Federally-facilitated Marketplace Assister Curriculum: Health Insurance Basics

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Center for Consumer Information & Insurance Oversight

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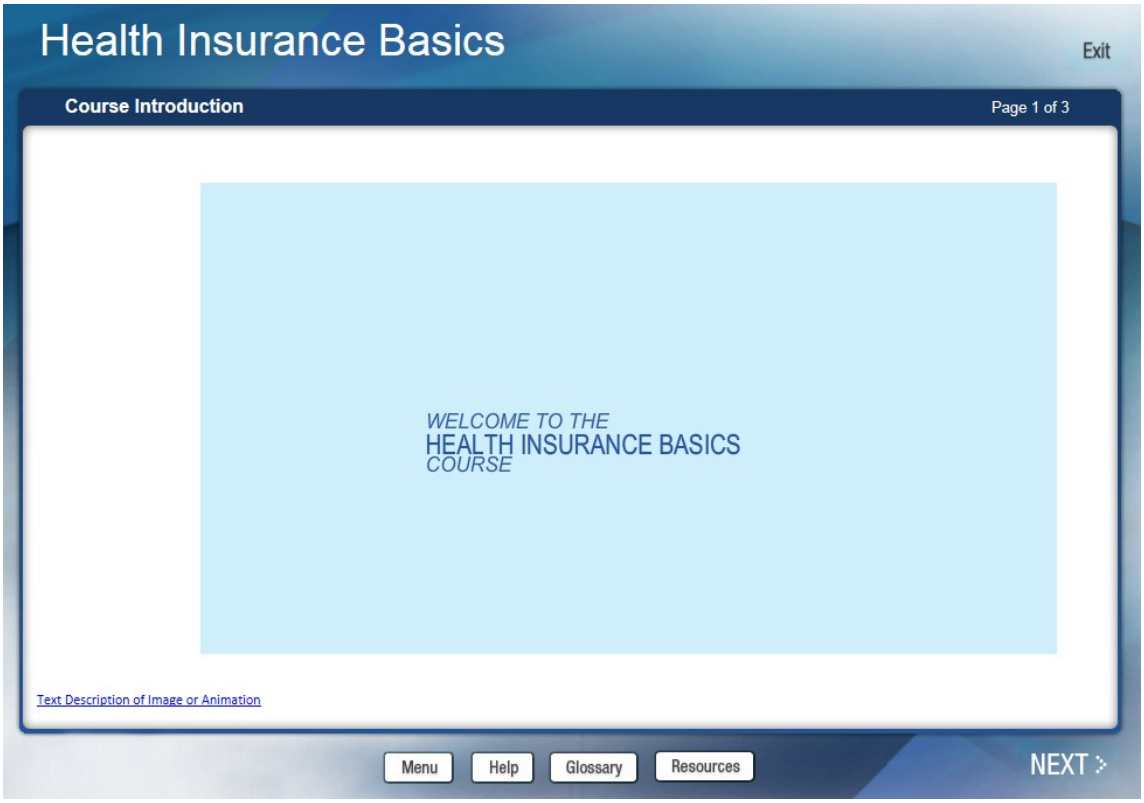
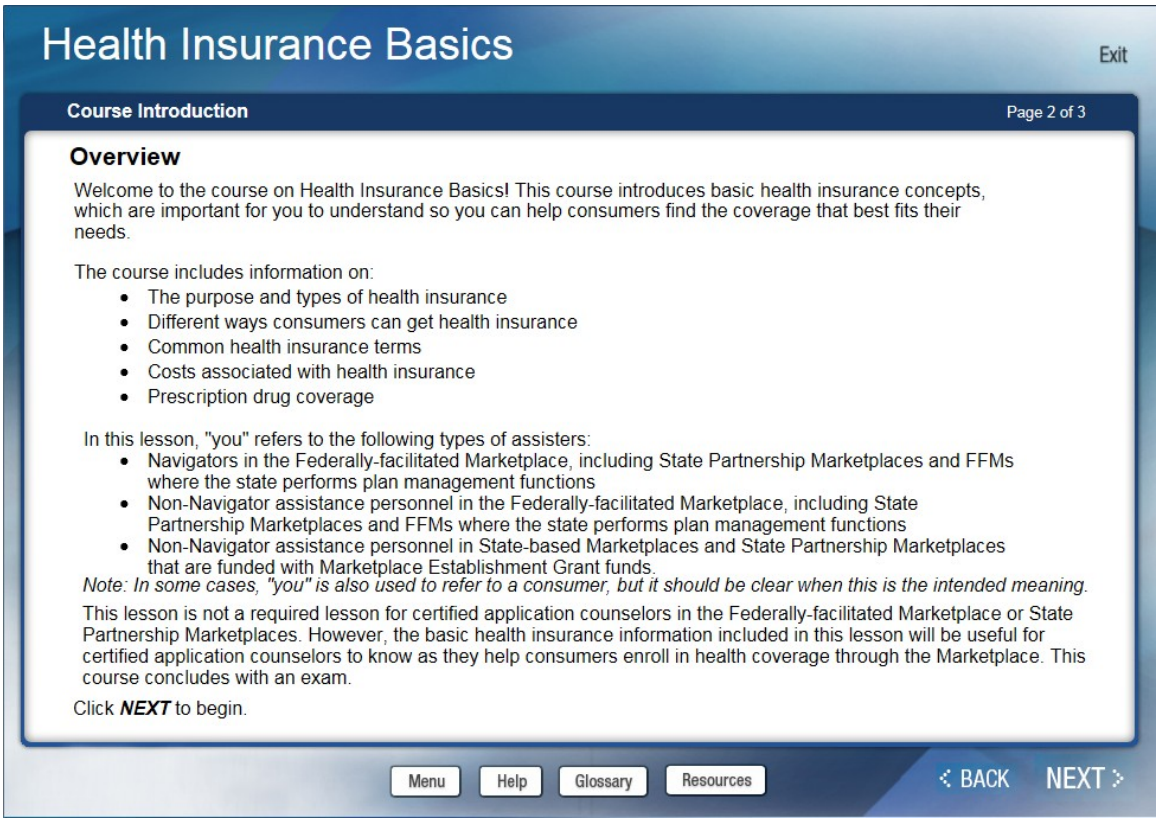
Health Insurance Basics Course

Course Introduction Module



Course Title

Welcome to the Health Insurance Basics Course



Overview

Welcome to the course on Health Insurance Basics! This course introduces basic health insurance concepts, which are important for you to understand so you can help consumers find the coverage that best fits their needs.

The course includes information on:

- The purpose and types of health insurance
- Different ways consumers can get health insurance
- Common health insurance terms
- Costs associated with health insurance
- Prescription drug coverage

In this lesson, "you" refers to the following types of assisters:

- Navigators in the Federally-facilitated Marketplace, including State Partnership Marketplaces and FFMs where the state performs plan management functions
- Non-Navigator assistance personnel in the Federally-facilitated Marketplace, including State Partnership Marketplaces and FFMs where the state performs plan management functions

- Non-Navigator assistance personnel in State-based Marketplaces and State Partnership Marketplaces that are funded with Marketplace Establishment Grant funds.

Note: In some cases, "you" is also used to refer to a consumer, but it should be clear when this is the intended meaning.

This lesson is not a required lesson for certified application counselors in the Federally-facilitated Marketplace or State Partnership Marketplaces. However, the basic health insurance information included in this lesson will be useful for certified application counselors to know as they help consumers enroll in health coverage through the Marketplace. This course concludes with an exam.

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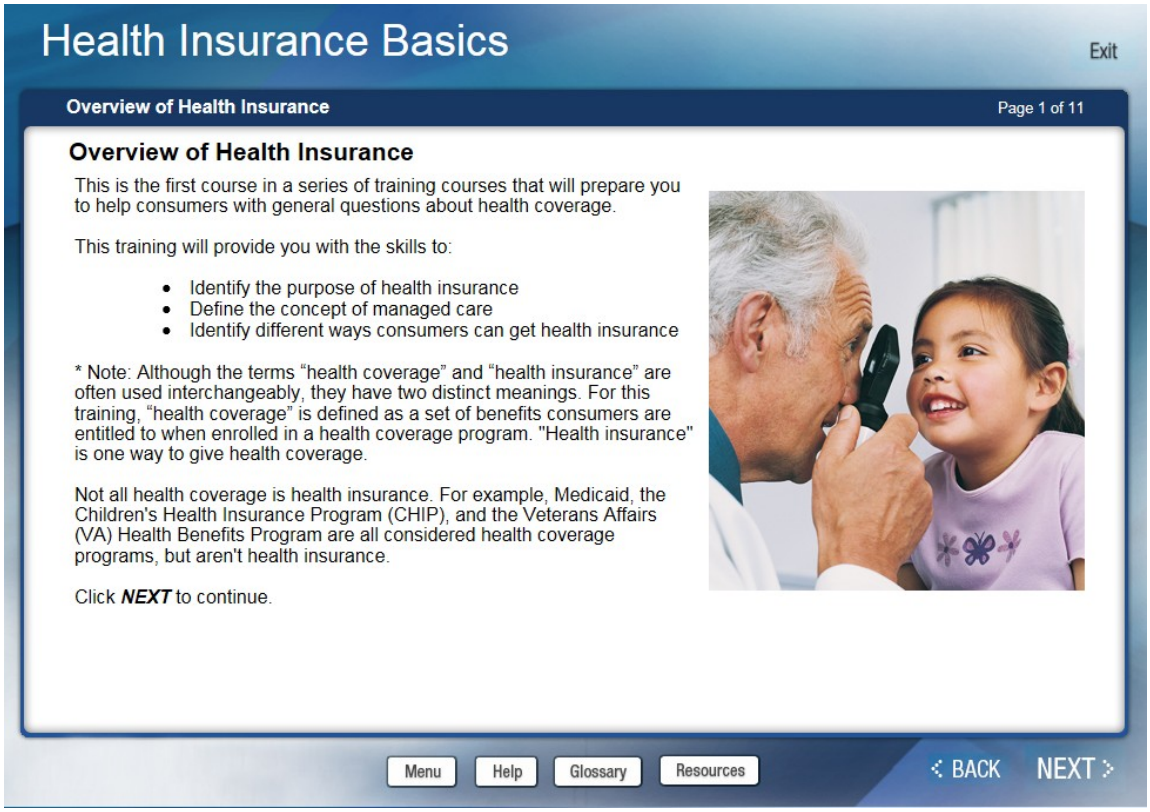
Overview of Health Insurance Module



