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 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
ASO - Administrative Services Only (Carrier Third Party Administrator)		A carrier 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.
Buyer		Buyers of medical care, including employers and individual patients.
Certificate of Need	CON	Legislation that restricts opening, expanding or building new medical facilities. These laws require owners of medical facility-care projects to prove public need and get approval for their projects before embarking upon them. The Federal Trade Comission and the Justice Department have encouraged states to abandon the laws as bad for competition, but they still exist in most states.
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 deductible 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%.
Concierge Medicine		In concierge medicine, the patient pays an annual/quarterly/monthly fee or retainer. Typically, concierge physicians still file insurance claims or charge fee for service.
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. **T**he co-payment is often a small portion of the actual cost of the medical service (**e.g.** $25 per office visit).
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.
Direct Primary Care	DPC	Direct Primary Care (DPC) is an alternative payment & practice model for primary care services. DPC physicians offer services for a flat monthly rate instead of a traditional fee for service arrangement. DPC physicians do not file insurance claims or recieve compensation of any kind from traditional insurance companies.
Electronic Health / Medical Records	EMR/HER	An Electronic Health Record (EHR) is an electronic version of a patients medical history~~,~~ that is maintained by the provider over time, and may include all of the key administrative clinical data relevant to that persons care under a particular provider. Under the ACA, physician non-compliance with EHR results in reduced payments.
EPO - Exclusive Provider Organization		Unlike a PPO, participants with an EPO network plan receive a lesser benefit (sometimes no benefit) if they visit medical care providers outside of their designated network of doctors and hospitals.

Term	*Also known as*	Definition
ERISA - Employee Retirement Income Security Act of 1974		ERISA is a federal law that 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.
Facilitator	Vendor Services (Third Party Administrators, Brokers, Consultants, IT vendors, all Non-Medical Providers of Services)	Third Party Administrators, Brokers, Consultants, IT vendors, all Non-Medical Providers of Services. All Services Providers/Facilitators will be vetted by the FMMA. Businesses who provide assistance to buyers & sellers of healthcare goods & services. Facilitator members who do not abide by the FMMA Pillars and Member Rules will have their membership revoked. Assessment and evaluation of these members is ongoing.
Fee for Service		In fee for service, doctors and other health care providers receive a fee for each service such as an office visit, test, procedure, or other health care service.
FMMA - Free Market Medical Association		The FMMA seeks to promote the free market movement in healthcare all over the United States to affect real change for everyone involved. The Free Market Medical Association is a non-partisan association that provides resources, support, and education to the membership, and to the public, about the free market movement in Healthcare. The FMMA helps defend and expand the practice of free market medicine against the interference and intrusion of the government and other third parties; and educates physicians, self-funded businesses, third party administrators, and other health care service providers/facilitators in how to further the movement. FMMA members include both the buyers and sellers of healthcare goods and services, connecting free market minded providers with individual patients and self-funded employers who have embraced transparency in healthcare. To learn more, visit the FMMA website www.marketmedicine.org
Formulary (RX)		A list of prescription drugs available to participants. Formularies vary drastically among 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.
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.
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.
Healthcare Reform	*Affordable Care Act (ACA) *Patient Protection and Affordable Care Act (PPACA) *Obamacare	On March 23, 2010, President Obama signed the 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.
HIPAA - Health Insurance Portability and Accountability Act		The HIPAA Privacy Rule regulates the use and disclosure of Protected Health Information (PHI) held by ``covered entities'' (generally, health care clearinghouses, employer sponsored health plans, health insurers, and medical service providers that engage in certain transactions.)
Maintenance of Certification	MOC	MOC includes assessment, educational and practice improvement activities that physicians need to complete to become board certified by one of 24 member boards of the American Board of Medical Specialties (ABMS). Some health plans and health systems require board certification for credentialing to maintain hospital privileges.
Meaningful Use		Meaningful Use is a CMS Medicare and Medicaid program that awards incentives for using certified electronic health records (EHRs) to improve patient care. To achieve Meaningful Use and avoid penalties, providers must follow a set of criteria that serve as a roadmap for effectively using an EHR.
Network (In-Network)	Preferred Provider Organization (PPO)	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).

Term	*Also known as*	Definition
Non-Formulary Drug		Drugs that are non-formulary are typically covered at a lower benefit or 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 among 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	On March 23, 2010, President Obama signed the 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.
Out-of-Pocket Maximum		The most a participant will pay during the year for covered benefits. 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.
Pillars of the FMMA		**Price** - PRICE is NOT a product. CARE is the product. Selling access to pricing is anti-free market. **"**Discount brokers" who get paid by selling "savings" are not transparent. **Value** - VALUE is established when the buyer and seller agree on a FULLY DISCLOSED, mutually beneficial price for care. If a vendor adds or changes that price IN ANY WAY, those amounts should be truthfully disclosed. **Equality** - PRICE EQUALITY is the basis of a free market. Cash is cash. Any willing buyer should be offered the same price regardless of any factor. Please see fmma.org/pillars-of-the-fmma for more details.
Pharmacy Benefit Manager	PBM	A pharmacy benefit manager (PBM) is a third-party administrator of prescription drug programs for commercial health plans, self-insured employer plans, Medicare Part D plans, the Federal Employees Health Benefits Program, and state government employee plans.
PPACA - Patient Protection and Affordable Care Act	*Affordable Care Act (ACA) ******Healthcare Reform *Obamacare	On March 23, 2010, President Obama signed the 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.
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).
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 among 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.
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.
Reference Based Pricing	RBP	A type of cost saving strategy that is utilized by some benefit plans which sets a maximum amount payable for specific procedures. Typically, the reimbursement assigned to a procedure is based on a percentage of Medicare allowables (**e.g.** 120% of Medicare).

Term	*Also known as*	Definition
Reinsurance	Stop Loss Coverage	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
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
Seller		Providers of medical services, including facilities, hospitals, physicians, ancillary providers, imaging providers, etc.
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 may 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.
Tiered Formulary Drug Plan		A type of drug plan with financial incentives for patients to select lower-cost drugs. Formularies vary drastically among 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.
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.
Usual & Customary (U&C)	Reasonable & Customary (R&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.
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