

## Glossary of Health Insurance Terms

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law. When making decisions about health coverage, consumers should know the specific meanings of terms used to discuss health insurance. Below are definitions for some of the more commonly used terms and how PPACA impacts their use.

### -A-

**Actuarial justification** — The demonstration by an insurer that the premiums collected are reasonable, given the benefits provided under the plan or that the distribution of *premiums* among policyholders are proportional to the distribution of their expected costs, subject to limitations of state and federal law. PPACA requires insurers to publicly disclose the actuarial justifications behind unreasonable premium increases.

**Adjusted community rating** — A way of pricing insurance where *premiums* are not based upon a policyholder's health status, but may be based upon other factors, such as age and geographic location. PPACA requires the use of adjusted community rating, with maximum variation for age of 3:1 and for tobacco use of 1.5:1.

**Annual limit** — Many health insurance plans place dollar limits upon the claims the insurer will pay over the course of a plan year. PPACA prohibits annual limits for *essential benefits* for plan years beginning after Sept. 23, 2010.

### -B-

**Balance billing** — When you receive services from a health care provider that does not participate in your insurer's network, the health care provider is not obligated to accept the insurer's payment as payment in full and may bill you for unpaid amount. This is known as "balance billing."

### -C-

**CHIP** — The Children's Health Insurance Program (CHIP) provides coverage to low- and moderate-income children. Like *Medicaid*, it is jointly funded and administered by the states and the federal government. It was originally called the State Children's Health Insurance Program (SCHIP).

**COBRA coverage** — Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. COBRA provides certain former employees, retirees, spouses, former spouses and dependent children the right to temporary continuation of health coverage at group rates. The law generally covers health plans maintained by private-sector employers with 20 or more employees, employee organizations, or state or local governments. Many states have "mini-COBRA" laws that apply to the employees of employers with less than 20 employees.

**Coinsurance** — A percentage of a health care provider's charge for which the patient is financially responsible under the terms of the policy.

**Community rating** — A way of pricing insurance, where every policyholder pays the same premium, regardless of health status, age or other factors.

**Co-Op Plan** — A health insurance plan that will be sold by member-owned and operated non-profit organizations through *Exchanges* when they open in 2014. PPACA provides grants and loans to help Co-Op plans enter the marketplace.

**Co-payment** — A flat-dollar amount which a patient must pay when visiting a health care provider.

**Cost-sharing** — Health care provider charges for which a patient is responsible under the terms of a health plan. Common forms of cost-sharing include *deductibles*, *coinsurance* and *co-payments*. *Balance-billed* charges from *out-of-network physicians* are not considered cost-sharing. PPACA prohibits total cost-sharing exceed \$5,950 for an individual and \$11,900 for a family. These amounts will be adjusted annually to reflect the growth of premiums.

-D-

**Deductible** — A dollar amount that a patient must pay for health care services each year before the insurer will begin paying claims under a policy. PPACA limits annual deductibles for small group policies to \$2,000 for policies that cover an individual, and \$4,000 for other policies. These amounts will be adjusted annually to reflect the growth of premiums.

**Disease management** — A broad approach to appropriate coordination of the entire disease treatment process that often involves shifting away from more expensive inpatient and acute care to areas such as preventive medicine, patient counseling and education, and outpatient care. The process is intended to reduce health care costs and improve the quality of life for individuals by preventing or minimizing the effects of a disease, usually a chronic condition.

-E-

**ERISA** — The Employee Retirement Income Security Act of 1974 (ERISA) is a comprehensive and complex statute that federalizes the law of employee benefits. ERISA applies to most kinds of employee benefit plans, including plans covering health care benefits, which are called employee welfare benefit plans.

**Essential Benefits** — PPACA requires all health insurance plans sold after 2014 to include a basic package of benefits including hospitalization, outpatient services, maternity care, prescription drugs, emergency care and preventive services among other benefits. It also places restrictions on the amount of *cost-sharing* that patients must pay for these services.

