

ACA Glossary



**A Comprehensive Glossary on ACA
Terminology and Definitions for the
State of Indiana**



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Acronyms

ACA	Affordable Care Act
ABP	Alternative Benefit Plan
ACO	Accountable Care Organization
AE	Application Entry
AG	Assistance Group
AIS	Automated Intake System
AO	Application Organization
APTCs	Advanced Premium Tax Credits
AR	Application Registration
AV	Actuarial Value
BIP	Balancing Incentive Program
CAC	Certified Application Counselor
CBT	Computer-Based Training
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CLRC	Case Load Running Record Comments
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
CSRs	Cost-Sharing Reductions
DDRS	Division of Disability and Rehabilitative Services
DFR	Division of Family Resources
DHS	Department of Homeland Security
DMHA	Division of Mental Health and Addiction
DOA	Division of Aging
DSH	Disproportionate Share Hospital
EA	Eligibility Associate
EBT	Electronic Benefits Transfer
EC	Eligible Child
EHBs	Essential Health Benefits
EPO	Exclusive Provider Organization



EPSDT	Early Periodic Screening, Diagnosis, and Treatment Services
ES	Eligibility Specialist
EVRIT	Eligibility Verification Requirements Informational Table
FACTS	Family Assistance and Care Through Technology Systems
FDSH	Federal Data Services Hub
FEHB	Federal Employees Health Insurance Benefit Plan
FFE	Federally Facilitated Exchange
FFM	Federally Facilitated Marketplace
FFS	Fee-for-Service
FICA	Federal Insurance Contributions Act
FLSA	Fair Labor Standards Act
FMAP	Federal Medical Assistance Percentage
FMLA	Family and Medical Leave Act
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FS/SNAP	Food Stamps/Supplemental Nutrition Assistance Program
FSSA	Family & Social Services Administration
FSA	Flexible Spending Account
FTE	Full-Time Equivalent
HCBS	Home and Community-Based Services
HDHP	High-Deductible Health Plan
HHS	United States Department of Health and Human Services
HIO	Health Information Organization
HIP	Healthy Indiana Plan
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIT	Health Insurance Tax or Health Information Technology
HMO	Health Maintenance Organization
HRA	Health Reimbursement Account
HSA	Health Savings Account
ICES	Indiana Client Eligibility System
IDOI	Indiana Department of Insurance
IEDSS	Indiana Eligibility Determination Services System



IHCP	Indiana Health Coverage Programs
IHS	Indian Health Service
IMPACT	Indiana Manpower Placement and Comprehensive Training
IPPM	Indiana Program Policy Manual
IRS	Internal Revenue Service
IVR	Interactive Voice Response
LMS	Learning Management System
LTC	Long-Term Care
MED Works	Medicaid for Employees With Disabilities
MA D	Medicaid Disability
MA DW	Medicaid Disabled Worker
MAGI	Modified Adjusted Gross Income
MCE	Managed Care Entity
MCO	Managed Care Organization
MEC	Minimum Essential Coverage
MFP	Money Follows the Person
MMAC	Medicaid Medical Advisory Cabinet
MRT	Medical Review Team
MSA	Medical Savings Account
NPHI	National Public Health Institute
NVRA	National Voter Registration Act of 1993
OEP	Open Enrollment Period
OMPP	Office of Medicaid Policy and Planning
OOP	Out-of-Pocket
OPS	Online Performance Support
PAL	Policy Answer Line
PCIP	Pre-Existing Condition Insurance Plan
PDF	Portable Document Format
PE	Presumptive Eligibility
PEPW	Presumptive Eligibility for Pregnant Women
PG	Participant Guide
PHI	Protected Health Information



PII	Personally Identifiable Information
PMPM	Per Member Per Month
POS	Point of Service Plan
PPO	Preferred Provider Organization
PPACA	Patient Protection and Affordable Care Act
PTC	Premium Tax Credit
QHP	Qualified Health Plan
RCA	Refugee Cash Assistance
RCC	Regional Change Center
RID	Medicaid Recipient Identification Number
SBE	State-Based Exchange
SEC	State Eligibility Consultant
SEM	State Eligibility Manager
SHOP	Small Business Health Insurance Options Program
SMA	State Medicaid Agency
SMART	Staff Management and Resource Tracking
SNAP	Supplemental Nutritional Assistance Program
SNP	Special Needs Plan
SOLQ	State Online Query
SPE	State Partnership Exchange
SRED	State Review Eligibility Determination
SSI	Social Security Income
TANF	Temporary Assistance for Needy Families
TRON	Training Resources Online Network
VADER	Adverse Action Calendar, Application Processing Time Frame, Deadline Calculator, EVRIT, Date Receipt Calculator
VBP	Value-Based Purchasing
VLP	Verify Lawful Presence
VR	Verification Required



#

1115 Waiver

Provides a vehicle for CMS to waive regulations and are intended to allow states to test new or existing ways to deliver and pay for healthcare services. In Indiana, HIP operates under an 1115 waiver.

A

Accountable Care Organization (ACO)

A group of healthcare providers who give coordinated care and chronic disease management to improve the quality of care a patient receives. The organization's payment is tied to achieving healthcare quality goals and outcomes that result in cost savings.

Actuarial Equivalent

The condition in which two or more health plans have the same value based on given and appropriate assumptions.

Actuarial Justification

Insurers must demonstrate a correlation between case characteristics and increased medical claims costs in the individual and small group markets.

Actuarial Value (AV)

The percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, then, on average, a person would be responsible for 30% of the costs of all covered benefits. Actuarial value is calculated based on the provision of essential health benefits to a standard population.

Advance Premium Tax Credits (APTC)

Advance payments of the tax credit, provided by the ACA, which can be used to lower monthly health insurance premium costs.

Adverse Action Calendar, Application Processing Time Frame, Deadline Calculator, EVRIT, Date Receipt Calculator

See [VADER](#).

Affordable Care Act (ACA)

A comprehensive healthcare reform law enacted in March 2010. The law was enacted in two parts. The PPACA was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.

Affordable Coverage

The cost of the lowest cost minimum essential coverage option greater than 8% of income for an individual or dependent.

Affordable Insurance Exchange

See [Marketplace](#).



Agent

See [Insurance Agent](#).

Aid Category

The number of eligibility categories within the Medicaid program. An individual is determined eligible for the appropriate category based on factors of eligibility such as age, income, pregnancy, disability, or blindness.

Allowed Charge

Discounted fees that insurers will recognize and pay for covered services. Insurers negotiate these discounts with providers in their health plan network, and network providers agree to accept the allowed charges as payment in full. Each insurer has its own schedule of allowed charges.

Alternative Benefit Plan (ABP)

State Medicaid benchmark benefit coverage options.

Ambulatory Care

Health care delivered to a patient on an outpatient basis within a calendar day.

Annual Limit

A cap on the benefits an insurance company will pay in a year for a particular health insurance plan. These caps are sometimes placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service.

Application Entry (AE)

The driver flow in ICES used to enter and update application information for clients.

Application Organization (AO)

Application Organizations (AOs) are organizations that have employees and/or volunteers helping consumers complete applications for Medicaid, Marketplace-based health plans and affordability programs, and state-based health coverage programs. Examples of possible AOs include: hospitals, community-based social service agencies, and Medicaid Enrollment Centers. Application Organizations are defined under Indiana Code [27-19-2-3](#).Application Registration (AR).

The driver flow in ICES used to push information from FACTS to ICES.

Assistance Group (AG)

The class of categories used to assign clients for the purpose of providing benefits.

