

Health Care and Insurance Related Acronyms

ACA	Affordable Care Act	LTC	Long Term Care
APTC	Advanced Premium Tax Credit	MCO	Managed Care Organization
CHIP	Children's Health Insurance Program	MLR	Medical Loss Ratio
CMS	Centers for Medicare & Medicaid Services	MOOP	Maximum Out-of-Pocket
COBRA	Consolidated Omnibus Budget Reconciliation Act	OEP	Open Enrollment Period
CSR	Cost-Sharing Reduction	OON	Out-of-Network
DUR	Drug Utilization Review	OOP	Out-of-Pocket
DME	Durable Medical Equipment	PA	Prior Authorization
ED	Emergency Department	PBM	Pharmacy Benefit Manager
EHB	Essential Health Benefits	PCP	Primary Care Provider
EMR	Electronic Medical Record	PDL	Preferred Drug List
EOB	Explanation of Benefits	POS	Point-of-Service Plan
EPO	Exclusive Provider Organization	PPO	Preferred Provider Organization
ERISA	Employee Retirement Income Security Act	QHP	Qualified Health Plan
ESI	Employer-sponsored Insurance	SBC	Summary of Benefits and Coverage
FDA	Food and Drug Administration	SEP	Special Enrollment Period
FFS	Fee-for-service	SNF	Skilled Nursing Facility
FPL	Federal Poverty Level	SPP	Specialty Pharmacy Provider
FSA	Flexible Spending Account	SSDI	Social Security Disability Income
HSA	Health Savings Account	SSI	Supplemental Security Income
HDHP	High Deductible Health Plan	TPA	Third Party Administrator

Health Care and Insurance Related Terms

A

Accountable Care Organization (ACO)

A group of health care providers that give coordinated care for chronic disease management with the goal of improving the quality of patient care. The “organization’s” payment is tied to achieving health care quality goals and outcomes that result in cost savings. ACOs can include various types of doctors – primary care, specialists, etc. – as well as other medical providers (nurses, physician’s assistants, etc.) and institutions (hospitals, multi-physician practices).

Advanced Premium Tax Credit (APTC)

Also referred to as a premium tax credit, this tax credit provided for in the Affordable Care Act helps make coverage purchased in the Marketplace more affordable for consumers. Advance payments of the tax credit can be used right away to lower monthly premium costs. If the amount of advance credit payments a consumer gets for the year is less than the tax credit, the consumer will get the difference as a refundable credit when they file their federal income tax return. If the consumer’s advance payments for the year are more than the amount of their credit, they must repay the excess advance payments with their tax return.

Affordable Care Act (ACA)

Also known as the Patient Protection and Affordable Care Act (PPACA), health care reform (HCR) and Obamacare, it is the comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: PPACA was signed into law on March 23, 2010. It was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The Affordable Care Act refers to the final, amended version of the law.

Affordable Coverage (as it relates to the APTC)

Employer coverage is considered affordable - as it relates to the Advanced Premium Tax Credit (APTC) - if the employee’s share of the annual premium for self-only coverage is no greater than 8.39% of annual household income.

Allowed Amount

Discounted fees that insurers will recognize and pay for covered services. Insurers negotiate these discounts with providers in their health plan network. Network providers agree to accept the allowed charge as payment in full. Each insurer has its own schedule of allowed charges. If you go out-of-network to obtain care, you may be asked to pay the difference between the allowed amount and the provider’s charge, known as balance billing.

Annual Limit

A cap on the benefits your insurance company will pay in a year while you’re enrolled in a plan. Annual caps are sometimes placed on services such as physical therapy, occupational therapy, etc. Annual limits may be placed on the dollar amount of covered services or on the number of visits for a service. After the annual limit is reached, you must pay all associated health care costs for the rest of the year.

Appeal

A request for a health insurer or plan to review a decision to deny coverage for a service, either the payment for services received or prior approval for a service, your doctor has recommended for you.

B

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. Balance billing may occur when an individual goes out of network for care, whether intentionally or unintentionally. The No Surprises Act bans balance billing, particularly when individuals obtain out-of-network care unintentionally, known as "surprise billing."