**Exchange** — PPACA creates new “American Health Benefit Exchanges” in each state to assist individuals and small businesses in comparing and purchasing *qualified health insurance plans*. Exchanges will also determine who qualifies for subsidies and make subsidy payments to insurers on behalf of individuals receiving them. They will also accept applications for other health coverage programs such as *Medicaid* and *CHIP*.

**External review** — The review of a health plan’s determination that a requested or provided health care service or treatment is not or was not medically necessary by a person or entity with no affiliation or connection to the health plan. PPACA requires all health plans to provide an external review process that meets minimum standards.

-F-

**Formulary** — The list of drugs covered fully or in part by a health plan.

-G-

**Grandfathered plan** — A health plan that an individual was enrolled in prior to March 23, 2010. Grandfathered plans are exempted from most changes required by PPACA. New employees may be added to group plans that are grandfathered, and new family members may be added to all grandfathered plans.

**Group health plan** — An employee welfare benefit plan that is established or maintained by an employer or by an employee organization (such as a union), or both, that provides medical care for participants or their dependents directly or through insurance, reimbursement or otherwise.

**Guaranteed issue** — A requirement that health insurers sell a health insurance policy to any person who requests coverage. PPACA requires that all health insurance be sold on a guaranteed-issue basis beginning in 2014.

**Guaranteed renewability** — A requirement that health insurers renew coverage under a health plan except for failure to pay premium or fraud. *HIPAA* requires that all health insurance be guaranteed renewable.

-H-

**Health Maintenance Organization (HMO)** — A type of managed care organization (health plan) that provides health care coverage through a network of hospitals, doctors and other health care providers. Typically, the HMO only pays for care that is provided from an *in-network provider*. Depending on the type of coverage you have, state and federal rules govern disputes between enrolled individuals and the plan.

**Health Savings Account (HSA)** — The Medicare bill signed by President Bush on Dec. 8, 2003 created HSAs. Individuals covered by a *qualified high deductible health plan (HDHP)* (and have no other first dollar coverage) are able to open an HSA on a tax preferred basis to save for future qualified medical and retiree health expenses. Additional information about HSAs can be found on the U.S. Treasury Web site: <http://www.treas.gov/offices/public-affairs/hsa/>.

**High Deductible Health Plan (HDHP)** — A type of health insurance plan that, compared to traditional health insurance plans, requires greater *out-of-pocket spending*, although *premiums* may be lower. In 2010, an HSA-qualifying HDHP must have a deductible of at least \$1,200 for single coverage and \$2,400 for family coverage. The plan must also limit the total amount of out-of-pocket *cost-sharing* for covered benefits each year to \$5,950 for single coverage and \$11,900 for families.

**High risk pool** — A state-subsidized health plan that provides coverage for individuals *with pre-existing health care conditions* who cannot purchase it in the private market. PPACA creates a temporary federal high risk pool program, which may be administered by the states, to provide coverage to individuals with pre-existing conditions who have been uninsured for at least 6 months.

**HIPAA (Health Insurance Portability and Accountability Act of 1996)** — The federal law enacted in 1996 which eased the “job lock” problem by making it easier for individuals to move from job to job without the risk of being unable to obtain health insurance or having to wait for coverage due to *pre-existing medical conditions*.

**-I-**

**In-Network provider** — A health care provider (such as a hospital or doctor) that is contracted to be part of the network for a managed care organization (such as an *HMO* or *PPO*). The provider agrees to the managed care organization’s rules and fee schedules in order to be part of the network and agrees not to *balance bill* patients for amounts beyond the agreed upon fee.

**Individual mandate** — A requirement that everyone maintain health insurance coverage. PPACA requires that everyone who can purchase health insurance for less than 8% of their household income do so or pay a tax penalty.

**Individual market** — The market for health insurance coverage offered to individuals other than in connection with a *group health plan*. PPACA makes numerous changes to the rules governing insurers in the individual market.

