Health Care and Reform Glossary

These definitions are not meant in every case to conform to the definitions in a member's health plan contract or evidence of coverage. Members should look to their health plan documents only for the definitions that govern their health plan benefits.

DEFINITION

Accidental Death and Dismemberment (AD&D) Insurance
Accidental death coverage provides benefits if the subscriber dies due to an accident. Dismemberment coverage provides a benefit to subscribers who suffer a dismemberment.

AD&D
See entry for "Accidental Death and Dismemberment (AD&D) Insurance"

Adjudication
Processing a claim through a series of edits to determine proper payment.

Administrative Services Only (ASO)
A type of health plan in which the employer or other group sponsor is financially responsible for paying plan expenses such as members' claims; the insurance company only provides administrative services. This is also called "self funded" or "self insured."

Advisory Committee on Immunization Practices (ACIP)
The committee that develops written recommendations for the routine administration of vaccines to children and adults in the civilian population. Recommendations include age for vaccine administration, number of doses and dosing interval, and precautions and contraindications. The ACIP is the only entity in the federal government that makes such recommendations.

Agent
A person who is licensed by the state to sell insurance and who may provide services to subscribers. An agent can be a sole proprietor, a member of a large firm or an employee of the insurance company. The insurer pays the agent a fee or commission. Also see entry for "Broker."

Ambulatory Surgical Center (ASC)
A freestanding outpatient surgical facility. It must be licensed as an outpatient clinic, according to state and local laws, and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or the Accreditation of Ambulatory Health Care.

Annual Limit/Annual Maximum
The maximum amount that a plan will pay toward a member's claims during the plan year. The health care reform bill phases out annual limits on the dollar value of essential health benefits starting in 2010.

Appeal
A request to review a decision on a claim that has previously been partially paid or denied. These reviews may be conducted internally by the health plan or externally through a third-party review organization.

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Archer Medical Savings Account (MSA)
A tax-deferred account that allows consumers to save money for medical expenses. Contributions to the MSA, whether made by the employer or the employee, earn interest and are not subject to federal income taxes. Any money not used for medical expenses in one year could be carried over and invested, like money in an IRA.

ASC
See entry for "Ambulatory Surgical Center (ASC)"

ASO
See entry for "Administrative Services Only (ASO)"

Balance Bill/Balance Billing
When an out-of-network provider holds a plan member responsible for costs above what the insurer will pay.

Beneficiary
A person who is eligible to receive insurance benefits.

Benefit Consultant
An individual or organization hired by an employer group, trade union, etc., to review, analyze and make recommendations about group plan benefit strategies, including benefit plan design, carrier selection, pricing, etc.; an insurance professional who provides information, advice and counseling for his or her clients.

Benefit Determination
Any decision a health plan makes involving:

- Eligibility to participate in a plan or coverage
- Whether a service is a covered benefit
- Use of pre-existing condition exclusions or other benefit limits
- Medical necessity
- Experimental treatment determinations
- Rescission of coverage

Benefits
The services and/or coverage available under the subscriber's health plan policy/contract.

Broker
A person who represents a client in the solicitation, negotiation or procurement of insurance contracts and who may provide services related to those functions. By law, the broker can also be an agent of the insurer for certain purposes, such as delivery of the policy or collection of the premium. Also see entry for "Agent."

Cadillac Plan
A plan that costs more than $10,200 for single coverage or $27,500 for family coverage. The health care reform law imposes a 40% excise tax these plans starting in 2018. The insurer or employer will be responsible for the tax.

CHDP
See entry for "Consumer-Driven Health Plan (CDHP)."

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Claim
A request to pay an insured person or provider for services rendered.

COBRA
See entry for “Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).”

Coinsurance
An amount the insured person pays that is a fixed percentage of the cost of covered health care services after the deductible has been paid. For example, an insurance plan might pay 80% of the allowable amount, with the insured person responsible for the remaining 20% of the allowable amount, which is referred to as the coinsurance amount.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
The federal law that permits employees and their covered family members to temporarily continue coverage under an employer's insurance plan when they would otherwise become ineligible due to a loss of employment or change in family status (such as a divorce). The full cost of the continuation coverage is paid by the individual. Small employers (generally with fewer than 20 employees) are generally not subject to COBRA but may be subject to state laws providing for continuation coverage.

Consumer-Driven Health Plan (CDHP)
A type of health plan designed to give members more control over their health care. A CDHP often includes a high-deductible health plan and is compatible with a spending account such as a:

- Health reimbursement arrangement (HRA)
- Health savings account (HSA)
- Health incentive account (HIA)

Copay/Copayment
The amount that a member pays for each doctor visit, a covered service or prescription drug. Normally a flat dollar amount per unit of service or unit of time.

