Introduction to Health Insurance

Great progress has been made in the treatment of primary immunodeficiency diseases. However, these treatments often come at a significant financial burden to the patient or family living with these diseases. The majority of patients rely on some form of insurance to assist with expenses, but dealing with health insurance and understanding the maze of issues involved can be overwhelming.

Often health insurers require additional paperwork to justify the use of the therapy prescribed. Added red tape and follow up phone calls can frustrate patients and caregivers. Even individuals who have adequate insurance coverage often face expensive insurance premiums or high co-payments or co-insurance. Patients may be confused about their insurance options. Others simply lack affordable health insurance and feel forced to stop treatment.

This chapter provides information regarding health insurance. While not designed to solve each and every problem, the information will help prepare you to be your own best advocate. It is essential to understand your family’s current utilization of healthcare and learn to evaluate and compare medical insurance plans available in your area. The selection of an appropriate insurance plan can affect the health and finances of both the patient with primary immunodeficiency disease and family members. When it comes to your healthcare insurance coverage, never hesitate to ask questions and search for as many resources as possible.

Group Health Insurance

Group health insurance coverage is a policy that is purchased by an employer and is offered to eligible employees of the company (and often to the employees’ family members) as a benefit of working for that company. The majority of Americans have group health insurance coverage through their employer or the employer of a family member. Many people do not realize that health insurance is issued differently for different types of employers, and that, because insurance is regulated at the state level of government, the laws regarding health insurance offered by the different types of employers can vary significantly from state to state. Millions of Americans work for small employers, which for health insurance purposes are generally those with 50 employees or less.

Millions of other Americans get their health insurance coverage through large employers. Generally, those are business with more than 50 employees. The laws about how coverage can be issued to large groups are different than those for small groups, and premium rates are also determined differently. Federal law mandates that no matter what pre-existing health conditions small employer group members may have, no small employer or an individual employee can be turned down by an insurance company for group coverage. This requirement is known in the insurance industry as “guaranteed issue.”
**COBRA**

If you lose your job or resign, you are usually able to continue your group health insurance benefits via federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). However, COBRA does not apply to all employers; so many states have developed other continuation-of-coverage options for people who are not covered by COBRA. Also, many people leaving group insurance to buy individual health insurance privately have portability benefits required by another federal law.

You are responsible for paying the premium, which is usually kept at 102% of what your employer was paying on your behalf. (The 2% is for administrative fees). For job termination or a reduction in hours, COBRA’s duration is normally 18 months. In the case of a divorce, separation or death of a spouse, COBRA may be available for up to 36 months. In the case of a dependent child ceasing to be a dependent child under the parent’s employer plan, coverage may be extended up to 36 months. If you are deemed disabled by Social Security within 60 days of your termination of employment or reduction in hours of employment, you are able to extend the COBRA continuation period from 18 months to 29 months. The extended period of time offered is designed to protect you until you become eligible for Medicare, since there is a 29 month waiting period before you can receive Medicare benefits.

When these situations, known as “qualifying events” occur, it is your responsibility, as the employee, to notify the human resources department of your employer (that person or group responsible for medical insurance) within 60 days or you lose the option.

For further information on COBRA coverage and your rights under COBRA law, you should contact the human resource department or the benefits manager within your organization or call your local Department of Labor.

**Individual Health Insurance**

Individual health insurance is coverage that a person buys independently. It can be for an individual, a parent and dependent children, or a family. The majority of Americans get their health insurance coverage through an employer or through a government program, and some of the population purchases private health coverage on an individual basis. Each state separately regulates how individual policies may be marketed and sold.

Individual health insurance is very different than group health insurance, which is the type of insurance that is offered through an employer. Benefits in individual plans are generally less extensive than what most people would receive through the group coverage they have through their employer. Individual consumers may be surprised to learn that some benefits that may be considered standard in a group policy may not be included in an individual plan.

Individual health insurance companies are much more limited than group insurance companies in their ability to “spread risk” among a large group of people, so the laws concerning individual health insurance are different in most states. This means that applicants for individual insurance will need to complete a medical
questionnaire when applying for benefits and, unlike a group insurance policy, in most states a company can decide not to cover people with very serious medical conditions, like primary immunodeficiency diseases, deeming them uninsurable.

The Affordable Care Act (ACA) of 2010, commonly known as healthcare reform, has mandated the creation of state exchanges for all states. An exchange is a marketplace where individuals and small employers will be able to shop for insurance coverage. They must be set up by October 1, 2013 and policies go into effect on January 1, 2014. Plans offered through the exchanges will be subject to the same restrictions against excluding coverage for those with pre-existing conditions as other health insurance plans. More information about state exchanges can be found under the Affordable Care Act section.

