

**THE MONEY CONFERENCE FOR WOMEN**  
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**Health Insurance in Massachusetts**  
**A Glossary of Key Terms**

**Appeal rights**

All health plans provide members with appeal rights and procedures. Consult the insurance contract, summary plan description or similar documents to determine appeal rights.

**Certificate of Creditable Coverage**

A document provided by your health plan that proves that you had coverage under that plan. Certificates of creditable coverage should be provided automatically when you leave a health plan and at other times by request.

**COBRA (Consolidated Omnibus Reconciliation Act of 1985)**

Private employers that employ more than 20 employees and offer a health benefit plan must offer COBRA continuation coverage to qualified beneficiaries who lose health coverage under the plan for certain reasons (e.g., termination of employment, divorce, death).

**Co-insurance**

A form of cost-sharing, the amount a person must pay for certain services under a health insurance policy, specified by percentage. For example, the insurance pays 80 percent and the insured person pays 20 percent of the charge for a service.

**Commonwealth Care**

A health insurance program for adult Massachusetts residents (19 years and up) who meet certain immigration and income requirements and do not have other health insurance.

**Connector**

The Commonwealth Health Insurance Connector Authority, created by the Massachusetts Health Reform Act passed in 2006, which runs Commonwealth Care and other programs intended to increase access to and affordability of health insurance for state residents.

**Conversion right**

The right of a person covered under a group policy to qualify for a nongroup (individual) policy without regard to health status or claims history, when the group policy ends. Conversion coverage may not offer the same benefits as the person had under the group policy.

**Copayment**

A form of cost-sharing, a set fee that a person has to pay for certain health services under the terms of an insurance contract (for example, \$15 per visit to the doctor).

**Cost-sharing**

Many plans cover only part of the cost of certain services, requiring members to contribute in the form of *copayments*, *co-insurance* and *deductibles*. Providers may bill for these amounts.

**Creditable Coverage**

Prior health coverage that counts toward reducing or eliminating any pre-existing condition exclusion period, including, but not limited to, a group health plan, Medicare, Medicaid (MassHealth), TRICARE, and the Federal Employees Health Benefits Program. (This term also refers to health insurance that satisfies the requirement under the *Health Reform Act* that all Massachusetts residents have health coverage that meets certain standards.)

**Deductible**

An amount you have to pay, usually on an annual basis, before the plan will begin paying for your medical care. Some medical providers require payment of a deductible at the time services are rendered (e.g., upon admission to the hospital).

**DOMA (Defense of Marriage Act)**

This 1996 federal law defines marriage for the purpose of federal programs and laws as between a man and a woman. As a result, health plans for federal and military employees do not cover same-sex spouses of federal employees. DOMA also permits self-insured private employer plans to deny coverage to the same-sex spouse of an employee.

**Domestic partner health coverage**

Some employers in Massachusetts offer health benefits to same-sex domestic partners (unmarried) of employees; some also offer these benefits to opposite-sex unmarried partners.

**ERISA (Employee Retirement Income Security Act of 1974)**

ERISA applies to most private employee benefit plans. ERISA does not require employers to establish any employee benefit plan, but imposes requirements on administration of a plan once established. Beneficiaries have the right to dispute a denied claim for benefits and file suit in court if necessary.

**ERISA Preemption**

In general, ERISA “preempts” (overrides) state laws that “relate to” an employee benefit plan. However, state laws that regulate insurance are exempt from this rule. This permits states to regulate insurance companies, even when they provide coverage to an employer-sponsored plan. But state insurance authorities may not directly regulate an employee benefit plan (as opposed to the insurance policy). An example of how this works is that, while a state can require insurance companies to include coverage for mandated benefits in the policies they sell, the state cannot require this coverage of a self-funded employer plan.

**Exclusion**

Most insurance contracts contain detailed lists of which services and supplies are included, and which ones are excluded. It is important to review such exclusion lists before purchasing an insurance policy. If a service appears on a list of excluded services, challenging a denial of coverage may not be possible.

