Health Care Reform Glossary of Terms

**Accountable Care Organization (ACO) (2012)**
Groups of health care providers and suppliers that work together to manage and coordinate care.

**Administrative Services Only (ASO)**
An arrangement in which a third-party administrator (TPA) or insurer provides administrative services to a self-insured employer’s health benefits plan (such as processing claims), but doesn’t insure the risk of paying benefits to enrollees.

**America’s Health Insurance Plans (AHIP)**
National association representing nearly 1,300 member companies providing health insurance coverage to more than 200 million Americans. (Note: CIGNA is a member of AHIP)

**Annual Limits Waiver (2010)**
Employers and insurance companies can apply for a waiver of the prohibition against annual dollar limits if compliance would result in significant loss of coverage or increase in premiums for enrollees. A waiver allows plans to continue to limit coverage until 2014, when annual limits are prohibited.

**Appeals and External Review (2010)**
All insurers and plans must have a standard internal claim appeal process and external review process. An appeal is a process available to the covered person or authorized representative to request reconsideration of a previous adverse claim determination.

**Automatic Enrollment (2014)**
Employers with more than 200 full-time employees will be required to enroll new full-time employees automatically in the health care plan option with the lowest employee premium, and to continue enrollment for existing employees, unless the employee makes an affirmative election to opt out or elects a different option. Automatic enrollment may be subject to a waiting period, to the extent permitted by PPACA.

**Cancellation of Coverage (Rescissions) (2010)**
Plans and insurers are prohibited from rescinding (i.e. retroactively terminating) coverage for a group or individual except in the case of fraud or intentional misrepresentation of a material fact provided the policy permits rescission.

If coverage is rescinded, 30 days advance notice to all enrollees is required.

**Comparative Effectiveness Research Fee (2012)**
$1 per enrollee tax on fully-insured and self-funded group health plans to fund comparative effectiveness research. For plan years ending after 9/30/2013, the fee increases to $2 per enrollee. This fee sunsets after 2019.

**Congressional Budget Office (CBO)**
Non partisan organization that provides Congress with objective and timely analyses for decisions on economic and budgetary issues and programs covered by the federal budget.

**Consolidated Omnibus Budget Reconciliation Act (COBRA)**
COBRA generally requires that group health plans sponsored by employers with 20 or more employees in the prior year offer employees and their families the opportunity for a temporary extension of health coverage (called continuation coverage) in certain instances where coverage under the plan would otherwise end, such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. Qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost to the plan.
Consumer-Driven Health Plan (CDHP) (2010)

A health care benefit plan designed to engage and educate individuals so that they understand the true cost and value of health care and can make informed choices that balance choice with value. CDHPs typically pair a tax advantaged account with a high deductible plan. Individuals may have the opportunity to use money that they do not spend in one year for future health care expenses. Health Reimbursement Accounts (HRA), and Health Savings Accounts (HSA), are examples of these plans.

Dependent Coverage to Age 26 (2010)

Health plans and policies that cover dependents are required to cover young adults to age 26 regardless of marital status, student status, residency, financial status, etc. A dependent is defined as a person eligible for coverage under an employee benefits plan because of that person’s relationship to an employee.

Doctor Choice (2010)

Allows enrollees to name as their primary care provider (PCP), any network provider who is able to accept the enrollee. Children must be allowed to name a pediatrician as PCP.

Dollar Limits: Annual and Lifetime (2010)

Lifetime dollar limits are not permitted on the dollar value of essential health benefits.

- Restricted annual limits are allowed on the dollar value of essential health benefits until 2014. After 2014, annual dollar limits will be prohibited on the dollar value of essential health benefits.
  - The following minimum annual limits are allowed for plan years beginning on or after these dates:
    9/23/10 – $750,000
    9/23/11 – $1.25 million
    9/23/12 – $2 million
    2014 – No annual dollar limits allowed

Early Retiree Reinsurance Program (ERRP) (2010)

To encourage companies to continue offering health insurance to early retirees, companies can be reimbursed for some of the cost of providing health insurance to retirees between the ages of 55 and 64. An early retiree is an individual between the age of 55 to 64 who isn’t an active employee and isn’t eligible for Medicare.

