



Healthcare and Insurance Related Acronyms

AAC: Actual Acquisition Cost
 ACA: Affordable Care Act
 ACO: Accountable Care Organization
 APTC: Advanced Premium Tax Credit
 AV: Actuarial Value
 CAC: Certified Application Counselor
 CAP: Consumer Assistance Program
 CClO: Center for Consumer Information and Insurance Oversight
 CDC: Centers for Disease Control and Prevention
 CHC: Community Health Center
 CHIP: Children's Health Insurance Program
 CHIPRA: Children's Health Insurance Program Reauthorization Act of 2009
 CMS: Centers for Medicare & Medicaid Services
 COB: Coordination of Benefits
 COBRA: Consolidated Omnibus Budget Reconciliation Act
 CON: Certificate of Need
 CO-OP: Consumer Operated and Oriented Plan
 CSHCNs: Children with Special Health Care Needs
 CSR: Cost-Sharing Reduction
 DUR: Drug Utilization Review
 DME: Durable Medical Equipment
 EAC: Estimated Acquisition Cost
 ECP: Essential Community Provider
 ED: Emergency Department
 EHB: Essential Health Benefits
 EMR: Electronic Medical Record
 EOB: Explanation of Benefits
 EPO: Exclusive Provider Organization
 EPSDT: Early Periodic Screening, Diagnostic & Treatment Services
 ERISA: Employee Retirement Income Security Act
 ESI: Employer-sponsored Insurance
 FDA: Food and Drug Administration
 FFM/FFE: Federally Facilitated Marketplace/ Federally Facilitated Exchange
 FFS: Fee-for-service
 FPL: Federal Poverty Level
 FQHC: Federally Qualified Health Center
 FSA: Flexible Spending Account
 HCR: Health Care Reform
 HCBS: Home and Community-Based Services
 HDHP: High Deductible Health Plans
 HHS: U.S. Department of Health and Human Services
 HIPAA: Health Insurance Portability and Accountability Act
 HIM/HIX: Health Insurance Marketplace/ Health Insurance Exchange
 HMO: Health Maintenance Organization
 HRP: High Risk Pool
 HRSA: Health Resources and Services Administration



HSA: Health Savings Account
HDHP: High Deductible Health Plan
HTC: Hemophilia Treatment Center
IPA: In-Person Assistors Program
LTC: Long Term Care
MAGI: Modified Adjusted Gross Income
MA: Medicare Advantage
MCO: Managed Care Organization
MLR: Medical Loss Ratio
MOOP: Maximum Out-of-Pocket
OEP: Open Enrollment Period
OON: Out-of-Network
OOP: Out-of-Pocket
P4P: Pay for Performance
PA: Prior Authorization
PBM: Pharmacy Benefit Manager
PCCM: Primary Care Case Management
PCMH: Patient-centered Medical Home
PCIP: Pre-existing Condition Insurance Plan
PCORI: Patient-Centered Outcomes Research Institute
PCP: Primary Care Provider
PDL: Preferred Drug List
PDP: Prescription Drug Plan under Medicare Part D
POS: Point-of-Service Plan
PMPM: Per-member Per-month
PPO: Preferred Provider Organization
QHP: Qualified Health Plan
SPA: State Plan Amendment
SBC: Summary of Benefits and Coverage
SBM/SBE: State Based Marketplace/State Based Exchange
SEP: Special Enrollment Period
SHOP: Small Business Health Options Program
SNF: Skilled Nursing Facility
SPM/SPE: State Partnership Marketplace/ State Partnership Exchange
SPP: Specialty Pharmacy Provider
SSDI: Social Security Disability Income
SSI: Supplemental Security Income
TPA: Third Party Administrator
UCR: Usual, Customary and Reasonable Charges
WAC: Wholesale Acquisition Cost



Glossary of Commonly Used Healthcare Terms

340B Program: The 340B Drug Pricing Program enables eligible health care organizations (known as covered entities) to purchase drugs from manufacturers at reduced prices. It is called 340B since that is the section of the Public Health Service Act that establishes the program. Eligible health care organizations/covered entities include hemophilia treatment centers as well as community health centers, children's and other types of hospitals, Ryan White clinics, and other safety net providers.

Accountable Care Organization (ACO): A group of healthcare providers that gives coordinated care for chronic disease management with the goal of improving the quality of patient care. The "organization's" payment is tied to achieving healthcare quality goals and outcomes that result in cost savings. ACOs can include various types of doctors – primary care, specialists, etc. – as well as other medical providers (nurses, physician's assistants, etc.) and institutions (hospitals, multi-physician practices).

Accreditation: This is the "seal of approval" given to the plan by an independent organization to show that the plan meets national quality standards.

Accumulator: Refers to the running total amount of money you have paid towards your out-of-pocket maximum for covered services. This includes the amount you have paid towards your deductible, copays and coinsurance, but not your monthly premium payments.

Accumulator Adjustment Programs: A program used by pharmacy benefit managers (PBMs) which allows them to identify when a manufacturer copay card has been used and prohibits it from counting towards your deductible or OOP maximum.

Actual Acquisition Cost (AAC): An estimate of the actual price a pharmacy provider pays for the drug.

Actuarial Value (AV): The percentage of total average costs for covered benefits that a plan will cover. *Example:* if a plan has an actuarial value of 70%, on average, people enrolled in the plan would be responsible for 30% of the costs of all covered benefits. However, your own share of costs could be higher or lower depending on your *actual* healthcare needs and terms of your insurance policy. The AV is a rough measure of how generous a plan's coverage is, but it won't tell you your own costs over the year or for any given service. Under the ACA, coverage must be offered in four categories, Bronze, Silver, Gold and Platinum, (sometimes called metal tiers) based on the actuarial value of providing essential health benefits to members. Two plans may be in the same metal tier, but that does not mean that they will cover the same benefits in the same way. (See Bronze, Silver, Gold and Platinum Health Plans and Fact Sheet).