Benefits

The health care items or services covered under a health insurance plan. Covered benefit and excluded services are defined in the health insurance plan's coverage documents.

Biologic

A biologic (also known as a biological product) is a type of complex medication such as a vaccine, blood or blood product, or other treatment that mimics proteins naturally present in the body. Rather than being created chemically like drugs, biologics are based on recombinant, cell or tissue-based proteins.

Biosimilar Biological Products

A biosimilar is the "follow-on" or subsequent version of a biologic. Biosimilars and biologic products have the same relationship that generic drugs have with brand name drugs, with an important distinction that due to their complexity, biosimilars are not identical to the original biologic product.

Bronze Health Plan

A plan in the health insurance Marketplace where the percentage the plan pays of the average overall cost of providing essential health benefits to members is 60%.

C

Capitation

A method of paying for health care services where providers receive a set payment for each person instead of receiving payment based on the number of services provided.

Care Coordination

The process of organizing your treatment across several health care providers. Medical homes and Accountable Care Organizations (see definition) are two common ways to coordinate care.

Center for Consumer Information and Insurance Oversight (CCIIO)

Located within the Centers for Medicare & Medicaid Services (part of the Department of Health & Human Services), the Center is the federal agency tasked with implementing many provisions of the Affordable Care Act related to private health insurance.

Centers for Disease Control and Prevention (CDC)

The federal agency responsible for protecting health and promoting quality of life through the prevention and control of disease, injury, and disability.

Centers for Medicare and Medicaid Services (CMS)

The federal agency that administers the Medicare, Medicaid, and Children's Health Insurance Programs, and implements many provisions of the ACA related to the health insurance Marketplaces.

Children's Health Insurance Program (CHIP)

Insurance program jointly funded by state and federal government that provides health insurance to low-income children. In some states, it covers pregnant women in families who earn too much income to qualify for Medicaid but cannot afford to purchase private health insurance coverage.

Children with Special Health Care Needs (CSHCN)

Maternal and Child Health Bureau (MCHB) defines CSHCN as those children that have or are at increased risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Claim

A request for payment that you or your health care provider submits to your health insurer after you receive covered items or services.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

A federal law that may allow you to temporarily keep health coverage if your employment ends or you are no longer eligible for coverage, you lose coverage as a dependent of the covered employee, or if there is another qualifying event. COBRA requires you pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

Coinsurance

A form of cost sharing that requires an insured person to pay a fixed percentage (rather than a set dollar amount) of expenses after the deductible amount, if any, was paid until the patient reaches their maximum out of pocket cost.

Note: coinsurance percentage amounts may differ depending on if the service or procedure was received by an in network or out of network provider or facility. Review your plan's Summary of Benefits document closely.

Consumer Assistance Program (CAP)

State programs are available to assist consumers with problems or questions concerning health care coverage. Consumers with questions can usually access the programs through phone or e-mail. See <https://www.cms.gov/ccio/resources/consumer-assistance-grants>.

Coordination of Benefits

A way to figure out who pays first when two or more health insurance plans are responsible for paying the same medical claim.

Copayment

A flat dollar amount you must pay for a covered program. Example: you may have to pay a \$15 copayment for each covered visit to a primary care doctor.

Note: copayment amounts differ depending on if the service or procedure was received by an in network or out of network provider or facility. Review your plan's summary of benefits document to determine the difference.

Copay Maximization Allowance Programs (also known as Copay Allowance Maximization Programs):

Generally, target a narrow list of specialty medications allowing plans to take advantage of the full annual value of the manufacturer copay coupons available on those drugs by increasing the beneficiary's monthly specialty copay amount, up to the monthly value of the copay coupon (annual face value of manufacturer copay coupon, divided by 12). Unlike the copay accumulator adjustment programs, the amount collected doesn't count towards the out of pocket. Given that this type of program changes the copays on some drugs (drug specific copays), health plans are required to update their summary plan description, making it more challenging for plans to implement. The uptake on these programs has been far more limited than that of the copay accumulator adjustment programs.

Cost Sharing

The share of costs covered by your insurance that you pay out-of-pocket. This share is commonly referred to as out-of-pocket (OOP) costs. The ACA sets an annual limit on out-of-pocket costs, which includes deductibles, coinsurance and copayments, or similar charges, but it doesn't include premiums, or the cost of non-covered services.