Medicare

Medicare is a federal health insurance program that provides coverage for people over the age of 65, blind, disabled individuals, and people with permanent kidney failure or end-stage renal disease. The Medicare program is administered by the Centers for Medicare and Medicaid Services (CMS) and pays only for medical services and procedures that have been determined as “reasonable and necessary.” Medicare is divided into four parts—Parts A, B, C and D.

Part A covers inpatient hospital services and certain follow-up care. This includes the cost of lab tests, x-rays, nursing services, meals, semi-private rooms, medical supplies, medications, necessary appliances, and operating and recovery rooms.

Part B covers physician’s services and other medical expenses. Medicare Part B will cover both the intravenous immunoglobulin (IVIG) product and administration when provided in a physician’s office or in the hospital outpatient setting. The coverage determination for immunoglobulin (Ig) therapy is reviewed by each Medicare regional carrier through their medical policy department. Each carrier will issue their own local coverage determination, which outlines the specific coverage guidelines for the use of Ig therapy. The Medicare Modernization Act created a home infusion coverage provision only for patients with primary immunodeficiency diseases.

While the law was written to only include coverage and reimbursement for the Ig product itself and to exclude coverage for items and services related to the infusion, the Medicare IVIG Access Act was signed into law in January 2013, creating a three-year demonstration project allowing for the payment of home infusion services for Medicare patients with primary immunodeficiency diseases to be implemented within one year of its signing. The demonstration project should prove the cost effectiveness of allowing Medicare patients with primary immunodeficiency diseases access to home infusions of IVIG, thus paving the way for a permanent fix to this issue.

Subcutaneous immunoglobulin (SCIG) therapy in the home setting is processed through the Medicare Part B DME (durable medical equipment) benefit. Beneficiaries must pay a monthly premium and a
Medicaid

Medicaid, jointly funded by the federal and state governments, serves as the U.S. primary source of health insurance coverage for low-income populations, as well as certain health categories, including persons who are blind, aged, disabled or pregnant.

Medicaid enrollment criteria also vary from state to state, but coverage is usually available only to those who are not eligible for any other type of health insurance and meet poverty guidelines. Each state has a pre-determined income level that an individual or family must meet to qualify for Medicaid benefits. The local office of the State Department of Social Services is responsible for reviewing applications and managing eligibility requirements. Some states require Medicaid beneficiaries to join managed care plans. Medicaid programs may require prior authorization for certain forms of treatment or prescription drugs. This means that your physician must contact Medicaid to obtain approval for reimbursement of the treatment before you receive it.

Part C (Medicare Advantage) plans allow you to choose to receive all of your healthcare services through a provider organization. These plans may help lower your costs of receiving medical services, or you may get extra benefits for an additional monthly fee, such as hearing, vision and dental benefits. You must have both Parts A and B to enroll in Part C. You should check with individual plans for how they cover Ig therapy, as like private insurance, the benefits will differ from plan to plan.

Part D the Medicare Prescription Coverage program (Medicare Part D) went into effect on January 1, 2006. Anyone who has Medicare coverage can choose the prescription coverage benefit. The prescription benefit coverage was passed by Congress to give Medicare beneficiaries more options for prescription drug coverage that had never before been covered under the Medicare program. As it relates to coverage of IVIG, Medicare Part D program does not cover Ig in the home for those who have a primary immunodeficiency disease. However, Medicare Part D may cover Ig in the home for other disease states. CMS administers the Part D program through contracts with commercial and private payers referred to as Medicare Prescription Drug Plans (PDPs). To learn more about the prescription drug coverage go to www.medicare.gov, or call 800-MEDICARE (800-633-4227).

For most of these services, Medicare pays 80% of the bill, and the beneficiary pays the 20% coinsurance. You must first have Part A before receiving Part B. If you apply for Social Security disability, you will receive Medicare benefits after being on disability for two years.

Individuals may also consider purchasing a Medigap (supplemental insurance) policy, which differ from state to state. Medigap policies help pay some of the healthcare costs that your original Medicare plan will not cover. Some of these plans will help pay for the 20% coinsurance under the Medicare Part B program. To learn more about the various plans and coverage guidelines go to www.medicare.gov/medigap, or call 800-MEDICARE (800-633-4227).
State Assistance Programs

Your state may have a special assistance program for people with particular chronic conditions. Most of these programs are funded by state and local budgets and are designed to meet the needs of adults and/or children who are not eligible for any other medical coverage. They may also serve as a secondary or supplemental coverage to Medicaid. The level of coverage available will change according to such variables as state needs and available funding. These programs may be identified under such names as Children with Special Health Care Needs, Crippled Children’s Services or Children’s Medical Services.

Coverage for children with a primary immunodeficiency disease may be severely restricted or not available at all. It is best to check with your local sources of information for eligibility information before considering this as a coverage option.