Advanced Premium Tax Credit (APTC): Also referred to as a premium tax credit, this new tax credit provided for in the Affordable Care Act helps make coverage purchased in the Marketplace/Exchanges more affordable for consumers. Advance payments of the tax credit can be used right away to lower monthly premium costs. Qualified consumers may choose how much advance credit payments to apply to their premiums each month, up to a maximum amount. If the amount of advance credit payments a consumer gets for the year is less than the tax credit due, the consumer will get the difference as a refundable credit when they file their federal income tax return. If the consumer's advance payments for the year are more than the amount of their credit, they must repay the excess advance payments with their tax return.



Affordable Care Act (ACA): Also known as the Patient Protection and Affordable Care Act (PPACA), health care reform (HCR) and Obamacare, it is the comprehensive healthcare reform law enacted in March 2010. The law was enacted in two parts: PPACA was signed into law on March 23, 2010. It was amended by the Health Care and Education Reconciliation Act on March 30, 2010. Affordable Care Act refers to the final, amended version of the law.

Affordable Coverage (as it relates to the APTC): Employer coverage is considered affordable - as it relates to the Advanced Premium Tax Credit (APTC) - if the employee's share of the annual premium for self-only coverage is no greater than 9.66% of annual household income in 2016 (this amount will grow annually). Individuals offered employer-sponsored coverage that's affordable and provides minimum value won't be eligible for a premium tax credit if they choose to purchase health insurance in the Marketplace.

Allowed Amount: Discounted fees that insurers will recognize and pay for covered services. Insurers negotiate these discounts with providers in their health plan network. Network providers agree to accept the allowed charge as payment in full. Each insurer has its own schedule of allowed charges. If you go out-of-network to obtain care, you may be asked to pay the difference between the allowed amount and the provider's charge, known as balance billing.

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

Appeal: A request for a health insurer or plan to review a decision to deny coverage for a service, either the payment for services received or prior approval for a service, your doctor has recommended for you.

Association Health Plan: Health insurance plans that are offered to members of an association. These plans are marketed to individual association members, as well as small businesses members. How plans are structured, who they sell to, and whether they are state-based or national associations determines whether they are subject to state or federal regulation, or both. More importantly, they are largely exempt from regulations and are not considered ACA compliant.

Balance Billing: The practice of billing a patient for charges not paid by his/her insurance plan because the charges exceed covered amounts. Balance billing amounts will often be charges that are above the usual and customary rates. Balance billing may occur when an individual goes out of network for care, whether intentionally or unintentionally. Some states ban balance billing, particularly when individuals obtain out-of-network care unintentionally, known as "surprise billing."

Benefits: The healthcare 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 CHIP, covered benefits and excluded services are defined in state program rules.

Biologic: A biologic (also known as a biological product) is a type of complex medication such as a vaccine, blood or blood product, or other treatment that mimics proteins naturally present in the body. Rather than being created chemically like drugs, biologics are based off of recombinant, cell or tissue-based proteins. Clotting factor is a biologic.



Biosimilar Biological Products: A biosimilar is the “follow-on” or subsequent version of a biologic. Biosimilars and biologic products have the same relationship that generic drugs have with brand name drugs, with an important distinction that due to their complexity, biosimilars are not identical to the original biologic product.

Bronze Health Plan: A plan in the health insurance Marketplace/Exchanges where the percentage the plan pays of the average overall cost of providing essential health benefits to members is 60%.

Capitation: A method of paying for health care services under which providers receive a set payment for each person or “covered life” instead of receiving payment based on the number of services provided or the costs of the services rendered. These payments can be adjusted based on the demographic characteristics, such as age and gender, or the expected costs of the members.

Care Coordination: The process of organizing your treatment across several healthcare providers. Medical homes and Accountable Care Organizations (see definition) are two common ways to coordinate care.

Catastrophic Plan: A high deductible healthcare plan (HDHP) that only covers expensive care, like hospitalizations. Under the ACA, catastrophic plans must cover 3 primary care visits and preventive services before the deductible. For other care, your plan will only pay for services after you’ve first paid up to a certain amount for covered services. Only individuals who are under 30 years old or cannot find affordable coverage are able to purchase a catastrophic plan.

Center for Consumer Information and Insurance Oversight (CCIIO): Located within the Centers for Medicare & Medicaid Services (part of the Department of Health & Human Services), the Center is the federal agency tasked with implementing many provisions of the Affordable Care Act related to private health insurance.

Centers for Disease Control and Prevention (CDC): The federal agency responsible for protecting health and promoting quality of life through the prevention and control of disease, injury, and disability. The CDC’s National Center on Birth Defects and Developmental Disabilities’ hemophilia homepage provides consumers with access to the most up-to-date resources including the complete hemophilia treatment center (HTC) directory, videos, brochures, fact sheets and numerous other health education and outreach resources. The HTC directory provides the names and contact information of treatment center staff who are part of the federally-funded HTC network.

Centers for Medicare and Medicaid Services (CMS): The federal agency that administers the Medicare, Medicaid, and Children’s Health Insurance Programs, and implements many provisions of the ACA related to private health insurance Marketplaces.

Certificate of Need (CON) Program: CON programs are aimed at restraining health care facility costs and facilitating coordinated planning of new services and facility construction. Many CON laws initially were put into effect across the country as part of the federal Health Planning Resources Development Act of 1974. Despite numerous changes, most states retain some type of CON program, law or agency.

