Consumer Health First

Access • Quality • Equity

Health Care Reform Glossary

This glossary contains terms used in the Patient Protection and Affordable Care Act (ACA) or related to its implementation. The terms generally apply to all states, but where there is information specific to how the ACA is being implemented in Maryland, this appears in the definition.

(Advance) Premium Tax Credit (APTC)	A refundable tax credit for the purchase of health coverage through a state health benefit exchange, which can be paid in advance directly to a health insurer on behalf of the person buying the insurance. Those eligible are people with household incomes > 133% and < 400% of the federal poverty level 1) who have no employer-sponsored insurance, 2) whose employer plan does not cover at least 70% of benefit costs, or 3) who pay more than 9.5% of income for employer-sponsored plan premiums. The APTC starts Jan. 1, 2014. This is not the only type of subsidy available (see "free choice voucher" below).
Affordable Care Act (ACA)	The comprehensive health care reform law enacted Mar. 23, 2010, formally known as The Patient Protection and Affordable Care Act (PPACA), as amended by the Health Care and Education Reconciliation Act.
Affordable coverage	Defines the maximum amount a household is expected to pay for health insurance premiums and out-of-pocket costs proportional to its income. Premiums for self-only coverage are considered affordable if they cost no more than 2% of household income for those at the low end of the income scale, and as much as 9.5% for those at 300% of the federal poverty level and above. The plan must also cover at least 94% of benefit costs for lowest-income households and 70% for households at 300% of the federal poverty level and above. The ACA directs the Secretary of the Department of Health and Human Services (HHS) to conduct a study of affordable coverage.
Assister	A non-certified employee or volunteer with a Maryland connector entity or one of its subcontracted community partners who provides in-person outreach and education on health benefits and subsidies; assists with application submissions for initial and renewed eligibility for APTC, cost sharing reductions, Medicaid and MCHP; and provides ongoing support for agency referrals, the selection of managed care organizations (MCOs), application submission, enrollment, and disenrollment for Medicaid and MCHP. An assister ***may not*** facilitate enrollment into a qualified health plan (QHP) on the state exchange.
Basic health program	An option under the ACA for a state to devise its own basic coverage program for people with incomes up to 200% of the federal poverty level who are not eligible for Medicaid and have no employer-sponsored plan. A state that does this can receive 95% of the federal subsidy that would have been offered through the health insurance exchange. Federal guidance has not yet been released for the BHP program. Maryland has opted to wait for such guidance before making a decision as to whether to go forward.

Benchmark coverage	42 CFR § 440.330 requires state exchanges to offer, at a minimum, coverage equal to either 1) the Federal Employees Health Benefit Plan, 2) that state's employee health plan, 3) the largest HMO plan generally available in the state, or 4) an equivalent approved by the DHHS Secretary. Maryland selected the CareFirst BlueCross BlueShield HMO small group plan as its benchmark, but had to add/substitute some missing benefits to comply with federal law or state needs. It adds adult habilitative (equal to rehabilitative) benefits; GEHA (a federal employee insurance product) mental health/substance use benefits; MCHP dental for pediatric dental coverage; FEP Blue Vision for pediatric vision; and in the individual market only, in vitro fertilization and hair prosthesis (hair loss due to cancer treatment). It used the Medicaid dental plan as the benchmark for pediatric dental coverage.
Captive producer	A licensed insurance broker or agent who has an exclusive contract with a single carrier to sell, solicit, or negotiate health insurance. Under the Maryland Health Progress Act of 2013, a captive producer can enroll a carrier's current enrollees into one of the qualified health plans (QHPs) it offers in the exchange, or enroll a person who contacts the carrier directly to purchase a plan. Maryland's Captive Producer program sunsets after three years. Maryland's Health Benefit Exchange (MHBE) and Insurance Administration (MIA) will examine the impact of the program on QHP enrollment and provide recommendations on its continuation by Dec. 1, 2015.
Center for Consumer Information & Insurance Oversight (CCIIO)	Within the Centers for Medicare & Medicaid Services, the unit that oversees implementation of ACA provisions related to private insurance. CCIIO ensures compliance with insurance market rules (like The Patient's Bill of Rights), helps states review rates and medical loss ratios, oversees the Exchanges and compiling data, and administers the Consumer Assistance Program, Pre-Existing Condition Insurance Plan, and Early Retiree Reinsurance Program.
Certified application counselor	State health insurance exchanges must have programs to train and certify application counselors at designated sites (community clinics, FQHCs, local government entities, and others that do not otherwise serve as navigators). Based upon interim regulations in Maryland, the counselor can help consumers enroll in qualified health plans (QHPs). They can also assist consumers in determining if they are eligible for public programs, but cannot enroll them. Unlike navigators or assisters, application counselors are not responsible for on-going support, referrals to social service agencies.
Children's Health Insurance Program (CHIP) – in Maryland: MCHP for Pregnant Women and Children	The ACA extends funding for the Children's Health Insurance Program (CHIP) through FY 2015 and continues authority for the program through 2019. CHIP is administered by states and funded through a combination of federal and state payments. Maryland's MCHP has been funding full health benefits for low-income children up to age 19 (≤ 200% FPL) since 1998. MCHP Premium expands coverage to otherwise uninsured children in two additional income tiers – 200-250% and 250-300% – through a parent's employer-sponsored plan or Medicaid in return for a small monthly premium. MCHP Premium also acts as secondary insurance that covers the cost of co-pays and deductibles associated with health care for children in the program. All children on MCHP and MCHP Premium also receive the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits required by Medicaid.

