Overview of the Health Insurance Industry

Health Insurance Industry Basics: Part 1 of 3

BeWell
New Mexico's Health Insurance Marketplace

BeWell New Mexico's Health Insurance Marketplace

Introduction

Health insurance offers a way for people and carriers to share medical costs. People pay premiums into a pool of money administered by a carrier so that there is money to pay for services when someone needs medical attention. New Mexican consumers have numerous options. Understanding health insurance industry basics will enable assisters (a collective term for agents, brokers, and enrollment counselors (ECs)) to educate and enroll New Mexicans in affordable, high-quality health insurance coverage.

Main Topics

- Health coverage vs. health insurance
- Why enroll in health insurance
- Shop and Compare Tool
- Basic health insurance terms
- Cost-sharing and plan tiers
- Providers
- Types of plans

Health Coverage vs. Health Insurance

While the terms health coverage and health insurance are often used interchangeably, they have two distinct meanings.

- Health coverage is defined as payment or reimbursement for health care costs that consumers are legally entitled to when enrolled in health coverage programs.
- Health insurance is a contract that requires a carrier to pay some or all of a consumer's health care costs in exchange for a premium.
    - Not all health coverage is health insurance. For example, Medicaid and the Veterans Affairs (VA) Health Benefits Program are not health insurance but do provide payment benefits for health services.

Basic Health Insurance Terms (1 of 9)

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There are several health insurance terms with which you should be familiar:

- Actuarial Value (AV)
  - The estimated percentage of total average costs for covered benefits that a plan will cover.
    - For example, if a plan has an actuarial value of 70%, on average, the consumer would be responsible for 30% of the costs of all covered benefits.
- Claim
  - What a provider sends to an insurance carrier to describe services rendered to a consumer for the provider to receive payment.

Basic Health Insurance Terms (2 of 9)

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- Coinsurance
  - The cost for a covered health care service a consumer pays after they have met their deductible. Coinsurance is a percentage (e.g., 20%) of the full allowed amount.
    - **Example**: A health insurance plan allows $100 for an office visit, and it has a coinsurance of 20%. If the consumer has paid their deductible, they would pay 20% of $100, or $20. The insurance company pays the rest. If the consumer has not met their deductible, they pay the full allowed amount, or $100.

Basic Health Insurance Terms (3 of 9)

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- Copayment (or "copay")
  - The cost for a covered health care service a consumer pays. A copayment is a fixed dollar amount (e.g., $20) of the total cost.
    - **Example**: A health insurance plan allows $100 for an office visit, and it has a copayment of $20. The consumer would pay $20 of $100. The insurance company pays the rest.

Basic Health Insurance Terms (4 of 9)

- Cost-sharing
  - The share of costs covered by the consumer's insurance plan that a consumer pays out of pocket.
    - Family cost-sharing is the share of cost the consumer, their spouse, and/or child(ren) must pay.
    - Some consumers will qualify for cost-sharing reductions (CSR). CSR are discounts that lower the amount consumers pay for deductibles, copayments, and coinsurance.

Basic Health Insurance Terms (5 of 9)

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- Deductible
  - An amount the consumer could owe during a coverage period (usually one year) for covered health care services before the plan begins to pay.
- Excluded Services
  - Health care services that a carrier does not pay for or cover.

Basic Health Insurance Terms (6 of 9)

- Explanation of Benefits (EOB)
  - This document illustrates how a medical claim was paid. It includes provider charges, the amount paid by the carrier, the consumer's responsibility, and the amount applied to the consumer's deductible.
- Guaranteed Issue
  - The requirement that health plans must permit a person to enroll regardless of health status, age, gender, or other factors that might predict their use of health services.

