



**NATIONAL HEMOPHILIA FOUNDATION**  
*for all bleeding and clotting disorders*

## Health Plan Comparison Guide

**D**etermining which health plan is most appropriate for your needs can often be a difficult process. Whether it is an individual plan or a group health plan offered through your employer, there are many things to consider when reviewing your options. These considerations usually fall under one of two categories: cost or benefits. Typically most people look at the cost of the plan when making a decision. Questions they ask may be:

1. What is the monthly/annual premium for the plan?
2. What is the sum total of my out of pocket costs, including medical and prescription co-pays, deductibles and co-insurance?
3. Does it cover all the services I need?
4. Are my physicians covered?
5. Are there annual limits? If so, is it a maximum annual benefit limit based on dollars or on number of visits. For example, mental health coverage is usually limited to a certain number of visits per year.
6. Are out of network benefits available? Am I covered if I get sick out of state?

For those affected by a bleeding disorder, there are often additional, more specific, questions we must ask that relate to what benefits are covered and how, such as:

1. Is clotting factor covered? If so, is it a major medical or a pharmacy benefit?
2. Do I have a choice of more than one pharmacy provider?
3. Is my hemophilia treatment center in network?
4. Is durable medical equipment covered?
5. Do I need a referral to see a specialist?
6. What services require prior authorization?

Answers to many of the questions above, both relative to cost and benefits, can be found by reviewing your plan's summary of benefits, drug formulary list and provider network directory. While this is often viewed as a tedious process, it is one of the most important steps you can take to insure that a plan meets your need. It is important to remember that *once you choose a plan, you cannot change until the next open enrollment period.*

In many instances, you may find that you have the option to choose between multiple plan types and designs: HMO, PPO, POS, EPO, etc. The attached "Health Plan Comparison Chart" is a tool designed to assist you in performing a side-by-side comparison of your plan options by helping to identify coverage benefits and out-of-pocket costs associated with each. The chart can be used in two ways: as a tool to make general comparisons between health plans or as a customized tool designed to highlight the costs and benefits specific to your individual needs. The steps below are specific to a more personalized evaluation.

# Getting Started

**Step 1.** Prepare a “Personal Health Experience” stat sheet taking into consideration the health services you have used in the previous 12 months. Ask yourself “In the past twelve months how many times have I: ”

- A) Visited my primary physician?
- B) Been seen by a specialist?
- C) Been seen at my HTC?
- D) Visited an ER or urgent care center?
- E) Been admitted to the hospital for an overnight stay?
- F) Purchased a prescription drug? How many per month?
- G) Required home healthcare services (i.e., home nursing service)?

**Step 2.** Print a copy of the attached “Health Terms” document.

**Step 3.** Collect from your Human Resources representative the following documents for each health plan being presented to me. (Note: often you will be provided a link to this information on the carrier’s Web site.)

- A) Benefit Summary
- B) Drug Formulary
- C) Provider Network Booklet

**Step 4.** Begin using your “Health Plan Comparison Chart”

While the documents referenced above may help answer many questions important to choosing the appropriate plan, there will be some questions that require additional resources to answer. There are many resources available to consumers who need additional help. For more information and/or a list of available resources, you can contact NHF, your local chapter and/or your HTC social worker.

For more information on health coverage options that may be available to you in your state, please visit: <http://finder.healthcare.gov> and choose your state.



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## Personal Health Experience Stat Sheet

**C**hoosing a healthcare plan can be very confusing. There are many things to consider; however two of the most important are cost and benefit design. When trying to determine your potential out-of-pocket costs, it is important to determine which benefits you (and your family, if you are all on the same policy) typically use and how often you use them. This will help you project your out-of-pocket costs for the upcoming benefit year. The easiest way to do this is to ask yourself the following questions:

“In the past twelve months I have:”

1. Visited my primary care physician \_\_\_\_ times.
  - a) Spouse has visited his/her primary care physician \_\_\_\_ times.
  - b) Child(ren) have visited their primary care physician \_\_\_\_ times.
2. Been seen by a specialist \_\_\_\_ times.
  - a) Spouse \_\_\_\_ times.
  - b) Child(ren) \_\_\_\_ times.
3. Visited an ER or urgent care center \_\_\_\_ times.
  - a) Spouse \_\_\_\_ times
  - b) Child(ren) \_\_\_\_ times
4. Purchased \_\_\_\_ number of prescriptions (including for my family) at my local pharmacy.
5. Been admitted to a hospital for an overnight stay \_\_\_\_ times.
  - a) Spouse \_\_\_\_ times
  - b) Child(ren) \_\_\_\_ times
6. Needed home health services (such as nursing care) \_\_\_\_ times.



