By David Leo, President of WMI® Mutual Insurance Company & WMI TPA®

Health Insurance *for Dummies*

If you've ever said to yourself, *"Self, I sure wish I knew the difference between a PPO, an HMO, and a POS,"* then this article is perfect for you. If you've never had that conversation with yourself, I invite you to read on anyway. Who knows, you may find an interesting tidbit of information you can use to impress the youngsters at the kids' table at your next Thanksgiving dinner.

Without intending to insult anyone's intelligence, this brief article attempts to define some of the more common health insurance terms and acronyms with simple but accurate explanations. I hope this cheat sheet will help clarify the alphabet soup we know as health insurance, and that it may even help the reader make more informed decisions while navigating the incredibly complex health care system.

Affordable Care Act, ACA, Obamacare – Various names for President Obama's signature health care law that was passed in March 2010.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – The federal law that allows participants covered under the health plan of an employer with at least 20 employees to continue health insurance coverage after experiencing a qualifying event that would otherwise result in a loss of coverage.

Coinsurance – The percentage share of your health care costs you are responsible to pay after you satisfy your deductible.

Copayment – The flat dollar share of your health care costs you are responsible to pay at the time of service (usually paid upfront without regard to whether you have satisfied your deductible and/or out-of-pocket maximum).

Deductible – The amount you have to pay toward your medical claims before your health insurer will pay anything. It should be noted, however, that some health care is often paid at 100% and is not subject to a deductible, co-payment and/or co-insurance (*e.g.*, certain immunizations and some types of routine wellness care).

The Employee Retirement Income Security Act of 1974 (ERISA) – The federal law that governs employer-sponsored health benefit plans. ERISA does not require an employer to provide health insurance, but it regulates the plan if the employer does.

Explanation of Benefits (EOB) – A document from your insurance company or health benefit plan that shows how a claim was processed, the amount the insurer paid, provider discounts (if any), and your financial responsibility.

Health Maintenance Organization (HMO) – An organization that provides or manages health care on a prepaid basis. HMO participants have more limited access to providers than PPO plans, but they generally charge cheaper premium rates in exchange for the limited access. HMOs often require members to use a primary care physician (*i.e.*, a gatekeeper) who acts as the first line of treatment and is responsible for managing the member's care and access to specialists.

Health Savings Account (HSA) – A savings account that is established in accordance with federal law. HSAs are financial accounts that are owned by an individual, and are used to pay for eligible health care on a tax-free basis. HSAs must be coupled with an eligible HDHP. Money contributed to the account is tax deductible, it grows tax free, and eligible expenses are paid on a tax-free basis.

High Deductible Health Plan (HDHP) – Any health insurance policy that complies with specific federal laws, including a minimum deductible and a maximum out-of-pocket. HDHPs allow insureds to establish federally qualified HSAs so they can pay for eligible health care on a tax-free basis.

Definitions ~

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) – The federal law that regulates the availability, portability and renewability of health insurance, as well as privacy, security and electronic transmission of medical information.

Medicare Advantage (Medicare Part C) – A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all of your Part A and Part B benefits (*e.g.*, hospital, facility, doctor, prescription drugs, etc.). Medicare Advantage Plans include HMOs, PPOs, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan and are not paid under original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare Supplement or Medigap – Standardized plans that are sold by private health insurance companies and that complement original Medicare coverage. These plans, which are subject to strict federal law requirements, are known as Plans A, B, C, D, F, G, K, L, M and N, and they pay various amounts toward things Medicare does not cover (*e.g.*, copayments, coinsurance, deductibles, travel outside the U.S.). Note: The Medigap plan naming convention is often confused with Medicare Parts A, B and D, which in general cover facility care, doctor care, and prescription drugs respectively.

Out-of-Pocket (OOP) Maximum – The maximum amount of money you will pay for eligible covered services during a plan year. Once your OOP is satisfied, eligible medical expenses are generally paid at 100%.

Point-of-Service (POS) – Not to be confused with the Urban Dictionary's definition of POS, these types of insurance plans are a hybrid of HMO and PPO plans. They generally have a more limited panel of doctors than PPOs, they require a "gatekeeper" doctor, and they allow referrals to out-of-network specialists who are compensated at a lower benefit level than in-network providers.

Preexisting Conditions (PEC) – A medical condition that existed before the effective date of insurance or health plan coverage. Prior to the passage of the ACA, coverage for preexisting conditions was either limited or excluded until the person had been insured for a period of time (usually 12-18 months). With very limited exception, the ACA eliminated the ability of health insurance companies and self-insured plans to exclude or limit coverage for preexisting conditions.

Preferred Provider Organization (PPO) – A network of doctors, hospitals and health care providers that offer financial discounts to insureds (and insurance companies) in exchange for member channeling and a higher benefit payment.

Premium – The amount you and/or your employer pay to the insurance company for insurance coverage. In the context of a self-funded plan, this amount is referred to as plan contribution.

Self-Insured Plan or Self-Funded Plan (including partially self-insured plans) – A customized health plan designed and offered by an employer that assumes a portion of the cost and risk. These plans operate as their own "mini insurance company," and they are financially responsible for eligible claims incurred by their plan participants (excluding deductibles, co-insurance and co-payments). These plans utilize TPAs to administer the plan, manage enrollment, and pay benefits, and they generally cede a portion of their financial risk to licensed reinsurance companies through stop-loss agreements.

Third Party Administrator (TPA) – A company that provides backroom administrative services to self-insured and partially self-insured plans. Amongst other things, TPAs manage enrollment, handle claims processing, manage accounting services, and work with agents and brokers on behalf of the plan to provide a seamless experience for plan participants.

Usual and Customary (U&C) – The amount an insurance company or health benefit plan will allow for benefit consideration from non-participating (*i.e.*, non-contracted) providers. There are various ways to calculate and determine U&C, but the most common are: (1) the prevailing amount charged by providers within a given service area; (2) a multiple of the amount that is allowed by Medicare (*e.g.*, 1.5 times the Medicare allowable); and (3) an allowed amount based on the in-network contract rate.

If you have questions about this article or would like to discuss your company's health insurance progam, feel free to contact me at ***(801) 263-8000*** or ***davidleo@wmimutual.com.***