Basic Health Insurance Terms (7 of 9)

- Out-of-pocket costs
  - The expenses for medical care that are not reimbursed by insurance.
  - Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that are not covered.
  - The out-of-pocket maximum is the most a consumer must pay for covered services in a plan year. After they spend this amount on deductibles, copayments, and coinsurance for in-network care and services, their health plan pays 100% of the costs of covered benefits. The out-of-pocket limit does not include:
    - Monthly premiums;
    - Costs for services a plan does not cover;
    - Out-of-network care and services; and
    - Costs above the allowed amount for a service that a provider may charge.
  - The out-of-pocket limit for plans varies but cannot go over a set amount each year.

Basic Health Insurance Terms (8 of 9)

- Policy (or Contract)
  - The legal document that sets the terms of the insurance arrangement. It is also known as the Evidence of Coverage (EOC).
- Policyholder (or Subscriber)
  - The person who purchased and owns the health insurance policy.
- Premium
  - The payment a consumer makes to the carrier (usually monthly) in exchange for insurance coverage. The first premium payment is called the "binder" payment and is made to secure health insurance coverage.
    - **Note**: New Mexico Marketplace plan premium payments are currently made to carriers through BeWell.

Basic Health Insurance Terms (9 of 9)

- Rate Review
  - A process in which state insurance departments review rate increases before carriers can apply them to consumers.
  - In New Mexico, this is conducted by the Office of Superintendent of Insurance (OSI).
- For other important basic health insurance terms, please visit BeWell's Glossary of Health Insurance Coverage Terms.

Cost-Sharing and Plan Tiers

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- Marketplaces have four tiers of health insurance plans:
  - Bronze
  - Silver
  - Gold
  - Platinum

Cost-Sharing and Plan Tiers: Bronze Plans

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- The tier with the lowest monthly premium and the highest costs when consumers need care.
  - On average, the plan pays 60% and consumers pay 40%.
  - Many carriers offer expanded bronze plans.
- Bronze plan deductibles can be thousands of dollars a year.
- This is a good choice for consumers who want a low-cost way to protect themselves from worst-case medical scenarios. Their monthly premium will be low, but they will have to pay for most of their routine care.

Cost-Sharing and Plan Tiers: Silver Plans

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- The tier with a moderate monthly premium and moderate costs when consumers need care.
  - On average, the plan pays 70% and consumers pay 30%.
- Silver deductibles are usually lower than those of Bronze plans.
- This is a good choice for consumers who qualify for "extra savings," or cost-sharing reductions (CSR). If consumers do not qualify for CSR, this is also a good choice if they are willing and able to pay a slightly higher monthly premium than Bronze to have more of their routine care covered.
  - **Note**: It is possible for Silver plans to cost more than Gold plans in some states, such as in New Mexico.

Cost-Sharing and Plan Tiers: Gold Plans

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- The tier with a higher monthly premium and lower costs when consumers need care.
  - On average, the plan pays 80% and consumers pay 20%.
- Deductibles are usually lower.
- This is a good choice for consumers who are willing and able to pay more each month to have more costs covered when they get medical treatment. Also, if consumers use a lot of care, a Gold plan could be a good value.

Cost-Sharing and Plan Tiers: Platinum Plans

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- The tier with the highest monthly premium and the lowest costs when consumers need care.
  - On average, the plan pays 90% and consumers pay 10%.
- Deductibles are generally lower than the other plan tiers, meaning the plan starts paying its share earlier than for other categories of plans.
- This is a good choice for consumers who usually use a lot of care and are willing and able to pay a high monthly premium, knowing nearly all other costs will be covered.
- **Note:** New Mexico does not currently offer Platinum plans.