Churn	The transition in enrollment or eligibility among employer-plans, qualified health plans, commercial plans outside the exchange and Medicaid that may occur when a person experiences a change in employment status, income fluctuations, or other life events (e.g., aging out of eligibility for certain programs).
Community health center	A nonprofit private or public entity that serves designated medically underserved populations/areas or special medically underserved populations comprised of migrant and seasonal farm workers, the homeless or residents of public housing. It must meet the requirements established under § 330 of the Public Health Service Act (42 U.S.C. § 254(b)). Community health centers provide or arrange for a broad range of primary health care services and must meet a series of criteria related to scope of care, charge sliding scale fees, geography and population served, and governance by a community board.
Community Health Resources Commission (CHRC)	Established in 2006, the purpose of the CHRC is to increase access to care for low-income, under- and uninsured Marylanders by providing support to community health resources. It does this primarily by awarding grants to community health resources, including health enterprise zones (see below).
Community integrated medical home (CIMH)	Building on the patient-centered medical home (see below), the Health Systems Infrastructure Administration (HSIA) at DHMH has conceptualized a statewide, multipayer CIMH program that takes the patient-centered medical home (PCMH) and incorporates engagement with enhanced local health improvement coalitions that offer complementary supports to high-risk patients, identify and respond to hot spots of health needs, and monitor community and population health. The proposal is predicated on the belief that a PCMH approach is insufficient to ensure better outcomes and lower costs because patients who lack the tools and resources to manage their health may not improve absent integrated community-based supports. Maryland received a 6-month $2.37 million State Innovation Model (see below) planning grant to develop the CIMH.
Connector Program (Maryland's navigator entities)	The entities in Maryland that contract directly with the Maryland Health Benefit Exchange to provide outreach and enrollment services comprise the Connector Program. Their charge is to help consumers learn about, apply for, and enroll in an appropriate health insurance product, including Medicaid, MCHP, and subsidized and non-subsidized QHPs. Maryland has six regional connector entities that contract with local partners. These are: HealthCare Access Maryland (central – Baltimore County & City, Anne Arundel); Calvert Healthcare Solutions (southern – Charles, Calvert, St. Mary's); Seedco (upper Eastern Shore – Cecil, Harford, Kent, Queen Anne's, Talbot, Caroline, Dorchester); Worcester County Health Department (lower Eastern Shore – Wicomico, Somerset, Worcester); Healthy Howard's Door to HealthCare - Western Maryland – Garret, Allegany, Washington, Frederick, Carroll, Howard); Montgomery County Department of Health and Human Services (capital – Montgomery and Prince George's counties).
Continuity of care	The Maryland Health Progress Act of 2013 included language to minimize disruption of services for those who transition from Medicaid to private insurance and between commercial plans—i.e., ensures continuity of care.

