A

- **Access:** The ability to obtain needed medical care. Access to care is often affected by the availability of insurance, the cost of the care and the geographic location of providers.
- **Accountable Care Organization (ACO):** A network of doctors, hospitals and other health care providers that provide a full range of health care services for patients. The network receives a payment for all care provided to a patient, and is held accountable for the quality and cost of care. The Affordable Care Act provides financial incentives to physicians and other health care providers to join or create ACOs.
- **Actuarial Equivalent:** A health benefit plan that offers coverage similar to a standard benefit plan.
- **Actuarial Value:** A measure of the average value of benefits in a health insurance plan, calculated as the percentage of benefit costs a plan expects to pay for a standard population, using standard assumptions and cost-sharing provisions. Placing an average value on health plan benefits allows different health plans to be compared.
- **Adjusted Community Rating (ACR):** The ACA allows insurers selling personal or small group plans to adjust premiums based on family size, place of residency, tobacco use and age. They cannot charge the oldest participants in the plan more than three times what they charge the youngest participants.
- **Affordable Care Act:** This is the shortened, official name of the HR 3590, the Patient Protection and Affordable Care Act, also known as "Obamacare." The law requires all Americans who are not otherwise insured or exempt from the law to get health insurance that meets the requirements of the law.
- **Affordable Coverage:** Access to affordable health coverage means an individual or family can afford to pay the costs of health insurance, including monthly premiums, copays and annual deductibles.
- **Annual Limit or Cap:** Under the ACA, insurance companies are no longer allowed to limit or cap the number of claims or amount of money paid out over a lifetime or in a year for the 10 essential health benefits listed in the legislation.
- **Affordable:** Employer-based coverage is considered affordable if the lowest-cost single-coverage option does not exceed 9.5 percent of an employee's taxable income.
- **Approved Health Care Facility or Provider:** Some insurance policies will only cover claims that come from an approved list of "in-network" health care facilities and providers. Care provided "out-of-network" may require the insured to pay all or a larger portion of the costs.
- **Association Health Plan:** A health insurance plan offered to members of an association. These may be subject to state or federal regulation, or may be exempt from regulations.

B

- **Benefit:** The general terms for any service covered by a health insurance policy. The ACA specified 10 benefits that must be included in every health insurance policy.
- **Benefit Package:** The set of services, such as doctor visits, hospitalizations and prescription drugs, covered by an insurance policy or health plan. The package will specify cost-sharing requirements, limits on services and other limits.
- **Benefit Year:** The period of time in which a health insurance plan runs; typically, a full calendar year.
- **Bronze Plan:** The ACA requires every state to offer its residents various plan levels which differ in cost and benefit coverage. The bronze plan is the lowest regular plan offered, and generally covers 60 percent of the costs of a claim.

C

- **COBRA:** Employees who lose their jobs are able to continue their employer-sponsored coverage for up to 18 months through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Typically, the ex-employee must pay the entire monthly premium.
- **Capitation:** A method of paying for health care services under which a doctor or hospital receive a set payment for each patient or "covered life" instead of receiving payment based on the services provided.
- **Carrier:** An insurance company or other organization that offers health insurance.
- **Case Management:** The process of coordinating medical care to patients with specific diagnoses or with high health care needs. Case managers can be physicians, nurses or social workers.
- **Catastrophic Coverage:** People younger than 30 and some people with limited incomes may buy a "catastrophic" health plan. These have lower premiums but provide less coverage and require the buyer to meet a very high deductible.
- **Centers for Medicare & Medicaid Services (CMS):** The federal agency that manages and implements Medicare, Medicaid, CHIP and the federal marketplace.
- **Certificate of Coverage:** A document provided by an insurance company that explains the policy limits and benefits of a particular plan so that the insured knows what the policy will and will not cover.
- **Certified Applicant Counselor:** A person who is available to help consumers apply for health insurance in the federal marketplace for free. These counselors are not licensed insurance agents and cannot give advice.
- **Children's Health Insurance Program (CHIP):** Health insurance for low-income children not eligible for Medicaid. CHIP is partially funded by the states and the federal government, and managed by each state.

