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Health Insurance: Terms You Should Know

Health insurance policies can take many different forms such as employer group plans, individual policies, COBRA, Medicare, Medicare supplemental, Medicare prescription drug coverage, managed care plans, indemnity, long-term care, etc. Here is a glossary of terms.

Certificate of Insurance

A printed description of the benefits and coverage provisions forming the contract between the carrier and the customer. It discloses what is covered, what is not, and dollar limits.

COBRA

Consolidated Omnibus Budget Reconciliation Act of 1985, federal legislation that allows you – if you work for an insured employer group of 20 or more employees – to continue to purchase health insurance for up to 18 months if you lose your job, or your employer-sponsored coverage is otherwise terminated.

Co-Insurance

Co-insurance refers to money that an individual is required to pay for services, after a deductible has been paid. In some health care plans, co-insurance is called “copayment.” Co-insurance is often specified by a percentage.

Copayment

A predetermined (flat) fee that an individual pays for health care services, in addition to what the insurance covers. For example, some HMOs require a $15 copayment for each office visit, regardless of the type or level of services provided during the visit. Copayments are not usually specified by percentages.

Deductible

The amount an individual must pay for health care expenses before insurance covers the costs. Often, insurance plans are based on yearly deductible amounts.

Elimination Period

An elimination period is the length of time between when an injury or illness begins and receiving benefit payments from an insurer. Also known as the "waiting" or "qualifying" period, policyholders must, in the interim, pay for these services. The resulting effect can be thought of as a deductible.

In general, the shorter the elimination period, the more expensive the policy and vice versa. Typically, most insurance policies have the best premium rates for 90-day elimination periods. A policy with anything longer than 90 days, while less expensive, may not save you much compared to the extra risk you take on.

The elimination period starts on the date that your injury or diagnosis renders you unable to work. For instance, if you were in a car accident that left you unable to work, and you filed a claim 30 days after the accident, the elimination period would begin the day of the accident. It's also possible that your first disability check won't arrive until 30 days after the elimination period ends, meaning if you choose a 90-day elimination period, it might be four months before you receive your first benefit.

Employer-sponsored Health Insurance

Many employees secure coverage through an employer-sponsored plan, often called *group health insurance.* Employers accept responsibility for a significant portion of the health care expenses. Group health plans are also guaranteed issue, meaning that a carrier must cover all applicants whose employment qualifies them for coverage. In addition, employer-sponsored plans typically are able to include a range of plan options from HMO and PPO plan to additional coverage such as dental, life, short- and long-term disability.

Employer-Sponsored Health Plans

Employer-sponsored health plans are more likely to be provided by larger companies. The plans face rapidly escalating premiums.

Group Health Insurance

Coverage through an employer or other entity that covers all individuals in the group.

Health Maintenance Organization (HMO)

These organizations represent "pre-paid" or "capitated" insurance plans in which individuals or their employers pay a fixed monthly fee for services instead of a separate charge for each visit or service. The monthly fees remain the same, regardless of types or levels of services provided. Services are provided by physicians who are employed by, or under contract with, the HMO. HMOs vary in design. Depending on the type of the HMO, services may be provided in a central facility, or in a physician's own office. Typically, this type of plan maintains a larger provider network, but requires referrals for specialty care.

Hybrid Policy

Hybrid long-term care policies combine the benefits of life insurance (or annuity) with long-term care benefits.

A person can buy a hybrid policy by paying a one-time lump sum premium or by paying over a number of years. If it turns out long-term care is not needed, the policy works much like a traditional life insurance policy, with a death benefit paid to a beneficiary when the insured person passes away.

If the insured person does need long-term care, the policy will pay benefits toward those expenses. Similar to a traditional long-term care policy, the benefits are paid in an amount chosen when the policy is purchased, and expressed as an amount per day, month or year.

If long-term care is never needed, the policy's life insurance death benefit is often similar to the amount paid for the policy. On the other hand, if long-term care is needed, the amount of money available can exceed the death benefit, often several times over, offering tremendous leverage of premium dollars.

Indemnity Health Plans

These plans are also called "fee-for-service." These are the types of plans that primarily existed before the rise of HMOs

and PPOs. With indemnity plans, the individual pays a predetermined percentage of the cost of health care services, and the insurance company pays the other percentage. For example, an individual might pay 20 percent for services and the insurance company pays 80 percent. The fees for services are defined by the providers and vary from physician to physician. Indemnity health plans offer individuals the freedom to choose their health care professionals.