**Internal review** — The review of the health plan’s determination that a requested or provided health care service or treatment health care service is not or was not medically necessary by an individual(s) associated with the health plan. PPACA requires all plans to conduct an internal review upon request of the patient or the patient’s representative.

**Interstate compact** — An agreement between two or more states. PPACA provides guidelines for states to enter into interstate compacts to allow health insurance policies to be sold in multiple states.

**-J-**

**Job Lock** — The situation where individuals remain in their current job because they have an illness or condition that may make them unable to obtain health insurance coverage if they leave that job. PPACA would eliminate job lock by prohibiting insurers from refusing to cover individuals due to health status.

**-L-**

**Lifetime limit** — Many health insurance plans place dollar limits upon the claims that the insurer will pay over the course of an individual’s life. PPACA prohibits lifetime limits on benefits beginning with on Sept. 23, 2010.

**Limited Benefits Plan** — A type of health plan that provides coverage for only certain specified health care services or treatments or provides coverage for health care services or treatments for a certain amount during a specified period.

**-M-**

**Mandated benefit** — A requirement in state or federal law that all health insurance policies provide coverage for a specific health care service.

**Medicaid** — A joint state and federal program that provides health care coverage to eligible categories of low-income individuals. Rules for eligible categories (such as children, pregnant women, people with disabilities, etc), and for income and asset requirements, vary by state. Coverage is generally available to all individuals who meet these state eligibility requirements. Medicaid often pays for long-term care (such as nursing home care). PPACA extends eligibility for Medicaid to all individuals earning up to \$29,326 for a family of four.

**Medical loss ratio** — The percentage of health insurance *premiums* that are spent by the insurance company on health care services. PPACA requires that large group plans spend 85% of premiums on clinical services and other activities for the quality of care for enrollees. *Small group* and *individual market* plans must devote 80% of premiums to these purposes.

**Medicare** — A federal government program that provides health care coverage for all eligible individuals age 65 or older or under age 65 with a disability, regardless of income or assets. Eligible individuals can receive coverage for hospital services (Medicare Part A), medical services (Medicare Part B), and prescription drugs (Medicare Part D). Together, Medicare Part A and B are known as Original Medicare. Benefits can also be provided through a *Medicare Advantage* plan (Medicare Part C).

**Medicare Advantage** — An option *Medicare* beneficiaries can choose to receive most or all of their Medicare benefits through a private insurance company. Also known as Medicare Part C. Plans contract with the federal government and are required to offer at least the same benefits as original Medicare, but may follow different rules and may offer additional benefits. Unlike original Medicare, enrollees may not be covered at any health care provider that accepts Medicare, and may be required to pay higher costs if they choose an *out-of-network provider* or one outside of the plan’s service area.

**Medicare Supplement (Medigap) Insurance** — Private insurance policies that can be purchased to “fill-in the gaps” and pay for certain out-of-pocket expenses (like deductibles and coinsurance) not covered by original *Medicare* (Part A and Part B).

**Multi-state plan** — A plan, created by PPACA and overseen by the U.S. Office of Personnel Management (OPM), that will be available in every state through *Exchanges* beginning in 2014.

-O-

**Open enrollment period** — A specified period during which individuals may enroll in a health insurance plan each year. In certain situations, such as if one has had a birth, death or divorce in their family, individuals may be allowed to enroll in a plan outside of the open enrollment period.

**Out-of-network provider** — A health care provider (such as a hospital or doctor) that is not contracted to be part of a managed care organization’s network (such as an *HMO* or *PPO*). Depending on the managed care organization’s rules, an individual may not be covered at all or may be required to pay a higher portion of the total costs when he/she seeks care from an out-of-network provider.

**Out-of-pocket limit** — An annual limitation on all *cost-sharing* for which patients are responsible under a health insurance plan. This limit does not apply to *premiums*, *balance-billed* charges from out of network health care providers or services that are not covered by the plan. PPACA requires out-of-pocket limits of \$5,950 per individual and \$11,900 per family, beginning in 2014. These amounts will be adjusted annually to account for the growth of health insurance *premiums*.

