

Glossary of Commonly Used Healthcare Acronyms and Terms

Healthcare and Insurance Related Acronyms

ACA: Affordable Care Act
ACO: Accountable Care Organization
APTC: Advanced Premium Tax Credit
AV: Actuarial Value
CAC: Certified Application Counselor
CAP: Consumer Assistance Program
CCIO: Center for Consumer Information and Insurance Oversight
CDC: Centers for Disease Control and Prevention
CHC: Community Health Center
CHIP: Children's Health Insurance Program
CMS: Centers for Medicare & Medicaid Services
COB: Coordination of Benefits
COBRA: Consolidated Omnibus Budget Reconciliation Act
CO-OP: Consumer Operated and Oriented Plan
CSR: Cost-Sharing Reduction
DME: Durable Medical Equipment
ECP: Essential Community Provider
EHB: Essential Health Benefits
EMR: Electronic Medical Record
EOB: Explanation of Benefits
EPO: Exclusive Provider Organization
EPSDT: Early Periodic Screening, Diagnostic & Treatment Services
ERISA: Employee Retirement Income Security Act
ESI: Employer-sponsored Insurance
FFM/FFE: Federally Facilitated Marketplace/ Federally Facilitated Exchange
FFS: Fee-for-service
FPL: Federal Poverty Level
FQHC: Federally Qualified Health Center
FSA: Flexible Spending Account
HCR: Health Care Reform
HCBS: Home and Community-Based Services
HHS: U.S. Department of Health and Human Services
HIPAA: Health Insurance Portability and Accountability Act
HIM/HIX: Health Insurance Marketplace/ Health Insurance Exchange
HMO: Health Maintenance Organization
HRP: High Risk Pool
HRSA: Health Resources and Services Administration
HSA: Health Savings Account
HDHP: High Deductible Health Plan
IPA: In-Person Assistants Program
LTC: Long Term Care
MAGI: Modified Adjusted Gross Income
MA: Medicare Advantage
MLR: Medical Loss Ratio
OEP: Open Enrollment Period
OON: Out of Network
OOP: Out of Pocket
PBM: Pharmacy Benefit Manager

PCIP: Pre-existing Condition Insurance Plan
PCORI: Patient-Centered Outcomes Research Institute
PCP: Primary Care Provider
PDP: Prescription Drug Plan under Medicare Part D
POS: Point-of-Service Plan
PPO: Preferred Provider Organization
QHP: Qualified Health Plan
SBC: Summary of Benefits and Coverage
SBM/SBE: State Based Marketplace/State Based Exchange
SEP: Special Enrollment Period
SHOP: Small Business Health Options Program
SNF: Skilled Nursing Facility
SPM/SPE: State Partnership Marketplace/ State Partnership Exchange
SPP: Specialty Pharmacy Provider
SSDI: Social Security Disability Income
SSI: Supplemental Security Income
TPA: Third Party Administrator
UCR: Usual, Customary and Reasonable Charges

Glossary of Commonly Used Healthcare Terms

340B Program: The 340B Drug Pricing Program enables eligible health care organizations (known as covered entities) to purchase drugs from manufacturers at reduced prices. It is called 340B since that is the section of the Public Health Service Act that establishes the program.

Accountable Care Organization (ACO): A group of healthcare providers that gives coordinated care for chronic disease management with the goal of improving the quality of patient care. The “organization’s” payment is tied to achieving healthcare 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).

Accreditation: If a health plan provided in the Marketplace/Exchange is approved, this is the “seal of approval” given to the plan by an independent organization to show that the plan meets national quality standards.

Actuarial Value (AV): The percentage of total average costs for covered benefits that a plan will cover. *Example:* if a plan has an actuarial value of 70%, on average you would be responsible for 30% of the costs of all covered benefits. However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual healthcare needs and the terms of your insurance policy. Under the Affordable Care Act, four health plan categories, Bronze, Silver, Gold and Platinum, (sometimes called metal tiers) will be offered in the Marketplaces/Exchanges. The tiers are based on the actuarial value of providing essential health benefits to members. While two plans may be in the same metal tier, that does not mean that they will cover the same benefits in the same way - the percentages are set over the entire plan and not any individual service. (See Bronze, Silver, Gold and Platinum Health Plans and Fact Sheet).

