

GLOSSARY OF KEY HEALTH INSURANCE CONCEPTS



Overview

A fundamental first step in accessing health care in the United States is having a way to pay for it, either out of pocket, or through some form of private or public health insurance coverage. Since health care costs are often unpredictable as well as prohibitively expensive, health insurance is vital. The health insurance and coverage system is made up of a dizzying array of individual components, each with its own terminology. The Patient Protection and Affordable Care Act of 2010 (ACA) built new coverage options and expanded on the existing health care system. This created a number of new concepts and vocabulary words. The following describes several key health insurance concepts that are important in understanding aspects of the law and the potential impact of health care reform on maternal and child health populations.

Cost-Related Concepts

Premiums

A premium is the cost of an insurance policy. Premium payments are usually made on a regular schedule and for a fixed amount. A health insurance premium can be paid by an individual, or in full or part by an employer on behalf of an employee. They are not considered cost-sharing.

Cost-sharing and its Implications

Whether an individual has private health insurance (usually through an employer) or is enrolled in a public benefit program (Medicaid, Medicare, or the Children's Health Insurance Program (CHIP)), the individual usually has to share the cost of each health care service with the payer covering the bill. Cost-sharing generally includes deductibles, co-insurance, or co-payments. Private insurance cost-sharing comes in a variety of forms and at varying amounts. Typically, the more an individual (or employer) pays in premiums, the lower the cost-sharing requirements. Insurance companies contract with specific providers (individuals, practices, hospitals, etc.) and create a list of them for their enrollees. These providers are considered "in-network." Using an out-of-network provider usually means higher cost-sharing, if the

service is covered at all. There are strict federal limits on cost-sharing that public benefit programs can require of enrollees.

Cost-sharing Types

- **Deductibles:** A deductible is the amount an individual has to pay out of pocket before the insurer begins to pay its share for covered health care services. A plan or policy with a \$1,000 deductible means the insured individual (or family) has to pay the first \$1,000 for allowable health care services before the insurer reimburses any costs. The amount of the deductible varies, depending on the type of plan. Depending on the type of health care service, there may not be a deductible (such as for preventive services). Conversely, some out-of-pocket costs that individuals pay do not apply towards the deductible. This includes services that the plan does not cover or that are provided by an out-of-network provider.
- **Co-insurance:** Unlike premiums, which are typically paid on a regular schedule and don't vary month-to-month, co-insurance is based on a percentage of the allowable cost of a specific health care service. A typical co-insurance split is 80/20, although this varies. An 80/20 split means the insurer will pay 80 percent of the cost it has defined as appropriate (or "allowable") for a health care service, while the insured individual pays 20 percent. If a plan includes a deductible, the individual has to pay the deductible before the insurer begins paying. For example, once the deductible is met, if a doctor visit costs \$200—and the visit is an allowable service under an individual's plan—the insurer will pay \$160 (80 percent) and the individual will pay \$40 (20 percent).
- **Co-payments or co-pays:** A co-pay is a set amount that an individual has to pay to use a particular kind of health service, regardless of the total cost. Most clinicians collect co-pays at the time of service. Typically, a co-pay for a visit with a primary care doctor ranges from \$15 to \$25. Co-pays are often higher for specialty providers. Generally, co-pays for name brand prescription medications are higher than for generic brands.

Eligibility Determination Concepts

Federal Poverty Level (FPL)

Every year, the U.S. Department of Health and Human Services (HHS) issues updated guidelines on the Federal Poverty Levels (FPL.) Various percentages of the FPL are used to determine eligibility for programs and benefits funded or subsidized by public dollars. Examples include Medicaid and CHIP enrollment eligibility and premium tax credits and subsidies under the Health Insurance Marketplace. A family's income in relation to the FPL is computed based on both family size and household income.

Modified Adjusted Gross Income (MAGI)

The Modified Adjusted Gross Income (MAGI) is the standardized formula used to determine income eligibility for Medicaid and CHIP enrollment and lower premium costs in the Health Insurance Marketplace. Generally, MAGI is an individual's gross income plus any tax-exempt Social Security, interest, or foreign income. Under the ACA, a standard five percent is subtracted from gross income to figure out adjusted gross income. Income eligibility for Medicaid under the optional expansion for states is 133 percent of the FPL, but is often referenced as 138 percent of the FPL. Both are correct; 133 percent comes directly from the ACA and 138 percent accounts for the five percent MAGI adjustment.

Marketplace-Related Concepts

Health Insurance Marketplace (formerly known as “Exchanges”)

According to HHS, the Health Insurance Marketplace is a starting place “where individuals, families, and small businesses can learn about their health insurance options; compare health insurance plans based on costs, benefits, provider network, and other important features; choose a plan; and enroll in coverage.”ⁱ It's a centralized resource that is accessible through websites and toll-free call centers. In-person assisters can also help individuals enroll. When individuals apply for coverage through the Health Insurance Marketplace, their eligibility for public benefit programs will also be assessed.