Certified Application Counselor (CAC): An individual (affiliated with a designated organization) who is trained to help consumers, small businesses, and their employees as they search for and enroll in health insurance options through the Marketplace created by the ACA. CAC services are free to consumers.



Children's Health Insurance Program (CHIP): Insurance program jointly funded by state and federal government that provides health insurance to low-income children. In some states, it covers pregnant women in families who earn too much income to qualify for Medicaid but cannot afford to purchase private health insurance coverage.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA): Reauthorized CHIP This legislation provided states with significant new funding, new programmatic options, and a range of new incentives for covering children through Medicaid and CHIP.

Children with Special Health Care Needs (CSHCN): Maternal and Child Health Bureau's (MCHB) defines CSHCN as those children that have or are at increased risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Claim: A request for payment that you or your healthcare provider submits to your health insurer after you receive covered items or services.

Consolidated Omnibus Budget Reconciliation Act (COBRA): A federal law that may allow you to temporarily keep health coverage if your employment ends or you are no longer eligible for coverage, you lose coverage as a dependent of the covered employee, or if there is another qualifying event. COBRA requires you pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

Coinsurance: A form of medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage (rather than a set dollar amount) of medical expenses after the deductible amount, if any, was paid.

Community Health Centers (CHC): Public and private, nonprofit organizations providing comprehensive, culturally competent, quality primary and related health care services to medically underserved communities and vulnerable populations. The centers are managed and governed by a community board, which is primarily comprised of patients and community members. There are several different types of CHCs: Federally Qualified Health Centers; non-grant supported health centers; and outpatient health programs/facilities operated by tribal organizations.

Consumer Assistance Program (CAP): State programs available to assist consumers with problems or questions concerning health care coverage. Consumers with questions can usually access the programs through phone or e-mail. See <https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

Consumer Operated Oriented Plan (CO-OP): Created by the ACA, a type of non-profit health insurance organization for which its insured people are also the owners. Cooperatives can be formed at a national, state, or local level and can include doctors, hospitals, and businesses as member-owners. Co-ops offer insurance through the Marketplace/Exchange but are not available in every state.

Coordination of Benefits (COB): A way to figure out who pays first when two or more health insurance plans are responsible for paying the same medical claim.

Copayment: A flat dollar amount you must pay for a covered program. *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-pocket. This share is commonly referred to as out-of-pocket (OOP) costs. The ACA sets an annual limit on out-of-pocket costs, which 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 non-covered services. For 2016, the annual limit on out-of-pocket costs is \$6,850 for an individual and \$13,700 for a family; this amount grows annually. Note that separate cost sharing limits apply in Medicaid and CHIP, which include premiums.

Cost-Sharing Reduction (CSR): A discount that lowers the amount you have to pay out-of-pocket for deductibles, coinsurance, and copayments. You can get this reduction if you get health insurance through the Marketplace/Exchange, your income is below a certain level, and you choose a Silver Health Plan (See "Metal Tiers" and "Silver Health Plan"). If you're a member of a federally recognized tribe, you may qualify for additional cost-sharing benefits.

Deductible: The amount you must pay for covered care before your health insurance begins to pay. Insurers apply and structure deductibles differently. **Example:** under one plan, a comprehensive deductible might apply to all services while another plan might have separate deductibles for benefits such as prescription drug coverage.

Deductibles for family plans may be embedded or non-embedded. Under an embedded deductible, each family member must meet his or her own deductible until the overall family deductible amount has been met. Under a non-embedded deductible, the overall family deductible must be met before the plan begins to pay.

Department of Health and Human Services (HHS): The federal agency charged with protecting the health of all Americans. Its agencies include the Centers for Medicare and Medicaid Services (CMS), Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA).

Dependent: A child or other individual for whom a parent, relative, or other person may claim a personal exemption tax deduction. Under ACA, individuals may be able to claim a premium tax credit to help cover the cost of coverage for themselves and their dependents.

Dependent Coverage: Insurance coverage for family members of the policyholder, such as spouse, children or partners. Under the ACA, all plans offering dependent coverage must cover dependents up to age 26, regardless of whether they are a tax dependent, live at home, or are a student.

Disability: A limit in action, restriction or impairment that can be physical and/or mental. Different state, federal or private programs may have different disability standards. A legal definition of disability can be found at: www.ada.gov/pubs/ada.htm

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. The donut hole is being phased out and will be closed entirely by the ACA in 2020.



Drug List: Also referred to as a formulary, it is a list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits.

Drug Utilization Review (DUR): Is an ongoing review of prescribing, dispensing and use of medication. It is often used as utilization management tool to control and promote more efficient use of scarce health care resources.

Dual Eligibles: A term used to describe an individual who is eligible for Medicare and for some level of Medicaid benefits. Most duals qualify for full Medicaid benefits including nursing home services, and Medicaid pays their Medicare premiums and cost sharing. For other duals Medicaid provides the “Medicare Savings Programs” through which enrollees receive assistance with Medicare premiums, deductibles, and other cost sharing requirements.

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Typically, DME may be considered a separate category under a health insurance plan. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Early Periodic Screening, Diagnostic & Treatment Services (EPSDT): The comprehensive set of benefits covered for children in Medicaid.

Electronic Medical Record (EMR): A digital version of a paper chart that contains all of a patient’s medical history from one practice.

Eligible Immigration Status: An immigration status that’s considered eligible for getting health coverage through the Marketplaces. The rules concerning eligible immigration status differ for Medicaid and Marketplace coverage.

Emergency Department (ED): Medical treatment facility that provides emergency room services.

Emergency Room Services: Evaluation and treatment of an illness, injury, or condition that needs immediate medical attention in an emergency room.