Supplemental Security Income (SSI) makes monthly payments to aged, disabled and blind people with limited income and resources. Children, as well as adults, may qualify for SSI payments. Eligibility and benefits vary by state, but more information can be obtained by contacting your local Social Security Office.

State Children’s Health Insurance Program (SCHIP)

As part of the Balanced Budget Act of 1997, Title XXI or State Children’s Health Insurance Program (SCHIP) of the Social Security Act was passed in late 1997. SCHIP gives grants to states to provide health insurance coverage to uninsured children up to 200% of the federal poverty level (FPL). States may provide this coverage by expanding Medicaid or by expanding and creating a separate state children’s health insurance program. The program’s primary purpose is to help children in working families with incomes too high to qualify for Medicaid but too low to afford private family coverage. Although benefits vary from state to state, children generally are eligible for regular check-ups, immunizations, eyeglasses, doctor visits, prescription drug coverage, and hospital care. Based on income levels, states can impose premiums, deductibles, or fees for some services. Since coverage and benefits do vary, it is important that families investigate the options available in their respective state.
Understanding Health Plans

Most health insurance companies offer several types of programs with many variations in deductibles, copayments and covered services. Review the details of any specific plan very carefully before purchasing to ensure it will meet the specific needs of you and your family. Below is a description of the different types of plans offered through insurance companies, starting with the most restrictive and typically least expensive plan.

**HMO** is a Health Maintenance Organization. As a member of an HMO, you select a primary care physician from a list of doctors in that HMO’s network. Your primary care physician will be the first medical provider you call or see for a medical condition. They will make any needed referrals to a medical specialist. Typically, these specialists will be part of the HMO network. If you obtain care without your primary care physician’s referral or obtain care from a non-network member, you will be responsible for paying the entire bill (with exceptions for emergency care). Normally HMOs have a copayment for the visit or service. This is the most restrictive type of plan.

**POS** is a Point-of-Service Plan. It is a type of managed care plan that is an HMO with an out-of-network option. You can decide whether to go to a network provider and pay a flat dollar amount or to an out-of-network provider and pay a deductible and/or a coinsurance charge.

**PPO** is a Preferred Provider Organization. As a member of a PPO, you can use the doctors and hospitals within the PPO network or go outside of the network for care. You do not need a referral to see a specialist. If you obtain care from a medical provider outside of the PPO network, you will pay more for the service. For example, a PPO might pay 80-90% of the cost for a visit with an in-network doctor, but only 60-70% of the cost for a visit to a non-network doctor. You will typically pay a copayment for each office visit. You will usually be responsible for paying an annual deductible.

**Indemnity** plans are commonly known as a fee for service or traditional plans. If you select an Indemnity plan, you have the freedom to visit any medical provider. You do not need referrals or authorizations; however, some plans may require you to pre-certify for certain procedures. Most indemnity plans require you to pay a deductible. After you have paid your deductible, indemnity policies typically pay a percentage of “usual and customary” charges for covered services; often the insurance company pays 80% and you pay 20%. Most plans have an annual out-of-pocket maximum, and once you have reached this they will pay 100% of all “usual and customary” charges for covered services. Many health insurance companies have moved away from indemnity plans. This is the least restrictive, therefore typically the most expensive type of health plan.

**FSA and HSA** - Flexible Spending Accounts (FSA) are accounts offered and administered by employers that allow employees to set aside, out of their paycheck, pretax dollars 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. FSAs can also be provided to cover childcare expenses, but those accounts must be established separately from medical FSAs.

**Health Savings Accounts** (HSA) are medical savings accounts available to taxpayers who are enrolled in insurance plans that meets federal rules. The funds contributed to the account are not subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses. Unlike a FSA, funds roll over year to year if you do not spend them.

For further information about FSA and HSA, you should contact the human resource department or the benefits manager within your organization.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

We all are susceptible to a variety of events in life that may affect health insurance coverage. Situations such as the onset of a chronic illness or disabling disease, changing jobs or a business closing can have adverse consequences when locating or attempting to keep your health insurance coverage. HIPAA protects health insurance coverage for workers’ families when they change or lose their jobs. Due to the fact that the HIPAA law is very complex and contains many more provisions than indicated in this writing, we recommend that you contact your employer’s benefits administrator or your State Insurance Commissioner’s office for further information about how HIPAA can affect you and/or your family.

Key Provisions of HIPAA

Group Health Insurance - Employees can credit time spent under their previous employer’s plan satisfying a pre-existing exclusion towards the new employer’s plan, as long as they do not have more than a 63 day break between coverage.

Moving from Group Health to an Individual Health Plan - If you are no longer eligible for group coverage, you are able to obtain coverage with an individual health plan if:

- You have an aggregate 18 months or more of previous coverage under a group health, government or church plan.
- You have had no lapse in coverage longer than 63 days.
- You are not eligible under another group plan, Medicare or Medicaid.
- You do not have any other health insurance coverage.
- You have exhausted any eligible COBRA coverage.
- You were not terminated from your most recent prior coverage due to non-payment of premiums or fraud.

