

HEALTH INSURANCE TERMINOLOGY

Accumulation Period: Time frame within a policy period in which deductible amounts are calculated. This may be calculated either on the calendar year or the effective beginning and end of the policy year.

Actuary: A professional who mathematically analyzes and determines the price of the risks associated with providing insurance coverage. An actuary may also determine the anticipated cost of providing future benefits. Factors considered in the study include the projection of future claims experience, administrative expenses and anticipated investment return.

Adjusted Community Rate (ACR): Uniform capitation rate that is charged to all enrollees in a plan based on adjustments for risk factors such as age and sex (see “community rating” below).

AD&D: Accidental death and dismemberment insurance.

Annual Limits: Under the Patient Protection and Affordable Care Act (PPACA), lifetime limits are no longer allowed and annual limits on essential benefits may be allowed as follows: \$750,000 after 9/23/10, \$1.25 million after 9/23/11, \$2 million after 9/23/12 and none beginning after 9/23/14.

Capitation: Method of compensation to pay providers (usually an HMO) a fixed amount for each enrollee regardless of the actual number or nature of services provided to each participant.

Coordination of Benefits (COB): Provisions made to avoid duplication of payments if more than one policy holder in the family has medical insurance. For purposes of filing claim forms, generally, one individual is determined to be the primary insured, or the insured adult with the earliest birthday in the year is the primary insured over all others in the family. The goal is to assure that, should you receive benefits from more than one health care provider, the benefits you receive from all sources do not exceed allowable medical expenses or avoid appropriate patient incentives to contain cost.

Co-insurance: The portion of the approved claim that you, the policy holder, are obligated to pay. A typical arrangement is for the insurance company and you to share the payment of all claims, based on a percentage basis up to an agreed amount of money, after which the insurance company then pays 100% of covered expenses during the remainder of the calendar year up to any limits of the policy.

Community Rating: A rating method that determines a single average premium based on the characteristics and claims experience of an entire membership in an insurance pool. See “adjusted community rate” above.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA): A federal law that requires most employers to allow eligible employees and their beneficiaries to continue to self-pay for their coverage after employment terminates for up to 18, 24, 29 or 36 months, depending on family status.

Co-Payment: A set fee paid by you for medical expenses upon each occurrence, such as a doctor’s office visit, pharmaceutical purchase, or other medical services. See co-insurance, above.

Covered Expense(s): A medical expense that will be reimbursed to you or paid directly to the provider, according to the terms of the plan or insurance contract.

Deductible: The amount that you must pay within a specified accumulation period before the insurance company will reimburse you for eligible expenses.

Dependent: The person(s) in the insured’s family entitled to receive benefits under a plan.

Diagnostic Related Group (DRG): A cost commitment schedule whereby medical service providers set a uniform payment for specific services.

Effective date: The date which an insurance policy becomes eligible to pay for claims.

Employee Retirement Income Security Act of 1974 (ERISA): A federal law that governs many of the terms and conditions of pension and/or health insurance plans presided over by employers and employee organizations such as unions.

Evidence of Insurability: Proof of one's physical condition and occupation.

Experience-Rated: Determination of premium rates for a group risk based wholly or partly on that group's previous cost and utilization experience.

Explanation of Benefits (EOB): A document sent to you when the plan or insurance company handles a claim. The document explains how reimbursement was made e.g., to the insured or to the provider, or why the claim was not paid, and if any additional information is needed. The appeals procedure should be outlined to advise you of your rights if there is dissatisfaction with the decision.

Family Deductible: A health insurance deductible that is based on the medical expenses of the collective members of a family rather than one individual.

Fee for Service: Traditional health insurance that puts no restrictions on choice of doctors, hospitals or medical services providers regardless of network affiliation.

First Dollar Coverage: Coverage that pays the entire amount covered without the application of a deductible.

Flexible Spending Account (“FSA”): An IRS regulated *employee-funded* medical expense reimbursement plan provided for in Section 125 of the Internal Revenue Code which allows you to pay for health premiums, over the counter medically related items, unreimbursed medical costs, and licensed child and dependent care costs with tax-free dollars. You determine the amount to be deducted regularly from your paycheck pretax. You do not pay federal, state, or local income tax, nor will you pay any social security taxes on the amount deducted. The money is placed in an account for future reimbursements to you. You must use the money to pay these bills or any unused amount reverts to the employer at the end of the year.

Formulary Drugs: List of preferred pharmaceutical products to be used by a managed care plan's network physicians. They are usually more expensive than generic or normal, brand-name drugs.

Fully-Insured Program: The employer pays the entire premium and, in return, transfers all of the risk and responsibility for claims payments to the insurance company.

Gatekeeper: (Primary Care Physician) A health professional within a managed-care environment who determines the patient's access to treatment. The primary care physician treats the patient and determines necessity of access to further treatment and specialists.

Generic Drugs: Prescriptions that are identical, or bioequivalent to a brand name drug in dosage form, safety, strength, route of administration, quality, performance characteristics, and intended use. They are typically sold at substantial discounts from the branded price.