Each state has a Health Insurance Marketplace, although some are run by the state, some by the federal government and some are state/federal partnerships.ⁱⁱ

Qualified Health Plan (QHP)

The qualified health plans (QHPs) are the plans sold through the Health Insurance Marketplace. These plans must meet certain consumer protection standards set by federal and state governments.

Essential Health Benefits

Essential health benefits (EHBs) are a set of broad health care service categories. EHBs are intended to ensure that all individual policies and small group insurance plans (sold inside or outside the Health Insurance Marketplace) as well as coverage under the Alternative Benefit Plans for the Medicaid expansion population not only provide affordable coverage to enrollees but also include a comprehensive set of benefits.

The essential health benefit categories include the following:

1. Ambulatory (outpatient) care
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

Employer plans covering large groups and grandfathered plans are **exempt**, as are self-funded plans. A self-funded (also known as ERISA) plan pays employees' health care costs directly, instead of contracting with an insurance company to do so. Self-funded plans are exempt from many state mandated benefit laws, as well as several ACA provisions.

ⁱ <https://www.healthcare.gov/glossary/health-insurance-marketplace-glossary/>

ⁱⁱ <http://kff.org/health-reform/state-indicator/state-decisions-for-creating-health-insurance-marketplaces/>

Private Insurance-Related Concepts

Grandfathered Health Plan

Not every provision of the ACA applies to every type of insurance coverage. One of the terms that is important to be aware of in this context is “grandfathered health plan.” A grandfathered health plan is one that was in place on or before March 23, 2010, the day the full ACA became law. An individual health insurance policy can have grandfathered status if it was purchased before that date. Grandfathered plans are exempt from most of the provisions of the ACA, including the essential health benefits. If a plan or policy changes significantly (by reducing benefits and/or increasing costs to enrollees above a certain level), it will lose its grandfathered status. Over time, grandfathered plans and policies will gradually phase out as insurance companies make changes to their products and/or prices. Once a plan or policy loses its grandfathered status, it becomes a “new” plan and is subject to all the consumer protections and provisions under the ACA.

One of the easiest ways for a person to know if they are in a grandfathered plan is to ask their employer’s human resources department or their insurance company. Insurers are also required to put this information in their plan materials.

New Plan

A health plan or policy that is not grandfathered (i.e. was NOT in place as of the signing into law of the ACA) is known as a “new” plan or policy. Unlike grandfathered plans, new plans/policies are subject to all the consumer protections provisions under the ACA.

Just because a plan or policy is new to an individual, it does not mean that it is a new plan in the context of the ACA. Individuals should check with their insurer to find out whether the plan they are signing up for is a grandfathered or a new plan.

Individual Responsibility Requirement (the “Individual Mandate”)

The ACA requires that everyone who can afford health insurance have it. Terms for this include the “individual responsibility requirement” and the “individual mandate.” If an individual can afford insurance and does not sign up

for it, that individual will have to pay a fee known as the individual shared responsibility payment. The payment is collected when income taxes are filed.

Situations that may qualify as exemptions from this requirement include being:

- Uninsured for less than three months of the year
- In the situation where the lowest-priced coverage available would cost more than 8 percent of an individual’s household income
- Without needing to file a tax return because income is too low (Learn about the filing limit.¹)
- A member of a federally recognized tribeⁱⁱⁱ or eligible for services through an Indian Health Services provider
- A member of a recognized health care sharing ministry
- A member of a recognized religious sect with religious objections to insurance, including Social Security and Medicare
- Incarcerated (either detained or jailed), and not being held pending disposition of charges
- Unlawfully present in the U.S.^{iv}

Situations based on hardship may also qualify an individual for an exemption. To find out if they qualify for an exemption, individuals may visit their state Health Insurance Marketplace website, healthcare.gov, or speak with a navigator, consumer-assister or broker to learn more about applying.

Minimum Essential Coverage (MEC)

Certain kinds of coverage count towards meeting the individual mandate for having insurance coverage. These plans are called “Minimum Essential Coverage” – they meet requirements laid out in the ACA for affordability and adequacy. Types of minimum essential coverage include QHPs purchased through the Health Insurance Marketplace, employer-sponsored coverage, Medicare, Medicaid, CHIP, TRICARE and certain other kinds of coverage.

ⁱⁱⁱ<https://www.healthcare.gov/glossary/federally-recognized-tribe/>

^{iv} <https://www.healthcare.gov/immigrants/immigration-status/>

Test your knowledge

1. **True or false:** Co-pays, co-insurance and deductibles are all types of cost-sharing.
2. **True or false:** The essential health benefits in the ACA apply to all kinds of private insurance.
3. **True or false:** Public benefit programs like Medicaid and CHIP are considered minimum essential coverage.



Find Out in Your State

1. What type of Health Insurance Marketplace operates in your state?
(See <http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/> for a list of Health Insurance Marketplace types by state)

Test Your Knowledge Answers: 1. True
2. False; the EHBs do not apply to large group, grandfathered or self-funded plans
3. True

This document is part of *The Affordable Care Act: A Working Guide for MCH Professionals*, available in its entirety on the Web at <http://www.amchp.org/Transformation-Station/Pages/ACA-101.aspx>

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