- **Claim:** A claim is created when an insured receives a medical service and the medical provider presents a demand for payment to the insurance company.
- **Chronic Care Management:** The coordination of health care and supportive services to patients with chronic conditions, such as diabetes and asthma. Programs include education to improve patients' self-management skills.
- **Co-Insurance:** Cost sharing which requires the plan member to pay a defined percentage of their medical costs, usually after a deductible has been met. The amount of the co-insurance will vary per plan level.
- **Coordination of Benefits:** Determining which policy will pay a claim when the insured has multiple health insurance policies, such as Medicare and coverage from an employer.
- **Co-pay or Co-payment:** The fixed amount of money an insured will pay for a particular service; the co-pay will vary by the service and plan level.
- **Common Control:** The ACA requires a business with 50 or more employees to provide insurance for all its workers or pay a fine. For two or more businesses under one owner or common control, all employees of the businesses are counted as a single group.
- **Community Rating:** A method for setting health insurance premiums under which all policy holders are charged the same premium for the same coverage. Insurers can vary premiums based on demographics (e.g. age, gender, location), but not policyholders' health status or claims history.
- **Consumer Operated and Oriented Plans (CO-OP):** Non-profit customer-governed health insurers that offer health plans in the exchanges.
- **Consumer-Directed Health Plans:** These provide incentives for consumers to consider costs when making health care decisions. They usually have high deductibles accompanied by a savings account for health care services, either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA).
- **Cost Containment:** Strategies aimed at controlling the growth of health care costs. These focus on reducing overutilization of services, eliminating waste, and increasing efficiency in the health care system.
- **Cost Sharing:** A catch-all phrase for co-payments, deductibles and other costs paid by individuals.
- **Cost Sharing Reduction:** Low-income people who buy health insurance through the federal marketplace may be eligible for reductions in deductibles, co-payments and co-insurance. Cost Sharing Reduction is only available to those who select a Silver level plan and who make less than 250 percent of the Federal Poverty Level.
- **Cost Shifting:** Increasing revenues from some payers to offset losses or lower reimbursement from other payers, such as government payers and the uninsured.

D

- **Deductible:** The amount, up to a specified dollar figure, that a consumer must pay for out-of-pocket before the insurance company will start to pay. The annual amount of the deductible will vary depending on the plan level and type.
- **Dental Insurance:** A separate insurance policy that pays for dental claims; most regular medical health insurance will not cover dental work.
- **Department of Health and Human Services (HHS):** The federal agency responsible for protecting the health of Americans. The Center for Medicaid & Medicare Services, which runs the federal marketplace, is managed by HHS.
- **Dependent:** The ACA requires businesses with more than 50 employees to offer coverage to employees' dependents up to 26 years old. The law does not require businesses to cover spouses.
- **Disproportionate Share Hospital (DSH) Payments:** Payments by a state Medicaid program to hospitals that serve a "disproportionate share" of low-income or uninsured patients.
- **Doughnut Hole:** The coverage gap in Medicare Part D prescription drug plans for seniors. Medicare currently pays 75 percent of the first $2,970 in drug costs (not including the deductible) and then 95 percent of costs above $4,750. Seniors are responsible for 100 percent of drug costs between those two amounts. Federal rebates help bridge the gap, and the "hole" will decrease annually until 2020.
- **Domestic Partnership:** Two people who live together but are not married or in a civil union are considered to be in a domestic partnership.
- **Dual Eligibles:** Individuals who are eligible for Medicare and for some level of Medicaid benefits.

E

- **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services:** One of the services states must include in their benefits package for Medicaid-eligible children under age 21. Services include screenings for physical and mental conditions, as well as vision, hearing and dental problems, and treatment to correct conditions uncovered in a screening.
- **Electronic Health Record/Electronic Medical Records:** Computerized records of a patient's health information, which can be shared among across health care organizations and locations.
- **Eligibility Date:** The date a person becomes eligible for health care.
- **Eligible Immigration Status:** Anyone living in the United States unlawfully is exempt from complying with the ACA, and will not be penalized for failing to buy health insurance. Any alien living in the country as a lawful permanent resident, who has asylum, is a refugee, is a battered spouse, child or parent, has a work or student visa, or has some other lawful temporary residential status, can buy health insurance through the federal marketplace and is considered to be lawfully residing in the United States.

