

Glossary of Health Care Terms

Frequently Used Acronyms

ACA: Affordable Care Act	CHIP: Children's Health Insurance Program
ESA: Employment Support Allowance	EHB: Essential Health Benefit
HMO: Health Maintenance Organization	HSA: Health Savings Account
HRA: Health Reimbursement Account	MLR: Medical loss Ratio
QHP: Qualified Health Plan	SBC: Summary of Benefits and Coverage
SSN: Social Security Number	SHOP: Small Business Health Options Program

Terms used in talking about health care

This Glossary contains all of the terms provided by the United States Government in their Glossary of Health Coverage and Medical Terms, as well as additional terms and phrases commonly used.

Actuarial Value

A health plan's actuarial value is the percentage of total average costs for benefits that a plan covers. Starting in 2014, all health plans will have an actuarial value assigned to them — bronze, silver, gold or platinum. As the metal category increases in value, so does the percent of medical expenses that a health plan will cover. This means the platinum-level plans will cover the highest percentage of health care expenses. These expenses are usually incurred at the time of health care services — when you visit the doctor or the emergency room, for example. The health plans that cover the greatest percentage of health care expenses also usually have higher premium payments.

Affordable Care Act

Enacted in March 2010, the federal Patient Protection and Affordable Care Act, commonly referred to as the ACA or "Obamacare," provides the framework, policies, regulations and guidelines for implementation of comprehensive health care reform by the states. The Affordable Care Act will expand access to high-quality affordable insurance and health care.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Ambulatory Patient Services

Medical care provided without need of admission to a health care facility. This includes a range of medical procedures and treatments such as blood tests, X-rays, vaccinations, nebulizing and even monthly well-baby checkups by pediatricians.

Annual Household Income

The total amount of income for a family in a calendar year.

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 or grievance again.

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A preferred provider may not balance bill you for covered services.

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.

Catastrophic Plan

Health plans that provide coverage for only high-cost services, such as a medical catastrophe, or when medical costs exceed a very high deductible.

Claim

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

COBRA

A federal law that may allow you to temporarily keep health coverage after your employment ends, after you lose coverage as a dependent of the covered employee, or as a result of another qualifying event. If you elect COBRA coverage, you pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20 percent) of the allowed amount for the service, is called coinsurance. You pay coinsurance plus any deductible you owe. For example, if the health insurance plan's allowed amount for an office visit is \$100 and you have met your deductible for the year, your coinsurance payment of 20 percent would be \$20. The health plan pays the rest of allowed amount.

Complications of Pregnancy

Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Copayment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

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 non-network providers, or the cost of noncovered services. Cost-sharing in Medicaid and Children's Health Insurance Program also includes premiums.

Deductible

The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is \$1,000, your plan won't pay anything until you have met your deductible for covered health care services. The deductible may not apply to all services.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition

A condition where there is an immediate need for health services. This happens when a person's life or health or ability to get, keep, or regain maximum function is in serious danger.

Emergency Medical Transportation

Ambulance services for an emergency medical condition.

Emergency Room Care

Emergency services you get in an emergency room.

Emergency Services

Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Essential Health Benefits

Health care service categories that must be covered by certain plans, starting in 2014. These service categories include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, behavioral health treatment, prescription drugs, rehabilitative and habilitation services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including dental and vision care. Insurance policies must cover these benefits in order to be certified and offered in the marketplace, and all Medicaid state plans must cover these services by 2014.

Exchange

The word "Exchange" is used in the federal health care law to describe the marketplace where individuals, families and small business owners in a state will access health insurance in 2014. In some states the exchange is run by the State in others it is run by the federal government.

Excluded Services

Health care services that your health insurance or plan doesn't pay for or cover.

Federal Poverty Level

A measure of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits. If you earn less than the Federal Poverty level, you qualify for various programs and service. In 2012, the federal poverty level for an individual was \$11,170 per year and \$23,050 per year for a family of four. To see a chart with more information on federal poverty levels, please visit <http://www.familiesusa.org/resources/tools-for-advocates/guides/federal-poverty-guidelines.html>

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.

Full-Time Equivalent Employees

The federal government has not yet defined “full-time” or “full-time equivalent” for purposes of determining whether a business is small or large. More information will be forthcoming in the months ahead.

Grandfathered Plans

As used in connection with the 2010 federal health law: 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 federal health law. 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.

Grievance

A complaint that you communicate to your health insurer or plan.