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# Health Plan Cost Comparison Worksheet

<b>Plan Name</b>				
Plan Type (EPO, HMO, PPO, POS)				
Does the plan require you to choose Primary care physician (PCP)	Yes	No	Yes	No
<b>Annual Premium</b>	\$		\$	\$
<b>Financial (deductible/coinsurance/annual limits)</b>				
Deductible Ind/Family	\$	\$	\$	\$
Co-Insurance (i.e. 80/20, 70/30)	\$		\$	\$
Maximum out of pocket single/family	\$		\$	\$
Does the plan have annual limits?	Yes	No	Yes	No
If so, what is the limit?	\$		\$	\$
<b>Preventive Care</b>				
Physical exam	\$		\$	\$
Routine pediatric care	\$		\$	\$
Immunizations	\$		\$	\$
<b>Major Medical (Do you have a copy of the plan's provider list?)</b>	Yes	No	Yes	No
<b>In- Network</b>				
<b>(Please note cost shares may vary when using Out of Network providers)</b>				
<b>Outpatient Care</b>				
Physician office co-pay	\$		\$	\$
Specialist co-pay	\$		\$	\$
Surgery	\$		\$	\$
Laboratory services	\$		\$	\$

<b>Hospital Care (Inpatient services)</b>			
Physician's and surgeon's services	\$	\$	\$
Semi-private room and board	\$	\$	\$
All drugs & medications	\$	\$	\$
<b>Emergency Care</b>			
Emergency room	\$	\$	\$
Urgent care center	\$	\$	\$
<b>Maternity Care</b>			
Pre-natal and post-natal care (per visit)	\$	\$	\$
Hospital services (mother & child)	\$	\$	\$
<b>Substance Abuse</b>			
Inpatient - ___ visits allowed per calendar year	\$	\$	\$
Outpatient ___ visits allowed per calendar year	\$	\$	\$
<b>Mental Health</b>			
Inpatient - _____ visits allowed per calendar year			
Outpatient _____ visits allowed per calendar year			
<b>Pharmacy Benefit (do you have a copy of the plan's drug formulary list)</b>			
	Yes No	Yes No	Yes No
Yearly deductible (pharmacy)	\$	\$	\$
Co-pay Tier 1 (generics)	\$	\$	\$
Co-pay Tier 2 (Formulary/brand)	\$	\$	\$
Co-pay Tier 3 (Non-Formulary)	\$	\$	\$
Co-insurance Tier 4 (Specialty Tier) - % cost share	%	%	%
IF your plan has a specialty tier with co-insurance is there a per prescription maximum? Is there a yearly maximum out of pocket	Yes \$ _____ No	Yes \$ _____ No	Yes \$ _____ No
Is clotting factor covered under the pharmacy benefit?	Yes No	Yes No	Yes No
Do you have more than one choice of pharmacy provider	Yes No	Yes No	Yes No
<b>Other (if offered)</b>			

Chiropractic	\$	\$	\$
Short term rehabilitation -inpatient	\$	\$	\$
Short term rehabilitation - outpatient	\$	\$	\$
Skilled nursing facility (SNF) (Is clotting factor is covered while inpatient?)	\$	\$	\$
Home health care	\$	\$	\$
Hospice care - Inpatient	\$	\$	\$
Hospice care - outpatient	\$	\$	\$
Durable medical equipment	\$	\$	\$
Total Estimated Cost			





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# Glossary of Healthcare Terms

## Health Insurance and Reform

**Accountable Care Organization (ACO):** A group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of patient care. The “organization’s” payment is tied to achieving health care quality goals and outcomes that result in cost savings. ACOs can include various types of doctors – primary care, specialists, etc. – as well as other medical providers (nurses, physician’s assistants, etc.) and institutions (hospitals, multi-physician practices).