- **Emergency Services:** Any medical service received in a hospital emergency room; coverage for emergency services is one of the 10 essential benefits required under the Affordable Care Act.
- **Employee Contribution:** The money an employee must pay for health insurance coverage obtained through their employer. This is usually deducted from the employee's paycheck.
- **Employee Retirement Income Security Act of 1974 (ERISA):** Legislation enacted to protect workers from the loss of workplace benefits. ERISA does not require employers to establish an employee benefit plan, but regulates the administration of a plan one if is established.
- **Employer Health Care Tax Credit:** An incentive to encourage employers to offer health insurance to their employees. It allows employers to deduct a percentage of their contribution to employees' premiums from the federal taxes they owe. These tax credits are also available to non-profit organizations that do not pay federal taxes.
- **Employer Mandate:** This requires employers with 50 or more workers to provide insurance for all full-time employees or pay a per-employee penalty. The mandate was waived in 2014 by President Obama and took effect in 2015.
- **Employer Shared Responsibility Payment (ESRP):** If an employer with at least 50 full-time or full-time-equivalent employees fails to provide adequate coverage or any coverage to at least one qualifying employee within their company, the employer must pay a tax called an Employer Shared Responsibility Payment.
- **Employer-Sponsored Insurance:** Coverage provided by a company to its employees and, in some cases, to their spouses and children.
- **Enrollment Period:** Under the ACA, people must enroll in health insurance either through the state or federal marketplace or through a private health insurance company during a set period of time every year. If a person has no health insurance at the close of the enrollment period, they will be not in compliance with the Affordable Care Act. The 2015 open enrollment period for regular health insurance was November 15, 2014 to February 15, 2015.
- **Entitlement Program:** Federal programs, such as Medicare and Medicaid, for which eligible people have a right to benefits. The federal government is required to spend the funds necessary for these programs, unlike discretionary programs for which Congress appropriates funds.
- **Essential Health Benefits:** The Secretary of Health and Human Services sets a package of 10 broad benefits insurers are required to offer. These include hospitalization, lab services, rehabilitative services, outpatient services, emergency care, prescription drugs, maternity and newborn care, preventive services, mental health and substance abuse treatment, and pediatric oral and vision care. The amount of co-payment and co-insurance may vary by the level of the insurance policy.
- **Exchanges:** Marketplaces where uninsured individuals who don't qualify for Medicaid can buy private health insurance.

- **Exemption:** Individuals belong to specific groups of people designated by the ACA as being exempt from complying with the law do not have to purchase insurance and will not be taxed for failing to have insurance. Exempted groups include**:** Native Americans and Alaskan tribes, a member of a recognized health care sharing ministry, a member of a religious sect that opposes health insurance, someone who is incarcerated, someone living in the U.S. unlawfully, people who have been without health care for three months or less, people who are 25 years or younger and remain on their parent's health insurance until their 26th birthday, and people who are exempt from filing a federal income tax return due to their income level if the lowest priced bronze plan offered to them is more than 8 percent of their household income.
- **Exemption of Certificate Number (ECN):** Those who apply and are approved for an exemption from the ACA will be assigned an ECN, which these individual must cite on their federal income tax returns to indicate they are exempt from complying with the law.
- **Explanation of Benefits (EOB):** A document an insurance company provides to an insured after it pays a claim. It explains what the claim was, how much was paid and how much the insured owes.

F

- **Federal Employee Health Benefits Program (FEHBP):** A program that provides health insurance to federal government employees.
- **Federal Marketplace:** The ACA required the federal government to create a website as an information hub and to enable Americans to shop for health insurance. The federal marketplace is available at healthcare.gov.
- **Federal Medical Assistance Percentage (FMAP):** The share of the costs of state Medicaid services the federal government covers. FMAP varies from 50 percent to 76 percent, depending upon a state's per capita income.
- **Federal Poverty Level (FPL):** The federal government's poverty guidelines, used by the HHS to determine eligibility for public programs and subsidies. The ACA says anyone who makes between 100 and 400 percent of the Federal Poverty Level is eligible for financial assistance. The amounts change every year based on the market and inflation. For 2015, the federal poverty level for a family of four was set at $24,250.
- **Federally Qualified Health Centers (FQHC):** Community health clinics and public housing centers, funded by the federal government, that provide health services regardless of an individual's ability to pay.
- **Fee-for-Service:** The traditional method of paying doctors and hospitals for each service they provide.
- **Flexible Spending Account (FSA):** Workers insured through their employers can set aside earnings up to $2,500 pre-tax in an FSA to pay for medical services, co-payments and some drugs.