Authorized Representative

An individual or organization designated by an insurance affordability program applicant or beneficiary to act responsibly on his or her behalf to assist with the individual's application and renewal of eligibility and other ongoing communications with the Medicaid agency. Authorized representatives may be authorized to sign an application on the applicant's behalf, complete and submit a renewal form, and



receive copies of the applicant or beneficiary's notices and other communications from the Medicaid agency.

Auto-Assignment

The process by which an individual who does not select a Hoosier HealthWise or HIP MCE at the time of application or within 14 days is assigned one.

Automated Intake System (AIS)

The Automated Intake System (AIS) is the CCDF Eligibility System and is an Internet-based solution that was developed and implemented in 2002 for the State of Indiana. AIS is a complete child care eligibility system that is capable of being implemented at the state or county level. AIS tracks family and child information, to determine eligibility and calculate subsidy and co-pay amounts based on market rates. In addition, AIS has full budget capabilities to track, allocate and procure funds and can easily exchange information with time and attendance systems located at the child care provider such as swipe card systems. Payment data can be sent to third party payment systems enabling providers to receive timely payments for only those children and amounts authorized. AIS can exchange data with TANF, Food Stamps and Medicaid systems.



B

Balance Billing

The provider bills the individual for the difference between the provider's charge and the allowed amount. A preferred provider may not balance bill individuals for services listed as "covered services" under the ACA.

Balancing Incentive Program (BIP)

The Balancing Incentive Program authorizes grants to States to increase access to non-institutional long-term services and supports (LTSS) by providing more options for home and community-based services as of October 1, 2011 (ACA Section 10202).

Benefits

See [Insurance Benefits](#).

Biosimilar Biological Products

The generic version of more complicated medications. The biosimilar biological product is highly similar to the reference product and shows no clinically meaningful differences from the reference product in terms of the safety, purity, and potency of the product.

Broker

See [Insurance Broker](#).

C

Capitation Rate

A PMPM payment made to an MCE regardless of the volume of services rendered. Rates are typically adjusted for factors such as age, gender, regional differences, and patient acuity. In Indiana, capitation rates are paid to the Hoosier Healthwise and HIP MCEs.

Care Coordination

The organization of treatment across several healthcare providers. Medical homes and ACOs are two common ways to coordinate care.

Case Load Running Record Comments (CLRC)

ICES screen CLRC (Running Record Comments) provides valuable running case record comments as entered by the worker. The information on CLRC should be considered a reflection of worker activity.

Catastrophic Plan

Described by some insurers as plans that only cover certain types of expensive care, like hospitalizations. Other times, insurers mean plans that have a high deductible where the plan begins to pay only after the enrollee first pays up to a certain amount for covered services.

Centers for Disease Control and Prevention (CDC)

CDC is one of the major operating components of the Department of Health and Human Services and CDC is the nation's premier health promotion, prevention, and preparedness agency and a global leader in public health. CDC is now focusing on becoming a more efficient and impactful agency by focusing on five strategic areas: supporting state and local health departments, improving global health, implementing measures to decrease leading causes of death, strengthening surveillance and epidemiology, and reforming health policies.

Centers for Medicare & Medicaid Services (CMS)

The federal agency that administers Medicare, Medicaid, and the State Children's Health Insurance Program. Provides information for health professionals, through Medicare, Medicaid, the Children's Hospital Insurance Program and soon, through the Health Insurance Marketplace.

Certificate of Coverage

The document that explains the health benefits covered under the referenced plan. It may also be known as a contract, evidence of coverage, or summary plan description.

Certified Application Counselors

A consumer assistant intended to serve as an unbiased, knowledgeable resource to help consumer confusion with health care through outreach, education, and enrollment assistance.

Children's Health Insurance Program (CHIP)

A health coverage program that provides health coverage to children in households in which income is too high to qualify for Medicaid. Authorized in 1997 under Title XXI of the Social Security Act, CHIP is



administered by states with joint funding from the Federal Government and the states. States can implement CHIP through a Medicaid expansion, separate CHIP, or combination of the two approaches. Indiana operates CHIP through both a Medicaid expansion and separate CHIP program.

Chronic Disease Management

An integrated care approach to managing illness that includes screenings, check-ups, monitoring and coordinating treatment, and providing patient education. It can improve quality of life while reducing healthcare costs from a chronic disease by preventing or minimizing the effects of a disease.

Churn

See [Transition Risk](#).

Claim

A request for payment submitted to a health insurer when care or services are provided.

Closed Network

A term used to refer to a provider network in which enrollees are required to use only those providers in the network. This is often used as a cost saving measure.

COBRA

A federal law that may allow a person to temporarily keep health insurance coverage after employment ends, coverage is lost as a dependent of the covered employee, or another qualifying event.

Coinsurance

The percentage of allowed charges for covered services that a person is required to pay. For example, the health insurance may cover 80% of charges for a covered hospitalization, leaving the person responsible for the other 20%. This 20% is known as the coinsurance.

Community-Based Organization

An entity that connects community members with prevention and wellness services, coordinates access to appropriate healthcare services, and links individuals to coverage.

Community Mental Health Centers (CMHC)

State-designated locations that provide services for individuals with a mental illness.

Community Rating

A rule that prevents health insurers from varying premiums within a geographic area based on age, gender, health status, or other factors.

Competitive Bidding

Open bidding for federal contracts between independent groups that compete for the contract by providing the best bid.



Computer-Based Training (CBT)

Interactive method of learning in which the courses are delivered on a computer and/or on an online format. Courses are often self-paced, interactive, and hands on.

Consumer Assistant

An entity intended to serve as unbiased, knowledgeable resource to help reduce consumer confusion through outreach, education, and enrollment assistance.

Conversion

The ability, in some states, to switch job-based coverage to an individual policy when job-based coverage eligibility is lost. Family members not covered under a job-based policy may also be able to convert to an individual policy if they lose dependent status (for example, after a divorce).

Copayment

A flat dollar amount a covered individual must pay for a covered program.

Cost Sharing

The share of costs covered by insurance that a covered individual pays OOP. This term generally includes deductibles, coinsurance and copayments, or similar charges. It does not include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost sharing in Medicaid and CHIP also includes premiums.

Cost-Sharing Reduction (CSR)

A program that decreases the cost-sharing obligations related to health care that qualifying individuals may owe for healthcare expenses.

Creditable Coverage

Health insurance coverage under any of the following: a group health plan; individual health insurance; student health insurance; Medicare; Medicaid; CHAMPUS and TRICARE; the Federal Employees Health Benefits Program; IHS; the Peace Corps; public health plan (any plan established or maintained by a state, the U.S. government, a foreign country); CHIP; or, a state health insurance high-risk pool. If an individual has prior creditable coverage, it will reduce the length of a pre-existing condition exclusion period under new job-based coverage.

Cultural Competency

The ability to interact effectively with people of different cultures and socioeconomic backgrounds. This is particularly relevant in the context of government agencies that have employees working with individuals from different cultural/ethnic backgrounds.

Culturally and Linguistically Appropriate Services (CLAS) Standards

National standards developed to improve health equity, improve quality, and eliminate healthcare disparities. A blueprint has been established to aid healthcare organizations in achieving success with the standards.



D

Deductible

The amount that must be paid by a covered individual for covered care before health insurance begins to pay. Insurers apply and structure deductibles differently. For example, under one plan, a comprehensive deductible might apply to all services, while another plan might have separate deductibles for benefits such as prescription drug coverage.

