allways HEALTH PARTNERS

Health Insurance Literacy Guide

Why employee health insurance literacy matters

Navigating the health care system and using health insurance can be challenging for many health care consumers. The trend towards consumer-centered health care requires individuals to be much more involved in making health care decisions than they were just 10 years ago. To become better health care consumers, employees need to understand basic health insurance concepts and the information given to them.

This guide:

- Describes the importance of health insurance literacy
- Demonstrates how employers can help employees
- Includes a detailed glossary of health insurance terms that employers can share with employees

Health insurance can be complicated

Health plan members are often confused by the alphabet soup of acronyms, terminology, and lingo used to describe their health insurance. Whether they're trying to choose a health plan or take advantage of the benefits offered, understanding insurance terminology can be like reading another language.

4% to 14% Only 4% to 14% of individuals could accurately respond to basic insurance questions

Bottom line: A poor understanding of health insurance terms makes an already complicated subject even more confusing. In fact, two national studies revealed that only 4% to 14% of individuals were able to accurately respond to a set of questions that addressed the basic understanding of health insurance.[1]

Understanding the ins and outs of health insurance is crucial to effectively accessing health care services and making the most of one's health coverage. As an employer or benefits advisor, you want your employees or those of your clients to understand insurance basics so they can become better health care consumers. This not only helps ensure satisfaction with their coverage, but it also gives them the confidence to evaluate health insurance plans, to select the plan that best meets their needs, and, most importantly, to use the plan to its maximum benefit once enrolled.

Health insurance illiteracy is real

Given the complexity of health insurance it's become clear that health insurance illiteracy is real.[2] A report from Alegeus, a provider of consumer driven health solutions, revealed the majority of consumers with employer-sponsored health plans lack the necessary financial health literacy to optimally manage their health plan finances.[3]

According to a Policygenius article that described a 2019 literacy survey, health literacy is a fairly new phenomenon. "If you shift the frame back say, even 20 years ago, people didn't know what [medical treatment] cost, but it didn't matter because their insurance company just covered it," Christine Wilson, a spokesperson for the National Patient Advocate Foundation, observed.[4] Today there is much more variation in how benefits are covered and what types of cost sharing may apply. And the growth of tools such as health reimbursement arrangements and health savings accounts have further complicated the landscape. This Policygenius survey found that more than two-thirds of respondents could not correctly define even basic insurance terms, such as premium, deductible, and copay.[5]

> **"If you shift the frame back say, even 20 years ago, people didn't know what [medical treatment] cost, but it didn't matter because their insurance company just covered it."**
>
> **Christine Wilson**, National Patient Advocate Foundation.

Another health insurance literacy survey by the Kaiser Family Foundation revealed many were able to answer some basic questions, like when premiums are paid. Questions involving calculations, however, proved more difficult. Only 51% of those surveyed could determine the out-of-pocket charges for a hospital stay where a deductible and copay were involved. And just 16% could calculate the cost of an out-of-network lab test where the health insurer paid a percent of allowed charges. Further, only one-third of survey respondents correctly defined a formulary.[6]

51% Only 51% could determine the out-of-pocket charges for a hospital stay involving a deductible and copay

16% Just 16% could calculate the cost of an out-of-network lab test when based on allowed charges

When health care consumers don't have a good understanding of the system, it can lead them to make poorly informed decisions about their care. For example, they may choose a plan based on premium alone, instead of also evaluating the possible out-of-pocket costs, network access, and benefit value. Fortunately, this is a mistake that can be avoided with some basic knowledge and education.

Low health literacy linked to delayed or avoidance of care

Research has also shown that health insurance literacy (or lack of) is a factor that contributes to consumers delaying or not seeking care.[7] And that includes preventive care, which is often covered by insurance with no cost sharing to the consumer.

Almost 30% of survey respondents to a national survey reported delaying or foregoing health care because of cost. Specifically, those with lower health literacy reported significantly greater avoidance of both preventive and non-preventive services.[8] Understanding the types of services available, what's covered and at what cost, can help individuals use their health plan wisely and obtain recommended health services. This trend toward foregoing care was also reported in a Policygenius study where 27% claimed uncertainty over their coverage led them to avoid treatment.[9]

In addition to delaying or avoiding important care, poor health literacy can also lead consumers to:

- Not understand the additional costs associated with out-of-network care
- Remain with the same plan year in and year out when a better alternative is available
- Not take full advantage of shopping for prescription drugs to save money

These situations create higher costs for them and for employers.