Be aware that your state law may provide for greater protection than HIPAA, but not less than the minimum requirement mandated by the HIPAA law.

The Affordable Care Act

The Affordable Care Act (ACA) of 2010, also known as healthcare reform, puts in place strong consumer protections, provides new coverage options and gives you the tools you need to make informed choices about your health. In this section, learn about how the law affects you and the primary immunodeficiency disease community as it relates to private health insurance. For more information related to the ACA, visit www.healthcare.gov. As the law is implemented, IDF will provide updated information in the IDF Patient Insurance Center: www.primaryimmune.org/patient-insurance-center.

Young Adult Coverage

insurance policy until they turn 26 years old. Before the ACA, insurance companies could remove enrolled children usually at age 19, sometimes older for full-time students. Now, most health plans that cover children
must make coverage available to children up to age 26. By allowing children to stay on a parent’s plan, the law makes it easier and more affordable for young adults to get health insurance coverage. Your children can join or remain on your plan even if they are married, not living with you, attending school, not financially dependent on you or eligible to enroll in their employer’s plan. There is one temporary exception: Until 2014, “grandfathered” group plans do not have to offer dependent coverage up to age 26 if a young adult is eligible for group coverage outside their parent’s plan. Your insurer was required to provide you notice of its decision to remain a grandfathered plan. If you are unsure about your plan’s status, ask your employer or insurer.

**Lifetime and Annual Limits**

The ACA prohibits health plans from putting a lifetime dollar limit on most benefits you receive. The law also restricts and phases out the annual dollar limits a health plan can place on most of your benefits and does away with these limits entirely in 2014. Before the healthcare law, many health plans set an annual limit, which was a dollar limit on their yearly spending for your covered benefits. Many plans also set a lifetime limit, which was a dollar limit on what they would spend for your covered benefits during the entire time you were enrolled in that plan. You were required to pay the cost of all care exceeding those limits.

**Affordable Insurance Exchanges**

Affordable Insurance Exchanges are designed to make buying health coverage easier and more affordable. Starting in 2014, exchanges will allow individuals and small businesses to compare health plans, get answers to questions, find out if they are eligible for tax credits for private insurance or health programs like the Children’s Health Insurance Program (CHIP), and enroll in a health plan that meets their needs. An exchange can help you look for and compare private health plans, get answers to questions about your health coverage options, find out if you are eligible for health programs or tax credits that make coverage more affordable, and enroll in a health plan that meets your needs. For individuals and families, the exchange is a single place where you can enroll in private or public health insurance coverage.

**Comparing Plans**

It is important to consider specific issues when deciding on a health insurance policy. It cannot be emphasized enough that it is critical for you to be your own best advocate when dealing with your health plan

- **You should compare**: the cost of premium, coinsurance, copayments, deductibles, and the prescription coverage.

- **Ask such questions as**: How are chronic conditions like primary immunodeficiency diseases covered within the plan? What about referrals to specialists? What are the procedures? Do they have restrictions on prescription drugs?

- Read your policy and then ask your personnel department, IDF and any other resource you can find lots of questions. Try to keep current with information concerning the new rules affecting your policy.

- Review your medical bills to check for mistakes; billing errors occur more often than you might think.
(Comparing Plans continued)

- **Keep important information** such as your policy number, your ID number, insurer’s address and phone number as well as you doctors’ contact information in one place to refer to whenever you communicate with your insurer. Use IDF ePHR to keep this and all of your medical information in one place: www.idfephr.org.

- **Many employers offer open enrollment** once a year when you may change your coverage to another plan offered by your employer. Ask your employer if and when an open enrollment period is offered. If you have difficulty getting benefits through your employer, consider coverage through associations, schools, professional groups, farm groups, or local chambers of commerce. You may qualify for individual or group benefits.

- **Document each time you contact your insurer.** Get the full name and title of each person you talk with whenever you contact your insurer. This information will be important if you experience difficulties with your coverage and need to document your situation in writing.

If your problem becomes more complicated, there are other courses of action. You, and/or your physician, may appeal to the medical director of the insurance company and may need to work with the provider to submit additional justification of your claim. Often, in the case of primary immunodeficiency diseases, insurers need to be educated as to what the condition is and what the approved forms of treatment are. Most of the manufacturers of Ig offer reimbursement support services for their products and can be an excellent source of information.

There may come a time when an insurance company terminates your policy. If it does so for any other reason than bankruptcy, they are required by state and federal law to find you new coverage. Enforcing this law is up to the State Insurance Commissioner. Arbitrary cancellation is illegal.