**Actuarial Value:** The percentage of total average costs for covered benefits that a plan will cover. *Example:* if a plan has an actuarial value of 70%, on average you would be responsible for 30% of the costs of all covered benefits. However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual health care needs and the terms of your insurance policy.

**Affordable Care Act (ACA):** The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. Affordable Care Act refers to the final, amended version of the law.

**Allowed Charge:** Discounted fees that insurers will recognize and pay for covered services. Insurers negotiate these discounts with providers in their health plan network, and network providers agree to accept the allowed charge as payment in full. Each insurer has its own schedule of allowed charges.

**Annual Limit:** A cap on the benefits your insurance company will pay in a year while you’re enrolled in a health insurance plan. Annual caps are sometimes placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits for a particular service. After the annual limit is reached, you must pay all associated health care costs for the rest of the year.

**Balance Billing:** The practice of billing a patient for charges not paid by his/her insurance plan because the charges are in excess of covered amounts. Balance billing amounts will often be charges that are above the usual and customary rates.

**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.

**Biosimilar Biological Products:** The generic version of more complicated medications. Technically, they are reproductions of biotechnologically manufactured biopharmaceuticals that partially mimic proteins naturally present in the body.

**Care Coordination:** The process of organizing your treatment across several health care providers. Medical homes and accountable care organizations (see definition) are two common ways to coordinate care.

**Chronic Disease Management:** An integrated care approach to managing illness – typically using multiple health care providers including

various physicians, nurses, and others – which includes screenings, check-ups, monitoring and coordinating treatment, and patient education. It can improve quality of life while reducing health care costs if you have a chronic disease, by preventing or minimizing the effects of a disease.

**Claim:** A request for payment that you or your health care provider submits to your health insurer when you get items or services you think are covered.

**COBRA:** It stands for Consolidated Omnibus Budget Reconciliation Act. A federal law that may allow you to temporarily keep health coverage if your employment ends, you lose coverage as a dependent of the covered employee, or if there is another qualifying event. COBRA requires you pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

**Co-insurance:** A form of medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid. Once any deductible amount and coinsurance are paid, the insurer is responsible for the rest of the reimbursement for covered benefits up to allowed charges: the individual could also be responsible for any charges in excess of what the insurer determines to be ‘usual, customary and reasonable.’

**Community Rating:** A rule that prevents health insurers from varying premiums for individuals and families on factors such as age, gender, and health. Most states do not have community rating and thus permit premiums to vary based on these factors.

**Copayment:** A flat dollar amount you must pay for a covered program. *Example:* you may have to pay a \$15 copayment for each covered visit to a primary care doctor.

**Cost Sharing:** The share of costs covered by your insurance that you pay out of pocket. Generally includes deductibles, coinsurance and copayments, or similar charges, 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.

**Creditable Coverage:** Health insurance coverage under any of the following: a group health plan; individual health insurance; student health insurance; Medicare; Medicaid; CHAMPUS and TRICARE; Veterans Administration (VA) coverage; the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps; Public Health Plan (any plan established or maintained by a State, the U.S. government, a foreign country), including the new federal high risk pool (PCIP, or the Pre-Existing Condition Insurance Program); Children’s Health Insurance Program (CHIP) or a state health insurance high risk pool. If you have prior creditable coverage, it will reduce the length of a pre-existing condition exclusion period under new job-based coverage. Depending on state law, this may also apply to other types of coverage – such as state high risk pools – in your state.

**Deductible:** The amount you must pay for covered care before your health insurance begins to pay. Insurers apply and structure deductibles differently. *Example:* under one plan, a comprehensive deductible might apply to all services while another plan might have separate deductibles for benefits such as prescription drug coverage.

**Dependent Coverage:** Insurance coverage for family members of the policyholder, such as spouses, children, or partners.

**Disability:** A limit in a range of major life activities. This includes activities like seeing, hearing, walking and tasks like thinking and working. Different state, federal or private programs may have different disability standards. A legal definition of disability can be found at: [www.ada.gov/pubs/ada.htm](http://www.ada.gov/pubs/ada.htm).

