Accountable Care Organization (ACO) A group of health care providers who give coordinated care, chronic disease management and, thereby, improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings.

Actuarial value 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%, on average, members would be responsible for 30% of the costs of all covered benefits. However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual health care needs and the terms of your insurance policy.

Affordable Care Act (ACA) The comprehensive health care reform law enacted in March 2010. The law was enacted in 2 parts: the Patient Protection and Affordable Care Act 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 health insurance As used in connection with the Affordable Care Act, affordable health insurance refers to a health insurance plan that costs the insured no more than 9.5% of their income.

Bronze plan A metallic plan level offered on the federally facilitated marketplace. Of the 4 metallic rankings, this level offers the lowest monthly cost and higher costs when care is received.

Catastrophic plan Currently, some insurers describe these plans as those that only cover certain types of expensive care, like hospitalizations. Other times insurers mean plans that have a high deductible, so that your plan begins to pay only after you've first paid up to a certain amount for covered services.

Centers for Medicare and Medicaid Services (CMS) A federal agency within the department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.

Children’s Health Insurance Program (CHIP) Enacted in 1997, CHIP is a federal-state program that provides health care coverage for uninsured low-income children who are not eligible for Medicaid. States have the option of administering CHIP through their Medicaid programs or through a separate program (or a combination of both). The federal government matches state spending for CHIP, but federal CHIP funds are capped.

COBRA (Consolidated Omnibus Budget Reconciliation Act) A federal law that may allow you to temporarily keep health coverage after your employment ends, you lose coverage as a dependent of the covered employee or another qualifying event. If you elect COBRA coverage, you pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

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

Community rating A rule that prevents health insurers from varying premiums within a geographic area based on age, gender, health status or other factors.
**Consumer operated and oriented plans (CO-OP)** Qualified nonprofit, customer-governed, private health insurers that will offer qualified health plans in the exchanges.

**Copayment** A flat dollar amount you must pay for a covered program. For example, you may have to pay a copayment for each covered visit to a primary care doctor.

**Cost sharing** The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance and copayments or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers or the cost of non-covered services.

**Deductible** The amount you must pay for covered care before your 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.

**Early renewal** An opportunity offered by health insurance companies that allows current coverage and costs to be extended into 2014 on policies that are renewed by a specified date.

**Employer shared responsibility provision** The employer shared responsibility provision, also known as the “employer mandate” or the “pay-or-play” provision, requires employers with 50 or more full-time equivalent employees to offer affordable, minimum essential coverage to substantially all of its full-time employees. Failure to do so can result in financial penalties imposed on the employer. This provision was originally scheduled to go into effect in 2014 but was delayed 1 year. The effective date is now January 1, 2015.

**Employer-sponsored insurance** Insurance coverage provided to employees and, in some cases, their spouses and children through an employer.

**Essential health benefits (EHB)** A set of health care service categories that must be covered by certain plans, starting in 2014.

The Affordable Care Act ensures health plans offered in the individual and small group markets, both inside and outside of the Affordable Insurance Exchanges (Exchanges), offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Insurance policies must cover these benefits in order to be certified and offered in Exchanges, and all Medicaid state plans must cover these services by 2014.

**Exchange** A new transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. These exchanges, also called marketplaces, can be public (run by the government) or private and will offer you a choice of health plans that meet certain benefits and cost standards.

**Federal Poverty Level (FPL)** A measure of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits.

**Federally facilitated marketplace (FFM)** A new transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Also referred to as a public exchange, the FFM is run by the federal government and will offer you a choice of health plans that meet certain benefits and cost standards.

**Flexible spending account (FSA)** A flexible spending account (FSA) allows you to put money aside from your paycheck on a pre-tax basis to spend on your health and/or dependent care expenses in the coming year. Generally, the FSA will be funded from your own income, although your employer may opt to contribute, as well. You choose how much money to deduct from each paycheck to use for your health care expenses and/or dependent care costs in the coming year. In 2013, the ACA enacted a provision that put a $2,500 cap on the amount an employee can contribute to his or her health FSA.

**Fully-insured health plan** A group health insurance plan in which an employer or company pays the health insurance premiums for coverage. Insurance companies that provide the group health insurance plan for an employer set the premium rates each year and assume the risk.
**Full-time equivalent (FTE)** As used in connection with the Affordable Care Act, a full-time equivalent is used by employers to calculate the number of employed individuals for which they would be subject to the shared responsibility fine. A full-time employee is one who works at least 30 hours a week. A full-time equivalent calculates part-time employees as part of the full-time employee count. This is calculated by adding the total hours worked by part-time employees per month and dividing the number by 120 (the minimum amount of hours an employee must work per month to qualify as a full-time employee).