Note: separate cost sharing limits apply in Medicaid and CHIP, which include premiums.

Cost-Sharing Reduction (CSR)

A discount that lowers the amount you have to pay out-of-pocket for deductibles, coinsurance, and copayments. You can get this reduction only if you get health insurance through the Marketplace, your income is below a certain level, and you choose a Silver Health Plan (See "Metal Tiers" and "Silver Health Plan"). If you're a member of a federally recognized tribe, you may qualify for additional cost-sharing benefits.

D

Deductible

The amount you must pay for covered care before your health insurance begins to pay. Insurers apply and structure deductibles differently. Example: under one plan, a comprehensive deductible might apply to all services while another plan might have separate deductibles for benefits such as prescription drug coverage. Deductibles for family plans may be embedded or non-embedded. Under an embedded deductible, each family member must meet their own deductible until the overall family deductible amount has been met. Under a non-embedded deductible, the overall family deductible must be met before the plan begins to pay.

Dependent

A child or other individual for whom a parent, relative, or other person may claim a personal exemption tax deduction. Under ACA, individuals may be able to claim a premium tax credit to help cover the cost of coverage for themselves and their dependents.

Dependent Coverage

Insurance coverage for family members of the policyholder, such as spouse, children or partners. Under the ACA, all plans offering dependent coverage must cover dependents up to age 26, regardless of whether they are dependent, live at home, or are a student.

Disability

A limit in action, restriction or impairment that can be physical and/or mental. Different state, federal or private programs may have different disability standards. A legal definition of disability can be found at: www.ada.gov/pubs/ada.htm.

Donut Hole, Medicare Prescription Drug

Most plans with Medicare prescription drug coverage (Part D) have a coverage gap, called a donut hole. This means that after you and your drug plan have spent a certain amount of money for covered drugs, you have to pay all costs out-of-pocket for your prescriptions up to a yearly limit. Once you have spent up to the yearly limit, your coverage gap ends, and your drug plan helps pay for covered drugs again. For more information: [Medicare Part D Donut Hole](#).

Drug Utilization Review (DUR)

It is an ongoing review of prescribing, dispensing and use of medication. It is often used as a utilization management tool to control and promote more efficient use of scarce health care resources.

Dual Eligibles

A term used to describe an individual who is eligible for Medicare and for some level of Medicaid. Most duals qualify for full Medicaid benefits including nursing home services, and Medicaid pays their Medicare premiums and cost sharing. For other duals Medicaid provides the "Medicare Savings Programs" through which enrollees receive assistance with Medicare premiums, deductibles, and other cost sharing requirements.

E

Early Periodic Screening, Diagnostic & Treatment Services

The comprehensive set of benefits covered for children in Medicaid.

Electronic Medical Record (EMR)

A digital version of a paper chart that contains all of the patient's medical history from one practice.

Eligible Immigration Status

An immigration status that's considered eligible for getting health coverage through the Marketplaces. The rules concerning eligible immigration status differ for Medicaid and Marketplace coverage.

Emergency Department (ED)

Medical treatment facility that provides emergency room services.

Emergency Room Services

Evaluation and treatment of an illness, injury, or condition that needs immediate medical attention in an emergency room.

Employer Mandate

The ACA requires certain employers with at least 50 full-time employees (or equivalents) to offer health insurance coverage to their full-time employees and their dependents (but not spouses) that meet certain minimum standards.

Employer-Sponsored Insurance (ESI)

This is health insurance provided by an employer, who typically covers a portion of the costs. Sometimes it is called group health insurance. Plan options may include HMOs, PPOs, and EPOs, among others.

Employee Retirement Income Security Act of 1974 (ERISA)

A federal law that establishes standards for employer-sponsored health insurance, particularly for self-insured employer-sponsored plans. (See Self-Insured Plan). Some employer plans are subject to state health insurance laws, in particular, small employer plans. Most large employer plans (sometimes referred to as “ERISA plans”) and all self-insured plans are subject only to ERISA and not state health insurance laws. In the context of the ACA, ERISA plans are also exempt from some of the private health insurance reforms.

