Need More Information?

Glossary of Health Care Financing Terms

Affordable Care Act (ACA)	The comprehensive health care reform law entitled The Patient Protection and Afforable Care Act was signed into law in 2010. The name "Affordable Care Act"(ACA) is sometimes referred as "Obama Care."
Authorized Representative	Someone who you choose to act on your behalf with the Marketplace, like a family member or other trusted person. Some authorized representatives may have legal authority to act on your behalf.
Benefit	The amount payable by the insurance company to an individual (or a provider) for a health care service that is part of the insured's coverage.
Catastrophic Health Plan	To qualify for a catastrophic plan, you must be under 30 years old OR get a "hardship exemption" because the Marketplace determined that you're unable to afford health coverage. This type of plan mainly protects you from very high medical costs and generally requires you to pay all of your medical costs up to a certain amount, usually several thousand dollars. Preventative care services are paid for before the deductible has been met. The premium is generally lower than for other plans, but the out-of-pocket costs for deductibles, copayments, and coinsurance are generally higher.
Certification of Prior Coverage	A certificate of prior coverage is issued when a person who was insured under employer sponsored coverage leaves their job. It provides information on the amount of time a person held insurance coverage. This can be important as it can be used as a credit to reduce pre-existing condition limitations when you enroll in a new plan.
Certified Applicant Counselor	An individual (affiliated with a designated organization) who is trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including helping them complete eligibility and enrollment forms. Their services are free to consumers. Also can be called: Certified Benefits Navigator.
Claim	A request to the insurance company by an individual (or his or her provider) to pay for services obtained from a provider.

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.
COBRA	The Consolidated Omnibus Reconciliation Act of 1985 (or COBRA) is 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	When you have co-insurance, instead of paying one set amount for a particular health care expense like you do with a co-pay, you pay a percentage of the total cost for your care, usually after paying a deductible. Co-insurance is common in indemnity and PPO plans.
Co-Pay	Most HMOs and some other plans provide full coverage for certain expenses with the insured paying only small, set co-pay to the provider at the time of service.
Deductible	The amount you must pay before your health insurance plan begins paying your health care expenses. HMO and POS plans may eliminate deductibles when you remain in-network for your care.
Dependents	Spouse and/or unmarried children (whether natural, adopted or step) relative, or other person who are claimed a personal exemption tax deduction. Under the ACA, individuals may be able to claim a premium tax credit to help cover the cost of coverage for themselves and their dependents.
Dependent Coverage	Insurance coverage for family members (tax dependents) of the policyholder, such as spouses, children, or partners.
Essential Health Benefits	A set of health care service categories that must be covered by certain plans, starting in 2014. The ACA ensures health plans offered in the individual and small

Essential Health Benefits *(continued)*	group markets, both inside and outside of the Health Insurance Marketplace, offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following 10 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.
Exclusions And Limitations	Depending on your policy, some services may not be included in your health plan benefits, like cosmetic dentistry or mental health care. And some items are limited, such as the length of time you can stay in the hospital. You are responsible for the cost of services excluded or limited by your plan.
Exclusive Provider Organization (EPO)	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). An EPO is like an HMO, without the PCP gatekeeper. While there are exceptions for emergencies, be cautious about signing up if you travel frequently or have a chronic condition that requires timely treatment by certain specialists. EPOs are suitable for people looking for lower premiums but also the flexibility of being able to self-refer to specialists.
Explanation of Benefits (EOB)	The insurance company's written explanation for aclaim, showing what they paid and what the subscriber must pay.
Federal Poverty Level (FPL)	Federal Poverty Level (FPL) 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.
Group Insurance	Coverage that is offered to an employee (and often his or her family) by an employer. The premiums for group insurance are generally less expensive than for individual insurance. In Florida, both a single, self-employed individual and an employer with employees are eligible to buy group insurance. Proof of self-employment or business existence through income tax records is usually required. Also referred to as: Job-Based Group Plan, Work- Based Health Plan, Employer Health Based Health Plan and Group Health Plan.