**Family and Medical Leave Act (FMLA)**

A federal law that permits up to 12 weeks of job-protected leave for certain employees when they take time off due to serious illness, to have/adopt a child, or to care for a family member. If you qualify for leave under FMLA, you can continue coverage under your group health plan.

**FEHB (Federal Employee Health Benefits Program)**

The health insurance program that covers most non-military federal government employees.



**Federal Poverty Level**

A guideline updated annually, which is widely used to determine eligibility for public programs.

**Federal Poverty Guidelines (2007) (annual income)**

Source: <http://aspe.hhs.gov/poverty/07poverty.shtml>

Size of Family Unit	48 Contiguous States and D.C.*
1	\$10,210
2	13,690
3	17,170
4	20,650
5	24,130
6	27,610
7	31,090
8	34,570
For each additional person add	3,480

\*FPL guidelines for Alaska and Hawaii are higher.

**Fully Insured Health Plan**

With a *fully insured* group health plan, the employer pays premiums to an insurance company (or HMO) and the insurance company accepts the financial risk of paying claims for benefits. Fully insured health plans are regulated by Massachusetts state insurance laws.

**Group Health Plan**

Health insurance sponsored by an employer, union, professional association or similar, that covers employees.

**GIC (Group Insurance Commission)**

The entity that offers health plans to Massachusetts state employees and retirees, as well as to many municipal and county workers and retirees.

**Guaranteed issue**

A requirement that insurers accept for coverage applicants in specified categories, generally without regard to health status or previous insurance claims. Small group and nongroup health insurance are guaranteed issue in Massachusetts, with limited exceptions.

**Guaranteed Renewability**

A requirement that a policyholder have the right to renew health insurance, with few exceptions. Small group and nongroup policies are guaranteed renewable in most circumstances.

**HIPAA (Health Insurance Portability and Accountability Act of 1996)**

This federal law sets a national floor for certain health insurance protections. Still, consumers' protections vary from state to state. Major areas addressed by HIPAA include portability, guaranteed issue and guaranteed renewal, nondiscrimination and privacy of health information.

**Health Maintenance Organization (HMO)**

A kind of managed care health insurance plan. HMOs usually limit coverage to care from doctors who work for or contract with the HMO.

**Health Reform Act**

Chapter 58 of the Acts of 2006 (and any amendments to that law), which created the *Connector*, *Commonwealth Care* and the *Individual Mandate*, among many other changes to Massachusetts law concerning health insurance benefits.

**Individual Health Insurance (also called Non-Group Insurance)**

Policies for people not connected to an employer group. Individual health insurance is regulated primarily by Massachusetts state insurance laws.

**Individual Mandate**

The requirement created by the *Health Reform Act* that every Massachusetts resident have health insurance that meets minimum standards to be set by the *Connector*, unless the person qualifies for an exemption based on religious belief or inability to afford insurance.

**Insurance Contract**

A document describing the benefits covered by a health insurance plan, which the insured person receives from the plan sponsor (usually employer) or the insurance company. The contract may be referred to by other names, including subscriber agreement, certificate or evidence of coverage and summary plan description (SPD).

**Managed Care Plan**

A health plan that uses systems and techniques to manage members' use of health services and control costs. Examples are Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs).

**Mandated Benefits**

Massachusetts requires health insurers to provide benefits for certain kinds of medical care. Federal law also sets standards for the provision of certain benefits, including: (1) coverage for mastectomies and breast reconstruction after a mastectomy; (2) minimum hospital stays following childbirth; and (3) for large employers (more than 50 employees), limited "parity" in mental health benefits.

**MassHealth**

The Medicaid program in Massachusetts, which covers certain low-income residents, including families with children, disabled persons and the elderly.

**Medically Necessary**

A term used by insurance companies and public health insurance programs, such as Medicare and Medicaid, to describe a requirement for approving coverage of a medical service. The term means services that are consistent with accepted principles of medical practice, and excludes treatments considered experimental or cosmetic.