Cost-Sharing and Plan Tiers: Turquoise Plans

- Individuals and families with household incomes 100-400% FPL who qualify for the federal PTC through BeWell are eligible for State Out-of-Pocket Assistance (SOPA). SOPA, which is funded by the Health Care Affordability Fund (HCAF), provides extra savings on out-of-pocket costs for certain plans. Plans with SOPA are labeled as Turquoise Plans.
  - For those who qualify, Turquoise Plans give consumers the most savings on out-of-pocket costs like deductibles, copayments, and coinsurance.
  - There are three variations on Turquoise plans based on household income:
    - 100-150% FPL (Level 1- Silver variant)
    - 150.01-200% FPL (Level 2- Silver variant)
    - 200.01-400% FPL (Level 3- Gold variant)
  - The BeWell enrollment and eligibility system will automatically apply the correct variant based on the consumer's income; therefore, the consumer will not need to take any additional steps to identify which plans qualify for SOPA.

Shop and Compare Tool

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- BeWell offers a Shop and Compare Tool that provides consumers with an idea of plan availability, benefits, and health care costs for premiums and services prior to shopping for a plan.
- The tool gives consumers a quick idea of estimated financial assistance that might be available to them. It also contains prescription drug and provider search functionality.
- The tool is mobile-friendly, has a chat option, and is available in English and Spanish.
- The Shop and Compare Tool can be found on the BeWell website.

Providers

- Types of Providers
  - Primary Care Provider (PCP)
    - A physician, obstetrician/gynecologist, pediatric physician, general practitioner, internal medicine physician, family practitioner, nurse practitioner, or physician assistant, who provides, coordinates, or helps a patient access a range of health care services.
  - Physician Specialist
    - A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.
  - Non-Physician Specialist
    - A provider who has more training in a specific area of health care (e.g., physical therapist).

Types of Health Insurance Plans

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- Consumers have an important choice to make about the type of health insurance they choose. The different types of plans have different rules, especially about the providers they pay and the way consumers access care.
- Some types of plans are:
  - Preferred Provider Organization (PPO) plan
  - Exclusive Provider Organization (EPO) plan
  - Health Maintenance Organization (HMO) plan

PPO

- A plan where coverage is provided to participants through a network of selected health care providers, such as hospitals and physicians. The enrollees may go outside the network but would incur larger costs in the form of higher deductibles, higher coinsurance rates, or non-discounted charges from the providers.
- The providers have a contract with the health insurer or plan to provide services at a discount. Some policies have a “tiered” network, and consumers must pay extra to see some providers.
- The plan may have preferred providers who are also “participating” providers. Participating providers also contract with the carrier or plan, but the discount may not be as great, and consumers may have to pay more.
- Historically, PPOs do not require a referral to see a specialist but may require prior authorization for some types of services.
- **Note**: PPO plans are not currently offered by BeWell.

EPO

- A more restrictive type of PPO plan where services are covered only if the customer goes to doctors, specialists, or hospitals in the plan's network (except in an emergency).
- Some EPO plans may require a referral to see a specialist and may require prior authorization for some types of services.
    - Consumers should refer to the Summary of Benefits (SOB) to see the prior authorization requirements.
- **Note**: EPO plans are not currently offered by BeWell.

HMO

- A health plan where comprehensive health coverage is provided through a specified network of physicians and hospitals for a fixed premium. Only visits within the network are covered, and a PCP within the network handles referrals. Some plans do not require referrals for certain specialty care.
- HMO plans generally will not cover out-of-network care except in an emergency. Rarely, there is a medical necessity that the plan cannot meet in-network. In these situations, the plan will arrange out-of-network care.
- HMO plans often provide integrated care and focus on prevention and wellness.

Key Points

- The costs resulting from serious illness or injury can be very expensive. Health insurance offsets many health care expenses.
- Health coverage is payment or reimbursement for health care costs that consumers are legally entitled to when enrolled in health coverage programs. Health insurance is a contract that requires a carrier to pay some or all of a consumer's health care costs in exchange for a premium.
- BeWell offers different tiers of health insurance plans through different carriers to best meet the needs of New Mexicans. These tiers include Bronze, Silver, Gold, and Turquoise (which are Silver and Gold variants based on household income).
- Different types of health insurance plans have different rules, especially about the providers they pay and the way consumers access care. The three types are PPO, EPO, and HMO.


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