Affordable Care Act Glossary of Terms

ACA: The Affordable Care Act. See also the Patient Protection and Affordable Care Act ("PPACA").

Affordable Coverage: Coverage is affordable if an employee's contribution toward the employee-only premium of the employer's cheapest plan are less than 9.5% of his/her household income. However, the government has provided three safe-harbor methods that employers may use in lieu of household income (which is likely unknown to the employer). The Safe Harbors are: 1) An employee's W-2 wages – Box 1; 2) An employee's monthly wages (hourly rate x 130 hours per month) (CA-Min = $98.80), or 3) The Federal Poverty Level for a single individual ($91.01). Affordability determination is not required for spouse, dependent, or family coverage.

CDC: The Centers for Disease Control and Prevention.

Community Rating: Beginning January 1, 2014, the ACA mandates the use of "modified community rating" to determine the pricing of individual and small employer group health care insurance premiums. Previously, health insurance underwriting in the individual and small group markets relied heavily upon health status and gender. Going forward, health insurers will only be able to consider age, tobacco use, geographic area, and family unit size in setting premiums for individuals and small groups.

Dependents: Dependents are children (whether step-children, natural or adopted) up to the age of 26 and must be offered coverage for the Employer to avoid penalties. Spouses are not included in the definition of Dependent.

DOL: United States Department of Labor.

EBSA: Employee Benefits Security Administration. A division of the DOL responsible for compliance assistance regarding benefit plans.

Employer Mandate: Employers with 50 or more Full Time Equivalents ("FTEs") must offer "affordable" and "minimum value" coverage to at least 95% of their full-time employees (part-time employees do not need to be offered coverage but must be counted as an FTE for purposes of determining whether the employer has more than 50 FTEs). The penalty for not offering coverage to at least 95% of all full-time employees is: $2,000 per full-time employee minus the first 30. The penalty for offering inadequate coverage (i.e., not affordable or does not meet minimum value) is: $3,000 per full-time employee receiving a subsidy through the exchange. There is no penalty for Employers with fewer than 50 FTEs. "Full-time" for purposes of the ACA is working, on average, 30 or more hours per week.

ERRP: The Early Retiree Reinsurance Program. A temporary program created under health care reform to provide coverage to early retirees.

Essential Health Benefits ("EHB"): Individual and Small Group markets must offer a comprehensive package which provides coverage in the following areas:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management, and
10. Pediatric services, including oral and vision care

Exchange or Marketplace: Starting October 1, 2013 for an effective date of January 1, 2014, individuals will be able to purchase individual insurance through a government run Exchange or Marketplace. These Marketplaces can be either state or federally sponsored and in some cases, individuals will be able to receive a subsidy to help pay for the coverage.

Fees and Taxes: Health Insurance Industry Fee. Estimated to be 2%–2.5% of premium (Excludes [SI]). Reinsurance Assessment – $63 PMPY (Per Member Per Year) in 2014, changes in future years (Medical). Patient Comparative Effectiveness Research – $1 PMPY, increases in future years. The Reinsurance Assessment and the Patient Comparative Effectiveness Research fee are levied based on all members of the plan, not just on employees.

FPL: Federal Poverty Level. A measure of income level issued annually by HHS and used to determine eligibility for certain programs and benefits.

FLSA: The Federal Fair Labor Standards Act. Amended by PPACA to incorporate health care reform-specific provisions.

Full Time Employee: Employees who work 30 or more hours per week are deemed Full Time Employees. Safe harbor methods may be used to determine the full-time status of current and new employees who work variable hours. These methods are complex.

HCERA: The Health Care and Education Reconciliation Act of 2010. Enacted on March 30, 2010 to amend and supplement PPACA.

HCR: Health Care Reform.

HHS: US Department of Health and Human Services.

Individual Penalty: For not having health insurance in 2014 that meets the standard of essential health benefits, will be assessed a penalty on tax return (Single/Family).

For 2014: The greater of $95/$285 or 1.0% of income above tax filing threshold
For 2015: The greater of $325/$975 or 2.0% of income above tax filing threshold
For 2016: The greater of $695/$2085 or 2.5% of income above tax filing threshold

IRO: An Independent Review Organization. An organization that performs independent external reviews of adverse benefit determinations.

IRS: Internal Revenue Service.

Minimum Value: A Plan must pay 60% of the costs of covered health services. The 60% is determined based on actuarial calculations.

MLR: Medical Loss Ratio. Refers to the claims costs and amounts expended on health care quality improvement as a percent of total premiums. This ratio excludes taxes, fees, risk adjustments, risk corridors and reinsurance.

NAIC: The National Association of Insurance Commissioners.

OCIIO: The Office of Consumer Information and Insurance Oversight. A division of HHS responsible for implementing many of the health care reform provisions.

PCIP: The Pre-Existing Condition Insurance Plan. A temporary high-risk insurance pool to provide coverage to eligible individuals until 2014.

Patient Protection and Affordable Care Act: Also known as the PPACA or the ACA, it was enacted on March 23, 2010 and is being implemented over a number of years. This is the primay health care reform law and along with other attached bills, provisions and interpretations, governs much of the health insurance and health care landscape.

Pre-Existing Conditions: Pre-Existing conditions can no longer be considered, excluded or used in opposition to an individual for individual or group insurance coverage. All coverage is "Guaranteed Issue" and guaranteed renewable.

QHP: Qualified Health Plan. A certified health plan that provides an essential health benefits package. Offered by a licensed health insurer.

SHOP Exchange: The Small Business Health Options Program. A program that each health insurance exchange must create to assist eligible small employers when enrolling their employees in qualified health plans offered in the small-group market.

Summary of Benefits and Coverage ("SBC"): All plans must provide a standardized SBC for open enrollment periods after 9-23-2012.

Waiting Periods: For Employers that have a waiting (Eligibility) period for medical coverage for new employees, a waiting period can be no longer than 90 days. For California residents, it is a maximum of 60 days, regardless of where the plan or employer is located.

Wellness rewards: ACA increased wellness rewards from 20% to 30%. A non-smoking reward can be as much as 50% of premium.

W-2 Reporting: Must report total cost of group medical coverage if more than 250 W-2's are sent out.

NOTE: This document provides a highlight of the plan provisions that might be offered by your employer and in no way serves as the Summary Plan Description or plan document for the plans. If any discrepancies exist between this flier and the plan documents, the plan documents shall govern. We reserve the right to modify any of these descriptions at anytime.