Acknowledging the problem is the first step

To address the challenge of health literacy, there are many initiatives in place by policymakers, payors, providers and employers. For example, the independent nonprofit Consumers Union (CU) confirmed that this lack of understanding was taking a toll on consumers' health and financial well-being, and agreed that a widely accepted measure of consumer health insurance literacy was needed.[10] Now called the Health Insurance Literacy Measure, it represents a self-assessment measure of consumers' ability to select and use private health insurance.[11]

This measurement is based on a conceptual framework that breaks health insurance literacy into four different components:

1) **Knowledge**, or recognizing the importance of understanding insurance terminology
2) **Information seeking behaviors,** or understanding the questions to ask and where to find the answers
3) **Document literacy** and being able to interpret benefits and explanation
4) **Cognitive skills**, which include an ability to calculate cost sharing, and assessing value based on cost vs. benefits

Knowledge	Information Seeking	Document Literacy	Cognitive Skills
• Insurance terms • Types of healthcare services (e.g., screening vs. diagnostic) • Insurance concepts (e.g., premium pays for insurance that protects you against an unexpected medical event) • Beneficiary rights	• Formulate and articulate questions • Locate health plan information (e.g., eligibility, coverage requirements) • Evaluate credibility of information sources • Navigate information sources (e.g., insurer, telephone trees, insurer and insurance exchange websites, decision support tools)	• Read and follow written instructions • Interpret summary of benefits and explanation of benefit documents • Use of schedules (e.g., provider and drug tiers) • Complete health insurance forms (e.g., enrollment, claim, mail order prescription, appeal)	• Assess preventive care needs and personal risk • Project healthcare utilization • Apply health plan benefits to personal situation • Calculate cost sharing • Assess value of coverage, weighing cost versus benefits relative to health service needs

Self-Efficacy
The confidence to perform the tasks noted above

Source: Journal of Health Communications

By measuring health insurance literacy and recognizing the components that contribute to this phenomenon, we can shape consumer education, policy development, and research around health insurance experiences. Additional efforts by the Department of Health and Human Services have elevated health literacy as a priority, as has the development of public marketplace exchanges.[12]

What employers can do to help improve health literacy

Investment in employee health demonstrates a commitment to keeping employees happy, healthy, and engaged at work. By being proactive in improving health literacy, employers will help their workers make the most of their health plan coverage, potentially reducing health care costs for both parties.

Here are five ways employers can start improving health literacy at their organization:

1. Survey employees to evaluate their understanding of health insurance terms and concepts before, during and after the annual benefits period. You can use these insights to specifically address the areas where your employees are uninformed.
2. Set up enrollment sessions or hold lunch and learn sessions with employees to share real examples of smart health care decisions. This offers employees the potential to save money on health care that can be used for other aspects of their lives.
3. Look at what your insurance carrier offers to support its members in understanding their health insurance benefits, including educational content, subscriber portals, online cost calculators, and mobile apps.
4. Tap into your benefits advisor or consultant as a resource. They often have tools that can help.
5. Share the glossary at the end of this guide, either in benefit communications with employees, benefits brochures, employee newsletters, your online employee portal that describes benefits, or any place you communicate with employees.

Glossary of commonly used words in health insurance

The following glossary includes some of the most common health insurance terms. You can save it as a reference for when you come across words you don't know, or read through to familiarize yourself with common health insurance lingo.

You can find more health insurance terminology at the following websites:

- Healthcare.gov
- Bureau of Labor Statistics (bls.gov)
- TheBalance.com
- Insurancemarketplace.org

Affordable Care Act (ACA)
The comprehensive federal health care reform law enacted in March 2010. This is also referred to as Patient Protection and Affordable Care Act (PPACA), "Obamacare" or "Health Care Reform."

Allowed amount
The allowed amount is the maximum amount that a health care plan will pay for a specific service. If a provider, who is not in the plan's network, charges more than this allowed amount, you may be expected to pay the difference. This may also be called payment allowance, negotiated rate, or eligible expense.

Ancillary services
Ancillary services are medical services or supplies that can improve patient health that are not rendered by acute care hospitals, doctors or health care professions. Examples of ancillary services are: laboratory, radiology, pharmacy, and physical therapy services.

Authorization (also known as a Prior or Preauthorization)
Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.

