Health Insurance Basics

This document explains key health insurance concepts that may be helpful to consumers in understanding their health coverage as well as to consumer advocates who help individuals resolve medical billing problems. This resource is not intended to describe everything that is important to know about insurance. For more complete information, see the Coverage to Care resources developed by the Centers for Medicare & Medicaid Services.

What is Health Insurance and Why is it Important?

Health insurance is a legal entitlement to payment or reimbursement for your health care costs, generally under a contract with a health insurance company. Health insurance provides important financial protection in case you have an accident or sickness. For example, health insurance may help to pay for doctors' services, medications, hospital care, and special equipment when someone is sick or injured, often in exchange for a monthly premium. It may help cover a stay at a rehabilitation hospital or even a portion of home health care. Heath insurance can also keep a consumer's costs down when they are not sick. For example, it can help pay for routine check-ups. Most health insurance also covers many preventive services at no cost, such as immunizations and cancer screening and counseling.

What is a Health Insurance Plan (also called a health plan or policy)?

A health insurance plan includes a package of covered health care items and services and sets how much it will pay for those items and services. In other words, a health plan will describe the types of health care items and services it will cover (help pay for), how much it will pay for those items and services (or groups of items and services), and for how long. Plans are often designed to last for a year at a time (known as a "plan year" or "policy year"). A health plan may be a benefit that an employer, union, or other group sponsor provides to employees or members to pay for their health care services.

What are Some Types of Health Care Coverage?

Health care coverage is often grouped into two general categories: private and public. The majority of people in the U.S. have private insurance, which they receive through their employer (which may include non-government employers or government employers at the federal, state or local level), buy directly from an insurance company, or buy through a Health Insurance Marketplace®.[1] Some people have public health care coverage through government programs such as Medicare, Medicaid, or the Veteran's Health Administration.

Health care coverage can also be categorized by the scope of benefits it offers or how long the coverage lasts. Health insurance often includes a wide range of covered services, including emergency and non-emergency services as well mental health benefits. Some people have very limited insurance plans, such as plans with benefits for only specific conditions or diseases (included in the list of "excepted benefits" under the Affordable Care Act, such as vision-only plans or cancer plans).

[1] Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.

This document is intended to provide clarity to the public about requirements related to surprise billing. It does not have the force and effect of law.

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As noted above, many health plans offer coverage for a year. However, some plans offer coverage for less than 12 months, including plans created to fill gaps in coverage. These plans are called short-term limited duration plans, and they often offer fewer benefits as compared to other health plans and lack some of the consumer protections available under other forms of coverage.

Self-Insured Employer Plans vs. Fully-Insured Plans

For consumers who receive health insurance through their employer, there are typically two different funding structures employers use to provide coverage:

- Some employers offer health care coverage to their employees through a self-insured plan. This is a type of health plan that is usually offered by larger companies where the employer collects contributions from employees via payroll deductions and takes on the responsibility of paying all related medical claims. These employers can contract with a third-party administrator (in some cases, a health insurance company acting as an administrator) for services such as enrollment, claims processing, and managing provider networks. Alternatively, these employers can self-administer the services. Self-insured plans are regulated by the federal government and are generally not subject to state insurance laws.
- A fully-insured employer plan is a health plan purchased by an employer from an insurance company. The insurance company, instead of the employer, takes on the responsibility of paying employees' and dependents' medical claims in exchange for a premium from the employer.

Does a Health Plan Typically Pay for Services from Any Doctor?

Not always. Some types of plans encourage or require consumers to get care from a specific set of doctors, hospitals, pharmacies, and other medical service providers who have entered into contracts with the plan to provide items and services at a negotiated rate. The providers in this designated set or network of providers are called "in-network" providers.

- **In-Network Provider:** A provider who has a contract with a plan to provide health care items and services at a negotiated (or discounted) rate to consumers enrolled in the plan. Consumers will generally pay less if they see a provider in the network. These providers may also be called "preferred providers" or "participating providers."
- **Out-of-Network Provider:** A provider who doesn't have a contract with a plan to provide health care items and services. If a plan covers out-of-network services, ***the consumer usually pays more to see an out-of-network provider than an in-network provider.*** If a plan does not cover out-of-network services, then the consumer may, in most non-emergency instances, be responsible for paying the full amount charged by the out-of-network provider. Out-of-network providers may also be called "non-preferred" or "non-participating" providers.

