mahp Michigan Association of Health Plans

Your *Source* for Health Care Information

GLOSSARY OF HEALTH CARE TERMS

A

AFFORDABLE CARE ACT (ACA)

A comprehensive health care law passed in 2010 by the federal government. The Affordable Care Act was aimed at reforming America's health care system to improve access and affordability for more Americans.

ALLOWABLE CHARGE

The maximum amount a health plan will reimburse a doctor or hospital for a given service.

ANNUAL DEDUCTIBLE

The amount you are required to pay annually before reimbursement by your health plan begins. The deductible requirement does not apply to certain preventive services.

B

BENEFITS

The health care items or services covered by a health plan. Your health plan may sometimes be referred to as a "benefits package."

BIOEQUIVALENT

When two prescription drugs have the same pharmaceutical ingredients and are nearly equivalent.

C

CATASTROPHIC PLAN

Catastrophic plans have lower premiums but begin to pay only after you've first paid a certain amount for covered services, or just cover more expensive levels of care, like hospitalizations.

CLAIM FORM

A form you or your doctor fill out and submit to your health plan for payment.

CLAIM

An itemized bill from a health care provider, for health services provided to a member.

COBRA

This stands for Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. This federal act requires group health plans to allow employees and covered dependents to continue their group coverage for a stated period of time following a qualifying event that causes the loss of group health coverage. Qualifying events include reduced work hours, termination of employment, a child becoming an over-aged dependent, Medicare eligibility, death or divorce of a covered employee, among others.

COINSURANCE

The percentage of costs of a medical service or prescription drug you are responsible for after meeting your deductible.

CONSUMER DIRECTED HEALTH PLAN (CDHP)

A health plan with a health savings account (HSA) or other tax-advantaged account. Consumer directed health plans give members more control of health care expenses, as the deducible is higher and care is paid for with the health savings account.

CONTRACTING HOSPITAL

A hospital that has contracted with a particular health plan to provide hospital services to members of that plan.

COORDINATION OF BENEFITS

When you need care and are on two different health plans, your insurers will coordinate your benefits to give you maximum coverage when you need it. It helps avoid duplicate payments and ensure the right payments are made by each plan.

COPAY

The set dollar amount you pay for a covered health care service at the time you get care or when you pick up a prescription drug.

COVERED PERSON

The eligible person enrolled in the health plan and any enrolled eligible family members.

COVERED SERVICE

A service that is covered according to the terms in your health plan.

CPT CODE

Current Procedural Terminology codes used by physicians and health care professionals as a means of reporting medical services and procedures.

D

DEDUCTIBLE

The amount you pay for most covered services before your health plan starts to pay. When you go to a provider that is in the plan's network, before you meet the deductible you may pay a discounted amount that has been negotiated with the provider. The deductible resets at the beginning of the calendar year or when you enroll in a new plan.

DEPENDENT

An eligible person, other than the member (generally a spouse or child), who has health care benefits under the member's policy.

DRUG FORMULARY

A list of preferred and non-preferred brand and generic drugs, biologic and biosimilar medications, and specialty drugs.

E

EFFECTIVE DATE OF COVERAGE

The date your coverage begins. Please note that the effective date can also represent the date a change in your coverage takes effect.

EMERGENCY MEDICAL CARE

Services provided for the initial outpatient treatment of an acute medical condition, usually in a hospital setting. Most health plans have specific guidelines to define emergency medical care.

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

A federal law that sets minimum patient protection standards and governs the operation of most commercial health plans that are self-insured by an employer, not a health plan.

EMPLOYER RESPONSIBILITY

Starting in 2015, if an employer with at least 50 full-time-equivalent employees doesn't provide affordable health insurance and an employee uses a tax credit to help pay for insurance through the Health Insurance Marketplace, the employer must pay a fee to help cover the cost of tax credits.

ESSENTIAL HEALTH BENEFITS

A set of basic and uniform health insurance coverage benefits that all insurers must cover with every policy.

EVIDENCE-BASED MEDICINE

An approach to health care where health plans use the best available scientific evidence from clinical research from health care professionals to help make informed health care decisions.

EXCLUSIONS

Specific medical conditions or circumstances that are not covered under a health plan.

EXPLANATION OF BENEFITS (EOB)

An EOB is created after a claim payment has been processed by your health plan. It explains the actions taken on a claim, such as the amount that will be paid, the benefit available, discounts, reasons for denying payment and the claims appeal process. EOBs are available as a paper copy or electronically.

F

FAMILY COVERAGE

Health care coverage for a primary policyholder (called a "subscriber") and their spouse and any eligible dependents.

FEDERAL POVERTY LEVEL (FPL)

The income level of an individual or household, issued annually, used by the Department of Health and Human Services to determine eligibility for certain programs and benefits. FPL will be used to determine the amount of tax credit you qualify for to offset the cost of buying health insurance.

G

GENERIC DRUG

A prescription drug that is the generic equivalent of a brand name drug listed on your health plan's formulary and costs the customer less than the brand name drug.

