



Commercial Health Insurance Primer

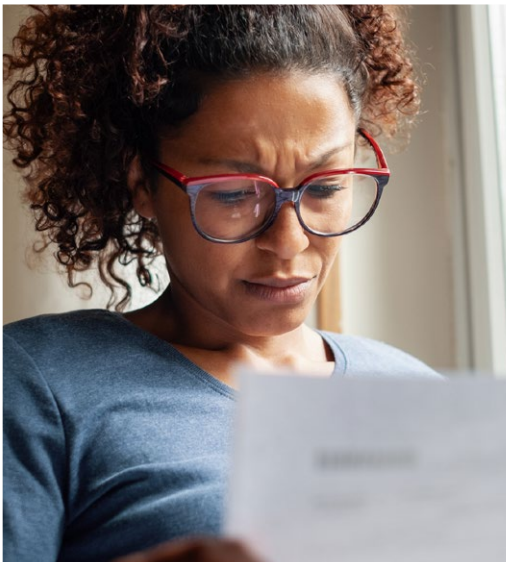
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Introduction

Commercial health insurance, also referred to as private insurance, is the most common form of health insurance in the United States, covering nearly two-thirds of Americans, most of whom receive coverage through their employer.¹ This paper provides an overview of commercial health insurance, including a description of comprehensive health insurance as opposed to other commercially available products and the key elements of a commercial health insurance product. It goes on to describe how commercial health insurance is regulated at the state and federal levels, and how requirements differ for different types of health insurance. Finally, it outlines major utilization management approaches used by insurers and providers.

Comprehensive Health Insurance versus Other Commercial Products

Most employer-sponsored health insurance plans, along with most plans sold on the individual market, are comprehensive health insurance plans (also referred to as “major medical” insurance). These plans cover a wide variety of health care services and most of the costs of those services. They are generally governed by state and federal requirements, including well-known requirements enacted by the Patient Protection and Affordable Care Act (ACA).

Additional products on the market provide some coverage or financial assistance for medical costs but are not considered comprehensive health insurance. Some of these products are intended to provide alternatives to ACA-compliant comprehensive coverage, often with a lower premium and fewer benefits and consumer protections. Examples include:²

- Short-term, limited duration plans
- Health care sharing ministries (HCSMs)
- Farm Bureau plans
- Association health plans (AHPs)

Other products are not intended to provide standalone coverage but may be helpful in supplementing comprehensive insurance by providing cash payments to cover deductibles, cost sharing, or other expenses such as lost wages. Examples include:

- Fixed indemnity policies
- Accident and critical illness policies
- Disability income policies

Additionally, workers compensation and liability insurance make payments for medical expenses but are not considered health insurance and are not subject to the ACA and state health insurance provisions. Employers are required to maintain workers compensation coverage to provide medical and wage benefits to employees who are injured or become ill in the course and scope of their job.³ Liability insurance covers damages (including medical expenses) incurred by a person due to the negligence of another.

¹ Keisler-Starkey, Katherine & Bunch, L.N. (2021, October 18). Health Insurance Coverage in the United States: 2020. U.S. Census Bureau. Retrieved December 22, 2021, from www.census.gov/library/publications/2021/demo/p60-274.html.

² Examples are defined further in the glossary.

³ The level of benefits is mandated by each state. In some states the fee schedule for provider reimbursement is also mandated by the state.

Elements of a Commercial Health Insurance Product

There are four major elements to a commercial health insurance product: benefit design, service delivery approach, provider payment method and coverage arrangement.

Benefit design

A benefit plan is defined by the services covered, limitations on services (if any), and out-of-pocket costs. For example, a plan might cover the 10 essential health benefits (EHB), limit physical therapy benefits to 20 visits per year, charge \$25 copayments for certain services and set a \$1,000 deductible. Individuals enrolled in high deductible health plans (HDHPs) can combine their HDHP with health savings accounts (HSAs) which allow them to use pre-tax dollars for eligible medical expenses.⁴

Service delivery approach

The service delivery approach refers to how members access services and from whom, including rules and requirements for participating providers and non-participating providers. Service delivery approaches (also referred to as plan type) include the following.