Some examples of plan types that use provider networks include the following:

- **Health Maintenance Organization (HMO):** A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency, or when a prior authorization to obtain care outside the network has been approved, or as otherwise required by law. An HMO may require a consumer to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness. An HMO may require enrollees to obtain a referral from a primary care doctor to access other specialists.
- **Exclusive Provider Organization (EPO):** A type of health plan where services are generally covered only if the consumer uses in-network doctors, specialists, or hospitals (except in an emergency). In general, EPOs do not require a referral from a primary care doctor to see other specialists, and in general there is very limited, if any, out-of-network coverage.
- **Point of Service (POS):** A type of plan where a consumer pays less if they use in-network doctors, hospitals, and other health care providers. POS plans may require consumers to get a referral from their primary care doctor in order to see a specialist.
- **Preferred Provider Organization (PPO):** A type of health plan where consumers pay less if they use in-network providers. They can use out-of-network doctors, hospitals, and providers without a referral for an additional cost.

Consumers can contact their insurance company or health plan to find out which providers are in-network. Health plans usually have online provider directories that tell patients whether their doctor, other provider, or hospital is in-network with the health plan. It is important to remember that networks can change. It's a good idea for consumers to check with their provider about whether they are in-network each time they make an appointment, so they know how much they will have to pay.

If a consumer has health coverage and receives care from an out-of-network provider or facility, their health plan might not cover the entire cost. Sometimes the out-of-network provider or facility could ask the consumer to pay the difference between the billed charge and the amount their health plan covers. This type of bill is called a "balance bill" or a "surprise bill." The No Surprises Act, a recent federal law, prohibits surprise billing in some circumstances. See the No Surprises Act: Overview of Key Consumer Protections.

Insurance Costs

Consumers typically pay the following types of costs when they have insurance.

- Premium: The premium is an amount of money a consumer pays for a health insurance plan. The consumer and/or their employer usually make this payment bi-weekly, monthly, quarterly, or yearly. The premium must be paid regardless of how many services, if any, the consumer uses.
- Cost Sharing: Cost sharing is the share of costs for covered services that consumers must pay out of pocket. This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for out-of-network providers, or the cost of non-covered services. Cost sharing in Medicaid and Children's Health Insurance Program also includes premiums.
- Deductible: The amount a consumer must pay for covered health care services received before their plan begins to pay. For example, if a consumer's deductible is $1,000, their plan won't pay anything until the consumer has paid $1,000 for covered health care services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. For example, a plan may have separate in-network and out-of-network deductibles.
- Copayment: A fixed amount ($20, for example) that a consumer pays for a covered health care service after they've paid their deductible.
- Coinsurance: The percentage of the costs of a covered health care service that a consumer pays (for example, 15% of the cost of a prescription) after paying a deductible.

See Appendix A for examples of how cost sharing works.

Tips to Know:

- Sometimes consumers with most types of health insurance don't have to pay any cost sharing for certain services. This is often true for preventive services like flu shots and some cancer screenings. The goal is to keep enrollees healthy and catch health problems early.
- Many health insurance plans have an out-of-pocket maximum. This is the most a consumer could pay during a coverage period (usually one year) for their share of the costs of covered services. After they meet this limit, the plan will usually pay 100% of the allowed amount. This limit never includes the premiums, balance-billed charges, or care that the consumer's plan doesn't cover. Some plans don't count all of a consumer's copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

- In the majority of situations, the most important document for tracking health insurance costs is usually called an Explanation of Benefits (EOB). The EOB is a summary of health care charges that a health plan may send after a consumer receives medical care. It is not a bill. It shows the consumer how much their provider is charging the health plan for the care they received, and the amount the plan will cover. If the plan does not cover the entire cost, the provider may send the consumer a separate bill, unless prohibited by law.