Genetic Information: Information about an individual's genetic tests and the genetic tests of an individual's family members, as well as information about the manifestation of a disease or disorder in an individual's family members (i.e. family medical history). Health plans are restricted in their use and collection of genetic information.

Grandfathered Plan: Under the Patient Protection and Affordable Care Act (PPACA), a grandfathered plan is a plan that existed on March 23, 2010 (when the PPACA was enacted) and that only makes limited or no changes to items like essential benefits, co-insurance percentage amounts, cost sharing requirements, copayments, employee contribution percentages and annual limits. These plans are exempt from some of the new requirements of the PPACA, including for example, the requirement that preventive care services must be provided without any cost sharing.

Non-Grandfathered Plans: Under the Patient Protection and Affordable Care Act (PPACA), a non-grandfathered was a plan that was not in existence as of March 23, 2010 or that made certain changes after that date resulting in a loss of grandfathered status. These plans are subject to the new mandates of the PPACA, including among others, the requirement that there be no cost sharing for certain preventive care received in-network, that plans must offer a choice of primary care provider, that there is no pre-authorization for emergency services even if out of network and no limits for emergency services received out of network.

Group Insurance: An insurance program designed to offer health insurance to persons belonging to a group (business, association, professional group, etc.) and their families. As a group, premiums are typically less expensive and choice of benefits broader than purchasing individual health policies.

Health Insurance Agent: Licensed by the state, performs the functions for sole proprietors and small businesses that Human Resource Departments do for larger businesses, gathers census data, prepares proposals, makes presentations to businesses, explains benefits to employers, and employees, does field underwriting when required, delivers policies and certificates, assists in handling claims, performs other related tasks required by the employer or sole proprietor.

Health Maintenance Organization (HMO): An organization that provides a wide range of comprehensive health care services for a specified group of enrollees for a fixed, pre-paid premium, regardless of the amount of actual services rendered. Generally, referrals for tests and specialist must be pre-approved. The employee and his/her dependents have no choice of the physician unless he/she is in the HMO.

Health Reimbursement Arrangement (HRA): An IRS regulated, *employer-funded* medical expense reimbursement plan provided for in Section 105 of the Internal Revenue Code. This plan has three mandatory elements: 1) no employee funding is allowed; 2) only income tax deductible medical expenses may be paid from HRA funds, and 3) no withdrawals are allowed for any purpose other than qualified medical reimbursement expenses. Unused amounts are not forfeited at the end of the plan year, but can be carried over for use in future years.

Health Savings Accounts (HSA): An IRS regulated *employee and/or employer-funded* medical expense reimbursement plan provided for in Section 105 of the Internal Revenue Code that allows you to pay for qualified medical expenses with pre-tax dollars, and save for retirement on a tax-deferred basis. Either you or your employer can contribute to your HSA, with a maximum yearly contribution and associated tax deduction of \$2,850 for individuals and \$5,650 for families. The HSA must be used in conjunction with a high-deductible HSA-eligible health insurance plan (minimum annual deductible of \$1,100 for individuals and \$2,200 for families, with the additional requirement that the sum of the annual deductible and other annual out of pocket expenses required to be paid under the plan, other than premiums, does not exceed \$5,500 for individuals and \$11,000 for families). Pre-tax money is deposited into your account and can be withdrawn at any time with no penalty or taxes to pay for qualified medical expenses. Withdrawals can also be made for non-medical purposes, but will be taxed as normal income and subject to a 10% penalty if withdrawn prior to age 65. Can be used to pay for health care plan deductibles, co-payments, coinsurance, prescription and over the counter drugs, dental services, vision care, certain psychological treatments, long term care services, and some health care retirement plans. Any HSA funds not used in one year remain in the account and earn interest tax-free to supplement medical expenses at any time in the future.

Hospitalization Insurance: Reimbursement for specified expenses while being hospitalized due to illness or injury.

Indemnity Plan: Health care insurance plan providing benefits either on a fee-for-service basis or at a predetermined amount for covered services. Traditionally, the insurance company pays on a fee-for-service basis.

Insured: The policyholder (e.g., the employer) or beneficiary group (e.g., the employees).

Insurer: The insurance company.

Lapse: The termination of an insurance policy for nonpayment of the premium.

Lifetime Limits: A limit on the amount of benefits that an individual can receive while covered under the Plan. Under the Patient Protection and Affordable Care Act, these limits are now prohibited for “essential health benefits.”

Long Term Disability Insurance (Long Term Care - LTC): Continuum of maintenance, custodial, and health services to the chronically ill, disabled, or mentally impaired over a lengthy period of time. Services may be provided in long-term care or on an outpatient basis (subacute care, rehabilitation facility, nursing home, mental hospital, outpatient, or at-home basis).

Major Medical Insurance: A policy that covers most serious medical expenses up to a maximum limit, usually after the deductible and coinsurance have been met.

Managed Care: Various plans that put limits on the number and types of treatments as well as the health care service providers and facilities that are covered. Each recognized provider agrees to a negotiated fee structure for health care procedures, thus lowering costs for both the insurance company and the insured. Managed care is provided through managed indemnity plans; Preferred Provider Organizations (PPOs), Exclusive Provider Organizations (EPOs), Health Maintenance Organizations (HMOs), or any other cost management environment.