- **Traditional indemnity.** Traditional indemnity plans do not have provider networks and allow members to receive services from any licensed health care provider. Except for indemnity plans in government employee groups, this delivery model has largely disappeared from the commercial market.
- **Preferred provider organization (PPO).** Plans contract with providers to deliver care to members at a discounted rate. Members may use out-of-network providers but face higher out-of-pocket charges for doing so. Referrals are not required.
- **Exclusive provider organization (EPO).** Members must use providers within the EPO's network (except in emergencies) but generally are not required to obtain referrals. EPOs often consist of a health insurer entering into a relationship with a large health system and then relying primarily or exclusively on that health system's providers to serve as the provider network in a given area.
- **Health maintenance organization (HMO).** Members must choose providers within the HMO's network (except in emergencies) and may need to obtain referrals from their primary care provider to see a specialist. HMOs typically operate under a different license than other insurance models and are often subject to different requirements because of their closed provider networks. For example, several states prohibit balance billing for HMOs.⁵
- **Point of service (POS).** POS plans, like PPO plans, contract with providers to deliver care to members at a discounted rate. Members may use out-of-network providers but face higher out-of-pocket charges for doing so. As with HMO plans, members may need to obtain referrals from their primary care provider to see a specialist.

⁴ Though less commonly available than HSAs, employers may offer a Health Reimbursement Arrangement for employees to use towards eligible medical expenses.

⁵ Lucia, K., Hoadley, J., & Williams, A. (2017, June 13). Balance Billing by Health Care Providers: Assessing Consumer Protections Across States. The Commonwealth Fund. Retrieved December 22, 2021, from www.commonwealthfund.org/publications/issue-briefs/2017/jun/balance-billing-health-care-providers-assessing-consumer.

Provider payment

Insurers can use a variety of different provider payment approaches, which generally fall into three major categories: fee for service (FFS), capitation and episode-based or bundled payment.

- **FFS.** Providers are paid a set rate per service provided. Payment rates are typically negotiated between the insurer and providers and are lower for in-network providers. Another approach used by some insurers is referenced-based pricing (RBP), in which the insurer pays a set price for each health care service instead of negotiating prices. Reference price contracts are often set as a percentage of Medicare; for example, a commercial insurer might offer a hospital a reference price of 175% of Medicare. When a provider bills for the service, the payer remits the set amount.⁶ Federal and state law permits most payers to use reference-based pricing for out-of-network claims, while only self-insured employer-based plans can use RBP as a comprehensive payment strategy.
- **Capitated arrangements.** Providers receive a payment per patient per month and assume risk for the total cost of care within the boundaries of capitated arrangement.
- **Episode-based or bundled payment.** Providers receive one payment per episode (for example, an inpatient stay and hospital services provided during the stay) or a “bundled” payment to cover the services of multiple providers involved in the episode, such as different physician specialties, hospital care, and post-acute care.

Insurers may use more than one approach and may combine approaches. They may also make performance-based incentive payments or deploy other alternative payment arrangements involving withholds and risk/bonus arrangements.

Coverage arrangement

The final key element in a health insurance product is the coverage arrangement, which affects how the insurance product is regulated (Table 1). Specifically:

- Whether the coverage is purchased on an individual level (i.e., the individual market) or purchased and provided to employees by an employer (i.e., the group market).
- Whether group coverage is being provided by an employer with 50 or fewer full-time-equivalent (FTE) employees (small group coverage) or more than 50 FTEs (large group coverage). (Some states set the threshold at 100 employees).
- Whether the group health plan is fully insured or self-insured. Fully insured employers pay a fixed premium to an insurer, (or HMO), while self-insured employers pay for each claim as they are incurred (effectively acting as a risk bearing entity).⁷ Self-insured employers typically contract with an insurance company or third-party administrator for plan and claims administration. TPAs may provide additional services, which could include collecting premiums, providing utilization review, and other ancillary services. They may issue membership cards to employees to facilitate these activities, but they do not underwrite risk. Self-insured employers often purchase stop-loss insurance, which is similar to reinsurance, to provide protection against very large claims.

⁶ To the extent permitted by state and federal law, if a provider is dissatisfied with the payment, they can bill the patient for the unpaid portion of the claim.

⁷ For the purposes of this document the term insurer includes an HMO but does not include a self-insured health plan.

