Health Insurance Glossary of Terms 01/25/2019
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Accountable care organization

- A group of health care providers who provide coordinated care, chronic disease management, and thereby improve the quality of patients' care. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings. Vermont's certified ACO is Onecare.

Actuarial value

- The average percentage an insurance company will pay for services covered by a person's plan. If a plan has an actuarial value of 70%, the company would pay for 70% of the costs of all covered benefits.

Advance Premium Tax Credit

- Money available to a person or their family to help pay the premiums. Vermonters whose income falls under 400 percent of the Federal Poverty Level may be eligible for some level of APTC. For example, an individual making less than $48,240 OR a family of four making less than $98,400 a year may be eligible.

Adverse Selection

- When an insurer (or a market as a whole) contains a disproportionate share of unhealthy individuals.
    - The ACA instituted an individual mandate with a tax penalty as one measure to reduce adverse selection
        - The tax penalty was eliminated in the 2017 Tax Bill (starting in 2019).

Annual Limit

- The maximum amount (dollars or visits) that an insurance company will pay on a particular insurance plan. These caps can be placed on services such as prescriptions or hospitalizations. After the limit is reached, the insured person must pay all associated health care costs for the rest of the year.

Balance billing

- When a provider bills for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $90 and the allowed amount is $70, the provider may bill the patient for $20.

Biosimilar Biological Products

- The generic version of more complicated medications.

Brand Name (Drugs)

- A drug sold by a drug company under a specific name and is protected by a patent.

Centers for Medicare & Medicaid Services (CMS)

- The federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Programs, and the federally facilitated Marketplace.

CHIP (Children's health insurance program)

- Insurance program that provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid but not enough to buy private insurance.

Churn

- Describes the cyclical nature of moving between coverage sources or uninsurance.

Claim

- A request for payment that the patient or health care provider submits to the health insurer for items that are covered.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

- A federal law that may allow a person to temporarily keep health coverage after a qualifying event. If a person chose COBRA coverage in Vermont, they would pay 100% of the premiums plus a 2% administrative charge.

Coinsurance

- The percentage of costs of a covered health care service a person pays (20%, for example) after they've paid their deductible. Generally speaking, plans with low monthly premiums have higher coinsurance, and plans with higher monthly premiums have lower coinsurance.

Community rating

- A rule that prevents health insurers from varying premiums within a geographic area based on age, gender, health status or other factors.

Coordination of Benefits

- A way to figure out who pays first when 2 or more health insurance plans are responsible for paying the same medical claim. When people are dually enrolled in Medicare and Medicaid, Medicare will always pay first.

Copayment

- A fixed amount (for example, $20) paid for a covered health care service after a person paid their deductible. Generally plans with lower monthly premiums have higher copayments.

Cost sharing

- The costs covered by a person's insurance that are paid by the person. This term generally includes deductibles, coinsurance, and copayments, but it doesn't 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.

Cost Sharing Reduction (CSR)

- A discount that lowers a person's payment on deductibles, copayments, and coinsurance. Cost-sharing reductions are often called "extra savings." If a person qualifies, they must enroll in a silver plan to get the extra savings.

Deductible

- A specified amount of money that the insured must pay before an insurance company will pay a claim.

Employer Shared Responsibility Payment (ESRP)

- A tax payment that employers with at least 50 full-time employees must pay if they do not offer health insurance coverage to their full-time employees (and their dependents) that meets minimum standards set by the Affordable Care Act.

Essential Health Benefits

- A set of 10 categories of services that health insurance plans must cover under the Affordable Care Act. These include hospital stays, emergency room visits, care before and after a baby is born, mental health care, prescription drugs, dental and vision care for children, lab tests, and vaccines.

Exclusive Provider Organization (EPO) Plan

- A plan where services are covered only if a person goes to doctors, specialists, or hospitals in the plan's network (except in an emergency).

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.

Federal Poverty Level (FPL)

- A measure of income issued every year by the Department of Health and Human Services. They are used to determine eligibility for programs and benefits, including savings on Marketplace health insurance, Medicaid and CHIP coverage.

Fee For Service

- A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.

Flexible Benefits Plan

- A benefit program that offers employees a choice between various benefits including cash, life insurance, health insurance, vacations, retirement plans, and childcare. A common core of benefits may be required, but the employee can choose how the remaining benefit dollars are to be allocated for each type of benefit from the total amount promised by the employer.

Flexible Spending Account (FSA)

- An arrangement through an employer that lets an employee pay for out-of-pocket medical expenses with tax-free dollars. Allowed expenses include copayments, deductibles, prescription drugs, insulin, and medical devices.

Formulary

- A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

Guaranteed Issue

- A requirement that health plans must permit a person 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 doesn't limit how much a person can be charged if they enroll.

Health Maintenance Organization (HMO)

- A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency.

Health Reimbursement Account (HRA)

- Health Reimbursement Accounts (HRAs) are employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year.

High Deductible Health plan (HDHP)

- A plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but a person will pay more health care costs before the insurance company starts to pay its share.