- **Full-Time and Full-Time-Equivalent Employees:** Employers with at least 50 full-time or full-time-equivalent employees must provide them with health insurance. An employee who works 30 or more hours per week is considered full-time. An employer must add up the total hours of service for which wages are paid during a year, and divide that by 2,080 to determine the number of full-time-equivalent employees.

G

- **Gold Plan:** The ACA requires insurers to offer multiple plan levels, named for different metals, with varying benefits and costs. A Gold Plan covers 80 percent of health care costs; the insured pays the remaining 20 percent. A Gold Plan typically has higher monthly premiums than lower-level plans, but lower co-pays, co-insurance and deductibles.
- **Grace Period:** The ACA requires insurance companies to extend a 90-day grace period for an insured person to make premium payments before the policy can be cancelled.
- **Grandfathered Plan:** Insurance policies that do not comply with the ACA and were in effect before March 23, 2010, when the ACA was signed into law, can be maintained for a limited period of time.
- **Group Health Insurance:** Health insurance offered to a group of people, such as employees of a company.
- **Guarantee Issue/Renewal:** Insurers are required to offer and renew coverage without regard to the insured's health status, use of services or pre-existing conditions.

H

- **Habilitative Services:** One of the ten essential benefits required to be covered by insurance policies under the ACA, habilitative services include occupational and physical or speech therapy intended to help a person re-acquire a skill that is missing because of sickness or injury.
- **Hardship:** A person who experienced a hardship that prevented them from buying health insurance during the regular enrollment period may obtain an exemption and get coverage when the hardship resolves, and not have to pay a penalty for failing to comply with the law. Hardships include homelessness, bankruptcy, foreclosure or eviction, death of a family member, a natural or human-caused disaster, and a number of other circumstances.
- **Health Care Cooperative (CO-OP):** A non-profit, member-run organization that provides health insurance to individuals and small businesses. Co-ops can operate at state, regional and national levels.
- **Health Insurance Exchange/Connector:** Arrangements through which insurers offer health insurance to small businesses and individuals. An example is the Commonwealth Connector, created in Massachusetts in 2006.
- **Health Insurance Marketplace:** Where individuals and families can obtain information and shop for health insurance. The marketplace includes the federal government's healthcare.gov and

marketplaces run by individual states. As of 2015, those states are**:** California, Colorado, Connecticut, Washington D.C., Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Vermont and Washington.

- **Health Insurance Portability and Accountability Act of 1996 (HIPAA):** This law enables those who lose group health coverage when they become unemployed to buy continuing coverage known as COBRA. HIPAA also establishes rules about the security and privacy of health data.
- **Health Reimbursement Account (HRA):** A tax-exempt account that can be used to pay for current or future health expenses. HRAs are funded solely by employer contributions, which are tax-deductible and excluded from the employee's wages. They are often paired with a high-deductible health plan, but need not be. Amounts unused at the end of the year can be rolled over to the next year.
- **Health Savings Account (HSA):** An HSA is established by an individual to pay for qualified medical expenses. It must be linked to a qualified high-deductible insurance plan. Both the employee and the employer can contribute to it. Employer contributions are tax-deducible, and employees are not taxed on these contributions. If the employee takes money out of the HAS for reasons other than to pay medical bills, it will be taxed.
- **High-Deductible Health Plan:** A plan that requires the consumer to pay a higher deductible for services before the plan begins to pay, but that has lower premiums than traditional plans. A qualified high-deductible plan may be combined with an HSA if the deductible meets specified minimums.
- **Health Maintenance Organization (HMO):** A common type of health insurance policy that requires the insured person to use doctors and medical facilities that are on an approved list, or "in-network." Often the insured must see a primary care physician in order to get a referral to see a specialist.
- **Home Health Care:** Health care services provided in the patient's home rather than in a medical facility.
- **Hospice Care:** Care given to a terminally ill patient inpatient in a hospice center or at the patient's home by a visiting medical provider.

I

- **In-Network:** Certain health insurance policies require their insured people to visit only health care facilities and physicians that are on a list. Those approved facilities and physicians are considered in-network. If an insured person received medical attention by a medical provider or facility that is not on the list, it is considered out-of-network and the claim may not be covered by the insurance policy.
- **Individual Insurance Market:** Where individuals who do not have group (usually employer-provided) coverage purchase private health insurance; also referred to as the non-group market.