Balance billing
Balance billing is the term for when a health care provider bills you for the difference between what the insurance company will cover (allowed amount) and what the provider charges. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may balance bill you for the remaining $30. A provider in the plan's network generally cannot balance bill you for covered services.

Benefits
The health care services or supplies covered under a health insurance plan. Covered and excluded benefits are defined in a health insurance plan's Evidence of Coverage (EOC) documents. See your plan's Schedule of Benefits (SOB) and your plan's Member Handbook plus amendments for full details.

Benefit year

This represents the annual cycle for your health insurance plan. A "calendar year" cycle always starts in January and ends in December. A "plan year" cycle can start any month and runs for 12 consecutive months. Your plan's deductibles, out-of-pocket maximums, visits, and other limits are tracked according to your plan's benefit year.

Biometric screening

Biometric screening is the measurement of specific characteristics, such as your height, weight, blood pressure, cholesterol, body mass index, etc. that providers can use to benchmark and evaluate changes in health status over time.

Care management

Care management allows for the coordination of quality health care services to meet an individual's specific health care needs. This involves facilitating care across agencies and organizations (home health, skilled nursing, hospitals) and creating cost effective alternatives for catastrophic, chronically ill or injured members. Examples of circumstances where care management may be beneficial include organ transplantation, asthma, congestive heart failure, diabetes, or traumatic injury such as burns.

Claim

A request for payment that a health care provider submits to a health insurer for covered medical services.

Coinsurance

This amount represents a member's share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Copayments

Also known as the copay, a copayment is the cost you're required to pay, usually when you receive the service, for certain covered services and/or prescription medications. For example, you might have to pay a $25 copay at each regular doctor's visit.

Cost sharing

Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually are not considered cost sharing.

Consumer-Driven Health Plan (CDHP)

Also called consumer-driven health care (CDHC), these types of insurance plans allow patients to pay for normal medical expenses from accounts, such as health savings accounts (HSAs) or health reimbursement accounts (HRAs). These plans usually have high deductibles, which patients should be aware of if they anticipate the possibility of a significant medical expense.

Deductible

This is the amount you pay in a benefit year for certain covered health care services before your health insurance plan starts to pay. For example, if your individual deductible is $3,000, you will need to pay this much for your covered services before your insurance starts to pay for them. The deductible may or may not include the cost of prescription medications. After you've met your deductible, you may also be required to pay a copayment and/or coinsurance. Below are two types of deductibles, and how they work differently:

- **Embedded deductible**
  An embedded deductible allows families to combine their deductibles to satisfy the family deductible. In other words, it ensures that one family member doesn't have to meet the entire family's deductible in order for post-deductible benefits to begin.

- **Aggregate Deductible**
  An aggregate deductible, also known as a non-embedded deductible, means that on a family policy, the total family deductible must be paid out-of-pocket before the insurer starts paying for health care services for any individual member.

Dependent

An individual for whom a parent, relative, or other person may claim a personal exemption tax deduction. Examples could include: a child, spouse, etc. Check with your insurer for a complete list.

Dependent care account

A dependent care account is a pre-tax account that can be used to pay for eligible dependent care services. Often, these include daycare and other child-based services. This type of account is also often called a dependent care flexible spending account (DCFSA).

Diagnostic

Any service covered by your plan that isn't preventive is diagnostic. Diagnostic services are tests your provider will recommend if you have symptoms or risk factors for a certain disease or illness, or have a known medical condition or injury. Examples of diagnostic tests can include: X-rays, MRIs, CT scans, bloodwork, pregnancy tests, and biopsies. Diagnostic services covered by your health plan may require cost sharing.

Disease management

Disease management is a type of care management used to control the treatment and services of patients who have chronic conditions. Helps patients to understand and take care of their chronic condition to avoid future problems.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency medical condition
An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Employee contribution
Employee contribution is the amount an employee pays through payroll deductions for insurance or health savings plan.

Exclusive Provider Organization (EPO)
An EPO is a type of health insurance plan that does not require a primary care provider but also does not allow its members to see doctors outside of its network.

Explanation of Benefits (EOB)
The EOB is a document provided by a health insurance company that details what portion of a medical claim was paid to the health care provider and what portion of the payment, if any, is the patient's responsibility. Also can be called a Summary of Payments (SOP).

Flexible Spending Account (FSA)
FSAs are a type of account where you can set aside money to pay for your eligible out-of-pocket medical costs. Any money you place in these accounts is tax-deductible. A certain amount of the money placed in an FSA can roll over to the next year. FSAs can only be obtained through an employer.

