

CHAPTER 4

FROM INSURANCE BASICS TO PLAN SELECTION

Author: Carriann Smith, BS, PharmD

By purchasing insurance, plan members are buying protection from a large debt in the event of a catastrophic need for medical care. However current practice in using insurance to cover non-catastrophic expenses causes higher premiums or decreases the amount available to pay for covered expenses.

On average, a three day hospital stay can cost about \$30,000 and a reasonable question might be how health insurance companies pay for the large bills.¹ The insurance company's job is to spend money to benefit the most members without having to raise premiums or deny additional services. This includes using profits to pay competitive salaries to employees. The business of health insurance in the United States relates as much to finance as it does to healthcare. Plan members pay for insurance through regular premiums and insurance companies invest that money to pay for illnesses that happen to anyone in the group. Proper investing and money management provides the best coverage to cost ratio for beneficiaries.

Insurance is paid via premiums, deductibles, co-payments, and co-insurance amounts. Premiums are a monthly payment to ensure the member stays covered under a plan (like a basic phone bill without usage charges). Many insurance plans require patients to pay a deductible at the beginning of each year of coverage, typically January 1. A deductible is the total amount a member must spend on their care per policy period (generally one year) before insurance will begin to cover their portion. Therefore, beneficiaries pay for coverage but the insurance doesn't work right away. Depending on the plan, deductibles may only apply to certain types of care. For instance, if the deductible does not apply to prescriptions, the patient does not have to pay the deductible first for prescriptions.

Once a patient has met their deductible, they may continue to have to pay a portion of their bills until they have reached their out-of-pocket maximum. Having beneficiaries paying some of their own costs, cost sharing, has been shown to engage them in keeping costs low. It also helps to keep the costs of premiums down by decreasing insurance company spending. The patient will pay a portion of costs through co-pays, which are flat fees, and co-insurance, which is a percentage of total charges. Insurance will cover the remainder of the bill.

Health insurance plans negotiate prices and have out-of-pocket maximums to help prevent members from going bankrupt despite having insurance. Once the out-of-pocket maximum is reached, insurance will cover 100% of a member's healthcare costs for the rest of the year.¹

RELATIONSHIPS BETWEEN PAYERS AND PROVIDERS

Fee-For-Service (FFS)

Before the 1970s, Medicare and private insurance primarily offered insurance, called indemnity insurance, that used a fee-for-service model. Fee-for-service means that each item or expense would be itemized to one or more bills. Providers would be paid a specified amount for each service amount established by each insurer. In the fee-for-service model, the patient chooses their own providers and has no restrictions on the use of specialty services. Providers who receive reimbursement directly from payers may then charge the patient what the insurance did not cover. This is referred to as balanced billing because the patient is billed for the remaining balance.²

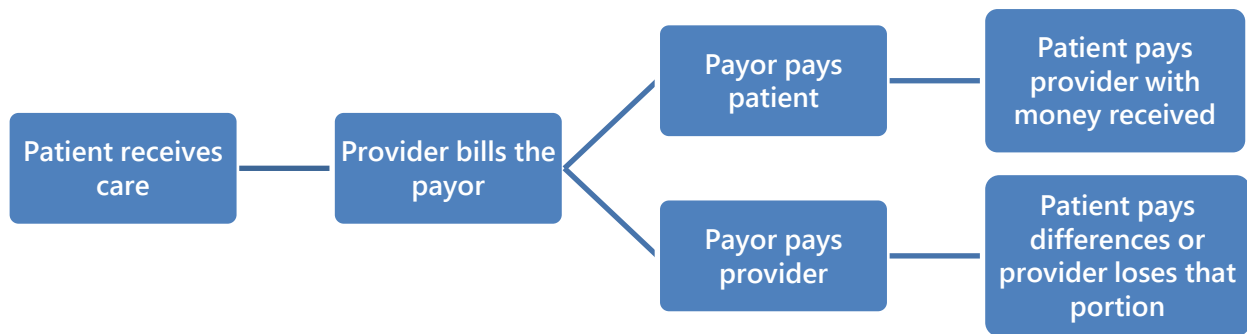


Figure 4-1. Fee for service model

In 1973, President Richard Nixon signed a law to help control the rising healthcare costs.³ With this law, a model for a managed care organization (MCO) was initiated.⁴ An MCO is a private insurance company with agreements in place with selected healthcare administrators and providers. This agreement is settled before patient care is delivered and outlines negotiated prices and payment arrangements. MCOs lower costs for patients by limiting their healthcare provider options to only those with an agreement. There are several types of

MCOs, including: Health Management Organizations (HMOs), Preferred Provider Organizations (PPOs), and Point of Service (POS) plans.³ The options described below outline the financial agreements between healthcare providers or administrators and payers in managed care coverage. This is important to help patients understand their coverage and to help providers understand how they will be reimbursed.

HEALTH MAINTENANCE ORGANIZATION (HMO)

Healthcare providers within an HMO network are usually paid by salary or a capitated (per person, per year) amount, allowing the HMO to exert more connection and possibly control over the providers and their healthcare decisions. Therefore, patients can only receive healthcare services from providers in the HMO network.³ If a patient uses a provider that is not an HMO provider, their insurance plan will not pay for any services from that provider and the patient is responsible for all associated costs.