Guaranteed Issue

A requirement that health plans must allow you to sign up for coverage, regardless of health status, age, gender, or other factors that might predict how much you use health services. 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. Guaranteed renewal doesn't limit how much you can be charged if you renew your coverage.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't 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.

Health Insurance

A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

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 Reimbursement Account (HRA)

Health Reimbursement Accounts (HRAs) are employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year. Unused amounts may be rolled over to be used in subsequent years. The employer funds and owns the account. Health Reimbursement Accounts are sometimes called Health Reimbursement Arrangements.

Health Savings Account (HSA)

A medical savings account available to taxpayers who are enrolled in a qualified High Deductible Health Plan. The funds contributed to the account aren't 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 don't spend them.

Home Health Care

Health care services a person receives at home.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

In-Network Co-Insurance

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 co-insurance usually costs you less than out-of-network co-insurance.

In-Network Co-Payment

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 co-payments usually are less than out-of-network co-payments.

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.

Medically Necessary

Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Medical Loss Ratio (MLR)

A basic financial measurement of how much of the premium is used to pay for medical care versus overhead. . If an insurer uses 80 cents out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care, the company has a medical loss ratio of 80%. A medical loss ratio of 80% indicates that the insurer is using the remaining 20 cents of each premium dollar to pay for overhead expenses, such as administrative costs, salaries, marketing and agent commissions, and/or retaining some as profit. Federal law sets minimum medical loss ratios for different markets, as do some state laws.

Medicare

A federal health insurance program for people 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).

Network

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

Non-Preferred Provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Open Enrollment

A designated period of time each year – usually a few months – during which insured individuals or employees can make changes in health insurance coverage.

Out-of-Network

Health care providers who are not a part of your health plan. Health plans do not have to cover services provided by out-of-network doctors. Always check if your health care provider is "in-network" to avoid paying additional costs.

Out-of-Network Co-Insurance

The percent (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 co-insurance usually costs you more than in-network co-insurance.

Out-of-Network Co-Payment

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 co-payments usually are more than in-network co-payments.

Out-of-Pocket Limit

The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit. In Medicaid and CHIP, the limit includes premiums.

Pre-existing Medical Condition

Any illness or condition a patient has prior to obtaining insurance. Under the ACA an insurance plan may not refuse to sell you insurance because of a pre-existing condition.

Physician Services

Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan

A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Policy

The contract (agreement) between the person buying health insurance and the company providing it, describing specific health care services that will be covered, any coverage limitations and any out-of-pocket costs (copays) that might be required.

Pre-authorization

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 isn't a promise your health insurance or plan will cover the cost.

Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay(s) it monthly, quarterly or yearly.

Prescription Drugs

Drugs and medications that by law require a prescription.

Prescription Drug Coverage

Health insurance or plan that helps pay for prescription drugs and medications.

Primary Care Physician

A doctor (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider

A doctor (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Preferred Provider

A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a “tiered” network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also “participating” providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Preferred Provider Organization (PPO)

A network of health care providers with which a health insurer has negotiated contracts for its insured population to receive health services at discounted costs. Health care decisions generally remain with the patient as he/she selects providers and determines his or her own need for services. Patients have financial incentives to select providers within the PPO network.

Provider

A doctor (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed (hospital, clinics), certified or accredited as required by state law.

Qualified Health Plan

An insurance product that is certified by a marketplace, 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 in which it is sold.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services

Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was 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 federal law, rescission is illegal except in cases of fraud or intentional misrepresentation of facts as prohibited by the terms of the plan or coverage.

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Special Enrollment

The opportunity for people who experience a life-changing event, such as the loss of a job, death of a spouse or birth of a child, to sign up immediately in an employer’s health plan, even if it is outside of the plan’s specified enrollment period.

Specialist

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

Subsidy

Starting in 2014, cost-sharing subsidies and tax credits will lower the cost of premiums and out-of-pocket expenses for health coverage that qualifying families purchase through Exchanges.

Tax Credit

One of the largest subsidy programs for health insurance, starting in 2014, to help consumers pay health insurance premiums. Tax credits will also be available to small businesses with no more than 25 full-time equivalent employees to help offset the cost of providing coverage.

UCR (Usual, Customary, Reasonable)

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

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.

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. Some examples of wellness programs include programs to help you stop smoking, diabetes management programs, weight loss programs, and preventative health screenings.