Advanced Premium Tax Credit (APTC): Also referred to as a premium tax credit, this new tax credit provided for in the Affordable Care Act helps make coverage purchased in the Marketplace/Exchanges more affordable for consumers. Advance payments of the tax credit can be used right away to lower monthly premium costs. Qualified consumers may choose how much advance credit payments to apply to their premiums each month, up to a maximum amount. If the amount of advance credit payments a consumer gets for the year is less than the tax credit due, 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 healthcare 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. 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 9.5% of annual household income. Starting in 2014, individuals offered employer-sponsored coverage that's affordable and provides minimum value will not be eligible for a premium tax credit if they choose to purchase health insurance in the Marketplace.

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.

Annual Limit: A cap on the benefits your insurance company will pay in a year while you are enrolled in a health insurance plan. Annual caps are sometimes placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits for a particular service. After the annual limit is reached, you must pay all associated healthcare costs for the rest of the year.

Appeal: A request for a health insurer or plan to review a decision or a grievance again.

Balance Billing: The practice of billing a patient for charges not paid by his/her insurance plan because the charges exceed covered amounts. Balance billing amounts will often be charges that are above the usual and customary rates.

Benefits: The healthcare items or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents. In Medicaid or CHIP, covered benefits and excluded services are defined in state program rules.

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 off of recombinant, cell or tissue-based proteins. Clotting immunoglobulin replacement therapy is a biologic.

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/Exchanges where the percentage the plan pays of the average overall cost of providing essential health benefits to members is 60%.

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

Catastrophic Plan: A healthcare plan that only covers certain types of expensive care, like hospitalizations. May also include plans that have a high deductible, so that your plan begins to pay only after you've first paid

up to a certain amount for covered services. You must be under 30 years old to purchase a catastrophic plan through a Marketplace/Exchange.

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 Affordable Care Act related to private health insurance Marketplaces/Exchanges.

Certified Application Counselor (CAC): An individual (affiliated with a designated organization) who is trained to help consumers, small businesses, and their employees as they search for and enroll in health insurance options through the Marketplace/Exchanges created by the ACA. CAC services are free to consumers. (See Fact Sheet).

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.

Claim: A request for payment that you or your healthcare 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, 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 medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage (rather than a set dollar amount) of medical expenses after the deductible amount, if any, was paid.

Community Health Centers (CHC): Public and private, nonprofit organizations providing comprehensive, culturally competent, quality primary and related health care services to medically underserved communities and vulnerable populations. The centers are managed and governed by a community board, which is primarily comprised of patients and community members. There are several different types of CHCs: Federally Qualified Health Centers; non-grant supported health centers; and outpatient health programs/facilities operated by tribal organizations.

Consumer Assistance Program (CAP): State programs 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/CCIIO/Resources/Consumer-Assistance-Grants/>.

Consumer Operated Oriented Plan (CO-OP): A non-profit health insurance organization for which its insured people are also the owners. Cooperatives can be formed at a national, state, or local level and can include doctors, hospitals, and businesses as member-owners. Co-ops will offer insurance through the Marketplace/Exchange.

Coordination of Benefits (COB): 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.

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. Cost sharing includes deductibles, coinsurance and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of noncovered services. Cost sharing in Medicaid and CHIP also includes 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 if you get health insurance through the Marketplace/Exchange, your income is below a certain level, and you choose a Silver Health Plan (See "Metal Tiers" and "Silver Health Plan"). If you are a member of a federally recognized tribe, you may qualify for additional cost-sharing benefits.

