

Key ACA Terms

A quick reference of frequently used terms

Accountable Care Organization (ACO)

A group of health care providers that give coordinated care and chronic disease management, thereby improving the quality of care received by patients. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings.

Affordable Health Care

Health care coverage is defined as affordable if the participant's cost for self-only coverage does not exceed 9.5% of the participant's household income.

Annual Limit

A cap on the benefits an insurance company will pay in a year in a particular health insurance plan. This cap is sometimes placed on particular services such as prescriptions or hospitalizations. An annual limit 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, all associated health care costs for the rest of the year are paid by the individual covered by the insurance. ACA provisions prohibit most annual limits on essential health benefits as of January 1, 2014.

Automatic Enrollment

The process by which an employer signs up all eligible workers for a benefit plan unless the worker tells the employer otherwise during the enrollment period.

Cadillac Tax

See "High-Cost Excise Tax."

Comparative Clinical Effectiveness Research Fee

See "Patient-Centered Outcomes Research Institute (PCORI) Fee."

Consumer Operated and Oriented Plan (CO-OP)

A qualified health plan sold through the exchanges by customer-governed, nonprofit organizations.

Early Retirement Reinsurance Program (ERRP)

A temporary reinsurance program to provide financial assistance to employers, unions, and state and local governments to help them maintain coverage for early retirees aged 55 and older who are not yet eligible for Medicare.

Employer Mandate or Responsibility

Starting in 2015, if an employer with at least 50 full-time equivalent employees doesn't provide affordable health insurance and a worker uses a tax credit (subsidy) to help pay for insurance through an exchange, the employer must pay a fee to help cover the cost of the tax credits.

Essential Health Benefits

The ACA requires that health plans sold in the individual and small group markets, both inside and outside of the 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 ten 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.

Federal Poverty Level (FPL)

A measure of income level issued annually by the Department of Health and Human Services. The federal poverty level is used to determine an individual's eligibility for certain programs and benefits, including subsidies that can be used to buy health coverage through the exchanges.

Full-Time Employee (FTE)

An individual who is employed on average at least 30 hours per week in any month or has worked a total of 130 hours in the month.

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. A grandfathered plan is exempted from many changes required under ACA. A plan or policy may lose its "grandfathered" status if it makes certain significant changes that reduce benefits or increase costs to those covered. A health plan must disclose in its plan materials whether it considers itself to be a grandfathered plan and must also advise individuals how to contact the Department of Labor or the Department of Health and Human Services with questions.

Health Insurance Exchange or Marketplace

A new insurance marketplace in each state, designed to be transparent and competitive, where individuals and small businesses can buy affordable and qualified health benefit plans. An exchange will offer individuals a choice of health plans that meet certain benefits and cost standards.

High-Cost Excise Tax

Starting in 2018, a 40% excise tax on health plans with values exceeding a specified threshold. The thresholds are \$10,200 for individual coverage and \$27,500 for family coverage (indexed to inflation). The excise tax will be assessed on the amount that exceeds the threshold, not on the whole value of coverage. Also known as the "Cadillac tax."

Individual Mandate or Responsibility

Starting in 2014, most individuals must be enrolled in a health insurance plan that meets basic minimum standards or pay a penalty.

Lifetime Maximum Limit

A cap on the total maximum amount an insurer will pay for all eligible medical expenses that an individual incurs while insured under the health insurance policy. 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 one gastric bypass per lifetime) or a combination of the two. ACA provisions prohibit lifetime limits on essential health benefits.

Medical Loss Ratio (MLR)

The percentage of premium dollars spent on direct care for patients and efforts to improve health care quality, as opposed to administrative costs or profits. ACA sets minimum medical loss ratios for different markets (i.e., 85% for large group insurers and 80% for individual and small group insurers).

Minimum Essential Coverage

The type of coverage an individual must have to meet the individual responsibility requirement under the ACA. This includes individual market policies or coverage through employment, Medicare, Medicaid, TRICARE, the Children's Health Insurance Program (CHIP) or certain other programs.

Minimum Value Health Plan

A health plan provides minimum value by covering at least 60% of the total allowed cost of benefits that are expected to be incurred under the plan.

Patient-Centered Outcomes Research Institute (PCORI) Fee

A new fee on health plan sponsors and insurance companies used to fund the Patient-Centered Outcomes Research Institute (PCORI). PCORI will conduct research that compares different medical treatments and interventions to provide evidence on which strategies are most effective in different populations and situations. For the first year, the fee is \$1 per covered individual per year. This increases in the second year to \$2 per covered individual. The fee is then indexed to national health expenditures until 2019, when it will no longer be collected.

Pay or Play Mandate

See "Employer Responsibility."

Preexisting Condition Exclusion Period

The time period during which a health plan won't pay for care relating to a preexisting medical condition. Under a job-based plan, this cannot exceed 12 months for an individual who enrolls as soon as possible or 18 months for an individual who enrolls later. ACA includes provisions prohibiting preexisting condition exclusions.

Preexisting Condition Insurance Plan (PCIP)

A new program that provides a health coverage option for individuals who have been denied coverage due to a preexisting condition and have been uninsured for at least six months. This program will provide coverage until 2014, when coverage will be available through an exchange.

Premium Subsidy

A fixed amount of money or a designated percentage of the premium cost that is provided as a tax credit to help low-income individuals buy health coverage through the exchanges.

Preventive Services

Routine health care that includes screenings, check-ups and patient counseling to prevent illnesses, disease or other health problems.

Rescission

The retroactive cancellation of a health insurance policy. Under 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.

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.

Small Business Health Options Program (SHOP)

State health insurance exchanges that are designed for small businesses up to 100 workers.

Small Business Tax Credit

A tax credit available to small businesses that offer health coverage to their workers. To qualify, a small employer must have 25 or fewer full-time workers, pay average annual wages under \$50,000 per full-time worker and pay at least half of the cost of single health coverage. Tax credits vary with the contribution, size and tax status of the small employer.

Subsidy

See "Premium Subsidy."

Summary of Benefits and Coverage (SBC)

ACA requires group health plans and health insurance companies to provide access to a brief, standardized document that describes the benefits and coverage under the applicable health plan so those covered can compare plan benefits among and between carriers.

Transitional Reinsurance Program Fee

A fee used to fund a transitional reinsurance program, established by ACA to stabilize the individual health insurance market during the first three years the state health insurance exchanges are in operation (2014-2016). The program will collect contributions from health insurers and self-funded group health plans. The Department of Health and Human Services has estimated that the fee assessed in 2014 will be \$63 for each covered individual (including participants and their dependents).

Uniform Glossary

In conjunction with the Summary of Benefits and Coverage, ACA requires group health plans and health insurance companies to provide standard definitions of terms commonly used in health insurance coverage.

Definitions drawn from www.healthcare.gov or developed by International Foundation staff.