Under an HMO plan, a patient is usually required to choose a primary care provider (PCP) who serves as a gatekeeper for their care.² As gatekeeper, the PCP provides primary care and is the only provider who can refer the patient to specialists for care beyond the PCP's scope of practice.²

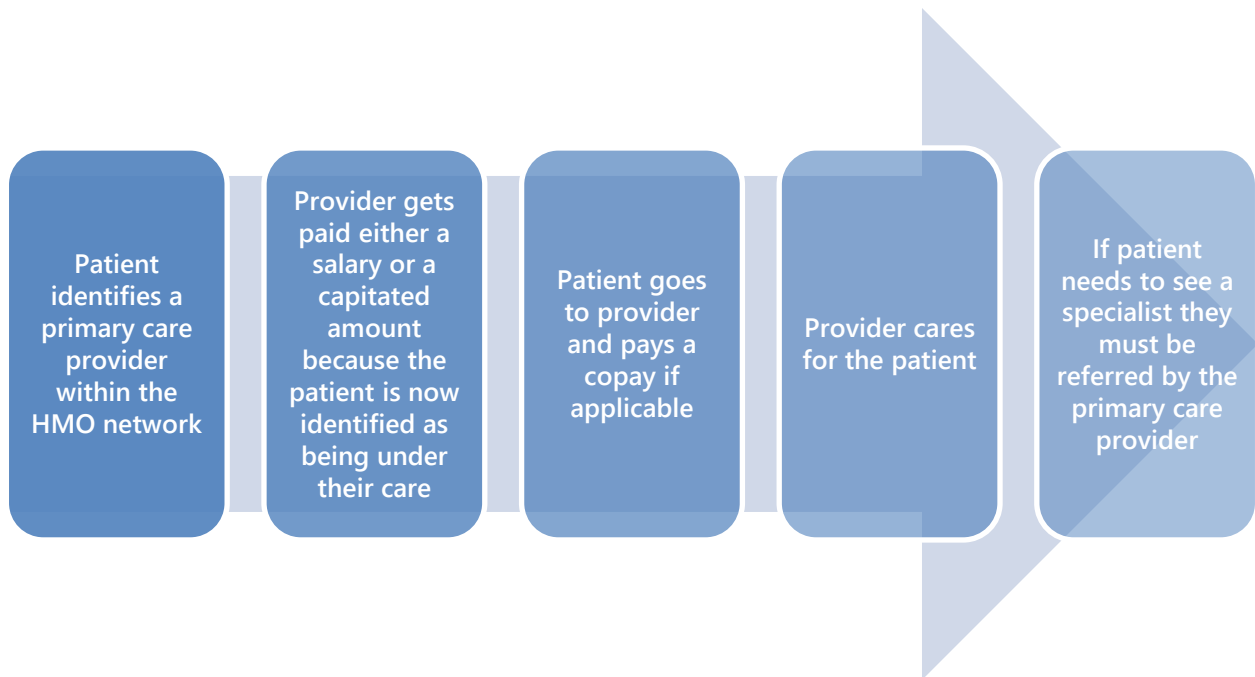


Figure 4-2. Health maintenance organization model

PREFERRED PROVIDER ORGANIZATION (PPO)

In a PPO, a patient has a preferred in-network list of providers from which to choose. If a patient chooses to see a provider who is out-of-network, it is more expensive than seeing a provider that is in-network but there will be some coverage from the insurer. In-network providers offer services at discounted rates in exchange for increased business from that insurance company. High deductibles may be options within PPOs (Figures 4-3 and 4-4), which can be offset by putting money into a tax-free account referred to as a Health Savings Account (HSA).