Overview of Health Insurance

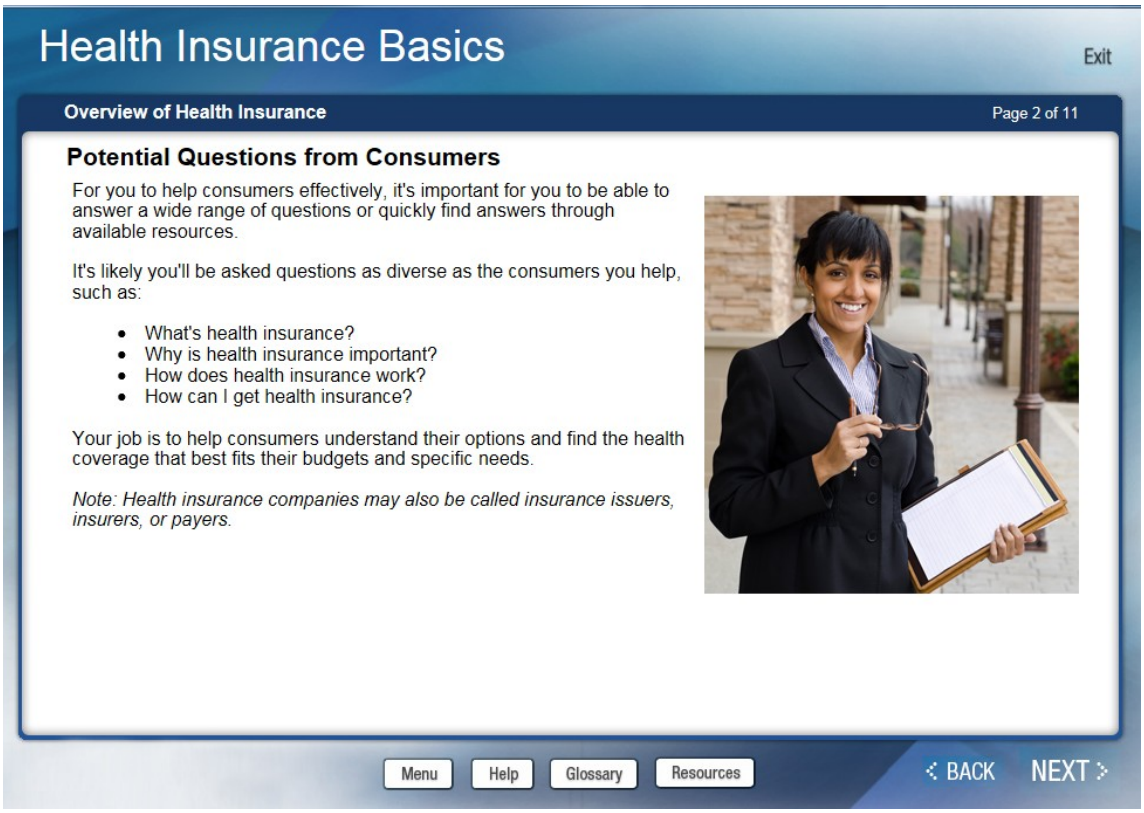
This is the first course in a series of training courses that will prepare you to help consumers with general questions about health coverage.

This training will provide you with the skills to:

- Identify the purpose of health insurance
- Define the concept of managed care
- Identify different ways consumers can get health insurance

* Note: Although the terms “health coverage” and “health insurance” are often used interchangeably, they have two distinct meanings. For this training, “health coverage” is defined as a set of benefits consumers are entitled to when enrolled in a health coverage program. "Health insurance" is one way to give health coverage.

Not all health coverage is health insurance. For example, Medicaid, the Children's Health Insurance Program (CHIP), and the Veterans Affairs (VA) Health Benefits Program are all considered health coverage programs, but aren't health insurance.



Potential Questions from Consumers

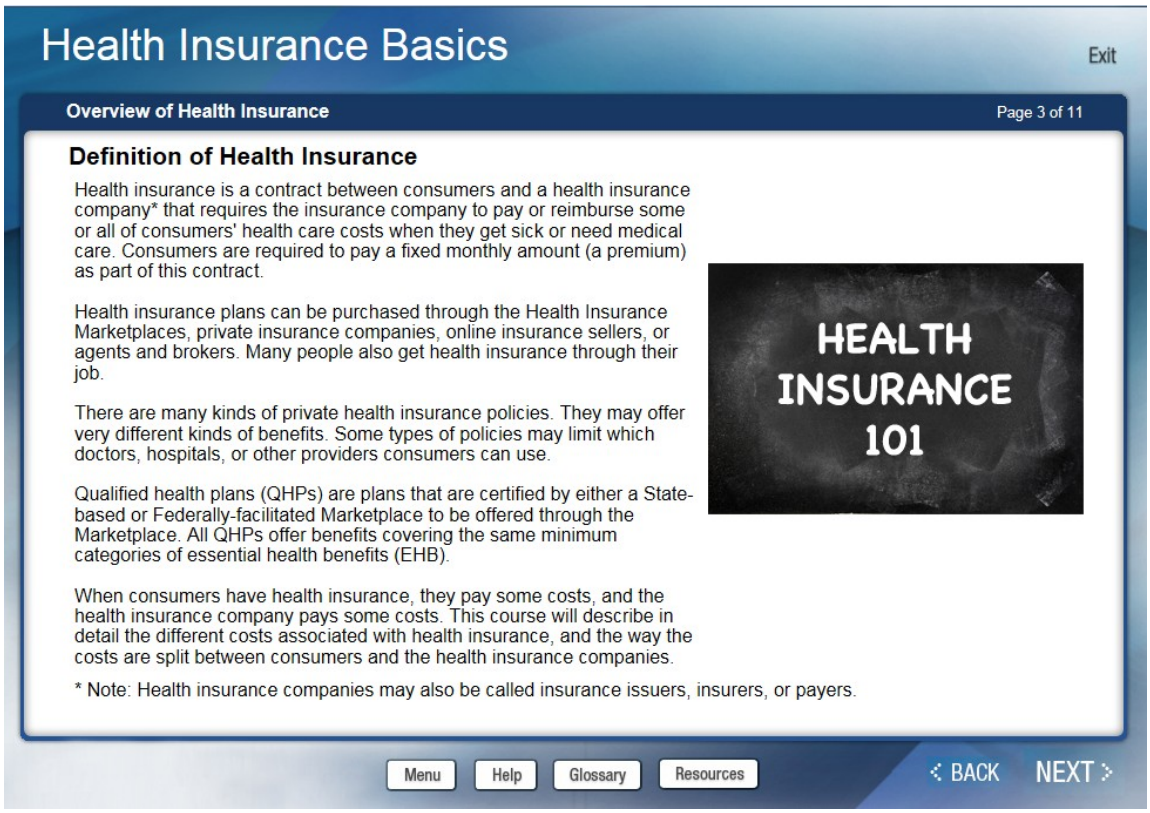
For you to help consumers effectively, it's important for you to be able to answer a wide range of questions or quickly find answers through available resources.

It's likely you'll be asked questions as diverse as the consumers you help, such as:

- What's health insurance?
- Why is health insurance important?
- How does health insurance work?
- How can I get health insurance?

Your job is to help consumers understand their options and find the health coverage that best fits their budgets and specific needs.

Note: Health insurance companies may also be called insurance issuers, insurers, or payers.



Definition of Health Insurance

Health insurance is a contract between consumers and a health insurance company* that requires the insurance company to pay or reimburse some or all of consumers' health care costs when they get sick or need medical care. Consumers are required to pay a fixed monthly amount (a premium) as part of this contract.

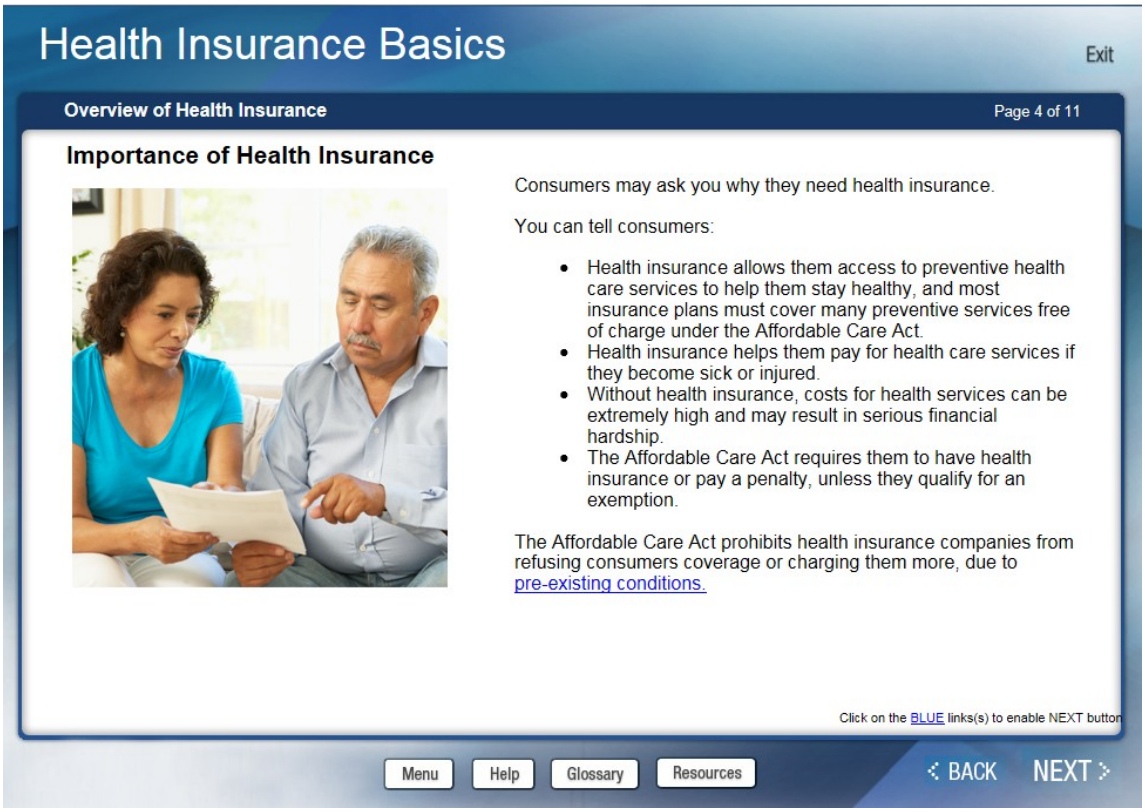
Health insurance plans can be purchased through the Health Insurance Marketplaces, private insurance companies, online insurance sellers, or agents and brokers. Many people also get health insurance through their job.

There are many kinds of private health insurance policies. They may offer very different kinds of benefits. Some types of policies may limit which doctors, hospitals, or other providers consumers can use.

Qualified health plans (QHPs) are plans that are certified by either a State-based or Federally-facilitated Marketplace to be offered through the Marketplace. All QHPs offer benefits covering the same minimum categories of essential health benefits (EHB).

When consumers have health insurance, they pay some costs, and the health insurance company pays some costs. This course will describe in detail the different costs associated with health insurance, and the way the costs are split between consumers and the health insurance companies.

* Note: Health insurance companies may also be called insurance issuers, insurers, or payers.



Importance of Health Insurance

Consumers may ask you why they need health insurance.

