HealthCare.gov

Glossary

A

Allowed Charge:

Discounted fees that insurers will recognize and pay for covered services. Insurers negotiate these discounts with providers in their health plan network, and network providers agree to accept the allowed charge as payment in full. Each insurer has its own schedule of allowed charges.

Accountable Care Organization:

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

Read a fact sheet about accountable care organizations.

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 would be responsible for 30% of the costs of all covered benefits. However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual health care needs and the terms of your insurance policy.

Affordable Care Act:

The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is used to refer to the final, amended version of the law.

Affordable Insurance Exchange:

See Exchange

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.

B

Benefits:

The health care items or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents. In Medicaid or CHIP, covered benefits and excluded services are defined in state program rules.

Biosimilar Biological Products:

The generic version of more complicated medications.

C

Care Coordination:

The organization of your treatment across several health care providers. Medical homes and Accountable Care Organizations are two common ways to coordinate care.

Catastrophic Plan:

Currently, some insurers describe these plans as those that only cover certain types of expensive care, like hospitalizations. Other times insurers mean plans that have a high deductible, so that your plan begins to pay only after you've first paid up to a certain amount for covered services.

Children’s Health Insurance Program (CHIP):

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

Chronic Disease Management:

An integrated care approach to managing illness which includes screenings, check-ups, monitoring and coordinating treatment, and patient education. It can improve your quality of life while reducing your health care costs if you have a chronic disease by preventing or minimizing the effects of a disease.

Claim:

A request for payment that you or your health care provider submits to your health insurer when you get items or services you think are covered.

COBRA:

A Federal law that may allow you to temporarily keep health coverage after your employment ends, you lose coverage as a dependent of the covered employee, or another qualifying event. If you elect COBRA coverage, you pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

Co-insurance:

The percentage of allowed charges for covered services that you're required to pay. For example, the health insurance may cover 80% of charges for a covered hospitalization, leaving you responsible for the other 20%. This 20% is known as the coinsurance.

Community Rating:

A rule that prevents health insurers from varying premiums within a geographic area based on age, gender, health status or other factors.

Competitive Bidding:

Open bidding for federal contracts between independent groups that compete for the contract by providing the best bid.

Conversion:

The ability, in some states, to switch your job-based coverage to an individual policy when you lose eligibility for job-based coverage. Family members not covered under a job-based policy may also be able to convert to an individual policy if they lose dependent status (for example, after a divorce).

Copayment:

A flat dollar amount you must pay for a covered program. For example, you may have to pay a copayment for each covered visit to a primary care doctor.

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. Cost sharing in Medicaid and CHIP also includes premiums.

Creditable Coverage:

Health insurance coverage under any of the following: a group health plan; individual health insurance; student health insurance; Medicare; Medicaid; CHAMPUS and TRICARE; the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps; Public Health Plan (any plan established or maintained by a State, the U.S. government, a foreign country); Children’s Health Insurance Program (CHIP) or a state health insurance high risk pool. If you have prior creditable coverage, it will reduce the length of a pre-existing condition exclusion period under new job-based coverage.

D

Deductible:

The amount you must pay for covered care before your health insurance begins to pay. Insurers apply and structure deductibles differently. For example, under one plan, a comprehensive deductible might apply to all services while another plan might have separate deductibles for benefits such as prescription drug coverage.

Dependent Coverage:

Insurance coverage for family members of the policyholder, such as spouses, children, or partners.

Disability:

A limit in a range of major life activities. This includes activities like seeing, hearing, walking and tasks like thinking and working. Because different programs may have different disability standards, please check the program you're interested in for its disability standards.

The list of activities mentioned above isn't exhaustive. A legal definition of disability can be found here: http://www.ada.gov/pubs/ada.htm. For the proposed EEOC ADA Amendments Act regulations, and related resources, see http://edocket.access.gpo.gov/2009/E9-22840.htm.

Donut Hole, Medicare Prescription Drug:

Most plans with Medicare prescription drug coverage (Part D) have a coverage gap (called a "donut hole"). This means that after you and your drug plan have spent a certain amount of money for covered drugs, you have to pay all costs out-of-pocket for your prescriptions up to a yearly limit. Once you have spent up to the yearly limit, your coverage gap ends and your drug plan helps pay for covered drugs again.

E

Early Periodic Screening, Diagnostic & Treatment Services (EPSDT):

A term used to refer to the comprehensive set of benefits covered for children in Medicaid.

Emergency Room Services:

Evaluation and treatment of an illness, injury, or condition that needs immediate medical attention in an emergency room.