Creditable Coverage: Health insurance coverage under any of the following: a group health plan; individual health insurance; student health insurance; Medicare; Medicaid; CHAMPUS and TRICARE; Veterans Administration (VA) coverage; the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps; Public Health Plan (any plan established or maintained by a state, the U.S. government, a foreign country); Children's Health Insurance Program (CHIP) or a state health insurance high-risk pool. If you have prior creditable coverage, it will reduce the length of a pre-existing condition exclusion period under new job-based coverage. Depending on state law, this may also apply to other types of coverage, such as state high-risk pools, in your state.

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.

Department of Health and Human Services (HHS): The federal agency charged with protecting the health of all Americans. Its agencies include the Centers for Medicare and Medicaid Services (CMS), Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA).

Dependent: A child or other individual for whom a parent, relative, or other person may claim a personal exemption tax deduction. Under the Affordable Care Act, 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.

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: <http://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. The donut hole is being phased out and will be closed entirely by the ACA in 2020.

Drug List: Also referred to as a formulary, it is a list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits.

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

Early Periodic Screening, Diagnostic & Treatment Services (EPSDT): 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 a patient's medical history from one practice.

Eligible Immigration Status: An immigration status that's considered eligible for getting health coverage through the Marketplace/Exchange. The rules concerning eligible immigration status may be different in each insurance affordability program.

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

Employer Mandate: The Affordable Care Act 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) that meets certain minimum standards set by the Affordable Care Act or to make a tax payment.

Employer-Sponsored Insurance (ESI): This is health insurance provided by an employer, who typically covers a portion of the costs. Sometimes called group health insurance. Plan options include HMOs, PPOs, and EPOs, among others.

Employee Retirement Income Security Act of 1974 (ERISA): A federal law that establishes standards for some employer-sponsored health insurance, particularly for self-insured employer-sponsored plans. (See Employer Sponsored Insurance and Self-Insured Plan). ERISA plans can only be regulated by federal law; state health insurance laws do not apply to them. In the context of the ACA, ERISA plans are exempt from some of the private health insurance reforms. (See Fact Sheet).

Essential Community Providers (ECP): The ACA designates certain providers as Essential Community Providers, those that are included in section 340B(a)(4) of the Public Health Service Act. Plans offered through the Marketplace/Exchanges are required to include some ECPs in their networks.

Essential Health Benefits (EHB): A set of healthcare service categories that must be covered by certain plans starting in 2014. The Affordable Care Act 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 a typical plan that existed in the state in 2011. Private health insurance policies must cover these benefits in order to be certified and offered in Marketplaces/Exchanges. Medicaid plans must cover a comprehensive bundle of services by 2014 as well.

Non-grandfathered health plans are no longer able to impose a lifetime dollar limit on spending for these services. All plans, except grandfathered individual health insurance policies, were required to begin phasing out annual dollar spending limits for these services starting with plan/policy years that began on or after September 23, 2010. For the majority of health insurance plans, annual dollar limits on essential health benefits will be completely phased out by 2014. (See Fact Sheet).

Exclusions: Items or services that are not covered under a contract for insurance and which an insurance company will not pay.

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).

Explanation of Benefits (EOB): A form sent by an insurance company to an insured that includes a 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. The plan must accept this decision.

Federally-Facilitated Marketplace/Federally-Facilitated Exchange (FFM/FFE): One of the three types of Marketplace/Exchange options for states under the Affordable Care Act. States opting for an FFM/FFE will have a Marketplace/Exchange that is run by the federal government.

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. For more information on FPL please visit: <http://aspe.hhs.gov/poverty/index.cfm>. Many public health insurance programs set eligibility based on a percentage of the FPL.

Federally Qualified Health Centers (FQHC): Federally-funded nonprofit health centers or clinics that serve medically underserved areas and populations. Federally qualified health centers provide primary care services regardless of your ability to pay. Services are provided on a sliding scale fee.

Fee for Service (FFS): A reimbursement plan in which doctors and other healthcare providers are paid for each service performed, such as for tests and office visits.