Regulation of Commercial Health Insurance Products

Products offered by insurers and self-insured group health plans are regulated under both state and federal law. In general, federal law establishes a minimum set of requirements (i.e., a floor) and the states may impose additional requirements, if those requirements do not conflict with federal law or prevent implementation of federal requirements. Although states are and have historically been primarily responsible for regulating the business of insurance, the ACA expanded the role of the federal government as it relates to regulation of commercial health insurance by effectively increasing the “federal floor.”

State regulation

As noted above, states are the primary regulators of the business of health insurance, as codified by the 1945 McCarran-Ferguson Act. Each state requires health insurers to be licensed to sell plans in the state and has a unique set of requirements that apply to insurers and plans. These requirements are broad in scope and address a variety of issues, including the legal structure and organization of insurers, business practices (e.g., marketing rules), market conduct (e.g., requirements related to claims and underwriting) benefits standards, consumer protections, taxes and fee structure, financial solvency and cash reserves, and others.

Notably, under ERISA, self-insured group health plans are not subject to state laws or oversight. ERISA preempts state laws as they relate to these plans and does not allow states to deem them to be “in the business of insurance.” As such, these plans are not subject to state requirements governing the business of insurance. They are subject to many provisions of federal law, described below, and are subject to oversight and enforcement by the U.S. Department of Labor.

Federal regulation

Federal health insurance requirements are codified in Title XXVII of the Public Health Service Act (PHSA), Part 7 of ERISA, and Chapter 100 of the Internal Revenue Code (IRC). These federal requirements collectively establish a federal floor with respect to access to coverage, premiums, benefits, cost sharing, and consumer protections. However, federal requirements do not apply uniformly across different types of individual or group plans (Table 1). For example, several requirements, including the requirement to provide the 10 essential health benefits and to use community rating practices, do not apply to fully insured plans issued to large groups or to self-insured group health plans.

Some additional health coverage products on the market are either exempt from or not compliant with the federal requirements outlined in Table 1. These include coverage arrangements that are specifically exempt from all federal requirements (e.g., short-term or limited duration health plans) and those that are exempt from some federal requirements (e.g., grandfathered plans, student health insurance coverage). Additional products, including HCSM coverage and Farm Bureau coverage, are not exempt but do not necessarily have to comply with federal requirements.⁸

⁸ Some stakeholders may consider AHPs to be in this category. An AHP is a type of Multi-Employer Welfare Association (MEWA) in which a group of individuals or employers with some type of connection or commonality (e.g., trade organization, professional organization) collectively offer a group health insurance plan designed for their members. In June 2018, the Trump Administration enacted a final rule making it easier for AHPs to become a single multi-employer plan considered a “large group,” meaning they would not have to comply with many of the ACA’s most significant consumer protections, including requirements related to community rating and essential health benefits. Critics noted that this rule violated the intent of the ACA and ERISA. The rule was vacated by a district court and, as of December 2021, is on hold as the Department of Health and Human Services considers further agency action. Fernandez, B., Forsberg, V. & Rosso, R. (2021, September 14), Federal

Table 1. Applicability of Selected Federal Requirements to Private Health Insurance Plans