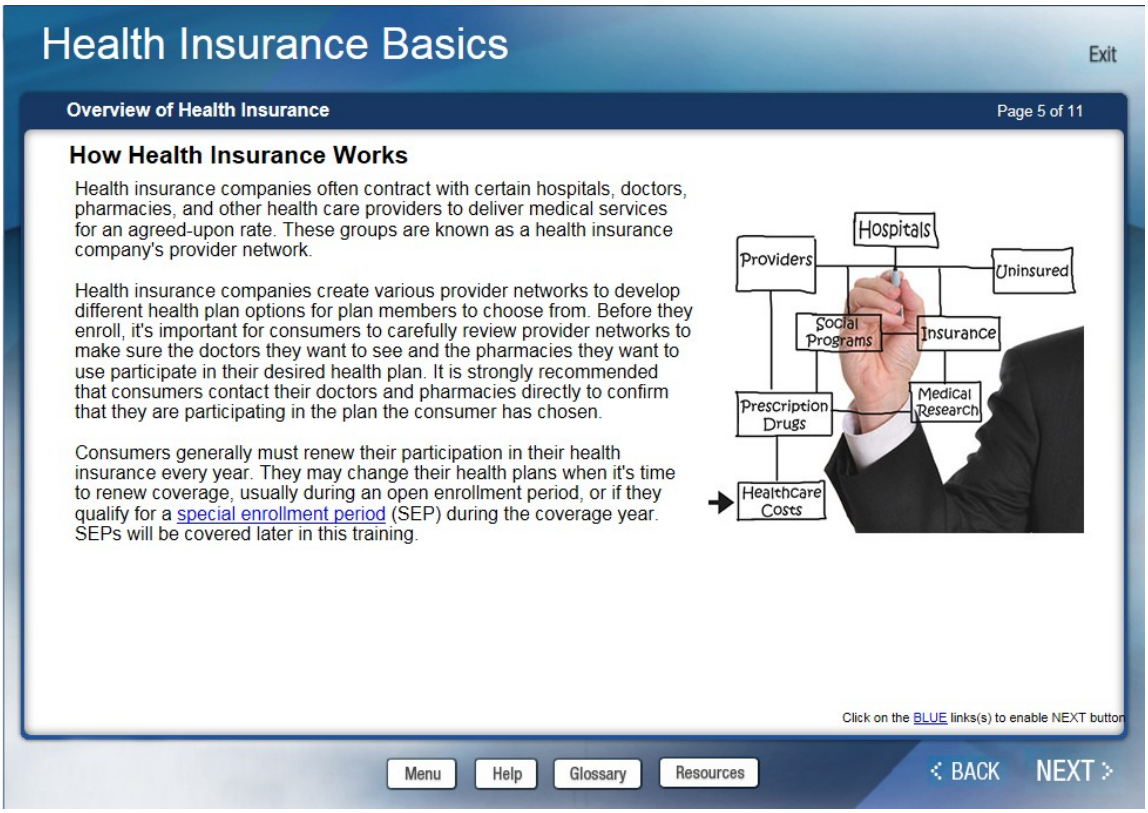
You can tell consumers:

- Health insurance allows them access to preventive health care services to help them stay healthy, and most insurance plans must cover many preventive services free of charge under the Affordable Care Act.
- Health insurance helps them pay for health care services if they become sick or injured.
- Without health insurance, costs for health services can be extremely high and may result in serious financial hardship.
- The Affordable Care Act requires them to have health insurance or pay a penalty, unless they qualify for an exemption.

The Affordable Care Act prohibits health insurance companies from refusing consumers coverage or charging them more, due to pre-existing conditions.

Definition of Pre-existing Conditions

Pre-existing conditions are medical conditions (such as asthma, back pain, diabetes, or cancer) that consumers had before the date coverage became effective.



How Health Insurance Works

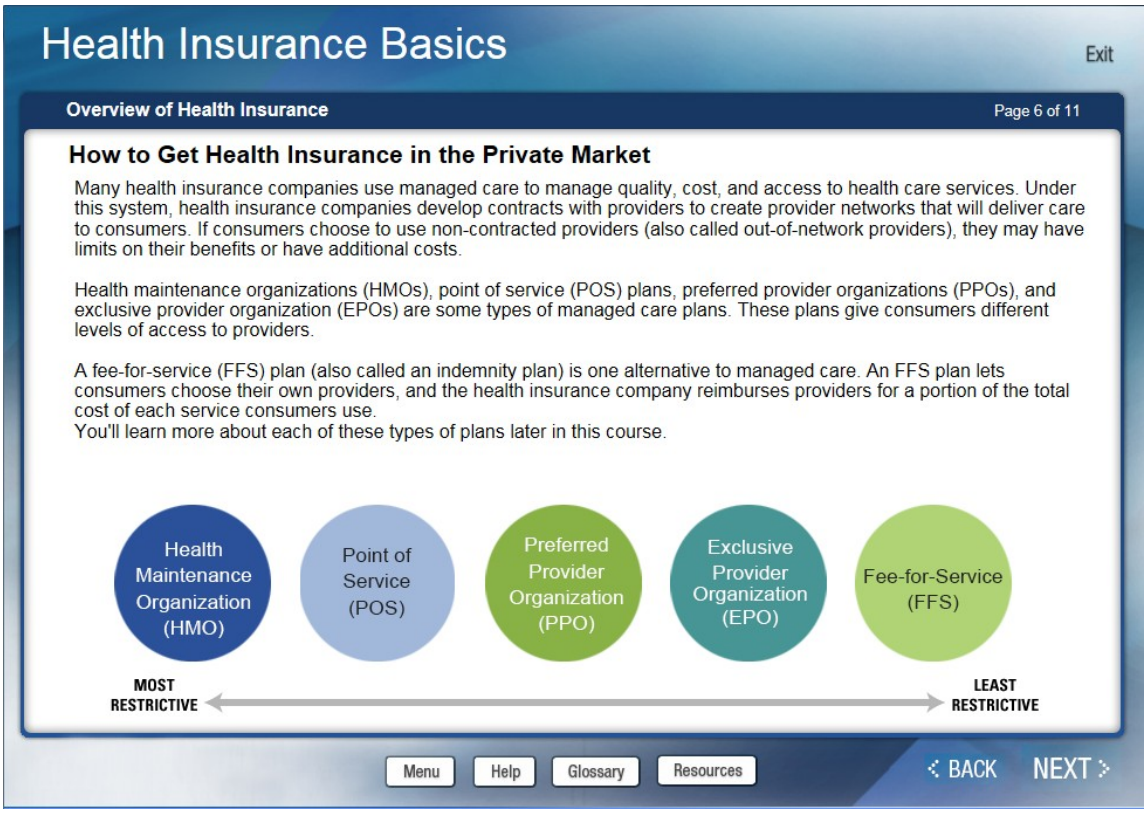
Health insurance companies often contract with certain hospitals, doctors, pharmacies, and other health care providers to deliver medical services for an agreed-upon rate. These groups are known as a health insurance company's provider network.

Health insurance companies create various provider networks to develop different health plan options for plan members to choose from. Before they enroll, it's important for consumers to carefully review provider networks to make sure the doctors they want to see and the pharmacies they want to use participate in their desired health plan. It is strongly recommended that consumers contact their doctors and pharmacies directly to confirm that they are participating in the plan the consumer has chosen.

Consumers generally must renew their participation in their health insurance every year. They may change their health plans when it's time to renew coverage, usually during an open enrollment period, or if they qualify for a special enrollment period (SEP) during the coverage year. SEPs will be covered later in this training.

Definition of Special Enrollment Period (SEP)

Outside of open enrollment periods, consumers generally can enroll in health coverage through a Marketplace only if they qualify for a special enrollment period (SEP).



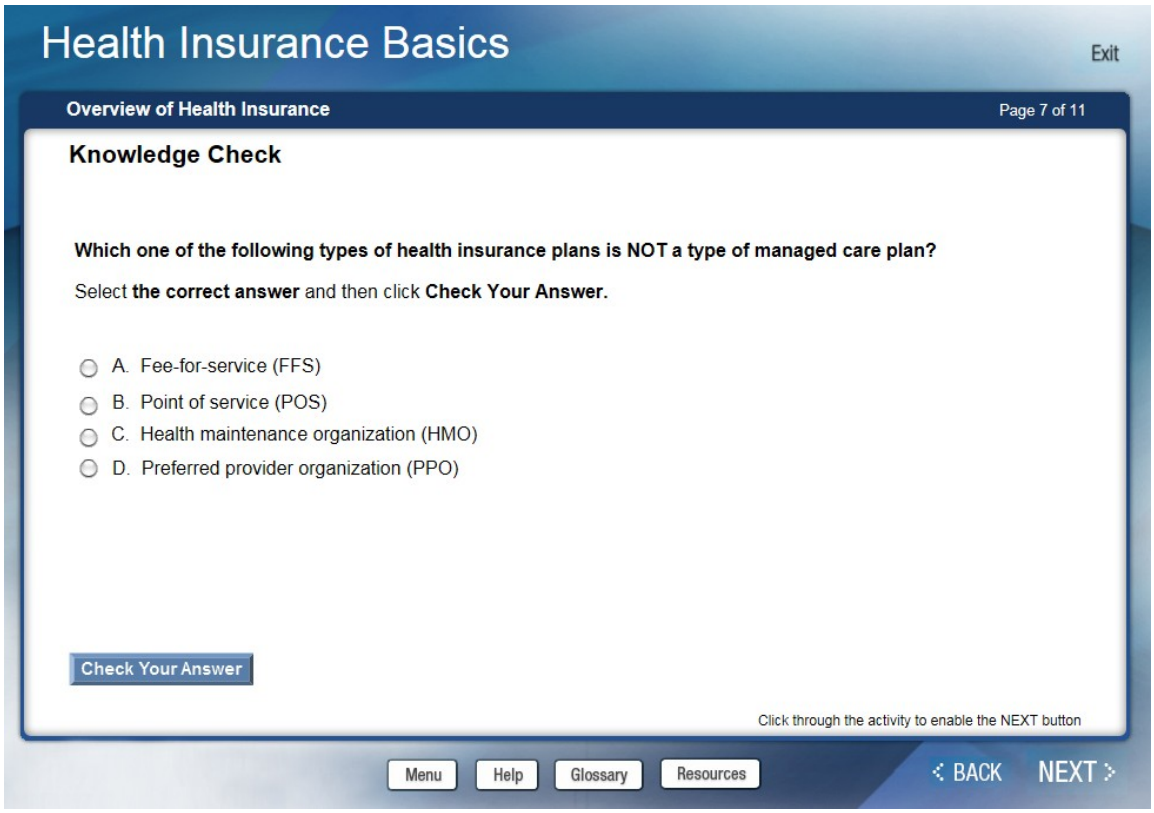
How to Get Health Insurance in the Private Market

Many health insurance companies use managed care to manage quality, cost, and access to health care services. Under this system, health insurance companies develop contracts with providers to create provider networks that will deliver care to consumers. If consumers choose to use non-contracted providers (also called out-of-network providers), they may have limits on their benefits or have additional costs.

Health maintenance organizations (HMOs), point of service (POS) plans, preferred provider organizations (PPOs), and exclusive provider organization (EPOs) are some types of managed care plans. These plans give consumers different levels of access to providers.

A fee-for-service (FFS) plan (also called an indemnity plan) is one alternative to managed care. An FFS plan lets consumers choose their own providers, and the health insurance company reimburses providers for a portion of the total cost of each service consumers use.

You'll learn more about each of these types of plans later in this course.



