

Glossary of Health Insurance Terms

When talking about health insurance, it helps to be familiar with the words and lingo. When President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law, new terms about healthcare were defined, and others were clarified. Below are definitions for some commonly used terms about health insurance, and how PPACA impacts their use.

-A-

Actuarial justification — The mathematical demonstration by an insurance company that the premiums collected are reasonable. Actuarial justifications must be publicly disclosed.

Adjusted community rating — A way of pricing insurance where premiums that are not based upon a policyholder's health status, but may be based upon other factors, such as age and geographic location.

Annual limit — The amount that many health insurance plans will pay up to over the course of a plan year. PPACA prohibits companies from placing annual limits for essential benefits (defined later in this document).

-B-

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

-C-

CHIP — The Children's Health Insurance Program (CHIP) provides coverage to eligible children up to age 19. Like Medical Assistance, it is jointly funded and administered by the states and the federal government.

COBRA coverage — Passed in Congress in 1986, the Consolidated Omnibus Budget Reconciliation Act (COBRA) provides certain former employees, retirees, spouses, former spouses and dependent children the right to temporarily continue their 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.

Coinsurance — A percentage of a health care provider's charge for which the patient is financially responsible to pay 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 — Beginning in 2014, a co-op plan will be a health insurance plan that will be sold by member-owned and operated non-profit organizations through Exchanges. PPACA provides grants and loans to help Co-Op plans enter the marketplace.

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

Cost-sharing — Charges from a health care provider that a patient is responsible to pay. Common forms of cost-sharing include deductibles, coinsurance and co-payments. PPACA defines the cost-sharing limits for individuals and families, and these amounts will adjust 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 insurance company will begin paying claims under a policy. PPACA limits annual deductibles by the type of policy, and these amounts will adjust annually to reflect the growth of premiums.

Disease management — The process 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 — A basic package of benefits including hospitalization, outpatient services, maternity care, prescription drugs, emergency care and preventive services, among other benefits. PPACA requires all health insurance plans sold after 2014 to have an essential benefits package and places restrictions on the amount of cost-sharing that patients must pay for these services.

Exchange — Available in 2014, Exchanges will be an online store where individuals and small employers will be able to buy health insurance products sold by insurance companies.

External review — The review of a health plan's determination, by a person or entity with no affiliation or connection to the health plan, that a requested or provided health care service or treatment is not or was not medically necessary.

-F-

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

Fully insured — A plan is fully insured when all benefits are guaranteed under a contract of insurance that transfers that risk to an insurance company.

-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 and family members may be added to group plans that are grandfathered.

Group health plan — An employee 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 insurance companies sell a health insurance policy to any person who requests coverage. All health insurance will be sold on a guaranteed-issue basis beginning in 2014.

Guaranteed renewability — A requirement that health insurance companies 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.

Health savings account (HSA) — Created in 2003, 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 website: <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.

High risk pool — A state-subsidized health plan that provides temporary coverage for individuals with pre-existing health care conditions. In Pennsylvania, our high risk pool is called PA Fair Care. High risk pools expire January 1, 2014.

HIPAA (Health Insurance Portability and Accountability Act of 1996) — A federal law enacted in 1996, HIPAA eases the problem for individuals who move from job to job so that they avoid the risk of being unable to obtain health insurance or have 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 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 have health insurance coverage. PPACA requires that everyone who can purchase health insurance for less than 8 percent of their household income do so or pay a tax penalty.

Individual market — The market for health insurance coverage offered to individuals not in a group health plan.

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. All plans are required to conduct an internal review upon request of the patient or the patient's representative.

Interstate compact — An agreement between two or more states that allows health insurance policies to be sold in multiple states.

-L-

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.

Medical assistance (MA) — Also known as Medicaid, MA is a joint state and federal program that provides health care coverage to eligible individuals.

Medical loss ratio (MLR) — 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 percent of premiums on clinical services and other activities for the quality of care for enrollees. Small group and individual market plans must devote 80 percent of premiums to these purposes.

Medicare — A federal program that provides health care coverage for all eligible individuals age 65 or older, or individuals 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 — Also known as Medicare Part C, this is an option Medicare beneficiaries can choose to receive most or all of their Medicare benefits through a private insurance company. 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.

Medicare supplement (Medigap) policy — 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).

Mini-COBRA — Pennsylvania's Mini-COBRA law works like federal COBRA, but applies to Pennsylvania companies with **2-19 employees**. You must contact your employer to receive instructions for enrolling in Mini-COBRA.

-O-

Open enrollment period — A specified period during the year when individuals may enroll in a health insurance plan. In certain situations, such as a birth, death or divorce in a 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. 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 — The limit that patients are responsible for paying 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 outlines limit amounts that will adjust annually to account for the growth of health insurance premiums.

-P-

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 or “ACA.”

Pre-existing condition exclusion — The period of time that an individual receives no benefits for an illness or medical condition under a 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 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. Insurance companies are required to provide coverage for preventive benefits without deductibles, co-payments or coinsurance.

-Q-

Qualified health plan — A health insurance policy will be sold through an Exchange. Qualified health plans must meet minimum standards contained in the law.

-R-

Rate review — The review by insurance regulators of proposed 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 that is purchased by insurance companies from other insurance companies to limit the total loss the company 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 — Rescission is voiding a health plan based on the grounds of material misrepresentation or omission on the application for insurance 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.

-S-

Self-insured — A plan is self-insured when the employer assumes the financial risk for providing health care benefits to its employees.

Small group market — The market for health insurance coverage offered to small businesses that employ between 2 and 50 individuals. 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.

-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.