HEALTH CARE GLOSSARY FOR AFFORDABLE CARE ACT (ACA)

Accountable Care Organization (ACO) – These organizations coordinate and provide the full range of health care services for you. The ACA provides incentives for providers who join together to form such organizations and who agree to be accountable for the quality, cost, and overall care of their patients.

Actuarial Justification – The demonstration by an issuer that the premiums collected are reasonable, given the benefits collected under the plan or that the distribution of premiums among policyholders are proportional to the distribution of their expected costs, subject to limitations of state and federal law. ACA requires insurers to publicly disclose the actuarial justifications behind unreasonable premium increases.

Adjusted Community Rating – A way of pricing insurance where premiums are not based upon a policyholder's health status, but may be based upon other factors, such as age and geographic location. The ACA requires the use of adjusted community rating, with maximum variation for age of 3:1 and for tobacco use of 1.5:1.

Affordable Care Act (ACA) (Public Law 111-148) – The ACA was implemented on March 23, 2010 and is intended to increase access to health care for more Americans, and includes many changes that impact the commercial health insurance market, Medicare and Medicaid. ACA is also referred to as the "health reform act" or "Patient Protection and Affordable Care Act" (PPACA).

Annual Benefit Limit – The maximum amount your plan will pay in a calendar year.

Balance Billing – Balance billing occurs when a provider bills you for the difference between his charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill your for the remaining $30. A preferred provider may not balance bill you.

Benefit Package – The set of health services, such as physician visits, hospitalizations, and prescription drugs, which are covered by your health plan.

Catastrophic Coverage – A coverage option with a limited benefit plan design accompanied by a high Deductible. The plan design is intended to protect primarily against the cost for unforeseen and expensive illnesses or injuries. These plans are attractive to young adults in relatively good health.

Co-insurance – Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the

service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you have met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Community Living Assistance Services and Supports (CLASS) Program – The CLASS program establishes a national voluntary long-term care insurance program for the purchase of non-medical services and support necessary for enrollees who have paid premiums into the program and become eligible (due to disability or chronic illnesses). Enrollees would receive benefits that help pay for assistance in the home or in a facility in future years. Enrollment begins January 1, 2011 (targeting working adults who can make voluntary premium contributions through payroll deductions or directly). The first benefits will be paid out to enrollees in 2016.

Community Rating – A method of pricing health plans, where all insureds are charged the same premium, regardless of health status, age or other factors. "Adjusted community rating" generally refers to a method where health issuers may vary premiums based on specified demographic characteristics (e.g. age, gender, location), but cannot vary premiums based on the health status or claims history of insureds.

Comparative Effectiveness Research – Research that is federally sponsored to compare existing health care interventions to determine which works best for certain patients and which pose the greatest benefits and harms. The research also aims to improve the quality of care and to control costs.

Co-Op Plan – A health plan that will be sold by member-owned and operated non-profit organizations through Exchanges open in 2014. ACA provides grants and loans to help Co-Op plans enter the marketplace.

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

Cost Sharing – You may be required to pay a portion of the costs of your care. Examples of these costs include Co-payments, Co-insurance and annual Deductibles. The ACA provides reduced cost sharing to eligible individuals and families based upon income.

Deductible – The amount you owe for covered health care services before your health plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. Beginning in 2014, deductibles for small group health plans will

be limited to $2,000 for individual policies and $4,000 for family policies.

Dual Eligibles – An individual who is eligible for Medicare and for some Medicaid benefits.

Employer Mandate – Beginning in 2014, employers meeting size or revenue thresholds will be required to offer minimum essential health benefit packages or pay a set portion of the cost of those benefits for use in the Exchanges.

Episode of Care – Refers to all the health services related to the treatment of a condition. For acute conditions (such as a concussion or a broken bone), the episode includes all treatment and services from the onset to resolution. For chronic conditions (such as diabetes), the episode refers to all services and treatments received over a given period of time. Some payment reform proposals involve basing provider payment on episodes of care instead of a Fee-for-Service basis.

Essential Health Benefits – General categories of benefits as defined by the ACA that must be included in a qualified health plan, effective January 1, 2014.

Exchange or Health Insurance Exchange – The ACA requires each state to create a Health Benefit Exchange (competitive insurance marketplace), where individuals and small employers can shop for health plans. Exchanges will assist individuals and small businesses in comparing and purchasing qualified health plans. If a state decides not to establish and Exchange, the federal government will establish an Exchange in that state.

External Review – The ACA requires all health plans (except Grandfathered plans) to provide an external review appeal process.