Employer Mandate: The ACA requires certain employers with at least 50 full-time employees (or equivalents) to offer health insurance coverage to their full-time employees and their dependents (but not spouses) that meets certain minimum standards set by the ACA. Employers that don’t offer coverage or offer coverage that fails to meet minimum standards will have to pay a penalty, if an employee qualifies for Marketplace coverage with premium tax credits

Employer-Sponsored Insurance (ESI): This is health insurance provided by an employer, who typically covers a portion of the costs. Sometimes called group health insurance. Plan options may include HMOs, PPOs, and EPOs, among others.

Employee Retirement Income Security Act of 1974 (ERISA): A federal law that establishes standards for employer-sponsored health insurance, particularly for self-insured employer-sponsored plans. (See Self-Insured Plan). Some employer plans are subject to state health insurance laws, in particular, small employer plans. Most large employer plans (sometimes referred to as “ERISA plans”) and all self-insured plans are

only subject to this federal law and not state health insurance laws. In the context of the ACA, ERISA plans are exempt from some of the private health insurance reforms.

Essential Community Providers (ECP): The ACA designates certain providers as Essential Community Providers, including those that are included in section 340B(a)(4) of the Public Health Service Act. This list includes CHCs, disproportionate share hospitals (DSH), and other providers eligible to participate in the 340B program, including HTC. Plans offered through the Marketplace are required to include some ECPs in their networks.

Essential Health Benefits (EHB): A set of healthcare service categories that must be covered by certain plans. The Affordable Care Act defines essential health benefits to “include at least the following general categories and the items and services covered within the categories: 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 and chronic disease management; and pediatric services, including oral and vision care.”

EHB services are defined differently in each state, based on what is covered by a benchmark plan. Private health insurance policies that are not grandfathered and are sold to individuals and small employers must cover these benefits, regardless of whether the policy is offered inside or outside the Marketplaces. Medicaid plans must cover a comprehensive bundle of services as well. Health plans are no longer able to impose a lifetime or annual dollar limit on spending for these services. Only grandfathered individual health insurance policies may still impose an annual limit.

Exclusions: Items or services that aren't covered under a contract for insurance and which an insurance company won't pay.

Exclusive Provider Organization (EPO) Plan: A managed care plan in which services are covered only if you go to doctors, specialists or hospitals in the plan's network (except in an emergency). EPOs are like HMOs except that individuals may not need a referral from a primary care physician to see a specialist.

Explanation of Benefits (EOB): A form sent by an insurance company to an insured that includes a such items as a summary of the claims processed for an insured since their last claim, a summary of what the insurer paid for the claim and what the insured's responsibility may be, and a summary of the person's year-to-date costs in the plan.

External Review: A review of a plan's decision to deny coverage for or payment of a service by an independent third-party not related to the plan. If the plan denies an appeal, an external review can be requested. In urgent situations, an external review may be requested even if the internal appeals process isn't yet completed. External review is available when the plan denies treatment based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; when the plan determines that the care is experimental and/or investigational; or for rescissions of coverage. An external review either upholds the plan's decision or overturns all or some of the plan's decision. The plan must accept this decision.

Federally-Facilitated Marketplace/Federally-Facilitated Exchange (FFM/FFE): One type of Marketplace option for states under the Affordable Care Act. States opting for an FFM/FFE will have a Marketplace that

is run by the federal government. All FFM/FFE will meet federal rules. States that operate their own Marketplace may have different rules but must meet federal minimum standards.

Federal Poverty Level (FPL): A measure of income level issued annually by the Department of Health and Human Services. FPL is used to determine eligibility for certain programs and benefits. FPL varies based on family size. For more information on FPL please visit: <http://aspe.hhs.gov/poverty/index.cfm>. Many public health insurance programs set eligibility based on a percentage of the FPL.

Federally Qualified Health Centers (FQHC): Federally-funded nonprofit health centers or clinics that serve medically underserved areas and populations. Federally qualified health centers provide primary care services regardless of your ability to pay. Services are provided on a sliding scale fee.

Fee for Service (FFS): A reimbursement plan in which doctors and other healthcare providers are paid for each service performed, such as for tests and office visits.

Flexible Benefits Plan: Offers employees a choice between various benefits including cash, life insurance, health insurance, vacations, retirement plans and child care. Although a common core of benefits may be required, you can choose how your remaining benefit dollars are to be allocated for each type of benefit from the total amount promised by the employer. Sometimes you can contribute more for additional coverage. Also known as a Cafeteria Plan or IRS 125 Plan. Note that these plans generally do not qualify as minimum essential coverage.

Flexible Spending Account (FSA): Accounts offered and administered by employers that allow employees to set aside pre-tax dollars out of their paycheck to pay for the employee's share of insurance premiums or medical expenses not covered by the employer's health plan. The employer may also make contributions to a FSA. Typically, benefits or cash must be used within the given benefit year or the employee loses the money. Flexible spending accounts can also be provided to cover childcare expenses, but those accounts must be established separately from medical FSAs.

Food and Drug Administration (FDA): Is responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation. The FDA also provides accurate, science-based health information to the public.

Formulary: Sometimes referred to as a "drug list," it is a list of drugs your insurance plan covers and may include how much you pay for each drug. If the plan categorizes drugs into different groups with different co-pays, also known as tiers, then the formulary will list drugs by these tiers. Formularies may include both generic drugs and brand-name drugs. The formulary may not include drugs that are administered under the major medical benefit of a plan.

Fully Insured Job-based Plan: A plan in which the employer contracts with another organization to assume financial responsibility for the enrollees' medical claims and for all incurred administrative costs.