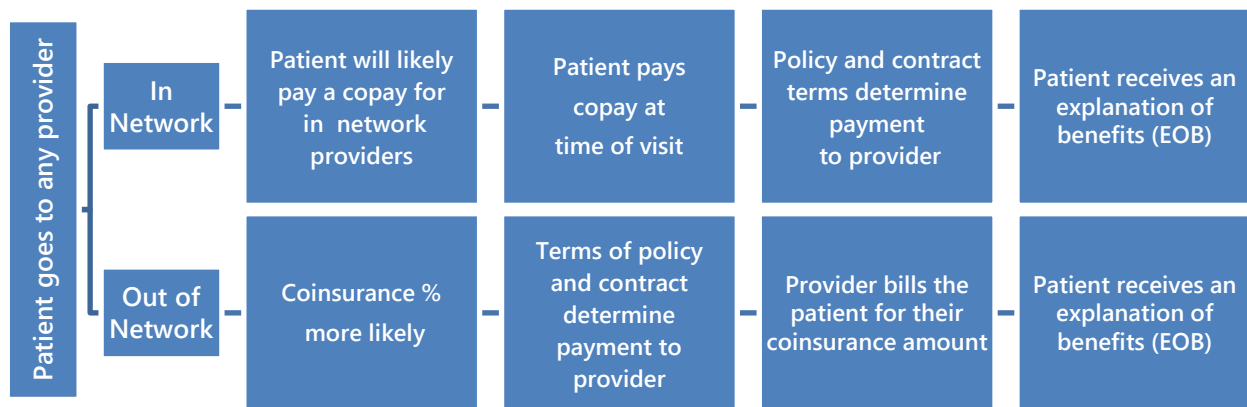


Figure 4-3. PPO plan without a high deductible

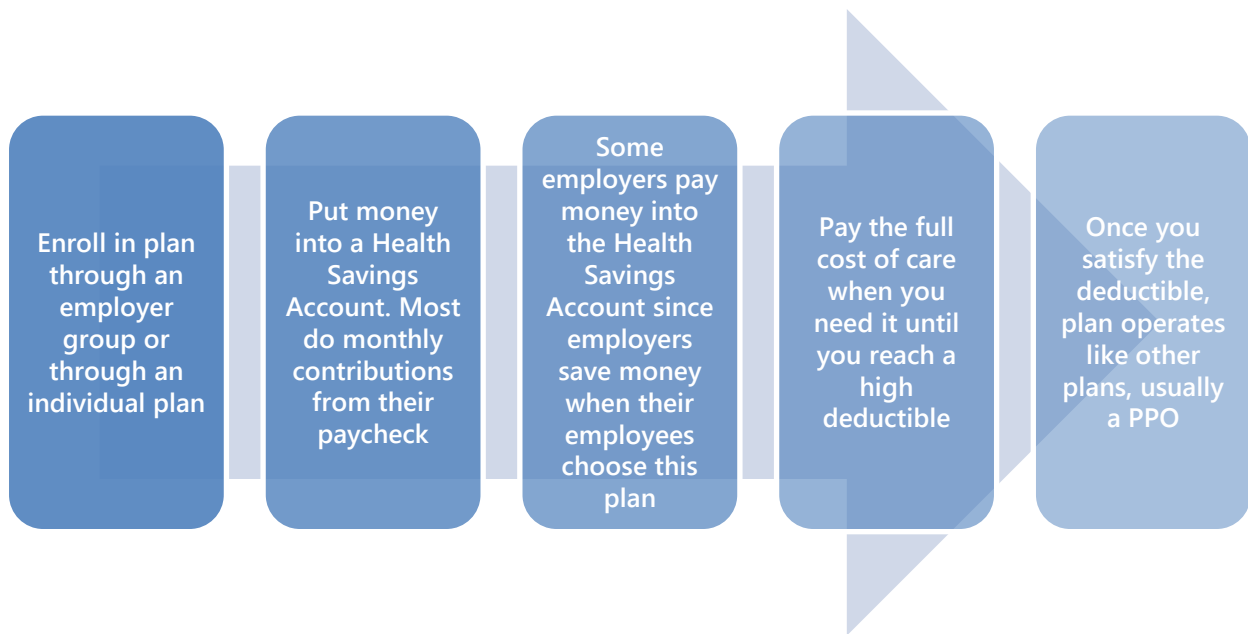


Figure 4-4. PPO plan with a high deductible

POINT OF SERVICE (POS)

A POS may be considered a combination of an HMO and PPO.³ In these plans, a patient is typically required to choose a primary care provider (PCP) similar to an HMO. The PCP coordinates the patient’s care and can refer them for additional services. At this point, the patient can choose to receive point of service (POS) care from a less expensive in-network or more expensive out-of-network provider.³ The out-of-network providers are more expensive because they are reimbursed on a fee-for-service basis.

In summary, managed care attempts to limit healthcare costs by steering patients toward specific providers and controlling the number and variety of paid for services. A lack of provider knowledge of costs, limited patient knowledge about the care they need, and third-party negotiations have made it difficult for patients embrace managed care. A trend toward a new structure, called accountable care, integrates healthcare providers to consider cost versus benefit with a focus on outcomes and value to patients.

ACCOUNTABLE CARE

The intent of the Patient Protection and Affordable Care Act (PPACA) was to shift from paying providers for the amount of care, fee-for-service, to paying providers based on the quality and value of the care they provide. The goal of pay-for-performance is to improve patient outcomes, enhance the quality of patient care, and reduce overall system costs.^{2,5}

Instead of having payers lead the decisions, the PPACA directed health care providers to be accountable for their patient care. This was done through changes to reimbursement for providers. New payment structures are based on measures of improving clinical outcomes, increasing overall patient satisfaction with the provider, minimizing adverse events, or decreasing length of stay and treatment times.⁶

Accountable Care Organizations

The PPACA established a new model to encourage and support accountable care: the accountable care organization (ACO). ACOs consists of groups of physicians, hospitals, and other health care providers. The ultimate goals of ACOs are to increase the use of evidence-based quality measures, actively engage patients in their care, and coordinate patient care between providers.⁵ Coordinated care is intended to provide patients with the right care, avoid unnecessary duplication, and improve patient outcomes.⁷

Medicare provides coverage to individuals who are at least 65 years old or those of any age who are permanently disabled. A new payment model, the Medicare Shared Savings Program, offers financial incentives to certain ACOs. Providers must meet different criteria but if they are successful and improving outcomes while cutting costs, they received a portion of the money saved back. To help measure success and determine reimbursement, ACOs are required to submit information to the Centers for Medicare & Medicaid Services (CMS) on quality measures which together comprise four domains: Patient/Caregiver Experience, Care Coordination/Patient Safety, Preventative Health, and At-Risk Populations.⁸ Looking at the domains, it is easy to see how the focus on both the patient experience and clinical care connects to providing value based care.

Accountable Care and Pharmacists

The sustainability of ACOs is dependent on how well they can control costs through coordinated care while improving healthcare quality. Pharmacists are in a position to help ACOs succeed. The pharmacist's role in accountable care will continue to include optimizing treatment choices, considering cost, ensuring medications are being prescribed and used properly, reducing medication-related adverse events, and helping other providers manage chronic disease states.^{5,9}

For example, think about a patient who has high cholesterol. The outcome of treatment is to lower the cholesterol. Lowering cholesterol may be done by changes in diet and exercise and by medications. This patient is self-employed and has a fee-for-service plan. Each time the physician meets with the patient and orders a lab test, it will be paid for by the insurance

company and the patient will pay a portion of the cost. If the physician is concerned the patient is at risk of a heart attack, they may be very aggressive may order frequent tests, prescribe new medications, and schedule regular appointments because each item will be paid. The physician is free to make clinical judgment without any review.

The patient changes jobs and now has employer coverage using a health maintenance organization (HMO). The physician the patient had been seeing is not in network, so he must go to a different provider. After making an appointment with the new physician, the patient learns this will be his primary care provider who will decide what additional care the patient needs. This is the gatekeeper and the name appears on the patient's insurance card. This physician is focused on maintaining the patient's health and limiting the use of expensive laboratory tests and medications to reduce cost for the HMO and the patient. This physician recommends more extensive exercise and nutrition. The physician makes recommendations based on the guidelines and policies provided by the HMO. The physician's payment and employment is based on following the HMO criteria and managing cost and risk to the HMO.