**Donut Hole, Medicare Prescription Drug:** Most plans with Medicare prescription drug coverage (Part D) have a coverage gap, called a donut hole. This means that after you and your drug plan have spent a certain amount of money for covered drugs, you have to pay all costs out of pocket for your prescriptions up to a yearly limit.



Once you have spent up to the yearly limit, your coverage gap ends and your drug plan helps pay for covered drugs again.

**Early Periodic Screening, Diagnostic & Treatment Services (EPSDT):** The comprehensive set of benefits covered for children in Medicaid.

**Emergency Room Services:** Evaluation and treatment of an illness, injury, or condition that needs immediate medical attention in an emergency room.

**Essential Health Benefits:** A set of health care service categories that must be covered by certain plans, starting in 2014. The Affordable Care Act defines essential health benefits to “include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.”

Insurance policies must cover these benefits in order to be certified and offered in Exchanges, and all Medicaid state plans must cover these services by 2014.

Starting with plan years or policy years that began on or after September 23, 2010, health plans can no longer impose a lifetime dollar limit on spending for these services. All plans, except grandfathered individual health insurance policies, must begin phasing out annual dollar spending limits for these services starting with plan/policy years that began on or after September 23, 2010. For the majority of health insurance plans, annual dollar limits on essential health benefits will be completely phased out by 2014.

The Department of Health and Human Services is working with a number of partners to develop the essential health benefits package. In the fall of 2011, HHS will launch an effort to collect public comment and hear directly from all Americans who are interested in sharing their thoughts on

this important issue. Learn more about this process at [www.healthcare.gov](http://www.healthcare.gov).

**Exchange:** A new transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Exchanges will offer a choice of health plans that meet certain benefits and cost standards.

**Exclusions:** Items or services that aren't covered under a contract for insurance and which an insurance company won't pay. *Example:* your policy may not cover pregnancy care or any services related to a pre-existing condition.

**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. When on leave under FMLA, you can continue coverage under your job-based plan. Learn more about FMLA at <http://www.dol.gov/whd/fmla/>.

**Federal Poverty Level (FPL):** A measure of income level issued annually by the Department of Health and Human Services. FPL is used to determine eligibility for certain programs and benefits. For more information on FPL please visit <http://aspe.hhs.gov/poverty/11poverty.shtml>.

**Fee for Service:** A reimbursement plan in which doctors and other health care providers are paid for each service performed, such as for tests and office visits.

**Flexible Benefits Plan:** Offers employees a choice between various benefits including cash, life insurance, health insurance, vacations, retirement plans, and child care. Although a common core of benefits may be required, you can choose how your remaining benefit dollars are to be allocated for each type of benefit from the total amount promised by the employer. Sometimes you can contribute more for additional coverage. Also known as a Cafeteria plan or IRS 125 Plan.



**Flexible Spending Account (FSA):** Accounts offered and administered by employers that allow employees to set aside, out of their paycheck, pretax dollars to pay for the employee's share of insurance premiums or medical expenses not covered by the employer's health plan. The employer may also make contributions to a FSA. Typically, benefits or cash must be used within the given benefit year or the employee loses the money. Flexible spending accounts can also be provided to cover childcare expenses, but those accounts must be established separately from medical FSAs.

**Formulary:** A list of drugs your insurance plan covers. May include how much you pay for each drug. If the plan categorizes drugs into different groups requiring different co-pays – also known as tiers – then the formulary may list drugs by these tiers. Formularies may include both generic drugs and brand-name drugs.

**Fully Insured Job-based Plan:** A plan in which the employer contracts with another organization to assume financial responsibility for the enrollees' medical claims and for all incurred administrative costs.

**Grandfathered Health Plan:** As defined in the Affordable Care Act, a group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010. Grandfathered plans are exempt from many changes required under the Affordable Care Act. Plans or policies may lose their grandfathered status if they make certain significant changes that reduce benefits or increase costs to consumers. A health plan must disclose in its plan materials whether it considers itself to be a grandfathered plan and must also advise consumers how to contact the U.S. Department of Labor or the U.S. Department of Health and Human Services with questions. Also see “New Plan” below.

**Guaranteed Issue:** A requirement that health plans must permit you 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 you can be charged if you enroll.

**Guaranteed Renewal:** A requirement that your health insurance issuer must offer to renew your policy as long as you continue to pay premiums. Except in some states, guaranteed renewal doesn't limit how much you can be charged if you renew your coverage.