Gold Health Plan: A plan in the health insurance Marketplaces/Exchanges where the percentage the plan pays of the average overall cost of providing essential health benefits to members is 80%. (See Actuarial Value)



Grandfathered Health Plan: As defined in the ACA, 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 exempt from many changes required under the ACA.

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 if it is a grandfathered plan. It must also advise consumers how to contact the U.S. Department of Labor or HHS with questions. (See New Plan)

Grievance: A complaint an insured communicates to his or her 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. However, you can generally only enroll in coverage during an annual open enrollment period.

Guaranteed Renewal: A requirement that your health insurance issuer must offer to renew your policy as long as you continue to pay premiums.

Habilitative/Habilitation Services: Health care services that help you 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. Habilitative services are one of the 10 essential health benefits (EHBs).

Department of Health and Human Services (HHS): HHS, also known as the Health Department, is a cabinet-level department of the U.S. federal government with the goal of protecting the health of all Americans and providing essential human services.

Health Care Reform (HCR): Also known as the Patient Protection and Affordable Care Act (PPACA), the Affordable Care Act (ACA) and Obamacare, it is the comprehensive healthcare reform law enacted in March 2010. The law was enacted in two parts: PPACA was signed into law on March 23, 2010. It was amended by the Health Care and Education Reconciliation Act on March 30, 2010. Health Care Reform refers to the final, amended version of the law.

Health Insurance Exchange (HIE): Also known as a Health Insurance Marketplace, these are new transparent and competitive health insurance Marketplaces where individuals and small businesses can buy qualified health plans that meet certain benefit and cost standards. Every state has a Marketplace.

Health Insurance Marketplace (HIM): Also known as a health insurance Exchange (HIE), these are new transparent and competitive health insurance Marketplaces where individuals and small businesses can buy qualified health plans that meet certain benefit and cost standards. Every state has a Marketplace.

Health Insurance Portability and Accountability Act (HIPAA): HIPAA is a 1996 law that eliminated discrimination by health insurers for those with pre-existing medical conditions. It also sets important privacy and security standards for health care entities so that consumers' health information is protected.

Health Maintenance Organization (HMO): An insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO and will require you to get a referral from your primary

care physician to see a specialist. Generally, won't cover out-of-network care except in an emergency, and may require you to live or work in its service area to be eligible for coverage.

Health Resources and Services Administration (HRSA): An agency of the U.S. Department of Health and Human Services that works to improve access to health care services for people. HRSA's Maternal and Child Health Bureau administers the National Hemophilia Program, which coordinates activities at and provides funding to the national network of HTC's located throughout the country. HRSA also administers the 340B program. (See 340B Program)

Health Savings Account (HSA): A tax-exempt medical savings account that can be used to pay for current or future qualified medical expenses. The funds contributed to the account aren't subject to federal income tax at the time of deposit. Employers may make HSAs available to their employees or individuals can obtain HSAs from most financial institutions. In order to open an HSA, an individual must have health coverage under an HSA-qualified high deductible health plan (HDHP). Unlike a Flexible Spending Account (FSA), funds roll over year to year if you don't spend them.

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

Hemophilia Treatment Center (HTC): A diagnostic and treatment facility comprised of a comprehensive, multidisciplinary team of medical professionals who specialize in treating individuals with hemophilia and related bleeding disorders. HTC's treat the whole person and the family, through continuous supervision of all the medical and psychosocial aspects of bleeding disorders. HTC multidisciplinary teams may include hematologists, pediatricians, orthopedists, physical therapists, nurses, dentists, social workers and other mental health professionals. HTC's can refer patients to other specialists for services that are not provided in-house. HTC care can reduce or eliminate complications in patients with bleeding disorders.

High-Deductible Health Plan (HDHP): A plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more of the healthcare costs yourself before the plan starts to pay its share (your deductible). An HDHP that meets federal standards for a minimum deductible can be combined with a health savings account (HAS) to allow you to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

High-Risk Pool (HRP) Plan (State): High-risk pool plans offer health insurance coverage that is subsidized by a state government. Not all states offer high-risk pools, and those that do have distinct rules in terms of cost, eligibility and benefits. Many high-risk pools will be phased out following the implementation of plans in the Marketplaces.

Home and Community-based Services (HCBS): 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. Covered when provided by care workers or, if your state permits it, by your family.

Home Healthcare: Healthcare services and supplies in your home that a doctor prescribes.

Hospital Readmission: A return by a patient to the hospital following discharge for the same or related care within 30, 60 or 90 days. Hospital readmissions are often used in part to measure the quality of hospital care.



Individual Health Insurance Policy: Policies for people who aren't connected to job-based coverage. Individual health insurance policies are regulated under state and federal law. Note that the phrase "individual policies" when used in this way – policies that are unconnected to employment – can be used for policies that cover a single person or multiple people (families, mother and dependent child, husband and wife, etc.).

Individual Mandate: Also known as "individual responsibility," under the ACA, you must be enrolled in a health insurance plan that meets basic minimum standards, known as Minimum Essential Coverage (MEC). If you aren't enrolled in MEC, you may be required to pay a penalty. Exempt from this are people with very low income for whom coverage is unaffordable, or for other reasons, including religious beliefs. The Summary of Benefits and Coverage for your plan must tell you if the plan is considered MEC.

In-Network Coinsurance: The percent (i.e., 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network coinsurance usually costs you less than out-of-network coinsurance.

In-Network Copayment: A fixed amount (i.e., \$15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

In-Network Provider: A physician, certified nurse midwife, hospital, skilled nursing facility, home healthcare agency, or any other duly licensed or certified institution or health professional under contract with your insurance provider.