Employer Responsibility:

Under the Affordable Care Act starting in 2014, if an employer with at least 50 full-time equivalent employees doesn't provide affordable health insurance and an employee uses a tax credit 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:

A set of health care service categories that must be covered by certain plans, starting in 2014.

The Affordable Care Act defines essential health benefits to “include at least the following general categories and the items and services covered within the 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 Exchanges, and all Medicaid State plans must cover these services by 2014.

Starting with plan years or policy years that began on or after September 23, 2010, health plans can no longer impose a lifetime dollar limit on spending for these services. All plans, except grandfathered individual health insurance policies, must phase out annual dollar spending limits for these services by 2014.

The Department of Health and Human Services is working with a number of partners to develop the essential health benefits package. In the fall of 2011, HHS will launch an effort to collect public comment and hear directly from all Americans who are interested in sharing their thoughts on this important issue. Learn more about this process.

Exchange:

A new transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Affordable Insurance Exchanges will offer you a choice of health plans that meet certain benefits and cost standards. Starting in 2014, Members of Congress will be getting their health care insurance through Exchanges and you will be able buy your insurance through Exchanges too. Learn more about Exchanges.

Exclusions:

Items or services that aren't covered under your contract for insurance and for which an insurance company won't pay. For example, your policy may not cover pregnancy care or any services related to a pre-existing condition.

Exclusive Provider Organization (EPO) Plan:

A managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan’s network (except in an emergency).

F

Family and Medical Leave Act (FMLA):

A Federal law that guarantees up to 12 weeks of job protected leave for certain employees when they need to take time off due to serious illness or disability, to have or adopt a child, or to care for another family member. When on leave under FMLA, you can continue coverage under your job-based plan.

Federal Poverty Level (FPL):

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

Federally Qualified Health Center (FQHC):

Federally funded nonprofit health centers or clinics that serve medically underserved areas and populations. Federally qualified health centers provide primary care services regardless of your ability to pay. Services are provided on a sliding scale fee based on your ability to pay.

Fee for Service:

A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.

Flexible Benefits Plan:

A benefit program that offers employees a choice between various benefits including cash, life insurance, health insurance, vacations, retirement plans, and child care. Although a common core of benefits may be required, you can choose how your remaining benefit dollars are to be allocated for each type of benefit from the total amount promised by the employer. Sometimes you can contribute more for additional coverage. Also known as a Cafeteria plan or IRS 125 Plan.

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 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. Your employer’s plan sets a limit on the amount you can put into an FSA each year.

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.

(Note: Flexible Spending Accounts are sometimes called Flexible Spending Arrangements.)

Visit this page for important information on what expenses qualify for reimbursement under FSAs (and HRAs/HSAs) as of January 1, 2011.

Formulary

A list of drugs your insurance plan covers. A formulary may include how much you pay for each drug. (If the plan uses “tiers,” the formulary may list which drugs are in which tiers.) Formularies may include both generic drugs and brand-name drugs.

Fully Insured Job-based Plan:

A health plan purchased by an employer from an insurance company.

G

Grandfathered:

As used in connection with the Affordable Care Act: Exempt from certain provisions of this law.

Grandfathered Health Plan:

As used in connection with the Affordable Care Act: A group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the Affordable Care Act. Plans or policies may lose their “grandfathered” status if they make certain significant changes that reduce benefits or increase costs to consumers. A health plan must disclose in its plan materials whether it considers itself to be a grandfathered plan and must also advise consumers how to contact the U.S. Department of Labor or the U.S. Department of Health and Human Services with questions. (Note: If you are in a group health plan, the date you joined may not reflect the date the plan was created. New employees and new family members may be added to grandfathered group plans after March 23, 2010). Learn more about grandfathered health plans.

Guaranteed Issue:

A requirement that health plans must permit you to enroll regardless of health status, age, gender, or other factors that might predict the use of health services. Except in some states, guaranteed issue doesn't limit how much you can be charged if you enroll.

Guaranteed Renewal:

A requirement that your health insurance issuer must offer to renew your policy as long as you continue to pay premiums. Except in some states, guaranteed renewal doesn't limit how much you can be charged if you renew your coverage.

H

Home and Community-Based Services (HCBS):

Services and support provided by most state Medicaid programs in your home or community that gives help with such daily tasks as bathing or dressing. This care is covered when provided by care workers or, if your state permits it, by your family.

Health Care Workforce Development:

The use of incentives and recruiting to encourage people to enter into health care professions such as primary care and to encourage providers to practice in underserved areas.

