hpio health policy institute of ohio

Private health insurance basics

Glossary of key insurance terms

Note: *Italicized terms are defined elsewhere in the glossary*

Actuarial value: The percentage a health plan will pay towards covered medical expenses based on a standard population. For example, in a health plan with an actuarial value of 70 percent, the consumer will pay approximately 30 percent of the total billed healthcare services and the insurance company will pay the rest.

Adverse selection: Occurs when less healthy people disproportionately enroll or remain in a health insurance plan. Generally, this happens because individuals with a higher risk of needing healthcare are more likely to purchase or retain their health insurance than healthier individuals, who may believe they can go without coverage.

Affordable Care Act (ACA) marketplace: Refers to the health insurance marketplaces established by states to allow consumers to easily shop for and compare individual insurance plans, with built-in subsidies for eligible individuals.

Association health plans (AHPs): A type of *Multiple Employer Welfare Arrangement (MEWA)* where a group of employers or self-employed individuals must share a similar trade or industry.

Catastrophic marketplace plan: A type of *Affordable Care Act marketplace plan* available to only some consumers with low monthly premiums and very high deductibles. These plans are designed to only protect against major medical emergencies and expenses.

Co-insurance: A method of cost sharing in which the consumer is required to pay a defined percentage of their medical costs, usually after their deductible has been met.

Co-payment: A method of cost sharing in which the consumer pays a flat rate dollar amount directly to the provider at the time of receiving a covered healthcare service.

Cost sharing reductions (CSR): Subsidy to reduce *out-of-pocket expenses* for low-income *ACA marketplace* enrollees who select silver-level plans.

Covered benefits: The set of services, items and treatments that an insurance plan will cover.

Deductible: A method of cost sharing in which the consumer pays a set amount during a benefit period or plan year for covered services before the insurer begins to make payments toward those covered services. Certain types of care such as preventive services may be exempted from the deductible and therefore immediately paid in full by the insurer.

Employer-sponsored insurance (ESI): Offered by employers to their employees, and in some cases their spouse and dependents, as part of an employee's compensation package. ESI is the most common form of health insurance in Ohio.

Exclusive provider organization (EPO): A type of *managed care* plan where consumers can only see *in-network providers* but do not need to receive referrals from their primary care provider to access specialty services. EPOs are not defined under Ohio law.

Farm Bureau plans: A *non-ACA compliant* form of coverage available to members of the American Farm Bureau Federation, an agricultural lobbying organization with state-level affiliates like the Ohio Farm Bureau.

Federal health insurance marketplace: The *Affordable Care Act marketplace* operated by the federal government through Healthcare.gov that states can use if they do not establish their own individual marketplace. Ohio and 27 other states use the federal health insurance marketplace.

Fee-for-service (FFS) payment: A form of reimbursement where providers are paid a separate fee for each type of service rendered. Traditional insurance models relied on FFS, but this form of payment incentivizes a higher volume of service usage independent of patient outcomes.

Flexible Savings Account (FSA): A tax-advantaged savings account offered by some employers that is similar to a *Health Savings Account* but with contributions that do not roll over each year. Funds can sometimes only be used for specific types of health services (e.g., dental care).

Fully insured plans: Refers to employer-sponsored coverage that is purchased by an employer from a health insurer who bears the full financial risk.

Gatekeeping: A *managed care* technique requiring coordination of a patient's care through a primary care provider.

Health maintenance organization (HMO): The most restrictive type of *managed care* plan where consumers can only see *in-network providers* and must receive referrals from their primary care provider for non-emergent specialty services. These plans tend to have lower premiums compared to other managed care models. Referred to as health insuring corporations (HICs) in Ohio.

Health Savings Account (HSA): A tax-advantaged savings account that enables consumers with *high-deductible health plans* to pay for qualifying medical expenses with untaxed dollars. A consumer can place pre-tax money into an HSA and use those funds to pay towards qualifying *out-of-pocket medical expenses* like *co-payments*, but not premiums.

Healthcare safety net: A system of providers that frequently deliver health services to people who are uninsured, including community health centers, free clinics, emergency departments and more.

Healthcare sharing ministries: A *non-ACA compliant* arrangement where members must agree to a common set of religious or ethical beliefs and help pay for medical expenses of other members through monthly contributions. These ministries do not function as insurance, and there is no guarantee of payment for medical bills.

High-deductible health plans (HDHPs): A health plan with a higher *deductible* that can typically be purchased for a lower monthly *premium*. The deductible amount at which a health plan becomes an HDHP is set by the federal government.

Hospital or other fixed indemnity plans: A *non-ACA compliant* arrangement that pays a limited predetermined amount for certain medical events or hospitalizations, regardless of the actual expenses incurred.