Federal Poverty Level (FPL) – The FPL for 2011 is set at $22,350 (total yearly income) for a family of four.

Fee-for-Service – A traditional method of paying for medical services where doctors and hospitals are paid a fee for each service they provide.

Flexible Spending Account (FSA) – A tax-exempt plan used to pay for medical expenses not paid for by insurance, such as deductibles, copayments, and coinsurance. ACA limits over-the-counter item reimbursements only to those purchased with a doctor's prescription.

Grandfathered Plan – A health plan that was in existence on the March 23, 2010, ACA effective date.

Group Health Plan – Health insurance that is offered by a plan sponsor, typically an employer, on behalf of its employees.

Guaranteed Issue – Beginning in 2014, the ACA requires issuers to offer coverage to all non-Grandfathered plans, without regard to the following:

- pre-existing conditions;
- health status;
- medical condition;
- claims experience;
- receipt of health care; or
- medical history.

Guaranteed Renewability - Issuers must renew coverage or continue it in force at the option of the plan sponsor or the individual.

Health Insurance Issuer (Issuer) - Health insurance issuer means an insurance company, insurance service, or insurance organization (including a health maintenance organization) which is licensed to engage in the business of insurance in Alabama and which is subject to Alabama law. Issuers may also be referred to as carriers, insurance companies, or insurers.

Health Maintenance Organization (HMO) – A health plan that provides coverage through a network of hospitals, physicians and other health care providers. HMOs typically require the selection of a primary care physician who is responsible for managing and coordinating all health care. Usually, referrals to specialist physicians are required, and the HMO pays only for care provided by an in-network provider.

Health Reimbursement Account (HRA) – A tax-exempt account that can be used to pay for qualified health expenses. HRAs are usually paired with a high-Deductible health plan and are funded solely by employer contributions.

Health Savings Account (HSA) – A tax-exempt savings account that can be used to pay for qualified medical expenses. Individuals can obtain HSAs from most financial institutions, or through their employer. Both employers and employees can contribute to the plan. To open an HSA, an individual must have health coverage under an HSA-qualified high-Deductible health plan.

High-Deductible Health Plan (HDHP) – These health insurance plans have higher Deductibles and lower premiums than traditional insurance plans. In 2011 and 2012, an HSA qualifying HDHP must have a deductible of at least $1,200 for single coverage and $2,400 for family coverage. The plan must also limit the total amount of out-of-pocket cost sharing for covered benefits.

For 2011 these amounts are $5,950 for single coverage and $11,900 for family coverage. For 2012 these amounts are $6,050 for single coverage and $12,100 for family coverage.

High-Risk Pool (Pre-existing Condition Insurance Plan)(PCIP) – The ACA expands upon the current state-based high-risk pool system. The ACA requires the government to establish or issue contracts to establish a temporary PCIP (through 2013) to provide coverage for eligible individuals with pre-existing conditions by appropriating $5 billion to subsidize premiums. Eligibility is limited to individuals who have been uninsured for at least six months and have certain pre-existing conditions. For details see https://www.pcip.gov.

Individual Mandate – The ACA requires that most individuals obtain minimum essential coverage or pay a penalty beginning in 2014. Exemptions to this requirement include, but are not limited to, religious objections, individuals with incomes less than 100% of FPL, Indian tribe members, and hardship waivers.

Internal Claims Appeal – The ACA requires all non-grandfathered health plans to conduct an internal review of an adverse claim determination at the request of the patient or the patient's representative. This process must comply with the Department of Labor's claims and appeals procedures.

Interstate Compact – The ACA provides guidelines for states to enter into interstate compact agreements to allow health plans to be sold in multiple states.

Lifetime Limits – The ACA prohibits a health plan from establishing lifetime dollar limits on "essential health benefits" (except for grandfathered individual plans).

Long-Term Care – Services for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital.

Medicaid (Title XIX of the Social Security Act) – A federal and state funded program that provides medical assistance for certain individuals and families with low income and resources. The ACA expands Medicaid eligibility to non-Medicare eligible individuals with incomes up to 133% of the FPL, establishing uniform eligibility for adults and children across all states by 2014.

Medical Loss Ratio (MLR) – The minimum percentage of premium dollars a health plan must spend on the reimbursement of certain medical costs.

Medicare (Title XVIII of the Social Security Act) – A federal program that

provides health care coverage to people age 65 and older, and to those who are under 65 and are permanently disabled or who have a congenital disability; or to those who meet other special criteria such as end-stage renal disease. Eligible individuals can receive coverage for hospital services (Medicare Part A), physician-based medical services (Medicare Part B), coverage through a private insurance plan (Medicare Part C – Medicare Advantage) and prescription drugs (Medicare Part D). Together, Medicare Part A and B are known as Original Medicare.