Cost Share/Cost Sharing
The portion of a member’s health care costs that the member is responsible for paying, such as a copayment or coinsurance percentage.

Covered Benefit
An eligible service that an insurance plan will pay for if the member requires the service.

Deductible
A portion of expenses a member may have to pay out of pocket for the calendar year for covered services before an insurer begins to pay benefits.

Dependent
Under the new health care reform legislation, dependent is defined as including a child of the subscriber or participant who is under the age of 26. Financial dependency on or residency with the subscriber or participant is not required. Additionally, there is no requirement to be a student, unmarried, employed or any combination of these factors. Note that this new definition is only for purposes of eligibility to remain on a group health policy. The definition of “dependent” for income tax purposes is not changed.

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Early Retiree
An individual between the age of 55 to 64 who isn't an active employee and isn't eligible for Medicare.

Effective Date
The date coverage begins under an insurance plan.

Enroll
The process of applying for coverage to establish membership and eligibility for insurance.

Enrollment Period
The period during which individuals can enroll for health care coverage. Also see entry for "See Open Enrollment Period."

EOB
See entry for "Explanation of Benefits (EOB)."

Essential Health Benefits
We still need additional guidance from the U.S. Department of Health and Human Services on the definition of "essential" benefits, but we do know the following are included:

- 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
- Chronic disease management
- Pediatric services, including oral and vision care

Exchange
See entry for "Insurance Exchange."

Explanation of Benefits (EOB)
An EOB is the statement you receive from your insurer after it processes a claim. It's not a bill. It's simply a summary showing you the patient name, the doctor name, the date of your appointment, the type of service you had, how much was charged, how much your insurance paid and how much (if anything) you owe.

Flexible Spending Account (FSA)
An account that reimburses employees for specified expenses (for example, health care or dependent care) as expenses are incurred. FSAs are usually funded through deductions from employees' paychecks. If the FSA meets rules under the Internal Revenue Code, contributions are not subject to federal income taxes or employment taxes.

Formulary
The list of covered prescription drugs established by an insurance company.

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FSA
See entry for “Flexible Spending Account (FSA).”

Fully Insured
A type of health plan in which an insurance company is financially responsible for paying plan expenses such as members’ claims. The group (employer or union) or individual pays a premium based on the number of people in enrolled in the plan. The insurance company then pays members’ health care claims based on the benefits in the policy purchased.

Generic Drug
A drug that is the chemical equivalent of a brand-name drug and is formulated to have the same effect in the body as the brand-name version. Generic drugs often become available when a brand-name drug's patent expires.

Grandfathered Plan
A health plan that was in effect on March 23, 2010, and hasn’t had certain changes since then. Some of the health care reform rules don’t apply to grandfathered plans. Dependents may be added or dropped from grandfathered plans without losing grandfathered status.

Grievance
A complaint about your health plan, your coverage, care provided to you or any benefit or coverage decisions the plan or its administrator makes.

Group Plan
Health insurance that a member receives through a group (company or union).

Guaranteed Issue Coverage
Coverage for a member or group is guaranteed, that is, the member or group can’t be turned down.

HDHP
See entry for “High-Deductible Health Plan (HDHP).”

Health and Human Services (HHS)
Short for “U.S. Department of Health and Human Services” – the division of federal government responsible for defining the provisions of the federal health care reform law.

Health Insurance Portability and Accountability Act (HIPAA)
A federal law passed in 1996 that protects confidentiality of members' private and medical information and regulates portability of health care coverage when changing health plans. HIPAA rules apply to health plans, health care clearinghouses and health care providers who transmit any health information in any electronic form in connection with transactions covered under HIPAA.

Health Maintenance Organization (HMO)
A type of health benefits plan for which members are required to receive health care only from providers that are part of the HMO network. A primary care physician coordinates each member’s health care. Services (except emergency care) performed by out-of-network providers aren’t covered except under specific circumstances.

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Health Reimbursement Arrangement (HRA)
An account that reimburses employees for specific health care expenses as expenses are incurred. HRAs are funded by employers.

Health Resources and Services Administration (HRSA)
The primary federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable. The HRSA is an agency of the U.S. Department of Health and Human Services.

Health Savings Account (HSA)
An account that reimburses employees for specific health care expenses. HSAs can be funded by the plan member, an employer or anyone else. The money contributed to your HSA belongs to you and can be used to cover eligible current or future medical expenses. If the HSA meets rules under the Internal Revenue Code, contributions, earnings and withdrawals for eligible expenses are not subject to federal income taxes or employment taxes.

HHS
See entry for "Health and Human Services."

High-Risk Pool
A health plan for people who have been unable to obtain health coverage because of a pre-existing health condition. The 2010 health care reform bill required all 50 states and the District of Columbia to create new high-risk pools. These pools will provide greater access to coverage until 2014, when individual coverage will be guaranteed-issue and sold through insurance exchanges. Also see entry for Pre-existing Condition Insurance Plan.