- **Individual Mandate:** The ACA's requirement that all individuals in the U.S. obtain health insurance or pay a penalty imposed by the IRS unless the individual qualifies for an exemption.
- **Inpatient Hospitalization:** A hospital stay that lasts for 24 hours or more. Inpatient hospitalization is one of the 10 essential health benefits the ACA requires an insurance policy to cover.
- **Insurance Agent:** A person licensed and regulated by the state to sell insurance. The agent paid a commission by the insurance company or carrier, and can work for an independent broker or for an insurance company.
- **Insurance Broker:** An insurance broker is regulated and licensed by the state, and is independent from any particular insurance company. Brokers can have agents working under them.

L

- **Laboratory Service:** A service ordered by a medical provider that is performed in a laboratory by medical scientists or technicians. Laboratory service is one of the ten essential health benefits the ACA requires insurance policies to cover.
- **Lifetime Benefit Maximum:** Insurance companies are no longer allowed to place dollar limits on any of the 10 essential health benefits required by the ACA.
- **Long-Term Care:** Services needed to live independently in the community, such as home health and personal care, as well as services provided in nursing homes. Many of these services are not covered by private insurance.

M

- **Managed Care:** A health delivery system that seeks to control costs and improve quality by controlling and utilizing health care services.
- **Mandatory Benefits:** Certain benefits or services, such as mental health services, substance abuse treatment, and breast reconstruction following a mastectomy, that states require insurance companies to cover in their plans. These benefits vary by state.
- **Marketplace:** Online health insurance market where consumers can buy private health insurance; also called an exchange.
- **Maternity and Newborn Care:** One of the 10 essential health benefits required to be covered by a health insurance plan, this includes medical services to a mother during her pregnancy or after she gives birth, and any medical services to newborns.
- **Medicaid:** Enacted in 1965 under the Social Security Act, Medicaid is a federal entitlement program that provides health and long-term care coverage to low-income Americans who cannot afford traditional health insurance. States design their own Medicaid programs within broad federal guidelines.

- **Medicaid Waiver:** The Secretary of Health and Human Services allowed some states to continue receiving federal Medicaid funds even if they were not in compliance with certain requirements of the Medicaid statute. States have used waivers to pay for home- and community-based services programs, managed care, and to cover some populations not otherwise eligible for Medicaid.
- **Medical Home:** A health care setting in which patients receive comprehensive primary care services; have an ongoing relationship with a primary care provider who directs and coordinates their care; and have access to linguistically and culturally appropriate care.
- **Medical Loss Ratio:** The percentage of premium dollars an insurance company spends on medical care, as opposed to administrative costs or profits. The ACA requires a medical loss ratio of at least 80 percent.
- **Medical Necessity:** A medical service or item necessary to treat, prevent or diagnose an illness or disease. Whether a medical service is consider a medical necessity can determine whether its cost is covered by an insurance policy.
- **Medical Savings Account:** Another term for Health Savings Account; an untaxed account set up to help cover out-of-pocket costs such as co-pays, co-insurance and deductibles. Money not used in a given year will roll over to the next year.
- **Medicare:** Enacted in 1965 under the Social Security Act, Medicare is a federal entitlement program that provides health insurance coverage to people age 65 and older, and to younger people with permanent disabilities. "Original Medicare" includes Part A, for hospital expenses, and Part B, for medical care. Part C, or Medicare Advantage, has the same benefits but is provided by private insurance companies rather than the federal government. Part D is prescription drug coverage.
- **Medicare Advantage:** Another term for Medicare Part C, but may also include vision, dental, hearing and other coverages.
- **Medigap:** Supplemental coverage to Medicare that covers the costs of co-pays and co-insurance.
- **Metal Levels:** The four levels of coverage available through exchange plans**:** bronze, silver, gold and platinum. Bronze plans have the lowest premiums, but cover only 60 percent of average costs. Platinum plans, with the highest premiums, cover 90 percent of most costs.
- **Minimum Creditable Coverage:** The minimum level of benefits that under the ACA must be included in a health insurance plan.
- **Minimum Value:** The ACA requires employers with 50 or more full-time equivalent workers to cover at least 60 percent of their employees' health care costs, or pay a penalty of $3,000 per employee.
- **Modified Adjusted Gross Income (MAGI):** An IRS term to determine eligibility for Medicaid and for tax credits to those who buy insurance in exchanges.