Provision	U.S. Code (citations to 42 U.S.C. unless otherwise noted)	Individual Market	Group Market Fully insured		
			Small group ¹	Large group ¹	Self-insured
Provisions related to obtaining coverage					
Guaranteed issue	§300gg-1	✓	✓	✓	N.A.
Prohibition on using health status for eligibility determinations	§300gg-4(a)	✓	✓	✓	✓
Dependent coverage extension (until age 26)	§300gg-14	✓	✓	✓	✓
Waiting period limitation	§300gg-7	N.A.	✓	✓	✓
Provisions related to keeping coverage					
Guaranteed renewability	§300gg-2	✓	✓	✓	N.A.
Prohibition on rescission of coverage	§300gg-12	✓	✓	✓	✓
COBRA continuation coverage	29 U.S.C. §1161- §1168	N.A.	✓ ²	✓	✓
Provisions related to developing health insurance premiums					
Prohibition on using health status as a rating factor	§300gg-4(b)	✓	✓	✓	✓
Rating restrictions, rate review, single risk pool	§300gg; §18032	✓	✓	N.A.	N.A.
Provisions related to covered services					
Minimum hospital stay after childbirth	§300gg-25	✓	✓	✓	✓
Mental health parity	§300gg-26	✓	N.A.	✓	✓
Reconstruction after mastectomy	§300gg-27	✓	✓	✓	✓
Nondiscrimination based on genetic information	§300gg-3, 4	✓	✓	✓	✓
Essential health benefits	§18022	✓	✓	N.A.	N.A.
Preventive health services without cost sharing	§300gg-13	✓	✓	✓	✓
Preexisting health conditions	§300gg-3	✓	✓	✓	✓
Cost-sharing limits					
Limits for annual out-of-pocket spending	§18022	✓	✓	✓	✓
Minimum actuarial value requirements	§18022	✓	✓	N.A.	N.A.
Prohibition on lifetime and annual coverage limits	§300gg-11	✓	✓	✓	✓
Consumer assistance and other patient protections					
Summary of benefits and coverage	§300gg-15	✓	✓	✓	✓
Medical loss ratio	§300gg-18	✓	✓	✓	N.A.
Appeals process, patient protections	§300gg-19, 19a	✓	✓	✓	✓
Nondiscrimination for clinical trial participation	§300gg-8	✓	✓	✓	✓
Plan requirements related to health care providers					
Nondiscrimination regarding health care providers; quality reporting requirements	42 U.S.C. §300gg-5, 17	✓	✓	✓	✓

Source. Fernandez, B., Forsberg, V. & Rosso, R. (2018, August 28), Federal Requirements on Private Health Insurance Plans. Congressional Research Service. Retrieved December 22, 2021 from <https://sgp.fas.org/crs/misc/R45146.pdf>.

Notes. COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985.

¹ States may elect to define large groups as groups with more than 50 individuals or more than 100 individuals.

² Employers with fewer than 20 employees are not required to comply with COBRA's coverage continuation requirement.

Requirements on Private Health Insurance Plans. U.S. Government Accountability Office. Retrieved December 22, 2021 from [crsreports.congress.gov/product/pdf/LSB/LSB10641](https://www.gao.gov/products/GAO-21-451).

Medicare Advantage and Medicaid Managed Care Plans

Medicare Advantage (MA) and Medicaid managed care plans are private plans that provide health coverage and deliver benefits to people with Medicare or Medicaid. MA plans contract with CMS to provide Medicare Part A, B, and often Part D coverage. Medicaid managed care plans contract with state Medicaid agencies to provide all or a subset of Medicaid-covered benefits. Because they are private plans, they are subject to state regulation with respect to licensing and certification and financial solvency in addition to federal and state requirements specific to the Medicare and Medicaid programs. MA and Medicaid managed care plans are subject to any additional contractual requirements negotiated between the plan and the state (Medicaid agency) or federal government, as applicable.

Utilization Management

Utilization management has no single, universally accepted definition. However, URAC (an accrediting organization) defines it as “the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan, sometimes called ‘utilization review.’” Although utilization management has historically been deployed by insurers to contain costs, it is also used as a tool to help ensure access to timely care and meet quality standards. Hospitals and other providers may also use utilization management techniques to help prevent or contest claim denials and to ensure care is being provided efficiently and appropriately, especially in the context of value-based payment arrangements.

Utilization management occurs at three different points:

- **Prospective review.** The need for health care services is assessed before the service is performed, or health services are limited to a certain quantity or frequency. Examples include prior authorization, referrals, step therapy, and quantity or periodicity limits on items and services.
- **Concurrent review.** Services are reviewed during the care episode to ensure the care being provided is necessary and the level and setting of care is appropriate. Examples include case management, discharge planning, and coordinating transitions to a home or setting that delivers a lower level of care.
- **Retrospective review.** Retrospective review occurs after the care was delivered. Hospitals and other providers may have specialized staff to perform reviews to ensure claim submissions are complete and correct. Insurers also review claims to ensure accurate payment and may deny or downgrade claims if a retrospective review finds that a claim was not properly billed, the services provided were not medically necessary or the most appropriate course of treatment, or the service is not covered by the plan.

Although plan design is not a utilization management tool, plan design may be used for the same purpose, e.g., to discourage expensive or unnecessary services. Higher cost sharing in the form of high copayments, coinsurance, or deductibles can discourage utilization.

