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community

Terms to Know: Health Insurance and the Affordable Care Act

The Affordable Care Act (ACA) expands access to health insurance by removing barriers to enrollment and making insurance more affordable. Under the ACA, which was passed by Congress and signed by President Obama in March 2010, many individuals will have health insurance for the first time.

The following list defines key terms related to the ACA and frequently-used terms regarding health insurance. These terms may not be familiar to many individuals enrolling in health insurance, especially for those accessing health insurance for the first time because of the ACA. In addition to the definitions and examples provided here, please click on the hyperlinks to read more detail about each term.

WHAT IS A HEALTH INSURANCE MARKETPLACE?

A health insurance marketplace is a price-comparison website designed to make buying health coverage easier and more affordable for individuals and small businesses. A marketplace is also called an "Exchange" or may have a state-specific name (like Minnesota's MNSure and Kentucky's Kynect).

- **State-Based Marketplace (SBM):** marketplace created and operated by a state. An updated list of SBM states can be found [here](#).
- **Federally-Facilitated Marketplace (FFM):** marketplace operated by the federal government in states that have chosen not to build their own marketplaces. An updated list of FFM states can be found [here](#).

WHAT IS AN ENROLLMENT PERIOD?

- **Open enrollment period:** period of time during which individuals can enroll in a plan, renew coverage or change to a different plan in the marketplace. [Click here for information regarding the open enrollment period.](#)
- **Special Enrollment Period (SEP):** time frame outside of an open enrollment period when individuals can sign up for or change health coverage in the marketplace if they experience certain qualifying life events. Examples of qualifying life events include moving to a new state, changes in family size (for example, if getting married or having a baby), and losing minimum essential coverage. [Click here to learn about getting health coverage outside of open enrollment.](#)

WHAT ARE THE DIFFERENT TYPES OF INSURANCE AVAILABLE TO CONSUMERS?

- **Qualified Health Plan (QHP):** health insurance plan certified by the Department of Health and Human Services or a state to be sold in a state or federal marketplace. QHPs must meet the requirements specified in the ACA to ensure plans provide a minimum level of coverage.

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- **Employer-Sponsored Insurance (ESI):** coverage provided to employees through their jobs; also referred to as job-based coverage.
- **COBRA:** an optional extension of ESI for consumers who lose health insurance coverage when they leave a job. More about COBRA can be found [here](#).
- **Medicaid:** a joint federal and state health program for low-income individuals and families, primarily children, pregnant women, people with disabilities and seniors. Income eligibility levels vary by state. Find out more about Medicaid [here](#). While the ACA intended to expand Medicaid to low-income childless adults in every state, a Supreme Court ruling made expansion of the program a state option. An updated list of state Medicaid expansion decisions can be found [here](#).
- **Children's Health Insurance Program (CHIP):** a joint federal and state health program for uninsured low-income children (and sometimes others such as pregnant women) whose families earn too much to qualify for Medicaid. Each state sets its own income-eligibility level for CHIP. Find out more about CHIP [here](#).
- **Catastrophic coverage:** high-deductible health insurance plans that protect consumers against large medical bills in case of emergency. Catastrophic plans generally have lower monthly premiums, higher deductibles, and limited benefits until the deductible is met.
- **Medicare:** a nationwide health insurance program for most people age 65 and older. It is also available to some individuals under 65 who have certain disabilities and to people with end-stage renal disease.
- **Co-pay (Co-payment):** a set amount a consumer pays when she uses health care services, such as going to the doctor, emergency room, or lab, or filling a prescription. A co-payment is often due at the time of service. *Sally has a \$10 co-pay to visit the doctor, a \$75 co-pay to visit a specialist, a \$150 co-pay if she goes to the emergency room (and is not admitted), and a \$5 co-pay for generic prescriptions.*
- **Co-insurance:** the percentage of a health care provider's charge consumers are required to pay after they meet the deductible. For example, consumers may have to pay 20% of doctor bills and hospital charges after meeting their deductible until they meet their out-of-pocket maximum. With a 20% co-insurance, a consumer who has a \$50 doctor bill will be responsible for paying \$10. *Sally has a coinsurance of 30% for hospital stays and specialty prescriptions. If Sally has a hospital bill of \$2,000, she is responsible for paying 30% of the bill or \$600 (assuming she has met her deductible).*
- **Out-of-pocket maximum:** the maximum amount a consumer must pay out-of-pocket for services each policy period (usually one calendar year). These payments include deductibles, co-insurance and copayments. Premium payments are not typically included as part of the out-of-pocket maximum. After a consumer meets her out-of-pocket maximum, the plan will pay 100% of costs for covered services for the remainder of the policy period. *Sally has an out-of-pocket maximum of \$6,350 for the year. After she spends \$6,350, which includes her deductible, co-payments and co-insurance costs, Sally's health plan will pay 100% for covered services. Sally's monthly premium of \$196 does not count toward her out-of-pocket maximum and she must continue to pay the \$196 each month after reaching her out-of-pocket maximum to keep her insurance.*

HOW DO CONSUMERS PAY FOR HEALTH INSURANCE?