Knowledge Check

Which one of the following types of health insurance plans is NOT a type of managed care plan?

Select **the correct answer**.

A. Fee-for-service (FFS)

B. Point of service (POS)

C. Health maintenance organization (HMO)

D. Preferred provider organization (PPO)

Feedback: The correct answer is A. A fee-for-service (FFS) plan is NOT a type of managed care plan, but a way of delivering services where consumers can freely choose their own providers.

How to Get Health Insurance in the Private Market

You may need to explain the different ways consumers can get health insurance. Health insurance programs can be run by private organizations (including non-profits) or by government agencies.

Health Insurance Through the Marketplace

Qualified consumers can enroll in individual market health coverage through the Marketplaces during the Open Enrollment period. For plan year 2017, Open Enrollment in Marketplace plans will begin on November 1, 2016, and end on January 31, 2017. The insurance plans offered in the Marketplaces are called qualified health plans (QHPs). The Marketplaces certify each QHP sold in a state. This means the plan, among other things, must provide a comprehensive benefits package (known as essential health benefits) and follow limits on cost sharing.

During Open Enrollment, if consumers enroll between November 1st and December 15th, their coverage starts on January 1st. If they enroll between December 16th and January 15th, their coverage starts on February 1st. And if they enroll between January 16 and January 31, their coverage begins on March 1st. Outside of Open Enrollment, consumers may enroll in coverage through the Marketplaces if they qualify for an SEP. (The Marketplace Enrollment and Appeals Assistance course goes into further detail on SEPs.)

Health Insurance Outside the Marketplace

Consumers can get individual market health insurance directly through a health insurance company that sells insurance outside of the Marketplaces. While health insurance companies are only required to accept enrollments outside the Marketplaces during the Open Enrollment period and certain other special and limited enrollment periods, consumers may also be able to enroll outside of the Marketplace Open Enrollment period. Coverage becomes effective based on the date a plan was selected, along the same timelines that apply in the Marketplaces. However, if they purchase health insurance outside of the Marketplaces, consumers won't benefit from Marketplace programs to help lower the cost of a QHP and covered services, even if their income is low.

Note: Plans offered outside the Marketplaces may not meet all of the same standards as QHPs.

Job-based Insurance

Consumers who are currently employed may be able to purchase employer- sponsored or job-based insurance through their employers.

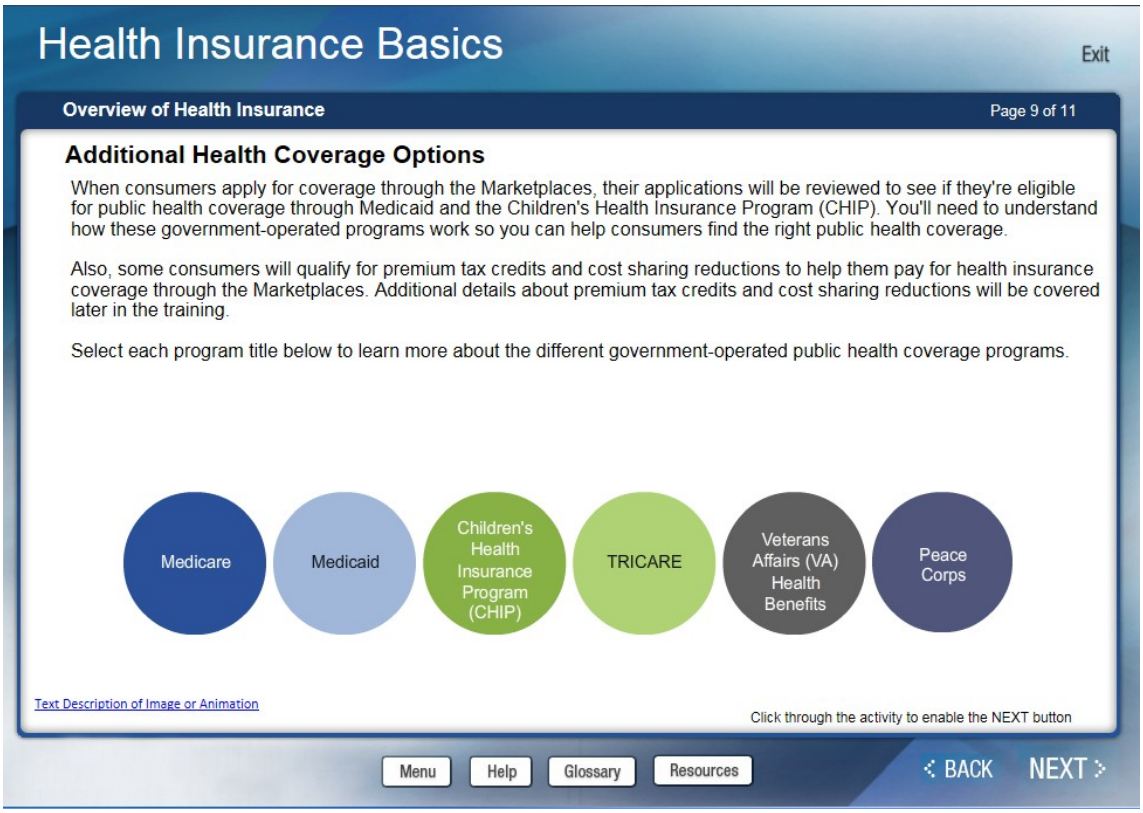
COBRA

Consolidated Omnibus Budget Reconciliation Act (COBRA) lets consumers continue with their existing health insurance coverage for a limited period of time, typically at a higher cost than when they were employed, as employers aren't required to pay any portion of the premiums.

Instead of choosing COBRA, qualified consumers who lose job-based health insurance coverage generally may enroll in coverage through a Marketplace or outside the Marketplaces. Note that there are special rules around enrolling in Marketplace coverage for consumers who have COBRA coverage. If consumers' COBRA coverage expires outside of the Open Enrollment period, then they're eligible for an SEP. If consumers choose to discontinue their COBRA coverage outside of the Open Enrollment period, they may not be eligible to apply for coverage through the Marketplaces until the next Open Enrollment period. HealthCare.gov provides additional details regarding COBRA coverage and the Marketplace.

Insurance Under a Parent's Policy

In all states, young adults are eligible to enroll in or remain on health insurance coverage under their parents' health insurance plans if those plans cover dependents. Depending on the state, the law requires or authorizes carriers to cover young adults for the entirety of their 26th birth year until the end of the year.



Additional Health Coverage Options

When consumers apply for coverage through the Marketplaces, their applications will be reviewed to see if they're eligible for public health coverage through Medicaid and the Children's Health Insurance Program (CHIP). You'll need to understand how these government-operated programs work so you can help consumers find the right public health coverage.

Also, some consumers will qualify for premium tax credits and cost sharing reductions to help them pay for health insurance coverage through the Marketplaces. Additional details about premium tax credits and cost sharing reductions will be covered later in the training.

Medicare

Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD). Medicare beneficiaries pay a premium for such coverage or qualify for such benefits based on payment of payroll taxes or pay a premium for such coverage.

Medicaid

A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and in some states, other adults. The Federal government provides a portion of the funding for Medicaid and sets

guidelines for the program. States also have choices in how they design their program, so Medicaid varies state by state and may have a different name in your state.

Children's Health Insurance Program (CHIP)

CHIP is a program jointly funded by the federal and state governments that provides health coverage to uninsured low-income children and, in some states, pregnant women, in families with income too high to qualify for Medicaid but who can't afford private health insurance.

TRICARE

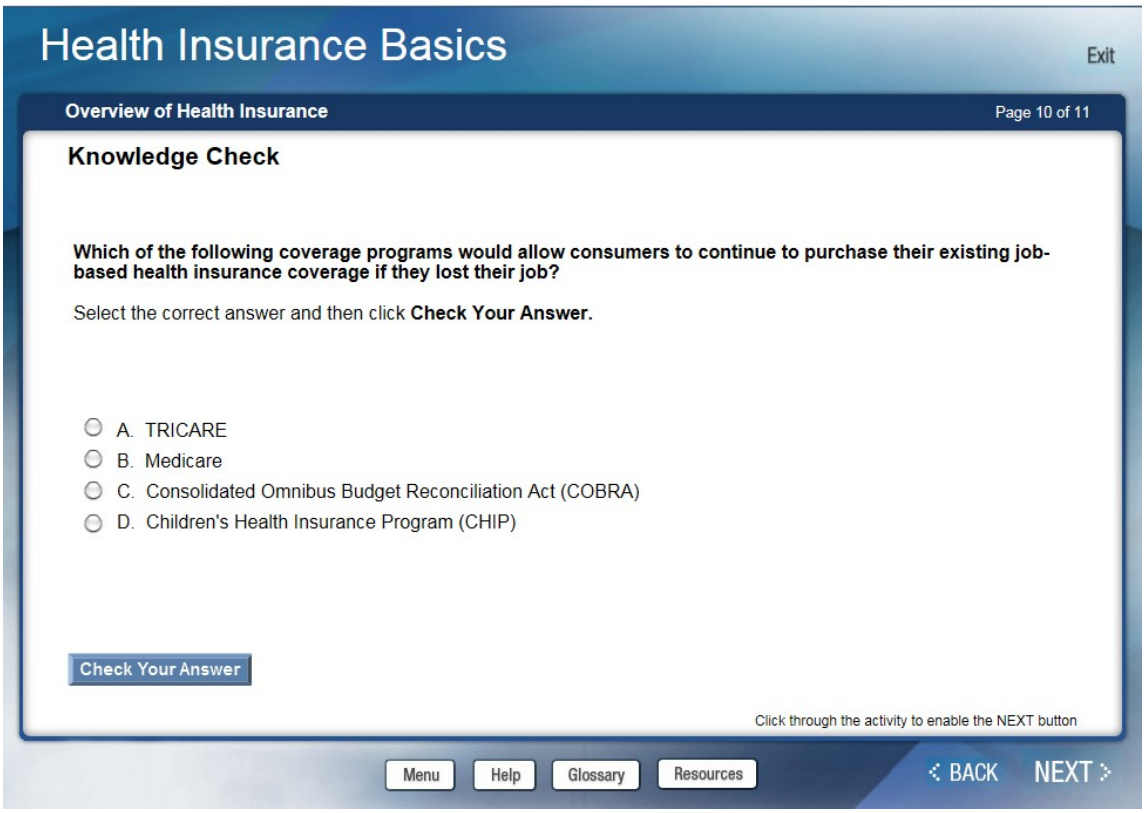
TRICARE is the Department of Defense (DoD) health care program available to eligible members and their families of the seven uniformed services: the U.S. Army, U.S. Navy, U.S. Air Force, U.S. Marine Corps, and U.S. Coast Guard, Commissioned Corps of the U.S. Public Health Service, and the National Oceanic and Atmospheric Administration.

Veterans Affairs (VA) Health Benefits

The U.S Department of Veterans Affairs (VA) provides health coverage for eligible veterans who served in the U.S military. The VA administers a variety of benefits and services that provide financial and other forms of assistance to service members, veterans, and their dependents and survivors.

Peace Corps

Peace Corps provides volunteers with comprehensive health and dental insurance during their Peace Corps service.