Appendix A

Examples of Health Insurance Cost Sharing

This appendix provides some examples of how health insurance cost sharing works for consumers. These examples show different outcomes depending on whether a consumer has met their deductible and whether their health insurance includes out-of-network coverage. This information is intended to illustrate some of the basic steps that are typically used to calculate cost sharing in the absence of consumer surprise billing protections (or when such protections don't apply).

IN-NETWORK:
A consumer receives covered items or services from an in-network provider or facility.

If the services are covered by the consumer's health plan and furnished by an in-network provider or facility, the amount a consumer pays will vary based on whether the consumer has met their in-network deductible as well as the level of their coinsurance. Note the "allowed amount" is the maximum payment the plan will pay for a covered health care item or service and is generally the basis for cost-sharing calculations.

Based on their in-network status with the health plan, the provider may only charge the consumer up to the "allowed amount."

In the next two examples, assume the consumer's health plan specifies that coinsurance is 20 percent of the allowed amount after the consumer has met a $2,000 deductible for in-network coverage.

1. The consumer has not paid anything toward the in-network deductible.	Example Amounts:
In-network provider bills health plan:	$1,000
Health plan "allowed amount" for provider:	$750
Health plan pays:	$0 (since consumer has not met deductible)
Consumer owes:	$750 (100 percent of allowed amount since consumer has not met deductible)
Provider bills consumer:	$750
Total the consumer pays:	$750

2. The consumer has fully met the in-network deductible.	Example Amounts:
In-network provider bills health plan:	$1,000
Health plan "allowed amount" for provider:	$750
Health plan pays:	$600 (80 percent of allowed amount after deductible is met)
Consumer coinsurance owed:	$150 (20 percent of allowed amount after deductible is met)
Provider bills consumer:	$150
Total the consumer pays:	$150

OUT-OF-NETWORK:
The consumer receives covered items or services from an out-of-network provider.

If the covered items or services are received out-of-network, a consumer's billed amounts will vary based on whether the consumer's health plan provides any out-of-network coverage and whether the consumer has met their out-of-network deductible.

In some circumstances, the No Surprises Act may limit what a consumer may be billed in each of the following examples. See the No Surprises Act: Overview of Key Consumer Protections.

3. The consumer has no out-of-network coverage for the services.	Example Amounts:
Out-of-network provider bills health plan:	$1,000 (claim subsequently rejected for lack of out-of-network coverage)
Health plan "allowed amount" for provider:	Not applicable – no out-of-network coverage
Health plan pays:	$0 (since no out-of-network coverage)
Consumer coinsurance owed:	Not applicable – no out-of-network coverage
Provider bills consumer:	$1,000 (provider bills full amount since consumer has no out-of-network coverage)
Total the consumer pays:	$1,000

In the next two examples, the plan covers out-of-network services with consumer coinsurance of 40 percent after the consumer has met a $4,000 deductible for out-of-network services. If the consumer has not paid anything toward the out-of-network deductible, the provider would bill the consumer for the full amount of the charges if the charges are less than $4,000 (example 4). If the consumer has already paid their full deductible, a provider might balance bill a consumer for the difference between what the provider receives from the health plan and the provider's initial billed amount (example 5).

4. The consumer has not paid anything toward the out-of-network deductible.	Example Amounts:
Provider bills health plan:	$1,000
Health plan "allowed amount" for provider:	$550
Health plan pays:	$0 (deductible not met)
Consumer owes:	$550 (100 percent of allowed amount since consumer has not met deductible)
Provider bills consumer:	$550 + possible $450 balance billed
Total the consumer pays:	$1,000 ($550 + $450)

5. The consumer has fully met the out-of-network deductible.	Example Amounts:
Provider bills health plan:	$1,000
Health plan "allowed amount" for provider:	$550
Health plan pays:	$330 (60 percent of allowed amount after deductible is met)
Consumer coinsurance owed:	$220 (40 percent of allowed amount after deductible is met)
Provider bills consumer:	$220 + possibly $450 balance billed
Total the consumer pays:	$670 ($220 + $450)