**Gold Plan** A metallic plan level offered on the federally facilitated marketplace. Of the 4 metallic rankings, this level is between silver and platinum.

**Grandfathered health plan** As used in connection with the Affordable Care Act: a group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the Affordable Care Act. Plans or policies may lose their “grandfathered” status if they make certain significant changes that reduce benefits or increase costs to consumers. A health plan must disclose in its plan materials whether it considers itself to be a grandfathered plan and must also advise consumers how to contact the U.S. Department of Labor or the U.S. Department of Health and Human Services with questions.

**Guaranteed issue** A requirement that health plans must permit you to enroll regardless of health status, age, gender or other factors that might predict the use of health services. Except in some states, guaranteed issue doesn't limit how much you can be charged if you enroll.

**Guaranteed renewal** A requirement that your health insurance issuer must offer to renew your policy as long as you continue to pay premiums. Except in some states, guaranteed renewal doesn't limit how much you can be charged if you renew your coverage.

**Health and Human Services (HHS)** Also known as the Health Department, this department of the U.S. federal government is responsible for protecting the health of all Americans and providing essential human services. HHS will be operating the federally facilitated marketplace.

**Health insurance marketplace** A competitive insurance marketplace where individuals and small businesses can buy qualified health benefit plans. Health insurance marketplaces will offer you a choice of health plans that meet certain benefits and cost standards. Also referred to as a “health benefit exchange” or “exchange.”

**Health reimbursement arrangement (HRA)** A tax-exempt account that can be used to pay for current or future qualified health expenses. HRAs are established benefit plans funded solely by employer contributions, with no limits on the amount an employer can contribute. HRAs are often paired with a high-deductible health plan, but are not required to do so.

**Health savings account (HSA)** A medical savings account available to taxpayers who are enrolled in a high-deductible health plan. The funds contributed to the account aren't subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses. Unlike a flexible spending account (FSA), funds roll over year to year if you don't spend them.

**High-deductible health plan (HDHP)** A plan that features higher deductibles than traditional insurance plans. HDHPs can be combined with a health savings account or a health reimbursement arrangement to allow you to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

**Individual health insurance policy** Policies for people who aren't connected to job-based coverage.

**Internal Revenue Service (IRS)** This department of the U.S. federal government is responsible for tax collection and tax law enforcement. The IRS will be managing parts of the Affordable Care Act including: the employer responsibility fines, individual mandate penalties, and premium tax credits and cost-sharing subsidies.

**Individual mandate** A federal requirement, effective January 1, 2014, that American citizens be enrolled in a health insurance plan that meets the basic minimum standards as defined by the Department of Health and Human Services and the Department of the Treasury. The failure to do so may result in a tax penalty imposed upon the individual. There are special exemptions for financial hardships and religious exemptions.
Lifetime limit  A cap on the total lifetime benefits you may get from your insurance company. An insurance company may impose a total lifetime dollar limit on benefits (like a $1 million lifetime cap) or limits on specific benefits (like a $200,000 lifetime cap on organ transplants or 1 gastric bypass per lifetime) or a combination of both. After a lifetime limit is reached, the insurance plan will no longer pay for covered services.

Medicaid  A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities and, in some states, other adults. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program.

Medical loss ratio (MLR)  A basic financial measurement used in the Affordable Care Act to encourage health plans to provide value to enrollees. If an insurer uses 80¢ out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care, the company has a medical loss ratio of 80%. A medical loss ratio of 80% indicates that the insurer is using the remaining 20¢ of each premium dollar to pay overhead expenses, such as marketing, profits, salaries, administrative costs and agent commissions. The Affordable Care Act sets minimum medical loss ratios for different markets, as do some state laws.

Medical underwriting  A process used by insurance companies to try to figure out your health status when you're applying for health insurance coverage to determine whether to offer you coverage, at what price and with what exclusions or limits.

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).

Metal level  Under the Affordable Care Act, health insurance plans offered on the federally facilitated marketplace will have 1 of 4 metal level designations or rankings (platinum, gold, silver or bronze). Each metal level provides a different way to manage health care costs.

Minimum value  An eligible employer-sponsored health plan that possesses at least 60% actuarial value.

Modified adjusted gross income (MAGI)  A definition of income from the tax system that will be used under the Affordable Care Act to determine eligibility for Medicaid in all states and for tax credits available to people buying insurance in exchanges. The income calculations will take into account family size and income from all family members.

Non-grandfathered plan  As used in connection with the Affordable Care Act, a health plan that is not a grandfathered health plan and, therefore, subject to all reforms in the Affordable Care Act.