Essential Health Benefits (EHB)

A set of health care service categories that must be covered by certain plans. The ACA defines essential health benefits to “include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.”

EHB services are defined differently in each state, based on what is covered by their benchmark plan. Private health insurance policies sold to individuals and small employers must cover these benefits, regardless of whether the policy is offered inside or outside the Marketplaces. Only grandfathered individual health insurance policies may still impose an annual limit.

Exclusions

Items or services that aren’t covered under a contract for insurance and which an insurance company will not pay for.

Exclusive Provider Organization (EPO) Plan

A managed care plan in which services are covered only if you go to doctors, specialists or hospitals in the plan’s network (except in an emergency). EPOs are similar to HMOs except that individuals may not need a referral from a primary care physician to see a specialist.

Explanation of Benefits (EOB)

A form sent by an insurance company to an insured that includes such items as a summary of the claims processed for an insured since their last claim, a summary of what the insurer paid for the claim and what the insured’s responsibility may be, and a summary of the person’s year-to-date costs in the plan.

External Review

A review of a plan’s decision to deny coverage for or payment of a service by an independent third-party not related to the plan. If the plan denies an appeal, an external review can be requested. In urgent situations, an external review may be requested even if the internal appeals process is not yet completed.

External review is available when the plan denies treatment based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; when the plan determines that the care is experimental and/or investigational; or for rescissions of coverage. An external review either upholds the plan’s decision or overturns all or some of the plan’s decision. All parties must accept this decision.

F

Federal Marketplace

A Marketplace that is run by the federal government. All Marketplaces must meet federal rules. States that operate their own Marketplace may have different rules but must meet federal minimum standards.

Federal Poverty Level (FPL)

A measure of income level issued annually by the Department of Health and Human Services. FPL is used to determine eligibility for certain programs and benefits. FPL varies based on family size. For more information on FPL please visit: <https://aspe.hhs.gov/topics/poverty-economic-mobility>. Many public health insurance programs set eligibility based on a percentage of the FPL.

Fee for Service (FFS)

A reimbursement plan in which doctors and other health care providers are paid for each service performed, such as for tests and office visits.

Flexible Spending Account (FSA)

Accounts offered and administered by employers that allow employees to set aside pre-tax dollars out of their paycheck to pay for the employee's share of insurance premiums or medical expenses not covered by the employer's health plan. The employer may also make contributions to an FSA. Typically, benefits or cash must be used within the given benefit year, or the employee loses the money. Flexible spending accounts can also be provided to cover childcare expenses, but those accounts must be established separately from medical FSAs.

Food and Drug Administration (FDA)

Is responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation. The FDA also provides accurate, science-based health information to the public.

Fully Insured Employer based Plan

A plan in which the employer contracts with another organization to assume financial responsibility for the enrollees' medical claims and for all incurred administrative costs.

G

Gold Health Plan

A plan in the health insurance Marketplaces where the percentage the plan pays of the average overall cost of providing essential health benefits to members is 80%.

Grandfathered Health Plan

As defined in the ACA, a group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010. Grandfathered plans are exempt from many changes required under the ACA.

Plans or policies may lose their grandfathered status if they make certain significant changes that reduce benefits or increase costs to consumers. A health plan must disclose in its plan documents if it is a grandfathered plan. It must also advise consumers how to contact the U.S. Department of Labor or HHS with questions.

Grievance

A complaint an insured communicates to his or her health insurer or plan.

Guaranteed Issue

A requirement that health plans must permit you to enroll regardless of health status, age, gender or other factors that might predict the use of health services. However, you can generally only enroll in coverage during an annual open enrollment period.

Guaranteed Renewal

A requirement that your health insurance issuer must offer to renew your policy as long as you continue to pay premiums.

H

Habilitative/Habilitation Services

Health care services that help you keep, learn, or improve skills and functionality for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Habilitative services are one of the 10 essential health benefits (EHBs).

Health Insurance Marketplace

Also known as a health insurance Exchange, these are new transparent and competitive health insurance Marketplaces where individuals and small businesses can buy qualified health plans that meet certain benefit and cost standards. Every state has a Marketplace.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA is a 1996 law that eliminated discrimination by health insurers for those with pre-existing medical conditions. It also sets important privacy and security standards for health care entities so that consumers' health information is protected.