Flexible Benefits Plan: Offers employees a choice between various benefits including cash, life insurance, health insurance, vacations, retirement plans and child care. Although a common core of benefits may be required, you can choose how your remaining benefit dollars are to be allocated for each type of benefit from the total amount promised by the employer. Sometimes you can contribute more for additional coverage. Also known as a Cafeteria Plan or IRS 125 Plan.

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 a 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.

Formulary: Sometimes referred to as a “drug list,” it is a list of drugs your insurance plan covers and may include how much you pay for each drug. If the plan categorizes drugs into different groups with different co-pays, also known as tiers, then the formulary may list drugs by these tiers. Formularies may include both generic drugs and brand-name drugs.

Fully Insured Job-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.

Gold Health Plan: A plan in the health insurance Marketplaces/Exchanges where the percentage the plan pays of the average overall cost of providing essential health benefits to members is 80%. (See Actuarial Value).

Grandfathered Health Plan: As defined in the Affordable Care Act, 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 Affordable Care Act.

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 materials if it is a grandfathered plan. It must also advise consumers how to contact the U.S. Department of Labor or HHS with questions. (See New Plan).

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. Except in some states, guaranteed issue doesn’t limit how much you can be charged if you enroll.

Guaranteed Renewal: A requirement that your health insurance issuer must offer to renew your policy as long as you continue to pay premiums. Except in some states, guaranteed renewal doesn’t limit how much you can be charged if you renew your coverage.

Habilitative/Habilitation Services: Health care services that help you keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not 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 Care Reform (HCR): Also known as the Patient Protection and Affordable Care Act (PPACA), the Affordable Care Act (ACA) and Obamacare, it is the comprehensive healthcare 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. Health Care Reform refers to the final, amended version of the law.

Health Insurance Exchange (HIE): Also known as a Health Insurance Marketplace, these are new transparent and competitive health insurance Marketplaces/Exchanges where individuals and small businesses can buy qualified health plans that meet certain benefit and cost standards. Every state will have a Marketplace/Exchange in 2014 and beyond.

Health Insurance Marketplace (HIM): Also known as a Health Insurance Exchange (HIE), these are new transparent and competitive health insurance Marketplaces/Exchanges where individuals and small businesses can buy qualified health plans that meet certain benefit and cost standards. Every state will have a Marketplace/Exchange in 2014 and beyond.

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 from doctors who work for or contract with the HMO. Generally will not 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 medical savings account available to taxpayers who are enrolled in a High-Deductible Health Plan. The funds contributed to the account are not subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses. Unlike a Flexible Spending Account (FSA), funds roll over year to year if you do not spend them.

Health Status: Refers to your medical conditions (both physical and mental health), claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability and disability.

High-Deductible Health Plan (HDHP): A plan that features higher deductibles than traditional insurance plans. HDHPs can be combined with a health savings account or a health reimbursement arrangement to allow you to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

High-Risk Pool (HRP) Plan (State): High-risk pool plans offer health insurance coverage that is subsidized by a state government. Not all states offer high-risk pools, and those that do have distinct rules in terms of cost, eligibility and benefits. Many high-risk pools will be phased out following the implementation of plans in the Marketplaces/Exchanges.

Home and Community-based Services (HCBS): Services and support provided by most state Medicaid programs in your home or community that gives 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 Healthcare: Healthcare services and supplies in your home that a doctor prescribes.

Hospital Readmission: A return by a patient to the hospital following discharge for the same or related care within 30, 60 or 90 days. Hospital readmissions are often used in part to measure the quality of hospital care.

Individual Health Insurance Policy: Policies for people who are not 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.).

Individual Mandate: Also known as "individual responsibility," under the Affordable Care Act. Starting in 2014, you must be enrolled in a health insurance plan that meets basic minimum standards. If you are not, you may be required to pay a penalty. Exempt from this are people with very low income for whom coverage is unaffordable, or for other reasons, including religious beliefs.