Medicare Part D Donut Hole – A gap in prescription drug coverage under Medicare Part D, where beneficiaries pay 100% of their prescription drug costs after their total drug costs exceed an initial coverage limit and until they qualify for a second tier of coverage.

Medicare Supplement (Medigap) Insurance – Private insurance policies that can be purchased to "fill-in the gaps" and pay for certain out-of-pocket expenses (like deductibles and coinsurance) not covered by Original Medicare.

Multi-State Plan – A qualified health plan, created by ACA and overseen by the U. S. Office of Personnel Management (OPM), which will be available in every state through Exchanges beginning in 2014.

Non-Preferred Provider – A health care provider (such as a hospital or doctor) that is not contracted with your health plan. Depending on the health plan's rules, you may not be covered at all or you may be required to pay a higher portion of the total costs when you use a non-preferred provider. These providers may also be known as out-of-network or non-participating providers.

Out-of-Pocket Costs – Health care costs that are not covered by your health plan, such as Deductibles, Co-payments, and Co-insurance. Out-of-pocket costs do not include premium costs.

Out-of-Pocket Maximum – An annual limit on the amount of money you are required to pay out-of-pocket for health care costs, excluding premiums. Beginning in 2014, the ACA places restrictions on the maximum amount your health plan can require you to pay.

Pre-existing Condition – An illness or medical condition, that existed prior to your applying for a health plan, whether or not any medical advice or treatment was recommended or received. The ACA prohibits health plans from imposing any pre-existing condition exclusions for plan and policy years beginning after September 23, 2010, for children under 19, and for all others beginning in 2014.

Preferred Provider – A health care provider (such as a hospital or doctor) that

contracts with your health plan. The provider agrees to the plan's rules and fee schedules and agrees not to balance bill you for amounts beyond the allowed fee schedule. These providers may also be known as in-network providers or participating providers.

Preferred Provider Organization (PPO) – A network of preferred providers that contract with a health plan. Plan members typically pay lower costs when they seek care from preferred providers.

Premium – The amount you pay, often on a monthly basis, for health insurance. The cost of the premium may be shared between you, your employer or government purchasers.

Premium Subsidies – A fixed amount of money, or a designated percentage of the premium cost, that is provided to help people purchase health insurance. The ACA provides premium subsidies to individuals with incomes between 133% and 400% of the FPL level that purchase health plan through the Exchanges beginning in 2014. These are also known as premium tax credits under the ACA.

Preventive Care Services – Health care that emphasizes the early detection, prevention, and treatment of disease.

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

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

Qualified Health Plan – Health plans that are offered through an Exchange, which have been certified as providing the essential health benefits package as required by the ACA.

Rate Review – Review by insurance regulators of a health plan's proposed premium and premium increases. Rates are reviewed to ensure they are sufficient to pay claims, are not unreasonably high in relation to the medical claim costs and the benefits provided, and are not unfairly discriminatory to any individual or group of individuals.

Reinsurance – The ACA includes a provision to establish a temporary reinsurance program for years 2014-2016 for issuers that cover high-risk individuals.

Rescission – Rescission is a retroactive cancellation or discontinuance of your coverage due to fraud or intentional misrepresentation of material fact.

Risk Adjustment – The process of increasing or reducing payments to health plans to reflect higher or lower than expected spending. Risk adjusting is designed to compensate health plans that enroll a sicker population as a way to discourage plans from selecting only healthier individuals.

Risk Corridor – A temporary provision in ACA for years 2014-2016 that requires plans whose costs are lower than anticipated to make payments into a fund that reimburses plans whose costs are higher than expected.

Self-Insured Plan – A health plan in which the employer assumes the financial responsibility of health care benefits for its employees. These health plans typically contract with a third-party administrator to provide administrative services for the plan. These plans are also known as self-funded or ERISA plans.

Small Business Tax Credit – The ACA provides certain small businesses that offer health plans a tax credit. These tax credits vary with the size, contribution and tax status of the small business.

Small Group – The Alabama Department of Insurance regulates small employer health plans with 2-50 employees. Alabama will expand this definition to 1-100 employees in 2016 as required by the ACA.

Tax Deduction – The ACA will raise the amount of itemized expenses that a person can deduct from adjusted gross income from the current 7.5% to 10% in 2013 (this increase is waived for individuals 65 and older for tax years 2013-2016).

Usual, Customary and Reasonable Charge (UCR) – The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount is sometimes used to determine the allowed amount.