Knowledge Check

Which of the following coverage programs would allow consumers to continue to purchase their existing job-based health insurance coverage if they lost their job?

Select the correct answer.

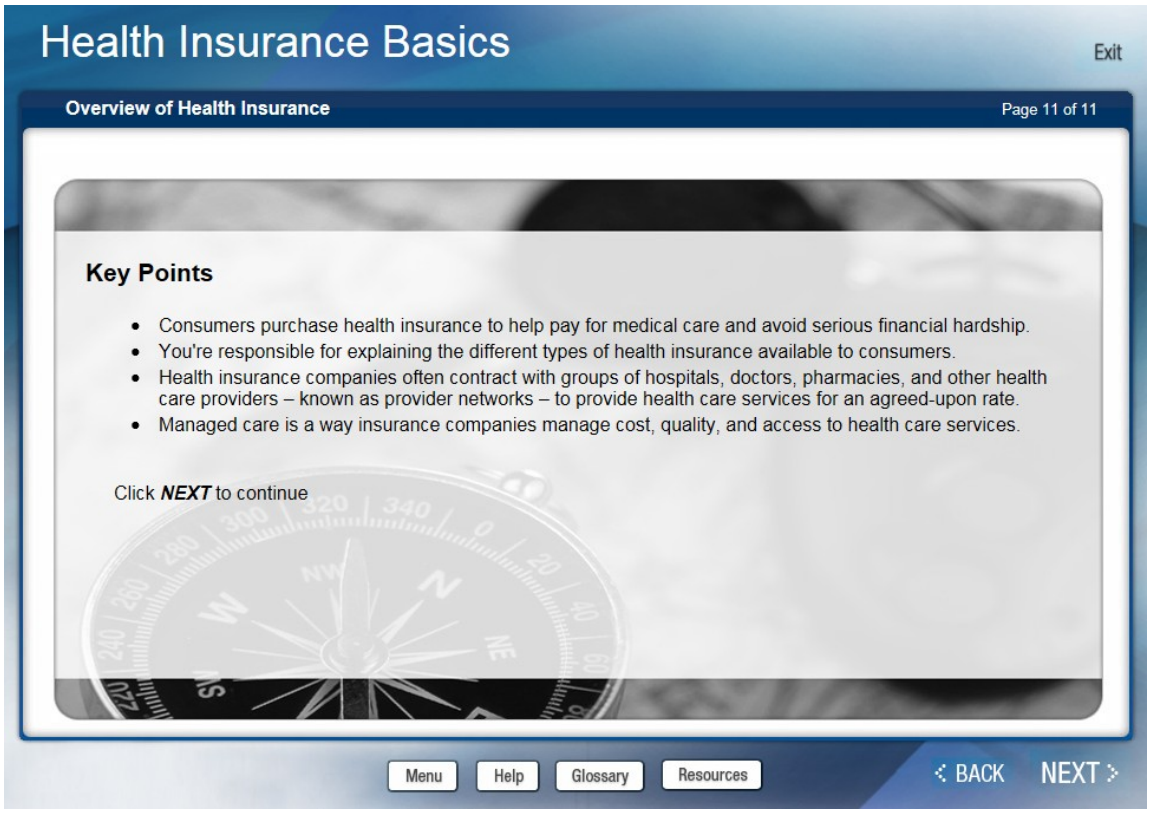
A. TRICARE

B. Medicare

C. Consolidated Omnibus Budget Reconciliation Act (COBRA)

D. Children's Health Insurance Program (CHIP)

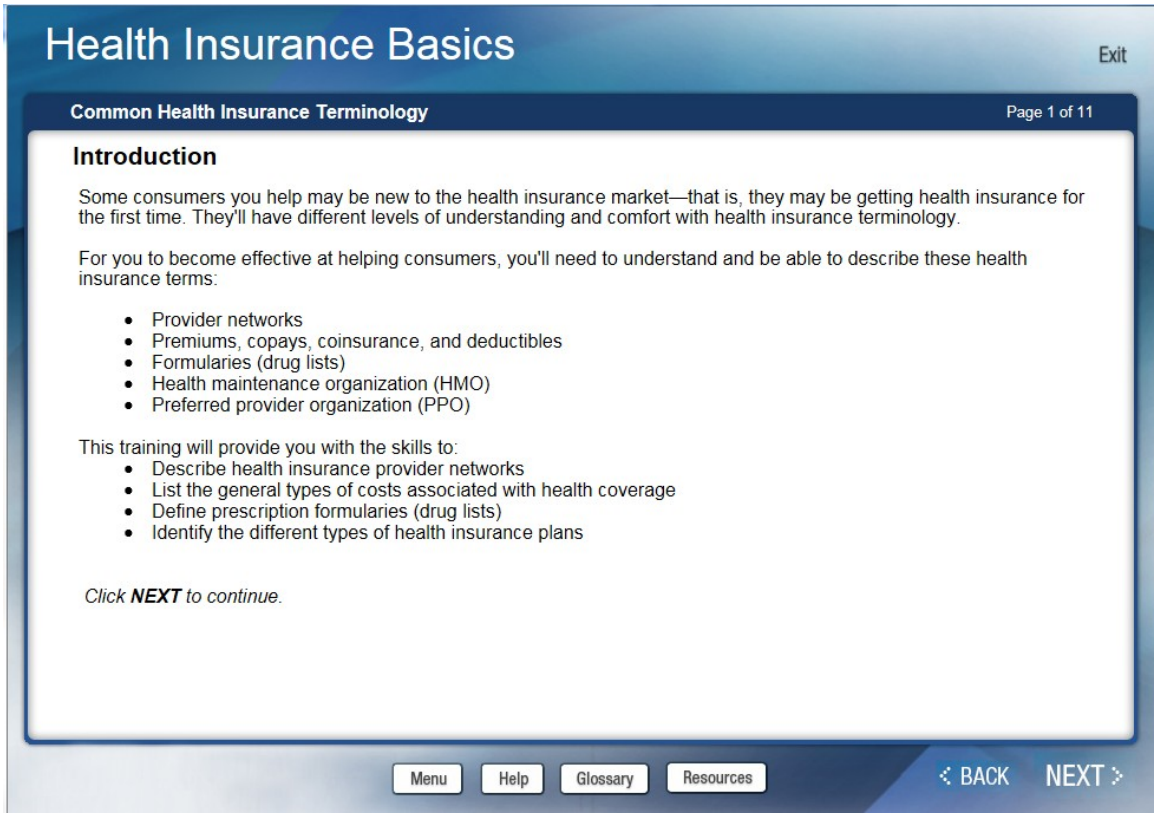
Feedback: The correct answer is C. COBRA lets consumers continue to purchase their same job-based health insurance if they lose or quit their jobs.



Key Points

- Consumers purchase health insurance to help pay for medical care and avoid serious financial hardship.
- You're responsible for explaining the different types of health insurance available to consumers.
- Health insurance companies often contract with groups of hospitals, doctors, pharmacies, and other health care providers – known as provider networks – to provide health care services for an agreed-upon rate.
- Managed care is a way insurance companies manage cost, quality, and access to health care services.

Common Health Insurance Terminology Module



Introduction

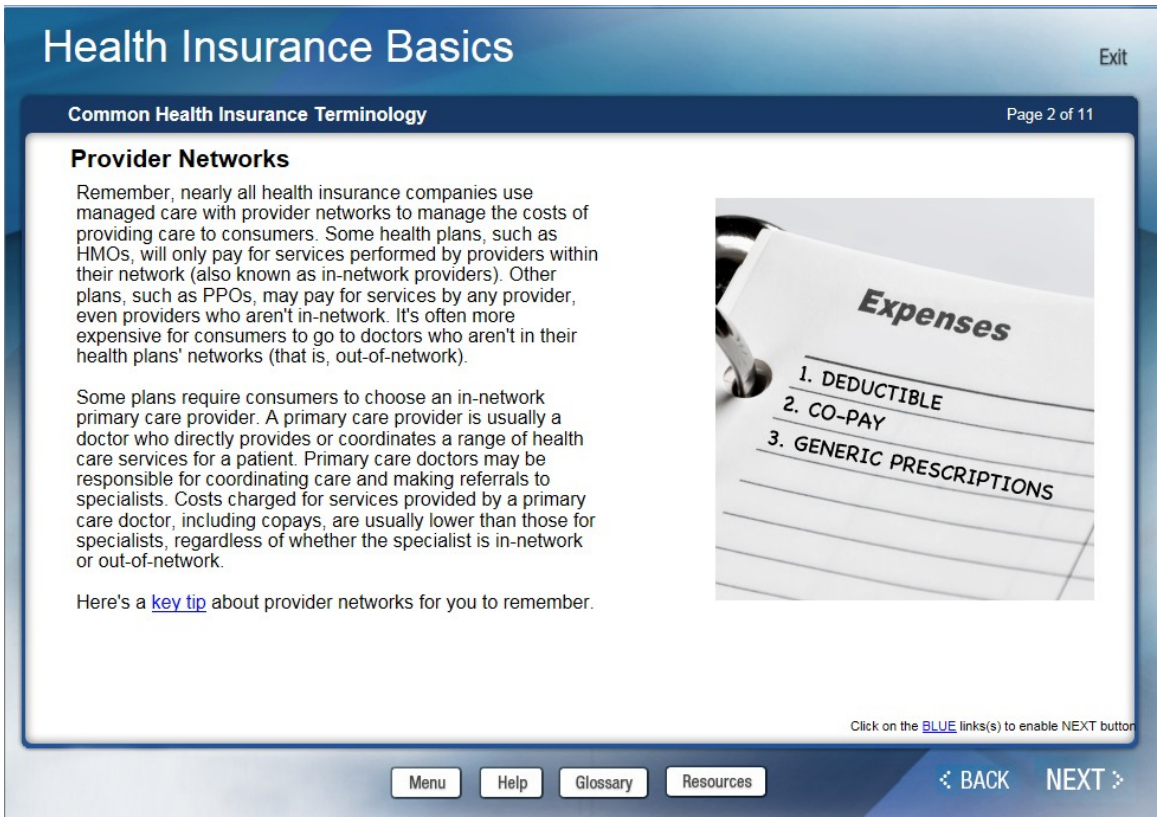
Some consumers you help may be new to the health insurance market—that is, they may be getting health insurance for the first time. They'll have different levels of understanding and comfort with health insurance terminology.

For you to become effective at helping consumers, you'll need to understand and be able to describe these health insurance terms:

- Provider networks
- Premiums, copays, coinsurance, and deductibles
- Formularies (drug lists)
- Health maintenance organization (HMO)
- Preferred provider organization (PPO)

This training will provide you with the skills to:

- Describe health insurance provider networks
- List the general types of costs associated with health coverage
- Define prescription formularies (drug lists)
- Identify the different types of health insurance plans



Provider Networks

Remember, nearly all health insurance companies use managed care with provider networks to manage the costs of providing care to consumers. Some health plans, such as HMOs, will only pay for services performed by providers within their network (also known as in-network providers). Other plans, such as PPOs, may pay for services by any provider, even providers who aren't in-network. It's often more expensive for consumers to go to doctors who aren't in their health plans' networks (that is, out-of-network).