O

- **Obamacare:** Another term for the Patient Protection and Affordable Care Act law, or the ACA.
- **Off-Exchange:** This refers to insurance policies sold by insurance providers directly, via third-party websites or through insurance agents or brokers.
- **On-Exchange:** The opposite of Off-Exchange, these policies are offered on state or federal Marketplaces.
- **Open Enrollment Period:** A specific period of the year when a person can enroll in or change their health insurance policy, or enroll in Medicare. Failure to enroll in an ACA plan before the end of the open enrollment period may result in tax penalties.
- **Out-of-Network:** Some health insurance plans require participants to use doctors and health care facilities on an approved list, or "in-network." If an insured uses a provider that is not on the list, the insurance policy will cover less or none of the claim.
- **Out-of-Pocket Costs:** The costs an insured person must pay to cover the portion of a claim that insurance does not cover. These may include an annual deductible, co-pays or co-insurance. Premiums are not included in out-of-pocket costs.
- **Out-of-Pocket Maximum:** The ACA limits the amount of money individuals are required to pay out of their own pockets for health care costs to $6,350 for an individual and $12,700 for a family policy.
- **Outpatient:** The term for medical care that does not require a person to stay overnight at a medical facility.

P

- **Part-Time Employee:** A person who works less than 30 hours per week is considered a part-time employee. The ACA does not require employers to provide health insurance to part-time employees.
- **Patient Protection and Affordable Care Act:** The formal name of HR 3590, the law commonly known as the Affordable Care Act, ACA or Obamacare.
- **Pay for Performance:** A health care payment system, aimed at improving the quality of care, in which providers receive incentives for meeting or exceeding goals for quality.
- **Payment Bundling:** A payment mechanism in which doctors or hospitals receive one payment for all the care provided for an episode of illness, rather than being paid for each service.
- **Platinum Plan:** The highest of the four levels of insurance plans under the ACA, the Platinum Plan has the highest level of coverage, at 90 percent of health care costs, lower annual deductibles, co-pays and co-insurance than other "metal" plans, but higher premiums.
- **Point of Service Plans (POS):** A type of insurance plan that restricts insureds to visit only specified doctors and facilities.

- **Portability of Coverage:** Rules that allow people to obtain coverage without a waiting period as they move from one job to another or in and out of employment.
- **Pre-Existing condition:** A health condition that existed before the start date of an individual's health insurance. The ACA bars insurance companies from denying coverage because of a pre-existing condition.
- **Preferred Provider Organization (PPO):** A type of insurance plan offered by many insurance companies, it is typically the most expensive but it offers the most flexibility about which medical providers and hospitals a patient can use.
- **Premium:** The amount paid, usually monthly, for health insurance.
- **Premium Subsidies:** Money provided by the government to help low-income people purchase health insurance.
- **Prescription Drug Coverage:** An insurance policy that helps to pay for prescription drugs.
- **Preventive Care:** Health care aimed at early detection and treatment of diseases. Preventive care services that the ACA requires policies to cover, without deductibles or co-payments, includes mammograms, colonoscopies and annual checkups.
- **Primary Care Provider:** A doctor the insured person will visit for all general medical issues, who is responsible for providing primary care, coordinating health care services for patients, and referring the insured to a specialist when necessary.
- **Provider Payment Rates:** The payments a doctor, hospital, or health center receives when medical services are provided to a patient.
- **Public Plan Option:** A proposal to create an insurance plan funded and run by federal or state government.

Q

- **Qualified Health Plan:** An insurance plan sold on an exchange that has been certified by the state and federal government as meeting minimum standards. Once certified, it becomes a qualified health plan.
- **Qualifying Life Event:** Every American must enroll in insurance during an open enrollment period or pay a tax penalty. An exception to this rule is if the person lost insurance due to a Qualifying Life Event; that allows the person to buy insurance outside the enrollment period. Examples of Qualifying Life Events are losing a job, moving to a new state, getting married or divorced, giving birth or adopting a child, or a change in income that qualifies or disqualifies the person the person for financial assistance, Medicaid or CHIP.

R

- **Referral:** A request by an insured's primary care doctor that the patient see a specialist. If the person visits a specialist without receiving a referral, the insurance may not cover the cost of the specialist's services.
- **Rehabilitative Service:** One of the 10 essential health benefits the ACA requires to be included by every health insurance policy, a Rehabilitative Service aims to help a person reacquire a skill or activity lost due to an illness or disease.
- **Reinsurance:** Insurance for insurance companies and for employers that self-insure their employees' medical costs. By limiting insurers' exposure to very high claim costs, reinsurance enables insurers to lower the premiums they charge to employers and individuals.