Health Maintenance Organization (HMO)

An insurance plan that usually limits coverage to care by doctors who work for or contract with the HMO and will require you to get a referral from your primary care physician to see a specialist. Generally, it won't cover out-of-network care except in an emergency and may require you to live or work in its service area to be eligible for coverage.

Health Resources and Services Administration (HRSA)

An agency of the U.S. Department of Health and Human Services that works to improve access to health care services for people.

Health Savings Account (HSA)

A tax-exempt medical savings account that can be used to pay for current or future qualified medical expenses. The funds contributed to the account aren't subject to federal income tax at the time of deposit. Employers may make HSAs available to their employees or individuals can obtain HSAs from most financial institutions. In order to open an HSA, an individual must have health coverage under an HSA-qualified high deductible health plan (HDHP). Unlike a Flexible Spending Account (FSA), funds roll over year to year if you don't spend them.

High-Deductible Health Plan (HDHP)

A plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more of the health care costs yourself before the plan starts to pay its share (your deductible). An HDHP that meets federal standards for a minimum deductible can be combined with a health savings account (HAS) to allow you to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

Home and Community-based Services

Services and support provided by most state Medicaid programs in your home or community that give help with such daily tasks as bathing or dressing. Covered when provided by care workers or, if your state permits it, by your family.

Home Health Care

Health care services and supplies in your home that a doctor prescribes.

Individual Health Insurance Policy

Policies for people who aren't connected to job-based coverage. Individual health insurance policies are regulated under state and federal law. Note that the phrase "individual policies" when used in this way – policies that are unconnected to employment – can be used for policies that cover a single person or multiple people (families, mother and dependent child, husband and wife, etc.).

Lifetime Limit

A cap on the total lifetime benefits your insurance policy will cover (also known as a lifetime cap). Before passage of the ACA, many insurers set a lifetime dollar limit on benefits (like \$1 million) and would not pay for covered services once the limit was hit. As of September 2010, non-grandfathered health plans can no longer set lifetime dollar limits on the Essential Health Benefits (EHBs). Plans can continue to limit specific benefits by number (for example, covering only a certain number of visits).

Long-Term Care (LTC)

Medical and non-medical services provided to people who are unable to perform basic activities of daily living such as dressing or bathing. Long-term support and services can be provided at home, in the community, in assisted living or in nursing homes. Individuals may need long-term support and services at any age. Medicare and most health insurance plans don't pay for long-term care.

Managed Care Organization (MCO)

A group or organization that provides managed care plans.

Managed Care Plan

A plan that generally provides comprehensive health services to its members and offers financial incentives for patients to use the providers who belong to the plan. Examples include health maintenance organizations (HMO), preferred provider organizations (PPO), exclusive provider organizations (EPO) and point of service plans (POS).

Managed Care Provisions

Features within health plans that provide insurers with a way to manage the cost, use and quality of health care services received by group members. Examples of managed care provisions include:

- Preadmission certification - Authorization for hospital admission given by a health care provider to a group member prior to hospitalization. Failure to obtain a preadmission certification in non-emergencies reduces or eliminates the health care provider's obligation to pay for services rendered.
- Utilization review - The process of reviewing the appropriateness and quality of care provided to patients. Utilization review may take place before, during or after the services are rendered.
- Preadmission testing - Requirement designed to encourage patients to obtain necessary diagnostic services on an outpatient basis prior to nonemergency hospital admission. The testing is designed to reduce the length of a hospital stay.

- Nonemergency weekend admission restriction - A requirement that imposes limits on reimbursement to patients for nonemergency weekend hospital admissions.
- Second surgical opinion - A cost-management strategy that encourages or requires patients to obtain the opinion of another doctor after a physician has recommended that a nonemergency or elective surgery be performed. Programs may be voluntary or mandatory in that reimbursement is reduced or denied if the participant does not obtain the second opinion. Plans usually require that such opinions be obtained from board-certified specialists with no personal or financial interest in the outcome.

Maximum Out-of-Pocket (MOOP)

A yearly cap on the amount of money individuals are required to pay out-of-pocket for health care costs, excluding the premium cost.