In the individual health insurance market, a plan that your family is purchasing for the first time will generally be a new plan.

In the group health insurance market, a plan that your employer is offering for the first time will generally be a new plan. Note that new employees and new family members may be added to existing grandfathered group plans—so a plan that is new to you and your family may still be a grandfathered plan.

In both the individual and group markets, a plan that loses its grandfathered status will be considered a new plan. A plan loses its grandfathered status when it makes significant changes to the plan, such as reducing benefits or increasing cost sharing for enrollees.

A health plan must disclose in its plan materials whether it considers itself to be a grandfathered plan and must also advise consumers how to contact the U.S. Department of Labor or the U.S. Department of Health and Human Services with questions.

Nonstandard plan  A qualified health plan offered in state and federal health insurance marketplaces by participating health insurance carriers that differs from a standard plan in covered benefits and cost sharing. Carriers can offer up to 2 nonstandard plans at each “metal” tier level on the New York Health Benefit Exchange.

Off-exchange  A platform for individuals and employers who are not eligible for subsidies or tax credits and prefer to have a direct relationship with the insurance company.

Open enrollment  A period of time set aside each year for the purchasing, renewing, or changing of health insurance plans. Health insurance cannot be purchased outside of this time period.
Out-of-pocket costs  Your expenses for medical care that aren’t reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance and copayments for covered services plus all costs for services that aren’t covered.

Out-of-pocket maximum (OOP) The maximum amount you will have to pay for covered services in a year. Generally, this includes the deductible, coinsurance and copayments. This definition may vary from plan to plan. For example, in some plans, the out-of-pocket limit doesn’t include cost sharing for all services, such as prescription drugs. Plans may have different out-of-pocket limits for different services.

PA Act 134  Gives the Pennsylvania Insurance Department authority to review and disapprove rate increases for small group health plans. This Act became effective on March 21, 2012.

Pennsylvania Insurance Department (PID) The state department responsible for regulating the health insurance industry in Pennsylvania.

Platinum plan A metallic plan level offered on the federally facilitated marketplace. Of the 4 metallic rankings, this level offers higher monthly costs and the lowest costs when care is received.

Pre-existing condition A condition, disability or illness (either physical or mental) that you have before you’re 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. The Affordable Care Act eliminates pre-existing condition exclusions, effective January 1, 2014.

Premium A monthly payment you make to your insurer to obtain and keep insurance coverage. Premiums can be paid by employers, unions, employees or individuals, or shared among different payers.

Preventive services Routine health care that includes screenings, checkups and patient counseling to prevent illnesses, disease or other health problems. The Affordable Care Act expands the amount of preventive services that are provided at no cost to members.

Qualified health plan (QHP) Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts) and meets other requirements. A qualified health plan will have a certification by each Exchange in which it is sold.

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

Reinsurance A reimbursement system that protects insurers from very high claims. It usually involves a third party paying part of an insurance company’s claims once they pass a certain amount. Reinsurance is a way to stabilize an insurance market and make coverage more available and affordable.

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 health care outcomes or health care costs.

Self-Insured Plan Type of plan usually present in larger companies where the employer itself collects premiums from enrollees and takes on 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 plan A metallic plan level offered on the federally facilitated marketplace. Of the 4 metallic rankings, this level when compared to bronze offers higher monthly costs and lower costs when care is received. The silver plan is the only plan that can have cost-sharing subsidies applied.

Small Business Health Options Program (SHOP) An Exchange tailored for small businesses to assist them in comparing and buying affordable and qualified health benefit plans.

Standard plan A federally mandated, qualified health plan to be included in state and federal health insurance marketplaces by participating health insurance carriers. Standard plans will be offered at each of the 4 “metal” tier levels and include a mandated catastrophic plan, child only plans, Native American plans and cost-share reduction (CSR) plans. The covered benefits and cost shares in each standard plan will be uniform for each carrier participating in the exchange, although the premium amounts and network arrangements will vary by carrier.
Subsidies  The Affordable Care Act establishes financial assistance in the form of premium tax credits and cost-sharing subsidies. These are available on a sliding scale for individuals and families with incomes from 100 to 400% of the federal poverty level to help purchase individual coverage through the federally facilitated marketplace.

Tax credit  The Affordable Care Act establishes financial assistance in the form of premium tax credits and cost-sharing subsidies. These are available on a sliding scale for individuals and families with incomes from 100 to 400% of the federal poverty level to help purchase individual coverage through the federally facilitated marketplace. These tax credits can be sent directly to the health insurance company each month.

Waiting period  The amount of time an employee must wait from their hire date until their health coverage becomes effective. Under the Affordable Care Act, the waiting period in 2014 cannot be longer than 90 days.