**Home and Community-based Services (HCBS):** Services and support provided by most state Medicaid programs in your home or community that gives help with such daily tasks as bathing or dressing. Covered when provided by care workers or, if your state permits it, by your family.

**Healthcare Workforce Development:** The use of incentives and recruiting to encourage people to enter into health care professions such as primary care and to encourage providers to practice in underserved areas.

**Health Insurance Portability and Accountability Act (HIPAA):** A 1996 federal act that eliminated discrimination by health insurers for those with preexisting medical conditions. *Example:* when leaving a group policy, patients cannot be denied coverage in other group policies based on a preexisting medical condition. In order to qualify for HIPAA, you must meet the following two conditions: (1) you have had 18 months of consecutive, continuous prior health coverage, and (2) you must get new coverage with another group medical plan within 63 days. Many insurance plans offer open-enrollment periods when anyone can join, regardless of preexisting conditions.

**Health Status:** Refers to your medical conditions (both physical and mental health), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

**HIPAA Eligible Individual:** It stands for Health Insurance Portability and Accountability Act. Your status once you have had 18 months of continuous creditable health coverage. To be HIPAA eligible, at least the last day of your creditable coverage must have been under a group health



plan; you also must have used up any COBRA or state continuation coverage for which you are eligible; you must not be eligible for Medicare or Medicaid; you must not have other health insurance; and you must apply for individual health insurance within 63 days of losing your prior creditable coverage. When you're buying individual health insurance, HIPAA eligibility gives you greater protections than you would otherwise have under state law.

**Home Health Care:** Health care services and supplies in your home that a doctor approves under a plan of care established by your doctor.

**Hospital Readmission:** A return by a patient to the hospital following discharge for the same or related care within 30, 60 or 90 days. Hospital readmissions are often used in part to measure the quality of hospital care, since it can mean that follow-up care wasn't properly organized, or that a patient wasn't fully treated before discharge.

**Individual Health Insurance Policy:** Policies for people who aren't connected to job-based coverage. Individual health insurance policies are regulated under state law. Note that the phrase "individual policies" when used in this way – policies that are unconnected to employment – can be used for policies that cover a single person or multiple people (families, mother and dependent child, husband and wife, etc.).

**Individual Responsibility:** Under the Affordable Care Act, starting in 2014, you must be enrolled in a health insurance plan that meets basic minimum standards. If you aren't, you may be required to pay a penalty. Exempt from this are people with very low income for whom coverage is unaffordable, or for other reasons, including religious beliefs.

**In-Network Provider:** A physician, certified nurse midwife, hospital, skilled nursing facility, home health care agency, or any other duly licensed or certified institution or health professional under contract with your insurance provider.

**Insurance Co-Op:** A non-profit entity in which the same people who own the company are insured by the company. Cooperatives can be

formed at a national, state or local level, and can include doctors, hospitals and businesses as member-owners.

**Job-based Health Plan:** Coverage that is offered to an employee (and often his or her family) by an employer.

**Lifetime Limit:** A cap on the total lifetime benefits you may get from your insurance policy. An insurance company may impose a total lifetime dollar limit on benefits (like \$1 million) or limit specific benefits (like a \$200,000 lifetime cap on organ transplants or one gastric bypass per lifetime) or a combination of the two. After a lifetime limit is reached, the insurance plan will no longer pay for covered services. By September 23, 2011, the majority of policies should not have lifetime limits on essential health benefits.

**Long-Term Care:** Medical and non-medical services 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. Individuals may need long-term supports and services at any age. Medicare and most health insurance plans don't pay for long-term care.

**Managed care provisions:** Features within health plans that provide insurers with a way to manage the cost, use and quality of health care services received by group members. Examples of managed care provisions include:

- *Preadmission certification* - Authorization for hospital admission given by a health care provider to a group member prior to hospitalization. Failure to obtain a preadmission certification in non-emergency situations reduces or eliminates the health care provider's obligation to pay for services rendered.
- *Utilization review* - The process of reviewing the appropriateness and quality of care provided to patients. Utilization review may take place before, during, or after the services are rendered.