Formulary
A list of prescription drugs approved for use, which are covered by the plan and dispensed through participating pharmacies. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers.

Generic drugs
A prescription drug that has the same active-ingredient formula as their brand-name counterpart. Generic drugs usually cost less than brand-name drugs.

Health Maintenance Organization (HMO)
A health maintenance organization licensed pursuant to M.G.L. c. 176G. HMOs have their own network of doctors, hospitals and other healthcare providers who have agreed to accept payment at a certain level for covered services they provide. This allows the HMO to keep costs in check for its members. With an HMO, members have an assigned primary care provider (PCP) who coordinates most member care and refers their patients to specialty care.

Health promotion programs

Health promotion programs, also called "wellness programs," focus on helping people engage in healthier activities in their workplaces and communities. They empower individuals and groups to make healthy choices and take control of their own wellness.

Health Reimbursement Account (HRA)

Employer-funded account from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year. Unused amounts may be rolled over to be used in subsequent years. These are also referred to as Health Reimbursement Arrangements.

Health Savings Account (HSA)

A Health Savings Account (HSA) is a fund you can establish to pay for medical expenses associated with a qualified High Deductible Health Plan (QHDHP) or invest for your future health needs. Any money you place in these accounts is tax-deductible. Unlike FSAs, HSAs can be privately purchased, but they are only available to those who have a qualified HDHPs.

High-Deductible Health Plan (HDHP)

This is a type of health insurance plan with lower monthly premiums and a higher deductible. The deductible applies to all services, except those deemed as preventive services. Once you reach your annual deductible, you may also be required to pay a copayment and/or coinsurance. Some of these plans are called Qualified High Deductible Health Plans (HSA-compliant plans that follow IRS rules) when they are offered alongside an HSA to help offset costs.

In-network

When a health care facility, doctor, or other provider is in-network that means they are part of the group of providers with which the insurance company has contracted to provide health care services. Some insurers also use the term "participating" or "preferred" providers vs "in-network."

Medically necessary

"Medically necessary" or "medical necessity" describes health care services that are consistent with generally accepted principles of professional medical practice.

Network

This is the group of doctors, facilities, vendors, and other health care service providers an insurance company has contracted with to provide covered health care services. Providers who are "in-network" participate in the plan. Providers who are "out-of-network" do not participate in the plan.

Open enrollment

Open enrollment is the annual time period where you can enroll in health insurance or switch to a different insurance plan. The open enrollment period for the Health Insurance Marketplace, also known as the Health Connector in Massachusetts, begins November 1st. If your insurance plan is obtained through your employer, the enrollment period may be different.

Out-of-network

Also called non-participating providers, out-of-network providers are not contracted with your health insurer. If you have an HMO plan, medical services received from out-of-network providers are usually not covered, and plans that provide "out of-network" coverage like PPOs typically have higher costs if you choose to see out-of-network providers.

Out-of-pocket maximum

This is the most you could pay in a plan year for covered health care services. After you reach this amount, your insurance pays 100% for covered services through the remainder of the benefit year. Generally, all medical, behavioral health, and prescription drug copayments, deductibles, and coinsurance amounts you have paid apply toward the out-of-pocket maximum. Some plans include a separate out-of-pocket maximum for prescription drugs. One might have an embedded out-of-pocket maximum or an aggregate out-of-pocket maximum. The same rules that apply to embedded and aggregate deductibles pertain to out-of-pocket maximum.

Out-of-pocket costs

Medical care expenses that aren't reimbursed by insurance, which you typically incur when you receive care. Out-of-pocket costs include deductibles, coinsurance, and copayments you pay for covered services.

Over-the-Counter (OTC) drugs

OTC drugs are medicines that can be purchased directly by the consumer without a prescription. Many insurers do not provide coverage for over the counter medications. Some insurers, like AllWays Health Partners, actually provide coverage for some over-the-counter medications with a prescription from a provider. Check with your insurer to understand your coverage details.

Point-of-Service Plan (POS)

Point-of-service plans are a hybrid of HMO and PPO plans. Like an HMO, participants designate an in-network physician to be their primary care provider. Like a PPO, participants may use providers outside the network, or see providers without referrals, but pay more in these situations.

Preferred Provider Organization (PPO)

PPO plans have a larger network than HMO plans. They also provide coverage for covered health care services with out-of-network providers, at higher cost sharing than with in-network providers. PPOs don't require you to have a PCP, which means you can go to any provider including a specialist without another provider's referral. (Note: There's always value in having a PCP to coordinate your overall health and well-being.)