Hardship Exemption	Under the Affordable Care Act, most people must pay a fee if they don't have health coverage that qualifies as "minimum essential coverage." One exception is based on showing that a "hardship" prevented them from becoming insured.
Health Insurance Marketplace	A resource where individuals, families, and small businesses can: learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The Marketplace also provides information on programs that help people with low to moderate income and resources pay for coverage. This includes ways to save on the monthly premiums and out-of-pocket costs of coverage available through the Marketplace, and information about other programs, including Medicaid and the Children's Health Insurance Program (CHIP). The Marketplace encourages competition among private health plans, and is accessible through websites, call centers, and in-person assistance. In Florida, the Marketplace is run by the federal government. In some states it is run by the state.
Health Plan Categories	Plans in the Marketplace are primarily separated into 4 health plan categories — Bronze, Silver, Gold, or Platinum — based on the percentage the plan pays of the average overall cost of providing essential health benefits to members. The plan category you choose affects the total amount you'll likely spend for essential health benefits during the year. The percentages the plans will spend, on average, are 60% (Bronze), 70% (Silver), 80% (Gold), and 90% (Platinum). This isn't the same as coinsurance, in which you pay a specific percentage of the cost of a specific service.
Health Maintenance Organization (HMO)	Available to groups and individuals, HMO plans offer payment of benefits with co-pays required. These plans usually do well in providing coverage for preventative care and routine health care needs like those in an uncomplicated pregnancy. Members must use doctors and other providers who are contracted with the HMO or obtain a referral or authorization to see an out-of network provider. The co-pay is sometimes higher for such providers.
Indemnity Plan	Insurance that allows the policyholder to use any doctor or other provider they want or need. Unlike PPO or HMO plans, there is no list of contracted providers or a network to be concerned about. Also referred to as fee-for-service or traditional health insurance.

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 Shared Responsibility Payment	If you don't have health coverage, you may have to pay a fee. The fee is paid on the federal income tax form. People with very low incomes and others may be eligible for waivers, exemptions from payment or hard exemptions. The fee is sometimes called the "penalty," "fine," "individual responsibility payment," or "individual mandate."
In-Network	Providers or health care facilities which are part of a health plan's network of providers with which it has negotiated a discount. Insured individuals usually pay less when using an in-network provider, because those networks provide services at lower cost to the insurance companies with which they have contracts.
Managed Care	A medical delivery system that attempts to manage the quality and cost of medical services that individuals receive. Most managed care systems offer HMOs and PPOs that individuals are encouraged to use for their health care services. Some managed care plans attempt to improve health quality, by emphasizing preventative care and covering wellness activities (like smoking cessation, weight control, etc.)
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.
Medicare	Medicare is a federal health insurance program for people who are age 65 or older, certain end-stage persons with disabilities, or those with kidney disease. Unlike Medicaid, Medicare is run by the federal government alone, so the eligibility rules and benefits are the same in every state.
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.

Modified Adjusted Gross Income (MAGI)	The figure used to determine eligibility for lower costs in the Marketplace and for Medicaid and CHIP. Generally, modified adjusted gross income is your adjusted gross income plus any tax-exempt Social Security, interest, or foreign income you have.
Navigator	An individual or organization that is trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including completing eligibility and enrollment forms. These individuals and organizations are required to be unbiased and their services are free to consumers.
Network	The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.
Non-Preferred Provider	A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.
Open Enrollment	Time period when members of group health insurance plans can enroll or change their benefits program; generally held once a year.
Out-of-Network	This phrase usually refers to physicians, hospitals or other health care providers who are considered non-participants in an insurance plan (usually an HMO or PPO). Depending on an individual's health insurance plan, expenses incurred through out-of-network health professionals may not be covered, or covered only in part by an individual's insurance company.
Out-of-Pocket Limit	The most you pay during a policy period (usually one year) before your health insurance or plan starts to pay 100% for covered essential health benefits. This limit must include deductibles, coinsurance, copayments, or similar charges and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits.
Point of Service (POS)	An insurance 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.