- *Preadmission testing* - Requirement designed to encourage patients to obtain necessary diagnostic services on an outpatient basis prior to non-emergency hospital admission. The testing is designed to reduce the length of a hospital stay.
- *Non-emergency weekend admission restriction* - A requirement that imposes limits on reimbursement to patients for non-emergency weekend hospital admissions.
- *Second surgical opinion* - A cost-management strategy that encourages or requires patients to obtain the opinion of another doctor after a physician has recommended that a non-emergency or elective surgery be performed. Programs may be voluntary or mandatory in that reimbursement is reduced or denied if the participant does not obtain the second opinion. Plans usually require that such opinions be obtained from board-certified specialists with no personal or financial interest in the outcome.

**Medical Loss Ratio (MLR):** A financial measurement used in the Affordable Care Act to encourage health plans to provide value to enrollees. *Example:* If an insurer uses 80 cents of every premium dollar to pay its customers’ medical claims and activities that improve the quality of care, the company has a medical loss ratio of 80%. This indicates that the insurer is using the remaining 20 cents of each premium dollar to pay overhead expenses, including salaries, administrative costs, and agent commissions. The Affordable Care Act sets minimum medical loss ratios for different markets, as do some state laws.

**Medically Necessary:** Services or supplies that are needed for the diagnosis or treatment of your health condition and meet accepted standards of medical practice.

**Medical Underwriting:** A process used by insurance companies that uses your health status when you’re applying for health insurance coverage to determine whether to offer you coverage, at what price, and with what exclusions or limits.

**Minimum Essential Coverage:** The type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual

market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

**New Plan:** As referenced in the Affordable Care Act, a health plan that is not grandfathered and therefore subject to all of the reforms in the Affordable Care Act. In the individual health insurance market, a plan that your family is purchasing for the first time. In the group health insurance market, a plan that your employer is offering for the first time. New employees and new family members may be added to existing grandfathered group plans – so a plan that is new to you and your family may still be a grandfathered plan.

In both the individual and group markets, a plan that loses its grandfathered status will be considered a new plan. This happens when it makes significant changes to the plan, such as reducing benefits or increasing cost-sharing for enrollees. Also see “Grandfathered Plan” above.

**Nondiscrimination:** A requirement that job-based insurance not discriminate based on health status by denying or restricting health coverage, or charging more. Job-based plans can restrict coverage based on other factors such as part-time employment that aren’t related to health status.

**Open Enrollment Period:** The period of time set up to allow you to choose from available plans, usually once a year.

**Out-of-Network Providers:** A duly licensed or certified institution or health professional not under contract with your insurance provider.

**Out-of-Pocket Costs:** Your expenses for medical care that aren’t reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren’t covered.

**Out-of-Pocket Limit (OOP):** The maximum amount you will be required to pay for covered services in a year. Generally, this includes the deductible, coinsurance, and copayments (varies



from plan to plan). *Example:* In some plans the out-of-pocket limit doesn't include cost sharing for all services, such as prescription drugs. Plans may have different out-of-pocket limits for different services. In Medicaid and CHIP, the limit includes premiums. Additionally, many plans do not have out-of-pocket limits.

**Plan Year:** A 12-month period of benefits coverage under a group health plan. This 12-month period might be different than the calendar year.

**Policy Year:** A 12-month period of benefits coverage under an individual health insurance plan. This 12-month period might be different than the calendar year.

**Pre-Existing Condition (Job-based Coverage):** Any condition (either physical or mental) including a disability for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period (the 6 month period is applicable to ERISA plans but may differ from state to state for small businesses, check your policy) ending on your enrollment date in a health insurance plan. Genetic information, without a diagnosis of a disease or a condition, cannot be treated as a pre-existing condition. Pregnancy cannot be considered a pre-existing condition and newborns, newly adopted children and children placed for adoption who are enrolled within 30 days cannot be subject to pre-existing condition exclusions. This term is defined under state law and varies significantly by state.

**Pre-existing Condition Exclusion Period (Job-based Coverage)\*:** The time period during which a health plan won't pay for care relating to a pre-existing condition. This cannot exceed 12 months for a regular enrollee or 18 months for a late-enrollee.