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 and sets guidelines. States also have choices in how they design their program, so Medicaid programs and eligibility vary from state to state and may have a different name in your state. Under the ACA, states have the option to expand Medicaid coverage to all individuals with income under 138% of the FPL.

Medically Necessary

Services or supplies that are needed for the diagnosis or treatment of your health condition and meet accepted standards of medical practice.

Medicare

A federal health insurance program for people who are age 65 or older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease (ESRD)/ Medicare is composed of four parts:

Medicare Part A

Hospital insurance that helps cover inpatient care in hospitals, skilled nursing facilities, hospice and home care. Most beneficiaries are enrolled in Part A automatically.

Medicare Part B

Medical coverage that helps to cover medically necessary services like doctors' services, outpatient care, home health services and other medical services. Part B also covers some preventive services, and physician-administered drugs like clotting factor. Most beneficiaries are enrolled in Part B automatically.

Medicare Part C/Medicare Advantage (MA)

A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. There are many types of Medicare Advantage Plans (MAP) including HMOs, PPOS, Private Fee-for-Service Plans, Special Needs Plans and Medicare Medical Savings Account Plans. If you're enrolled in an MA plan, Medicare services are covered through the plan and aren't paid for under Parts A and B. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare Part D

An optional program that provides prescription drug coverage. There are two ways to get Medicare prescription drug coverage: through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that includes drug coverage. These plans are offered by insurance companies and other private companies approved by Medicare.

Minimum Essential Coverage (MEC)

The type of coverage an individual must have to meet the individual responsibility requirement under the ACA. This includes policies sold through a health insurance Marketplace, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage. The summary of benefits and coverage (SBC) for your plan must tell you if the plan is MEC. Note that some plans sold outside the Marketplace to individuals do not meet these standards and will not count toward the requirement to have coverage. Check with the insurance company for the plan to confirm whether it is “minimum essential coverage.”

Modified Adjusted Gross Income (MAGI)

The figure used to determine eligibility for lower costs in the Marketplace/Exchange and for Medicaid and CHIP. Generally, modified adjusted gross income is your adjusted gross income plus any tax-exempt Social Security, interest, or foreign income you have.

N

Navigator

An individual or organization that's trained to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplaces established pursuant to the ACA. Navigators assist consumers with completing eligibility and enrollment forms. These individuals and organizations are required to be unbiased, and their services are free to consumers.

Nondiscrimination

A requirement that job-based insurance not discriminate based on health status by denying or restricting health coverage or charging more. Job-based plans can restrict coverage based on other factors such as part-time employment that aren't related to health status.

O

Open Enrollment Period (OEP)

The time-period set up to allow you to choose from available plans, usually once a year.

Out-of-Pocket (OOP) Limit

The maximum amount you will be required to pay for covered services in a year, before the plan covers 100% of all costs. Generally, this includes the deductible, coinsurance, and copayments (varies from plan to plan), but not premiums. Plans can set different out-of-pocket limits for different services, and some plans do not have out-of-pocket limits.

P

Pay for Performance

A health care payment system where providers receive incentives for meeting or exceeding quality, and sometimes cost, benchmarks. Some systems also penalize providers who do not meet established benchmarks. The goal of pay for performance programs is to improve the quality of care over time.

Pharmacy Benefit Manager (PBM)

Health plans and sponsors contract with Pharmacy Benefit Managers to handle the claims processing and administrative functions involved with prescription drug programs. In addition to processing and paying claims, PBMs develop and maintain a program drug formulary, contract with participating pharmacies and negotiate discounts and rebates with drug manufacturers.

Plan Year

A 12-month period of benefits coverage under a health plan. This 12-month period might be different than the calendar year, depending on when your health plan renews. Sometimes referred to as Policy year.

Platinum Health Plan

A plan in the health insurance Marketplaces where the percentage the plan pays of the average overall cost of providing essential health benefits to members is 90%.

Point-of-Service Plan (POS) Plan

A type of plan in which you pay less if you use doctors, hospitals and other health care providers that belong to the plan's network. POS plans may also require you to get a referral from your primary care doctor in order to see a specialist.