Preferred Provider Organization (PPO)	An insurance plan, usually with a deductible and co-insurance, which offers full benefits when using in-network providers. Benefits are available out-of-network, but at a lower level and/or higher cost. Some PPO plans have Primary Care Provider referral requirements (see referral) and some PPO plans offer benefits with a co-pay and no deductible for certain services.
Pre-Existing Condition	A medical condition that is excluded from coverage by an insurance company because the condition was believed to exist prior to the individual obtaining a policy from the particular insurance company. Beginning in September, 2010, the ACA ensured that insurance companies will no longer be able to deny coverage due to pre-existing conditions to children under age 19. Beginning January, 2014, insurers were no longer allowed to deny adults with pre-existing conditions.
Premiums	Total monthly or annual payment to the insurance company in return for providing coverage.
Premium Tax Credit	The ACA provides a tax credit to help you afford health coverage purchased through the Marketplace. Advance payments of the tax credit can be used right away to lower your monthly premium costs. If you qualify, you may choose how much advance credit payments to apply to your premiums each month, up to a maximum amount. If the amount of advance credit payments you get for the year is less than the tax credit you're due, you'll get the difference as a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return.
Preventive Services	Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.
Primary Care Provider (PCP)	A physician [either a Medical Doctor (M.D) or Doctor of Osteopathic Medicine (O.D.)], nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services. Some plans require the insured obtain a referral from the PCP before seeing a specialist.
Prior Authorization	Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.

Private Health Insurance	Insurance plans marketed by the private health insurance industry. Coverage includes policies obtained through employer-sponsored insurance, with approximately 62% of non-elderly Americans receiving insurance provided as a benefit of employment.
Provider Network	A list of doctors, hospitals, and other providers that an HMO or PPO has a contract with to provide health care services to its members. Many provider networks have contracts with more than one insurance company and some are established and maintained by the insurance company or HMO themselves.
Public Health Insurance	Health insurance coverage that is funded by public (tax) dollars, usually through the state or federal government. Publically funded programs in include Medicare, Medicaid and the Children's Health Insurance Program (CHIP). Also refer to as government-funded insurance.
Qualified Health Plan (QHP)	Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A QHP will have a certification by each Marketplace in which it is sold.
Qualifying Life Event (QLE)	A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events are moving to a new state, certain changes in your income, and changes in your family size (for example, if you marry, divorce, or have a baby).
Referral	A written order from your primary care provider (PCP) for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for the services.
Self Insured Plans	Under the ACA, an insurance plan that is certified by the Coverage offered by a company, typically a large employer, that chooses to pay employees' health care costs directly, instead of purchasing health insurance coverage through a private insurance company. Benefits are usually administered through a health plan.

Special Enrollment Period (SEP)	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.
State Mandated Benefits	A specific benefit that must be covered by private insurers as a matter of state law. Companies that self-insure are exempt from such mandates. See Florida State Mandated Benefits at www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/fl-state-required-benefits.pdf
Student Health Coverage	Many colleges require proof of health insurance for students. Coverage options include insurance through family policies and coverage through school-sponsored student health plans. Generally, student health plans offer lower deductibles, access to your on-campus student health centers and flexible coverage that travels with you anywhere you go.
Subscriber/ Policyholder/ Insured	The subscriber/policyholder/insured is the individual or organization to whom the health care coverage is issued. In group plans the employee is the "certificate holder." • Generally, the subscriber/certificate holder pays the monthly premiums. • The subscriber/policyholder can have insurance through a group plan that covers just that person or their dependent family members. • A subscriber can also purchase a single or family plan directly from an insurance company.
TRICARE	A health care program for active-duty and retired uniformed services members and their families.
Tax Household	The taxpayer(s) and any individuals who are claimed as dependents on one federal income tax return. A tax household may include a spouse and/or dependents.

Resources: *A Consumer's Glossary of Health Insurance Terms*, Glossary from the healthcare.gov, and The Catalyst Center.

Additional Resources

National

HealthCare.gov
www.healthcare.gov
From U.S. Center for Medicaid & Medicaid Services, an interactive website to guide you through coverage options in your state,

healthfinder.gov
www.healthfinder.gov
An encyclopedia of over 1,600 health topics from trusted sources.