**Medicare**

Federal health insurance for most people over 65 years old and for certain disabled persons receiving Social Security Disability Insurance (SSDI) benefits. Medicare also covers people with kidney failure (ESRD). Medicare members can choose traditional (fee-for-service) Medicare or managed care (Medicare Advantage). Private "Medigap" policies cover some of the gaps in Medicare coverage, as does MassHealth for low-income Medicare beneficiaries. Many people also purchase Medicare Part D prescription drug plans, as "original" Medicare (Parts A and B) does not cover most medications.



**“Mini” COBRA**

A state law that is modeled after federal COBRA, which provides continuation of coverage to employees of small employers (2 to 19 employees) and their dependents.

**Office of Patient Protection**

A state office that assists members of managed care plans, issues guidance, and processes requests for independent review of insurance coverage denials.

**Portability**

Some health plans exclude benefits for treatment of preexisting medical conditions for a period of time after enrollment. HIPAA requires insurance carriers and employer group plans to limit preexisting condition exclusion periods to 12 months. Any preexisting condition exclusion period must be reduced by the number of months that the enrollee had “creditable” coverage. For these protections to apply, the time between lapse of prior coverage and enrollment in the new plan cannot exceed 63 days.

**Pre-Existing Condition**

Under HIPAA, any condition (either physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period immediately preceding enrollment in a health plan. Pregnancy and genetic information (absent a diagnosed medical condition) do not count as preexisting conditions in group health plans. Newborns, newly adopted children, and children placed for adoption cannot be subject to pre-existing condition exclusions.

**Pre-Existing Condition Exclusion**

The time during which a health plan will not pay for covered care relating to a pre-existing condition. In Massachusetts, fully insured group health plans and individual health insurance cannot exclude coverage for pre-existing conditions for more than 6 months. Self-insured group health plans can exclude coverage for pre-existing conditions for up to 12 months (but see *Portability*).

**Preferred Provider Organization (PPO)**

Also referred to as a Preferred Provider Arrangement. A PPO is a network of health care providers that agree to provide services at discounted rates and/or pursuant to certain rules to members of health plans with which the PPO contracts. Enrollees are given financial incentives, such as lower copayments, to use providers in the PPO network.

**Self-insured group health plan**

When a group health plan is *self-insured* (also called *self-funded*), the employer retains financial risk for employees' claims for benefits. This means that the employer pays some or all of the cost of employees' claims out of the employer's assets, instead of paying a premium to an insurance company. Employer sponsors of self-funded health plans usually contract with an outside entity (third party administrator, insurance company or HMO) to administer the plan. Self-insured plans are regulated by the U.S. Department of Labor under a federal law called *ERISA* and are not subject to state insurance laws.

**Small Group Health Plan**

In Massachusetts, a plan covering an employer with one (self-employed) to 50 employees.

**Special Enrollment Period**

A time outside the regular enrollment period during which an employee (and/or the employee's dependents) may sign up for coverage under a group health plan. Employers and group health insurers

must make such a period available to employees and their dependents when their family status changes (e.g., marriage, birth) or when their health insurance status changes.

**Summary Plan Description (SPD)**

ERISA requires the administrator of an employee health plan to provide a summary plan description (SPD) to people covered under the plan. The SPD must clearly inform enrollees of their rights under ERISA. The SPD must also disclose whether an insurer is responsible for funding, or only for administering the plan (self-insured). The SPD must include information about how to file a claim for benefits and how to appeal denial of a claim.

**TRICARE**

The health insurance program for active duty and retired military personnel and their families.

**Uncompensated Care Pool**

Often referred to as “Free Care,” this program helps pay for hospital and community health center services for uninsured and underinsured Massachusetts residents with income below a certain level.

**USERRA (Uniformed Services Employment and Reemployment Rights Act)**

A federal law that creates special health insurance continuation (and other) rights for military personnel who leave civilian employment for active military service.

**Waiting Period**

The time you may be required to work for an employer before you are eligible for health benefits. Waiting periods do not count as gaps in health insurance for purposes of determining whether coverage is continuous.