The ABCs of Health Insurance

JUSTWORKS.

BENEFITS & PERKS

HIRING & ONBOARDING

MANAGING YOUR TEAM

KEEPING COMPLIANT

RUNNING A BUSINESS 101

Table of Contents

INTRODUCTION

Understanding Health Insurance

Do you walk around in a fog when people start speaking about health insurance? You're not alone.

A 2016 **PolicyGenius survey** of 2,000 American health insurance consumers found that most people people couldn't correctly define common health insurance terms. For example, just 22% of people could explain "coinsurance," and only 50% knew what "deductible" means. Millennials had the lowest health insurance knowledge — only 36% of Millennials correctly identified any of the terms.

22%

could explain "coinsurance"

36%

correctly identified **any** health insurance terms

50%

knew what "deductible" means

Given these findings, it should come as no surprise that many people don't feel confident about their health insurance or the associated costs. According to a **Consumer Voices survey**, 57% of Americans say they lack confidence that they'll be able to afford health insurance. Additionally, a 2017 study found that **27% of Millennials don't go to the doctor** to avoid paying high medical bills, and 50% have received a medical bill they didn't budget for.

It doesn't add up to a good picture.

All this suggests that a lot of insured adults don't understand the essentials for choosing the right health insurance coverage to meet their needs or manage their healthcare expenses. Considering Americans' spending on out-of-pocket costs continues to rise — we spent more than **$350 billion in 2016** — it's worth more than pocket change to get a working knowledge of the terminology.

57% of Americans say they lack confidence that they'll be able to afford health insurance.

PART ONE

Health Insurance Glossary

Hey, we've all been there, wondering about the difference between a cost sharing reduction plan, deductible, and coinsurance.

Let us break it down for you so you can read your statement of benefits like an old pro and take advantage of the services available to you in your plan, all in good time before the next open enrollment.

A

Affordable Care Act (ACA)

The Affordable Care Act is a law designed to improve healthcare quality while lowering costs. The regulation mandates health insurance for most individuals, but makes coverage easier to obtain. The Health Insurance Marketplaces, gives individuals and small businesses access to several competing health benefit plans. The ACA also prohibits health insurance companies from denying coverage or increasing rates due to pre-existing conditions.

B

Benefit Limits / Caps

The ACA put a stop to this. Insurance companies can no longer cap payments and must pay for all the care you need.

C

Catastrophic Plan or Minimum Coverage Plan

These plans have low monthly premiums but high out-of-pocket costs and deductibles, and are not eligible for premium tax credits. You must be under 30 years old or eligible for a "hardship exemption" in order to get a catastrophic plan.

Coinsurance

This is the percentage of the cost of a service or fee the insurance carrier will cover after the deductible (if any) is met. For example, if a plan has 80% coinsurance, Aetna will cover 80% of the service and the remaining 20% will be paid for by the member. Typically, the coinsurance for out-of-network services will be lower than for in-network services, which will result in reimbursement that is significantly less of the cost for out-of-network services in general.

Copay

The pre-set dollar amount you have to pay for a specific type of service or visit regardless of its cost before the deductible is met for all plans, except HDHPs. Copays count toward the out-of-pocket maximum but not the deductible.

Cost-sharing

How cost is divided between the member and the insurance carrier for services/care.

D

Deductible

This is the amount of money you must pay out-of-pocket for covered health services before the carrier begins to pay. After you pay your deductible, you usually pay your copay or coinsurance, up to the out-of-pocket maximum. Typically copays will not apply toward your deductible. Health insurance plans will have a deductible for each individual on a plan, and a combined family deductible.

One thing to note is that all plans accessible through Justworks have embedded deductibles. This means that no individual is responsible for meeting more than their individual deductible, even if they are on a family plan.

For example, an employee and their spouse are enrolled in a plan with a $7,000 family deductible and a $3,000 individual deductible. If the spouse reaches the $3,000 individual deductible limit, even if the $7,000 family deductible is not met, insurance will begin to cover the spouse's benefits.