Eliminating the Medicare Part D coverage gap (Donut Hole) (2011)

The law gradually closes the gap between now and 2020. In 2010, enrollees received a $250 rebate from the government if they entered the Part D coverage gap.

Emergency Care (2010)

Out-of-network emergency services must be covered at the in-network level if care is received out-of-network.

Employer Mandate (2014)

Beginning in 2014, if an employer with 50 or more employees does not offer coverage to full-time (30+ hours) employees and any full-time employee received premium assistance from the federal government, the employer must pay an annual fee of $2,000 for each full-time employee minus 30.

If coverage is offered by an employer with over 50 employees but any full-time employee still receives premium assistance from the federal government, the employer must pay the lesser of: 1) $3,000 for each employee receiving premium assistance or 2) $2,000 per employee for each full-time employee minus 30.

Essential Health Benefits (2014)

We are still awaiting guidance from the US. Department of Health and Human Services on the definition of “essential health benefits,” but the law includes the following categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services (including behavioral health treatment)
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Exchange (2014)

By 2014, states are required to operate a health care Exchange(s) that will be a new option for individuals and “small employers” to purchase health insurance or defer to the federal government to establish an Exchange for its citizens.

PPACA Provisions (year effective)
Excise “Cadillac” Tax (2018)

A tax on plans that cost more than $10,200 for single coverage or $27,500 for family coverage. The health care reform law imposes a 40% excise tax on these plans starting in 2018. The insurer or employer (self-insured plans) will be responsible for the tax. Amounts not used in one year cannot be rolled over to future years.

Flexible Spending Account (FSA)

An account that reimburses employees for specified expenses (for example, health care or dependent care) as expenses are incurred. FSAs are usually funded through deductions from employees’ paychecks. An FSA can be used to reimburse expenses allowed under IRS section 213(d).

FSA funds that are not spent at the end of the plan year (which may include a grace period) are forfeited.

Free Choice Voucher

Voucher that employers must provide to employees with income less than 400 percent of the federal poverty line whose share of the cost of coverage exceeds 8 percent but is less than 9.8 percent of their household income and who choose to enroll in the health insurance Exchange. The voucher must be equal in value to what the employer would have contributed otherwise to the cost of the employees coverage.

Fully Insured

A health plan where an insurance company is responsible for all claims for plan benefits.

Grandfathered Status (2010)

The PPACA includes a provision that treats health plans that existed on March 23, 2010, as “grandfathered.” Grandfathered plans are not required to comply with some of the PPACA provisions. Grandfathered plans can make routine changes to plan designs without losing grandfathered status. However, plans will lose their grandfathered status if they make changes that significantly cut benefits, increase out-of-pocket spending for individuals or reduce the employer contribution toward the cost of the plan. A November 2010 amendment allows employers to switch insurance carriers and/or change their funding from ASO to Fully Insured without losing their grandfathered status.

Health and Human Services (HHS)

Short for “U.S. Department of Health and Human Services” – the division of federal government responsible for issuing the regulations for most of the provisions of the federal health care reform law.

Health Care Financing Administration (HCFA)

The federal agency responsible for administering Medicare and federal participation in Medicaid.

Health Insurance Fee

There will be a new $8 billion annual excise tax for health insurance companies starting in 2014, which will grow to $14.3 billion a year by 2018 and rise with inflation thereafter.

Health Insurance Portability and Accountability Act (HIPAA)

A federal law effective in 1996 that protects confidentiality of individuals’ private and medical information and regulates portability of health care coverage when changing health plans. HIPAA privacy rules apply to health plans, health care clearinghouses and health care professionals who transmit any health information in any electronic form in connection with transactions covered under HIPAA.