The patient now retires and enrolls in Medicare. The patient changes physicians to one that takes Medicare. This physician is part of an accountable care organization (ACO). This physician knows that his reimbursement is based on the patient achieving his cholesterol goal and staying out of the hospital. He implements a diet, exercise and medication plan that fits nationally recognized guidelines and the physician's clinical experience. The physician considers the costs of care and balances that with maximizing the benefits for the patient. The physician considers what quality measures exist for patients with high cholesterol and set goals for the patient that match this goal. If this and other patients meet their quality measures for cholesterol management, the physician will receive the remainder of his reimbursement.

This is a simplified approach to understanding the difference between payment structures to clearly delineate how healthcare providers may be impacted. It is not likely that a provider would change their treatment by the type of insurance coverage but different settings are likely to place different emphasis on treatment options. There is certainly overlap between what drives different providers and their use of quality measures, national guidelines, payer guidelines, and clinical experience.



Figure 4-5. Transition from Fee for Service to Accountable Care.

PATIENT TO PAYER CONNECTIONS

Fundamental knowledge of insurance terminology is necessary for navigating patient to payer interactions. The primary purpose of health insurance is to help protect an individual from financial risks of medical expenses, which can often be very high, and to help avoid significant financial loss.¹ Health insurance in the United States usually includes both medical insurance (doctor and hospital coverage) as well as prescription coverage. A common misconception is the belief that insurance will pay for all health care expenses that occur.¹⁰

Health insurance plans identify services or expenses that are covered or eligible for insurance payment.¹¹ It may also list items that are excluded, where an individual will pay any expenses incurred without insurance help. When a health care provider or patient submits these expenses to the insurance company for processing (send in the bill), the expenses are referred to as claims. Additional vocabulary such as deductible, coinsurance, etc. is defined in the glossary.

Types of Insurance Coverage

Figure 4-6 below provides an overview of the primary types of health insurance coverage available in the US.¹¹ Health insurance may be purchased privately, either individually or as part of a group, or publicly, through state or federal government. Employer coverage, a form of group coverage, is the most common type of private insurance.¹¹

Employers who offer health insurance plans to their employees generally offer better coverage at a cheaper rate than if the employee were to purchase it on their own as an individual policy. Employers may also choose to cover a portion of the premium for each employee. The employees then pay their portion of the premium through paycheck deductions.¹¹

Others are not able to obtain employer health insurance. These individuals may not work

enough hours to qualify for employer coverage, are unemployed or work for a small employer who does not offer regular group coverage. These individuals can purchase private coverage through the health insurance marketplace (online) or from private agents.

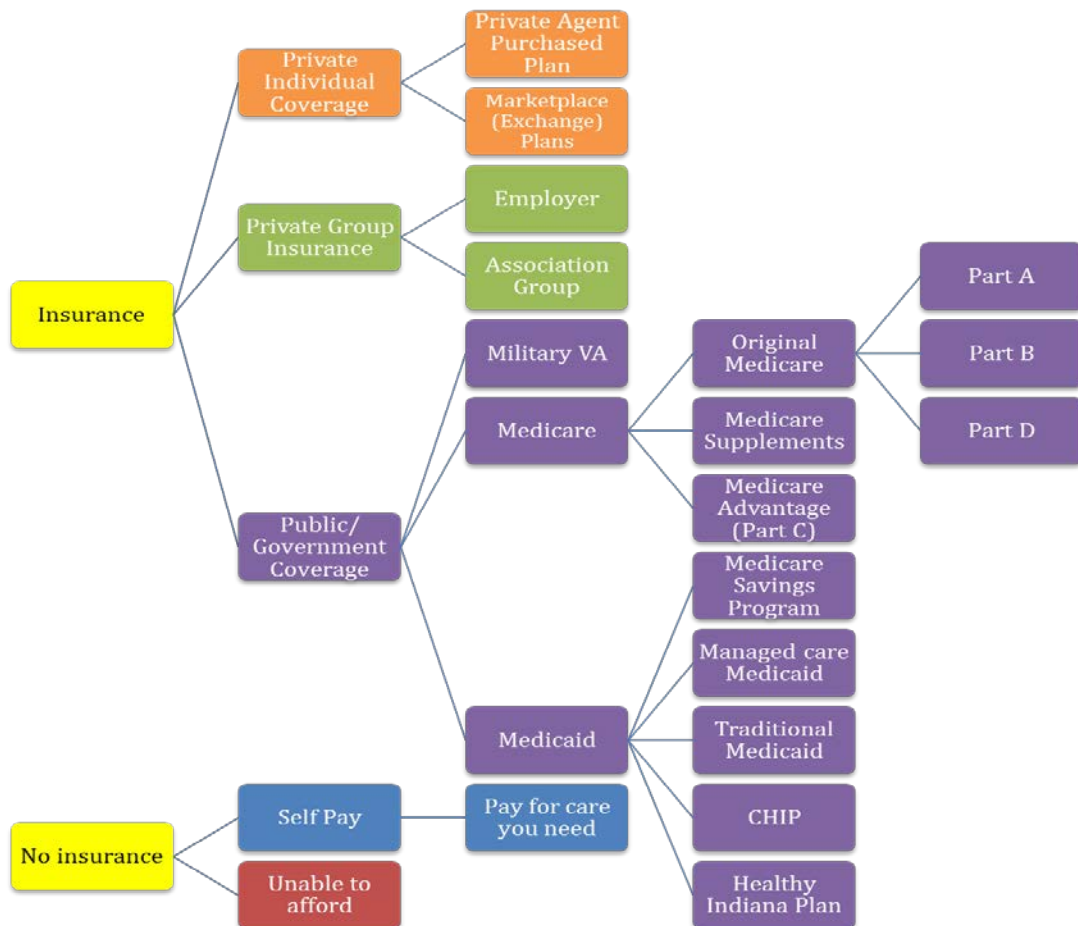


Figure 4-6. An overview of the types of insurance coverage available to Americans