Deductibles reset each calendar year on January 1st.

Deductible Rollover

Most health plans have annual deductibles. Some plans permit participants to apply the money that they spend towards the deductible in the fourth quarter to the following year's annual deductible.

E

Essential Health Benefits

A set of 10 categories of services health insurance carriers must cover under the ACA. All plans must include ambulatory patient services, laboratory services, prescription drugs, hospitalizations, emergency services, maternity and newborn care, pediatric care, mental health and substance abuse services, rehabilitative services, as well as preventative, wellness, and chronic disease care.

Exclusive Provider Organization (EPO)

Provides in-network coverage only without pre-authorization (exception in life or death emergencies).

Exemption

Individuals are required to sign up for health insurance or pay a fine, unless they qualify for an exemption.

H

Health Insurance Marketplace or Exchange

The Health Insurance Marketplace or Exchange is a service operated by federal or state government where you go to find information about health insurance, compare and purchase plans, and get help.

Health Maintenance Organization (HMO)

Regional networks with a limited number of providers and the plans always require a referral to see a specialist.

High Deductible Health Plan (HDHP)

These plans have a deductible of at least $1,350 and an out-of-pocket maximum on in-network expenses of $6,650 for the employee-only tier of coverage. With the exception of preventative care, the coinsurance and all cost sharing will not apply to any services before the deductible has been met. You may be eligible to contribute to a HSA if enrolled in a HDHP.

I

Individual Responsibility Payment

If you choose not to sign up for health insurance and are not eligible for an exemption, you will have to pay a fine when you file your taxes.

M

Medicaid

Low-income individuals and families who meet certain requirements are eligible for this free or low-cost health insurance.

Minimum Essential Coverage

The ACA requires that individuals, unless they qualify for an exemption, have a basic health insurance plan that qualifies as minimum essential coverage or else pay a fine. Sometimes referred to as “qualifying health coverage”.

N

Network

The network determines which providers and facilities are covered by the selected insurance plan.

It’s important to note the difference between plan type and plan network. Plan type would be something like EPO, POS, HMO, PPO, etc. while plan network would have a name like Aetna Open Access Elect Choice EPO or Aetna Open Access Managed Choice POS, etc.

O

Open Enrollment

Employees can sign up for health insurance or change their plan once a year during an open enrollment period. During this time you may add or drop dependents, choose a different medical plan, or sign up for new offerings, such as a dental plan. Check with your employer to find out when your open enrollment period begins and ends. If you experience a qualifying life event, you may be eligible for a Special Enrollment Period outside of Open Enrollment.

Out-of-pocket Maximum / Payment Limit

This is the most you would have to pay for qualifying services in a calendar year. The carrier covers 100% of the cost for qualifying claims after this is exceeded. Once you've met this amount, the carrier will generally cover 100% of subsequent procedures and charges.

The plans accessible through Justworks have embedded out-of-pocket maximums. This means that no individual is responsible for meeting more than the amount of the individual out-of-pocket maximum, even if they are on a family plan and the family out-of-pocket maximum is not met. Out-of-pocket maximum resets each year on January 1st.

P

Point of Service (POS)

Provides in- and out-of-network coverage. Traditionally speaking, POS plans are "gated," meaning a member must choose a PCP who is the "point of service." All Aetna POS plans accessed through Justworks are "open access," meaning participants do not need a referral from a PCP to see a specialist. As with PPOs or any other plans covering both in and out of network services, if you choose to access health care services outside of your network, you'll have higher out-of-pocket costs, and not all services may be covered.

Preferred Provider Organization (PPO)

A healthcare organization that has agreed to provide health care through a network. Care may also be provided by out of network providers but higher fees may apply.