**Summary**

Some patients are fortunate to never have to experience health insurance issues. Others may spend many hours in a seemingly endless search for insurance coverage or adequate reimbursement. Never hesitate to seek assistance from resources. Heath insurance remains a complex issue in America today. It is important for all individuals to be educated about their health insurance, as it directly impacts the well-being of the individual and their family.

Every effort was made to assure that the information provided in this chapter was accurate at the time of publication. However, because matters regarding health insurance change frequently, scan the QR code to the right to visit the IDF Patient Insurance Center for updated information.
Glossary of Health Insurance Terms

Healthcare and Insurance Related Acronyms

ACA: Affordable Care Act
ACO: Accountable Care Organization
CAP: Consumer Assistance Program
CHIP: Children's Health Insurance Program
COB: Coordination of Benefits
COBRA: Consolidated Omnibus Budget Reconciliation Act
DME: Durable Medical Equipment
EOB: Explanation of Benefits
EPO: Exclusive Provider Organization
FMLA: Family and Medical Leave Act
FPL: Federal Poverty Level
FSA: Flexible Spending Account
GEP: General Enrollment Period
HDHP: High Deductible Health Plan
HHS: Health and Human Services
HIPAA: Health Insurance Portability and Accountability Act
HMO: Health Maintenance Organization
HRA: Health Reimbursement Arrangement
HSA: Health Savings Account
MAP: Medicare Advantage Plan
MLR: Medical Loss Ratio
OEP: Open Enrollment Period
OON: Out-of-Network
OOP: Out-of-Pocket
PBM: Pharmacy Benefit Manager
PCP: Primary Care Physician
PDP: Prescription Drug Plan
PFTs: Pulmonary Function Tests
POS: Point-of-Service Plan
PPO: Preferred Provider Organization
SEP: Special Enrollment Period
SNF: Skilled Nursing Facility
TPA: Third Party Administrator
UCR: Usual, Customary and Reasonable

Healthcare Plans and Systems

Catastrophic Plan: A healthcare plan that only covers certain types of expensive care, like hospitalizations. It may also include plans that have a high deductible, so that your plan begins to pay only after you have first paid up to a certain amount for covered services.

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

Durable Medical Equipment (DME): Specialized equipment that is prescribed by a healthcare provider and furnished by a supplier, which is to be used in a patient's home or institutions constituting a home. DME may include but are not limited to items such as standard oxygen delivery systems, hospital bed, wheelchair, walker, traction apparatus, intermittent positive pressure breathing machine, brace, crutch or any other items that are determined Medically Necessary.
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).

Flexible Spending Account (FSA): Accounts offered and administered by employers that allow employees to set aside, out of their paycheck, pretax dollars 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.

Health Maintenance Organization (HMO): An insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. Generally the plan will not 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. HMOs often provide integrated care and focus on prevention and wellness.

Health Reimbursement Arrangement (HRA): A medical savings account to which employers contribute funds that can cover an employee’s costs not covered by the plan. The employer can choose whether or not to allow unused funds to rollover to the following year.

Health Savings Account (HSA): A medical savings account available to taxpayers who are enrolled in a High Deductible Health Plan (HDHP) that meets federal rules. In 2013, to qualify for use with an HSA, an HDHP plan must have a minimum deductible of $1,250 for an individual plan and $2,500 for a family plan, and an out-of-pocket maximum of $6,250 for an individual plan and $12,500 for a family plan (these number are adjusted annually). The funds contributed to the account are not 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 do not spend them.

High Deductible Health Plan (HDHP): A plan that features higher deductibles than traditional insurance plans. HDHPs can be combined with a health savings account (under certain circumstances) or a health reimbursement arrangement to allow you to pay for qualified out-of-pocket medical expenses on a pre-tax basis. (See Health Savings Account [HSA].)

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 (HMOs), preferred provider organizations (PPOs), exclusive provider organizations (EPOs), and point of service plans (POSs).

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 state by state and may have a different name in your state.

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.

Medicare Part A: Hospital insurance that helps cover inpatient care in hospitals, skilled nursing facility, hospice and home care.
Glossary of Health Insurance Terms

(Healthcare Plans and Systems continued)

**Medicare Part B:** Medical coverage that helps to cover medically-necessary services like doctors’ services, outpatient care, home health services, other medical services and preventive services.

**Medicare Advantage (Medicare Part C):** A type of Medicare health plan offered by a private company that contract with Medicare to provide Medicare Part A and Part B benefits.

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

**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.

**Preferred Provider Organization (PPO) Plan:** A type of healthcare 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 that belong to the plan’s network. You can use doctors, hospitals and providers outside of the network for an additional cost.

**Pharmacy Benefit Manager (PBM):** A third party administrator of prescription drug programs. They are primarily responsible for processing and paying prescription drug claims. They also are responsible for developing and maintaining the formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

**Primary Care Physician (PCP):** A physician who usually is the first health professional to examine a patient and who recommends secondary care physicians, medical or surgical specialists with expertise in the patient’s specific health problem, if further treatment is needed. Formerly known as the family doctor.