**Pre-existing Condition Exclusion Period (Individual Policy):** The time period during which an individual policy won't pay for care relating to a pre-existing condition. Conditions may be excluded permanently (known as an exclusionary rider). Rules on pre-existing condition exclusion periods in individual policies vary widely by state.

\*Pre-existing conditions exclusions for children

under age 19 are prohibited for plan years effective after September 23, 2010 and will be prohibited for adults for plan years effective after January 1, 2014.

**Premium:** A monthly payment you make to your insurer to get and keep insurance coverage. Premiums can be paid by employers, unions, employees or individuals or shared among different payers.

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

**Primary Care:** Health services that cover a range of prevention, wellness, and treatment for common illnesses. Primary care providers include doctors, nurses, nurse practitioners, and physician assistants. They often maintain long-term relationships with you and advise and treat you on a range of health-related issues. They may also coordinate your care with specialists.

**Qualified Health Plan:** Under the Affordable Care Act, 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.

**Qualifying Event:** Any event or occurrence such as death, termination of employment, divorce, or a terminal illness that changes an employee's eligibility status and permits an acceleration or continuation of benefits or coverage under a group health plan. The term is most frequently used in reference to COBRA eligibility

**Rate Review:** A process that allows state insurance departments to review rate increases before insurance companies can apply them to you.

**Reinsurance:** A reimbursement system that protects insurers from very high claims. It usually involves a third party paying part of an insurance company's claims once they pass a certain



amount. Reinsurance is a way to stabilize an insurance market and make coverage more available and affordable.

**Rescission:** The retroactive cancellation of a health insurance policy. Insurance companies will sometimes retroactively cancel your entire policy if you made a mistake on your initial application when you buy an individual market insurance policy. Under the Affordable Care Act, rescission is illegal except in cases of fraud or intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.

**Rider (exclusionary rider):** An amendment to an insurance policy. Some riders add coverage while other riders exclude coverage (known as exclusionary rider). *Example:* You buy a maternity rider to add coverage for pregnancy to your policy. An exclusionary rider is an amendment permitted in individual policies that permanently excludes coverage for a health condition, body part, or body system (such as a certain disease state or disability). Beginning in September 2010, exclusionary riders cannot be applied to coverage for children. Starting in 2014, no exclusionary riders will be permitted in any health insurance.

**Risk Adjustment:** A statistical process that takes into account the underlying health status and health spending of the enrollees in an insurance plan when looking at their health care outcomes or health care costs.

**Self-Insured Plan:** Type of plan usually present in larger companies where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees' and dependents' medical claims. These employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third party administrator, or they can be self-administered.

**Skilled Nursing Facility Care:** Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. *Example:* Physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

**Special Enrollment Period:** A time outside of the open enrollment period during which you and your family have a right to sign up for job-based health coverage. Job-based plans must provide a special enrollment period of 30 days following certain life events that involve a change in family status (such as marriage or birth of a child) or loss of other job-based health coverage.

**Special Health Care Need:** The health care and related needs of children who have chronic physical, developmental, behavioral or emotional conditions. Such needs are of a type or amount beyond that required by children generally.

**State Continuation Coverage:** A state-based requirement similar to COBRA that applies to group health insurance policies of employers with fewer than 20 employees. In some states, state continuation coverage rules also apply to larger group insurance policies and add to COBRA protections. *Example:* in some states, if you're leaving a job-based plan, you must be allowed to continue your coverage until you reach the age of Medicare eligibility.

**Third party administrator (TPA):** An individual or firm hired by an employer to handle claims processing, pay providers, and manage other functions related to the operation of health insurance. The TPA is not the policyholder or the insurer. The TPA may often be a company you associate with health insurance, such as Aetna or Blue Cross, but in this role they are not the actual insurer but are simply managing the plan on behalf of the employer.

**Uncompensated Care:** Health care or services provided by hospitals or health care providers that don't get reimbursed. Often uncompensated care arises when people don't have insurance and cannot afford to pay the cost of care.

**Usual, customary, and reasonable (UCR) charges:** A healthcare provider's usual fee for a service that does not exceed the customary fee in that geographic area, and is reasonable based on the circumstances. Instead of UCR charges,



PPO plans often operate based on a negotiated (fixed) schedule of fees that recognize charges for covered services up to a negotiated fixed dollar amount. Conventional indemnity plans typically operate based on UCR charges.

