Term	*Also known as*	Definition
ACA - Affordable Care Act	* Patient Protection and Affordable Care Act (PPACA) *Healthcare Reform * Obamacare	On March 23, 2010, President Obama signed the the hotly contested health reform bill into law which made significant changes to the way employers and employees purchased health benefits, along with significant changes to the healthcare delivery system. The goals of the ACA were to increase the quality and affordability of health insurance, lower the uninsured rate by expanding public and private insurance coverage, and reduce the costs of healthcare for individuals and the government. Since it's passage, the law has been challenged in court numerous times by states, private industry, and others for a number of it's provisions which defendants have claimed to be unconstitutional.
ASO - Administrative Services Only (Carrier Third Party Administrator)		A carrier (such as Blue Cross, Aetna, Cigna, United) acting as a Third Party Administrator of a self-funded Plan. Many health insurance carriers offer both fully-insured and third party administrative services, which are often called administrative services only (ASO) often performed under an administrative services contract (ASC). Health insurance carriers and their subsidiaries provide most of the administrative services for enrollment covered under TPA agreements for health benefits.
Balance Billing		Refers to a provider billing a patient for the difference between the provider's charge and the payment received from the plan.
COBRA - Consolidated Omnibus Budget Reconciliation Act		Provides individuals with the right to continue health coverage under an employer plan for a limited time after certain events, such as the loss of a job.
Coinsurance		A shared dollar amount, typically a percentage, between the participant and the insurer or plan. Coinsurance may apply to any specific benefit, but is generally applied to a claim after the decuctible has been met. For example, after the deductible has been met, the participant may be responsible for 20% of the remaining amount, while the insurer or plan pays 80%.
Co-payment/Co-pay		A fixed payment for a covered service, defined by a participant's benefit plan, which is paid by a covered person each time a medical service is rendered. Though the co-payment is often a small portion of the actual cost of the medical service (i.e. $25 per office visit), it is meant to prevent people from seeking medical care that may not be necessary.
Deductible		The amount of expenses that must be paid out-of-pocket by the individual before an insurer or plan will pay any expenses. Typically, the deductible only applies to claims that happen outside of the physicians office unless it is a "Qualified High Deductible Health Plan." For example, a patient with a deductible of $1,500 having an outpatient surgery will be responsible for the first $1,500 of charges for that surgery before the benefit plan makes any payment to the provider.
ERISA - Employee Retirement Income Security Act of 1974		A federal law that is supposed to protect the employee. ERISA requires employer health plans to provide plan participants with plan information, requires an establishment of an appeals process for participants, and gives participants the right to sue for benefits and breaches of fiduciary duty. ERISA also describes and provides guidelines for fiduciary responsibilities for those who manage and control plan assets. HIPAA and COBRA are amendments to ERISA.
EPO - Exclusive Provider Organization		Unlike a PPO, participants with an EPO network plan receive no reimbursement or benefit if they visit medical care providers outside of their designated network of doctors and hospitals.
Formulary (RX)		A list of prescription drugs available to participants. Formularies vary drastically between drug plans and differ in the number of drugs covered and costs of co-pays. Most formularies cover at least one drug in each drug class. Generic substitution is always encouraged and many times is mandatory. Many also have step therapy protocol requirements.
FMMA - Free Market Medical Association		The FMMA is dedicated to bringing together physicians, patients, and self-funded employers to promote transparency in healthcare. The FMMA provides resources to promote a successful industry while defending the practice of free market medicine without the intervention of government or other third parties who seek to make healthcare opaque. To learn more, visit the FMMA website www.marketmedicine.org

Term	*Also known as*	Definition
Fully Insured plan		A group health plan purchased and insured by a licensed insurance company. The employer pays a fixed monthly premium to the insurance company, regardless of the plan's claim costs. It is the insurance company that assumes the financial and legal risk of loss if claims exceed projections. If the employer has a good claims year, it is also the insurance company who 'wins' and keeps the excess premiums.
HIPAA - Health Insurance Portability and Accountability Act		As an amendment to ERISA, HIPAA provided important protections for working Americans and their families who have pre-existing medical conditions or might otherwise suffer discrimination in health coverage based on factors that relate to an individual's health. HIPAA has been mostly replaced by language in the Affordable Care Act.
Healthcare Reform	*Affordable Care Act (ACA) *Patient Protection and Affordable Care Act (PPACA) *Obamacare	See Affordable Care Act (ACA)
HDHP - High Deductible Health Plan		A health plan with lower premiums and higher deductibles than a traditional health plan. Being covered by an "Qualified" HDHP is also a requirement for having a Health Savings Account. If an HDHP is a "Qualified" HDHP, Federal guidelines apply.
Network (In-Network)	Preferred Provider Organization (PPO)	See Preferred Provider Organization (PPO)
Non-Formulary Drug		Drugs that are non-formulary are typically not covered by a health plan.
