Healthcare reform TERMINOLOGY

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

The Affordable Care Act

(officially, the Patient Protection and Affordable Care Act, aka PPACA, ACA or Obamacare)

This is the healthcare reform bill signed into law by President Obama on March 23, 2010. The ACA focuses on access to healthcare by ensuring that people with pre-existing conditions can obtain coverage, expanding Medicaid eligibility, subsidizing individual coverage for lower income and middle class purchasers, extending the age for dependent coverage and requiring almost everyone to have health insurance.

Cadillac Plan

A high-cost plan that provides high-cost healthcare coverage to the employer's employees. An excise tax will be imposed either on the employer or insurer for the "excess benefit" provided to the employees. In 2018, a plan is considered a Cadillac plan if the plan costs more than $10,200 for an individual policy and $27,500 for a family policy in 2018.

Catastrophic Illness A very serious health condition that could be life threatening or cause life-long disability. The cost of medical services alone for this type of serious condition could cause financial hardship.

Co-op

New nonprofit, member-run health insurance issuer.

ESSENTIAL BENEFITS FOR 2014

Starting in 2014, new health plans for individuals, families, and small groups must provide coverage for approved medical costs in these areas of care. How much of the expenses are covered will vary by plan type.

- AMBULATORY PATIENT SERVICES
- EMERGENCY SERVICES
- HOSPITALIZATION
- MATERNITY AND NEWBORN CARE
- MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT
- PRESCRIPTION DRUGS
- REHABILITATION AND HABILITATIVE SERVICES AND DEVICES
- LABORATORY SERVICES
- PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT
- PEDIATRIC SERVICES, INCLUDING ORAL AND VISION CARE

D9560 Healthcare.gov: Essential health benefits (accessed October 2012). 0817-9-13

Exchange (aka "The Health Insurance Marketplace")

A new health insurance marketplace to enable individuals and small businesses to compare and purchase policies and apply for subsidies. In the ACA, states were given the choice to establish a state-run exchange or allow consumer access through a federally facilitated exchange—Arizona Gov. Brewer has opted for Arizona consumers to obtain access to coverage through the federal government exchange rather than creating a state-based exchange.

Grandfathering

Any group health plan or individual coverage that was in effect on or before March 23, 2010, the date of the ACA's enactment. The law provides that grandfathered plans do not need to comply with certain provisions of the ACA.

Guaranteed Issue

Beginning in 2014, insurers must offer coverage to anyone regardless of health status and cannot vary premiums based on health status.

Individual Mandate

Almost all Americans will be required to have health insurance, whether it is through an employer, a government program or the individual insurance market. The law will assess a tax to people who fail to carry insurance. The amount of the tax will increase over the years, and applies to coverage being required in 2014.

Insurer Fee

A provision of the ACA that levies an annual fee on health insurers of $8 billion starting in 2014 (increasing to $14.8 billion by 2018, then increasing annually thereafter based on premium growth).

Healthcare reform terminology...*continued*

Lifetime Maximum

Insurance policies are no longer allowed to require a specific dollar maximum paid for essential health benefits. Regulations also permit individuals who previously reached a lifetime maximum and who are otherwise still eligible for coverage an opportunity to re-enroll. The prohibition on lifetime limits for essential health benefits applies to all employer and individual plans. An employer health plan may impose limits on benefits that are not essential health benefits.

Mandated Benefit

A requirement in state or federal law that all health insurance policies provide coverage for a specific healthcare service. For example, in Arizona, there is a benefit mandate requiring that plans cover certain cancer screenings.

3.8% TAX

Medicare Surcharge (aka Medicare Surtax)

In effect Jan. 1, 2013, this is a 3.8% tax on unearned income (e.g. interest, dividends, capital gains, annuities, rental income, etc.) applying to those with adjusted gross income of more than $250,000 if married or $250k if single.

Medical Loss Ratio Rebate Provision

Medical Loss Ratio, or MLR, refers to a health insurer's spending on medical care and expenses to improve the quality of care, relative to their income from premium payments. According to PPACA, insurance companies must spend at least 80 percent of premium dollars on medical expenses such as claims, services and wellness programs that improve healthcare quality. The remaining 20 percent is used to pay administrative costs, broker fees where applicable, and other fees. When an insurance company does not spend 80 percent of premium dollars on medical expenses (and activities that improve healthcare quality), customers may receive a rebate for the difference.

Patient Centered Outcomes Research Fee

The ACA-imposed fee on plan sponsors and issuers of individual and group policies. The first year of the fee is $1 per covered life per year, the second year of the fee adjusts to $2 per covered life then it is indexed to nation health expenditures thereafter until it ends in 2019.

Pay or Play /Employer Mandate

Requiring employers of a certain size to provide health insurance for their workers or pay a fee or penalty to the government. Some small businesses under various reform scenarios would be exempt from this rule.

Pre-existing Condition

A health problem that exists before an insurance plan is in effect. (Definitions of what's classifies as a pre-existing condition varies by insurance company.)

Preventive Care

The ACA provision that mandates certain healthcare services be administered without cost sharing to insurance plan members when provided by an in-network physician.

Qualified Health Plan (QHP)

A health insurance plan that has been certified by an exchange as meeting a set of minimum standards. All QHPs will be required to provide essential health benefits (see Types of Medical Expenses Covered).

"Metal" Plans (Bronze, Silver, Gold & Platinum)

Categories an exchange uses to label different qualified health plan options. These labels are based on the average portion of eligible costs that the plan will cover (referred to as the plan's 'actuarial value'). For example, a plan with an actuarial value of 70% (referred to as a "silver" plan below) means that for a standard population, the plan will pay 70% of healthcare expenses, while the enrollees themselves will pay 30% through some combination of deductibles, copays, and coinsurance. The metal plans break down as follows:

Bronze	plans provide	60%	coverage	Silver	plans provide	70%	coverage
Gold	plans provide	80%	coverage	Platinum	plans provide	90%	coverage

Subsidies Premium tax and cost-sharing reductions available from the federal government to help offset healthcare costs for those who can't afford it. Subsidies are available to those with household incomes of up to 400 percent of the federal poverty level (FPL). The subsidy is set up so that a person pays no more than a certain percentage of his or her income for health insurance. Subsidies will also be available for cost-sharing expenses such as deductibles and copays. To obtain a subsidy, eligible individuals must purchase health insurance through the health insurance marketplace (see "Exchange" above).

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