Facts for Employers

A Guide to Acronyms and Terminology in Health Care Reform

Federal healthcare reform has brought a large number of terms and acronyms – some new and some old – into regular use in the news and in discussions about health care and health insurance. Here are some of the more commonly used ones and an explanation of what they mean:

ACA or PPACA – Patient Protection and Affordable Care Act. The 2010 federal law that has changed many of the rules about health care and health insurance across the country.

ACO – Accountable Care Organization. A group of health care providers that has assumed responsibility for the care of a specific group of patients and that is eligible to receive financial incentives for improving the quality and efficiency of that care.

APTC – Advance Premium Tax Credit. Tax credits that will be available to individuals and families who purchase their health coverage on an Exchange and whose income is between 200 and 400 percent of the Federal Poverty Level. These are designed to make it more affordable for people who do not have employer-provided health coverage to purchase health coverage.

AV – Actuarial Value. The proportion of medical expenses an insurance plan is expected to cover.

CCIIO – Center for Consumer Information and Insurance Oversight. An agency within HHS that is responsible for overseeing the implementation of the provisions of the ACA related to private health insurance.

CHIP – Children's Health Insurance Program. A federal program that provides health coverage to children in families with incomes too high to qualify for Medicaid but who can't afford private coverage.

CMS – Center for Medicare and Medicaid Services. The agency within HHS that administers and oversees both the Medicare and Medicaid programs.

CO-OP – Cooperative Health Plan. A qualified non-profit health plan authorized by the ACA to sell QHPs primarily through an Exchange.

CSR – Cost Sharing Reduction. Subsidies available to individuals and families who purchase their health coverage on an Exchange and whose income is between 200 and 300 percent of the Federal Poverty Level. These are designed to help eligible individuals pay copays, deductibles, and coinsurance.

EHB – Essential Health Benefits. The categories of benefits that all health plans in the individual and small group markets must provide. Under the ACA, those categories are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; 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. All benefits that were mandated by Massachusetts prior to December 31, 2011 are also included in EHB. The ACA requires that EHBs are not subject to annual dollar limits.

EXCHANGE – An online marketplace where individuals and small employers can purchase health coverage. Most government subsidies are only available through an Exchange. The Health Connector Authority will operate the Massachusetts Exchange.

FPL – Federal Poverty Level. The set minimum amount of gross income a family needs for food, clothing, transportation, shelter and other necessities. Under the ACA, individuals and families with modified adjusted gross income up to 400% of FPL can receive subsidies to pay for health coverage. The amount of the subsidy decreases as income increases.

FSA – Flexible Spending Account. A special account that allows an employee to set aside pre-tax wages to be used for various expenses, including copays and deductibles. Funds in an FSA must be used during the benefit year or the employee loses the funds.

FTE – Full Time Equivalent. The number of working hours that represent one full-time employee during a time period. For purposes of the ACA, FTE is 30 hours per week.

HHS – Department of Health and Human Services. The federal cabinet-level department that administers federal health, welfare, and human services programs and activities.

HIT – Health Insurance Tax. An annual fee to be paid by the issuers of insured health plans beginning in 2014. In 2014, the total fee nationwide will be $8 billion; the fee will increase in later years. The fee does not apply to self-insured health plans.

HRA – Health Reimbursement Account or Health Reimbursement Arrangement. An employer-funded, tax advantaged health benefit plan that reimburses employees for out of pocket medical expenses not covered by the employer's standard health coverage. Any unused funds remain with the employer.

HSA – Health Savings Account. A special account that allows an employee who is enrolled in a high deductible health plan to set aside pre-tax wages to be used for qualifying medical expenses, including copays, deductibles, and coinsurance. Funds in an HSA belong to the employee and can roll over from year to year.

MAGI – Modified Adjusted Gross Income. Generally, your adjusted gross income plus any tax-exempt interest income. Under the ACA, MAGI will be used to determine eligibility for Medicaid or federal subsidies such as APTCs and CSRs.

MEC – Minimum Essential Coverage. The level of coverage that a large group health plan must provide. For a plan to provide MEC, it must have an AV of 60. Failure to provide MEC could cause a large employer to be subject to tax penalties.

MLR – Medical Loss Ratio. The proportion of a health plan's premium revenues that is spent on medical care and quality of care improvement expenses. In 2014, each health plan's MLR must be at least 88%. If a health plan does not meet this standard, it will have to pay rebates to its members.

OOPM – Out-of-Pocket Maximum. The yearly maximum amount your health coverage requires you to contribute toward the cost of your health care. Under the ACA, all types of cost-sharing (copays, deductibles, and coinsurance) for EHBs must be included when calculating your out-of-pocket total.

PCORI – Patient-Centered Outcomes Research Institute. A special federal authority created by the ACA to advance the quality and relevance of research initiatives that can be used to help patients, providers, purchasers, and policymakers make informed health care decisions.

QHP –Qualified Health Plan. A health plan offered in the individual and small group market that provides EHB and an AV of either 60 % (bronze plan), 70% (silver plan), 80% (gold plan) or 90% (platinum plan). QHPs may be sold both inside and outside of an Exchange.

SHOP – Small Business Health Option Program. The Exchange where small employers can purchase health insurance for their employees beginning in 2014. The Health Connector Authority will operate the SHOP in Massachusetts.

3Rs – Risk Adjustment, Risk Corridors, and Transitional Reinsurance. Three programs established by the ACA to help spread the financial risks to health plans caused by providing health coverage to a large number of previously uncovered individuals, many of whom will incur high health care costs.

TRF – Transitional Reinsurance Fee. A temporary fee established by the ACA that will fund a program to protect QHP issuers against unpredictably high medical claims. The fee will be imposed on health plan issuers and self-insured health plans from 2014 through 2016.