IN-DEPTH LOOK AT THE MARKETPLACE

Marketplace

The Patient Protection and Affordable Care Act, PPACA, created a new, private insurance marketplace in all 50 states and the District of Columbia.¹² Some states created their own marketplace and others utilize the federal health insurance marketplace. These marketplaces

include a central online location, called the Small Business Health Options (SHOP) Exchange, that enable individuals and small groups to shop for private health insurance plans.^{12,13} Here, small businesses, currently defined by the federal government as 100 or fewer employees, can set up accounts to allow individuals to compare available plans specifically selected by the small employer.¹³ In the SHOP, individuals have fewer options than on the individual marketplace, but the employer pays a portion of the premium.¹³

People who select insurance plans through the individual health insurance marketplace may be eligible for tax credits to help cover their premium. These credits are based on the person's income.¹⁴ Some individuals may also choose to self-pay for medical bills, rather than pay for insurance coverage. However, this choice will result in penalty taxes the individual will be required to pay, unless they qualify for a tax exemption.¹⁴

Marketplace exchanges support individual access and comparison of health insurance coverage. Resources are available to help individuals navigate the exchanges. HealthCare.gov offers a wide variety of information regarding navigation and utility of the federal health insurance marketplace. Individuals can apply online, by phone, via a paper application, or with in-person help using a tool on HealthCare.gov, which enables individuals to enter their location information, and select the type of coverage they are searching.^{14,15}

Function and Navigation

Individuals can enroll in plans during yearly open enrollment periods (OEP) that is set by the federal government.¹⁴ During this timeframe, individuals may browse and enroll in a health insurance plan for the following year. Enrollment outside of the OEP cannot occur unless the patient, also known as a beneficiary, qualifies for a special enrollment period.¹⁴ Special enrollment periods occur over a 60 day period following particular life events that result in a change of family status, such as marriage, childbirth, or after the loss of prior health coverage.¹⁴

HealthCare.gov offers screening tools to help individuals determine if they are eligible for either Medicaid, Children's Health Insurance Program (CHIP), or a special enrollment period. Both Medicaid and CHIP are discussed later in this chapter.

Marketplace Plans

The federal health insurance marketplace categorizes insurance plans into four "metals": Bronze, Silver, Gold, and Platinum. Although a common misconception, the "metals" do not reflect or categorize plans according to quality or amount of care provided by each plan.⁷ Each

metal level reflects the cost of monthly plan premiums and the portion of costs for care or services, such as hospital visits or prescriptions, that the patient will be expected to pay.⁷ “Metal” categories are defined in **Figure 4-7**.¹⁶

“Metal” Federal Health Insurance Marketplace Categories	
Bronze	<ul style="list-style-type: none"> • Health plan covers approximately 60% of total average costs • Beneficiary covers approximately 40% of total average costs
Silver	<ul style="list-style-type: none"> • Health plan covers approximately 70% of total average costs • Beneficiary covers approximately 30% of total average costs
Gold	<ul style="list-style-type: none"> • Health plan covers approximately 80% of total average costs • Beneficiary covers approximately 20% of total average costs
Platinum	<ul style="list-style-type: none"> • Health plan covers approximately 90% of total average costs • Beneficiary covers approximately 10% of total average costs

Figure 4-7. “Metal” insurance plans for the federal health insurance marketplace

Catastrophic health plans, often referred to as a ‘fifth category’ within the marketplace, exist for individuals under 30 years of age or those who have a hardship exemption.¹⁶ Hardship exemptions are a set of specific criteria, such as being homeless, experiencing domestic violence, or facing substantial medical debt, that enable an individual from having to obtain health insurance coverage for a particular period of time.^{16,17} Catastrophic plans focus their benefits on high medical costs such as serious injury or hospitalization rather than outpatient, chronic care.¹⁷ Under these Catastrophic plans, health insurance companies pay less than 60% of the total average costs of care, placing more payment responsibilities on the patient.¹⁶ These plans are an option for younger individuals who are healthier and do not utilize their insurance coverage on a regular basis.¹⁷ Individuals under hardship exemptions are eligible, regardless of age or income, to purchase a Catastrophic health plan, but are not required.¹⁷

Public/Government Insurance Coverage Options

Individuals who have a very limited income and significant medical need may obtain health insurance through the state government Medicaid program. Medicaid is a collection of programs available for different levels of need. Medicaid provides health insurance options

for low-income families and children, pregnant women, the elderly, and people with disabilities. Low income in most states is defined as at or below 133 percent of the federal poverty level.¹⁸ Some states have expanded their Medicaid programs to cover all adults below 138% (133%+/-5%) levels.¹⁸ Medicaid recipients typically don't pay a premium and copays are low to nonexistent since coverage is funded by the state and federal government.

Although each state administers their own program, the federal government provides some financial support to assist with Medicaid funding. The federal government also sets minimum guidance standards, such as criteria for enrollment and evaluation of claims, Medicaid programs must follow to ensure some consistency of coverage between state programs.¹⁸ Therefore, though all states must meet minimum standards, Medicaid benefits vary between states based on individual state budgets and overall population need.

