

## Health Insurance Matters Glossary of Terms

Below is a glossary of commonly used terms related to health plans, coverage, and access to care.<sup>1</sup>

### A

**Access** – The ability of an individual or a patient population to obtain or receive health care.

**Adverse Tiering** – The practice in which a health plan places most, if not all, medications that treat a particular condition or disease on the highest pharmacy tier of a plan’s formulary. As a result, plan enrollees who have the condition must pay high out-of-pocket costs for their medications.

**Affordable Care Act (ACA)** – The abbreviated name for the Patient Protection and Affordable Care Act, often referred to as Obamacare, which was passed in March 2010. Among its provisions, the ACA eliminates practices that deny coverage or result in discrimination due to pre-existing conditions; caps annual out-of-pocket costs; and requires that individual and small group health plans cover 10 essential health benefits, including hospitalizations, ambulatory services, maternity and newborn care, and prescription drug coverage.

**Allowed Amount** – The highest amount a health plan will pay for a covered health care service. Also referred to as a “benefit maximum.”

**Ambulatory Care** – Health services provided on an outpatient basis in contrast to services provided in the home, hospital, or long-term care facility.

**Appeal** – A request for a health insurance company to review and reconsider a decision to deny a benefit or payment. If a health plan refuses to pay a claim or continue plan coverage, individuals may have the right to appeal the decision, and have the decision reviewed by a third party if the appeal is denied.

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<sup>1</sup> Many of the definitions herein are based on the Glossary from HealthCare.gov.



## B

**Balance Billing** – When an individual receives services from a health care provider that does not participate in the insurer's network, the health care provider is not obligated to accept the insurer's payment as a payment in full and may bill the patient for the unpaid amount. This is known as “balance billing.”

**Benefit Period** – The period when services are covered under a health plan, usually one calendar year. The benefit period has a start and end date, and defines the time when benefit maximums, deductibles, and coinsurance limits accrue.

**Benefits** – The health care items or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents.

## C

**Clinical Evidence** – Evidence gained from peer-reviewed, scientific research to guide health decision-making.

**Clinical Pathway** – A sequenced, multidisciplinary plan on when and how to treat a patient's disease at each stage of care – from diagnosis to medical procedures, follow-up therapies and treatments, and supportive care. Also known as care maps, clinical pathways are intended to provide quality care to patients while controlling health care costs. While many clinical pathways are developed based on evidence-based research and clinical studies, some insurer-developed pathways are based on cost reduction.

**Clinical Practice Guideline** – A statement developed based on a systematic review of clinical evidence and that assists health care practitioners and patients in making decisions on appropriate care for the patients' individualized circumstances. Clinical practice guidelines are developed by medical professional societies, physician organizations and research institutions based on a rigorous peer-reviewed process.

**Coinsurance** – The portion of the cost of a covered service or treatment to be paid by the plan enrollee. This amount is usually calculated as a percentage (for example, 20%) of the allowed amount for a service or treatment. The plan enrollee pays coinsurance after meeting his or her deductible. For example, if the health insurance plan's allowed amount for an office visit is \$100, and the plan enrollee has met the deductible, a 20% coinsurance payment would require the plan enrollee to pay \$20. The health insurance plan would pay the remainder.

**Copay Accumulator** – An insurance practice in which a health plan does not count manufacturer’s copayment assistance (e.g., coupon or rebate) toward a plan enrollee’s deductible or out-of-pocket maximum obligation.

**Copayment** – A flat fee that a plan enrollee pays for a covered health care service or medication.

**Copayment Assistance** – A program to aid a plan enrollee in paying the enrollee’s copayment obligations for a covered health care service or medication. These programs are usually provided by drug manufacturers or charitable organizations.

**Cost Sharing** – The share of costs not covered by the health plan, and for which the plan enrollee is responsible.

## **D**

**Deductible** – The amount a plan enrollee must pay out-of-pocket during the benefit period before the health plan will pay for a covered health service. For example, if a plan’s deductible is \$1,000, the plan will not cover anything until the enrollee pays \$1,000 out-of-pocket during the benefit period for covered services.

**Denial** – An insurance company’s refusal to cover a service or treatment.

## **E**

**Effective Date** – The date that a person’s insurance coverage begins.

**ERISA** – The Employee Retirement Income Security Act of 1974 (ERISA) is a comprehensive and complex federal law that sets forth minimum standards for employee benefit plans. ERISA applies to most kinds of employee benefit plans, including plans covering health care benefits. The law requires plan administrators to provide plan enrollees with certain information about their plans, including plan features; sets forth responsibilities for those who manage and control plan assets; requires plan administrators to establish appeals processes; and establishes remedies that plan enrollees may seek if a plan administrator violates ERISA.

**Essential Health Benefits** – Ten categories of benefits that most health insurance plans must cover. They include hospitalization; ambulatory services; emergency services; maternity and newborn care; mental health and substance abuse treatment; prescription drugs; lab tests; chronic disease management, well services and preventive care; pediatric services, including dental and vision care; and rehabilitative services.

**Excluded Services** – Health care services that a health insurance plan does not cover or pay for.

## **F**

**Fee for Service** – A health insurance payment model in which health care providers are paid for each service performed for a patient.

**Fee Schedule** – A list of the maximum amounts a health plan will pay for specified covered services or procedures.

**Formulary** – A list of prescription medications a plan will cover.

**Formulary Tier** – Formulary tiers are groups of drugs that are categorized primarily based on cost. The tier that a particular medication is on determines the portion of cost-sharing for which the plan enrollee is responsible. For example, drugs listed on higher formulary tiers will generally require plan enrollees to pay higher copayment or coinsurance amounts compared to drugs listed on lower tiers.