⁹ Melanie Lite Matthews. Physicians of Southeast Washington. Managed Care 101: Utilization Management. October 27, 2016. <https://www.apg.org/wp-content/uploads/2018/10/Managed-Care-101-Melanie-Lite-Matthews.pdf>.

¹⁰ Giardino, A. & Wadhwa, R. (2021, July 15). *Utilization Management*. Retrieved December 22, 2021 from <https://www.ncbi.nlm.nih.gov/books/NBK560806/>.

¹¹ Giardino, A. & Wadhwa, R. (2021, July 15). *Utilization Management*. Retrieved December 22, 2021 from <https://www.ncbi.nlm.nih.gov/books/NBK560806/>.

Appendix: Glossary of Health Coverage and Medical Terms

Accident/critical illness policy

Policies that provide lump sum cash payments to the member to help cover costs associated with or reimbursement for medical bills from qualifying accidents or critical illnesses.

Allowable charge

The maximum amount an insurer will reimburse a physician or hospital for a given service.

Annual limit

A cap on the annual benefits members may receive from their insurance company. A health plan may have an annual limit on the dollar amount that will be paid during one year for a certain treatment or service, or for all benefits provided in a year. Under the ACA, annual limits are no longer allowed on essential health benefits, such as emergency services and hospital stays.

Appeal

A request that the health insurer review a decision that denies a benefit or payment (either in whole or in part).

Association health plan

A type of Multi-Employer Welfare Association (MEWA) in which a group of employers with some type of connection or commonality (e.g., trade organization, professional organization) collectively offer a group health insurance plan designed for their members.

Balance billing

When a provider bills the patient for the balance remaining on the bill that insurance did not cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is \$200 and the allowed amount is \$110, the provider may be permitted to bill the patient for the remaining \$90. This happens most often when patients receive services from an out-of-network provider (non-preferred provider).

Benefits

The health care items, or services covered by an insurance plan.

Catastrophic plan

The health insurance exchange will include a catastrophic plan option. Catastrophic plans have lower premiums but begin to pay benefits only after members have first met a high deductible, except for three preventive care visits per year. They may also only cover more expensive levels of care, like hospitalizations. Catastrophic plans are available only to people under age 30 and to people for whom coverage would otherwise be unaffordable.

Claim

A request for a benefit (including reimbursement of a health care expense) made by the member or the member's health care provider to the member's health insurer for items or services believed to be covered.

Claim form

A form the member or the member's health care provider completes and submits to the member's insurer or health plan.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985. This federal act requires certain group health plans to allow employees and covered dependents to continue their group coverage for a stated period following a qualifying event that causes the loss of eligibility for the group health coverage. Qualifying events include reduced work hours, termination of employment, a child reaching the limiting age (i.e., age 26), Medicare eligibility, death, or divorce.

Coinsurance

The member's share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. The member generally pays coinsurance plus any deductible. (For example, if the plan's allowed amount for an office visit is \$100 and the member has met their deductible, their coinsurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.) The member's share is usually lower for in-network covered services (referred to as in-network coinsurance) than for out-of-network services (referred to as out-of-network coinsurance).

Contracting hospital

A hospital that has a contract to provide hospital services to members of a plan.

Copayment

A fixed amount (for example, \$15) the member pays for a covered health care service, usually at the point of service. The amount can vary by the type of covered health care service. Copayments for providers that are in-network (referred to as in-network copayments) usually are lower than copayments for out-of-network providers (referred to as out-of-network copayments).

Cost sharing

The member's share of costs for covered services (sometimes called "out-of-pocket costs"). Cost sharing includes copayments, deductibles and coinsurance. Other costs, including premiums, penalties, balance billing payments, or costs for excluded (or non-covered) services are not considered cost sharing.

Covered service

A service that is eligible for benefits according to the terms of the health insurance plan.

Deductible

An amount the member must pay during a coverage period (usually one year) for covered health care services before the plan begins to pay benefits. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles.

Effective date of coverage

The date coverage begins.

Employee Retirement Income Security Act of 1974

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established retirement and health plans in private industry to provide protection for individuals in these plans. In general, ERISA does not cover plans established or maintained by governmental entities, churches for their employees, or plans which are maintained solely to comply with applicable workers compensation, unemployment or disability laws.

