

Health Care Reform

Glossary

June 2013

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The following are definitions of common terms related to health care reform.

Affordable Care Act

The law, also known as health care reform, went into effect in March 2010. The name “Affordable Care Act” is used to refer to the final, amended version of the law. The goal of the Affordable Care Act is to make health insurance available to everyone, regardless of medical history or ability to pay.

Affordable Coverage

Affordable coverage is where your costs are less than 9.5% of your income. If your employer offers coverage that is considered affordable and meets minimum standard coverage requirements and you choose to buy insurance through an exchange, you may not qualify for financial help.

Children’s Health Insurance Program (CHIP)

CHIP is an insurance program that provides health insurance to low-income children. In some states, it also provides health insurance for pregnant women in families that don’t qualify for Medicaid and can’t afford private health insurance.

If you don’t qualify for financial assistance through the marketplace but can’t afford health insurance, you may still be eligible for Medicaid or CHIP.

Deductible

The deductible is what you pay out of pocket before your insurance starts paying its share of your costs. How the deductible works depends on the plan level you choose.

- **The Bronze and Silver plan levels have a “true family deductible.”** This means that the entire family deductible must be met before your insurance will pay benefits for any covered family members. There is no “individual deductible” in these plans when you have family coverage.
- **The Gold plan level has a traditional deductible.** Once a covered family member meets the *individual* deductible, your insurance will begin paying benefits for that family member. Charges for all covered family members will continue to count toward the family deductible. Once the family deductible is met, your insurance will pay benefits for all covered family members.

Essential Health Benefits

A package of state-mandated benefits that insurance companies are required to offer as part of coverage purchased through an exchange. Essential health benefits must include items and services within at least the following 10 categories:

- Ambulatory, or “outpatient,” care
- 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, such as physical therapy
- Laboratory services, such as blood tests and X-rays
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Health Savings Account (HSA)

An HSA is a special account that works alongside a Bronze or Silver plan in the exchange. It can help you build **tax-free** savings for qualified out-of-pocket health care expenses. You can use your HSA to pay current health care expenses or save for future health care expenses. There are no “use it or lose it” rules—the money is yours.

Individual Mandate

The individual mandate is the requirement that most Americans obtain health insurance by January 1, 2014. If you don’t have health insurance in 2014, you’ll pay a penalty equal to the greater of \$95 per adult and \$47.50 per child (up to \$285 per family), or 1% of your family income. The penalty will increase significantly in 2015 and 2016:

- **For 2015:** The greater of \$325 per adult and \$162.50 per child (up to \$975 per family), or 2% of your income.
- **For 2016 and later:** The greater of \$695 per adult and \$347.50 per child (up to \$2,085 per family), or 2.5% of your income.

Marketplace (“Exchange”)

An online marketplace, or “exchange,” is a website where health insurance companies come together to give you a place to shop for health insurance. That way you have one place to compare options for private health insurance side by side.

Medicaid

Medicaid is a state-operated federal program that provides health and long-term care coverage to certain categories of low-income Americans.

If you don't qualify for financial assistance through the marketplace but can't afford health insurance, you may still be eligible for Medicaid or CHIP.

Medicare

A federal program that provides health insurance coverage to people who are:

- Age 65 and older
- Younger than age 65 and who have permanent disabilities, end-stage renal disease, or Lou Gehrig's disease

Out-of-Pocket Maximum

The most you and your covered family members would have to pay in a year for medical and prescription drug costs. Generally, it includes the deductible, applicable copayments, and the portion of any eligible expenses that insurance doesn't pay. It doesn't include amounts taken out of your paycheck for health coverage.

Preventive and Wellness Services

Services, including tests and immunizations, that can help you avoid illness and improve your health. Under the Affordable Care Act, preventive care services recommended by the U.S. Preventive Services Task Force must be covered at no cost to you. That means you won't pay anything for these services as long as you get them from a doctor, lab, or other provider who is part of your health plan's network.



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