Individuals who are over 65, disabled for 24 months or longer, have End Stage Renal Disease (ESRD), and/or ALS (amyotrophic lateral sclerosis or Lou Gehrig's disease) qualify for another government program called Medicare.¹⁹ It is important to note that individuals may qualify for both Medicaid and Medicare. **Table 4-8** describes the different types of Medicare programs available to patients.¹⁹

Types of Medicare	
Medicare Part A & B ("Original Medicare")	Original Medicare is a fee-for-service health plan that has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). After the member pays a deductible, Medicare pays its share of the Medicare-approved amount, and the member pays their share (coinsurance and deductibles).
Medicare Part C ("Medicare Advantage")	Medicare health plan that contracts with Medicare and uses managed care arrangements with providers to provide Part A and Part B benefits to Medicare patient. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. Patients choose either Medicare Advantage or Original Medicare. Most Medicare

	Advantage Plans offer prescription drug coverage.
Medicare Part D	A separate program that helps pay for prescription medications for people with Medicare. All Medicare Part D plans are offered through private insurance or prescription benefit companies, there is no "original" Medicare Part D plans offered by the federal government. There are two ways to get Medicare prescription drug coverage: through a stand alone Medicare Prescription Drug Plan or a Medicare Advantage Plan that includes medication coverage.

Table 4-8. Types of Medicare

Other examples of government-funded programs include federal coverage through the Department of Defense for military members and their families and coverage for veterans through the Veterans' Administration (VA).¹⁹ Government-funded coverage may also be referred to as public health coverage.

Fee for Services versus Managed Care Organizations

As discussed earlier in this chapter, there are three primary forms or categories of health insurance plans:

1. fee-for-service
2. health maintenance organizations
3. preferred provider organizations.^{10,11}

Traditional fee-for-service plans are often the most expensive coverage options but offer patients the most flexibility when choosing health care providers.¹¹ Health maintenance organizations (HMOs) offer lower co-pays for patients than traditional fee-for-service plans and cover most costs for preventative care, but patients are only allowed to use a limited number of health care providers and facilities except in emergency situations.^{11,20} HMOs require their patients to select a primary care provider in order to receive coverage.^{11,20,21} Additionally, HMOs may require referrals from a single primary care provider, also known as a gatekeeper, to see providers outside of the plan's network.²⁰ Point-of-service options may

also be offered by some HMOs and allow patients to receive care outside the preferred network, but at a higher, out-of-pocket cost through higher premiums.²⁰

Preferred provider organizations (PPOs) offer lower co-pays than traditional fee-for-service plans and provide more flexibility to patients when selecting health care providers or facilities.²⁰ PPOs typically provide the most coverage for providers within network but allow patients to receive care out-of-network at higher costs and usually do not require referrals for such care.^{21,22} Unlike HMOs, PPOs do not require patients to choose a primary care provider.^{11,22}

Comparing and Selecting Health Insurance Plans

Ultimately, selecting a health care insurance plan requires evaluation by the individual seeking coverage. They must first understand the types of coverage available to them, such as private or public. Based on the type of coverage, different forms of reimbursement (HMO, PPO, fee-for-service) may impact a patient's choice.^{20,21,22} A patient's current health status, health behaviors, and financial situation must also be considered when selecting insurance plans. Acceptance of risk should also be taken into consideration.²¹ Like a warranty plan for an appliance, paying for more insurance coverage decreases the risk that an individual would have to pay out of pocket for unplanned medical expenses. Alternatively, if patients do not wish to pay for coverage they may not need, they may want to reduce the amount of coverage they select. Patients not expecting to go to the doctor may select a plan with lower monthly premiums but less coverage.^{14,16} However, a healthy patient wishing to avoid the expense of unexpected healthcare services may choose to pay higher premiums under a private insurance plan to ensure better coverage.

Less coverage may be defined in different ways: it may mean the insurance plan covers fewer expenses or that the insurance company covers the same number of expenses but the patient must pay more out of pocket.^{14,16} Paying a higher cost share may mean a patient pays 30% instead of 20% of the medical cost, for example.^{14,16} Insurance plans may also have different coverage for different levels of care, referring to the location of where care was received.¹⁴ For instance, a patient with a fever and flu symptoms would likely pay much more for a visit to the ED than an urgent care. The same visit would cost even less at a physician's office.

In choosing a plan, the patient should be aware of how networks function. Based on the plan they choose, they may have little to no coverage at certain providers who are out of network.^{20,21,22} If there is a certain provider or service needed, the patient should make sure it is covered under their intended plan. By limiting the number of providers that a patient can

receive care from allows the insurance company to reduce expenses and pass that savings on to the patient.^{20,21,22} For example, seeing a primary care physician for a physical may be covered, whereas seeing a renal specialist for the same physical may not be covered. This helps direct patients to the most appropriate provider for their care need.

Some plans may offer tax-exempt Health Savings Accounts (HSAs) or Flexible Spending Accounts (FSAs).²³ These accounts enable patients to deposit and save money, tax-free, to help pay for future medical expenses. Typically, a percentage of a patient's paycheck will be directly pulled and deposited into the accounts.²³ This is a great way to save money and manage healthcare costs. Since the accounts are commonly used with high-deductible policies, patients typically pay higher costs upfront and track their expenses more carefully.²³

It is important to determine if the plan includes prescription drug coverage, especially if the patient is currently taking prescription medications. Patients should consider a health insurance company's formulary when selecting plans to better determine their prescription coverage needs and/or costs.^{24,25,26} Medications or brands not on the formulary can be much more expensive or may not be covered at all. Sometimes the plan will place formulary restrictions on certain medications and only cover them after the patient has completed a step therapy or other type of prior authorization, discussed later in this chapter, to prove the medication is medically necessary.^{24,25,26}

Ultimately, premiums, deductibles, and benefits must be weighed and balanced. Patients who need high cost prescriptions may purchase a different plan than a person who primarily needs support for wellness and emergency care.

Explanations of Benefits

Explanations of benefits are sent to patients by the insurance company to explain their health insurance coverage. These explanations of benefits (EOBs) outline what claims were covered, the negotiated contracted price for the medication, the amount owed by the patient, the amount paid by the insurance company and the reason for any claim rejections, where the insurance company refuses to cover a particular medication and/or therapy.

