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Understanding Health Reform

Commonly Used Terms in Health Reform

The Affordable Care Act was passed by Congress and signed into law by President Obama on March 23, 2010; the comprehensive health care reform has a number of changes that will affect you, your family, and your friends. Implementation of health reform will make health care more affordable, hold health insurers more accountable, expand health coverage to all Americans, and make the health system sustainable, which will stabilize family budgets, the Federal budget, and the economy.

To help you understand the changes that are happening now and in the near future, we want to make sure you understand the terminology being used. Health care coverage is complex enough, and you shouldn't be stifled because of the health care jargon that is used. Below you will find a glossary of terms.

What do all these terms mean?

Accountable Care Organization
A network of health care providers that band together to provide the full continuum of health care services for patients. The network would receive a payment for all care provided to a patient and would be held accountable for the quality and cost of care. New pilot programs in Medicare and Medicaid are included in the health reform law would provide financial incentives for these organizations to improve quality and reduce costs by allowing them to share in any savings achieved as a result of these efforts.

Allowed Charge for a Covered Service
The maximum dollar amount that a third party, usually an insurance company, will reimburse a provider for a specific service.

Annual Limit
A cap on the benefits your insurance company will pay in a year while you're enrolled in a particular health insurance plan. These 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 that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.

Appeal
A request for your health insurer or plan to review a decision made or to review action on a grievance filed.




Benefits
The health care 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 Children's Health Insurance Program (CHIP), covered benefits and excluded services are defined in State program rules. For more information, please visit http://www.healthcare.gov.

Care Coordination
The organization of your treatment across several health care providers. Medical homes and accountable care organizations are two common ways to coordinate care.

Children's Health Insurance Program (CHIP)
Insurance program jointly funded by State and Federal government to provide health insurance to low-income children and in some States, pregnant women in families who earn too much income to qualify for Medicaid but cannot afford to purchase private health insurance coverage.

Chronic Disease Management
An integrated care approach to managing illness which includes screenings, checkups, monitoring and coordinating or treatment, and patient education. It can improve your quality of life while reducing your health care costs if you have a chronic disease by preventing or minimizing the effects of a disease and by promoting earlier and more effective recovery.

Claim
A request for payment that you or your health care provider submits to your health insurer when you get items or services you think are covered.

Consolidated Omnibus Budget Reconciliation Act (COBRA)
A Federal law that may allow you to temporarily keep health coverage after your employment ends, you lose coverage as a dependent of the covered employee, or another qualifying event. If you elect COBRA coverage, you pay 100 percent of the premiums, including the share the employer used to pay, plus a small administrative fee.

Coinsurance
The percentage of allowed charges for covered services that you're required to pay. For example, the health insurance may cover 80 percent of charges for a covered hospitalization, leaving you responsible for the other 20 percent. This 20 percent is known as the coinsurance.

Copayment
A flat dollar amount you must pay for a covered service. For 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 your own pocket. This term generally includes deductibles, coinsurance and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for nonnetwork providers, or the cost of noncovered services. Cost sharing in Medicaid and CHIP also includes premiums.

Deductible
The amount you must pay each year or policy period for covered care before your health insurance begins to pay.




Dependent Coverage
Insurance coverage for family members of the policyholder, such as spouses, children, or partners.

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.

Essential Health Benefits
A set of health care service categories that must be covered by certain plans starting in 2014. These include doctor office visits, prescriptions, hospitalizations, and mental health and substance use disorder benefits. Insurance policies must cover these benefits to be certified and offered in exchanges, and all Medicaid State plans must cover these services by 2014.

Exchange
An exchange is a new open and competitive marketplace where individuals, including those who don't have coverage or who can't afford coverage through their employer, and small businesses can buy affordable health plans.

Exclusions
Items or services that aren't covered under your contract for insurance and for which an insurance company won't pay. For example, your policy may not cover experimental approaches to care or any services related to a pre-existing condition.

Federal Poverty Level
A measure of income level issued annually by the U.S. Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits. You can find the Federal Poverty Guidelines at http://aspe.hhs.gov/poverty/.

Fee for Service
A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.

Fully Insured Job-Based Plan
A health plan purchased by an employer from an insurance company.

Grandfathered Health Plans
As used in connection with 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 exempted 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 whether it considers itself to be a grandfathered plan and must also advise consumers how to contact the U.S. Department of Labor or the U.S. Department of Health and Human Services with questions. (Note: If you are in a group health plan, the date you joined may not reflect the date the plan was created. New employees and new family members may be added to grandfathered group plans after March 23, 2010).




Grievance
A complaint that you communicate to your 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.

Health Homes
A health home is not a physical home; a health home is a provider or team of health care professionals. That home then becomes accountable for that person's care: managing and coordinating all of the services a person receives, promoting good health, helping with transitions from one kind of setting to another, providing support to both the person and family members, and offering referrals to community and social support services. Health information technology helps link all of these services together.

Health Maintenance Organization (HMO)
A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

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

Home and Community-Based Services
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. This care is covered when provided by care workers or, if your State permits it, by your family.

Individual Health Insurance Policy
Policies for people who aren't connected to job-based coverage or Government health insurance programs such as Medicaid and Medicare. Individual health insurance policies are regulated under State law.

Lifetime Limit
A cap on the total lifetime benefits you may get from your insurance company. An insurance company may impose a total lifetime dollar limit on benefits (like a $1 million lifetime cap) or limits on specific benefits (like a $200,000 lifetime cap on organ transplants or one gastric bypass per lifetime) or a combination of the two. After a lifetime limit is reached, the insurance plan will no longer pay for covered services. Lifetime limits are no longer allowed under the Affordable Care Act.