From Coverage to Care
https://marketplace.cms.gov/outreach-and-education/downloads/c2c-roadmap.pdf
A Roadmap to Better Care and a Healthier You! A step-by–step guide on what having health insurance means and how to navigate provider visits, from the U.S. Centers for Medicare & Medicaid Services.

Getting Covered
http://gettingcovered.org
From Young Invincibles, this site educates young adults and their families about health care coverage,

Questions are the Answer
www.ahrq.gov/questionsaretheanswer
You can improve your care and the care of your loved ones by taking an active role in your health care.: ask questions, understand your condition(s), and evaluate your options.

Health Insurance Resource Center
www.healthinsurance.org
A wealth of general and state-specific information, including a glossary of health care terms.

Social Security Online
www.ssa.gov/disability
Eligibility information and application for SSDI and SSDI disability benefits.

GovBenefits.gov
www.benefits.gov
Easy-to-use confidential online screening tool allows individuals and families to find out which federal and state government benefits they may be eligible to receive.

HealthPocket
www.healthpocket.com
Allows you to compare health insurance plans.

National Disability Navigator
www.nationaldisabilitynavigator.org/state/fl/
Provides national and state-level information and support to ensure people with disabilities receive accurate information when selecting and enrolling in insurance through the ACA Marketplace.

Kaiser Family Foundation
www.kff.org
Research and navigate health reform issues, including policy and costs for Medicaid, Medicare, and private insurance.

Alliance For Health Reform
www.allhealth.org/
Issue briefs, policy resources and web links.

Catalyst Center
www.hdwg.org/catalyst
National Center dedicated to improving health care coverage and financing for children and youth with special health care needs.

AARP
www.aarp.org/health
Information to better understand health care law, the Marketplace, Medicare, Medigap, and Medicaid.

State

Health Insurance and Health Maintenance Organizations: A Guide for Consumers
www.myfloridacfo.com/division/Consumers/understandingCoverage/Guides/documents/healthguide.pdf
A comprehensive guide to health insurance in Florida from the Florida Department of Financial Services. You may also call the Consumer Helpline toll-free at (877) 693-5236, M-F 8 AM – 5 PM ET.

Florida Health Finder
www.floridahealthfinder.gov
A collection of resources, health information, and provider locations in Florida.

Florida Consumer Assistance Program
https://localhelp.healthcare.gov
Helps people access health insurance, including Medicare, Medicaid, and private health plans, as well as assists individuals who encounter difficulties using the health benefits they have. On this site, you can enter your zip code to find a list of resources in your area.

Florida CHAIN
http://floridachain.org
A statewide consumer health advocacy organization that is dedicated to improving the health of all Floridians

Florida Medicaid Information
www.fdhc.state.fl.us/Medicaid/index.shtml
Florida's Medicaid program covers prescription drugs and medical services for low-income individuals.

Florida Health and Transition Services (FloridaHATS)
www.floridahats.org
Clearinghouse of resources and information for adolescents and young adults transitioning from pediatric to adult care.

References

*In addition to sources listed throughout the guide

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2. Kaiser Family Foundation, Kaiser Health Tracking Poll (2013).

3. U.S. Department of Labor. *Fact Sheet: Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens of Families and Businesses* (2010). Available at www.dol.gov/ebsa/newsroom/fsdependentcoverage.html.

4. U.S. Department of Health & Human Services. *5 Years later: How the Affordable Care Act is Working for Florida* (2015). Available at www.hhs.gov/healthcare/facts/bystate/fl.html.

5. *A Consumer's Glossary of Health Insurance Terms.* Available at www.healthinsurance.org/insterms.html.

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7. University of Montana. *Planning Your Transition from Pediatric to Adult Health Care - A Workbook to Help You Take Charge of Your Health* (2013). Available at http://ruralinstitute.umt.edu/transition/Handouts/Planning_Your%20Transition_from_Pediatric_to_Adult_Health_Care_Workbook-2014.pdf.