In-Network Coinsurance: The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network coinsurance usually costs you less than out-of-network coinsurance.

In-Network Copayment: A fixed amount (for example, \$15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

In-Network Provider: A physician, certified nurse midwife, hospital, skilled nursing facility, home healthcare agency, or any other duly licensed or certified institution or health professional under contract with your insurance provider.

In-Person Assisters (IPA): Individual or organizations that are trained to provide help to consumers, small businesses, and their employees as they look for health coverage options through the Marketplace/Exchanges. IPAs help consumers complete eligibility and enrollment forms and are required to be unbiased. Their services are free to consumers. (See Fact Sheet).

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). (See Fact Sheet).

Long-Term Care (LTC): Medical and nonmedical services provided to people who are unable to perform basic activities of daily living such as dressing or bathing. Long-term supports and services can be provided at home, in the community, in assisted living or in nursing homes. Individuals may need long-term supports and services at any age. Medicare and most health insurance plans do not pay for long-term care.

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 (HMOs), preferred provider organizations (PPOs), exclusive provider organizations (EPOs) and point of service plans (POSs).

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

- *Preadmission certification* - Authorization for hospital admission given by a healthcare provider to a group member prior to hospitalization. Failure to obtain a preadmission certification in nonemergencies reduces or eliminates the healthcare 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.

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.

Medical Loss Ratio (MLR): A financial tool that measures the percentage of premium dollars taken in by a health insurer that are spent on customers' medical claims and quality improvement activities as compared with money spent on overhead expenses, including salaries, administrative costs and agent commissions. The Affordable Care Act sets minimum medical loss ratios for different markets, as do some state laws. If your plan does not meet an applicable MLR, then you or your employer could receive a refund.

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

Medical Underwriting: A process used by insurance companies that uses your health status when you are applying for health insurance coverage to determine whether to offer you coverage, at what price and with what exclusions or limits. 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 immunoglobulin replacement therapy for patients with most kinds of primary immunodeficiency diseases. 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) include HMOs, PPOS, Private Fee-for-Service Plans, Special Needs Plans and Medicare Medical Savings Account Plans. If you are enrolled in an MA plan, Medicare services are covered through the plan and are not 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: The type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

Minimum Value: A health plan meets this standard if it's designed to pay at least 60% of the total cost of medical services for a standard population. Starting in 2014, individuals offered employer-sponsored coverage that provides minimum value and that is affordable will not be eligible for a premium tax credit if they choose to purchase health insurance through the Marketplace/Exchange.

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.

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 Marketplace/Exchanges established pursuant to the Affordable Care Act. 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 (See Fact Sheet).

New Plan: As referenced in the Affordable Care Act, a health plan that is not grandfathered and therefore subject to the reforms in the Affordable Care Act. In the individual health insurance market, a plan that your family is purchasing for the first time. In the group health insurance market, a plan that your employer is offering for the first time. New employees and new family members may be added to existing grandfathered group plans – so a plan that is new to you and your family may still be a grandfathered plan.

In both the individual and group markets, a plan that loses its grandfathered status will be considered a new plan. This happens when it makes significant changes to the plan, such as reducing benefits or increasing cost-sharing for enrollees. (See Grandfathered Plan).

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 are not related to health status.

Open Enrollment Period (OEP): The time period set up to allow you to choose from available plans, usually once a year.

Out-of-Network Coinsurance: The percentage (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network (OON) coinsurance usually costs you more than in-network coinsurance. The amount of coinsurance you pay may be more when you use an out-of-network provider.

Out-of-Network Copayment: A fixed amount (for example, \$30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network (OON) copayments usually are more than in-network copayments. The copayment you pay may be more when you use an out-of-network provider.

Out-of-Network Providers: A duly licensed or certified institution or health professional not under contract with your insurance provider.

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.

Patient-Centered Outcomes Research Institute (PCORI): Institute authorized by the ACA to conduct comparative effectiveness research (CER).