Fees for Not Having Health Insurance

As set in the PPACA, individuals may be subject to penalties should they not have health insurance coverage. Individuals who can afford health insurance but choose not to purchase coverage are required to pay a fee called the Individual Shared Responsibility Payment, also known as a penalty, fine, or individual mandate.^{25,28} Individuals without coverage are

required to pay the fee for any month they, their spouse, or their tax dependents do not have health insurance coverage that qualifies as minimum essential coverage.²⁸ Payments are required upon filing for federal tax returns for the year coverage was not held.²⁸ Fees are calculated per person as a percentage of an individual's household income. HealthCare.gov provides resources to estimate mandated fees.

Exemptions for the Individual Shared Responsibility payment may be available for qualifying individuals. An individual must meet one of the following criteria, (see **Figure 4-9**), to be exempt, which prevents them from holding minimum health insurance coverage:²⁶

Have no affordable coverage options due to the fact that the minimum required costs for the annual premium rises more than 8% above the household income¹⁷

Have gap in health coverage lasting less than 3 consecutive months¹⁷

Qualify for an exemption for at least one various reason, such as having a hardship that prevents an individual from obtaining coverage or belonging to a group explicitly exempt from the health insurance coverage requirement¹⁷

Figure 4-9. Criteria for exemptions for Individual Shared Responsibility payment

Simply holding insurance coverage may not enable an individual to avoid penalties. Under the PPACA, health insurance coverage must meet minimum comprehensive benefit standards.¹³ **Figure 4-10** outlines these essential health benefit standards.²⁹

Essential Health Benefits	
Ambulatory Patient Services (outpatient care, non-hospital admittance)	Mental Health/Substance Use Disorder Services (counseling, psychotherapy, etc.)
Emergency Services	Laboratory Services
Hospitalizations (surgery, overnight stays, etc.)	Pregnancy, Maternity, and Newborn Care
Prescription Drugs	Rehabilitative/Habilitative Services/Devices (help gain or recover mental/physical skills)
Pediatric Services (oral, vision, etc.)	Preventative/Wellness Services and Chronic Disease Management

Figure 4-10. Essential Health Benefits

All marketplace plans meet minimum standards.^{12,28,29} Most plans obtained through employer, government, or state programs also meet minimum standards.²⁸ Providers should advise patients who wish to purchase insurance outside of these programs to ensure all coverage requirements are being met. HealthCare.gov can be used to help identify whether a plan meets minimum standards.

Pharmacists in different practice settings may assist patients and providers in making the most of their insurance benefits including plan and benefit selection. While this chapter has focused on medical (hospital and office visit) benefits. The next chapter will focus on pharmacy benefits (outpatient prescription) benefit.

GLOSSARY

Annual Limit

The maximum amount a member's insurance company will pay for healthcare in a year. These caps may be placed on particular services such as hospitalizations as dollar limits or number of services such as number of therapy appointments. After the annual limit is reached, the member must pay all associated healthcare costs for the rest of the year.

Beneficiary

A patient who is insured under a specific insurance policy. This could be the primary cardholder or any dependents.

Benefits

The health care items or services covered by a health insurance plan. Covered benefits are defined in the health insurance plan's coverage documents such as the policy or certificate.

Claim

A request for payment (bill) that the member or their healthcare provider submits to the health insurer for healthcare products or services.

Coinsurance

The percent the patient pays (for example, 20%) of the allowed amount for a covered healthcare service or product.

Copayment

A fixed amount (for example, \$15) paid for a covered healthcare service, usually when the service is provided.

Covered Expense

A healthcare service or product that is covered as part of the specific insurance plan. A covered expense does not mean it is covered at 100%, but instead that some amount of coverage will be provided.

Deductible

The amount the patient must pay towards a covered health care product or service before the

health insurance plan begins to pay. For example, if the deductible is \$1,000, the plan won't pay anything until the member has paid \$1,000 for covered services. If a covered expense is NOT subject to deductible, then the patient will not have to pay the deductible first.

Dependent

A child or other patient that benefits from the insurance policy but is not the cardholder. One type of beneficiary.

Excluded Services

Health care services that the health insurance or plan doesn't pay for or cover. This may also be referred to as non-covered.

Flexible Spending Account (FSA)

An arrangement set up through the employer to allow employees to designate money from their paycheck to be used for healthcare before taxes are taken out. This makes the use of these funds tax free. The member decides how much of their pre-tax wages are taken out of their paycheck and put into an FSA. Unlike an HAS, there is no carry-over of FSA funds at the end of the plan year.

Formulary

A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits.

Health Savings Account (HSA)

A savings account that can be set up at a bank for patients enrolled in a High Deductible Health Plan. The funds contributed to the account aren't subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses. Unlike a Flexible Spending Account (FSA), funds roll over year to year if they are not spent.

Lifetime Limit

The maximum amount that an insurance company will pay during a person's lifetime. After a lifetime limit is reached, the insurance plan will no longer pay for covered services. The PPACA eliminated lifetime limits from most insurance plans.

Member

A member is a patient who benefits from an insurance plan. Member is another word for

beneficiary. Member is more likely to be used with managed care plans.

Network

The list of all facilities, providers and suppliers the health insurer or plan has contracted with to provide health care services.

Out-of-Pocket Maximum

The most the member will have to pay for covered services in a policy period (usually one year). After reaching this amount, the health plan will pay 100% for covered essential health benefits until the annual or lifetime limit is reached. The calculation towards out-of-pocket maximum includes the yearly deductible and may also include any cost sharing after the deductible. It doesn't have to count premiums, out-of-network cost-sharing, or non-covered expenses.

Preauthorization

A decision by the health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before the member receives them, except in an emergency. Preauthorization is not a guarantee that the health insurance or plan will cover the cost.

Premium

The amount that must be paid to keep coverage under a health insurance or plan. The member and/or employer usually pay it monthly, quarterly or yearly.