Premium

This is the cost of your health care, usually billed monthly, direct from a health plan sponsor or through your employer. In most cases, your employer contributes to paying your premium (called the "employer contribution"). You pay a portion of the premium, and that is usually deducted from your paycheck.

Prescription drug coverage

Similar to coverage for medical services, this is the health insurance or plan that helps pay for covered prescription drugs and medications.

Preventive care
Preventive is a term for a very specific list of services. This list is defined by nationally established guidelines. These services typically look for or prevent health issues and are done before you are diagnosed with a condition, while you're healthy and show no symptoms. Health plans offer many preventive services at no cost.

Primary Care Provider (PCP)
A health care professional qualified to provide general medical care for common health care problems who: supervises, coordinates, prescribes, or otherwise provides or proposes health care services; initiates referrals for specialist care; and maintains continuity of care within the scope of practice.

Provider
A health care professional or facility licensed as required by state law. Providers include doctors, hospitals, laboratories, pharmacies, skilled nursing facilities, nurse practitioners, registered nurses, physician assistants, psychiatrists, social workers, licensed marriage and family therapists, licensed mental health counselors, clinical specialists in psychiatric and mental health nursing, and others.

Qualifying Life Event (QLE)
A QLE is a circumstance that can make you eligible for a special enrollment period. QLEs can include having a baby, losing your health insurance, getting married, etc.

Referral
A written order from your primary care provider (PCP) for you to see a specialist or get certain health care services. HMO plans require a referral before you can get some health care services from anyone except your PCP. If you don't get a referral first, the plan may not pay for the services.

Second opinion
A second opinion is when you seek another opinion from another qualified individual on a medical matter. A second opinion might be necessary to help you make an informed decision about your medical care. Second opinions may or may not be covered by insurance, depending on your health care plan.

Special enrollment period
This is the time period when people who have had a baby, gotten married, or experienced another QLE can obtain or change health care insurance outside of the regular open enrollment period.

Specialist
A specialist is a type of provider who has specialized knowledge of specific medical issues, conditions, areas, or functions of the body. A podiatrist—a doctor who treats the feet and ankles—is a type of specialist.

Subscriber
A subscriber is the person who is the primary enrollee in the health insurance plan, pays its premiums and receives covered services. The subscriber can enroll dependents under family coverage.

Summary of Payments (SOP)
See Explanation of Benefits (EOB).

Telehealth/telemedicine/virtual visits

Telehealth, also called telemedicine, is when health care services are provided remotely via the use of interactive audio, video or other electronic media for a diagnosis, consultation or treatment of a patient's physical or mental health. For example, a patient can discuss their medical needs with a doctor via video chat without leaving their home.

Urgent care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care.

Utilization review

Utilization review is a set of formal review techniques designed to monitor the use of – or evaluate the clinical necessity, appropriateness or efficiency of – covered health care services, procedures, or health care settings.

References

1. "Association Between Health Insurance Literacy and Avoidance of Health Care Services Owing to Cost." JAMA Network. (2018, Nov. 16).

2. "Development of the Health Insurance Literacy Measure (HILM)." Journal of Health Communication. (2014, Oct. 14).

3. "Alegeus Predicts that Consumers and Employers Will Leave Billions in Tax Savings on the Table This Open Enrollment Season Due to Low Consumer Health & Financial Fluency." Alegeus. (2018, Sept. 18).

4. "Health Insurance Literacy Survey 2019." Policygenius. (2019, Oct. 29).

5. "Health Insurance Literacy Survey 2019." Policygenius. (2019, Oct. 29).

6. "Assessing Americans' Familiarity With Health Insurance Terms and Concepts." KFF. (2014, Nov. 11).

7. "People with limited health insurance literacy more likely to avoid care." Healthcare Dive. (2018, Nov. 21).

8. "Association Between Health Insurance Literacy and Avoidance of Health Care Services Owing to Cost." JAMA Network. (2018, Nov. 16).

9. "Health Insurance Literacy Survey 2019." Policygenius. (2019, Oct. 29).

10. "Measuring Health Insurance Literacy: A Call to Action." Consumers Union. (2012, Feb.).

11. "Development of the Health Insurance Literacy Measure (HILM)." Journal of Health Communication. (2014, Oct. 14).

12. "Health Literacy Workgroup." Health.gov.