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Health Insurance Terminology 2022

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HSAs, self-funded plans, HMOs and deductibles can all feel like foreign concepts if you don't actively work within the healthcare industry. Use this guide to understand health insurance terms in order to make informed decisions about your coverage with confidence.

TYPES OF HEALTH INSURANCE PLANS

Flexible Benefits Plans

A flexible benefits plan is a program that allows individuals to distribute a predetermined amount of funds supplied by their Employer. Employees with this plan can allocate these funds however they want to benefits like life insurance, health insurance, vacations, retirement plans, and child care.

Fully-Insured Plans

A fully-insured health plan is a common employer-sponsored healthcare plan. With a fully-insured plan, the Carrier takes on the risks involved with healthcare claims, along with charging employers an annual premium, which is partially paid for by employees. In addition to the premium, employees and dependents covered under a fully-insured plan are responsible to pay any deductible amounts or co-payments required for covered services under the policy.

Grandfathered Status Plan

Any group or individual health plan that was created on or before March 23, 2010, when the Affordable Care Act (ACA) was signed into law, is considered a grandfathered status plan. These health plans are exempted from certain mandatory provisions under the ACA, such as requiring benefits deemed “essential,” but are required to meet new standards like extending dependent coverage to adult children until they turn 26. Plans or policies may lose their “grandfathered” status if significant changes that reduce benefits or increase costs to consumers are made.

Health Maintenance Organization (HMO)

An HMO is a type of group coverage where employees pay for specific health services through monthly premiums. Under these health plans, employees will have access to a network of healthcare providers, but services will be limited to those that fall under that network. This allows for HMOs to be more affordable than other types of group health plans. However, seeing any physicians or facilities not included in your HMO network can result in an employee having to foot the entire bill.

High Deductible Health Plan (HDHP)

As the name implies, an HDHP is based around higher deductibles, with the tradeoff of lower premiums. Because of the high deductible, members will have to pay more out of pocket before the plan starts paying for its share. This type of health plan can be popular with young and healthy employees who don’t use many healthcare services.

Individual Health Plans

Individual health plan, or individual health insurance policy, refers to any coverage that is not supplied by an Employer. These plans are regulated under state law and are not attached to an individual's employment status.

Level-Funded Plans

Level-funded plans enable Employers pay a set, monthly payment to a Carrier that covers an Employee's medical claims, administrative costs, and premiums associated with stop-loss coverage. At the end of a level-funded contract, Employers may receive a refund if their set-payments surpassed the amount of funds used.

Qualified Health Plans

A qualified health plan is an insurance policy that meets specific requirements established by the Health Insurance Marketplace® and the Affordable Care Act (ACA). These requirements include providing essential health benefits, establishing limits on cost-sharing, and meeting the ACA's minimum essential coverage guidelines.

Self-Funded Plans

While the Carriers cover the cost of health care expenses in a fully-insured plan, the employer bears the burden in a self-funded (or self-insured) health plan. Self-funded plans can be popular among large employers and can often lead to more affordable rates and control over a plan. The tradeoff; however, is that the employer, rather than the Carrier, accepts the risk of having to pay for health care claims. Employers are also responsible for any administrative costs that may incur.

Stop-Loss Insurance

Stop-loss insurance is a policy that can be purchased by Employers that self-fund their benefits plans but do not want to assume 100% of the potential losses that may occur by doing so. When an Employer purchases a stop-loss policy, the Carrier, not the Employer, is liable for any losses that exceed a predetermined limit, also known as a deductible.

Supplemental Insurance

Supplemental insurance, also known as ancillary benefits, refers to any secondary policy that supplements coverage "gaps" in an individual's primary health insurance coverage. Examples of supplemental insurance include dental and vision insurance, life insurance, and accident insurance.

Partially Self-Funded Plans

A partially self-funded plan is similar to a traditional self-funded plan in that an Employer covers the health insurance costs for their Employees. The primary difference with a partially self-funded plan is that Employers reduce their risk by paying a reoccurring monthly fee to a Carrier. In return, the Carrier covers additional costs if an individual exceeds a predetermined dollar amount in claims.

Preferred Provider Organization (PPO)

PPO health plans are similar to HMO plans, but with greater flexibility. PPOs feature a network of healthcare providers, but employees have the option to go to out-of-network physicians and practices without being fully responsible for the entire bill. Instead, these visits will result in higher co-pays and additional service fees, giving employees greater freedom than HMO plans.

HEALTH SAVINGS OPTIONS

Flexible Spending Account (FSA)

A flexible spending account (or flexible spending arrangement) is similar to an HSA in that it's a type of health savings account that employees can make tax-free contributions. The funds in an FSA can be used to cover deductibles, co-payments and any other out-of-pocket health care expenses. However, the funds must either be used or forfeited by the end of the plan year.