Pre-Existing Condition

With certain limited exceptions, a pre-existing condition is any condition (physical, mental or a disability) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period before you enrolled in a health insurance plan. Before passage of the ACA, insurers could either not offer health insurance to you if you had a pre-existing condition or could refuse to cover any services related to a pre-existing condition (known as a pre-existing condition exclusion). Under the ACA non-grandfathered health insurance plans can't refuse to cover you or charge you more just because you have a pre-existing health condition.

Preferred Drug List (PDL)

A PDL is a list of medications that are covered without the need to obtain prior authorization. Drugs are designated as either preferred or non-preferred.

Preferred Provider Organization (PPO)

A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers who belong to the plan's network. You can use doctors, hospitals and providers outside of the network for an additional cost.

Premium

A monthly or annual payment you make to your insurer to get and keep insurance coverage. Premiums can be paid by employers, unions, employees or individuals or shared among different payers.

Prescription Drug Coverage

Health insurance or plan that helps pay for prescription drugs and medications.

Preventive Services

Routine health care that includes screenings, checkups, and patient counseling to prevent illnesses, disease or other health problems.

Primary Care

Health services that cover a range of prevention, wellness and treatment options for common illnesses. Primary care providers (PCP) include doctors, nurses, nurse practitioners and physician assistants. They advise and treat you on a range of health-related issues. They may also coordinate your care with specialists.

Primary Care Provider (PCP)

Includes doctors, nurses, nurse practitioners and physician assistants; they provide health services for a wide range of common illnesses, wellness and prevention.

Primary Care Case Management

A model of Medicaid managed care outlined in Medicaid law. State Medicaid agencies contract with primary care providers to provide, locate, coordinate, and monitor primary care services for Medicaid beneficiaries who select them or are assigned to them by the state. The primary care provider – usually a physician or a physician practice, but sometimes a nurse practitioner, physician assistant, or other provider – serves as a beneficiary’s “medical home” for primary and preventive care. Under their contracts with primary care providers, states pay them a small monthly case management fee in addition to regular FFS payments.

Prior Authorization (PA)

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

Provider Network

A list of *doctors*, other health care *providers*, and hospitals that a plan contracts with to provide medical care to its members.

Out-of-network Provider

A duly licensed or certified institution or health professional not under contract with your insurance provider.

In-Network Provider

A duly licensed or certified institution or health professional under contract with your insurance provider.

Q

Qualified Health Plan (QHP)

An insurance plan that is certified by a health insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts) and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

Qualifying Event

Any event or occurrence such as death, termination of employment, divorce or a terminal illness that changes an employee’s eligibility status and permits an acceleration or continuation of benefits or coverage under a group health plan. The term is most frequently used in reference to COBRA eligibility.

R

Rate Review

A process that allows state insurance departments to review rate increases before insurance companies can apply them to you.

Referral

A written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for the services.

Rehabilitative/Rehabilitation Services

Health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Rider (Exclusionary Rider)

An amendment to an insurance policy. Some riders add coverage while other riders exclude coverage (known as exclusionary rider). Example: You buy a maternity rider to add coverage for pregnancy to your policy. An exclusionary rider is an amendment permitted in individual policies that permanently excludes coverage for a health condition, body part or body system (such as a certain disease state or disability). Under the ACA, no exclusionary riders will be permitted in non-grandfathered health insurance plan.

Risk Adjustment

A statistical process that takes into account the underlying health status and health spending of the enrollees in an insurance plan when looking at their health care outcomes or health care costs.

S

Self-Insured Plan

Type of plan usually present in larger companies where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees' and dependents' medical claims. These employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third-party administrator, or they can be self-administered. Self-insured plans do not follow state insurance rules. They are regulated under the federal rule known as ERISA and overseen by the U.S. Department of Labor.

Silver Health Plan

A plan in the health insurance Marketplaces where the percentage the plan pays of the average overall cost of providing essential health benefits to members is 70%.

Skilled Nursing Facility (SNF) Care

Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Example: Physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Short-Term, Limited Duration Health Plans

These plans are low-cost, limited coverage insurance plans that are meant to help individuals who have a temporary gap in health insurance coverage. Insurers could offer a short-term plan for up to three (3) years. These plans typically do not cover pre-existing conditions, prescription drugs, or maternity care.