Department of Homeland Security (DHS)

Oversees the development of Indiana's public safety capabilities by providing statewide leadership, customer service, and subject matter expertise for the enhancement of public and private partnerships and the assurance of local, state and federal collaboration.

Dependent Coverage

Insurance coverage for family members of the policyholder, such as a spouse, children, or partner.

Disability

A limit in a range of major life activities, including activities such as seeing, hearing, walking, and tasks like thinking and working. Different programs may have different disability standards.

Disproportionate Share Hospital (DSH)

Hospital that serves a disproportionate number of low-income individuals with special needs.

Division of Family Resources (DFR)

The Division of Family Resources (DFR) is responsible for establishing eligibility for Medicaid, Supplemental Nutrition Assistance Program (SNAP - food assistance) and Temporary Assistance for Needy Families (TANF - cash assistance) benefits. The division also manages the timely and accurate delivery of SNAP and TANF benefits.

Donut Hole, Medicare Prescription Drug

A coverage gap in most plans with Medicare prescription drug coverage (Part D) (called a "donut hole"). After a drug plan has spent a certain amount of money for covered drugs, the covered individual must pay all costs OOP for prescriptions up to a yearly limit. Once the yearly limit has been met, the coverage gap ends and the drug plan helps pay for covered drugs again.

Dual Eligible

An individual enrolled in both Medicaid and Medicare.



E

Early Periodic Screening, Diagnosis, and Treatment Services (EPSDT)

A term used to refer to the comprehensive set of benefits covered for children in Medicaid.

Electronic Benefits Transfer (EBT)

EBT stands for Electronic Benefit Transfer. It is the electronic distribution of benefits to Indiana families who qualify for the Supplemental Nutrition Assistance Program (SNAP/food assistance) and Temporary Assistance to Needy Families (TANF/cash assistance). In Indiana, participants in SNAP and TANF access their EBT benefits using the Hoosier Works card. The card works like a bank debit card and replaces the paper food coupons and paper checks used in the past. Indiana cardholders can use their Hoosier Works card at any store in the United States that accepts food assistance.

Eligible Adult (EA)

Adults eligible for Medicaid.

Eligible Child (EC)

Children eligible for Medicaid.

Eligibility Associate (EA)

The front-line employees at DFR local offices.

Eligibility Specialist (ES)

Employees whose primary responsibility is to process applications and enter client data.

Eligibility Verification Requirements Informational Table (EVRIT)

Provides specific documentation that a case worker needs to authorize or deny a case.

Emergency Room Services

Evaluation and treatment of an illness, injury, or condition that needs immediate medical attention in an emergency room.

Employer Responsibility

The fee an employer must pay to help cover the cost of the tax credits used by an employee who uses a tax credit to help pay for insurance through a Marketplace. Under the ACA, starting in 2014, if an employer with at least 50 FTE employees does not provide affordable health insurance and an employee uses a tax credit to help pay for insurance, the employer must pay this fee to help cover the cost of the tax credits.

Employer-Sponsored Coverage

Coverage supported totally or in part by an employer or group to provide healthcare benefits for employees.



Encounter Data

The information documenting provider services performed for health plan enrollees. It is often used to develop cost profiles of a particular group of enrollees and guide decisions related to premiums.

Essential Health Benefits (EHBs)

A set of health benefits that insurance policies must cover in order to be certified and offered in Marketplaces. A Medicaid State plan must cover these services by 2014.

Ethics

The set of standards governing the conduct of a person or members of a profession.

Exchange

See [Marketplace](#).

Exclusions

Items or services not covered under the contract for insurance.

Exclusive Provider Organization (EPO) Plan

A managed care plan that covers services only when provided by physicians, specialists, or hospitals in the plan's network (except in an emergency).

Exemptions

The release from requirements imposed on others in the population. The ACA allows for individuals to apply for exemptions from certain requirements.

F

Fair Labor Standards Act (FLSA)

A federal law which establishes minimum wage, overtime pay eligibility, recordkeeping, and child labor standards affecting full-time and part-time workers in the private sector and in federal, state, and local governments.

Family and Medical Leave Act (FMLA)

A Federal law that guarantees up to 12 weeks of job-protected leave for certain employees when they need to take time off due to serious illness or disability, to have or adopt a child, or to care for another family member. When on leave under FMLA, an enrollee can continue coverage under his or her job-based plan.

Family and Social Services Administration (FSSA)

Indiana's healthcare and social service funding agency comprised of five divisions that administer services to over one million Hoosiers. The agencies within the FSSA include DFR, OMPP, DDRS, DMHA, and DOA.

Family Assistance and Care Through Technology Systems (FACTS)

The system used after beginning a DFR case in SMART. FACTS has specific case tasks and document management. FACTS works like a case filing cabinet and manages all of the documents for a particular DFR case.

Federal Data Services Hub (FDSH)

Also known as the "DH" and "DSH" – CMS is also building a tool called the Data Services Hub to help with verifying applicant information used to determine eligibility for enrollment in qualified health plans and insurance affordability programs. The hub will provide one connection to the common federal data sources (including but not limited to SSA, IRS, DHS) needed to verify consumer application information for income, citizenship, immigration status, access to minimum essential coverage, etc. CMS has completed the technical design, and reference architecture for this work, is establishing a cross-agency security framework as well as the protocols for connectivity, and has begun testing the hub. The hub will not store consumer information, but will securely transmit data between state and federal systems to verify consumer application information.

Federal Employees Health Insurance Benefit Plan (FEHB)

The Federal Employees Health Benefits (FEHB) Program came into effect in 1960. It is the largest employer-sponsored group health insurance program in the world, covering over 9 million Federal civilian employees, retirees, former employees, family members, and former spouses. A voluntary program, it is intended to assist workers and eligible family members with expenses of illness and accident, and is paid for through employee and employer contributions.



Federal Health Insurance Marketplace

The Health Insurance Marketplace available to consumers and small business in every state and the District of Columbia. Open enrollment is scheduled to launch in October 2013. Also known as the "federal marketplace."

Federal Medical Assistance Percentage (FMAP)

Used in determining the amount of federal matching funds for state expenditures for Medicaid and CHIP. The FMAP is based on a formula that is based on state per capita income. States with lower per capita income receive a higher FMAP and vice versa. Federal match for expenditures for certain populations and services are not calculated by the FMAP formula including, but not limited to, family planning services and supplies which are funded with 90% federal funding, and administrative costs which are generally matched at 50%. The FMAP is updated annually.

Federal Online Streamlined Application

Under the ACA, the Secretary of Health and Human Services will provide states with a single, streamlined application to be used for all insurance affordability programs, including Medicaid, CHIP, and advanced premium tax credits to help purchase coverage through new health benefit exchange marketplaces. Beginning in 2014, all states will be required to use this application unless they receive Secretary approval to use an alternative application. States also will be required to meet other requirements including ensuring accessibility of the application and providing application assistance.

Federal Paper Application for Health Coverage

The five-page federal form to be used by those who need health coverage. This form should be submitted and processed by the federal marketplace.

Federal Paper Application for Health Coverage & Help Paying Costs

The twelve-page form to be used by persons applying for health coverage for a family member or members. This form should be submitted and processed by the federal marketplace.

Federal Paper Application for Health Coverage & Help Paying Costs (Short Form)

The five-page form to be used by single adults who are not offered health coverage from their employer, do not have any dependents, and cannot be claimed as a dependent on another person's tax return.

