

Affordable Care Act Glossary of Terms

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, you will be responsible for 30% of the costs of all covered benefits. Starting in 2014, actuarial value will be used to categorize health plans sold in the individual and small group markets into coverage tiers.

Annual Limit: A cap on the benefits your insurance company will pay in a year while you're enrolled in 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. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.

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.

Employer Mandate: An approach that requires all employers, meeting size or revenue thresholds, to offer health benefits that meet a defined standard, and pay a set portion of the cost of those benefits on behalf of their employees.

Essential Health Benefits: ACA requires all health insurance plans sold to individuals and small groups, after 2014 to include a basic package of benefits including hospitalization, outpatient services, maternity care, prescription drugs, emergency care and preventive services among other benefits.

Exchange: The ACA created "American Health Benefit Exchanges" in each state to assist individuals and small businesses in comparing and purchasing qualified health insurance plans. Exchanges will also determine who qualifies for subsidies and make subsidy payments to insurers on behalf of individuals receiving them.

Federal Poverty Level (FPL): The federal government's working definition of poverty that is used as the reference point to determine the number of people with income below poverty and the income standard for eligibility for public programs. The federal government uses two different definitions of poverty. The U.S. Census poverty threshold is used as the basis for official poverty population statistics, such as the percentage of people living in poverty. The poverty guidelines, released by the U.S. Department of Health and Human Services (HHS), are used to determine eligibility for public programs and subsidies. For 2013, the Department of Health and Human Services designated the poverty guideline for a family of four to be \$23,550. For more information regarding the Federal Poverty Level, please visit [HHS's poverty guidelines](#).

Flexible Spending Account (FSA): An arrangement you set up through your employer to pay for many of your out-of-pocket medical expenses with tax-free dollars. These expenses include insurance copayments and deductibles, and qualified prescription drugs, insulin and medical

Affordable Care Act Glossary of Terms

devices. You decide how much of your pre-tax wages you want taken out of your paycheck and put into an FSA. You don't have to pay taxes on this money. The current limit is \$2500.

It is important to note that there is no carry-over of FSA funds. This means that FSA funds you don't spend by the end of the plan year can't be used for expenses in the next year. An exception is if your employer's FSA plan permits you to use unused FSA funds for expenses incurred during a grace period of up to 2.5 months after the end of the FSA plan year.

Grandfathered Plan: A health plan that an individual was enrolled in prior to March 23, 2010. Grandfathered plans are exempted from most changes required by ACA. New employees may be added to group plans that are grandfathered, and new family members may be added to all grandfathered plans, provided that substantial changes were not made to the plan and benefits.

Guaranteed Issue: A requirement that insurance companies issue a health plan to any applicant (individual or group) regardless of the applicant's health status or other factors, including those with pre-existing conditions.

Habilitative Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. 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.

Health Care Cooperative (CO-OP) Plan: A health insurance plan that will be sold by member-owned and operated non-profit organizations through exchanges and otherwise, when they open in 2014. ACA provides grants and loans to help Co-Op plans enter the marketplace.

Health Savings Account (HSA): Individuals covered by a qualified high deductible health plan (HDHP) (and have no other first dollar coverage) are able to open an HSA on a tax preferred basis to save for future qualified medical and retiree health expenses. HSAs are similar to Flexible Spending Accounts, but funds **do** carry over from year to year.

Individual Mandate: A requirement that everyone maintains health insurance coverage or face a penalty. ACA requires that everyone who can purchase health insurance for less than 8% of their household income do so or pay a tax penalty.

Lifetime Limit: A cap on the amount of money insurers will pay toward the cost of health care services over the lifetime of the insurance policy. The ACA now prohibits group health plans and health insurers to establish any lifetime limits on the dollar amount of benefits.

Medical Loss Ratio: The percentage of health insurance premiums that are spent by the insurance company on health care services. ACA requires that large group plans spend 85% of premiums on clinical services and other activities for the quality of care for enrollees. Small group and individual market plans must devote 80% of premiums to these purposes.

Affordable Care Act Glossary of Terms

Medicare: A federal government program that provides health care coverage for all eligible individuals age 65 or older or under age 65 with a disability, regardless of income or assets. Eligible individuals can receive coverage for hospital services (Medicare Part A), medical services (Medicare Part B), and prescription drugs (Medicare Part D). Together, Medicare Part A and B are known as Original Medicare. Benefits can also be provided through a Medicare Advantage plan (Medicare Part C).

Medicare Advantage: An option Medicare beneficiaries can choose to receive most or all of their Medicare benefits through a private insurance company. Also known as Medicare Part C. Plans contract with the federal government and are required to offer at least the same benefits as original Medicare, but may follow different rules and may offer additional benefits. Unlike original Medicare, enrollees may not be covered at any health care provider that accepts Medicare, and may be required to pay higher costs if they choose an out-of-network provider or one outside of the plan's service area.

Navigator: An entity or individual whom has received funding from an exchange to perform duties relating to; Conducting public education activities regarding qualified health plans, distributing information regarding enrolling in a qualified health plan, facilitating enrollment in a qualified health plan, and assisting individuals with questions or complaints regarding these matters; all in a fair and impartial manner. Navigators will be able to provide information in a manner that is appropriate to the cultural and linguistic needs of the population which the exchange serves.

Open Enrollment Period: A specified period during which individuals may enroll in a health insurance plan each year and usually the only time an individual can make changes or enroll except for certain situations, such as a birth, death or divorce in the family.

Patient Protection and Affordable Care Act (ACA): Legislation (Public Law 111-148) signed by President Obama on March 23, 2010. Commonly referred to as the ACA, the law includes multiple health reform provisions that would take effect over a matter of years, including the establishment of health insurance exchanges and expanding Medicaid eligibility.

Pre-Existing Condition: An illness or disability that an individual had before enrolling in a health coverage plan. Each state law defines pre-existing conditions differently. Examples of pre-existing conditions are asthma, diabetes and cancer.

Qualified Health Plan: A health insurance policy that is sold through an exchange. ACA requires exchanges to certify that qualified health plans meet minimum standards contained in the law.

Rescission: The retroactive cancellation of a health insurance policy. Insurance companies will sometimes retroactively cancel your entire policy if you made a mistake on your initial application when you buy an individual market insurance policy. Under the ACA and Ohio law, rescission is illegal except in cases of fraud or intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.

Affordable Care Act Glossary of Terms

Rehabilitative Services: Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Small Business Health Options Program (SHOP): Businesses with fewer than 100 employees will be able to purchase coverage through the SHOP Exchange beginning in 2014. These exchanges are intended to allow employers to shop for qualified health coverage. In 2017, states will have the option to open SHOP to allow businesses with more than 100 employees to purchase coverage through this exchange.

Small group market: The market for health insurance coverage offered to small businesses – those with between 2 and 50 employees in Ohio. Beginning in 2016, the ACA will mandate that every state defines small employers as those with fewer than 100 employees.