Individual Coverage Health Reimbursement Arrangement (ICHRA): A tax-free contribution that an employer can provide to an employee to help cover medical expenses, including *premiums,* for coverage that employees secure themselves. ICHRAs are often referred to as Custom Health Option and Individual Care Expense (CHOICE) Arrangements.

In-network provider: A healthcare provider that is under contract with a health plan to see patients in exchange for payment at the contracted rate.

Insurance death spiral: A cycle stemming from *adverse selection* where rising insurance premiums and costs lead to an increasing number of healthy consumers dropping their coverage, further raising costs to cover the less healthy people remaining on the insurance plan. Eventually, the insurance pool can collapse entirely.

Insurance pool: The group of consumers who are collectively covered by an insurance plan.

Managed care: Health plans that have various mechanisms in place to control the cost and delivery of healthcare services to plan enrollees, including the use of *provider networks* and *utilization review*.

Medical loss ratio: A requirement of the Affordable Care Act that insurance companies spend a certain minimum percentage of premium revenue on medical care rather than administrative costs or profits.

Metal levels: Tiers of marketplace plans based on their *actuarial value*. Platinum-level plans have the highest premiums but lowest levels of cost sharing, while bronze level plans have the lowest premiums but higher levels of cost sharing.

Multiple Employer Welfare Arrangement (MEWA): Allows two or more employers not under common ownership to pool contributions and offer health benefits to employees, which can help smaller companies that may not be able to independently offer coverage.

Network adequacy: Refers to whether a health plan's network contains a sufficient number of providers and facilities within a geographic area to ensure enrollees have reasonable, timely access to healthcare services covered by a health plan.

Non-ACA compliant plans: Types of individual health coverage that do not comply with Affordable Care Act (ACA) consumer protections and comprehensive coverage requirements.

Off-exchange plans: Individual insurance plans that can be purchased directly from a health insurance company rather than through the *Affordable Care Act marketplace*. Insurers that offer a marketplace plan must offer an identical off-exchange plan that complies with the same regulations. Insurers can also offer other off-exchange plans.

Out-of-network provider: A healthcare provider that is not under contract with a health plan.

Out-of-pocket expenses: Expenses that a consumer pays for themselves when receiving health services that can take different forms. Sometimes referred to as cost sharing.

Out-of-pocket maximum: An amount (excluding premiums) after which the insurer will cover all care costs. The federal government sets out-of-pocket maximums for some types of plans.

Point of service (POS) plan: A type of *managed care* plan where consumers can use *out-of-network providers* at a higher cost and do not need to receive referrals from their primary care provider to access specialty services.

Preferred provider organization (PPO): The least restrictive type of *managed care* plan in which consumers can use *out-of-network* providers at a higher cost and do not need to receive referrals from their primary care provider for non-emergent specialty services.

Premium tax credits (PTC): Tax credit that reduces monthly payments for *ACA marketplace plan* enrollees by setting a cap on an individual or family's monthly *premium* contribution amounts, depending on their income level.

Premiums: A set amount paid in regular increments (usually monthly) to keep insurance, regardless of whether the covered individual or family receives health services. The entity responsible for premiums can vary; it may be solely the consumer's responsibility or partially/fully covered by an employer or subsidy.

Prior authorization: A form of *utilization review* where the insurer must approve coverage of some treatments before a patient receives them.

Private health insurance: Health coverage provided through an employer, another organization (such as an association or union) or purchased directly from a private insurance company.

Provider network: Group of healthcare providers contracted with an insurer to provide services under a health plan based on specified terms and negotiated reimbursement rates.

Public health insurance: Includes coverage provided by a federal, state and/or local entity. Medicare, Medicaid, military and veteran coverage are examples of public health insurance.

Qualifying life event (QLE): A set of situations, such as marriage, having a baby, loss of prior insurance coverage, and more, that allow a consumer to change health plans outside of normal enrollment periods.

Reimbursement rate: The negotiated or pre-established payment that a provider (e.g., hospital or physician) receives from an insurance plan.

Selective contracting: A *managed care* technique of working with a more limited network of providers to negotiate lower reimbursement rates for services.

Self-insured plans: Refers to employer-sponsored coverage where the employer assumes the full risk of providing health coverage to its employees and pays employees' healthcare claims to providers through its own funds.

Short-term, limited duration insurance (STLDI): A *non-ACA compliant* form of temporary coverage for individuals transitioning between insurance plans, such as people changing employers.

Third-party administrator (TPA): An independent organization that helps manage a *self-insured plan* for an employer. TPAs are often health insurance companies that offer their own insurance plans separately.

Utilization review: A *managed care* technique to monitor use of certain (usually more expensive) health services and ensure that treatment decisions are clinically appropriate.

About Health Insurance Basics

The full brief, along with additional resources, can be found on **HPIO's website**.

Use the QR code to access the full publication

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