**Waiting Period (Job-based coverage):** The time that must pass before coverage can become effective for an employee or dependent, who is otherwise eligible for coverage under a job-based health plan. Applies to all new employees, and is not based on health status. This is different than a pre-existing condition exclusion period, which is applied to individual employees and is based on health status.

**Well-baby/Well-child Visits:** Routine doctor visits for comprehensive preventive health services that occur when a baby is young and annual visits until a child reaches age 21. Services include physical exam and measurements, vision and hearing screening, and oral health risk assessments.

**Wellness Programs:** A program intended to improve and promote health and fitness that's usually offered through the work place, although insurance plans can offer them directly to their enrollees. The program allows your employer or plan to offer you premium discounts, cash rewards, gym memberships, and other incentives to participate. *Examples:* programs to help you stop smoking, diabetes management programs, weight loss programs, and preventative health screenings.

## Healthcare Plans and Systems

**Catastrophic Plan:** A healthcare plan that only covers certain types of expensive care, like hospitalizations. May also include plans that have a high deductible, so that your plan begins to pay only after you've first paid up to a certain amount for covered services.

**Children's Health Insurance Program (CHIP):** Insurance program jointly funded by state and federal government that provides health insurance to low-income children and, in some states, pregnant women in families who earn too much income to qualify for Medicaid but cannot afford to purchase private health insurance coverage.

**Exclusive Provider Organization (EPO) Plan:** A managed care plan in which services are covered only if you go to doctors, specialists, or hospitals in the plan's network (except in an emergency).

**Health Maintenance Organization (HMO):** An insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. Generally won't cover out-of-network care except in an emergency, and may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

**Health Savings Account (HSA):** A medical savings account available to taxpayers who are enrolled in a High Deductible Health Plan. The funds contributed to the account aren't subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses. Unlike a Flexible Spending Account (FSA), funds roll over year to year if you don't spend them.

**High Deductible Health Plan (HDHP):** A plan that features higher deductibles than traditional insurance plans. HDHPs can be combined with a health savings account or a health reimbursement arrangement to allow you to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

**High Risk Pool Plan (State):** Safety net plan that provides coverage if you have been locked out of the individual insurance market because of a pre-existing condition. May also offer coverage if you're HIPAA eligible or meet other requirements. High-risk pool plans offer health insurance coverage that is subsidized by a state government. Typically, your premium is up to twice as much as you would pay for individual coverage if you were healthy. Not all states offer high risk pools, and those that do have distinct rules in terms of cost, eligibility, and benefits.

**Managed care plan:** A plan that generally provides comprehensive health services to its' members, and offers financial incentives for patients



to use the providers who belong to the plan. Examples include: health maintenance organizations (HMOs), preferred provider organizations (PPOs), exclusive provider organizations (EPOs), and point of service plans (POSs).

**Medicaid:** A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and in some states, other adults. The federal government provides a portion of the funding and sets guidelines. States also have choices in how they design their program, so Medicaid programs and eligibility vary state by state and may have a different name in your state.

**Medicare:** A federal health insurance program for people who are age 65 or older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease.

**Medicare Part A:** Hospital insurance that helps cover inpatient care in hospitals, skilled nursing facility, hospice, and home care.

**Medicare Part B:** Medical coverage that helps to cover medically-necessary services like doctors' services, outpatient care, home health services, and other medical services. Part B also covers some preventive services.

**Medicare Advantage (Medicare Part C):** A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

**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. These plans are offered by insurance companies and other private companies approved by Medicare.

**Point-of-Service Plan (POS) Plan:** 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 may also require you to get a referral from your primary care doctor in order to see a specialist.

**Pre-existing Condition Insurance Plan (PCIP):** A new program that will provide a health coverage option if you have been uninsured for at least six months, have a pre-existing condition, and have been denied coverage (or offered insurance without coverage of the pre-existing condition) by a private insurance company. Provides coverage until 2014 when you will have access to affordable health insurance choices through an Exchange, and you can no longer be discriminated against based on a pre-existing condition. Every state has a PCIP program; in some states it is operated by the state while in others it is operated by the federal government.

**Preferred Provider Organization (PPO):** A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

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The BLS National Compensation Survey