Health Maintenance Organization (HMO):

A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

Health Savings Account (HSA):

A medical savings account available to taxpayers who are enrolled in a High Deductible Health Plan. The funds contributed to the account aren't subject to federal income tax at the time of deposit.

Funds must be used to pay for qualified medical expenses. Unlike a Flexible Spending Account (FSA), funds roll over year to year if you don't spend them.

Visit this page for important information on what expenses qualify for reimbursement under HSAs/FSAs as of January 1, 2011.

Health Status:

Refers to your medical conditions (both physical and mental health), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

High-Cost Excise Tax:

Under the Affordable Care Act starting in 2018, a tax on insurance companies that provide high-cost plans. This tax encourages streamlining of health plans to make premiums more affordable.

High Deductible Health Plan:

A plan that features higher deductibles than traditional insurance plans. HDHPs can be combined with a health savings account or a health reimbursement arrangement to allow you to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

High Risk Pool Plan (State):

Similar to the new Pre-Existing Condition Insurance Plan under the Affordable Care Act, for years many states have offered plans that provide coverage if you have been locked out of the individual insurance market because of a pre-existing condition. High-risk pool plans may also offer coverage if you're HIPAA eligible or meet other requirements. High-risk pool plans offer health insurance coverage that is subsidized by a state government. Typically, your premium is up to twice as much as you would pay for individual coverage if you were healthy.

HIPAA Eligible Individual:

Your status once you have had 18 months of continuous creditable health coverage. To be HIPAA eligible, at least the last day of your creditable coverage must have been under a group health plan; you also must have used up any COBRA or state continuation coverage; you must not be eligible for Medicare or Medicaid; you must not have other health insurance; and you must apply for individual health insurance within 63 days of losing your prior creditable coverage. When you're buying individual health insurance, HIPAA eligibility gives you greater protections than you would otherwise have under state law.

Home Health Care:

Health care services and supplies a doctor decides you may get in your home under a plan of care established by your doctor.

Hospital Readmissions:

A situation where you were discharged from the hospital and wind up going back in for the same or related care within 30, 60 or 90 days. The number of hospital readmissions is often used in part to measure the quality of hospital care, since it can mean that your follow-up care wasn't properly organized, or that you weren't fully treated before discharge.

I

Individual Health Insurance Policy:

Policies for people that aren't connected to job-based coverage. Individual health insurance policies are regulated under state law.

Individual Responsibility:

Under the Affordable Care Act, starting in 2014, you must be enrolled in a health insurance plan that meets basic minimum standards. If you aren't, you may be required to pay an assessment. You won't have to pay an assessment if you have very low income and coverage is unaffordable to you, or for other reasons including your religious beliefs. You can also apply for a waiver asking not to pay an assessment if you don't qualify automatically.

Insurance Co-Op:

A non-profit entity in which the same people who own the company are insured by the company. Cooperatives can be formed at a national, state or local level, and can include doctors, hospitals and businesses as member-owners.

J

Job-based Health Plan:

Coverage that is offered to an employee (and often his or her family) by an employer.

L

Lifetime Limit:

A cap on the total lifetime benefits you may get from your insurance company. 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. After a lifetime limit is reached, the insurance plan will no longer pay for covered services.

Long-Term Care:

Services that include medical and non-medical care provided to people who are unable to perform basic activities of daily living such as dressing or bathing. Long-term supports and services can be provided at home, in the community, in assisted living or in nursing homes. Individuals may need long-term supports and services at any age. Medicare and most health insurance plans don’t pay for long-term care.

M

Medicaid:

A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and in some states, other adults. The Federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their program, so Medicaid varies state by state and may have a different name in your state.

Medical Loss Ratio (MLR):

A basic financial measurement used in the Affordable Care Act to encourage health plans to provide value to enrollees. If an insurer uses 80 cents out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care, the company has a medical loss ratio of 80%. A medical loss ratio of 80% indicates that the insurer is using the remaining 20 cents of each premium dollar to pay overhead expenses, such as marketing, profits, salaries, administrative costs, and agent commissions. The Affordable Care Act sets minimum medical loss ratios for different markets, as do some state laws.

Medically Necessary:

Services or supplies that are needed for the diagnosis or treatment of your health condition and meet accepted standards of medical practice.

Medical Underwriting:

A process used by insurance companies to try to figure out your health status when you're applying for health insurance coverage to determine whether to offer you coverage, at what price, and with what exclusions or limits.

Medicare:

A Federal health insurance program for people who are age 65 or older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Medicare Advantage (Medicare Part C):

A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare Hospital Insurance Tax:

A tax under the Federal Insurance Contributions Act (FICA) that is a United States payroll tax imposed by the Federal government on both employees and employers to fund Medicare.