Federal Poverty Level (FPL)

A figure used by the Federal Government to define who is poor. It is updated and released annually by HHS. For 2013, the FPL for a family of four is \$23,550 or \$11,490 for a single-person household.

Federally Facilitated Exchange (FFE)

See [Federal Health Insurance Marketplace](#).

Federal Insurance Contributions Act (FICA)

Social Security payroll taxes are collected under the authority of the Federal Insurance Contributions Act (FICA). The payroll taxes are sometimes even called FICA taxes.



Federally Qualified Health Center (FQHC)

Federally funded nonprofit health centers or clinics that serve medically underserved areas and populations. FQHCs provide primary care services regardless of a person's ability to pay. Services are provided on a sliding scale fee based on a person's ability to pay.

Fee-for-Service (FFS)

A method in which doctors and other healthcare providers are paid for each service performed. Examples of services include tests and office visits.

Financial Risk

Term meaning the risk associated with financing. The level of financial risk can be used to estimate the chance of an individual or company defaulting on debts.

First Dollar Coverage

An insurance policy that holds the insurer is responsible for all expenses for particular services or events up to a maximum.

Flexible Benefits Plan

A benefit program that offers employees a choice between various benefits, including cash, life insurance, health insurance, vacations, retirement plans, and child care. Although a common core of benefits may be required, an employee could typically choose how remaining benefit dollars are to be allocated for each type of benefit from the total amount promised by the employer. This type of plan is also known as a Cafeteria plan or IRS 125 Plan.

Flexible Spending Account (FSA)

An arrangement set up through an employer to pay for many OOP medical expenses with tax-free dollars. These expenses include insurance copayments and deductibles and qualified prescription drugs, insulin, and medical devices. There is no carry-over of FSA funds.

Formulary

A list of drugs covered by an insurance plan. Formularies may include both generic and brand-name drugs.

Fully Insured Job-Based Plan

A health plan purchased by an employer from an insurance company.

Full-Time Equivalent (FTE)

The number of employees on full-time schedules plus the number of employees on part-time schedules converted to a full-time basis. The ACA requires that businesses calculate FTEs and considered them in their employee numbers to help determine if the business is considered a large or small employer.



G

Grandfathered

Exempt from certain provisions of this law (as used in connection with the ACA).

Grandfathered Health Plan

A group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010 (as used in connection with the ACA). Grandfathered plans are exempted from many changes required under the ACA. Plans or policies may lose their “grandfathered” status if they make certain significant changes that reduce benefits or increase costs to consumers.

Guaranteed Issue

A requirement that health plans must permit enrollment regardless of health status, age, gender, or other factors that might predict the use of health services.

Guaranteed Renewal

A requirement that the health insurance issuer must offer to renew a policy as long as the enrollee continues to pay premiums.



H

Habilitation

The process of providing health care services that help individuals keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Hardship Exemption

Shows an issue or “hardship” that prevents an individual from becoming insured and waives the fee individuals must pay if they don’t have health coverage, as mandated by the ACA.

Healthcare Workforce Development

The use of incentives and recruiting to encourage people to enter into healthcare professions such as primary care and to encourage providers to practice in underserved areas.

Health Coverage

Language found on the online “button” that will take individual to the online Indiana application.

Health Information Organization (HIO)

An organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards.

Health Insurance

An insurance policy that provides coverage for healthcare services such as physician visits, medical procedures, prescription drugs, and hospital services.

Health Insurance Tax (HIT)

A new sales tax starting in 2014 on health insurance.

Health Information Technology (HIT)

Health information technology (health IT) makes it possible for health care providers to better manage patient care through secure use and sharing of health information. Health IT includes the use of electronic health records (EHRs) instead of paper medical records to maintain people's health information.

Health Maintenance Organization (HMO)

A health plan under which enrollees receive care from network providers. Enrollees select a primary care physician who coordinates and manages all of his or her healthcare services. Referrals to specialists are required.



Health Reimbursement Account (HRA)

An account that allows individuals to pay for cost-sharing responsibilities. HRAs are owned by the employer.

Health Savings Account (HSA)

A medical savings account available to taxpayers who are enrolled in an HDHP. The funds contributed to the account are not subject to federal income tax at the time of deposit.

Health Status

Refers to the medical conditions (both physical and mental health), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability of a patient.

Healthy Indiana Plan (HIP)

Indiana's consumer-driven health coverage program for non-disabled adults between the ages of 19 – 64 with income up to 138% FPL. It is authorized through an 1115 Waiver with CMS. Individuals can make monthly contributions to a POWER account and receive vision and dental benefits or maternity services.

High-Cost Excise Tax

Under the ACA, starting in 2018, a tax on insurance companies who provide high-cost plans. This tax encourages streamlining of health plans to make premiums more affordable.

High-Deductible Health Plan (HDHP)

A plan that features higher deductibles than traditional insurance plans. HDHPs can be combined with an HSA or an HRA to allow an enrollee to pay for qualified OOP medical expenses on a pre-tax basis.

High-Risk Pool Plan (State)

Similar to the new PCIP under the ACA. For years, many states have offered plans that provide coverage if a person was locked out of the individual insurance market because of a pre-existing condition. High-risk pool plans may also offer coverage if they are HIPAA-eligible or meet other requirements. High-risk pool plans offer health insurance coverage that is subsidized by a state government. Typically, the premium is up to twice as much as what it would be for individual coverage for a healthy person.

HIPAA-Eligible Individual

Enrollee status once 18 months of continuous creditable health coverage has been met. To be HIPAA-eligible, at least the last day of creditable coverage must have been under a group health plan. The enrollee must also have used up any COBRA or state continuation coverage and must not be eligible for Medicare or Medicaid or have any other health insurance. The enrollee must apply for individual health insurance within 63 days of losing prior creditable coverage.

Home and Community-Based Services (HCBS)

Services and support provided by most state Medicaid programs in the community that provides help with such daily tasks as bathing or dressing.



Home Health Care

Health care services and supplies a doctor decides to be administered in the home under a plan of care established by the doctor.

Hospital Presumptive Eligibility (PE)

A hospital-based presumptive eligibility program. See [Presumptive Eligibility](#).

Hospital Presumptive Eligibility (PE) Identification Number (ID)

Reference for the unique ID assigned at the point of hospital PE application approval.

Hospital Readmissions

A term referring to a patient being discharged from the hospital and subsequently readmitted for the same or related care within 30, 60, or 90 days.

I

Immunizations

A term used to induce immunity to disease by fortifying the immune system.

Insurance Producer

A term referring to an individual that sells health insurance.

Indian Health Service (IHS)

The Indian Health Service (IHS), an agency within the [Department of Health and Human Services](#) is responsible for providing federal health services to American Indians and Alaska Natives. The IHS provides a comprehensive health service delivery system for approximately 1.9 million American Indians and Alaska Natives who belong to [566 federally recognized tribes](#) in 35 states.

Indiana Application for Health Coverage

New Indiana paper application form to be used by those who need health coverage. This form should be submitted and processed by DFR.

Indiana Application for the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF)

Indiana paper application form to be used by those who are seeking assistance from the SNAP or TANF programs.

Indiana Client Eligibility System (ICES)

ICES is the automated eligibility system used by the local offices of the Division of Family Resources and the Hoosier Healthwise Central Enrollment Unit in the determination of eligibility for TANF (Cash Assistance), SNAP (Food Assistance) and Medicaid/ Hoosier Healthwise (HHW; Health Coverage).