Health Reimbursement Arrangement (HRA)

The HRA is an employer-funded account providing employees an allowance each year to help pay their eligible medical expenses. The HRA automatically pays 100% of eligible medical expenses until it is used up. Qualified health care expenses paid by the HRA apply towards the individual’s annual deductible. Typically, unused HRA dollars roll over to the next plan year and can be used for future eligible medical expenses.

Health Savings Account (HSA)

A reimbursement account through which the participant pays for health costs through a fully insured, tax-exempt savings account. Individuals or employers or both fund the account. An individual must be covered under a qualified High Deductible Health Plan (HDHP) to be eligible to contribute to an HSA. An HSA provides tax free usage of funds for expenses allowed under IRS section 213(d). All unused amounts carry over indefinitely during a participant’s lifetime.

Health Savings Account Tax Penalty (2011)

If an individual uses HSA funds for expenses that do not satisfy the federal tax definition of eligible medical expenses, the IRS may impose a 20% tax penalty on the dispersed amount. Prior to January 1, 2011, this penalty had been 10%.

Individual Mandate (2014)

Beginning in 2014, all U.S. citizens and legal residents will be required to have “minimum essential” coverage; if they do not, they will be subject to a tax penalty.

Individual Plan

An insurance policy sold to individuals to cover individuals and/or family members.
Institute of Medicine (IOM)

Established in 1970, IOM is an independent, nonprofit organization that helps those in government and the private sector make informed health decisions by providing up-to-date information they can use to enhance their knowledge and expertise.

Interim Final Regulations (IFRs)

Regulations issued by a federal agency that are not yet final, but treated as final during the interim period between issuance of the IFR and promulgation of the final regulation. During this interim period additional public comments are solicited for consideration in final rule-making. IFRs are generally used when regulations must be issued under a tight timeframe which may not allow for a fulsome comment period prior to issuance.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

The JCAHO is an independent, not-for-profit organization whose mission is to improve the quality of care provided to the public through the provision of health care accreditation and related services which support performance improvements in health care organizations.

Large Group Plans

Under PPACA, plans sponsored by employers employing more than 100 employees. State law typically defines large employers as more than 50 employees.

Limited Medical Plans

Plans that provide cost-affordable solutions to part-time and low-wage workers who in many cases would otherwise not have access to health care coverage.

Medicaid

Health insurance for low income individuals of all ages and people with disabilities. More people will become eligible for Medicaid under PPACA.

Medical Device Fee

There will be a 2.9% national sales tax for medical devices sold after December 31, 2012.

Medical Loss Ratio (2010)

A medical loss ratio is the percent of premium a carrier spends on claims and other medical services. Carriers must provide an annual rebate to covered individuals if the medical loss ratio of the block of business to which the individual or group belongs is less than 85% for large groups or 80% for small groups or individuals.

Medicare

Title XVIII of the Social Security Act that provides payment for medical and health services to the population aged 65 and over regardless of income, as well as certain disabled persons and persons with end-stage renal disease (ESRD).

Medicare Part A

Hospital insurance provided by Medicare that can help pay for inpatient hospital care, medically necessary inpatient care in a skilled nursing facility, home health care, hospice care and ESRD.

Medicare Part B

Medicare-administered medical insurance that helps pay for certain medically necessary practitioner services, outpatient hospital services and supplies not covered by Part A hospital insurance of Medicare coverage.

Medicare Part D

Prescription drug coverage option run by Medicare-approved private insurance companies that helps cover the cost of prescription drugs.

Medicare Annual Enrollment Period (AEP)

The period each year where an individual may enroll in and disenroll from a Medicare Advantage and/or Medicare Part D plan. Beginning with Plan Year 2012, the Annual Enrollment Period will change and will now be October 15 - December 7.

National Association of Insurance Commissioners (NAIC)

An organization of government officials that includes the state insurance regulators for each of the 50 states, Washington, D.C., and the U.S. territories. Officials in each state regulate the sale of insurance in their state.