Medicare Part D:

A program that helps pay for prescription drugs for people with Medicare who join a plan that includes Medicare prescription drug coverage. There are two ways to get Medicare prescription drug coverage: through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that includes drug coverage. These plans are offered by insurance companies and other private companies approved by Medicare.

Medicare Prescription Drug Donut Hole:

Most plans with Medicare prescription drug coverage (Part D) have a coverage gap (called a "donut hole"). This means that after you and your drug plan have spent a certain amount of money for covered drugs, you have to pay all costs out-of-pocket for your prescriptions up to a yearly limit. Once you have spent up to the yearly limit, your coverage gap ends and your drug plan helps pay for covered drugs again.

Minimum Essential Coverage:

The type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

N

Nondiscrimination:

A requirement that job-based coverage not discriminate based on health status. Coverage under job-based plans cannot be denied or restricted. You also can't be charged more because of your health status. Job-based plans can restrict coverage based on other factors such as part-time employment that aren't related to health status.

New Plan:

As used in connection with the Affordable Care Act: A health plan that is not a grandfathered health plan and therefore subject to all of the reforms in the Affordable Care Act.

In the **individual health insurance** market, a plan that your family is purchasing for the first time will generally be a new plan.

In the **group health insurance market**, a plan that your employer is offering for the first time will generally be a new plan. Please note that new employees and new family members may be added to existing grandfathered group plans – so a plan that is "new to you" and your family may still be a grandfathered plan.

In both the individual and group markets, a plan that loses its grandfathered status will be considered a new plan. A plan loses its grandfathered status when it makes significant changes to the plan, such as reducing benefits or increasing cost-sharing for enrollees.

A health plan must disclose in its plan materials whether it considers itself to be a grandfathered plan and must also advise consumers how to contact the U.S. Department of Labor or the U.S. Department of Health and Human Services with questions.

O

Out-of-Pocket Limit (OOP):

The maximum amount you will have to pay for covered services in a year. Generally, this includes the deductible, coinsurance, and copayments. This definition may vary from plan to plan. For example, in some plans the out-of-pocket limit doesn't include cost sharing for all services, such as prescription drugs. Plans may have different out-of-pocket limits for different services. In Medicaid and CHIP, the limit includes premiums.

Open Enrollment Period:

The period of time set up to allow you to choose from available plans, usually once a year.

Out-of-Pocket Costs:

Your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.

P

Patient-Centered Outcomes Research:

Research that compares different medical treatments and interventions to provide evidence on which strategies are most effective in different populations and situations. The goal is to empower you and your doctor with additional information to make sound health care decisions.

Patient Protection and Affordable Care Act:

See Affordable Care Act

Payment Bundling:

A payment structure in which different health care providers who are treating you for the same or related conditions are paid an overall sum for taking care of your condition rather than being paid for each individual treatment, test, or procedure. In doing so, providers are rewarded for coordinating care, preventing complications and errors, and reducing unnecessary or duplicative tests and treatments.

Plan Year:

A 12-month period of benefits coverage under a group health plan. This 12-month period may not be the same as the calendar year. To find out when your plan year begins, you can check your plan documents or ask your employer. (Note: For individual health insurance policies this 12-month period is called a “policy year”).

Point-of-Service Plan (POS) Plan:

A type of plan in which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan’s network. POS plans also require you to get a referral from your primary care doctor in order to see a specialist.

Policy Year:

A 12-month period of benefits coverage under an individual health insurance plan. This 12-month period may not be the same as the calendar year. To find out when your policy year begins, you can check your policy documents or contact your insurer. (Note: In group health plans, this 12-month period is called a “plan year”).

Pre-Existing Condition (Job-based Coverage):

Any condition (either physical or mental) including a disability for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on your enrollment date in a health insurance plan. Genetic information, without a diagnosis of a disease or a condition, cannot be treated as a pre-existing condition. Pregnancy cannot be considered a pre-existing condition and newborns, newly adopted children and children placed for adoption who are enrolled within 30 days cannot be subject to pre-existing condition exclusions.

Pre-Existing Condition (Individual Policy):

A condition, disability or illness (either physical or mental) that you have before you're enrolled in a health plan. Genetic information, without a diagnosis of a disease or a condition, cannot be treated as a pre-existing condition. This term is defined under state law and varies significantly by state.

Pre-Existing Condition Exclusion Period (Job-based Coverage):

The time period during which a health plan won't pay for care relating to a pre-existing condition. Under a job-based plan, this cannot exceed 12 months for a regular enrollee or 18 months for a late-enrollee.