Some plans require consumers to choose an in-network primary care provider. A primary care provider is usually a doctor who directly provides or coordinates a range of health care services for a patient. Primary care doctors may be responsible for coordinating care and making referrals to specialists. Costs charged for services provided by a primary care doctor, including copays, are usually lower than those for specialists, regardless of whether the specialist is in-network or out-of-network.

Here's a key tip about provider networks for you to remember.

Key Tip

When helping consumers compare Marketplace plans, advise them to make sure that any drug(s) they're currently taking are listed on a plan's drug formulary before enrolling in that plan.

Costs Associated with Health Insurance

To help consumers choose the right health coverage, you'll need to make sure they understand terms related to health insurance costs.

- Premium
- Copayment (or copay)
- Deductible
- Coinsurance
- Out-of-Pocket

Premium

A premium is the amount that must be paid to a health insurance company for a health insurance plan. Consumers and/or their employers usually pay it every month.

Copayment (or copay)

A copayment is a fixed amount (e.g., $15) consumers pay to the health care provider for a covered health care service, usually at the time of service. The amount can vary by the type of covered service, such as seeing a doctor, filling a prescription, or going to the emergency room. Copays are generally lower for services delivered by primary care

doctors and higher for services delivered by specialists. Remember that copays for in-network providers are typically lower than copays for out-of network providers. Copays are also typically lower for generic prescription drugs than for brand name prescription drugs.

Deductible

A deductible is the amount consumers owe for health care services before their health insurance plans begin to pay. Premiums and copays don't count towards the deductible. For example, if a consumer's deductible is $1,000, the plan won't pay anything until the consumer has paid $1,000 for covered health care services. However, some health care services aren't subject to the deductible and may be covered by health insurance plans, even if consumers haven't met the deductible. The deductible may not apply to all services.

Coinsurance

Coinsurance is a consumer's share of the cost of a covered health care service, calculated as a percent (e.g., 20%) of the amount allowed by the health plan for that service. Consumers pay coinsurance plus any deductibles that they owe. For example, if the health insurance plan's allowed amount for an office visit is $100 and a consumer has met the deductible, the coinsurance payment of 20% would be $20. The health insurance plan pays the rest of the amount owed. Some plans may require both a copay and coinsurance for particular types of services.

Out-of-Pocket

Out-of-pocket costs are your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services. You'll pay these out-of-pocket costs in addition to your monthly premiums. You may be eligible for savings on out-of-pocket costs, called cost-sharing reductions, based on your household income and size.

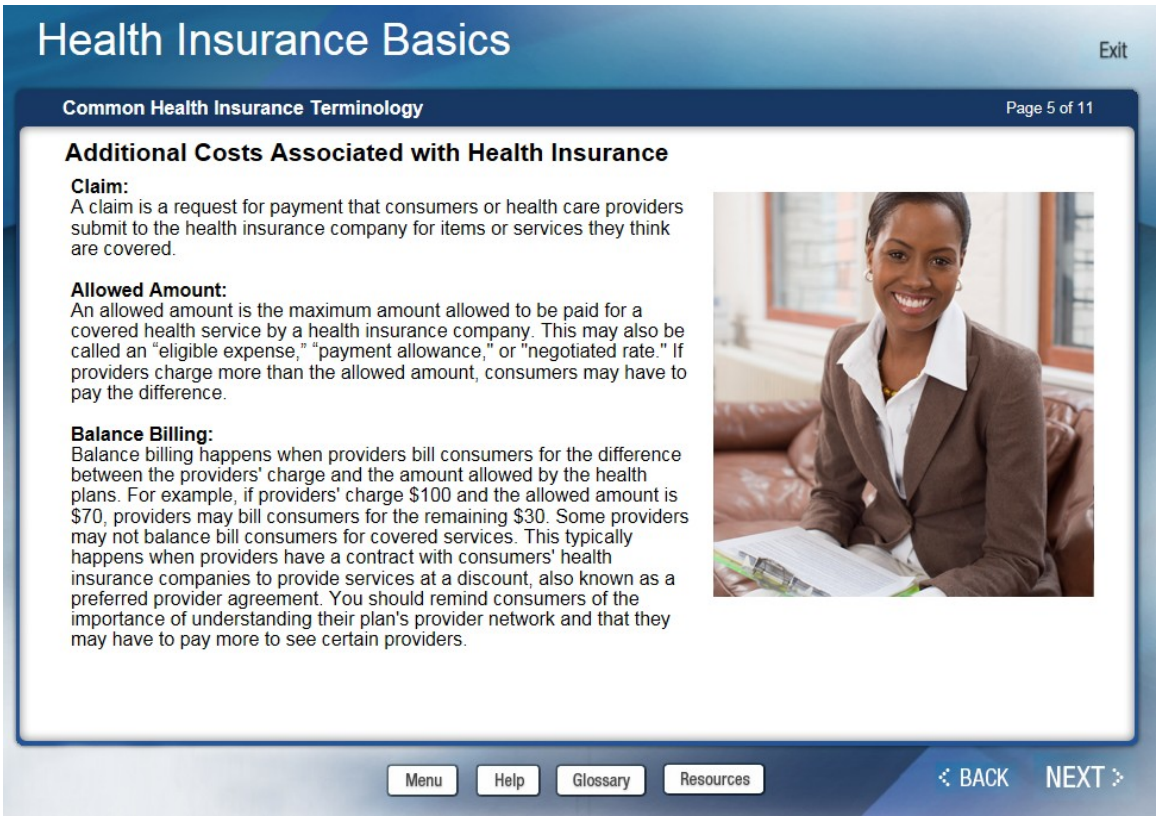
The amount you pay is limited by an out-of-pocket maximum. After you reach your out-of-pocket maximum, your insurance company must pay for all of your covered essential health benefits. This limit includes deductibles, copayments, coinsurance, and any other amount that you may be required to pay for essential health benefits. This limit doesn't include premiums, extra amounts you pay for out-of-network cost-sharing, or the cost of benefits that are not considered essential.

Costs Associated with Health Insurance (cont.)

A man and woman are discussing coinsurance with an Assister. The female consumer is looking over the shoulder of the male consumer who is in the middle.

The woman says, "Wow. I didn't realize coinsurance was that important. What's it going to cost me for my knee surgery?"

The Assister says, "If the coinsurance on your managed care plan is 20%, then you'll pay for the deductible on your plan plus 20% of the covered expenses for your knee surgery. Keep in mind that your covered expenses will be significantly lower if you have your knee surgery done in a hospital that's part of your managed care plan's provider network."



Additional Costs Associated with Health Insurance

Claim

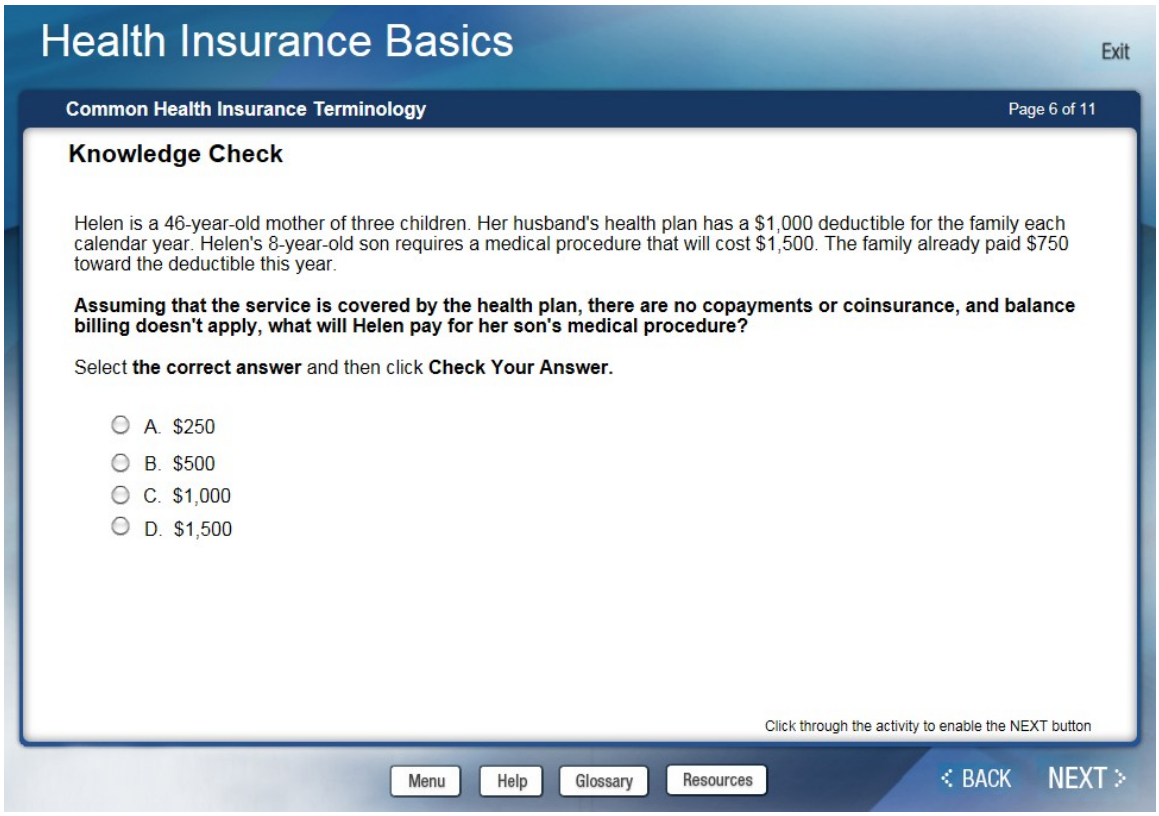
A claim is a request for payment that consumers or health care providers submit to the health insurance company for items or services they think are covered.

Allowed Amount

An allowed amount is the maximum amount allowed to be paid for a covered health service by a health insurance company. This may also be called an “eligible expense,” “payment allowance," or "negotiated rate." If providers charge more than the allowed amount, consumers may have to pay the difference.

Balance Billing

Balance billing happens when providers bill consumers for the difference between the providers' charge and the amount allowed by the health plans. For example, if providers' charge $100 and the allowed amount is $70, providers may bill consumers for the remaining $30. Some providers may not balance bill consumers for covered services. This typically happens when providers have a contract with consumers' health insurance companies to provide services at a discount, also known as a preferred provider agreement. You should remind consumers of the importance of understanding their plan's provider network and that they may have to pay more to see certain providers.



Knowledge Check

Helen is a 46-year-old mother of three children. Her husband's health plan has a $1,000 deductible for the family each calendar year. Helen's 8-year-old son requires a medical procedure that will cost $1,500. The family already paid $750 toward the deductible this year.

Assuming that the service is covered by the health plan, there are no copayments or coinsurance, and balance billing doesn't apply, what will Helen pay for her son's medical procedure?

Select **the correct answer**.