Health Reimbursement Account/Arrangement (HRA)

An HRA is an employer-funded account that can be paired with another health plan to et employees pay for qualified medical expenses not covered by their health plans. The main difference between an HSA and an HRA is that the employer is the sole contributor to these accounts. As a result, HRAs also stay with the employer in the event an employee leaves or is terminated.

Health Savings Account (HSA)

Health plans can be paired with savings options like a health savings account (HSA). HSAs are rising in popularity due to the ability for employees and employers to make tax-free contributions and earn tax-free interest. The funds roll over every year and stay with the employee, even if there is a change in employment. These funds can also be available for use in retirement, making them a great supplement to retirement savings accounts.

HEALTHCARE COSTS BREAKDOWN

Affordable Care Act (ACA)

The Affordable Care Act, or ACA, refers to the health care reform law that was enacted in March 2010. The law works to make affordable health insurance available to more people throughout the United States by establishing limits on cost-sharing, enforcing guidelines on minimum essential coverage and the expansion of government-funded health care programs and services such as Medicaid.

Annual Limit

An annual limit is a cap to the benefits an insurance company will cover for a specific plan over the course of a year. They can be in the form of financial limits placed on individual programs like prescriptions, or limits on the number of visits for services like annual checkups.

Coinsurance

Coinsurance is the percentage of costs for a covered service. It's usually applied after the deductible has been met. For example, you might have a 10 percent coinsurance, meaning you would pay 20 percent of the medical bill and the Carrier would cover the remaining 80 percent. The difference between coinsurance and a copayment is that coinsurance is a percentage of the health care costs, while a copay is a flat fee.

Copayment

A copayment (or copay) is a flat fee that you pay out-of-pocket for a covered service. For example, you might have a $10 copay on any doctor's visit. Some health plans don't have copays, or don't require a copay until the deductible is met.

Deductible

A deductible refers to the amount of money you need to spend (in addition to premium payments) before your insurance plan starts to pay. For example, if you have a $2,000 deductible, you'll need to pay $2,000 for health care out-of-pocket (in addition to your monthly premiums) before you can receive money from your Carrier. After you pay your deductible, you usually only pay a copayment or coinsurance for covered services. Deductibles reset every year.

Out-of-Pocket Maximum

As the name implies, an out-of-pocket maximum refers to how much money you can expect to spend on deductibles, copayments and coinsurance in one year. Once you reach this maximum, the Carrier will cover 100 percent of the costs moving forward (except for the premium).

Premium

A healthcare premium is the amount of money you pay your insurance company each year. Premiums are deducted from the checks of employees who receive insurance through an employer-sponsored health plan.

Total Cost Estimate

A total cost estimate is an individual's premium + deductible + out-of-pocket costs + copayments/coinsurance. Total cost estimates can be used to compare plans before selection coverage.

UNDERSTANDING YOUR HEALTH PLAN

Essential Health Benefits

Essential health benefits refers to the 10 categories of services that health insurance plans must cover under the Affordable Care Act to be deemed compliant.
The 10 services vary by state, but will most likely include:

- Ambulatory patient services
- Emergency services
- Hospitalizations
- Pregnancy and newborn care
- Mental health and substance use services
- Prescriptions
- Rehabilitative services
- Laboratory services
- Preventive services and disease management
- Pediatric services including oral and vision care

Medical Underwriting

Medical underwriting is the formal process of evaluating an individual's health status to determine type of coverage, price of coverage and any potential exclusions and limits.

Provider Network

Choosing between an in-network and out-of-network provider could make the difference between footing your entire medical bill or not paying a dime. A “network” refers to the doctors and other medical providers who agree to accept your health insurance. Carriers negotiate lower rates for health care with the doctors, hospitals and clinics that are in their networks. So, in-network medical providers are covered by insurance, while out-of-network providers are not.

Summary of Benefits and Coverage (SBC)

An SBC covers the basics of your health plan. It’s an easy-to-read summary that lets you make apples-to-apples comparisons of costs and coverage between health plans. You can compare options based on price, benefits and other features that may be important to you.

ADDITIONAL TERMS

Dependent

Dependents are any individuals who are eligible for coverage under a policyholder's primary health insurance coverage. Dependents can be spouses, domestic partners and children.

Household

Household is used to determine an individual's eligibility for savings by evaluating the total income of all household members. A household is typically an individual, their spouse, if married and any tax dependents.

Telemedicine

Telemedicine refers to health programs and services that are offered virtually. Individuals can use video, email and online portals to speak with healthcare specialists.

Qualifying Life Event (QLE)

A qualifying life event refers to specific changes in an individual's life situation that would allow them to enroll or change their health insurance outside of the annual open enrollment period. Qualifying life events include loss in coverage, marriage and having a child, among others.

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