In-Person Assisters (IPA): Individual or organizations that are trained to provide help to consumers, small businesses, and their employees as they look for health coverage options through the Marketplace/Exchanges. IPAs help consumers complete eligibility and enrollment forms and are required to be unbiased. Their services are free to consumers.

Lifetime Limit: A cap on the total lifetime benefits your insurance policy will cover (also known as a lifetime cap). Before passage of the ACA, many insurers set a lifetime dollar limit on benefits (like \$1 million) and would not pay for covered services once the limit was hit. As of September 2010, non-grandfathered health plans can no longer set lifetime dollar limits on the Essential Health Benefits (EHBs). Plans can continue to limit specific benefits by number (for example, covering only a certain number of visits).

Long-Term Care (LTC): Medical and nonmedical services 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.

Managed Care Organization (MCO): A group or organization that provides managed care plans.

Managed Care Plan: A plan that generally provides comprehensive health services to its members, and offers financial incentives for patients to use the providers who belong to the plan. Examples include: health maintenance organizations (HMO), preferred provider organizations (PPO), exclusive provider organizations (EPO) and point of service plans (POS).



Managed Care Provisions: Features within health plans that provide insurers with a way to manage the cost, use and quality of healthcare services received by group members. Examples of managed care provisions include:

- *Preadmission certification* - Authorization for hospital admission given by a healthcare provider to a group member prior to hospitalization. Failure to obtain a preadmission certification in non-emergencies reduces or eliminates the healthcare provider's obligation to pay for services rendered.
- *Utilization review* - The process of reviewing the appropriateness and quality of care provided to patients. Utilization review may take place before, during or after the services are rendered.
- *Preadmission testing* - Requirement designed to encourage patients to obtain necessary diagnostic services on an outpatient basis prior to nonemergency hospital admission. The testing is designed to reduce the length of a hospital stay.
- *Nonemergency weekend admission restriction* - A requirement that imposes limits on reimbursement to patients for nonemergency weekend hospital admissions.
- *Second surgical opinion* - A cost-management strategy that encourages or requires patients to obtain the opinion of another doctor after a physician has recommended that a nonemergency or elective surgery be performed. Programs may be voluntary or mandatory in that reimbursement is reduced or denied if the participant does not obtain the second opinion. Plans usually require that such opinions be obtained from board-certified specialists with no personal or financial interest in the outcome.

Maximum Out-of-Pocket (MOOP): A yearly cap on the amount of money individuals are required to pay out-of-pocket for health care costs, excluding the premium cost.

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 and sets guidelines. States also have choices in how they design their program, so Medicaid programs and eligibility vary from state to state, and may have a different name in your state. Under the ACA, states have the option to expand Medicaid coverage to all individuals with income under 138% of the FPL.

Medical Loss Ratio (MLR): A financial tool that measures the percentage of premium dollars taken in by a health insurer that are spent on customers' medical claims and quality improvement activities as compared with money spent on overhead expenses, including salaries, administrative costs and agent commissions. The Affordable Care Act sets minimum medical loss ratios for different markets, as do some state laws. If your plan does not meet an applicable MLR, then you or your employer could receive a refund.

Medically Necessary: Services or supplies that are needed for the diagnosis or treatment of your health condition and meet accepted standards of medical practice.

Medical Underwriting: A process used by insurance companies that uses your health status when you're applying for health insurance coverage to determine whether to offer you coverage, at what price and with what exclusions or limits. Under the ACA, all non-grandfathered plans are prohibited from using medical underwriting to deny coverage or determine premiums.

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 (ESRD)/ Medicare is composed of four parts:



Medicare Part A: Hospital insurance that helps cover inpatient care in hospitals, skilled nursing facilities, hospice and home care. Most beneficiaries are enrolled in Part A automatically.

Medicare Part B: Medical coverage that helps to cover medically necessary services like doctors' services, outpatient care, home health services and other medical services. Part B also covers some preventive services, and physician-administered drugs like clotting factor. Most beneficiaries are enrolled in Part B automatically.

Medicare Part C/Medicare Advantage (MA): 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. There are many types of Medicare Advantage Plans (MAP) include HMOs, PPOS, Private Fee-for-Service Plans, Special Needs Plans and Medicare Medical Savings Account Plans. If you're enrolled in an MA plan, Medicare services are covered through the plan and aren't paid for under Parts A and B Most Medicare Advantage Plans offer prescription drug coverage.

Medicare Part D: An optional program that provides 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.

Minimum Essential Coverage (MEC): The type of coverage an individual must to have to meet the individual responsibility requirement under the ACA. This includes policies sold through a Marketplace, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage. The summary of benefits and coverage (SBC) for your plan must tell you if the plan is MEC. Note that some plans sold outside the Marketplace to individuals do not meet these standards and will not count toward the requirement to have coverage. Check with the insurance company for the plan to confirm whether it is "minimum essential coverage."

Minimum Value: A health plan meets this standard if it's designed to pay at least 60% of the total cost of medical services for a standard population. Individuals offered employer-sponsored coverage that provides minimum value and that's affordable won't be eligible for a premium tax credit if they choose to purchase health insurance through the Marketplace.

Modified Adjusted Gross Income (MAGI): The figure used to determine eligibility for lower costs in the Marketplace/Exchange and for Medicaid and CHIP. Generally, modified adjusted gross income is your adjusted gross income plus any tax-exempt Social Security, interest, or foreign income you have.

Navigator: An individual or organization that's trained to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplaces established pursuant to the ACA. Navigators assist consumers with completing eligibility and enrollment forms. These individuals and organizations are required to be unbiased and their services are free to consumers

New Plan: As referenced in the ACA, a health plan that is not grandfathered and therefore subject to the reforms in the ACA. In the individual health insurance market, a plan that your family is purchasing for the first time. In the group health insurance market, a plan that your employer is offering for the first time. New employees and new family members may be added to existing grandfathered group plans – so a plan that is new to you and your family may still be a grandfathered plan.



