ACA Update Insurance 101: A Review of Insurance Terms and Policy

By Emily McKinley, Health Information Specialist

As the October 1 opening of the Insurance Marketplace draws nearer, Family Voices Indiana wishes to empower our followers to be informed consumers. Because so many of the individuals and families we serve will soon find themselves shopping for the best insurance coverage for their family, we hope to not only educate our readers about the Marketplace, but also about general insurance terms and policy. Here's a quick review:

Grandfathered Plans: Grandfathered plans are those that were in existence and have remained largely the same since before the ACA legislation was signed (March 23, 2010). Individuals who purchased insurance after the ACA became law may have a grandfathered plan. The grandfathering status is dependent upon the date the plan was created, not the date of purchase. Grandfathered plans must identify their grandfathered status in benefits and other materials sent to those insured by their plan. Grandfathered plans are exempt from many of the protections offered by the ACA, so it is important to know the plan's status and your rights as a consumer. It is also important to note that some of the information in this ACA Update will not apply to those insured by a grandfathered plan. For more information about grandfathered plans, please visit https://www.healthcare.gov/what-if-i-have-a-grandfathered-health-plan.

Premium: An insurance premium is the cost of an insurance plan. Typically, premiums are paid on a monthly basis.
Deductible: A deductible is the amount that must be spent by the policy holder on covered health care services before insurance coverage begins. Deductibles can range from hundreds to thousands of dollars. The ACA requires Marketplace insurance plans to offer preventative health care services without copayment, coinsurance, and regard to whether the deductible has been met, provided the services are administered by an in-network provider.

Coinsurance: Once the insured individual has met the deductible, the plan may stipulate a form of cost-sharing, called coinsurance. This means the insurer will cover a certain percentage of the costs of services and the insured will pay the remaining percentage. So, if an insured individual with a 30% coinsurance responsibility is seen by a physician who charges $100, that patient will pay $30, and the insurance company will pay the additional $70.

Copayment: A copayment is a set dollar amount that an insured individual must pay for stipulated health care services. Copays are another form of cost-sharing. Insurance plans may designate copays for visits to the doctor, urgent care, and emergency room. Additionally, many plans will have copays established for hospital stays, prescription drug benefits, and other services. Some insurance plans will use both copayment and coinsurance cost-sharing methods.

Network Providers: Insurance plans typically only apply to "network" or "in-network" providers. That is to say, the insurer has contracted with specific hospitals, pharmacies, physicians, and other providers. As such, insurance coverage and benefits are limited to those network providers. Before purchasing a plan, be sure to confirm whether the providers you wish to stay with are network providers.

Essential Health Benefits: The ACA has established a list of essential health benefits (EHB) that must be covered by health care plans beginning January 1, 2014. The EHB categories include: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventative and wellness services and chronic disease management; and pediatric services, including oral and vision care. While EHB-related items and services must be included in an insurance plan, the scope of these services may be determined by the insurer.

Out-of-Pocket Limit/Maximum: The out-of-pocket maximum is the most money the insured must pay during a policy period (typically, one year) before costs associated with covered health care services are covered in full by the insurer. Beginning in 2014, the out-of-pocket maximums will be capped at $6,350 for an individual and $12,700 for a family. Out-of-pocket maximums include copayments and deductibles but do not include premium payments. It is important to note, however, that if the insurance issuer uses more than one benefits administrator (for example, an administrator for general health care services and an administrator for pharmacy or prescription benefits), then the insured may have to meet an out-of-pocket limit for each benefit category. This will be allowable for one year (2014) only.

Actuarial Value: In order to facilitate ease-of-understanding, the ACA requires insurance plans on the Marketplace to be grouped by actuarial value. These values are represented by the metals platinum, gold, silver, and bronze. Platinum plans must cover 90% of costs associated with covered essential health benefits; gold plans, 80%; silver plans, 70%; and bronze plans, 60%. Typically, plans with a higher actuarial value will also carry higher premiums. Individuals eligible for cost-sharing reductions must purchase silver plans, or those with an actuarial value of 70%, in order to take advantage of those reductions. Family Voices will discuss cost-sharing reductions in more detail in a future ACA Update.

Before purchasing an insurance plan, Family Voices hopes consumers will carefully review and compare their insurance options. We will continue to offer updates and support regarding the ACA and other health care topics, and you may contact us with questions or for resources by emailing info@fvindiana.org or calling 317-944-8982. For more information about the ACA and insurance, we encourage you to view our blog (http://fvindiana.blogspot.com/) and website (www.fvindiana.org) as well as www.healthcare.gov.

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