HEALTH INSURANCE TERMINOLOGY 101

It can be hard to choose a health plan if you don't understand what a deductible is or the difference between an HSA and an HRA. Reference the healthcare terms in this guide to make more informed healthcare decisions.

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Health Insurance Terminology 101

Types of Health Insurance Plans

Fully-Insured Plans

A fully-insured health plan is a common employer-sponsored health 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.

Self-Funded Plans

While the Carriers cover the cost of healthcare 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 healthcare claims. Employers are also responsible for any administrative costs.

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 some of the provisions required 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.

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.

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.

Health Savings Options

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 rollover 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.

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 healthcare expenses. However, the funds must either be used or forfeited by the end of the plan year.

Health Reimbursement Account (HRA)

An HRA is an employer-funded account that can be paired with another health plan to let employees pay for qualified medical expenses not covered by their health plans. The main differences 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.

Healthcare Costs Breakdown

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

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 healthcare 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.

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.

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 healthcare costs, while a copay is a flat fee.

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).

Understanding Your Health Plan

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.

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 healthcare with the doctors, hospitals, and clinics that are in their networks. So, in-network medical providers are coved by insurance, while out-of-network providers are not.

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