Indiana Department of Insurance (IDOI)

The Indiana Department of Insurance (IDOI) protects Indiana's insurance consumers by monitoring and regulating the financial strengths and market conduct activities of insurance companies and agents. The IDOI also oversees the administration of several dedicated funds entrusted to the Department. IDOI issues reports and consumer alerts so that Indiana consumers are well informed of the latest concerns in the insurance marketplace. The Department monitors insurance companies and agents for compliance with state laws to protect consumers and to offer them the best array of insurance products available and assists Hoosiers with insurance questions and provides guidance in understanding how insurance policies work.

Indiana Eligibility Determination Services System (IEDSS)

Replacement to the ICES system to support the administration and the workers determining eligibility for Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), Medicaid, and the Children's Health Insurance Program (CHIP). These programs are administered by the Family and Social Services Administration (FSSA) hereafter known as the Agency.



The FSSA Division of Family Resources (DFR) has the responsibility for managing the policies for SNAP and TANF and the eligibility processing and approval for these programs and the Medicaid and CHIP programs. The FSSA Office of Medicaid Policy and Planning (OMPP) is the state's single state agency for Medicaid with responsibility for Medicaid policy. The federal agencies representing these programs include the USDA's Food and Nutrition Services (FNS) agency, the U.S. Health and Human Services (HHS), the Center for Medicare and Medicaid Services (CMS), and the Administration for Children and Families (ACF).

Indiana Health Coverage Programs (IHCP)

Term used to refer to Indiana's Medicaid programs, including, but not limited to: Hoosier Healthwise, HIP, Care Select, Traditional Medicaid, and Medicaid HCBS waivers.

Indiana Manpower Placement and Comprehensive Training (IMPACT)

Indiana Manpower and Comprehensive Training (IMPACT) provides services designed to help recipients of Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) achieve economic self-sufficiency. IMPACT services are a component of Indiana's Welfare-to-Work program, a critical element of Indiana's welfare reform initiatives which places an increasing emphasis on "work first". "Work First" means that individuals are expected to accept a job when it can be secured with their existing education and skills.

Indiana Program Policy Manual (PPM)

The Program Policy Manual (PPM) is an integrated eligibility manual that contains information about the following benefit programs administered by the Division of Family Resources (DFR): cash assistance under Temporary Assistance for Needy Families (TANF) and Refugee Cash Assistance; health coverage under Medicaid and Hoosier Healthwise; and food assistance under the Supplemental Nutrition Assistance Program (SNAP). The requirements for State Burial Assistance are also included. The Manual contains eligibility and administrative policies based on State and Federal laws and regulations that govern the programs, and system procedures using the Indiana Client Eligibility System (ICES). ICES is the automated eligibility system used by the local offices of the Division of Family Resources and the Hoosier Healthwise Central Enrollment Unit in the determination of eligibility for the listed programs.

Individual Health Insurance Policy

Term used for policies for enrollees that are not connected to job-based coverage. Individual health insurance policies are regulated under state law.

Individual Health Plan

Health plans for individuals.

Individual Responsibility

The term used to describe the requirement for each individual to have minimum essential health covered each month under the ACA, starting in 2014.

In-Network Provider

Healthcare provider contracted with a health insurance company to provide services to enrollees at a negotiated rate.



Interactive Voice Response (IVR)

An automated telephone information system that speaks to the caller with a combination of fixed voice menus and data extracted from databases in real time. The caller responds by pressing digits on the telephone or speaking words or short phrases. Applications include bank-by-phone, flight-scheduling information and automated order entry and tracking.¹

In-Person Assisters

See [Non-Navigator Assistance Personnel](#).

In-Person Counselors

See [In-Person Assisters](#).

Individual Mandate

The ACA requirement that subjects individuals to a tax penalty if minimum health coverage is not maintained.

Insurance Affordability Programs

Various public or private insurance programs for which a Navigator may assist potential eligible consumers with education and information, such as Medicaid and CHIP, in addition to a QHP.

Insurance Agency

An entity or organization that sells insurance.

Insurance Agent

An individual that sells insurance.

Insurance Benefits

The healthcare items or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents. In Medicaid or CHIP, covered benefits and excluded services are defined in state program rules.

Insurance Broker

An individual or agent that sells insurance.

Insurance Carrier

The term that refers to the company or entity that issues the insurance.

Insurance Cooperative

A nonprofit entity in which the same people who own the company are insured by the company. Cooperatives can be formed at a national, state, or local level and can include doctors, hospitals, and businesses as member-owners.

¹ PC MAG.COM <http://www.pcmag.com/encyclopedia/term/45521/ivr>



Insurance Producer

An insurance producer (also called an agent, independent agent or an insurance broker) is an individual licensed by IDOI to sell insurance in Indiana. There are different categories of insurance and a producer must be licensed in each category he or she wishes to transact business. Health Insurance is one category.



J

Job-Based Health Plan

Health coverage that is offered to an employee (and often his or her family) by an employer.



K



L

Large Group Health Plan

Group health plan that covers employees of an employer that has 101 or more employees. Until 2016, in some states large groups are defined as 51 or more employees.

Learning Management System (LMS)

A learning management system (LMS) is a software application or Web-based technology used to plan, implement, may track, and can assess the learning process and progress. Many learning management system provides an instructor with a way to create and deliver content, monitor student participation, and assess student performance. A learning management system may also provide students with the ability to use interactive features. The Advanced Distance Learning group, sponsored by the United States Department of Defense, has created a set of specifications called Shareable Content Object Reference Model ([SCORM](#)) to encourage the standardization of learning management systems.

Lifetime Limit

A cap on the total lifetime benefits available from an insurance company. An insurance company may impose a total lifetime dollar limit on benefits or limits on specific benefits. After a lifetime limit is reached, the insurance plan will no longer pay for covered services.

Linguistic Competency

A term used to refer to a speaker's implicit knowledge of the rules of his or her language.

Long-Term Care (LTC)

Services that include medical and non-medical care provided to people who are unable to perform basic activities of daily living such as dressing or bathing. Long-term supports and services can be provided at home, in the community, in assisted living, or in nursing homes. Individuals may need long-term supports and services at any age.



M

Managed Care Entity (MCE)

A general term used to describe health plans that are designed to control the quality and cost of healthcare delivery. Plans include models such as HMOs and PPOs. In Indiana, benefits are delivered in Hoosier Healthwise and HIP through MCEs.

Managed Care Organization (MCO)

See [Managed Care Entity](#).

Marketplace

Previously known as "Exchange," the Marketplace is a set of standardized and regulated healthcare plans from which individuals may purchase health insurance that is eligible for federal subsidies.

Medicaid

A means-tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act. Medicaid offers federal matching funds to states for costs incurred in paying healthcare providers for serving eligible individuals.

Medicaid Disability (MAD)

Medicaid services provided to individuals with disabilities.

Medicaid Disabled Worker (MA DW)

Individual who meets the Medicaid definition of disability without regard to the person's employment.

Medicaid for Employees with Disabilities (MED)

Medicaid benefits for disabled individuals who work. This program offers the same coverage levels as regular Medicaid. Small monthly premiums may apply depending on the amount of money the disabled worker earns.

Medical Loss Ratio (MLR)

A basic financial measurement used in the ACA to encourage health plans to provide value to enrollees.

Medical Loss Ratio (MLR) Rebate

The reimbursement to enrollees to compensate for excess premium collected. Under the ACA, group health plans are required to spend a certain percentage of their annual revenue on medical costs.

Medical Review Team (MRT)

Team that determines an applicant's eligibility for Indiana Medicaid based on a disability.