**Accountable Care Organization (ACO):** A group of healthcare providers who give coordinated care, chronic disease management, and thereby improve 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).

**Affordable Care Act (ACA):** The comprehensive healthcare reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Healthcare and Education Reconciliation Act on March 30, 2010. Affordable Care Act refers to the final, amended version of the law.
(Health Insurance and Reform continued)

**Allowed Charge:** Discounted fees that insurers will recognize and pay for covered services. Insurers negotiate these discounts with providers in their health plan network, and network providers agree to accept the allowed charge as payment in full. Each insurer has its own schedule of allowed charges.

**Annual Limit:** A cap on the benefits your insurance company will pay in a year while you are 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. Under the Affordable Care Act, all group health plans (existing and new) and all new individual policies (issued after 3/23/2010) must phase out annual limits. Plan or policy years starting after 9/23/2011 but before 9/23/2012 cannot have an annual limit lower than $1.25 million. For the following year, plans cannot have an annual limit lower than $2 million. No annual dollar limits are allowed on “essential” services in 2014.

**Balance Billing:** The practice of billing a patient for charges not paid by his/her insurance plan because the charges are in excess of covered amounts. Balance billing amounts will often be charges that are above the usual and customary rates.

**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.

**Biosimilar Biological Products:** The generic version of more complicated medications. Technically, they are reproductions of biotechnologically manufactured biopharmaceuticals that partially mimic proteins naturally present in the body.

**Care Coordination:** The process of organizing your treatment across several healthcare providers. Medical homes and accountable care organizations are two common ways to coordinate care.

**Chronic Disease Management:** An integrated care approach to managing illness – typically using multiple healthcare providers including various physicians, nurses, and others – which includes screenings, check-ups, monitoring and coordinating treatment, and patient education. It can improve quality of life while reducing healthcare costs if you have a chronic disease, by preventing or minimizing the effects of a disease.

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

**COBRA (Consolidated Omnibus Budget Reconciliation Act):** A federal law that may allow you to temporarily keep health coverage if your employment ends, 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.

**Co-insurance:** A form of medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid. Once any deductible amount and coinsurance are paid, the insurer is responsible for the rest of the reimbursement for covered benefits up to allowed charges: the individual could also be responsible for any charges in excess of what the insurer determines to be ‘usual, customary and reasonable.’

**Co-payment:** 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.
(Health Insurance and Reform continued)

**Cost Sharing:** The share of costs covered by your insurance that you pay out-of-pocket. Generally includes deductibles, coinsurance and copayments, or similar charges, but it does not include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost sharing in Medicaid and CHIP also includes premiums.

**Creditable Coverage:** Health insurance coverage under any of the following: a group health plan; individual health insurance; student health insurance; Medicare; Medicaid; CHAMPUS and TRICARE; Veterans Administration (VA) coverage; the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps; Public Health Plan (any plan established or maintained by a State, the U.S. government, a foreign country), including the new federal high risk pool (PCIP, or the Pre-Existing Condition Insurance Program); Children’s Health Insurance Program (CHIP) or a state health insurance high risk pool. If you have prior creditable coverage, it will reduce the length of a pre-existing condition exclusion period under new job-based coverage.

Depending on state law, this may also apply to other types of coverage, such as state high risk pools, in your state.

**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. Some plans may also cover some services before the deductible is met, such annual exams.

**Dependent Coverage:** Insurance coverage for family members of the policyholder, such as spouses, children, or partners. Under the Affordable Care Act, plans must cover children up to age 26 on their parent’s policy.

**Disability:** A limit in a range of major life activities. This includes activities like seeing, hearing, walking and tasks like thinking and working. 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](http://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.

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

**Essential Health Benefits:** A set of healthcare service categories that must be covered by certain plans, starting in 2014. 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.”

All new plans sold to individuals and small businesses, including those offered in Exchanges, and all Medicaid state plans must cover these services by 2014.

Starting with plan years or policy years that began on or after September 23, 2010, health plans can no longer impose a lifetime dollar limit on spending for...
these services. All plans, except grandfathered individual health insurance policies, must begin phasing out annual dollar spending limits for these services starting with plan/policy years that began on or after September 23, 2010. For the majority of health insurance plans, annual dollar limits on essential health benefits will be completely phased out by 2014.

The Department of Health and Human Services has issued guidance outlining a process for selecting EHBs in each state, based on existing coverage options in the small group and other employer plans. Learn more about this process at www.healthcare.gov.

**Exchange:** New state-based organizations that will be set up to create a more organized and competitive market place for individuals and small businesses to buy health insurance. Exchanges will offer a choice of different health plans, which meet certain benefits and cost standards, and provide information to help consumers better understand their options.

