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Healthcare re-FORUM

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# Healthcare Terminology Definitions (Part II)

**As we discuss and review provisions in the Patient Protection and Affordable Care Act (PPACA) and the companion Health Care and Education Reconciliation Act (HCERA) there are still terms that create confusion. This issue of *Healthcare Re-Forum* focuses on defining terminology that may be new or confusing, or that has new elements or additional requirements from the healthcare reform laws.**

## Healthcare Reform Terminology:

- **Co-op plan** - A health insurance plan that will be sold by member-owned and operated non-profit organizations through the American Health Benefit Exchanges (Exchanges) when they become operatiobal in 2014. PPACA provides grants and loans to help co-op plans enter the marketplace, and there must be at least one co-op plan available in each state.
- **Cost sharing** - Healthcare provider charges for which a patient is responsible under the terms of a health plan. Cost sharing includes deductibles, coinsurance and copayments. PPACA will cap total cost sharing at $5,950 for an individual and $11,900 per year for a family when the Exchanges are operational in 2014. These amounts will be adjusted annually. (Grandfathered plans are exempt from this requirement.)
- **Deductible** - A dollar amount that a patient must pay for healthcare services each year before the insurer will begin paying claims under a policy. PPACA limits annual deductibles for small-group policies to $2,000 for policies that cover an individual and $4,000 for policies that cover more than one person. These amounts will be adjusted annually to reflect the growth of premiums. (Grandfathered plans are exempt from this requirement.)
- **External review** - Part of the health insurance claims denial process. External review typically occurs when an independent third party reviews a claim that has been denied to determine whether the health plan followed the terms of the plan. It is one of several steps that comprise the appeal and review process, and is performed after the member has exhausted the health plan's internal appeal process without success. The Department of Health and Human Services (HHS) has recently issued rules to standardize the appeals process, including the external review process. (Grandfathered plans are exempt from this requirement.)
- **Guaranteed issue** - A requirement that health insurers sell a health insurance policy to any person who requests coverage. Beginning in 2014, PPACA requires that the health status (past or present) of the applicant is not considered when issuing coverage.
- **High risk pool** - A temporary federal high risk pool program created by PPACA, also called the Pre-Existing Condition Insurance Plans, which will be administered at the state level to provide coverage to individuals with pre-existing conditions who have been uninsured for at least six months. The temporary high risk pool is subsidized by the federal government and administered in Ohio by Medical Mutual. This program is intended to function until the Exchanges are operational in 2014 unless funds are exhausted prior to 2014.

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- **Individual mandate** - A mandate for most individuals to have health insurance or pay a penalty for each month of noncompliance, beginning in 2014. Individuals will be required to maintain minimum essential coverage for themselves and their dependents.
- **Internal review** - The requirement that enrollees in non-grandfathered plans can receive a "full and fair review" of a denied claim. Enrollees who still face refusal will then be able to submit the case to an independent, external review (see "External review" above). New Interim Final Rules standardize the appeals process for both internal and external appeals.
- **Medical loss ratio (MLR)** - The percentage of health insurance premiums that are spent by an insurance company on healthcare services. PPACA requires insurers of large group plans to spend 85 percent of premiums on clinical services and other activities for the quality of care for enrollees. Small-group and individual market insurance plans must devote 80 percent of premiums to these purposes. Further clarification on the calculation of MLRs is expected from the National Association of Insurance Commissioners, as well as find rules from HHS.
- **Multi-state plan** - The requirement for the Office of Personnel Management (OPM), which administers the federal employees' health benefit plan (FEHBP), to contract with at least two health insurers (one of which must be non-profit) to offer insurance in the individual and small-group markets in multiple states through the Exchanges. This provision is intended to create nationwide coverage: the multi-state plan may phase in coverage, with 60 percent of the states in year one, 70 percent in year two, 85 percent in year three and 100 percent in year four and each subsequent year.
- **Risk adjustment** - A process through which insurance plans that enroll a disproportionate number of sick individuals are reimbursed for that risk by other plans that enroll a disproportionate number of healthy individuals. PPACA requires states to conduct risk adjustment for all non-grandfathered health insurance plans (See "Risk corridor" below).
- **Risk corridor** - A temporary provision in PPACA that requires plans whose costs are lower than anticipated to make payments into a fund that reimburses plans whose costs are higher than expected. This mandatory federal risk corridor program will be in place from 2014 – 2016 for qualified health benefit plans in the individual and small group markets, excluding grandfathered plans.
- **Small-group market** - The market for health insurance coverage offered to small businesses with between 2 and 50 employees. PPACA will broaden the small-group market definition to businesses with between 1 and 100 employees on January 1, 2016.
- **Waiting period** - A period of time that an individual must wait either after becoming employed or submitting an application for a health insurance plan, before coverage becomes effective and claims may be paid. Premiums are not collected during this period. Plans may not impose a waiting period in excess of 90 days. Grandfathered plans must comply with this requirement beginning with their first plan year on or after January 1, 2014.

**Future Topics**:
- Review of Appeals Process (New IFR)
- New W-2 Reporting Requirements