Long-Term Care
Services that include medical and nonmedical care 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 don't pay for long-term care.

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 for Medicaid and sets guidelines for the program. States also have choices in how they design their program, so Medicaid varies State by State and may have a different name in your State. For more information on Medicaid, please visit http://www.healthcare.gov.

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 (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Medicare Advantage (Medicare Part C)
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. Medicare advantage plans include HMOs, preferred provider organizations (PPOs), private fee-for-service plans, special needs plans, and Medicare medical savings account plans. If you're enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under original Medicare. Most Medicare advantage plans offer prescription drug coverage.

Medicare Part D
A program that helps pay for prescription drugs for people with Medicare who join a plan that includes Medicare 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.

Minimal Essential Coverage
The type of coverage an individual needs to have to meet the individual responsibility to have minimum insurance coverage as required under the Affordable Care Act. Minimum essential coverage can be acquired through individual market insurance policies, job-based insurance coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverages.

Network
The facilities, providers, and entities your health insurer or plan has contracted with to provide health care services.

Nonpreferred Provider
A provider who does not have a contract with your health insurer or plan to provide services to you. You may pay more to see a nonpreferred provider. If you have a PPO plan, it will likely cost less if you go to a preferred provider.




Open Enrollment Period
The period of time set up to allow you to choose from available plans and to process an annual enrollment. This takes place usually once a year unless you have had a change in life status, such as getting married or divorced or moving to a new job (see special enrollment period).

Out-of-Pocket Costs
Your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services, plus all costs for services that aren't covered.

Plan Year/Policy Year
A 12-month period of benefits coverage under a group health plan. This 12-month period may not be the same as the calendar year. To find out when your plan year begins, you can check your plan documents or ask your employer. (Note: For individual health insurance policies, this 12-month period is called a "policy year").

Point-of-Service (POS)
A type of plan in which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans 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, or prescription drugs are medically necessary. Sometimes this is called prior authorization, prior approval, or precertification. Your health insurance or plan may require preauthorization for certain services before you can receive them, except in an emergency. Preauthorization isn't a promise that your health insurance or plan will cover the cost.

Pre-Existing Condition (Job-Based Coverage)
Any condition (either physical or mental) including a disability for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on your enrollment date in a health insurance plan. Genetic information, without a diagnosis of a disease or a condition, cannot be treated as a pre-existing condition. Pregnancy cannot be considered a pre-existing condition and newborns, newly adopted children, and children placed for adoption who are enrolled within 30 days cannot be subject to pre-existing condition exclusions.

Pre-Existing Condition Exclusion Period (Job-Based Coverage)
The time period during which a health plan won't pay for care relating to a pre-existing condition. Under a job-based plan, this cannot exceed 12 months for a regular enrollee or 18 months for a late enrollee.

Pre-Existing Condition (Individual Policy)
A condition, disability, or illness (either physical or mental) that you have before you're enrolled in a health plan. This term is defined under State law and varies significantly by State. Genetic information, without a diagnosis of a disease or a condition, cannot be treated as a pre-existing condition.




Pre-Existing Condition Exclusion Period (Individual Policy)
The time period during which an individual policy won't pay for care relating to a pre-existing condition. Under an individual policy, conditions may be excluded permanently (known as an "exclusionary rider"). Rules on pre-existing condition exclusion periods in individual policies vary widely by State.

Pre-Existing Condition Insurance Plan
A new program that will provide a health coverage option for you if you have been uninsured for at least 6 months, you have a pre-existing condition, and you have been denied coverage (or offered insurance without coverage of the pre-existing condition) by a private insurance company. This program will provide coverage until 2014, when you will have access to affordable health insurance choices through an Exchange, and you can no longer be discriminated against based on a pre-existing condition. For more information go to http://www.healthcare.gov.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount.

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 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.

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

Primary Care
Health services that cover a range of prevention, wellness, and treatment for common illnesses. Primary care providers 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
Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by an 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 exchange in which it is sold.

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




Where can I find more information on Health Reform?

The Affordable Care Act was passed by Congress and signed into law by President Obama on March 23, 2010; the comprehensive health care reform has a number of changes that will affect you, your family and your friends. There are a number of resources available to help you find information about the Affordable Care Act. Some resources available are:

- http://www.healthcare.gov
- http://www.samhsa.gov/healthreform
- http://blog.samhsa.gov
- http://www.hhs.gov
- http://www.ncsl.org

The most comprehensive resource available is the federal government's new website http://www.healthcare.gov. Healthcare.gov provides you with a number of resources. On healthcare.gov you can:

- Find and compare health care coverage options in your state, including Medicaid services.
- Access information and timelines about the different provisions in the Affordable Care Act.
- Compare care quality of hospitals.
- Learn about health prevention and get prevention tips.

If you want to know more about your rights under the Affordable Care Act, go to: http://www.healthcare.gov/law/provisions/billofright/patient_bill_of_rights.html.

Rescission
The retroactive cancellation of a health insurance policy. Insurance companies will sometimes retroactively cancel your entire policy if you made a mistake or intentionally misrepresent your medical condition 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.

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.

Special Enrollment Period
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 (for example, marriage, birth of a child, aging out of dependent coverage) or loss of other job-based health coverage.

Specialist
A physician specialist focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

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. For example, in some States, if you're leaving a job-based plan, you must be allowed to continue your coverage until you reach the age of Medicare eligibility.

Uncompensated Care
Health care or services provided by hospitals or health care providers that don't get reimbursed. Often, uncompensated care arises when people don't have insurance and cannot afford to pay the cost of care.

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.