S

- **Safety Net:** Health care providers that deliver services to patients regardless of their ability to pay.
- **Section 125 Plan:** A plan that allows employees to receive benefits, including health insurance, on a pre-tax basis whether the insurance is provided by the employer or purchased in the individual market.
- **Self-Insured Plan**; A plan where the employer takes responsibility for collecting premiums and paying employee's medical claims. Employers who self-insure typically hire a third-party administrator or insurance company to administer the plan.
- **Shared Responsibility Payment:** The formal name for the tax payment penalty assessed by the IRS on a person who fails to obtain health insurance under the ACA during the open enrollment period.
- **SHOP (Small Business Health Options Program):** The marketplace created by the ACA where small businesses with less than 50 full-time employees can shop for a group health care plan for their employees.
- **Short-Term Health Plans:** A type of health insurance that lasts only for a short period of time (a year or less) and provide limited coverage for people who are between regular insurance policies. These plans do not comply with the ACA and may result in the insured being charged a tax penalty.
- **Silver Plan:** The medium level insurance plan offered under the ACA, a Silver Plan will cover about 70 percent of health care claims, with the insured person covering the rest.
- **Single-Payer System:** A system in which a single entity, such as a government agency, pays for health care services but is not involved in the delivery of health care.
- **Skilled Care Services:** Services provided by a technician or therapist in the patient's home or in a nursing home.

- **Skilled Nursing Care:** Care provided under Medicare by a nurse in a patient's home or in a nursing home.
- **Small-Business Health Care Tax Credit:** Businesses with less than 25 full-time workers who earn on average less than $50,000 may qualify for a tax credit of up to 50 percent of the premiums they pay for their employees.
- **Small Business Health Options Program (SHOP):** State health insurance exchanges open to businesses that have up to 100 employees.
- **Small Group Market:** Firms with less than 50 employees can purchase health insurance for their employees through this state-regulated market.
- **Socialized Medicine:** A system in which the government operates health care facilities and employs health care professionals.
- **Special Enrollment Period:** If a person loses health insurance due to a Qualifying Life Event when the enrollment period is closed, he or she can sign up for insurance on the federal marketplace within 60 days of the Qualifying Life Event.
- **State Exchange:** The term used to refer to a state's marketplace. The states that have created their own state exchange or marketplace as of 2015 are**:** California, Colorado, Connecticut, Washington D.C., Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Vermont and Washington.
- **Subsidy:** Financial assistance provided by the federal government to Americans who obtain health insurance through healthcare.gov and who earn between 100 percent and 400 percent of the Federal Poverty Level.

T

- **Tax Credit:** An amount that a person or family can subtract from income tax they owe. An ACA tax credit provides eligible people help paying their monthly premium bills, either in the form of discounted monthly premiums or an annual credit at the end of the year.
- **Tax Penalty:** The fine levied on individuals who violate the individual insurance mandate. In 2015, it's $325 or 2 percent of taxable income, whichever is greater. For 2016, it's $695 or 2.5 percent of taxable income. Thereafter, it is adjusted for inflation.
- **Tax Preference for Employer-Sponsored Insurance:** The amount employers contribute to health benefits are excluded from most workers' taxable income, and contributions made by employees toward the premium cost for health insurance are made on a tax-free basis. In contrast, individuals who do not receive health insurance through an employer may only deduct the amount of their total health care expenses that exceeds 7.5 percent of their adjusted gross income.
- **TRICARE:** The health care program for active and retired members of the military and their families.

U

- **Uncompensated Care:** Health care services that are provided but not paid for by the patient or insurance. The cost is borne by health care providers and the federal government.
- **Underinsured:** People who have health insurance but whose ability to pay for health care is limited by out-of-pocket costs or benefit limits.
- **Urgent Care:** A medical facility that provides urgent medical attention for issues not so severe they require emergency care from a hospital.
- **Vision Care Coverage:** Insurance coverage for vision care, typically provided by a separate health insurance policy.

W

- **Wellness Plan/Program:** Employment-based program to promote health.

Y

- **Young Adult Health Plan:** Health plans designed to meet the needs of young adults; most offer lower premiums, high deductibles and limited benefit packages.