Small Business Health Options Program (SHOP)

The Marketplace is available to small businesses under the ACA. Small businesses buying plans in the SHOP select the plan and decide how much they pay toward employee premiums. Participating small businesses may qualify for a small business health tax credit worth up to 50% of their premium costs.

Social Security Disability Income (SSDI)

Income payable by the federal government to individuals who are determined to be totally disabled.

Supplemental Security Income (SSI)

Social Security administers this program. SSI pays monthly benefits to people with limited income and resources who are disabled, blind, or age 65 or older. Blind or disabled children may also receive SSI.

Special Enrollment Period (SEP)

A time outside of the open enrollment period during which you and your family have a right to sign up for health coverage. Job-based plans must generally provide a special enrollment period of 30 days following certain life events that involve a change in family status (such as marriage or birth of a child) or loss of other job-based health coverage. Plans sold to individuals, including Marketplace plans, must provide 60 days to enroll.

Specialty Pharmacy Provider (SPP)

A pharmacy designated to provide specialized medication for complex, genetic, rare, and chronic health conditions. Specialty pharmacy providers may provide home health or nursing services.

State Based Marketplace

One type of Marketplace option. States opting for an SBM/SBE manage their own Marketplace in accordance with applicable federal laws.

State Continuation Coverage

A state-based requirement similar to COBRA that applies to group health insurance policies for employers with fewer than 20 employees. In some states, state continuation coverage rules also apply to larger group insurance policies and add to COBRA protections. Example: in some states, if you're leaving a job-based plan, you must be allowed to continue your coverage until you reach the age of Medicare eligibility. One type of Marketplace option for states under the ACA. States opting for an SPM/ SPE will have a Marketplace that is run by the federal and state government jointly.

Summary of Benefits and Coverage (SBC)

The ACA requires plans to offer this easy-to-read summary that lets you make apples-to-apples comparisons of costs and coverage between health plans. You'll get the "Summary of Benefits and Coverage" (SBC) when you shop for coverage on your own or through your job, renew or change coverage, or request an SBC from the health insurance company.

Supplemental Security Income (SSI)

A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or 65 or older. SSI benefits are different than Social Security retirement or disability benefits.

T

Third Party Administrator (TPA)

An individual or firm hired by an employer to handle claims processing, pay providers and manage other functions related to the operation of health insurance. The TPA is not the policyholder or the insurer. The TPA may often be a company you associate with health insurance, such as Aetna or Blue Cross, but in this role, it is not the actual insurer but simply managing the plan on behalf of the employer.

TRICARE

A health care program for active-duty and retired uniformed services members and their families.

U

Urgent Care

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

Usual, Customary and Reasonable (UCR) Charges

A health care provider's usual fee for a service that does not exceed the customary fee in that geographic area and is reasonable based on the circumstances. Instead of UCR charges, PPO plans often operate based on a negotiated (fixed) schedule of fees that recognize charges for covered services up to a negotiated fixed dollar amount. Conventional indemnity plans typically operate based on UCR charges.

V

Veteran's Health Benefits

Veterans may be eligible for a broad range of services, including health care benefits, through the Veteran's Administration.

W

Waiting Period (Employer -Based coverage)

The time that must pass before coverage can become effective for an employee or dependent, who is otherwise eligible for coverage under a job-based health plan. Applies to all new employees and is not based on health status. Under the ACA, employer plans cannot impose a waiting period of more than 90 days.

Well-Baby/Well-Child Visits

Routine doctor visits for comprehensive preventive health services that occur when a baby is young and annual visits until a child reaches age 21. Services include physical exam and measurements, vision and hearing screening, and oral health risk assessments. Under the ACA's rules for preventive services, well child visits may be covered without cost-sharing.

Wellness Programs

A program intended to improve and promote health and fitness that's usually offered through the workplace, although insurance plans can offer them directly to their enrollees. The program allows your employer or plan to offer you premium discounts, cash rewards, gym memberships and other incentives to participate. Examples: programs to help you stop smoking, diabetes management programs, weight loss programs and preventive health screenings.

Sources:

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