**Exclusions:** Items or services that are not covered under a contract for insurance and which an insurance company won’t pay. Example: your policy may not cover certain therapies or medications.

**Explanation of Benefits (EOB):** A form or document sent by the insurance company to both enrollees and providers. The document provides necessary information about claim payments and patient responsibility amounts of healthcare services however it is not a bill. It should include data on what was paid or is in process of being reviewed for payment by the insurance company. Your EOBs may help you track your healthcare expenditures and serve as a reminder of the medical services you received during the past several years.

**Family and Medical Leave Act (FMLA):** A federal law that guarantees up to 12 weeks of job protected leave for certain employees when they need to take time off due to serious illness or disability, to have or adopt a child or to care for another family member. When on leave under FMLA, you can continue coverage under your job-based plan. Learn more about FMLA at: http://www.dol.gov/whd/fmla.

**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. For more information on FPL please visit: http://aspe.hhs.gov/poverty/12poverty.

**Fee for Service:** 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.

**Formulary:** A list of drugs your insurance plan covers. May include how much you pay for each drug. If the plan categorizes drugs into different groups requiring different co-pays, also known as tiers, then the formulary may list drugs by these tiers. Formularies may include both generic drugs and brand-name drugs.
Fully Insured Job-based Plan: A plan in which the employer contracts with an insurer to assume financial responsibility for the enrollees’ medical claims and for all incurred administrative costs.

General Enrollment Period: Medicare beneficiaries who did not enroll in Part B when they first became eligible for Medicare may elect Part B coverage during the General Enrollment Period, which extends from January 1 through March 31 each year. Enrollment becomes effective on July 1 of the same year.

Grandfathered Health Plan: As defined in the Affordable Care Act, a group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010. Grandfathered plans are exempt from many changes required under the Affordable Care Act. Plans or policies may lose their grandfathered status if they make certain significant changes that reduce benefits or increase costs to consumers. A health plan must disclose in its plan materials whether it considers itself to be a grandfathered plan and must also advise consumers how to contact the U.S. Department of Labor or the U.S. Department of Health and Human Services with questions. (See New Plan.)

Guaranteed Issue: A requirement that health plans must permit you to enroll regardless of health status, age, gender or other factors that might predict the use of health services. Except in some states, guaranteed issue does not limit how much you can be charged if you enroll.

Guaranteed Renewal: A requirement that your health insurance issuer must offer to renew your policy as long as you continue to pay premiums. Except in some states, guaranteed renewal does not limit how much you can be charged if you renew your coverage.

Healthcare Workforce Development: The use of incentives and recruiting to encourage people to enter into healthcare professions such as primary care and to encourage providers to practice in underserved areas.

Health Insurance Portability and Accountability Act (HIPAA): A 1996 federal act that eliminated discrimination by health insurers for those with preexisting medical conditions. Example: when leaving a group policy, patients cannot be denied coverage in other group policies based on a pre-existing medical condition. In order to qualify for HIPPA, you must meet the following two conditions: (1) you have had 18 months of consecutive, continuous prior health coverage, and (2) you must get new coverage with another group medical plan within 63 days. Many insurance plans offer open-enrollment periods when anyone can join, regardless of pre-existing conditions.

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.

HIPAA Eligible Individual: Your status once you have had 18 months of continuous creditable health coverage. To be HIPAA eligible, at least the last day of your creditable coverage must have been under a group health plan: you also must have used up any COBRA or state continuation coverage for which you are eligible; you must not be eligible for Medicare or Medicaid; you must not have other health insurance; and you must apply for individual health insurance within 63 days of losing your prior creditable coverage. When you are buying individual health insurance, HIPAA eligibility gives you greater protections than you would otherwise have under state law.
(Health Insurance and Reform continued)

**Home Healthcare:** Healthcare services and supplies in your home that a doctor approves under a plan of care established by your doctor.

**Individual Health Insurance Policy:** Policies for people who are not connected to job-based coverage. Individual health insurance policies are regulated under state 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 Responsibility:** Under the Affordable Care Act, starting in 2014, you must be enrolled in a health insurance plan that meets basic minimum standards. If you aren’t, you may be required to pay a penalty. Exempt from this are people with very low income for whom coverage is unaffordable based in their household income, or for other reasons, including religious beliefs.

**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.

**Insurance Co-Op:** A non-profit entity in which the same people who own the company are insured by the company. Cooperatives can be formed at a national, state or local level, and can include doctors, hospitals and businesses as member-owners.

**Job-based Health Plan:** Coverage that is offered to an employee (and often his or her family) by an employer.

**Lifetime Limit:** A cap on the total lifetime benefits you may get from your insurance policy. An insurance company may impose a total lifetime dollar limit on benefits (like $1 million) or limit specific benefits (like a $200,000 lifetime cap on organ transplants or one gastric bypass per lifetime) or a combination of the two. After a lifetime limit is reached, the insurance plan will no longer pay for covered services. By September 23, 2011, the majority of policies should not have lifetime dollar limits on essential health benefits.

