Health Insurance Marketplace Continuing Education
Glossary of Terms and Acronyms

Actuarial Value (AV) (which correlates to “Metal Level”)

Actuarial Value, or AV, is calculated as the percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an AV of 70 percent, on average, a consumer could expect to be responsible generally for 30 percent of the costs of all covered benefits in that plan. Beginning in 2014, non-grandfathered health plans in the individual and small group markets must meet certain AVs, or metal levels: 60 percent for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan, and 90 percent for a platinum plan. Issuers may offer catastrophic-only coverage to eligible individuals. “Metal levels” will allow consumers to compare plans with similar levels of coverage, which along with consideration of premiums, provider networks, and other factors, help the consumer make an informed decision.


Advance Payment Tax Credit (APTC)

A new tax credit to help afford health coverage purchased through the Marketplace. Advance payments of the tax credit can be used right away to lower monthly premium costs. If qualified, individuals may choose how much advance credit payments to apply to their premiums each month, up to a maximum amount. If the amount of advance credit payments for the year is less than the tax credit due, the individual gets the difference as a refundable credit when they file federal income tax return. If advance payments for the year are more than the amount of the credit, the individual must repay the excess advance payments with their tax return.

(Source: www.healthcare.gov)

The Patient Protection and Affordable Care Act (ACA)

Comprehensive health reform legislation which became law on March 23, 2010. The health care law, sometimes known as "Obamacare," has two parts: The Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 11-152).

(Source: www.healthcare.gov)
The Children’s Health Insurance Program (CHIP)

Insurance program jointly funded by state and federal government that provides health coverage to low-income children and, in some states, pregnant women in families who earn too much income to qualify for Medicaid but can’t afford to purchase private health insurance coverage.

(Source: www.healthcare.gov)

Cost Sharing Reduction Plans (CSR)

A discount that lowers the amount an individual must pay out-of-pocket for deductibles, coinsurance, and copayments. An individual is eligible for this reduction if they get health insurance through the Marketplace, their income is below a certain level, and they choose a health plan from the Silver plan category (or “silver metal level plan”). Members of a federally recognized tribe may qualify for additional cost-sharing benefits.

(Source: www.healthcare.gov)

Essential Health Benefits (EHBs)

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 Health Insurance Marketplace, 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 the Health Insurance Marketplace. States expanding their Medicaid programs must provide these benefits to people newly eligible for Medicaid.

(Source: www.healthcare.gov)

Essential Health Benefits Benchmark Plan

The Affordable Care Act directs that Essential Health Benefits be equal in scope to benefits offered by a “typical employer plan.” To meet this requirement in every state, the final rule defines essential health benefits based on a state-specific “benchmark plan.” States can select a benchmark plan from among several options, including the largest small group private health insurance plan by enrollment in the state. The final rule provides that all plans subject to essential health benefits offer benefits substantially equal to the benefits offered by the benchmark plan.
The benchmark plan options include: (1) the largest plan by enrollment in any of the three largest products by enrollment in the state’s small group market; (2) any of the largest three state employee health benefit plans options by enrollment; (3) any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment; or (4) the HMO plan with the largest insured commercial non-Medicaid enrollment in the state.


To get information about a state’s benchmark plan:
1) Call that state’s Department of Insurance; or
2) Go to: https://www.statereforum.org/analyses/state-progress-on-essential-health-benefits for an updated list of benchmark plans in each state.

Federally-Facilitated Marketplace (FFM)

A Marketplace that is entirely run by the Federal Government

Federal Poverty Level (FPL)

A measure of income level issued annually by the U.S. Department of Health and Human Services. Federal poverty levels are used to determine eligibility for certain programs and benefits.

The following 2014 numbers are used for calculating eligibility for Medicaid:

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<td>$11,670 for individuals</td>
<td>$27,910 for a family of 5</td>
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<tr>
<td>$15,730 for a family of 2</td>
<td>$31,970 for a family of 6</td>
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<tr>
<td>$19,790 for a family of 3</td>
<td>$36,030 for a family of 7</td>
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<tr>
<td>$23,850 for a family of 4</td>
<td>$40,090 for a family of 8</td>
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The following 2013 numbers are used for calculating eligibility for lower costs on private insurance plans in the Marketplace for 2014 coverage:

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<tr>
<td>$19,530 for a family of 3</td>
<td>$35,610 for a family of 7</td>
</tr>
<tr>
<td>$23,550 for a family of 4</td>
<td>$39,630 for a family of 8</td>
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(Source: www.healthcare.gov)

Five Percent Disregard

The ACA created a new mandatory Medicaid eligibility group for all nonelderly, non-pregnant individuals (e.g., childless adults, certain parents, certain people with disabilities) who are not otherwise eligible for Medicaid and are also not entitled to or enrolled in Medicare Part A or enrolled in Medicare Part B. For such individuals, the ACA establishes an income threshold of 133% of the
federal poverty level (FPL) as the new mandatory minimum Medicaid income eligibility level. The law also specifies that an “income disregard in the amount of 5% FPL” will be used to determine Medicaid eligibility based on “modified adjusted gross income”; thus, the effective minimum income-eligibility threshold for such individuals in this new eligibility group will be 138% FPL.


**Full-time Equivalent Employee (FTE)**

With regard to SHOP eligibility, full-time equivalent employees are counted as follows:

- Full-time employees that work at least 30 hours per week in any month are counted as one full-time employee. This amount is added to the number of part-time employees.
- Part-time employees are calculated by taking the hours worked by all part-time employees in a week and dividing that amount by 30.
- Seasonal employees aren’t counted in the calculation for those working up to 120 days in a year.

