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IAF GLOSSARY OF HEALTH INSURANCE AND HEALTHCARE TERMS

This glossary defines commonly used health insurance and health care terms. This glossary is intended for educational purposes and may differ from the terms used in your insurance plan/policy.

ambulatory services

Health services provided to members who are not confirmed to a health care institution.

affordable care act (ACA)

The comprehensive health care reform law enacted in March 2010 (sometimes known as ACA, PPACA, or “Obamacare”).

benefit year

A year of benefits coverage under an individual health insurance plan. The benefit year for plans bought inside or outside of the Marketplace begins January 1 of year and ends December 31 of the same year. Any changes to benefits or rates to a health insurance plan are made at the beginning of the calendar year.

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. In Medicaid or CHIP, covered benefits and excluded services are defined in state program rules.

biologic

Medicine composed of a whole living cell,

part of a cell (such as an enzyme), or the product of a cell (such as an antibody). They must be grown or produced by living cells, either human, animal or plant cells. Biologics are typically larger and more complex than traditional chemical medications.

coinsurance

A certain percent you must pay each benefit period after you have paid your deductible

copayment (copay)

The amount you pay to a healthcare provider at the time you receive services. Not all plans have a copay.

copay accumulator programs

A health insurance program that prevents patients from using a copay card or coupon to cover their out-of-pocket costs. When a patient uses a copay coupon or a card, the

health plan receives the payment from the

card or coupon, but the amount of support on the coupon or card does not count toward the patient's out-of-pocket costs.

cobra

A federal law that may allow you to temporarily keep health coverage after your employment ends, you lose coverage as a dependent of the covered employee, or another qualifying event. If you elect COBRA coverage, you pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

care coordination

The organization of your treatment across several health care providers. Medical homes and Accountable Care Organizations are two common ways to coordinate care.

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center for medicare and medicaid services (cms)

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

deductible

The amount you pay for your healthcare services before your health insurer pays. Deductibles are based on your benefit period (typically a year at a time).

flexible spending account (fsa)

An arrangement you set up through your employer to pay for many of your out-of-pocket medical expenses with tax-free dollars. You decide how much of your pre-tax wages you want taken out of your paycheck and put into an FSA. If you don't spend by the end of the year there are no carry-over FSA funds.

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federal poverty level

A measure of income issued every year by the Department of Health and Human Services (HHS). FPL is used to determine your eligibility for certain programs and benefits, including savings on Marketplace health insurance, and Medicaid and CHIP coverage.

formulary

a list of covered prescription drugs by a drug plan or a health insurer.

generic drugs

A prescription drug that has the same active ingredient formula as a brand-name drug. Generic drugs usually cost less than brand name drugs. These drugs are as effective and safe as brand-name as stated by the Food and Drug Administration (FDA).

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health maintenance organization (hmo)

Offers healthcare services only with specific HMO providers. Under an HMO plan, you might have to choose a primary care doctor. The doctor will be your primary physician and will refer you to another HMO specialist when needed. Services from providers outside of the HMO plan are hardly ever covered.

health savings account (hsa)

An account that lets you save for future medical costs. Money put in the account is not subject to federal income tax when deposited.

Funds can build up and be used year to year. They are not required to be spent in a single year. Must be paired with certain high deductible health insurance plans

(HDHP).

health insurance portability and accountability act (hipaa)

United States legislation that provides data privacy and security provisions for safeguarding medical information. Signed into law by President Bill Clinton in August 1996.

high-risk pool plan (state)

Similar to the Pre-Existing Insurance Plan under the Affordable Care Act, for patients that have been locked out of the individual insurance market because of pre-existing conditions. High-risk pool plans offer health insurance coverage that is subsidized by a state government. Typically, the premium for high-risk pools are twice as much as if you were healthy.

inpatient services

Services received when admitted to a hospital and a room and board charge is made.

in-network coinsurance

The percent you pay of the allowed amount or covered health care service to providers who contract with your health insurance or plan. In-network coinsurance usually costs you less than out-of-network coinsurance.

infusion

the delivery of medication directly into the veins (intravenously), using gravity or a pump to regulate the rate of administration. Doctors often recommend infusion therapy when a patient's condition cannot be treated by traditional medicine.

long-term care

Services that include medical and non-medical care provided to people who are unable to perform basic activities of daily living such as dressing or bathing. Long-term supports and services can be provided at home, in the community, in assisted living or in nursing homes. Medicare and most health insurance plans don't pay for long-term care.