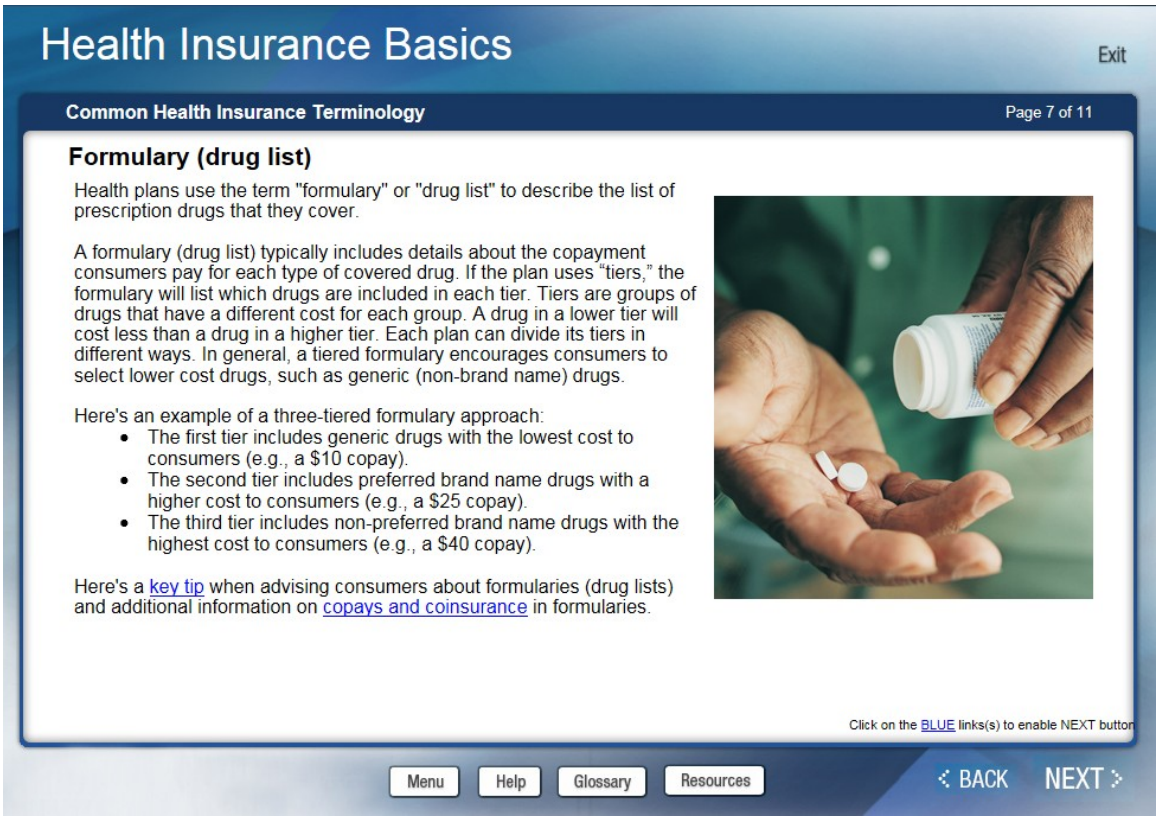
A. $250

B. $500

C. $1,000

D. $1,500

Feedback: The correct answer is A. Helen's cost for her son's medical procedure will be $250 since this is the remaining balance on the $1,000 annual deductible before the health plan will pay any expenses for covered health care services.



Formulary (drug list)

Health plans use the term "formulary" or "drug list" to describe the list of prescription drugs that they cover.

A formulary (drug list) typically includes details about the copayment consumers pay for each type of covered drug. If the plan uses “tiers,” the formulary will list which drugs are included in each tier. Tiers are groups of drugs that have a different cost for each group. A drug in a lower tier will cost less than a drug in a higher tier. Each plan can divide its tiers in different ways. In general, a tiered formulary encourages consumers to select lower cost drugs, such as generic (non-brand name) drugs.

Here's an example of a three-tiered formulary approach:

- The first tier includes generic drugs with the lowest cost to consumers (e.g., a $10 copay).
- The second tier includes preferred brand name drugs with a higher cost to consumers (e.g., a $25 copay).
- The third tier includes non-preferred brand name drugs with the highest cost to consumers (e.g., a $40 copay).

Here's a key tip when advising consumers about formularies (drug lists) and additional information on copays and coinsurance in formularies.

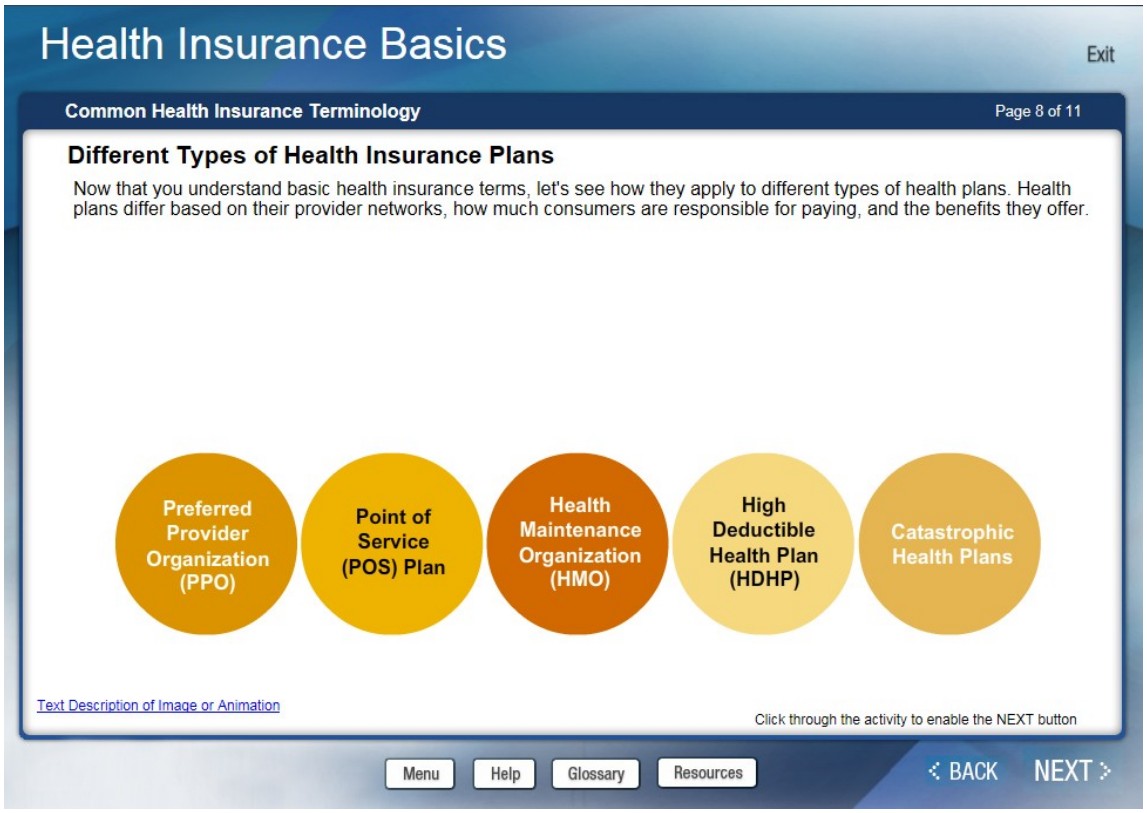
Key Tip

When helping consumers compare plans through the Marketplace, advise them to make sure that any drug(s) they're currently taking are listed on a plan's drug formulary before enrolling in that plan.

Additional Information: Copays and Coinsurance in Formularies

Note that some plans use coinsurance for prescription drugs instead of copays. As you've learned, coinsurance requires consumers to pay a percentage of the total cost of a procedure or drug, instead of a set amount. For brand name drugs, this can be very costly.

For example, a 20% coinsurance for a $1,000 drug would cost a consumer $200. That same drug under a plan that charges copays might cost only $40. Be sure to ask consumers to consider what types of drugs they currently take when choosing a plan. Plans that charge copays for prescription drugs may be more affordable for certain consumers than plans that charge coinsurance for prescription drugs.



Different Types of Health Insurance Plans

Now that you understand basic health insurance terms, let's see how they apply to different types of health plans. Health plans differ based on their provider networks, how much consumers are responsible for paying, and the benefits they offer.

- Preferred Provider Organization (PPO)
- Point of Service (POS) Plan
- Health Maintenance Organization (HMO)
- High Deductible Health Plan (HDHP)
- Catastrophic Health Plan

Preferred Provider Organization (PPO)

A PPO is a type of health plan that contracts with health care providers, such as hospitals and doctors, to create a network of participating providers. Consumers pay less if they use providers that belong to the plan's network. Consumers can visit doctors, hospitals, and providers outside of the network at an additional cost. Referrals are not needed to see specialists. In exchange for greater access to providers, premiums are generally higher in a PPO than in an HMO.

Point of Service (POS) Plan

A POS plan is a type of plan in which consumers pay less if they use doctors, hospitals, and other health care providers that belong to the plan's network. With this type of plan, a consumer may go to out-of-network providers at a higher cost. Unlike PPO plans, POS plans require consumers to get a referral from their primary care doctor to see a specialist.

Health Maintenance Organization (HMO)

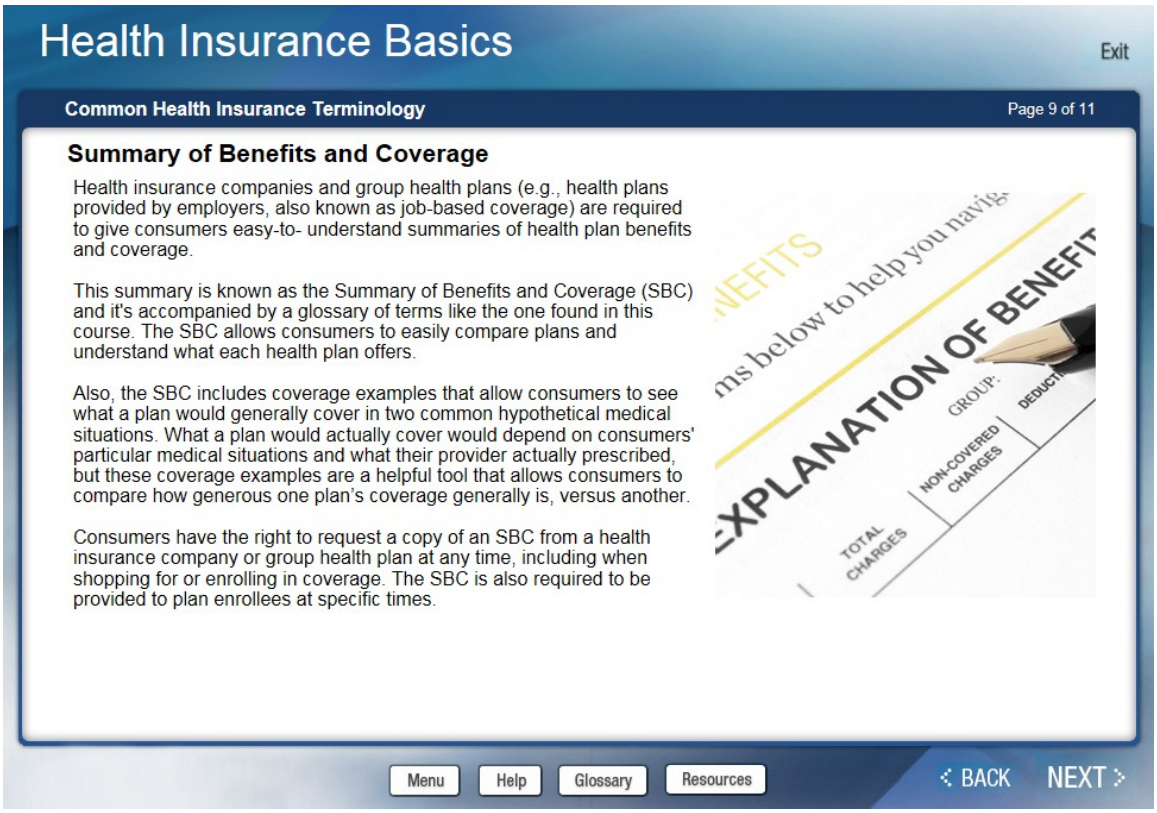
An HMO is a type of health insurance plan that usually limits coverage to care from in-network doctors who work for or contract with the HMO. HMO plans require consumers to get a referral from their primary care doctor to see a specialist, and they generally won't cover out-of-network care except in an emergency. An HMO may require consumers to live or work in its service area to be eligible for coverage. In exchange for the limited access to providers, premiums are typically lower in an HMO than in other types of plans.

