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Healthcare re-FORUM

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Definition of Terms Utilized in Healthcare Reform Law

The passage of the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (HCERA) have created significant changes in every part of the healthcare delivery system. There are a number of new terms used within the new healthcare laws that are not well understood. To help minimize confusion, we will dedicate several issues of *Healthcare Re-Forum* to define new or difficult terminology.

Healthcare Reform Terminology

- **Actuarial justification**
  The demonstration by an insurer that its premiums are reasonable based on the benefits provided and anticipated costs to manage policyholder claims. PPACA requires insurers to publicly disclose the actuarial justifications behind premium increases.
- **Adjusted community rating**
  A way of pricing insurance where premiums are not based on a policyholder's health status. PPACA requires the use of adjusted community rating beginning in 2014, with maximum variation for age of 3:1 and for tobacco use of 1.5:1. For example, the premium for a 50-year-old cannot be more than three times the premium for a 25-year-old. Geographic area and family composition (such as "employee plus spouse" or "employee plus child") may also be considered.
- **Attained age**
  Age at which an individual ceases to qualify for coverage. This term has been commonly used to explain dependent eligibility and the maximum allowable age under federal or state law.
- **Cost sharing**
  Healthcare provider charges for which a patient is responsible under the terms of a health plan. Cost sharing includes deductibles, coinsurance and co-payments. PPACA will cap total cost sharing at $5,950 for an individual and $11,900 per year for a family when the exchanges are operating in 2014. These amounts will be adjusted annually.
- **Essential benefits**
  The basic package of benefits included in a health insurance plan by 2014. General coverage includes: ambulatory patient services; emergency services; hospitalization for maternity and newborn care; mental health and substance abuse; prescription drugs; rehabilitative services and devices; laboratory services; preventive and wellness services; and pediatric services, including oral and vision coverage. Health and Human Services (HHS) is expected to further define "essential benefits."
- **Exchange**
  A program that will be overseen by Health and Human Services that will create a state-level marketplace for individuals and small businesses to purchase insurance. As part of the program allowable benefit structures, actuarial rules and applicable cost sharing will be defined. An essential element of the program will be the ability for a consumer or small business to compare and purchase health coverage. A standardized format will be used for presenting benefit options and each plan will be assigned a rating. Exchanges will also determine who qualifies for subsidies and who makes subsidy payments.
- **Grandfathered plan**
  Any insured or self-insured plan in existence on March 23, 2010. These plans are exempt from certain provisions of the new law. Details regarding maintaining a "grandfathered" status have just been released. A future issue of *Healthcare Re-Forum* will be dedicated to the details of the provision.

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- **Group health plan**
  Any plan, fund or program established or maintained to provide medical care to members, employees or their dependents (as defined by the plan) directly through insurance or reimbursement. A plan under this provision is established or maintained by an employer, an employee organization or both. "Group health plans" generally include self-insured and fully insured plans.
- **Health insurance issuer**
  A company, service or organization (including a health maintenance organization) that is licensed and regulated by a state to engage in the business of insurance. An issuer does not include a group health plan.
- **Job lock**
  The situation where individuals remain in their current jobs because they have an illness or condition that may make them unable to obtain health insurance coverage if they leave their jobs. PPACA would eliminate "job lock" by prohibiting insurers from refusing to cover individuals due to health status. For children under 19, the effective date is September 23, 2010. For adults, this protection goes into effect in 2014.
- **Medical loss ratio**
  The percentage of health insurance premiums that is spent by the insurance company on healthcare services. PPACA requires that large group insurance plans spend 85 percent of premiums on clinical services and other activities for enrollees' quality of care. Small group and individual market insurance plans must devote 80 percent of premiums to coverage of medical claim costs. The National Association of Insurance Commissioners (NAIC) is currently working on refining the qualifications.
- **Open enrollment period**
  A specified period during which individuals may enroll in a health insurance plan each year. In certain situations, such as a birth, death or divorce, a special enrollment may be allowed outside the usual open enrollment period.
- **Plan year**
  The year that is designated within the plan document of a group health plan that defines the timeframe for benefit coverage. If a plan is governed by ERISA, the plan year will be set forth in the plan's 5500 reporting form that is filed annually with the Department of Labor.
  If there is no plan document, "plan year" can be defined as follows:
  - The deductible timeframe or limit year (maximum allowable coverage) used under the plan
  - If the plan does not impose deductibles or limits on a yearly basis, the plan year is the policy year
  - If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, the plan year is the employer's taxable year
  - In any other case, the plan year is the calendar year
- **First plan year**
  This is when a provision (regulation) in the healthcare reform law goes into effect for a group or insurer. In 2010, group plans have many provisions that will go into effect on the first day of the first plan year or after September 23. If the group uses a calendar year, the first plan year would begin on January 1, 2011.
- **Pre-existing condition clause**
  The period of time that an individual cannot receive benefits after enrollment in a healthcare plan due to an illness or medical condition for which medical advice, diagnosis, care or treatment was received during a period of time prior to enrollment. For example, plans may exclude coverage for 12 months for a condition that a person received treatment for during the six months prior to enrolling in the plan. All pre-existing condition limitations will be eliminated from plans in 2014 under the PPACA.
- **Qualified health plan**
  A health insurance policy that will be sold through an Exchange in 2014. Exchanges require certification of qualified health plans to ensure minimum standards are met, as specified in PPACA.

As information is made available and requirements are defined under the healthcare reform law, we will cover any new terminology in *Healthcare Re-Forum*.

Future Topics:
- Grandfathered Plans (Updated Regulations)
- Prohibition of Discrimination Based on Salary
- National High Risk Pool