**Long-Term Care:** Medical and non-medical 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 do not pay for long-term care.

**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-emergency situations 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 non-emergency hospital admission. The testing is designed to reduce the length of a hospital stay.

Non-emergency weekend admission restriction - A requirement that imposes limits on reimbursement to patients for non-emergency 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 non-emergency 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.

Medical Loss Ratio (MLR): A financial measurement used in the Affordable Care Act to encourage health plans to provide value to enrollees. Example: If an insurer uses 80 cents 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%. This indicates that the insurer is using the remaining 20 cents of each premium dollar to pay 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. Insurers who do not meet the minimum MLR must issue rebates to policy holders beginning in 2012.

Medical Underwriting: A process used by insurance companies that uses your health status when you are applying for health insurance coverage to determine whether to offer you coverage, at what price and with what exclusions or limits.

Minimum Essential Coverage: The type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

New Plan: As referenced in the Affordable Care Act, a health plan that is not grandfathered and therefore subject to all of the reforms in the Affordable Care Act. 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. Also see “Grandfathered Plan” above.

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 are not related to health status.

Open Enrollment Period (OEP): The period of time set up to allow you to choose from available plans, usually once a year.
Out-of-Network (OON) Providers: A duly licensed or certified institution or health professional not under contract with your insurance provider.

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

Out-of-Pocket Limit (OOP): The maximum amount you will be required to pay for covered services in a year. Generally, this includes the deductible, coinsurance, and copayments (varies from plan to plan). Example: In some plans the out-of-pocket limit does not include cost sharing for all services, such as prescription drugs. Plans may have different out-of-pocket limits for different services. In Medicaid and CHIP, the limit includes premiums. Additionally, many plans do not have out-of-pocket limits.

Plan Year: A 12-month period of benefits coverage under a group health plan. This 12-month period might be different than the calendar year.

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.

Pre-authorization: A pre-authorization requirement means that the insurance company will not pay for a service unless the provider gets permission to provide the service. This permission is to ensure that a patient has benefit dollars remaining and that a particular kind of service is eligible for payment under the patient's contract. Authorization could be granted retroactively after receiving emergency care; generally a patient or hospital may have a 24-hour window to notify a payer.

Pre-certification: A pre-certification requirement means that a payer must review the medical necessity of a proposed service and provide a certification number before a claim will be paid. This is often true with augmentation therapy as well as other elective procedures. A physician or nurse with the payer must review a physician's order and the medical record to agree that a proposed procedure is medically appropriate. (Many insurers have adopted strict guidelines in regards to coverage for augmentation therapy.)

Premium: A monthly payment you make to your insurer to get and keep insurance coverage. Premiums can be paid by employers, unions, employees or individuals or shared among different payers.

Preventive Services: Routine healthcare that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

Primary Care: Health services that cover a range of prevention, wellness and treatment for common illnesses. Primary care providers include doctors, nurses, nurse practitioners and physician assistants. They often maintain long-term relationships with you, and they advise and treat you on a range of health-related issues. They may also coordinate your care with specialists.

Qualified Health Plan: Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Exchange in which it is sold.
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. Under the Affordable Care Act, insurers that submit rate increases of 10% or more are considered “unreasonable” and are subject to additional review.

Reinsurance: A reimbursement system that protects insurers from very high claims. It usually involves a third party paying part of an insurance company’s claims once they pass a certain amount. Reinsurance is a way to stabilize an insurance market and make coverage more available and affordable.

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). Beginning in September 2010, exclusionary riders cannot be applied to coverage for children. Starting in 2014, no exclusionary riders will be permitted in any health insurance.

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.

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.

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

Special Healthcare Need: 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.
State Continuation Coverage ("Mini-COBRA"): 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, older workers (generally 55 or older) leaving a job-based plan may be allowed to continue COBRA coverage until they reach the age of Medicare eligibility.

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 they are not the actual insurer but are simply managing the plan on behalf of the employer.

Uncompensated Care: Healthcare or services provided by hospitals or healthcare providers that do not get reimbursed. Often uncompensated care arises when people do not have insurance and cannot afford to pay the cost of 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.

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. It applies to all new employees and is not based on health status. This is different than a pre-existing condition exclusion period, which is applied to individual employees and is based on health status.

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.

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. Programs that tie financial incentives to achieving certain outcomes (like set goals such as BMI, glucose levels or blood pressure) must meet certain federal rules. Examples of some wellness programs: programs to help you stop smoking, diabetes management programs, weight loss programs, and preventative health screenings.

Source: www.healthcare.gov/glossary/04262011a.pdf

The BLS National Compensation Survey