Medical Savings Account (MSA)

Plan that combines a high-deductible health plan with a medical savings account.



Medical Underwriting

A health insurance term to refer to the use of information in the evaluation of an applicant for coverage by an insurance company.

Medically Necessary

Activities or supplies necessary and appropriate for the treatment or care of a patient.

Medicare

A federal health insurance program for people who are age 65 or older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Medicare Advantage (Medicare Part C)

A type of Medicare health plan offered by a private company contracted with CMS to provide all Medicare Part A and Part B benefits. Medicare Advantage Plans include HMOs, PPOs, Private FFS Plans, SNPs, and Medicare MSA Plans.

Medicare Hospital Insurance Tax

A federal payroll tax under the FICA imposed on both employees and employers to fund Medicare.

Medicare Part D

A program that helps pay for prescription drugs for people with Medicare who join a plan that includes Medicare prescription drug coverage.

Medicare Prescription Drug Donut Hole

Most plans with Medicare prescription drug coverage (Part D) have a coverage gap (called a "donut hole"). After a drug plan has spent a certain amount of money for covered drugs, the covered individual must pay all costs OOP for prescriptions up to a yearly limit. Once the yearly limit has been met, the coverage gap ends and the drug plan helps pay for covered drugs again.

Metal Tier

Four levels of health coverage designated under the ACA. The metal tiers, listed as bronze, silver, gold, and platinum, are based on the actuarial value of the plans.

Minimum Essential Coverage (MEC)

The type of coverage an individual is required to maintain in order to meet the individual responsibility requirement under the ACA.

Minimum Essential Value

The term used to refer to the percentage equal to, or above 60 percent of the total allowed costs of benefits.



Minimum Value

The standard a health plan meets if it is designed to pay at least 60% of the total cost of medical services for a standard population.

Mixed Eligibility

Children in the same family often have differing eligibility status for public coverage. Mixed eligibility is associated with higher uninsurance rates, even when all children in a family are eligible. Medicaid policies play an important role in creating mixed-eligibility families via age-related eligibility thresholds and limited benefits for immigrants; states running separate Children's Health Insurance Program (CHIP) programs have higher uninsurance rates among eligible children.

Modified Adjusted Gross Income (MAGI)

A methodology implemented for eligibility effective January 1, 2014, for insurance affordability programs. MAGI equals adjusted gross income plus tax-excluded foreign earned income, tax-exempt interest, and tax-exempt Title II SSI. MAGI methodologies are applied to individuals applying for APTCs and in the Medicaid program to children, pregnant women, and parent and caretaker relatives and adults.

Modified Adjusted Gross Income (MAGI) Conversion

As part of the transition to MAGI-based methodologies in 2014, states are required to convert current Medicaid income eligibility standards to a MAGI equivalent. The goal of the MAGI conversion process is to establish a MAGI-based income standard that is not less than the effective income eligibility standard as applied on the date of the ACA enactment for each eligibility group.

Money Follows the Person (MFP)

The Money Follows the Person (MFP) Rebalancing Demonstration Grant helps states rebalance their Medicaid long-term care systems. Over 31,000 people with chronic conditions and disabilities have transitioned from institutions back into the community through MFP programs as of December 2012. The ACA expanded the MFP program allowing more states to apply. Forty-five states and the District of Columbia have MFP programs.



N

National Voter Registration Act of 1993 (NVRA)

The National Voter Registration Act of 1993 (also known as the “NVRA” or “motor voter law”) sets forth certain voter registration requirements with respect to elections for federal office. Section 5 of the NVRA requires that States offer voter registration opportunities at State motor vehicle agencies. Section 6 of the NVRA requires that States offer voter registration opportunities by mail-in application. Section 7 of the NVRA requires that States offer voter registration opportunities at certain State and local offices, including public assistance and disability offices. Section 8 of the NVRA contains requirements with respect to the administration of voter registration by States.

Navigators

Entities intended to serve as unbiased, knowledgeable resources that help reduce consumer confusion through outreach, education, and enrollment assistance.

Network Adequacy Standards

Refers to the network of healthcare providers that is sufficient in numbers and types of providers to ensure that all services are accessible to enrollees without unreasonable delay. Adequacy is determined by a number of factors, including, but not limited to: provider/member ratios, geographic accessibility and travel distance, waiting times for appointments, and hours of agency operations. The network adequacy standards for QHP issuers are governed by Federal Regulations at 45 CFR 156.230 and for Medicaid MCOs at 42 CFR 438.206.

New Plan

A health plan that is not a grandfathered health plan and, therefore, subject to all of the reforms in the ACA (as used in connection with the ACA).

Nondiscrimination

A requirement that job-based coverage not discriminate based on health status. Coverage under job-based plans cannot be denied or restricted. An enrollee also cannot be charged more because of health status. Job-based plans can restrict coverage based on other factors such as part-time employment that are not related to health status.

Non-Exchange Health Plan

See [Non-Market Health Plan](#).

Non-Exempt Individuals

Employees not exempt from the FLSA requirements.

Non-Market Health Plan

Health plans offered through direct purchased from carriers or through agents, brokers, or Web sites. Non-Market health plans are not subject to additional requirements that are placed on QHPs.



Non-Modified Adjusted Gross Income (Non-MAGI)

The Medicaid eligibility determination process for populations exempt from MAGI methodologies. Current Medicaid eligibility methodologies are maintained for non-MAGI populations in 2014 and beyond. For Medicaid, non-MAGI methodologies are applied to individuals age 65 or older when age is a condition of eligibility; individuals are determined eligible on the basis of blindness or disability; individuals apply for long-term services and supports for which a level of care need is a condition of eligibility; individuals' eligibility does not require an income determination to be made by the Medicaid agency; and/or individual apply for Medicare cost-sharing and former foster children under age 26.

Non-Navigator Assistance Personnel

A consumer assistant intended to serve as an unbiased, knowledgeable resource to help consumer confusion with health care through outreach, education, and enrollment assistance.

Non-Preferred Provider

A term used to refer to a provider who does not have a contract with the health plan.

Non-Qualified Health Plan

A plan that does not participate in the Health Insurance Marketplace.

Notice

An official form of communication that informs individuals about the status of their applications, their eligibility for programs, or other important information. Notices may be sent by the Marketplace or by health insurers.



O

Online Performance Support (OPS)

Access to information and support right when it is needed, often in online resources or other virtual means, such as Web chat.

Open Enrollment Period (OEP)

The period of time set up to allow potential enrollees to choose from available plans, usually once per year.

Out-of-Network Provider

A term used to refer to a provider who does not have a contract with the health plan.

Out-of-Pocket (OOP) Costs

A term used to refer to the expenses for medical care that are not reimbursed by insurance.

Out-of-Pocket (OOP) Limit

The maximum amount an enrollee is required to pay for covered services in a year. Generally, this includes the deductible, coinsurance, and copayments.



P

Participant Guide (PG)

Typically a training product that provides learners with an overview, specific curriculum and activities often used in conjunction with a facilitator's or instructor's guide. The participant guide is used by course participants to follow- along with instruction, take notes, and even use as a hands-on workbook.

Partnership Exchange

See [Partnership Marketplace](#).

Partnership Marketplace

A Marketplace hybrid in which the state partners with the Federal Government who runs certain functions of the Marketplace and makes key decisions, allowing the state to tailor the Marketplace to local needs and market conditions.

Patient-Centered Outcomes Research

Research to compare different medical treatments and interventions with the goal of providing evidence for the most effective strategies for different populations and situations.