Consumers pay for health insurance coverage and individual health care or medical services in different ways. For the terms below related to paying for health insurance, an example is provided about a consumer, Sally, who has purchased a Silver plan through the marketplace.

- **Premium:** the amount of money that must be paid, usually on a monthly basis, to keep health insurance coverage. *Sally's monthly premium is \$196. She must pay this amount each month to keep her insurance.*
- **Deductible:** the amount of money a consumer must spend on health care services in each policy period (usually one calendar year) before her insurance plan begins to pay for most covered services. Deductibles can range from less than \$1,000 to \$10,000 or more depending on the plan. The deductible may not apply to all health care services, but often includes laboratory tests, doctor visit bills, and hospital bills until the deductible is met. The monthly premium paid by consumers does not count toward the deductible. *Sally has a deductible of \$3,750. This means that Sally must spend \$3,750 on health care or medical services before her health insurance begins to pay for most services.*

WHAT ARE THE WAYS CONSUMERS CAN GET HELP PAYING FOR HEALTH INSURANCE?

- **Advanced Premium Tax Credits (APTCs):** subsidies provided by the federal government as tax credits to offset a portion of health insurance premiums for qualifying individuals. APTCs make health insurance more affordable for consumers because the federal government applies the tax credit by paying a portion of the monthly health insurance premium directly to the insurer. Eligibility for APTCs is based on consumers' family size and income. In general, a family must have income between 100% and 400% of the Federal Poverty Level (FPL) to qualify for APTCs. Many legal permanent residents under 100% FPL may also qualify for APTCs.

Consumers can choose how much of their tax credit they want to apply to their insurance premium each month. When eligible consumers choose to apply their tax credit as a lump sum at the end of the year, and not in advance on a monthly basis, it is considered a premium tax credit.

- **Cost-Sharing Reductions (CSRs):** subsidies provided by the federal government that lower the amount consumers pay to access health care services. CSRs reduce the amount eligible consumers have to pay for out-of-pocket expenses, such as deductibles, co-pays and co-insurance. CSRs also cap annual out-of-pocket expenses that consumers are responsible for paying. In general, consumers with incomes between 100% and 250% FPL qualify for CSRs. Members of federally recognized tribes with incomes up to 300% FPL and many legal permanent residents under 100% FPL also qualify for CSRs.

WHO CAN HELP CONSUMERS ENROLL IN MARKETPLACE COVERAGE?

Enrollment assisters provide important support for consumers to help them navigate the health insurance marketplace efficiently and effectively. Assisters go by different titles including Navigators, in-person assistance personnel, and Certified Application Counselors (CACs). Assisters help consumers prepare electronic and paper applications to establish eligibility and enroll in coverage. [Click here for more information regarding assistance roles to help consumers apply and enroll in health coverage through the marketplace.](#)

- **Navigators:** assisters who fulfill training requirements and help consumers complete electronic, phone and paper applications for coverage in addition to conducting outreach. FFM Navigators are funded through a federal grant program and certified by the Centers for Medicare & Medicaid Services. Navigators in SBMs may be initially funded through marketplace establishment grants (section 1311 funds) and ultimately funded by the SBMs themselves.
- **In-person assistance personnel:** assisters who perform the same functions as Navigators, but work only in state-based or partnership marketplaces. They are funded through grants or contracts administered at the state level, and must complete comprehensive training. These assisters often refer to themselves as Navigators.
- **Certified Application Counselors (CACs):** assisters who perform many of the same functions as Navigators and in-person assistance personnel, but who complete fewer training hours. CACs in FFM and partnership marketplaces are certified by organizations designated by the FFM. Many health care entities, such as community health centers and hospitals, may have staff or volunteers who serve as CACs. An SBM may choose to certify application counselors directly rather than designate organizations to do so.
- **Agents and Brokers:** licensed health insurance agents and brokers help enroll individuals, small employers, and employees in health coverage. They are required to participate in federal and state training and certification programs and are generally compensated by issuers.

MORE INFORMATION AND RESOURCES:

[In the Loop Fact Sheets](#)

[From Coverage to Care A Roadmap to Better Care and Healthier You](#), Centers for Medicare & Medicaid Services

[Video: From Coverage to Care “Words to Know” - Chapter 3](#), Centers for Medicare & Medicaid Services

[Glossary](#), HealthCare.gov