Individual Health Insurance

Coverage is based on an individual, not a group. The premium is usually higher for an individual health insurance plan than for a group policy, but you may not qualify for a group plan.

Long-term Disability Insurance

Pays an insured a percentage of their monthly earnings if he or she become disabled.

Long-Term Care Insurance

Long-term care insurance is a type of insurance developed specifically to cover the costs of nursing homes**,** assisted living**,** non-medical in-home care and other long-term care services. These services are usually not covered by traditional health insurance or Medicare**.**

The majority of policies sold today are comprehensive policies. They typically cover care and services in a variety of long-term care settings.

Managed Care

A medical delivery system that attempts to manage the quality and cost of medical services that individuals receive. Most managed care systems offer HMOs and PPOs that individuals are encouraged to use for their health care services. Some managed care plans attempt to improve health quality, by emphasizing prevention of disease.

Medicaid

Medicaid is the program providing medical and health-related services, including nursing home care, to America's poorest people. Recipients must meet income and asset eligibility criteria. It covers more than 80 million individuals, including children, the aged, blind, and/or disabled, and people who are eligible to receive federally assisted income maintenance payments. Within broad national guidelines that the federal government provides, each of the states:

- establishes its own eligibility standards;
- determines the type, amount, duration, and scope of services;
- sets the rate of payment for services; and
- administers its own Medicaid program.

In Tennessee, the Medicaid program is called TennCare, which operates under a waiver that authorizes the state to contract with for-profit companies to manage care. “CHOICES” is TennCare’s program for long-term services and supports for elderly (65 years of age and older) or disabled (21 and older).

Medicare

A federal health insurance program created to provide health coverage for Americans aged 65 and older and later expanded to cover younger people who have permanent disabilities or who have been diagnosed with end-stage renal disease **or** amyotrophic lateral sclerosis (ALS).

Medicare Advantage Plan

Medicare Advantage is part of the Medicare program offered to older people and disabled adults who qualify. Also referred

to as Part C plans, Medicare Advantage (MA) plans are provided by private insurance companies instead of the federal government. They include the same Part A hospital and Part B medical coverage that Original Medicare provides but not hospice care. Most MA plans also include Part D prescription drug coverage. Anyone who joins an MA plan still has Medicare. Medicare Advantage plans provide additional incentives like basic vision and dental coverage, but also come with very limited networks and very high out of network costs. Consult an educated Medicare specialist before transitioning to a Medicare Advantage plan.

Medicare Part D (Prescription Drug Coverage)

As a result of the Medicare Modernization Act, Medicare prescription benefits became available in 2006. Known as Part D, it is voluntary for anyone who is eligible for Medicare. Except in special situations, individuals who wish to have the drug coverage must choose and enroll in one of the drug plans that contract with Medicare.

Medicare Supplemental or Medigap Plans

These plans offer supplemental benefits sold by private companies to extend traditional Medicare. Standardized plans offer varying combinations of benefits, ranging from coverage of copayments and deductibles to coverage of foreign travel emergency expenses, at-home care and preventive care.

Patient Protection and Affordable Care Act

Also known as the Affordable Care Act or ACA – is the landmark health reform legislation passed by Congress and signed into law by President Barack Obama in March 2010. The legislation includes a long list of health-related provisions that began taking effect in 2010 and will continue to be rolled out over the years. Key provisions are intended to extend coverage to millions of uninsured Americans, to implement measures that will lower health care costs and improve system efficiency, and to eliminate industry practices that include rescission and denial of coverage due to pre-existing conditions**.**

Preferred Provider Organization (PPO)

This is a managed care organization of health providers who contract with an insurer to provide health insurance coverage to policy holders represented by the insurer. Policy holders receive substantial discounts from health care providers who are partnered with the PPO. If policy holders use a physician outside the PPO plan, they typically pay more for the medical care. Typically, this type of plan maintains a smaller provider network, but does not require referrals for specialty care.

Rider

A modification made to a Certificate of Insurance regarding the clauses and provisions of a policy (usually adding or excluding coverage).

Stop-Loss

The dollar amount of claims filed for eligible expenses at which point you've paid 100 percent of your out-of-pocket and the insurance begins to pay at 100 percent. Stop-loss is reached when an insured individual has paid the deductible and reached the out-of-pocket maximum amount of coinsurance.

TennCare

See: Medicaid.