medicaid

A federally funded health care program that is run at the state level to assist lower income families or individuals paying for long-term medical and custodial care costs.

medical underwriting

A process used by insurance companies to try to figure out your health status when

you're applying for health insurance coverage to determine whether to offer coverage, at what price, and with what exclusions or limits.

medicare

A federal program for people age 65 or older that pays for certain healthcare expenses.

medicare part a

Inpatient or hospital coverage provided by the federal program, Medicare, that covers hospital stays, skilled nursing facility care, hospice care and some home health care.

medicare part b

Medical insurance provided by the federal program, Medicare, that covers certain healthcare provider services, physician-administered medications,

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hospital

outpatient care, medical supplies and preventative services.

medicare part c (medicare advantage)

A plan that offers hospital and medical insurance through a private Medicare contractor. These plans can also offer a separate drug plan, but you cannot purchase a Medigap plan with Medicare Part C.

medicare part d

A program that helps pay for prescription drugs for people with Medicare who join a plan that includes Medicare prescription drug coverage. There are two ways to get Medicare prescription drug coverage: through a Medicare Prescription Drug Plan

or a Medicare Advantage plan that includes drug coverage.

medigap

Medicare Supplement Insurance that is offered by private, Medigap-contracting insurance companies. Medigap plans can help cover the remaining costs of healthcare services and supplies, such as copayments and coinsurance.

network

The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

network provider

A healthcare provider who is part of a health plan's network.

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nonmedical switching (NMS)

A strategy that health insurers use to control their costs and maximize profits by forcing stable patients to switch from their current, effective medications to drugs that may not be as effective, for reasons unrelated to health.

open enrollment period

The yearly period when people can enroll in a health insurance plan. Open Enrollment generally runs from November 1st to December 15th, but it is important to check each year.

outpatient services

Services that do not need an overnight stay in a hospital. Often these services are provided in a doctor's office, hospital or clinic.

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out-of-pocket cost

Cost you must pay. Out-of-pocket costs vary by plan and each plan has a maximum

out of pocket (MOOP) cost.

original medicare

Traditional Medicare that includes Medicare Part A and Part B.

patient-centered outcome research

Research that compares different medical treatments and interventions to provide evidence on which strategies are most effective in different populations and situations.

pharmacy benefit manager (PBMs)

Third-party entities that contract the management of pharmacy benefits for

government programs and employer-sponsored health plans. PBMs develop and maintain drug formularies, contract with pharmacies, negotiate rebates and contracts with manufacturers.

point of service (pos)

A type of plan in which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans also require you to get a referral from your primary care doctor in order to see a specialist.

preferred provider organization (ppo)

A type of insurance plan that offers more extensive coverage for the services of healthcare providers who are part of the plan's network, but still offers coverage for providers who are not part of the plan's

network. PPO plans generally offer more flexibility than HMO plans, but premiums tend to be higher.

premium

Payments you make to your insurance provider to keep your coverage. These payments have certain due dates.

preventative services

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

prior authorization

A pre-approval requirement by health insurers for certain health care services. The insurer makes the decision of whether the services prescribed are medically necessary before the patient receives them.

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primary care provider

A physician, nurse practitioner, clinical nurse specialist or physician assistant, as

allowed under state law, who provides, coordinates or helps a patent access a range of health care services.

referral

A written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. Without a referral from your primary care doctor, the plan may not pay for the services.

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small business health options program (shop) marketplace

A health insurance exchange that helps small business owners provide medical and dental insurance to their employees. Some smaller employers qualify for tax credits if

they buy health insurance through the SHOP Marketplace.

special enrollment period (sep)

A time outside of the yearly Open Enrollment Period when you can sign up for health insurance. You qualify for a Special Enrollment Period if you've had certain life events, including loss of coverage, moving, getting married, having a baby, or adopting a child.

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state health insurance assistance program (ship)

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

step therapy

Also known as “fail-first” is a cost-

utilization tool used by health insurance plans. This strategy requires patients to try and “fail” one or more of the insurer’s “preferred” treatment options before pursuing another treatment.

subsidized coverage

Health coverage available at reduced or no cost for people with incomes below certain levels.

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Resources: healthcare.gov/glossary

For additional educational materials and resources, please visit patientaccess.org.