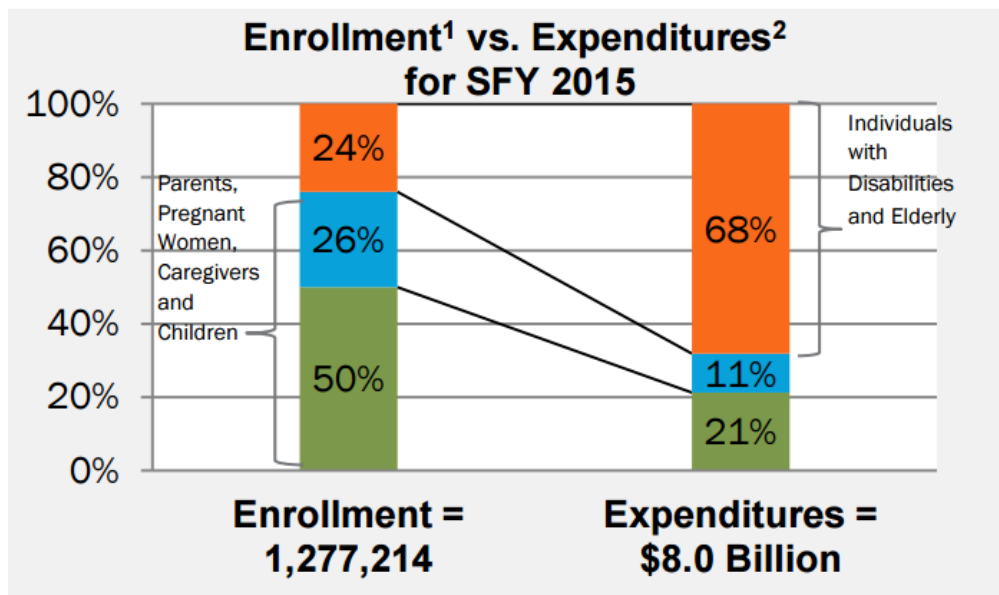
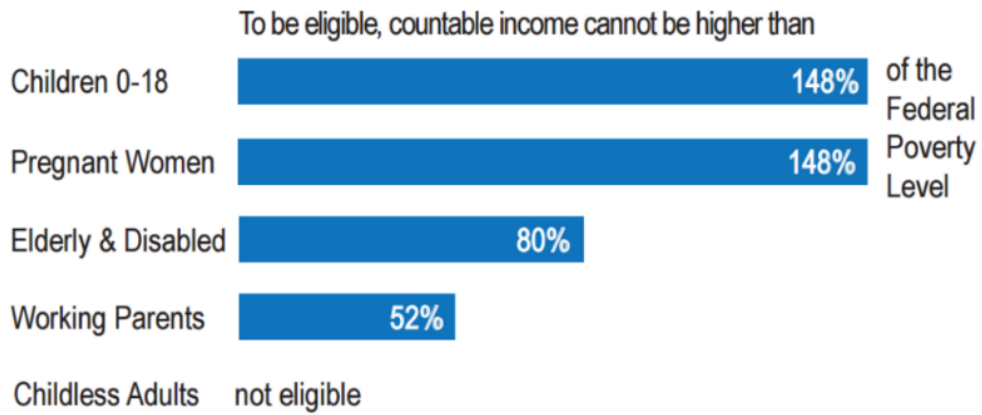
*Survey Question A:* The cost of Virginia’s Medicaid program has increased nearly \$1 billion in the state’s latest 2-year budget encompassing about 18% of state funds. Do you support tightening eligibility requirements or reducing benefits to enrollees to free up state revenue for other purposes?

Total Surveyed: 20    Yes: 15

No: 5

*Survey Question B:* The cost of Virginia’s Medicaid program has increased nearly \$1 billion in the state’s latest 2-year budget encompassing about 18% of state funds. Below are the income eligibility requirements to enroll in Medicaid, the breakdown of beneficiaries, and the allocation of expenditures for each group. For reference, the federal poverty line is \$20,160 for two parents and one child.





Source: “2016 Virginia Medicaid at a Glance” by Virginia Department of Medical Assistance Services, 2016.

Do you support tightening eligibility requirements or reducing benefits to enrollees to free up state revenue for other purposes?

Total Surveyed: 20    Yes: 2  
    No: 18

## **Appendix B: Republicans' Plans to Replace Obamacare - Pro/Con**

- **High risk pools:** Moves the costliest individuals to insure into their own insurance market that is subsidized with state and federal funding.
  - Pro: Makes insurance cheaper for everyone outside of the high risk pools.
  - Con: Subsidizing this group can be very costly. \$25 billion would cover only about 3 million people according to the Congressional Budget Office.
- **Continuous coverage mandate:** Makes those who have a lapse in health coverage exempt from pre-existing conditions protections preventing their rates from increasing.
  - Pro: Prevents healthy people from waiting until sick to get health insurance.
  - Con: It puts people with volatile incomes, which include those diagnosed with a major illness, at risk of losing coverage during down times.
- **Narrowing health benefits:** Reduces minimum standards that insurance plans must provide.
  - Pro: Reduces costs for those who just want catastrophic health coverage.
  - Con: Reduces what is covered by health insurance, increasing out of pocket costs and the likelihood of avoiding preventative care due to cost.
- **Increasing the age band:** Changes the regulation that requires the most expensive plan insurers offer, targeted at older enrollees, to be no more than three times the cost of the cheapest plan insurers offer, targeted at younger enrollees.
  - Pro: Reduces the cost for young people to purchase health insurance which should lead to more healthy people entering the health insurance market.
  - Con: Increases the cost for those near retirement age which may price some out of the market when they are most at risk of a costly health condition.

Source: "Republicans' Many Plans to Replace Obamacare", by Healthcare Triage, 2016.

## **Glossary**

**Actuarial value:** The percentage of the cost of care that a health insurance plan will cover. Plans with higher actuarial value cost more up front but require you to pay less later.

**Co-insurance:** A percentage of health care costs for a given treatment that the insured pays.

**Co-pay:** Set fees that are charged to enrollees for health care such as a doctor's appointment.

**Deductible:** Amount of money that enrollees are responsible for paying out of their own pocket before the insurers cover costs. Higher deductibles usually mean lower premiums. Preventive care is generally not included in the deductible by most health insurers.

**Employer sponsored health insurance:** Health insurance paid for by a business for its employees. It is typically paid for indirectly by employees in reduced potential wages.

**Health insurance:** Groups individuals together to share costs of health coverage. Healthy people fund sick people based on the promise that if they become sick they will pay less.

**Out-of-pocket maximum:** The maximum amount of money that enrollees have to pay per year for a given plan. Any cost above the out-of-pocket maximum is covered by the insurer.

**Premium:** Monthly recurring cost of a health insurance plan. Plans with higher premiums tend to have lower deductibles.

**Provider network:** Healthcare providers that a given health insurer has negotiated rates with. The healthcare providers "in-network" will generally be cheaper than those "out-of-network."

**Tax deduction:** Expenses that can be subtracted from total taxable income prior to paying taxes.

Source: "Definitions of Health insurance terms", by Bureau of Labor Statistics, 2016. Retrieved from <http://www.bls.gov/ncs/ebs/sp/healthterms.pdf>