GRANDFATHERED HEALTH PLAN

A health plan that was in place when the Affordable Care Act was passed into law in 2010. A grandfathered plan is exempt from some requirements of the law. The grandfather rule allows businesses and families to keep the plan they have, if they wish to.

GROUP PLAN

A group of people covered under the same health plan and identified by their relation to the same employer or organization.

GUARANTEED ISSUE

A requirement under the Affordable Care Act that health insurers must permit you to enroll in some form of insurance coverage regardless of health status, age, gender or other factors.

H

HEALTH INSURANCE MARKETPLACE

The Health Insurance Marketplace, or Health Insurance Exchange, is a federal government website where you can shop, compare and buy plans offered by participating health insurance companies in your area. You can access the Marketplace at Healthcare.gov

HEALTH MAINTENANCE ORGANIZATION (HMO)

A type of health plan that provides health care coverage to its members through a network of doctors, hospitals and other health care providers.

HEALTH SAVINGS ACCOUNT

With a Health Savings Account, or HSA, you set aside money before taxes. When you visit a doctor or go to a hospital, you can pay for qualified expenses from your HSA. Only certain plans meet the high deductible amounts needed for you to be able to use your HSA.

HIPAA

A federal law (Health Insurance Portability & Accountability Act) that outlines the rules and requirements plans must follow to provide health care insurance coverage for individuals and groups.

I

INDIVIDUAL & FAMILY OUT-OF-POCKET MAXIMUMS

The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copays and coinsurance, your health plan pays 100 percent of the costs of covered benefits. For plans that cover more than 1 person, individual out-of-pocket maximums counts toward the family out-of-pocket maximum. Once the family out-of-pocket maximum is reached, the plan pays 100 percent of the cost of covered benefits for everyone on your plan. The out-of-pocket maximum doesn't include your monthly premium payments or anything you spend for services your plan doesn't cover.

INDIVIDUAL COVERAGE HRA (ICHRA)

Starting January 1, 2020, employers can offer their employees an individual coverage Health Reimbursement Arrangement (HRA) instead of a traditional group health plan. This type of account may help reimburse qualifying health care expenses. As examples, these expenses could be monthly premiums and out-of-pocket costs, such as copays and deductibles.

INDIVIDUAL HEALTH PLAN

Health care coverage for an individual with no covered dependents. Also knows as individual coverage.

INFUSION DRUG CARE

Infusion drug treatments are often used for chronic "maintenance" conditions like asthma, immune deficiencies or rheumatoid arthritis. The drugs are often covered under your health plan's medical benefit, not the drug benefit. Where you get this care could change your out-of-pocket costs.

IN-NETWORK

Services provided by a physician or other health care provider with a contractual agreement with the insurance company and covered at a higher benefit level.

INPATIENT SERVICES

Services provided when a member is registered as a bed patient in a health care facility, such as a hospital.

INSURED PERSON

The person who a contract holder (an employer or insurer) has agreed to provide coverage for, often referred to as a member/subscriber.

L

LIFETIME UNIT

A cap on the total benefits you may get from your insurance company over the life of your plan for certain conditions. A health plan may have a total lifetime dollar limit on benefits (like a $1 million lifetime cap) or limits on specific benefits (like one gastric bypass per lifetime), or a combination of the two. After a lifetime limit is reached, the health plan will no longer pay for covered services. There are no lifetime limits on essential health benefits, such as emergency services and hospital stays.

M

MANAGED CARE

A type of health insurance that manages the financing, delivery, and quality of integrated health care services. The value of managed care is to provide the best service to customers by focusing on prevention and care management to improve outcomes and healthier living.

MEDICAID

A joint federal and state funded program that provides health care coverage for low-income children and families, and for certain aged and disabled individuals.

MEDICAL COST-SHARING GROUP

A medical cost-sharing group (also called health-sharing ministries) is a group of like-minded individuals that help each other pay their medical expenses. These groups are similar to a health plan. However, instead of paying a monthly premium bill, contributions are made to a shareable account. This way, when a member is in need of health care funds, the shared money may be used to help cover the costs.

MEDICAL GROUP

A group of doctors and other health professionals that have a shared medical practice and contract with a health plan to deliver health care services to plan members.

MEDICAL LOSS RATIO (MLR)

The share of health care premiums that a health insurance provider spends on health care claims and activities to improve patient quality of care. If a health plan has a MLR of 85%, that means that 85 cents of every premium dollar must go to pay for health care claims and quality of care efforts. The remaining 15 cents on other expenditures, such as operating a customer service center, combating fraud and abuse, and pay state and federal taxes would be allowable under the 15 cents.

MEDICARE

The federal program established to provide health care coverage for eligible senior citizens and certain eligible disabled persons under age 65.

MEMBER

The person to whom health care coverage has been extended by the policyholder (such as their employer) or any of their covered family members. Sometimes referred to as the insured or insured person.

N

NETWORK

The group of doctors, hospitals and other health care professionals that contracts with a health plan to deliver medical services to its members.