In both the individual and group markets, a plan that loses its grandfathered status will be considered a new plan. This happens when it makes significant changes to the plan, such as reducing benefits or increasing cost-sharing for enrollees. (See Grandfathered Plan).

Nondiscrimination: A requirement that job-based insurance not discriminate based on health status by denying or restricting health coverage, or charging more. Job-based plans can restrict coverage based on other factors such as part-time employment that aren't related to health status.

Open Enrollment Period (OEP): The time period set up to allow you to choose from available plans, usually once a year.

Out-of-Network (OON) Coinsurance: The percentage (for example, 40%) you pay of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network (OON) coinsurance usually costs you more than in-network coinsurance. The amount of coinsurance you pay may be more when you use an out-of-network provider.

Out-of-Network Copayment: A fixed amount (for example, \$30) you pay for covered health care services from providers who don't contract with your health insurance or plan. Out-of-network (OON) copayments usually are more than in-network copayments. The copayment you pay may be more when you use an out-of-network provider.

Out-of-Network Providers: A duly licensed or certified institution or health professional not under contract with your insurance provider.

Out-of-Pocket (OOP) Limit: The maximum amount you will be required to pay for covered services in a year, before the plan covers 100% of all costs. Generally, this includes the deductible, coinsurance, and copayments (varies from plan to plan), but not premiums. Plans can set different out-of-pocket limits for different services, and some plans do not have out-of-pocket limits.

Patient-centered Medical Home (PCMH): The patient centered medical home (PCMH) is a model for transforming the organization and delivery of primary care. It is also referred to as primary care medical home, advanced primary care, and the healthcare home.

Patient-Centered Outcomes Research Institute (PCORI): Institute authorized by the ACA to conduct comparative effectiveness research (CER).

Pay for Performance (P4P): A health care payment system where providers receive incentives for meeting or exceeding quality, and sometimes cost, benchmarks. Some systems also penalize providers who do not meet established benchmarks. The goal of pay for performance programs is to improve the quality of care over time.

Per-member Per-month (PMPM): Applies to a payment or cost for each enrolled plan member each month. For capitation payments, like in an HMO (Health Maintenance Organization), an insurance company pays a PMPM amount to a physician based on the number of members on the plan, regardless of whether the physician has an encounter with the patient that month or not. For cost, it is the average cost to cover each plan member each month.



Pharmacy Benefit Manager (PBM): Health plans and sponsors contract with Pharmacy Benefit Managers to handle the claims processing and administrative functions involved with prescription drug programs. In addition to processing and paying claims, PBMs develop and maintain a program drug formulary, contract with participating pharmacies and negotiate discounts and rebates with drug manufacturers.

Plan Year: A 12-month period of benefits coverage under a health plan. This 12-month period might be different than the calendar year, depending on when your health plan renews.

Platinum Health Plan: A plan in the health insurance Marketplaces where the percentage the plan pays of the average overall cost of providing essential health benefits to members is 90%.

Policy Year: A 12-month period of benefits coverage under an individual health insurance plan. This 12-month period might be different than the calendar year.

Point-of-Service Plan (POS) Plan: A type of plan in which you pay less if you use doctors, hospitals and other healthcare providers that belong to the plan's network. POS plans may 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, 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.

Pre-Existing Condition: With certain limited exceptions, a pre-existing condition is any condition (physical, mental or a disability) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period before you enrolled in a health insurance plan. Before passage of the ACA, insurers could either not offer health insurance to you if you had a pre-existing condition or could refuse to cover any services related to a pre-existing condition (known as a pre-existing condition exclusion). Under the ACA non-grandfathered health insurance plans can't refuse to cover you or charge you more just because you have a pre-existing health condition.

Pre-Existing Condition Insurance Plan (PCIP): High-risk pool operated by the states and the federal government that provided coverage for individuals who have been denied coverage for a pre-existing condition or have a pre-existing condition. Individuals must have been without health insurance for at least six months. *Ended in 2014.*

Preferred Drug List (PDL): A PDL is a list of medications that are covered without the need to obtain prior authorization. Drugs are designated as either preferred or non-preferred.

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 or annual 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.



Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Preventive Services: Routine healthcare 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 options for common illnesses. Primary care providers (PCP) 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.

Primary Care Provider (PCP): Includes doctors, nurses, nurse practitioners and physician assistants; they provide health services for a wide range of common illnesses, wellness and prevention.

Primary Care Case Management (PCCM): A model of Medicaid managed care that is outlined in the Medicaid statute. In PCCM programs, state Medicaid agencies contract with primary care providers to provide, locate, coordinate, and monitor primary care services for Medicaid beneficiaries who select them or are assigned to them by the state. The primary care provider – usually a physician or a physician practice, but sometimes a nurse practitioner, physician assistant, or other provider – serves as a beneficiary’s “medical home” for primary and preventive care. Under their contracts with primary care providers, states pay them a small monthly case management fee in addition to regular FFS payments.

Prior Authorization (PA): A decision by your health insurer that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called preauthorization, 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.

Qualified Health Plan (QHP): An insurance plan 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.

Qualifying Event: Any event or occurrence such as death, termination of employment, divorce or a terminal illness that changes an employee’s eligibility status and permits an acceleration or continuation of benefits or coverage under a group health plan. The term is most frequently used in reference to COBRA eligibility.

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

Referral: A written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don’t get a referral first, the plan may not pay for the services.

Rehabilitative/Rehabilitation Services: Health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were 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 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.