Premium

This is the monthly cost of your health insurance plan. Employees may pay their portion of the premium on a monthly, pre-tax basis. Your employer may or may not contribute an amount towards your premium. Premiums are based on four tiers:

- Employee only/individual
- Employees + spouse/domestic partner
- Employee + child(ren)
- Family (employee + spouse/domestic partner + child(ren)

Information about monthly cost to you for each plan and tier will be available during open enrollment.

Premium Tax Credits

You can receive a discount on your monthly premium based on your annual income. By selecting a plan through the Marketplace, you can choose whether to apply this tax credit directly to your monthly premium to lower the amount you pay to your insurer , or get a discount in the form of a credit when you pay your taxes. Employees are typically not eligible for a tax credit if they receive health coverage through their employer.

Preventative Care

Services that are required to be covered at 100% and the deductible is waived for the services (e.g. wellness visits, women's health visits, etc.).

Pre-Existing Condition Exclusions

ACA made this one a no-no, too, and insurers cannot deny coverage for any pre-existing condition, such as diabetes, cancer, or pregnancy.

Primary Care Provider (PCP)

Provider (e.g. family/general practitioner) you coordinate primary care through.

Q

Qualifying Life Event or Status Change

Life changes like getting married, having a child, or getting divorced can qualify you for a Special Enrollment — a time outside the yearly open enrollment period when you can sign up for health insurance — to change your plans.

R

Reimbursement Rate

Each medical plan will utilize one of two types of reimbursement for out-of-network coverage. Please refer to the plan document to determine which rate of reimbursement is used for each plan.

- **140% Medicare**: This method of reimbursement uses the Medicare cost of services as a baseline for determining the average cost of a service. This fee schedule is determined by the Center for Medicare and Medicaid service and is based on national average costs for medical expenses, services, and facilities. The insurance company takes 140% of the Medicare cost to determine the total reimbursable amount for that service and then applies the out of network coinsurance to the reimbursable maximum. The member is then responsible for the difference between the charge and the amount covered by the carrier. This is the most common reimbursement method used in Aetna medical plans accessed through Justworks.
- **Usual, Customary, Reasonable (UCR)**: This reimbursement rate will look at hyper-localized pricings of procedures by determined by the HIAA (Health Insurance Association of America) rather than using the Medicare fee schedule. These pricings typically reflect a cost of service that is reflective of the cost of living in any given area. For example, in areas with a higher cost of living, the UCR determined fee for service is generally higher. For example, the UCR baseline for Aetna is 80%, meaning they will use 80% of the UCR cost as the maximum reimbursable amount. They then apply any out of network coinsurance to the calculated amount. After that amount is determined, the member will be responsible for the difference between the charge and the amount covered by the carrier.

S

Specialist

A provider in a specialized practice area (e.g. cardiologist).

W

Waiver

A waiver of coverage is for an employee who declines health insurance offered by an employer. If you waive coverage, you may not cover dependents under the employer's plan, and will be subject to a penalty if you don't obtain coverage on your own.

PART TWO

Basic Health Plan Acronyms

Should you pick an HMO, EPO, PPO or POS?

This is where it all gets confusing, because there's so much more to understand than what the acronyms stand for. The type of plan you select determines what doctors you can see and the out-of-pocket costs you may face. For those who might find this a bit daunting, here is a quick guide to the different types of plans and how they differ in terms of doctor networks and costs.

The type of plan you select determines what doctors you can see and the out-of-pocket costs you may face.

HMO

A health maintenance organization (HMO) provides you coverage through a specific network of doctors and hospitals only. A primary care doctor manages your care and refers you to specialists when you need one. HMO plans typically require patients to have referrals from a primary care physician, and won't cover out-of-network care.

What it means

- Covered health care providers are in-network only.
- Out-of-pocket costs are fairly predictable.
- There's minimal paperwork since everything's already negotiated with your in-network providers.

- For out-of-network, you'll have to foot the bill yourself.
- You'll need a referral before you can see a specialist.

What you pay

- There's the monthly premium, of course.
- Typically you have copays for each type of visit and no deductibles to meet.