Readmission

When a patient returns to the hospital shortly after being discharged this is considered a readmission. This is usually counted if it is within 30 days of the discharge. It may count if it is for the same condition or another condition.

Reimbursement

Reimbursement is the amount a payer provides to the health care provider in response to a claim. For managed care plans, reimbursement amount may be based on the terms of the contract. Usual, customary and reasonable amounts may apply to fee for service plans.

Referral

A written order from a primary care doctor for the member to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), a referral is necessary receiving medical care from anyone except the primary care doctor. Without getting a referral first, the plan may not pay for the services.

REFERENCES

1. Why is health insurance important: protection from high medical costs. Healthcare.gov. <https://perma.cc/B9WB-AW7B>. Accessed May 28, 2018.
2. Shi L, Singh DA. Health Services Financing. In: *Delivering Health Care in America: A Systems Approach*. 6th ed. Burlington, MA: Jones & Bartlett Learning; 2015:p226-230.
3. Niles NJ. Managed Care Impact on Healthcare Delivery. In: *Basics of the U.S. Health System*. 2nd ed. Burlington, MA: Jones & Bartlett Learning; 2015:p237-244.
4. Sekhri NK. Managed care: the US experience. *Bull World Health Organ*. 2000; 78(6): 830-44. PMID: 10916920
5. Daigle L. Pharmacist's role in accountable care organizations. ASHP Policy Analysis. <https://perma.cc/5VVM-YA2B>. Published January 2011. Accessed May 28, 2018.
6. Askin E, Moore N. *The Health Care Handbook: A Clear and Concise Guide to the United States Health Care System*. St. Louis, MO: Washington University; 2012:p48.
7. Accountable care organizations (ACOs): General Information. Centers for Medicare and Medicaid Services. <https://perma.cc/3D4F-7SZA> Updated May 4, 2016. Accessed: May 28, 2018.
8. Medicare shared savings program quality measure benchmarks for the 2015 reporting year. Centers for Medicare and Medicaid Services. <https://perma.cc/G3B9-3XDJ> Accessed May 28, 2018
9. Lui LL, Wertheimer A. Affordable Care Act: A review and discussion of its impact on healthcare today, and a primer for pharmacists. *Inov Pharm*. 2013; 4(1): 1-6. <https://pubs.lib.umn.edu/index.php/innovations/article/view/292>
10. Bernell S. *Health Economics: Core Concepts and Essential Tools*. Chicago, IL: Health Administration Press; 2016.
11. Morrissey MA. *Health Insurance*. 2nd ed. Chicago, IL: Health Administration Press; 2016.
12. Blumenthal D, Collins SR. Health care coverage under the affordable care act – a progress report. *N Engl J Med*. 2014; 371(3): 275-81.
13. Weil A, Shafir A, Zemel S. Health insurance exchange basics. National Academy for State Health Policy. <https://perma.cc/4B47-AQ2J>. Published February 2011. Accessed May 28, 2018.
14. U.S. Centers for Medicare & Medicaid Services. A quick guide to the health insurance marketplace. HealthCare.gov: <https://perma.cc/5KAK-A2J5> Accessed: May 28, 2018.
15. U.S. Centers for Medicare and Medicaid Services. Find someone nearby to help you apply. HealthCare.gov: <https://perma.cc/BXG5-YDHT>. Accessed May 28, 2018.

16. CMS. 5 questions to ask yourself when choosing a plan. <https://perma.cc/Z59S-H9CU>. Revised October 2016. Accessed May 28, 2018.
17. Health coverage exemptions: forms & how to apply. HealthCare.gov: <https://perma.cc/3FYK-KUL6>. Accessed May 28, 2018.
18. U.S. Centers for Medicare & Medicaid Services. Medicaid expansion & what it means for you. HealthCare.gov: <https://perma.cc/Z2LL-LBLD>. Accessed: May 28, 2018.
19. Glossary at Healthcare.gov. <https://perma.cc/EK72-T35F>. Accessed May 28, 2018.
20. U.S. Center for Medicare & Medicaid Services. Health maintenance organizations (HMO) plan Medicare.gov: <https://perma.cc/8CNQ-PG86>. Accessed May 28, 2018.
21. Preferred provider organization (PPO) Plans. Medicare.gov: <https://perma.cc/EN6P-KLTN>. Accessed May 28, 2018.
22. PPO insurance plans. eHealth Insurance: <https://perma.cc/UA4G-U8D7>. Published 2016. Accessed May 28, 2018.
23. People with Coverage through a Job: using a Flexible Spending Account (FSA). HealthCare.gov. <https://perma.cc/TTH7-K7UA>. Accessed May 28, 2018.
24. Academy of Managed Care Pharmacy. Formulary management. <https://perma.cc/ULP6-3TMG>. Published November 2009. Accessed May 28, 2018.
25. Academy of Managed Care Pharmacy. The Academy of Managed Care Pharmacy's Concepts in Managed Care Pharmacy: Prior authorization. AMCP.org: <https://perma.cc/CV85-DU7J>. Published April 2012. Accessed May 28, 2018.
26. U.S. Center for Medicare & Medicaid Services. Appeals if you have Medicare prescription drug coverage. Medicare.gov: <https://perma.cc/WM5V-RSMU>. Accessed May 28, 2018.
27. Explanation of benefits. BlueCross BlueShield of North Carolina: <https://perma.cc/4FE9-YKUG>. Published December 1, 2011. Accessed July 2016.
28. U.S. Centers for Medicare & Medicaid Services. The fee for not having health insurance. HealthCare.gov: <https://perma.cc/65PD-UZ6U>. Accessed May 28, 2018.
29. U.S. Centers for Medicare & Medicaid Services Health Benefits and Coverage: what marketplace health insurance plans must cover. HealthCare.gov: <https://perma.cc/5H49-9RHE>. Accessed May 28, 2018.