Rider (Exclusionary Rider): An amendment to an insurance policy. Some riders add coverage while other riders exclude coverage (known as exclusionary rider). Example: You buy a maternity rider to add coverage for pregnancy to your policy. An exclusionary rider is an amendment permitted in individual policies that permanently excludes coverage for a health condition, body part or body system (such as a certain disease state or disability). Under the ACA, no exclusionary riders will be permitted in non-grandfathered health insurance plan.

Risk Adjustment: A statistical process that takes into account the underlying health status and health spending of the enrollees in an insurance plan when looking at their healthcare outcomes or healthcare costs.

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. Self-insured plans do not follow state insurance rules. They are regulated under the federal rule known as ERISA and overseen by the U.S. Department of Labor.

Silver Health Plan: A plan in the health insurance Marketplaces/Exchanges where the percentage the plan pays of the average overall cost of providing essential health benefits to members is 70%.

Skilled Nursing Facility (SNF) Care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. *Example:* Physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Short-Term, Limited Duration Health Plans: These plans are low-cost, limited coverage insurance plans that are meant to help individuals who have a temporary gap in health insurance coverage. Insurers could offer a short-term plan for up to three (3) years. While the premium is lower, many of these plans come with high deductibles. These plans typically do **not** cover pre-existing conditions, prescription drugs, or maternity care.

Small Business Health Options Program (SHOP): The Marketplace available to small businesses under the ACA. Small businesses buying plans in the SHOP select the plan and decide how much they pay toward employee premiums. Participating small businesses may qualify for a small business health tax credit worth up to 50% of their premium costs.

Social Security Disability Income (SSDI): Income payable by the federal government to individuals who are determined to be totally disabled.



Supplemental Security Income (SSI): Social Security administers this program. We pay monthly benefits to people with limited income and resources who are disabled, blind, or age 65 or older. Blind or disabled children may also get SSI.

Special Enrollment Period (SEP): A time outside of the open enrollment period during which you and your family have a right to sign up for health coverage. Job-based plans must generally provide a special enrollment period of 30 days following certain life events that involve a change in family status (such as marriage or birth of a child) or loss of other job-based health coverage. Plans sold to individuals, including Marketplace plans, must provide 60 days to enroll.

Special Healthcare Need(s): The healthcare and related needs of children who have chronic physical, developmental, behavioral or emotional conditions. Such needs are of a type or amount beyond that required by children generally.

Specialty Pharmacy Provider (SPP): A pharmacy that is designated to provide specialized medication for complex, genetic, rare, and chronic health conditions. Specialty pharmacy providers may provide home health or nursing services.

State Based Marketplace/State Based Exchange (SBM/SBE): One type of Marketplace option for states. States opting for an SBM/SBE will manage their own Marketplace in accordance with applicable federal laws.

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. *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.

State Partnership Marketplace/State Partnership Exchange (SPM/SPE): One type of Marketplace option for states under the ACA. States opting for an SPM/SPE will have a Marketplace that is run by the federal and state government jointly.

State Plan Amendment (SPA): A process to change administrative aspects of a state Medicaid plan. Every state has a Medicaid state plan that outlines the details of its Medicaid program. Each state plan is different, reflecting the level of flexibility that states have in their Medicaid programs. If a state wants to change its Medicaid program, one option is to file a SPA.

Summary of Benefits and Coverage (SBC): The ACA requires plans to offer this easy-to-read summary that lets you make apples-to-apples comparisons of costs and coverage between health plans. You'll get the "Summary of Benefits and Coverage" (SBC) when you shop for coverage on your own or through your job, renew or change coverage, or request an SBC from the health insurance company.

Supplemental Security Income (SSI): A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or 65 or older. SSI benefits are different than Social Security retirement or disability benefits.

Third Party Administrator (TPA): An individual or firm hired by an employer to handle claims processing, pay providers and manage other functions related to the operation of health insurance. The TPA is not the



policyholder or the insurer. The TPA may often be a company you associate with health insurance, such as Aetna or Blue Cross, but in this role it is not the actual insurer but simply managing the plan on behalf of the employer.

TRICARE: A health care program for active-duty and retired uniformed services members and their families.

Uncompensated Care: Healthcare or services provided by hospitals or healthcare 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.

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.

Usual, Customary and Reasonable (UCR) Charges: A healthcare provider's usual fee for a service that does not exceed the customary fee in that geographic area, and is reasonable based on the circumstances. Instead of UCR charges, PPO plans often operate based on a negotiated (fixed) schedule of fees that recognize charges for covered services up to a negotiated fixed dollar amount. Conventional indemnity plans typically operate based on UCR charges.

Veteran's Health Benefits: Veterans may be eligible for a broad range of services, including health care benefits, through the Veteran's Administration.

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. Applies to all new employees, and is not based on health status. Under the ACA, employer plans cannot impose a waiting period of more than 90 days

Well-Baby/Well-Child Visits: Routine doctor visits for comprehensive preventive health services that occur when a baby is young and annual visits until a child reaches age 21. Services include physical exam and measurements, vision and hearing screening, and oral health risk assessments. Under the ACA's rules for preventive services, well child visits may be covered without cost-sharing.

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. *Examples:* programs to help you stop smoking, diabetes management programs, weight loss programs and preventive health screenings.

Wholesale Acquisition Cost (WAC): The manufacturer's list price for the drug to wholesalers or direct purchasers, excluding discounts, rebates pay or reductions in price. This price is defined by federal law.

© National Hemophilia Foundation, 2018 Sources:

- www.healthcare.gov/glossary/
- www.hrsa.gov
- www.healthit.gov
- www.cms.gov
- www.hhs.gov
- www.pcori.org
- www.va.gov
- www.cdc.gov
- www.dol.gov