## **H**

**Health Insurance Exchange** – Also known as the “health insurance marketplace,” the health insurance exchange was established under the ACA as an online marketplace where consumers can compare and buy individual health insurance plans.

**High-Deductible Health Plan (HDHP)** – A health plan that covers preventive care, including office visits and prescription drugs, but no other medical services or treatment until the plan enrollee meets the deductible. These plans have higher deductible amounts compared to other health insurance plans. As a result, enrollees must pay more out-of-pocket before the plan begins to cover services other than preventative care. Compared to plans with lower deductibles, HDHPs often have lower premiums.

**Hospital Outpatient Care** – Health care provided in a hospital without formally admitting a patient to the hospital.

## **I**

**Inpatient Care** – Health care provided to a patient who is formally admitted to a hospital. Such patients generally stay at the hospital for at least one night.

## **L**

**Limited Benefits Plan** – Sometimes referred to as a “skinny plan,” a type of health plan that provides coverage for only certain specified health care services and treatments. Limited benefits plans offer far fewer and more restricted benefits compared to traditional health plans, but with lower premiums.

## **M**

**Medical Benefit** – Covered medical services and treatments delivered by health care providers. Additionally, certain medications that are administered to a patient by a health care provider, such as medications administered intravenously or by implantation or injection, may be covered under a health plan’s medical benefit.

**Medical Necessity** – A treatment or service that a health plan deems appropriate to evaluate, diagnose, or treat a patient's illness, injury, condition, disease, or symptoms, based on generally accepted standards of care.

## **N**

**Network** – The facilities, health care providers, and suppliers with which a health plan has contracted to provide health care services.

**Network Adequacy** – A health plan's ability to provide plan enrollees with reasonable access to a sufficient number of in-network primary care and specialty health care providers and services.

**Network Provider/In-network Provider** – A health care provider who has contracted with a health plan to provide plan enrollees with health services at contracted reimbursement rates. Plan enrollees are generally charged lower copayment and coinsurance amounts when receiving services and treatments from providers who have contracted with their plans.

**Nonmedical Switching** – A practice whereby an insurer or pharmacy benefit manager requires a stable patient to switch from his or her current, effective medication to a less costly, alternative (but not generic) drug by removing the medication from the formulary list, moving a drug to a higher cost tier, or increasing the out-of-pocket costs owed. This switch occurs after the plan year has begun or during the plan year’s renewal period.

**Non-network Provider/Out-of-network Provider** – A health care provider who has not contracted with a health plan to provide plan enrollees with health services at contracted reimbursement rates. A plan enrollee may be responsible for higher out-of-pocket costs

when obtaining treatment from an out-of-network provider, or the insurance plan may not provide coverage for the health service at all.

## O

**Oral Parity** – A legal requirement that health plans cover oral and injectable/ intravenous versions of a drug equitably, so plan enrollees pay the same cost percentage for each type of treatment.

**Out-of-Pocket Costs** – Health care expenses that are not reimbursed by the health plan. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services or treatment, as well all costs for services or treatments that are not covered.

**Out-of-Pocket Maximum** – An annual cap on the amount that plan enrollees are responsible for paying for covered services or treatments under a health insurance plan. After plan enrollees reach their out-of-pocket maximum, the health plan will pay 100 percent of the costs of covered benefits. Also referred to as “out-of-pocket limit.”

## P

**Patient Assistance Programs (PAP)** – Programs that provide aid to individuals who cannot afford their medication so that they can obtain their prescribed treatment. These programs may be offered by non-profit organizations, pharmaceutical companies, or state agencies to provide free or low-cost prescription drugs to qualifying individuals.

**Payer** – A health insurer, company, government agency, or any other entity that pays for a patient’s health service or treatment.

**Pharmacy Benefit** – The portion of a health plan’s coverage for medications that are self-administered, including those that are oral, self-injectable, or offer a route of administration that a patient can manage at home.

**Pharmacy Benefit Manager (PBM)** – A company hired by a health plan to administer the plan’s prescription drug benefit program. PBMs develop formularies, contract with pharmacies, negotiate discounts and rebates, and process and pay prescription drug claims.

**Plan Enrollee** – An eligible person or employee who is a member of a health insurance plan.

**Precertification** – A decision by a health insurer or plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary.

**Pre-existing Condition** – A medical condition that was diagnosed before the plan enrollee enrolled in a particular health plan.

**Premium** – The monthly payment that a plan enrollee makes to the health insurer to maintain coverage.

**Prior Authorization** – The requirement that a health care provider or plan enrollee obtain advance approval from a health plan or PBM before the cost of certain treatments and medications will be covered by the insurer.

**Provider** – A hospital, facility, physician, or other licensed health care professional that provides health care services to patients.

**Provider Network** – A list of doctors, other health care providers, and hospitals that a health insurer has contracted with to provide medical care to plan enrollees.

## **S**

**Step Therapy** – A practice also called “fail first,” that requires a patient to try and fail on one or a series of less expensive treatments, sometimes with adverse effects, before the insurer or PBM will cover a prescribed treatment.

**Summary of Benefits and Coverage (SBC)** – An easy-to-read summary that allows consumers to compare costs and coverage benefits between health insurance plans.

## **T**

**Telehealth** – The use of telecommunication technology, such as phone or video conference, to provide healthcare remotely. Also referred to as “telemedicine.”