High Deductible Health Plan (HDHP)

An HDHP is a type of health plan that features higher deductibles than traditional insurance plans, in exchange for lower monthly premiums. HDHPs can be combined with a health savings account (HSA) or a flexible spending account (FSA). HSAs and FSAs let a consumer pay for qualified out-of-pocket medical expenses on a pre-tax basis. The money that's contributed to an HSA or an FSA isn't subject to federal income tax at the time of deposit, but must be used to pay for qualified medical expenses. A consumer uses the money in the HSA to help meet the deductible before the HDHP kicks in. Funds contributed to an HSA roll over year-to-year if a consumer doesn't spend them, but FSA funds don't carry over from year to year. In other words, any FSA funds that consumers don't spend by the end of the plan year can't be used for expenses in the next year. HDHPs may not be appropriate for consumers with chronic or serious health conditions that require multiple specialist visits and procedures. It's important that you remind consumers to consider these financial factors before deciding on a plan.

Catastrophic Health Plan

A catastrophic health plan is designed to provide emergency services to protect consumers from unexpected medical costs, but it has limits on regular doctor visits. Generally, people under 30 years of age or people with hardship exemptions or affordability exemptions may buy a catastrophic health plan. The premium amount a consumer pays each month for a catastrophic health plan is generally lower than other types of plans, but the out-of-pocket costs for deductibles, copayments, and coinsurance are generally much higher.



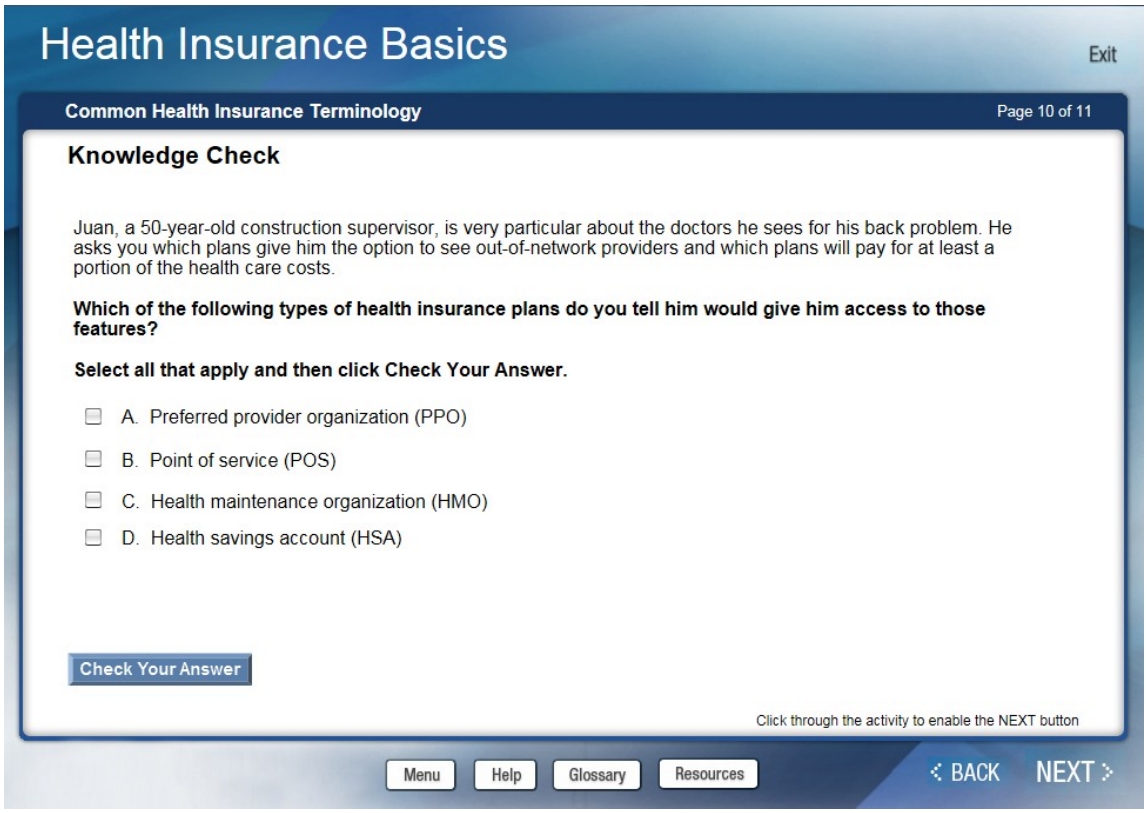
Summary of Benefits and Coverage

Health insurance companies and group health plans (e.g., health plans provided by employers, also known as job-based coverage) are required to give consumers easy-to-understand summaries of health plan benefits and coverage.

This summary is known as the Summary of Benefits and Coverage (SBC) and it's accompanied by a glossary of terms like the one found in this course. The SBC allows consumers to easily compare plans and understand what each health plan offers.

Also, the SBC includes coverage examples that allow consumers to see what a plan would generally cover in two common hypothetical medical situations. What a plan would actually cover would depend on consumers' particular medical situations and what their provider actually prescribed, but these coverage examples are a helpful tool that allows consumers to compare how generous one plan's coverage generally is, versus another.

Consumers have the right to request a copy of an SBC from a health insurance company or group health plan at any time, including when shopping for or enrolling in coverage. The SBC is also required to be provided to plan enrollees at specific times.



Knowledge Check

Juan, a 50-year-old construction supervisor, is very particular about the doctors he sees for his back problem. He asks you which plans give him the option to see out-of-network providers and which plans will pay for at least a portion of the health care costs.

Which of the following types of health insurance plans do you tell him would give him access to those features?

Select all that apply.

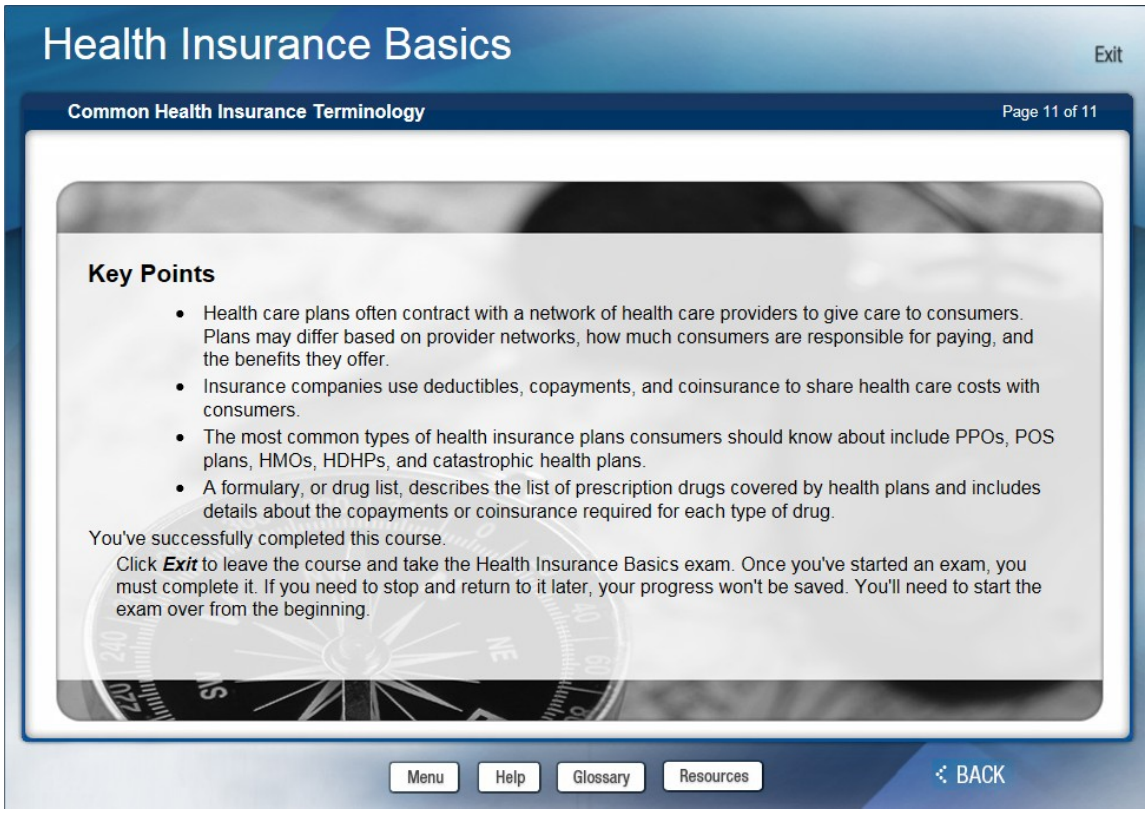
A. Preferred provider organization (PPO)

B. Point of service (POS)

C. Health maintenance organization (HMO)

D. Health savings account (HSA)

Feedback: The correct answers are A and B. PPO and POS plans could allow consumers to see out-of-network providers and will pay for a portion of those health care costs for covered benefits.



Key Points

- Health care plans often contract with a network of health care providers to give care to consumers. Plans may differ based on provider networks, how much consumers are responsible for paying, and the benefits they offer.
- Insurance companies use deductibles, copayments, and coinsurance to share health care costs with consumers.
- The most common types of health insurance plans consumers should know about include PPOs, POS plans, HMOs, HDHPs, and catastrophic health plans.
- A formulary, or drug list, describes the list of prescription drugs covered by health plans and includes details about the copayments or coinsurance required for each type of drug.

You've successfully completed this course.

Health Insurance Basics Resources

More About COBRA

Additional information for consumers who have health coverage through the Consolidated Omnibus Reconciliation Act (COBRA).

HealthCare.gov/what-if-i-currently-have-cobra-coverage/

Healthcare.gov Glossary

An index to reference key terms about health coverage.

http://www.healthcare.gov/glossary/