Health Savings Account (HSA)

- A type of savings account that lets a person set aside money on a pre-tax basis to pay for qualified medical expenses. By using untaxed dollars in a Health Savings Account to pay for deductibles, copayments, coinsurance, and some other expenses, a person can lower their overall health care costs.

Individual Health Insurance Policy

- Policies for people that aren't connected to job-based coverage. Individual health insurance policies are regulated under state law.

Large group Health Plan

- A health plan that covers employees of an employer that has 101 or more employees.

Medical Loss Ratio (MLR)

- The percent of premium an insurer spends on claims and expenses that improve health care quality.

Medicare Advantage (Medicare Part C)

- A Medicare-approved private health insurance plans that provides all Medicare Part A (hospital insurance) and Medicare Part B (medical insurance) coverage. They generally offer additional benefits and many include prescription drug coverage. These plans often have networks.

Medicare Part D

- Is an optional federal-government program to help Medicare beneficiaries pay for self-administered prescription drugs through prescription drug insurance premiums (the cost of almost all professionally administered prescriptions is covered under Medicare Part B).

Metal Levels

Bronze Health Plans

- Have the lowest monthly premiums but the highest costs for care. They are a good choice if a person uses few medical services and wants protection from very high costs if they get seriously sick or injured.

Silver Health Plans

- The most common choice of Marketplace shoppers. A person pays moderate premiums and moderate costs when they need care. If a person qualifies for “cost sharing reductions”, they can save a lot of money on deductibles, copayments, and coinsurance when they get care if they pick a Silver plan.

Gold Health Plans

- Have higher premiums but lower costs when the insured gets care. Gold may be a good choice if a person uses a lot of medical services or would rather pay more up front and know that they’ll pay less when they get care.

Platinum Health Plans

- Have the highest premiums of any plan category but pays the most when a person gets medical care. They work well if a person expects to use a great deal of health care .

Minimum Essential Coverage

- Any insurance plan that meets the Affordable Care Act requirement for having health coverage. Examples of plans that qualify include: Marketplace plans, job-based plans, Medicare, Medicaid, and CHIP.

Non-preferred provider

- A provider who doesn't have a contract with a person's health insurer or plan. A person will pay more to see a non-preferred provider.

Open Enrollment Period

- The yearly period when people can enroll in a health insurance plan.

Out-of-Pocket Maximum

- The most a person could pay for covered services in a year. After a person spends this amount, their insurer pays the total cost of covered benefits.

Point of Service (POS) Plans

- A plan where a person pays less if they use doctors, hospitals, and other providers belonging to the plan's network. They require a person to get a referral from their primary care doctor in order to see a specialist.

Pre-Existing Condition

- A health problem, like asthma, diabetes, or cancer, which a person has before the date that new health coverage starts. Insurance companies can't refuse to cover treatment for a pre-existing condition or charge more.

Premiums

- The amount a person pays for their health insurance every month.

Prior Authorization

- Approval from a health plan before a person gets a service or fills a prescription in order for the service/prescription to be covered.

Provider networks

- A list of the doctors, other health care providers, and hospitals that a plan has contracted with to provide medical care to its members.

Qualified Health Plan (QHP)

- An insurance plan, certified by the Vermont Health Connect, that provides essential health benefits, follows established limits on cost sharing, and meets other requirements under the Affordable Care Act.

Risk adjustment

- A method to offset the cost of providing health insurance for individuals—such as those with chronic health conditions—who represent a relatively high risk to insurers.

Second Lowest Silver Plan (SLCSP)

- The silver plan with the second lowest cost and available in the area in which the taxpayer lives. The Premium Tax Credit is based on the SLCSP that is available in the area in which the individual taxpayer lives.

Silver loading

- Insurers packed Cost saving reduction-related premium rate increases into silver-level plan premiums, which increased the amount of federal subsidies available to individuals with annual incomes below 400% FPL. As a result, when premiums for silver plans rose, federal subsidies rose along with them.

Small Business Health Options Program (SHOP)

- Helps small business owners provide medical and/or dental insurance to their employees.

Solvency

- Measures a company's ability to meet its financial obligations.

Special Enrollment Period

- A person qualifies if they've had certain life events, such as losing health coverage, moving, getting married, having a baby, or adopting a child.

State Health Insurance Assisted Program (SHIP)

- A state program that gets funding from the federal government to provide free local health coverage counseling to people with Medicare.

TRICARE

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

Uncompensated Care

- Health care services provided by hospitals or health care providers that don't get reimbursed. Usually arises when people don't have insurance and cannot afford to pay the cost of care.

Vermont Health Connect

- Another term for the Health Insurance Marketplace in Vermont, a service available in every state that helps individuals, families, and small businesses shop for and enroll in affordable medical insurance.

Vermont Premium Assistance

- Money from the state of Vermont available to a person or their family to help pay for premiums for any metal level health plan. This money is in addition to the money the federal government may have awarded.

Worker's Compensation

- Insurance plan that employers are required to have to cover employees who get sick or injured on the job.