Patient Protection and Affordable Care Act (PPACA)

See [Affordable Care Act](#).

Payment Bundling

A payment structure in which different healthcare providers treating a patient for the same or a related condition are paid an overall sum rather than being paid for each individual treatment, test, or procedure.

Personally Identifiable Information (PII)

PII is any information that permits the identity of an individual to be directly or indirectly inferred, including any other information that is linked or linkable to that individual regardless of whether the individual is a U.S. citizen, legal permanent resident, or a visitor to the U.S.

Pharmacy

A location where medicinal drugs are dispensed and sold.

Plan Year

A twelve-month period of benefits coverage under a group health plan. This twelve-month period may not be the same as the calendar year.

Point-of-Service (POS) Plan

A type of plan in which the enrollee pays less money OOP if plan or network providers are used for care. POS plans require a referral from the primary care doctor in order to see a specialist.



Policy Answer Line (PAL)

A reference product that can be used as a resource by case workers with ICES in the administration of eligibility by DFR.

Policy Year

A twelve-month period of benefits coverage under an individual health insurance plan. This twelve-month period may not be the same as the calendar year.

Portable Document Format (PDF)

Per Adobe, Portable Document Format (PDF) is now an open standard for electronic document exchange maintained by the International Organization for Standardization (ISO). When you convert documents, forms, graphics, and web pages to PDF, they look just like they would if printed. But unlike printed documents, PDF files can contain clickable links and buttons, form fields, video, and audio — as well as logic to help automate routine business processes.

Pre-Authorization

See [Prior Authorization](#).

Pre-Existing Condition (Individual Policy)

A condition, disability, or illness (either physical or mental) that a person has before he or she is enrolled in a health plan. Genetic information, without a diagnosis of a disease or a condition, cannot be treated as a pre-existing condition. This term is defined under state law and varies significantly by state.

Pre-Existing Condition (Job-Based Coverage)

Any condition (either physical or mental) including a disability for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date in a health insurance plan. Genetic information, without a diagnosis of a disease or a condition, cannot be treated as a pre-existing condition. Pregnancy cannot be considered a pre-existing condition and newborns, newly adopted children, and children placed for adoption who are enrolled within 30 days cannot be subject to pre-existing condition exclusions.

Pre-Existing Condition Exclusion Period (Individual Policy)

The time period during which an individual policy will not pay for care relating to a pre-existing condition. Under an individual policy, conditions may be excluded permanently (known as an "exclusionary rider"). Rules on pre-existing condition exclusion periods in individual policies vary widely by state.

Pre-Existing Condition Exclusion Period (Job-Based Coverage)

The time period during which a health plan will not pay for care relating to a pre-existing condition. Under a job-based plan, this cannot exceed 12 months for a regular enrollee or 18 months for a late enrollee.

Pre-Existing Condition Insurance Plan (PCIP)

A new program that will provide a health coverage option if the enrollee has been uninsured for at least six months, has a pre-existing condition, and has been denied coverage (or offered insurance without



coverage of the pre-existing condition) by a private insurance company. This program will provide coverage until 2014 when people will have access to affordable health insurance choices through a Marketplace.

Preferred Provider

A term used to refer to a provider who is contracted with the health plan.

Preferred Provider Organization (PPO)

A health plan that has contracts with a network of providers. Enrollees in a PPO are not required to select a primary care provider and referrals to see network providers are not required. Care received out-of-network is at a higher cost.

Pregnancy Presumptive Eligibility (PE) Identification Number (ID)

Reference for the unique ID assigned at the point of pregnancy PE application approval.

Premium

A monthly payment made to an insurer to get and keep insurance coverage. Premiums can be paid by employers, unions, employees, individuals, or shared among different payers.

Premium Tax Credits (PTC)

Term used by IDOI. See [Advance Premium Tax Credits](#).

Presumptive Eligibility (PE)

Medicaid benefits provided during a period following a determination by a qualified entity, on the basis of preliminary information, that the individual has gross income at or below the applicable Medicaid income standard. Indiana operates two PE programs: PE for Pregnant Women and Hospital PE.

Presumptive Eligibility for Pregnant Women (PEPW)

Medicaid pregnancy-related benefits provided during a period following a determination by a qualified entity, on the basis of preliminary information, that the individual has gross income at or below the applicable Medicaid income standard.

Presumptive Eligibility (PE) Qualified Entity (Quality Provider)

An entity that is determined by the SMA to be capable of making determinations of PE and meets all the qualifications established by the state.

Prevention

Activities to prevent illness such as routine check-ups, immunizations, patient counseling, and screenings.

Preventive Services

Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems. This also provides patients with the ability to learn more about preventive care and services.



Primary Care

Health services that cover a range of prevention, wellness, and treatment for common illnesses. Primary care providers include doctors, nurses, nurse practitioners, and physician assistants.

Prior Authorization

A term used to reference the approval needed from a health plan required to receive a service or fill a prescription covered by the health plan.

Privacy Rule

The Privacy Rule protects all "*individually identifiable health information*" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information "protected health information (PHI)." A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well-being.

Private Insurance Company

A company that offers health insurance coverage for purchase on the private market.

Private Insurance Plan

An insurance plan offered by a private insurance company.

Private Market Health Insurers

Companies that offer health insurance coverage for purchase on the private market.

Producer

See [Insurance Producer](#).

Protected Health Information (PHI)

The Privacy Rule protects all "*individually identifiable health information*" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information "protected health information (PHI)."

"Individually identifiable health information" is information, including demographic data, that relates to:

- the individual's past, present or future physical or mental health or condition,
- the provision of health care to the individual, or
- the past, present, or future payment for the provision of health care to the individual,

and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.¹³ Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

The Privacy Rule excludes from protected health information employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g."



Public Health

A field that seeks to improve lives and the health of communities through the prevention and treatment of disease and the promotion of healthy behaviors such as healthy eating and exercise.



Q

Qualified Health Plan (QHP)

Under the ACA, starting in 2014, an insurance plan that is certified by a Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and OOP maximum amounts), and meets other requirements. A QHP will have a certification by each Marketplace in which it is sold.



R

Rate Review

A process that allows state insurance departments to review rate increases before insurance companies can apply them.

Redetermination

Medicaid recipients have their eligibility re-determined on an annual basis. If sufficient information is available in a beneficiary's electronic account to renew eligibility, an eligibility notice is sent and the individual is required to contact the Medicaid agency if any information is inaccurate. If insufficient data is available to renew eligibility, a pre-populated renewal form is sent to the beneficiary detailing the required information.

Refugee Cash Assistance (RCA)

Program helps refugees by providing cash and medical assistance (Refugee Medical Assistance program) during their first eight months in the U.S.

Reinsurance

A reimbursement system that protects insurers from very high claims. A third-party entity is often included and responsible for paying part of an insurance company's claims once a specified cap is reached. Reinsurance is a way to stabilize an insurance market and make coverage more available and affordable.

Rescission

The retroactive cancellation of a health insurance policy. Under the ACA, rescission is illegal except in cases of fraud or intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.

Reserve Requirement

The requirement that insurance companies hold a portion of assets as cash or marketable investments.

Recipient Identification Number (RID)

A unique number generated for each Medicaid recipient. It is utilized by providers to verify eligibility and submit claims for reimbursement.

Rider (Exclusionary Rider)

A rider is an amendment to an insurance policy that often adds coverage to the policy. Starting in 2014, no exclusionary riders will be permitted in any health insurance.