Pre-Existing Condition Exclusion Period (Individual Policy):

The time period during which an individual policy won't pay for care relating to a pre-existing condition. Under an individual policy, conditions may be excluded permanently (known as an "exclusionary rider"). Rules on pre-existing condition exclusion periods in individual policies vary widely by state.

Pre-existing Condition Insurance Plan (PCIP):

A new program that will provide a health coverage option for you if you have been uninsured for at least six months, you have a pre-existing condition, and you have been denied coverage (or offered insurance without coverage of the pre-existing condition) by a private insurance company. This program will provide coverage until 2014 when you will have access to affordable health insurance choices through an Exchange, and you can no longer be discriminated against based on a pre-existing condition.

Preferred Provider Organization (PPO):

A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Premium:

A monthly payment you make to your insurer to get and keep insurance coverage. Premiums can be paid by employers, unions, employees or individuals or shared among different payers.

Prevention:

Activities to prevent illness such as routine check-ups, immunizations, patient counseling, and screenings.

Preventive Services:

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

Pricing Information:

HealthCare.gov's Insurance Finder tool provides price estimates and detailed benefit information for private health insurance plans. To find this data, visit our Insurance Finder tool and input the requested information. Use this tutorial to learn how to use the pricing and benefit features.

Primary Care:

Health services that cover a range of prevention, wellness, and treatment for common illnesses. Primary care providers include doctors, nurses, nurse practitioners, and physician assistants. They often maintain long-term relationships with you and advise and treat you on a range of health related issues. They may also coordinate your care with specialists.

Public Health:

A field that seeks to improve lives and the health of communities through the prevention and treatment of disease and the promotion of healthy behaviors such as healthy eating and exercise.

Q

Qualified Health Plan:

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

R

Rate Review:

A process that allows state insurance departments to review rate increases before insurance companies can apply them to you.

Reinsurance:

A reimbursement system that protects insurers from very high claims. It usually involves a third party paying part of an insurance company's claims once they pass a certain amount. Reinsurance is a way to stabilize an insurance market and make coverage more available and affordable.

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 Affordable Care Act, rescission is illegal except in cases of fraud or intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.

Rider (exclusionary rider):

A rider is an amendment to an insurance policy. Some riders will add coverage (for example, if you buy a maternity rider to add coverage for pregnancy to your policy.) In most states today, an exclusionary rider is an amendment, permitted in individual health insurance policies that permanently excludes coverage for a health condition, body part, or body system. Starting in September 2010, under the Affordable Care Act, exclusionary riders cannot be applied to coverage for children. Starting in 2014, no exclusionary riders will be permitted in any health insurance.

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.

S

Self-Insured Plan:

Type of plan usually present in larger companies where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees' and dependents' medical claims. These employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third party administrator, or they can be self-administered.

Skilled Nursing Facility Care:

Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period:

A time outside of the open enrollment period during which you and your family have a right to sign up for job-based health coverage. Job-based plans must provide a special enrollment period of 30 days following certain life events that involve a change in family status (for example, marriage or birth of a child) or loss of other job-based health coverage.

Special Health Care Need:

The health care and related needs of children who have chronic physical, developmental, behavioral or emotional conditions. Such needs are of a type or amount beyond that required by children generally.

State Continuation Coverage:

A state-based requirement similar to COBRA that applies to group health insurance policies of employers with fewer than 20 employees. In some states, state continuation coverage rules also apply to larger group insurance policies and add to COBRA protections. For example, in some states, if you're leaving a job-based plan, you must be allowed to continue your coverage until you reach the age of Medicare eligibility.

U

Uncompensated Care:

Health care or services provided by hospitals or health care providers that don't get reimbursed. Often uncompensated care arises when people don't have insurance and cannot afford to pay the cost of care.

V

Value-Based Purchasing (VBP):

Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.

W

Waiting Period (Job-based coverage):

The time that must pass before coverage can become effective for an employee or dependent, who is otherwise eligible for coverage under a job-based health plan.

Well-baby and Well-child Visits:

Routine doctor visits for comprehensive preventive health services that occur when a baby is young and annual visits until a child reaches age 21. Services include physical exam and measurements, vision and hearing screening, and oral health risk assessments.

Wellness Programs:

A program intended to improve and promote health and fitness that's usually offered through the work place, although insurance plans can offer them directly to their enrollees. The program allows your employer or plan to offer you premium discounts, cash rewards, gym memberships, and other incentives to participate. Some examples of wellness programs include programs to help you stop smoking, diabetes management programs, weight loss programs, and preventative health screenings.

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