Non-Preferred Name Brand Drug		Part of a Tiered Formulary, Non-Preferred Name Brand drugs will have a higher co-pay than Preferred Name Brand drugs. All Name Brand drugs have higher co-pays than Generic drugs. Formularies vary drastically between drug plans and differ in the number of drugs covered and co-pays. Most formularies cover at least one drug in each drug class. Generic substitution is always encouraged and many times is mandatory. High dollar Name Brand drugs often require prior authorization and clinical review to determine medical necessity.
Obamacare	*Affordable Care Act (ACA) *Patient Protection and Affordable Care Act (PPACA) *Healthcare Reform	See Affordable Care Act (ACA)
Out-of-Pocket Maximum		The most a participant will pay during the year. On a written benefit summary provided by the carrier or benefits administrator, this listed out-of-pocket maximum amount may or may not include the deductible depending on how it is written. There can be a lower plan out-of-pocket maximum, in addition to the new ACA Federal out-of-pocket maximum. If the plan out-of-pocket maximum is lower than the mandated federal amount, the participant will continue to pay co-pays until the Federal amount is reached. A participant can have both an in-network and out-of-network out-of-pocket maximum for their plan that accrue separately.
PPACA - Patient Protection and Affordable Care Act	*Affordable Care Act (ACA) *****Healthcare Reform *Obamacare	See Affordable Care Act (ACA)
Preferred Name Brand Drug		Part of a Tiered Formulary, Preferred Name Brand drugs will have a lower co-pay than a Non-Preferred Name Brand drugs, but a higher co-pay than Generic drugs. Formularies vary drastically between drug plans and differ in the number of drugs covered and co-pays. Most formularies cover at least one drug in each drug class. Generic substitution is always encouraged and many times is mandatory.

Term	*Also known as*	Definition
PPO - Preferred Provider Organization	Network (In-Network)	A group of medical doctors, hospitals, and other health care providers who have agreed with an insurer or third party to provide health care at reduced rates or a percentage off billed charges to the insurer's or administrator's clients. Preferred Provider Organizations themselves earn money by charging an access fee to the clients for the use of their network. They also commonly make money off of the percentage of savings amount (the amount in between the billed charges and the paid amounts).
Reasonable & Customary (R&C)	Usual & Customary (U&C)	The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The "reasonable" amount sometimes is used to determine the "allowed" amount.
Reinsurance	Stop Loss Coverage	See Stop Loss Coverage
Self-Funded plan	Self-Insured plan	A plan in which the employer assumes the financial risk for providing health care benefits to its employees. In practical terms, self-insured employers pay for claims from general assets as they are presented instead of paying a pre-determined premium to an insurance carrier for a fully-insured plan. Unless exempted, such plans create rights and obligations under ERISA. Typically, self-funded employers purchase stop loss insurance to guard against catastrophic claims. For additional information - http://www.kemptongroup.com/KemptonMain/education/self-funding-101.php
SPBA - Society of Professional Benefit Administrators		A national association of Third Party Administration (TPA) firms who provide comprehensive ongoing administrative services to client employee benefit plans.
Specialty Drug		Often referred to as Biotech drugs, Specialty drugs typically require special handling, administration or monitoring, and are commonly injectable or infusions. Very rarely can Specialty drugs be obtained without medical review or prior authorization by the insurer or plan. They can cost tens of thousands of dollars and are for serious illnesses.
Step Therapy (RX)		Requires a participant to try lower cost medications before "stepping up" to a higher cost medication. If a lower cost medication has not been tried, the higher cost medication will not be covered.
Stop Loss Coverage	Reinsurance	A product designed to protect employers and self-funded health plans from catastrophic losses. There are two types of coverage: Specific - employer protection against a large expenditure by an individual Aggregate - employer protection against excessive claim expenditures for the entire group For additional information - http://www.kemptongroup.com/KemptonMain/education/stop-loss-101.php
Taft-Hartley Plan		A union or multi-employer plan. These plans may be fully-insured or self-funded.
TPA - Third Party Administrator		A company that processes claims and helps manage an employer's self-funded plan. Responsibilities include maintaining eligibility, adjudicating and paying claims, client and provider customer service, utilization management, etc. It also provides services such as arranging for stop loss coverage, provider network access, a pharmacy benefit management company, case management and assisting with employee education. There are three types of TPAs, independent, ASO (carrier owned), and a hybrid of two (an independent who utilizes carrier networks). The type of TPA an employer hires drastically impacts their interactions with a provider.
Tiered Formulary Drug Plan		A type of drug plan with financial incentives for patients to select lower-cost drugs. Formularies vary drastically between drug plans and differ in the number of drugs covered and co-pays. Most formularies cover at least one drug in each drug class. Generic substitution is always encouraged and many times is mandatory.
Usual & Customary (U&C)	Reasonable & Customary (R&C)	See Reasonable & Customary (R&C)