National Committee on Quality Assurance (NCQA)

An independent, nonprofit organization which assesses the quality of managed care plans, managed behavioral health care organizations and credentials verification organizations.

Non-Grandfathered Status (2010)

A health plan that was established after March 23, 2010, or has had certain changes since then such as significant reduction of benefits, increase in coinsurance rates or a reduction in employer contributions.
Open Enrollment Period
A designated period each year when an eligible person can enroll initially or transfer from his or her existing coverage to a different plan. Most employer-sponsored group plans provide an annual open enrollment period.

Over-the-Counter Drugs (2011)
Medications used to treat conditions such as pain, heartburn, allergies, colds and flu that can be purchased without a doctor’s prescription. Effective January 1, 2011, over-the-counter drugs cannot be reimbursed from health spending accounts (HRA, HSA or FSA) unless the individual has a doctor’s prescription for the drug. A prescription for insulin or diabetic supplies is not required for reimbursement from health spending accounts.

Patient Bill of Rights
Consumer protections included in the PPACA provisions that limit pre-existing condition exclusions, prohibit rescissions, protect choice of physicians, ensure coverage for emergency care and end annual and lifetime limits on coverage. These provisions will be phased in between now and 2014.

Patient Protection and Affordable Care Act (PPACA)
The full name of the legislation commonly known as federal health care reform which President Barack Obama signed the into law on March 23, 2010.

‘Pay or Play’
Option of employer to provide health benefits or pay penalties for not providing a group health plan for employees in 2014.

Pharmaceutical Fee
There will be a $2.5 billion tax starting in 2011 for the pharmaceutical industry.

Pre-existing Condition Exclusion (2010)
A pre-existing condition limitation cannot be applied to any enrollee (employee, spouse or dependent) who is under the age of 19. A pre-existing condition is defined as a health condition (other than a pregnancy) or medical problem that was diagnosed or treated before enrollment in a new health plan or insurance policy.

Preventive Services/Immunizations Without Cost Share (2010)
Preventive care services and immunizations must be covered with no cost-sharing. Cost-sharing includes deductibles, coinsurance, copayments, or any other payment required when care is received. Dollar limits are also prohibited. Preventive services are defined as medical services aimed at early detection and intervention. Does not apply to grandfathered plans.

Prohibition in Favor of Highly Compensated Individuals (2010)
Insured plans cannot discriminate in favor of highly-compensated employees, unless the distinction is based on a reasonable job classification such as hourly, salaried and geographic location. Previously, this prohibition applied only to self-funded plans. Employers may be subject to penalties under Section 105(h) of the IRS. Does not apply to grandfathered plans.

Provisions
Specific elements of the PPACA and the year each is effective.

Qualified Health Benefits Plan (QHBP)
Under PPACA, 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.

Small Business Health Options Program (SHOP)
Program intended to make health insurance more affordable, predictable, and accessible for small businesses and the self-employed by offering tax incentives to encourage states to improve small group insurance markets; encourages the development of state purchasing pools backstopped by a voluntary, nationwide pool.

Small Group Plan
PPACA defines a small group plan as a plan offered to employers with at least 1 but no more than 100 employees. However, until 2016, PPACA allows states to define as 1-50 employees.

Temporary High-Risk Pools (2010)
Temporary high-risk pools have been established to provide coverage for individuals with pre-existing conditions who have been uninsured for at least six months. These pools will be available until state Exchanges are established in 2014. Carriers and employers will be held responsible for health care expenses paid by a high-risk pool if they engage in actions that encourage individuals to leave their current plan to join a high-risk pool.

U.S. Preventive Services Task Force (USPTF)
A panel of physicians and health care professionals who evaluate the latest scientific evidence and make recommendations about which preventive care services should be covered by health plans.

W-2 Reporting (2012 for tax year 2011)
Employers must report the value of employer-sponsored health coverage on the employee’s W-2 excluding salary reduction amounts to health FSAs, HSAs, and medical savings accounts (MSAs).

PPACA Provisions (year effective)