Employer responsibility

Starting in 2015, if an employer with at least 50 full-time equivalent employees doesn't provide affordable health insurance and an employee uses a tax credit to help pay for insurance through a Health Insurance Marketplace, the employer must pay a fee to help cover the cost of tax credits.

Essential health benefits (EHB)

A set of 10 categories of health care services comprehensive health insurance plans in the individual and small group markets must cover under the Affordable Care Act (ACA). These include (1) ambulatory patient services; (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; and (10) pediatric services, including oral and vision care. Some plans cover more services.

Excluded services

Health care services that are not covered by the plan.

Exclusive provider organization (EPO)

A type of managed health plan in which members are required to use providers within the EPO's network (except in emergencies) but generally are not required to obtain referrals.

Explanation of benefits (EOB)

An EOB is created after a claim payment has been processed by the health plan. It explains the actions taken on a claim such as the amount that will be paid, the benefit available, discounts, reasons for denying payment and the claims appeal process.

Farm Bureau plans

In some states, the local Farm Bureau offers health plans to individuals or small groups as an alternative to ACA-compliant coverage. They generally offer fewer benefits and consumer protections and have lower premiums than comprehensive ACA-compliant coverage. In Tennessee, Iowa, Kansas, Indiana, and South Dakota, farm bureau plans are not considered health insurance and are exempt from state insurance regulation.

Fixed indemnity policy

Fixed indemnity policies pay a pre-determined amount on a per-period or per-incident basis (e.g., \$200 per day while a patient is hospitalized) regardless of the actual costs of services incurred.

Fully insured health plan

A group health plan in which the group (for example, the employer) purchases health insurance from an insurance company or HMO in order to provide coverage for its employees.

Grandfathered health plan

The ACA provided that group health plans and health insurance coverage in which at least one individual was enrolled as of enactment of the ACA (March 23, 2010) could be grandfathered. For as long as a plan maintains its grandfathered status, it is exempt from specified federal health insurance requirements established under the ACA.

Group

A group of people covered under the same health care plan and identified by their relation to the same employer or employer organization.

Guaranteed issue

A requirement under the ACA that health plans must permit eligible persons to enroll in some form of insurance coverage regardless of health status, age, gender or other factors during an annual enrollment period or when a person qualifies for a special enrollment period.

Grievance

A complaint that the member communicates to their health insurer or plan.

Habilitation services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health care sharing ministries (HCSMs)

Health care sharing ministries (HCSMs) are groups of persons who share a common set of religious beliefs and contribute funds (or "share") to reimburse the medical expenses of other members. HCSMs do not guarantee payment of medical claims. States generally do not consider HCSMs to be insurance and most states have statutes that specifically exempt HCSMs from state insurance regulation.

Health insurance

A contract that requires a health insurer to pay some or all health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan."

Health maintenance organization (HMO)

An organization that provides health care coverage to its members through a network of physicians, hospitals and other health care providers. Out-of-network services are typically not covered (except in an emergency), and members may need to receive a referral from their primary care provider to see a specialist.

Health savings account (HSA)

A Health Savings Account allows individuals to pay for current health expenses and save for future qualified medical expenses on a pre-tax basis. Funds deposited into an HSA are not taxed, the balance in the HSA and interest grows tax free, and that amount is available on a tax-free basis to pay qualified medical expenses, including copays, coinsurance and deductible. Only people enrolled in high deductible health plans may contribute to and use an HSA.

High deductible health plan (HDHP)

A plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but members pay more health care costs out of pocket before the insurance company starts to pay benefits (up to a deductible). An HDHP can be combined with a health savings account (HSA), allowing members to pay for certain medical expenses with money free from federal taxes. For 2022, the IRS defines a high deductible health plan as any plan with a deductible of at least \$1,400 for an individual or \$2,800 for a family. An HDHP's total yearly out-of-pocket expenses (including deductibles, copayments, and coinsurance) can't be more than \$7,050 for an individual or \$14,100 for a family. (This limit doesn't apply to out-of-network services.)

Individual responsibility requirement (individual mandate)

Sometimes called the "individual mandate," the requirement to be enrolled in health coverage that provides minimum essential coverage or face a tax penalty. This requirement was repealed and is not in effect for plan years beginning in 2019.