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**Patient Protection and Affordable Care Act (PPACA)** — Legislation (Public Law 111-148) signed by President Obama on March 23, 2010. Commonly referred to as the health reform law.

**Pre-existing condition exclusion** — The period of time that an individual receives no benefits under a health benefit plan for an illness or medical condition for which an individual received medical advice, diagnosis, care or treatment within a specified period of time prior to the date of enrollment in the health benefit plan. PPACA prohibits pre-existing condition exclusions for all plans beginning January 2014.

**Preferred Provider Organization (PPO)** — A type of managed care organization (health plan) that provides health care coverage through a network of providers. Typically the PPO requires the policyholder to pay higher costs when they seek care from an *out-of-network provider*. Depending on the type of coverage you have, state and federal rules govern disputes between enrolled individuals and the plan.

**Premium** — The periodic payment required to keep a policy in force.

**Preventive benefits** — Covered services that are intended to prevent disease or to identify disease while it is more easily treatable. PPACA requires insurers to provide coverage for preventive benefits without *deductibles*, *co-payments* or *coinsurance*.

-Q-

**Qualified health plan** — A health insurance policy that is sold through an *Exchange*. PPACA requires Exchanges to certify that qualified health plans meet minimum standards contained in the law.

-R-

**Rate review** — Review by insurance regulators of proposed *premiums* and premium increases. During the rate review process, regulators will examine proposed premiums to ensure that they are sufficient to pay all claims, that they are not unreasonably high in relation to the benefits being provided, and that they are not unfairly discriminatory to any individual or group of individuals.

**Reinsurance** — Insurance purchased by insurers from other insurers to limit the total loss an insurer would experience in case of a disaster or unexpectedly high claims. PPACA directs states to create temporary reinsurance programs to stabilize their *individual markets* during the implementation of health reform.

**Rescission** — The process of voiding a health plan from its inception usually based on the grounds of material misrepresentation or omission on the application for insurance coverage that would have resulted in a different decision by the health insurer with respect to issuing coverage. PPACA prohibits rescissions except in cases of fraud or intentional misrepresentation of a relevant fact.

**Risk adjustment** — A process through which insurance plans that enroll a disproportionate number of sick individuals are reimbursed for that risk by other plans who enroll a disproportionate number of healthy individuals. PPACA requires states to conduct risk adjustment for all non-*grandfathered* health insurance plans.

**Risk corridor** — A temporary provision in PPACA that requires plans whose costs are lower than anticipated to make payments into a fund that reimburses plans whose costs are higher than expected.

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**Self-insured** — *Group health plans* may be self-insured or fully insured. A plan is self-insured (or self-funded), when the employer assumes the financial risk for providing health care benefits to its employees. A plan is fully insured when all benefits are guaranteed under a contract of insurance that transfers that risk to an insurer.

**Small group market** — The market for health insurance coverage offered to small businesses – those with between 2 and 50 employees in most states. PPACA will broaden the market to those with between 1 and 100 employees.

**Solvency** — The ability of a health insurance plan to meet all of its financial obligations. State insurance regulators carefully monitor the solvency of all health insurance plans and require corrective action if a plan's financial situation becomes hazardous. In extreme circumstances, a state may seize control of a plan that is in danger of insolvency.

-U-

**Usual, Customary and Reasonable charge (UCR)** — The cost associated with a health care service that is consistent with the going rate for identical or similar services within a particular geographic area.

Reimbursement for *out-of-network providers* is often set at a percentage of the usual, customary and reasonable charge, which may differ from what the provider actually charges for a service.

-W-

**Waiting period** — A period of time that an individual must wait either after becoming employed or submitting an application for a health insurance plan before coverage becomes effective and claims may be paid. *Premiums* are not collected during this period.