NON-CONTRACTING HOSPITAL

A hospital that has not contracted with a particular health plan to provide hospital services to members in that plan.

O

OPEN ENROLLMENT PERIOD

The period of time set up to allow you to enroll in a health plan, usually once a year.

OUT-OF-NETWORK

Services are considered out-of-network when you use a doctor or other provider that does not have a contract with your health plan. Out-of-network services may not be covered or may be covered at a lower level. You may be responsible for all or part of an out-of-network provider's bill.

OUT-OF-POCKET MAXIMUM

The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copays and coinsurance, your health plan pays 100 percent of the costs of covered benefits. The out-of-pocket maximum doesn't include your monthly premium payments or anything you spend for services your plan doesn't cover.

OUTPATIENT SERVICES

Treatment that is provided to a patient who is able to return home after care without an overnight stay in a hospital.

P

PARTICIPATING PROVIDER OPTION (PPO)

A health plan that supplies services at a higher level of benefits when members use contracted health care providers. PPOs also provide coverage for services rendered by health care providers who are not part of the PPO network; however, the plan member generally shares a greater portion of the cost for such services.

PHARMACY BENEFIT MANAGER (PBM)

A separate, or third-party, company that handles your health plan's pharmacy benefit. A PBM processes and pays for your prescription drug claims based on the terms of your pharmacy benefit.

PREMIUM

The ongoing amount that must be paid for your health plan. You and/or your employer usually pay it monthly, quarterly or yearly. The premium may not be the only amount you pay for insurance coverage. Typically, you will also have a copay or deductible amount.

PREMIUM TAX CREDIT

Based on your family size and income, you may qualify for a tax credit. Unlike tax credits you claim when you file your taxes, these tax credits can be used right away to lower your monthly premium costs. Sometimes called an advanced premium tax credit (APTC), or tax credit.

PRESCRIPTION DRUGS

Prescription drugs must be ordered by a prescriber and obtained through a pharmacy. They are reviewed and approved by a formal process set by the U.S. Food and Drug Administration (FDA).

PRESCRIPTION DRUG LIST

A list of commonly prescribed drugs (also known as a drug formulary). Not all drugs listed in a plan's prescription drug list are automatically covered under that plan.

PRESCRIPTION DRUG PAYMENT LEVEL TIER

A prescription drug list has different levels of payment coverage, called “tiers." These tiers determine how much you will pay out of pocket for your prescription drug, based on the terms of your pharmacy benefit and whether the drug is covered on the drug list. Drugs in a lower tier will often cost less than drugs in a higher tier.

PREVENTIVE CARE SERVICES

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

PRIMARY CARE PHYSICIAN (PCP)

The physician you choose to be your primary source for medical care. Your PCP coordinates all your medical care, including hospital admissions and referrals to specialists. Not all health plans require a PCP.

PRIOR AUTHORIZATION (AKA PREAUTHORIZATION)

The process by which a plan member or their doctor gets approval from their health plan before the member undergoes a course of care, such as a hospital admission or a complex diagnostic test.

PROVIDER

A licensed health care facility, program, agency, doctor or health professional that delivers health care services.

Q

QUALIFIED HEALTH PLAN

A health plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (deductibles, copays, and out-of-pocket amounts) and meets other requirements.

QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENT (QSEHRA)

Small companies may offer their employees a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) if they don’t offer group health coverage. This kind of account may help pay for things like monthly premiums or other qualifying health care costs.

R

REFERRAL

A written order from a members primary care physician to see a specialist or get certain medical services.

S

SPECIALIST

A health care professional whose practice is limited to a certain branch of medicine, including specific procedures, age categories of patients, specific body systems or certain types of diseases.

SPECIAL ENROLLMENT PERIOD

A time outside the open enrollment period during which you can sign up for health insurance. You generally qualify for a special enrollment period of 60 days following certain life events that change your family status (for example, marriage or birth of a child) or loss of other health coverage.

SPECIALTY DRUG

A prescription drug used to treat complex health conditions. These drugs are usually given as a shot, but may be added to the skin or taken by mouth. Also, they may:

- Require following a specific treatment plan
- Have special handling or storage needs
- Not be sold in retail pharmacies

Conditions like hepatitis C, hemophilia, multiple sclerosis and rheumatoid arthritis are treated with specialty drugs.

STEP THERAPY

A process associated with taking prescription drugs to treat a medical condition to ensure medically sound and cost-effective medications are prescribed appropriately.

SUBSIDY (ALSO KNOWN AS PREMIUM TAX CREDIT)

Based on your family size and income, you may qualify for a subsidy, also known as a premium tax credit. Unlike tax credits you claim when you file your taxes, these tax credits can be used right away to lower your monthly premium bill.

U

USUAL & CUSTOMARY RATES

The amount paid for a medical service in a certain geographic region based upon what providers in that area charge for the same service.

UTILIZATION MANAGEMENT

The way health plans review the type and amount of care you're getting. This involves looking at the setting for your care and its medical necessity. Examples include prior authorization and step therapy.