High-Deductible Health Plan (HDHP)
A high-deductible health plan is a health benefits plan with an annual deductible higher than those of more traditional health plans. Generally, these plans are in conjunction with health savings accounts – see HSA.

HIPAA
See entry for "Health Insurance Portability and Accountability Act (HIPAA)."

HMO
See entry for "Health Maintenance Organization (HMO)."

Hospice
An agency or organization primarily engaged in providing palliative care (pain control and symptom relief) to terminally ill people and supportive care for those people and their families to help them cope with terminal illness. This care may be provided in the home or on an inpatient basis.

Hospital
A facility that provides diagnosis, treatment and care of people who need acute hospital care under the supervision of physicians. It must be licensed as a general acute care hospital, according to state and local laws. It must also be registered as a general hospital by the American Hospital Association and meet JCAHO's accreditation standards.

HRA
See entry for "Health Reimbursement Arrangement (HRA)."

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HSA
See entry for “Health Savings Account (HSA).”

ID Card
The card issued by the insurer to the subscriber as evidence of membership. It shows the subscriber’s name, identification number, coverage plans, where to send claims, customer service telephone numbers, etc.

IFR
See entry for “Interim Final Regulations (IFRs).”

Indemnity
A traditional insurance plan that reimburses for health care services provided to members based on providers’ bills submitted after the services are rendered.

Individual Plan
An insurance policy sold to individuals who are not eligible for medical insurance under a group policy, choose not to enroll in a group policy or need more coverage than is available to them through their group plan.

In Network
Refers to providers who participate in an insurer’s network.

Inpatient
A patient who is admitted to a hospital for services for at least a 24-hour period.

Insurance Exchange
State-run programs that will act as a new sales channel for health insurance beginning in 2014. The 2010 health care reform law requires states to establish exchanges for individuals and small employers. Subsidies will be available to low-income people and small businesses that buy insurance through an exchange.

Interim Final Regulations (IFRs)
Publications from the Office of Consumer Information and Insurance Oversight (part of the Department of Health and Human Services) that clarify provisions of federal health care reform. Once the government issues an IFR, it provides a period of time during which health plans and anyone else can comment on the rules. You may also see the term “interim final rules.”

Investigative/Investigational
Procedures or medications that have progressed to limited use on humans but that aren’t generally accepted as proven and effective within the organized medical community.

Lifetime Limit/Lifetime Maximum
The maximum amount that a plan will pay toward a member’s claims in over his or her lifetime. The health care reform bill eliminates lifetime limits on the dollar value of essential health benefits for plan years beginning on or after Sept. 23, 2010.

Medical Loss Ratio (MLR)
The percentage of premiums that insurers spend on medical care, as opposed to the percentage spent on administrative expenses like customer service.

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Medically Necessary
Procedures, supplies, services or equipment that the insurer determines to be:

- Appropriate and necessary to diagnose or treat the medical condition.
- Provided to diagnose or direct care and treat the medical condition.
- Within standards of good medical practice within the organized medical community.
- Not primarily for the member's convenience, or for the convenience of the physician or another provider.
- The most appropriate procedure, supply, equipment or service that can safely be provided.

Member
A person who is enrolled in and covered by a health plan – sometimes called a subscriber or an enrollee. Also see entry for "Subscriber."

MLR
See entry for "Medical Loss Ratio (MLR)."

MSA
See entry for "Archer Medical Savings Account (MSA)."

Network
Physicians, hospitals, facilities and/or other health care professionals contracted by a health plan to provide services for health plan members.

Nondiscrimination
Rules to determine whether a health plan's policies have the effect of giving higher-paid employees better benefits – or greater access to benefits – than lower-paid employees. These rules have been around since the 1970s, but the 2010 health care reform law requires more plans to comply with them.

Nongrandfathered
A health plan that was purchased after March 23, 2010, or has had certain changes since then such as raising the deductible.

Open Enrollment Period
Usually a designated month each year when an eligible person can enroll initially or transfer from his or her existing coverage to a different plan.

Out of Network
The use of health care providers who haven't contracted with the health plan to provide services. HMO members generally aren't covered if they go to out-of-network providers, except in emergency or certain specific situations. PPO members can use out-of-network providers, but they usually must pay a higher out-of-pocket amount.

Out-of-Pocket Maximum
Refers to the maximum amount that an insured person must pay for services covered by the health plan.

Outpatient
A patient who is receiving ambulatory care at a hospital or other health facility, without being admitted to the facility.

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Patient Protection and Affordable Care Act (PPACA)
The full name of the legislation commonly known as federal health care reform. President Barack Obama signed the PPACA into law on March 23, 2010.