In-network/network provider

Services provided by a physician or other health care provider that has entered into a contract with the plan. A provider who has a contract with a health insurer or plan who has agreed to provide services to members of that plan is referred to as a network provider, preferred provider or participating provider. Members usually pay lower out-of-pocket costs to see providers in the network.

Insured person

A person enrolled in a health care plan and entitled to benefits under the plan, often referred to as a covered person, enrollee, member or subscriber.

Lifetime limit

A cap on the total lifetime benefits members may get from their insurance company for certain conditions. A health plan may have a total lifetime dollar limit on benefits, limits on specific benefits, or a combination of the two. After a lifetime limit is reached, the insurance plan will no longer pay for covered services. Under the ACA, lifetime limits are no longer allowed on essential health benefits, such as emergency services and hospital stays.

Managed health care plans

Managed health care plans are plans that have contracts with health care providers and medical facilities, forming a network. These contracts allow members to pay a reduced cost for services when they receive services from in-network providers. HMO, PPO, POS and EPO plans are examples of managed care plans. Managed health care plans engage in utilization management (e.g., prior authorization, claim review).

Marketplace

The marketplace for health insurance created by the ACA where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange". The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP).

McCarran-Ferguson Act

This federal law contains the basic delegation of authority to the states regarding the regulation and taxation of the business of insurance. There are two contingencies: First, that Congress can enact legislation applicable to the business of insurance by affirmatively stating that the legislation applies to the business of insurance. Second, that when states do not enact or maintain laws to regulate the business of insurance, such regulation is left to Congress.

Medically necessary

Health care services or supplies that a health care provider, exercising reasonable clinical judgement, determines are needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine. Health insurance plans provide their specific definition of medically necessary (also referred to as medical necessity) in the policy documents. Each state may also have a definition of "medical necessity" within their laws or regulations.

Member

A person enrolled in health care coverage. Sometimes referred to as covered person, enrollee, insured person, or subscriber.

Minimum essential coverage (MEC)

The type of health coverage an individual needs to maintain throughout the year in order to meet the (now repealed) individual responsibility requirement under the ACA. Health plans that are considered MEC include individual and family plans bought through the Health Insurance Marketplace or directly through an insurance company, employer-based coverage; Medicare; Medicaid, CHIP, TRICARE; and certain other coverages.

Minimum value standard

A basic standard to measure the percent of permitted costs the plan covers. The minimum value is 60% of the total allowed costs of benefits. People who are offered employer-sponsored insurance that meets minimum value may not be eligible for premium tax credits to buy a plan from the Marketplace.

Multiple employer welfare arrangement (MEWA)/Association health plans.

A MEWA is an employee welfare benefit plan, or any other arrangement which is established or maintained for the purpose of offering or certain types of benefits, including health care, to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries. Employers participating in a MEWA must make contributions to the plan based on the number of employees they have and the estimated costs associated with each employee. An association health plan is a type of MEWA in which a group of employers with some type of connection or commonality (e.g., trade organization, professional organization) collectively offer a group health insurance plan designed for their members.

Network

The physicians, hospitals and other health care providers that a managed care plan has contracted with to deliver health care services to its members.

Open enrollment period

The period of time set up to allow eligible individuals to choose from and enroll in available health insurance plans, usually once a year.

Out-of-network provider (non-preferred provider)

A provider who does not contract with the plan or insurer. If the plan covers out-of-network services, the member must usually pay more to see an out-of-network provider than a preferred provider. May also be called “non-preferred” or “non-participating” instead of “out-of-network provider.”

Out-of-pocket limit (out-of-pocket maximum)

The most a member could pay during a coverage period (usually one year) for their share of the costs of covered services. After meeting this limit the plan will usually pay 100% of the allowed amount. The limit never includes premium, balance-billed charges or cost of services not covered by the plan. Additionally, some plans do not count all copayments, deductibles, coinsurance payments, out-of-network payments or other expenses toward this limit.

Outpatient services

Treatment that is provided to a patient who is able to return home after receiving health care services without an overnight stay in a hospital or other inpatient facility.

Plan

Health coverage issued to the member directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called health insurance plan, policy, health insurance policy or health insurance.

Point of service (POS)

Point of service (POS) plans, like PPO plans, contract with providers to deliver care to members at a discounted rate. Members may use out-of-network providers but face higher out-of-pocket charges for doing so. Like HMO plans, they may be required to obtain referrals from their primary care provider to see a specialist.