EPO

Exclusive Provider Organizations (EPOs) are a lot like HMOs as they generally don't cover care outside the plan's network of doctors, specialists, and hospitals.

What's the big difference from an HMO

- You can choose in-network doctors without that referral from a primary care physician.

PPO

Preferred Provider Organizations (PPO) provide the most flexibility as you can visit in-network and out-of-network health care providers. Referrals aren't required but out-of-pocket costs are higher for visits out of network.

What it means

- You can choose from both in-network and out-of-network health care providers.
- You don't need a referral before seeing a specialist.

- For out-of-network, you'll have to cover more of the bill yourself.
- That freedom tends to translate into higher out-of-pocket costs.
- And you'll be facing more paperwork if you go out-of-network, too.

What you pay

- There's the monthly premium, of course, which tends to be higher than for an HMO or EPO.
- You'll most likely have to cover copays and coinsurance for services. Staying in-network means lower fees all the way around.
- Typically PPOs have a deductible to meet so check your statement of benefits to be sure.

POS

A Point-of-Service (POS) plan is a cross between an HMO and a PPO. You'll still have a primary care physician who can refer you to an in-network provider but you can also see out-of-network providers at a premium.

What it means

- A primary care physician manages your care and refers you to other providers, in-network or out-of-network.

- For out-of-network, you'll pay greater out-of-pocket costs.
- And you'll be facing more paperwork if you go out-of-network, too.

What you pay

- There's the monthly premium, of course, which is higher than for an HMO but generally lower than a PPO.
- Typically you have copays just like with the other plans.
- Coinsurance costs tend to be higher for out-of-network visits.
- And you may also have a deductible to meet that's higher for out-of-network services so check your statement of benefits to be sure.

HDHP

High Deductible Health Plans (HDHPs) and Health Savings Accounts (HSAs) offer members the opportunity to pay less for their insurance with a high-deductible health plan. HDHPs can be part of an HMO, PPO, or POS.

What it means

- HDHPs have higher out-of-pocket costs than most plans, but if you reach the maximum out-of-pocket amount, the plan then pays 100% of your care.
- Pairing your HDHP with a health savings account (HSA) helps pay for your care because the money you put in savings is tax-free.

What you pay

- There's the monthly premium, of course, which tends to be one of the lowest monthly premiums of all.
- The deductible is high but remember preventative care is free, even if you haven't met the deductible.
- The kind of health plan you have — HMO, POS, or PPO — determines your copay and coinsurance.

PART THREE

How Much Does This All Cost?

Of course, the big question is: How much will all this cost me? Turns out that answer depends on the health plan that you select, as well as how often you get care and what kind of care you need.

Expenses to Watch

Monthly Premium

The amount you pay for your health care plan each month. The monthly premium can differ drastically based on the plan and which health care providers are covered.

Out-of-pocket costs in copayments or coinsurance

This amount depends on how many times you go to the doctor, buy prescriptions, and receive other types of services. A copayment is a flat fee per visit and coinsurance is the percentage of costs you are responsible for after the insurance company pays its percentage. Keep in mind that every plan has an out-of-pocket maximum.

Deductibles

This is the set amount you pay out of your own pocket before your insurance plan kicks in to cover part of your costs. It could be $500 or $2,000 but once you reach this amount, the health plan starts paying their portion of covered services.

Care not covered by insurance

These are the most unpredictable costs. You are responsible for 100% of these costs like over-the-counter medicines, vitamins, acupuncture or chiropractic care, and out-of-network providers.

CONCLUSION

Justworks Can Help

If you're looking for affordable health coverage for your team, Justworks can help. Justworks is a PEO that helps growing businesses obtain access to corporate-level benefits. Take a look at our benefits and explore the plans we offer access to.

Justworks takes the busyness out of growing a business and alleviates the unknown. We've combined a simple platform and exceptional 24/7 customer service with the power of a PEO, so all teams have more time to focus on what matters. Get access to benefits, seamless payroll, HR tools, and compliance support — all in one place.