PCIP
See entry for " Pre-existing Condition Insurance Plan (PCIP)."

PCP
See entry for "Primary Care Physician (PCP)."

Plan Year/Policy Year
The 12-month period when a benefit plan is in effect. Your plan year may follow the calendar year (January 1 – December 31) or it may span a different 12-month period (for example, April 1 – March 31).

PPACA
See entry for "Patient Protection and Affordable Care Act (PPACA)."

PPO
See entry for "Preferred Provider Organization (PPO)."

Precertification Review
Utilization management performed before a patient's admission, stay or other service or course of treatment. Also see entries for "Prior Authorization/Preauthorization" and "Utilization Review."

Pre-existing Condition
According to www.healthcare.gov, a pre-existing condition is a condition, disability or illness (either physical or mental) that you have before you enrolled in a health plan.

Pre-existing Condition Exclusion
A section of an insurance policy that states the plan will not pay benefits for a condition, disability or illness that existed before the policy began.

Pre-existing Condition Insurance Plan (PCIP)
The federal high-risk pool for people who have been unable to obtain health coverage because they have a pre-existing health condition. Also see entry for "High-Risk Pool."

Preferred Provider Organization (PPO)
A plan that allows members to choose any provider but offers higher levels of coverage if members receive services from health care providers in the plan's PPO network. These in-network providers have contracted with the health plan to provide services at negotiated reimbursement rates.

Premium
The amount payable to the insurer, usually monthly, for health care coverage.

Preventive Care
Starting with the plan year that begins on or after September 23, 2010, health plans that aren't grandfathered must cover in-network preventive services with no member cost sharing. The required preventive services fall into four categories:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force

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with respect to the individual involved

- Immunizations for routine use in children, adolescents and adults that are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration
- With respect to women, certain evidence-informed preventive care screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. (These additional guidelines for women are being developed by HHS and will likely be issued no later than August 1, 2011.)

Primary Care Physician (PCP)
The main doctor for HMO members who provides most of their care and coordinates other health care services. Primary care physicians include general and family practitioners, internists, pediatricians and other specialists who are approved as designated primary care physicians.

Prior Authorization/Preauthorization
Getting approval from your plan before you get a medical service. For example, your plan may require prior authorization before you're admitted to a hospital or before you fill certain prescriptions. If your plan requires prior authorization and you or your doctor don't get it, you may be responsible for all of the cost.

Referral
Getting approval from your primary care physician before you visit another in-network provider. For example, depending on the type of plan you have, you may need a referral to go to a specialist or urgent care center. If your plan requires a referral and you don't get it, you may be responsible for all of the cost for the visit.

Rescind
See entry for "Rescission."

Rescission
Retroactive cancellation of an individual plan member's coverage. Insurers rarely use this process to reduce fraud and protect members. The 2010 health care reform law says plans can only rescind policies of policyholders who intentionally misrepresent material facts or are involved in fraud.

Retail Health Clinic
A walk-in clinic usually located in a retail store like a pharmacy or supermarket. Retail clinics are staffed by medical professionals (like a physician's assistant or nurse practitioner) who provide basic medical services.

Second Opinion
The voluntary or mandatory requirement to obtain a second opinion from another physician or surgeon about a diagnosis, course of treatment or certain types of elective surgery.

Self Funded/Self Insured
A type of health plan where the employer or other group sponsor is financially responsible for paying plan expenses such as members' claims. The insurance company only provides administrative services. This is also called "administrative services only."

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Skilled Nursing Facility
An institution that provides continuous skilled nursing services. It must be licensed according to state and local laws and be recognized as a skilled nursing facility under Medicare.

Specialist
A physician with extra training in a special field, such as sports medicine or cancer treatment for seniors.

Stay
An inpatient confinement that begins when a member is admitted to a facility and ends when the member is discharged from that facility.

Subscriber
The person under whose name the health insurance contract exists. A subscriber's covered dependent isn't considered a subscriber. The terms "member" or "enrollee" can refer to either subscribers or their enrolled dependents.

U.S. Preventive Services Task Force
A panel of health care experts that evaluates the latest scientific evidence on clinical preventive services.

Underwriting
A process to determine whether a customer qualifies for insurance coverage and what the premium should be.

Urgent Care Center
A clinic that treats problems that should be looked at right away but aren't as serious as emergencies. For example, an urgent care center can do X-rays, lab tests and stitches.

Utilization Review
The review to determine medical necessity is designed to ensure the necessity, appropriateness and efficiency of the use of health care services, procedures and facilities. Hospital admissions are reviewed by a professional review organization to oversee medical necessity.

Waiting Period
The period of time that must elapse before benefits are payable under a health plan.

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