Prior authorization

A decision by the health insurer or plan that a health care service, treatment plan, prescription drug or other supplies is medically necessary. Sometimes called preauthorization, prior approval or precertification. The health insurance or plan may require preauthorization for certain services prior to receipt of services, except in an emergency. Preauthorization is not a promise that the health insurance or plan will cover the cost.

Pre-existing condition

A condition, disability or illness that an individual has been treated for before applying for health coverage.

Premium

The ongoing amount that must be paid for the health insurance or plan. The member and/or their employer usually pay it monthly, quarterly or yearly.

Preferred provider option (PPO)

Also referred to as a participating provider option. A health care plan that supplies services at a higher level of benefits when members use contracted health care providers. PPOs also provide coverage for services rendered by health care providers who are not part of the PPO network, however the plan member generally pays higher cost sharing for such services.

Premium tax credits

Based on family size and income, individuals and families may qualify for a tax credit to purchase health insurance coverage in the state’s Marketplace. These tax credits can be used right away to lower monthly premium costs. Sometimes called advanced premium tax credit (APTC), or premium tax credit.

Prescription drug coverage

Coverage under a plan that helps pay for prescription drugs. If the plan’s formulary uses “tiers” (levels), prescription drugs are grouped together by type or cost. The amount the member pays in cost sharing will be different for each “tier” of covered prescription drugs.

Prescription drug formulary

A list of commonly prescribed drugs (also known as a drug formulary). Not all drugs listed in a plan’s prescription drug list are automatically covered under that plan.

Prescription drug payment level tier

A prescription drug formulary has different levels of payment coverage, called “tiers.” These tiers determine how much the member pays out of pocket for a covered prescription drug, based on the terms of the pharmacy benefit and whether the drug is covered on the formulary. Drugs in a lower tier will often cost less than drugs in a higher tier.

Qualified health plan

An insurance plan that is certified by, and offered for sale on, the Marketplace and provides essential health benefits, follows established limits on cost-sharing (deductibles, copayments and out-of-pocket amounts) and meets other minimum standards.

Referenced-based pricing

A provider payment approach in which the plan pays a set price for each health care service instead of negotiating prices with the provider of such services. When a provider bills for the service, the payer remits the set amount. Federal and state law permit most payers to use reference-based pricing for out-of-network claims, while only self-insured employer-based plans can use RBP as a comprehensive payment strategy.

Referral

As applicable to HMO or point of service (POS) coverage, a written authorization from a member's primary care physician (PCP) to receive care from a different contracted physician, specialist or facility.

Rehabilitation services

Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening

A type of preventive care that includes tests or exams to detect the presence of something, usually performed when the patient has no symptoms, signs or prevailing medical history of a disease or condition.

Self-insured employer health plan

A type of employer-sponsored health plan in which the employer itself takes on the responsibility of paying for covered services. These employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third-party administrator, or they can be self-administered.

Short-term, limited duration health plans

Short-term, or limited duration plans offer health coverage for up to one year and typically offer fewer benefits and consumer protections and lower premiums than comprehensive coverage sold on the exchange or provided through an employer. These plans may be helpful for people changing jobs, who missed open enrollment or otherwise need non-comprehensive coverage for only a short period of time.

Special enrollment period

A time outside of the open enrollment period during which individuals can sign up for a health insurance plan. Individuals generally qualify for a special enrollment period of 30 to 60 days following certain life events that changes family status (for example, marriage or birth of a child) or loss of other health coverage.

Traditional indemnity plan

Indemnity health insurance plans are also called fee-for-service. These are the types of plans that primarily existed before the rise of HMOs, PPOs and other network plans. With an indemnity plan, there is no provider network, so patients can choose their own physicians and hospitals.

Usual, customary, reasonable (UCR)

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Utilization management (utilization limits)

Utilization management has no single, universally accepted definition. URAC defines it as "the evaluation of the medical necessity, appropriateness and efficiency of the use of health care services, procedures and facilities under the provisions of the applicable health benefits plan." Examples of utilization management include prior authorization, discharge planning and retrospective claims review.

Worker's compensation/liability insurance

Work-injured employees may receive worker's compensation for medical and recovery expenses and for liability expenses when a business is sued over a work injury.

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