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.

Platinum Health Plan: A plan in the health insurance Marketplaces/Exchanges where the percentage the plan pays of the average overall cost of providing essential health benefits to members is 90%.

Policy Year: A 12-month period of benefits coverage under an individual health insurance plan. This 12-month period might be different than the calendar year.

Point-of-Service Plan (POS) Plan: A type of plan in which you pay less if you use doctors, hospitals and other healthcare 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.

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

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). As of September 23, 2010 (for children) and as of January 1, 2014 (for adults), health insurance plans cannot refuse to cover you or charge you more just because you have a pre-existing health condition. Coverage for pre-existing conditions begins immediately.

Pre-Existing Condition Insurance Plan (PCIP): A health insurance program created by the ACA beginning in 2010 and scheduled to expire December 31, 2013, that provided coverage for individuals that were uninsured, had pre-existing conditions and were denied health coverage as a result. Every state had a PCIP program. In some states it was operated by the state, while in others it was operated by the federal government.

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 healthcare 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 often maintain long-term relationships with you, and advise and treat you on a range of health-related issues. They may also coordinate your care with specialists.

Qualified Health Plan (QHP): Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by a Marketplace/Exchange, 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/Exchange 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.

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 do not get a referral first, the plan may not pay for the services.

Rehabilitative/Rehabilitation Services: Healthcare 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.

Rescission: The retroactive cancellation of a health insurance policy. Insurance companies will sometimes retroactively cancel your entire policy if you made a mistake on your initial application when you buy an individual market insurance policy. Under the Affordable Care Act, rescission is illegal except in cases of fraud or intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.

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). Beginning January 1, 2014, no exclusionary riders will be permitted in any 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 healthcare outcomes or healthcare costs.

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.

Silver Health Plan: A plan in the health insurance Marketplaces/Exchanges 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.

Small Business Health Options Program (SHOP): The Marketplace/Exchange available to small businesses under the Affordable Care Act. 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.

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 job-based health coverage. Job-based plans must 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.

Special Healthcare Need: The healthcare and related needs of children who have chronic physical, developmental, behavioral or emotional conditions. Such needs are of a type or amount beyond that required by children generally.

Specialty Pharmacy Provider (SPP): A pharmacy that is 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/State Based Exchange (SBM/SBE): One of the three types of Marketplace/Exchange options for states under the Affordable Care Act. States opting for an SBM/SBE will manage their own Marketplace/Exchange in accordance with applicable federal laws.

State Continuation Coverage: A state-based requirement similar to COBRA that applies to group health insurance policies of 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 are leaving a job-based plan, you must be allowed to continue your coverage until you reach the age of Medicare eligibility.

State Partnership Marketplace/State Partnership Exchange (SPM/SPE): One of the three types of Marketplace/Exchange options for states under the Affordable Care Act. States opting for an SPM/SPE will have a Marketplace/Exchange 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 will 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.

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 healthcare program for active-duty and retired uniformed services members and their families.

Uncompensated Care: Healthcare or services provided by hospitals or healthcare providers that do not get reimbursed. Often uncompensated care arises when people do not have insurance and cannot afford to pay the cost of care.

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 healthcare 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.

Veteran's Health Benefits: Veterans may be eligible for a broad range of services, including healthcare benefits, through the Veteran's Administration.

Waiting Period (Job-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. This is different than a pre-existing condition exclusion period, which is applied to individual employees and is based on health status.

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.

Wellness Programs: A program intended to improve and promote health and fitness that's usually offered through the work place, 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.

Source:

- <http://www.healthcare.gov/glossary>
- <http://www.hrsa.gov>
- <http://www.healthit.gov>
- <http://www.cms.gov>
- <http://www.hhs.gov>
- <http://pcori.org/>
- <http://www.va.gov>
- <http://www.cdc.gov>
- <http://www.dol.gov>
- <http://www.healthinsurance.org>

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