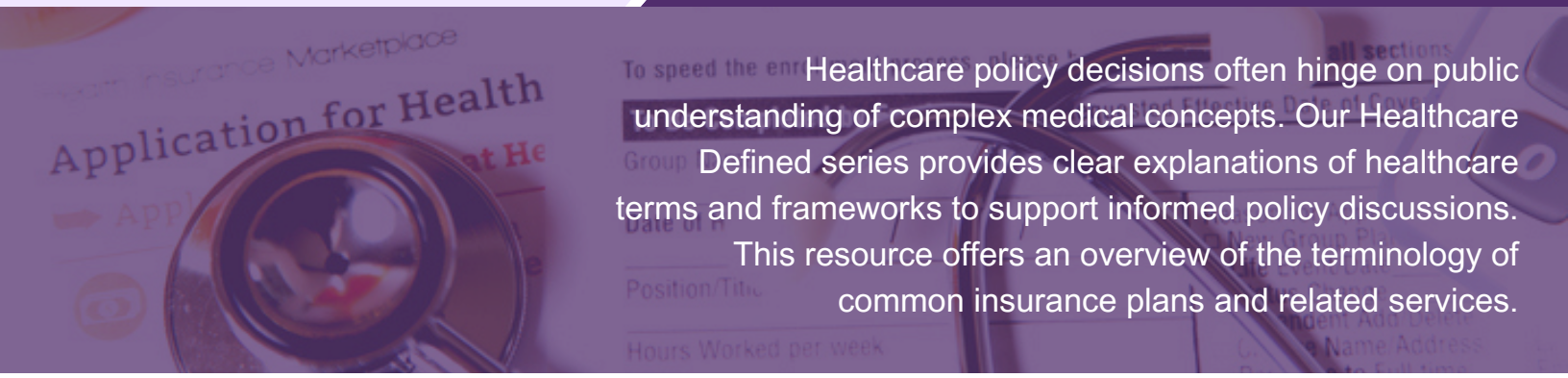
Center for Public Policy Solutions

HEALTHCARE DEFINED



Healthcare policy decisions often hinge on public understanding of complex medical concepts. Our Healthcare Defined series provides clear explanations of healthcare terms and frameworks to support informed policy discussions. This resource offers an overview of the terminology of common insurance plans and related services.

Navigating Insurance

Insurance Premium

An insurance premium is the amount an enrollee pays their insurance company to maintain an active policy. Premium rates change every year to reflect an insurance company's new contracts and other economic factors. The cost of an enrollee's premium is also influenced by where they purchased their plan: employer-based insurance, Medicaid, Medicare, Marketplace plans available through the Affordable Care Act (ACA), or other privately available plans. The type of plan, HMO, PPO, HDHP, is also a factor in premium and out-of-pocket costs for patients.

High Deductible Health Plans (HDHP)

Enrolling in a HDHP typically lowers monthly premiums for patients but requires them to pay higher deductibles than traditional plans. For 2026, enrollees in these plans may be required to pay up to $8,500 (individual plan) or $17,000 (family plan) to meet their deductible, before their plan begins cost sharing. HDHPs are typically used by younger individuals who are in good health and want a lower cost coverage option.

Health Savings Accounts (HSA)

To enroll in an HSA, a patient must first have an eligible HDHP. HSAs are tax-advantaged accounts that allow people to contribute a capped amount of money annually to pay for healthcare costs like doctor visits, prescriptions and certain over-the-counter items. HSAs may not be used to pay for health insurance premiums.

Health Maintenance Organization (HMO)

When a patient enrolls in an HMO, they are covered for care with a particular group of hospitals, doctors, and providers. The patient's primary care physician (PCP) usually coordinates care and provides referrals to in-network clinicians when specialized care is needed. Providers offer this care at a specific payment rate that gives HMOs the ability to monitor costs for their plan enrollees. HMO plans are typically associated with lower premiums and out-of-pocket costs for the patient. However, when enrolled in an HMO plan, patients are not covered for care from an out-of-network clinician unless the care is defined as a true medical emergency. The insurance company typically handles claims and pays the healthcare provider directly.

Preferred Provider Organizations (PPO)

A PPO gives patients greater flexibility in choosing their provider but at a higher cost than an HMO plan. PPO enrollees can access care from providers, regardless of their network, and don't need a referral to see a specialist. As a result, premiums and out-of-pocket related expenses associated with a PPO are typically higher than an HMO. Depending on the provider, there are also instances where patients may be required to provide payment at the time of service, then seek reimbursement from their insurance plan.

Premium Subsidy

Premium subsidies are refundable tax credits that reduce the cost of health insurance premiums on plans purchased through the Affordable Care Act Marketplace. Families with incomes between 100% and 400% of the federal poverty level are eligible for these subsidies. The credit can be paid directly to the insurer to lower the upfront cost of monthly premiums paid by the patient or it can be claimed by the patient later when filing taxes.

Enhanced Premium Tax Credit (EPTC)

Enhanced Premium Tax Credits were established in 2021 by the American Rescue Plan Act and extended by the 2022 Inflation Reduction Act. EPTCs eliminated the 400% federal poverty level income cap and limited premiums to a maximum of 8.5% of household income, enabling more patients to afford to access health insurance coverage. EPTCs were in addition to already established premium subsidies for ACA Marketplace plans. EPTCs expired on December 31, 2025.

Open Enrollment

Open enrollment refers to the annual period during which individuals select their health insurance coverage for the coming year. Individuals may choose to enroll in a plan from a new insurer, maintain existing coverage by re-enrolling in their current plan, or adjust their current coverage by adding or dropping dependents, updating their medical conditions, or selecting new benefits. Coverage cannot be obtained or changed outside of the open enrollment period, barring a significant life event.