Risk Adjustment

A statistical process that takes into account the underlying health status and health spending of the enrollees in an insurance plan when looking at their healthcare outcomes or costs.



S

Safe Harbor

Regulations that describe various payment and business practices that, although they potentially implicate the Federal anti-kickback statute, are not treated as offenses under the statute.

Self-Insured Plan

Type of plan in which the employer collects premiums from enrollees and takes the responsibility of paying employees' and dependents' medical claims. These employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third-party administrator, or they can be self-administered.

Silver Health Plan

The metal tier qualified health plan that has a 70% actuarial value.

Single Streamlined Application

Beginning in 2014, all states will use a single streamlined application for insurance affordability programs including Medicaid, CHIP, PTCs, and CSRs. The application is developed by the Secretary of HHS unless federal approval is obtained by a state to use an alternative application. A paper and electronic application are both available. In Indiana, the application is referred to as the Indiana Application for Health Coverage.

Skilled Nursing Facility Care

Skilled nursing care and rehabilitation services provided on a continuous, daily basis in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Small Business Health Insurance Options Program (SHOP)

A program that may allow small businesses to purchase group health coverage for employees.

Small Group Health Plan

Health insurance plans for small businesses. Small businesses have 100 or less employees. Until 2016, in some states small businesses are defined as 50 or less employees.

Supplemental Security Income (SSI)

The Supplemental Security Income (SSI) program pays benefits to disabled adults and children who have limited income and resources. SSI benefits also are payable to people 65 and older without disabilities who meet the financial limits.

Special Enrollment Period

A time outside of the OEP during which people and their families have a right to sign up for job-based health coverage. Job-based plans must provide a special enrollment period of 30 days following certain life events that involve a change in family status (for example, marriage or birth of a child) or loss of other job-based health coverage.



Special Healthcare Need

The health care and related needs of children who have chronic physical, developmental, behavioral, or emotional conditions. Such needs are of a type or amount beyond that generally required by children.

Special Needs Plan (SNP)

Special Needs Plans (SNPs) were created by Congress in the Medicare Modernization Act (MMA) of 2003 as a new type of Medicare managed care plan focused on certain vulnerable groups of Medicare beneficiaries: the institutionalized, dual-eligibles and beneficiaries with severe or disabling chronic conditions. These beneficiaries are typically older, with multiple comorbid conditions, and thus are more challenging and costly to treat.

Spend-Down

In Indiana, the Spend-Down program is available to individuals whose income or resources are too high to qualify for Medicaid, but they otherwise meet the Medicaid eligibility criteria based on age, blindness, or disability. Spend-down operates similarly to a deductible. Under this program, an individual qualifies for Medicaid after his or her spend-down is met. This is the amount of money the individual must spend on qualified medical expenses (including health insurance premiums for individuals with other insurance coverage) on a monthly basis before Medicaid pays for services.

Stability Period

Safe harbor that provides certainty as to which employees would be considered full-time for a particular coverage period.

Staff Management and Resource Tracking (SMART)

One of three common systems used by the SEC and used frequently throughout a DFR case. SMART is the initial system in which work is assigned.

Stand-Alone Dental Plans

Dental plan that is separate and not included in a main health plan.

Stand-Alone Plans

A separate plan that is not part of the main health plan.

State-Based Exchange (SBE)

See [State-Based Marketplace](#).

State-Based Marketplace (SBM)

A Marketplace created and operated by the state.

State Continuation Coverage

A state-based requirement similar to COBRA that applies to group health insurance policies of employers with fewer than 20 employees. In some states, state continuation coverage rules also apply to larger group insurance policies and add to COBRA protections. For example, in some states, if a



person leaves a job-based plan, he or she must be allowed to continue coverage until he or she reaches the age of Medicare eligibility.

State Eligibility Consultant (SEC)

A state employee to each application for services under the Medicaid program, the Temporary Assistance for Needy Families (TANF) program, and the federal Food Stamp Program. The bill requires DFR to give each applicant the name and telephone number of the state employee assigned to the applicant's case. It requires the state employee to be responsible for the case until an eligibility determination is made.

State Online Query (SOLQ)

Allows States' real-time online access to the Social Security Administration's Social Security Number verification and, if permitted, retrieval of Title 2 and/or Title 16 data. This enables authorized State personnel to rapidly obtain information they need to qualify individuals for programs.

State Partnership Exchange (SPE)

Through a hybrid model called a State Partnership Exchange, States may assume primary responsibility for many of the functions of the Federally-facilitated Exchange permanently or as they work towards running a State-based Exchange. For example, states may carry out many plan management functions through what is referred to throughout this guidance as a State Plan Management Partnership Exchange. In addition, states can choose to assume responsibility for in-person consumer assistance and outreach, through what is referred to throughout this guidance as a State Consumer Partnership Exchange. States also have the option to assume responsibility for a combination of these main Exchange activities.

With a State Partnership Exchange, states can continue to serve as the primary points of contact for issuers and consumers, and will work with HHS to establish an Exchange that best meets the needs of state residents. This guidance provides a framework and basic roadmap for states considering a State Partnership Exchange. This guidance also describes how the Department of Health and Human Services (HHS) will work with states independent of State Partnership Exchange.

Supplemental Nutrition Assistance Program (SNAP)

A federal aid program administered by the Food and Nutrition Service of the U.S. Department of Agriculture with benefits distributed at the state level. The program provides food assistance to low-income individuals and families with the goal to raise the nutritional level of low-income households. Low-income families may buy nutritious food through EBT cards.



T

Temporary Assistance for Needy Families (TANF)

A program that provides cash assistance and supportive services to assist families with children under age 18, helping them achieve economic self-sufficiency.

Third Party

An entity involved in a transaction without being one of the primary or principal parties.

Transition Risk

The risk incurred when a transition of care takes place.



U

Uncompensated Care

Health care or services provided by hospitals or healthcare providers that do not get reimbursed. Often, uncompensated care arises when people do not have insurance and cannot afford to pay the cost of care.

Underserved Populations

Individuals that lack adequate health insurance, are low-income, or reside in rural areas often cannot access preventive and primary care services and do not have a regular source of care. As a result, health problems may go undiagnosed and/or untreated, increasing the long-term risk of serious illness and death among the medically underserved.



V

VADER

Stands for the Adverse Action Calendar, Application Processing Time Frame, Deadline Calculator, EVRIT, Date Receipt Calculator. These are separate reference materials.

Value-Based Purchasing (VBP)

Links provider payments to improved performance by healthcare providers. This form of payment holds healthcare providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.

Verify Lawful Presence (VLP)

A service used to verify immigration and document numbers for an applicant requesting health coverage and will be automatically triggered through The State Online Query (SOLQ).

Vulnerable Populations

Individuals defined by socio-economic status, geography, gender, age, disability status, risk status related to sex and gender, and among other populations identified to be at-risk for health disparities.



W

Waiting Period (Job-Based Coverage)

The time that must pass before coverage can become effective for an employee or dependent, who is otherwise eligible for coverage under a job-based health plan.

Web Interchange

Secure Web site operated by IHCP to allow providers to check member eligibility, receive information on claims payment, update their provider profile, and submit PE applications.

Well-Baby and Well-Child Visits

Routine doctor visits for comprehensive preventive health services that occur when a baby is young and annual visits until a child reaches age 21. Services include physical exam and measurements, vision and hearing screening, and oral health risk assessments.

Wellness Programs

Programs intended to improve and promote health and fitness that are usually offered through the work place. Insurance plans can also offer them directly to their enrollees.



X



Y



Z