Medical Savings Account: See Health Saving Account

Medical Expense Reimbursement Plan (MERP): Similar to a HSA, this is an employee benefit that enables *either you or your employer* to set up an account from which you can pay with pre-tax dollars for health, prescription, dental, and vision expenses not covered by your insurance plan. A maximum of \$2,500 annually may be deposited into your MERP. Any money remaining in your account at the end of the plan year is forfeited.

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA): An act that requires large group health plans (employers with more than 50 employees) to offer mental health and substance abuse disorder benefits that are no more restrictive than the predominant requirements or limits that apply to substantially all medical/surgical benefits.

Multiple Employer Welfare Arrangement (MEWA): An employee welfare arrangement designed to provide benefits to employees of two or more employers.

Network Providers: Limited grouping or panels of providers in a managed care arrangement. You may be required to use only network providers or may have financing liability for using non-network providers for medical services.

Out of Network Providers: Medical services obtained by managed care members from unaffiliated or non-contracted health care providers. Often, such care will not be reimbursed unless previous authorization is obtained.

Out of Pocket Expenses: That percentage of medical expenses paid by you for deductibles, co-payments, or if you receive medical services from a provider not associated with the approved network.

Out of Pocket Maximum Expenses: The maximum amount paid by you before 100% of medical expenses will be covered by the insurance company. Also called “stop-loss.”

Patient Protection and Affordable Care Act (PPACA): A comprehensive health care reform law that imposes many requirements on group health plans and plans in the individual market.

Point of Service Plans (POS): Combination of medical insurance that offers both an HMO and PPO. The policyholder may choose to utilize the HMO, the PPO or a non-aligned medical service. Co-payments vary, depending on the policyholder’s choice.

Policyholder: The insured or other entity who is named on the insurance policy and is responsible for payment of premiums.

Policy year: The year beginning with the effective date or the renewal date of a policy

Pre-Authorization: Previous approval required for referral to a specialist or non-emergency health care services.

Preexisting Conditions: Generally, a condition for which a participant received or a participant’s physician recommended medical advice, diagnoses, care or treatment within the six months prior to coverage in a group health plan. A group health plan can exclude preexisting conditions for most people for 12 months, but that period is reduced by the time a participant had “creditable coverage,” including coverage under a group health plan.

Preferred Drugs: Prescriptions that are most commonly prescribed by network providers. See “generic” and “formulary,” above.

Preferred Provider Organizations (PPOs): Managed care arrangement consisting of a group of hospitals, physicians, and other providers (a “network”) who have contracts with an insurer, employer, third-party administrator, and/or other sponsoring groups. Pre-approval for tests and specialists is generally not required.

Premium: Periodic payment to keep an insurance policy in force.

Primary Care Physician: In a HMO or PPO plan that includes this requirement, the program-approved health care provider whom you must contact first with all medical concerns. Generally is a non-specialist who provides basic routine medical care, initiates referrals to a specialist, and provides follow-up care. Referrals are generally to other contracted providers and contracted hospitals. See Gatekeeper.

Self-Funded Plan: An arrangement under which some or all of the risk associated with providing medical insurance is assumed by the employer and not covered by an insurance contract.

Short-Term Insurance: Short-term medical coverage is a major medical plan designed to protect you in the event of an illness or injury during "gaps" in your traditional medical coverage -- when you are between jobs or plans, a recent graduate, on strike, etc. Short-term plans are not meant to cover routine exams and preventive care.

Specialty Physicians: Those physicians practicing in areas other than internal medicine, family practice, or pediatrics (e.g., ob-gyn, oncologist, cardiologist).

Stop-Loss Insurance: Insurance protection purchased by self-insured managements and some managed care arrangements against the risk of large losses or severe adverse claim experience.

Taft-Hartley Plans: Private welfare and/or pension plans that must adhere to the Taft-Hartley Act and ERISA. These plans are set up and administered jointly by unions and participating employers.

Third Party Administrator (TPA): Method by which an outside person or firm, not a party to a contract, provides specific administrative duties, including premium accounting, claims review and payment, arranges for utilization review, and stop-loss coverage for a health plan.

Underwriters: Insurance company employees who are responsible for identifying and classifying the degree of risk represented by a proposed insured group and determining the premium costs.

Usual and Customary Fees: Fees paid to health care provider that have been established by insurance companies and their underwriters that are consistent with charges from similar providers for identical or similar services in a given locale.

Well Baby Care: The goals of well baby care are 1) to immunize; 2) to provide parents with reassurance and counseling on safety, nutrition and behavioral problems; and 3) to identify and treat physical and developmental problems.

Wrap-Around Coverage: Programs of HMOs that, in some states, were prevented by state law from taking on financial risk for out-of-plan care and joined with insurers to cover the out-of-plan portion of care. Such programs led to the development of point-of-service (POS) plans.

These definitions are intended to provide the layperson with a basic idea of the meaning of basic medical insurance terms. In many instances the definitions have been oversimplified for easier understanding. ICSOM wishes to advise you that these definitions should not be relied upon in any legal or quasi-legal context.