

## GLOSSARY OF AFFORDABLE CARE ACT TERMS

**ACA:** Affordable Care Act, passed in 2010. (Also known as “Obamacare.”) Full name is the Patient Protection and Affordable Care Act (PPACA).

**Defined Contribution Health Care:** The Health Insurance Exchanges provide for a new model of health benefits, in which employers would make a certain contribution toward the cost of coverage, but would not provide a “defined benefit” as most plans are typically designed today. If health care inflation rises faster than the employer contribution toward coverage, the increased cost would be borne solely by employees.

**Essential Health Benefits:** All plans offered in state-based Health Insurance Exchanges must provide “essential health benefits” including: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services.

**Flexible Savings Account (FSA):** An employer benefit offered to employees that allows a fixed amount of pre-tax wages to be set aside for qualified expenses, including child care or uncovered medical expenses. Employees lose any unused dollars in the account at year-end. (See chart below for more details.)

**Grandfathered Plan:** A plan that was in effect on the day that health reform was passed, March 23, 2010. This is the way that health reform helps to insure that employees keep the plans they had prior to the passage of health reform. A plan can lose grandfathered status by eliminating coverage for a particular condition; increasing deductibles or copays in excess of medical inflation, increasing co-insurance, or decreasing the employer’s share of total costs.

**Health Insurance Exchange (HIX):** Online and telephone marketplace for buying and selling of health insurance plans. The ACA provides that each state will have an individual exchange as well as a small business (SHOP) exchange, which can be merged together, at each state’s discretion. Private health insurance exchanges, which will be similar in design to the state-based HIX but privately run with individuals ineligible for subsidies, are being developed as well.

**Health Reimbursement Account (HRA):** An employer-funded, tax-advantaged employer health benefit plan that reimburses employees for out of pocket medical expenses and individual health insurance premiums. (See chart below for more details.)

**Health Savings Account (HSA):** A tax-advantaged, employee-owned medical savings account available to individuals who are enrolled in a high-deductible health plan. Unused dollars may roll over from year to year. (See chart below for more details.)

**Insured Plan:** A plan of coverage purchased from an insurance company for a set price – a premium, for a set period, usually one year. Individuals and most small employers buy coverage through an insured plan, because they do not have sufficient size for self insurance. The ACA rules will require that insured plans accept all applicants, price benefits equally for all applicants, and cannot stop paying benefits when a person gets sick.

**Medicaid:** A federal health program for low-income adults, their children, and people with certain disabilities. It is a means-tested program that is jointly funded by the state and federal governments, and is managed by the states. The ACA sought to expand Medicaid by mandating coverage to all individuals and families with incomes below 133% of the Federal Poverty Level, but the Supreme Court has ruled that states may opt out of this expansion at their discretion.

**Medicare:** A federal health program that pays for certain health care expenses for people aged 65 or older, as well as certain younger people with disabilities. Enrolled individuals must pay deductibles and co-payments, but much of their medical costs are covered by the program. Medicare is divided into four parts: Part A covers hospital bills, Part B covers doctor bills, Part C provides the option to choose from a package of health care plans, and Part D provides prescription drug coverage.

**Navigator Program:** Customer service program provided through state-based HIX for those wishing to purchase coverage. Navigators are experts in eligibility, enrollment, and program specifics. They must provide fair, accurate, impartial information, as well as culturally and linguistically appropriate information.

**Non-Grandfathered Plan:** A plan that is not grandfathered must provide certain benefits as of January 2011, including 100% coverage of preventive care and contraception, Emergency Room coverage without pre-authorization or network penalties, access to OB/GYN and pediatricians without referral, an internal and an external appeals process. A grandfathered plan will not have to provide such benefit improvements.

**“Play or Pay”:** Informal reference to the ACA’s provision that large employers must either provide coverage to employees or pay a penalty of \$2,000 per full-time worker (less the first 30 workers).

**Pre-Existing Condition:** An injury or illness that was first diagnosed prior to an individual applying for or receiving his/her current health insurance coverage. Many health insurance plans have denied certain individuals coverage based on a pre-existing condition, or limited health benefits related to a pre-existing condition. As of 2014, however, the ACA mandates that insurers may not deny coverage due to a pre-existing condition. Pre-Existing Condition Insurance Plans (PCIPs) are available to those with preexisting conditions prior to 2014.

**Pre-Existing Condition Insurance Plan (PCIP):** An insurance program created by the ACA to provide health coverage for people who have been without health coverage for at least six months and have a pre-existing condition, or have been denied health coverage because of their health condition. PCIPs are available until 2014, when individuals may begin enrolling in the larger state-based Health Insurance Exchanges, and cannot be denied due to a pre-existing condition.

**Preventative Care:** The ACA requires that all new plans provide coverage, with no cost to the patient, for: physicals, check-ups, immunizations, and screening tests. This removes the financial obstacle which currently prevents people from checking regularly on their health in order to insure the early detection and treatment of any problem.

**PPACA:** The Patient Protection and Affordable Care Act, passed in 2010. Also known as the ACA (Affordable Care Act) or “Obamacare.”

**Private Health Insurance Exchange:** Aon-Hewitt and other actuarial firms are designing Health Insurance Exchanges outside of the state-based exchanges. These will largely be targeted at groups ineligible for the state-based exchanges, such as large employers.

**Qualified Health Plan (QHP):** All plans offered through state-based Exchanges must be certified “Qualified Health Plans” and provide the following: 10 “Essential Health Benefits” and an adequate network; essential community providers for low-income and underserved; regulated marketing practices; rate justifications, quality disclosures, transparency, and standardization.

**Self-Insured Plan:** A plan in which an employer pays the cost for health services actually used by plan participants. Employers will often use a “third-party administrator” to negotiate with a network of providers, administer the plan, and pay claims. The administrator is often a division of a larger insurance company. Most large employers are self-insured because it lowers the cost of their coverage by avoiding reserves and other costs required in insured plans.

**SHOP Exchange:** Stands for “Small Business Health Options Program.” This is the small employer health insurance exchange created in the ACA. Each state will have a SHOP exchange in which employers with fewer than 50-100 employees may purchase coverage.