To calculate a businesses’ number of FTEs, go to the “Full-time Equivalent (FTE) Employee Calculator” at www.healthcare.gov.

(Source: www.healthcare.gov)

**Habilitation Services (also called Habilitation Services)**

Health care services that help 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.

(Source: www.healthcare.gov)

**Hardship Exemption**

An exemption from the individual responsibility requirement of the ACA under the following circumstances that affect an individual’s ability to purchase health insurance coverage:

1. You were homeless.
2. You were evicted in the past 6 months or were facing eviction or foreclosure.
3. You received a shut-off notice from a utility company.
4. You recently experienced domestic violence.
5. You recently experienced the death of a close family member.
6. You experienced a fire, flood, or other natural or human-caused disaster that caused substantial damage to your property.
7. You filed for bankruptcy in the last 6 months.
8. You had medical expenses you couldn’t pay in the last 24 months.
9. You experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member.
10. You expect to claim a child as a tax dependent who’s been denied coverage in Medicaid and CHIP, and another person is required by court order to give medical support to the child. In this case, you do not have to pay the penalty for the child.

11. As a result of an eligibility appeals decision, you’re eligible for enrollment in a qualified health plan (QHP) through the Marketplace, lower costs on your monthly premiums, or cost-sharing reductions for a time period when you weren’t enrolled in a QHP through the Marketplace.

12. You were determined ineligible for Medicaid because your state didn’t expand eligibility for Medicaid under the Affordable Care Act.

13. Your individual insurance plan was cancelled and you believe other Marketplace plans are unaffordable.

(Source: www.healthcare.gov)

Minimum Essential Coverage (MEC)

The type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act.

In 2014, an individual is considered covered by the following:
- Any Marketplace plan, or any individual insurance plan you already have
- Any employer plan (including COBRA), with or without “grandfathered” status. This includes retiree plans
- Medicare
- Medicaid
- The Children’s Health Insurance Program (CHIP)
- TRICARE (for current service members and military retirees, their families, and survivors)
- Veterans health care programs (including the Veterans Health Care Program, VA Civilian Health and Medical Program (CHAMPVA), and Spina Bifida Health Care Benefits Program)
- Peace Corps Volunteer plans
- Self-funded health coverage offered to students by universities for plan or policy years that begin on or before Dec. 31, 2014

(Source: www.healthcare.gov)

Out-of-Pocket Maximum/Limit

The most that is allowed to be paid during a policy period (usually one year) before health insurance or plan starts to pay 100% for covered essential health benefits. This limit must include deductibles, coinsurance, copayments, or similar charges and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This limit does not have to count premiums, balance billing amounts for non-network providers and other out-of-network cost-sharing, or spending for non-essential health benefits.

The maximum out-of-pocket cost limit for any individual Marketplace plan for 2014 can be no more than $6,350 for an individual plan and $12,700 for a family plan.

(Source: www.healthcare.gov)

Summary of Benefits & Coverage (SBC)
An easy-to-read summary that lets consumers make apples-to-apples comparisons of costs and coverage between health plans. A "Summary of Benefits and Coverage" (SBC) is provided for each qualified health plan when consumers shop for coverage. All individual and group health plans must use the same standard form. Consumers can compare options based on price, benefits, and other features that may be important to them. The SBC also includes details, called coverage examples, which allow consumers to see what the plan would cover in 2 common medical situations: diabetes care and childbirth. When comparing plans on the Marketplace website, a link is provided to each plan’s SBC. They can also be requested from the insurance carrier.

(Source: www.healthcare.gov)

**State-Based Marketplace (SBM)**

A Marketplace that is entirely run by the state.

**Small Business Health Options Plan (SHOP)**

A new health care insurance marketplace that offers small businesses increased purchasing power to obtain a better choice of high-quality coverage at a lower cost. Costs are lowered because small businesses can pool their risk, lowering administrative costs. To enroll, eligible employers must have an office within the service area of the SHOP and offer SHOP coverage to all full-time employees. Starting in 2014, small businesses with generally up to 50 employees will have access to SHOP. In 2016, employers with up to 100 employees will be able to participate in SHOP.

(Source: www.Business.USA.gov)

**State-Partnership Marketplace (SPM)**

A Marketplace under which a State formally assumes responsibility for carrying out certain operational functions (consumer assistance and outreach, plan management, or both), while the federal government is responsible for all remaining Marketplace functions.

[Source: Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers (Final Rule, Interim Final Rule). Federal Register 77:59 (March 27, 2012)]

**Qualified Health Plan (QHP)**

Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by the Health Insurance Marketplace, 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 Marketplace in which it is sold.

(Source: www.healthcare.gov)

**Qualifying Life Event**

A change in an individual’s life that can make them eligible for a Special Enrollment Period to enroll in health coverage. Qualifying life events that create a special enrollment period include:
• Getting married
• Having, adopting, or placement of a child
• Permanently moving to a new area that offers different health plan options
• Losing other health coverage (for example due to a job loss, divorce, loss of eligibility for Medicaid or CHIP, expiration of COBRA coverage, or a health plan being decertified). **Note:** Voluntarily quitting other health coverage or being terminated for not paying your premiums are not considered loss of coverage. Losing coverage that is not minimum essential coverage is also not considered loss of coverage.
• For people already enrolled in Marketplace coverage, having a change in income or household status that affects eligibility for tax credits or cost-sharing reductions.

(Source: [www.healthcare.gov](http://www.healthcare.gov))