	Specifically, pre-authorizations for treatment from prior plan must be accepted by the enrollee's new plan for the lesser of 90 days or the course of treatment. Also for the lesser of 90 days or the course of treatment, people with acute conditions, serious chronic conditions, or mental health or substance use disorders who are transitioning into another plan will be able to continue to receive services from their current provider at the in-network rate, even if the provider is not a participating provider in the new plan. The law also includes specific protections relating to transition care for pregnant women and for dental services. It does not apply to those moving from commercial plans into Medicaid fee for service. Goes into effect for all contracts issued or renewed on or after Jan. 1, 2015. In the interim, data will be collected to determine the efficacy of current standards and revise as necessary future ones.
Consolidated service center (CSC)	A contact, or call, center that supports consumer inquiries for exchange services. It is required to be easily accessible through a toll-free number and website with live agent support; use culturally and linguistically appropriate communication channels; ensure customer privacy and data security; offer clear, accurate, responsive information tailored to the inquiring consumer's needs and be fully compliant with the ADA. The goal is for the CSC to serve as a one-stop shop for information, enrollment assistance, and referrals to and from navigators and others providing consumer assistance. During the open enrollment period, effective Oct. 1, 2013, the hours will be: weekdays 8 a.m.-8 p.m.; Sat. 8 a.m.-6 p.m. and Sun. 8 a.m.-2 p.m. The toll-free number for the Maryland CSC is 1-855-642-8572 and 1-855-642-8573 (TTY).
Consumer Operated and Oriented Plan (CO-OP)	The ACA calls for the establishment of a CO-OP Program that provides federal loans to foster the creation of state-based consumer-governed, private, nonprofit health insurance issuers (CO-OP) to offer competitive health plans in the individual and small group markets. These plans must be federally approved and promote accountability, affordability, and innovative integrated models of care. The goal is to have at least one CO-OP in each state, but funding has been cut back. The Maryland CO-OP Evergreen was approved and received a loan.
Cost-sharing	A requirement that people with insurance pay a portion of their medical costs, whether as a deductible, a flat dollar copayment, or coinsurance (i.e., a percentage of the total paid claim for a covered benefit or service). The term generally does not include the cost of premiums, balance billing for the use of non-network providers, or non-covered services.
Cost-sharing reductions (CSR)	People who buy coverage through an exchange will have a cap on their total out-of-pocket spending, including deductibles, co-pays and co-insurance. But those in greatest need will get additional ***cost sharing reductions*** that lower the cap. Those with incomes ≤ 250% of the federal poverty level who buy a silver level plan (covers 70% of cost) will get an automatic subsidy based on income that reduces out-of-pocket costs from 30% to anywhere from 6% to 27%. Those who qualify for subsidies will also have their maximum out-of-pocket spending capped at lower levels.

Culturally and linguistically appropriate and competent services	The U.S. Department of Health and Human Services (HHS) established National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care to advance health equity, improve quality, and help eliminate health care disparities. The standard of competence is providing effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.
Dual eligible	A person who meets the eligibility requirements for both Medicaid and Medicare and so has coverage under both programs. Medicare covers acute care and Medicaid covers Medicare premiums and cost-sharing, long-term care, and some others. Generally, Medicare is the primary payer and Medicaid pays for whatever Medicare does not pick up, including wrap around services, and when Medicare limits are exhausted.
Early retiree	Defined under the ACA as a person aged 55 and over who is not yet eligible for Medicare.
Electronic health record (EHR)	An electronic system for collecting, storing, and sharing health information about individuals or populations for many purposes, including improving the coordination and quality of care. Because it is in digital format, it can be embedded in network-connected enterprise-wide information systems so it can be shared across different health care settings.
Employer mandate/ responsibility	The ACA does not have an employer mandate—only an individual mandate to purchase health insurance. Instead, businesses with 50 or more full-time equivalent employees are penalized under certain circumstances if at least one of their employees purchases a health plan through a state exchange and receives a subsidy. The penalty provision goes into effect on Jan. 1, 2015. Learn more.
Essential community provider (ECP)	A health care entity that serves predominantly low-income, medically underserved populations. These are defined as including those in § 340B(a)(4) of the Public Health Service Act, described in § 1927(c)(1)(D)(i)(IV) of the Social Security Act, and otherwise eligible to participate in the 340B drug program. A state may expand its ECP definition beyond that of federal law. Under the ACA, "A QHP issuer must have a ***sufficient number and geographic distribution*** of essential community providers, where available, to ***ensure reasonable and timely access*** to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the exchange's network adequacy standards." (45 CFR § 156.235.) CMS maintains a database with a non-exhaustive list of ECPs in each state to facilitate meeting network sufficiency standards. Maryland defines a service area as at least a county. It is currently adhering to Federal policy in this area, but will collect data to determine whether an expansion of the definition is required in the future.
Essential health benefits (EHB)	The minimum package of services (in 10 categories) that must be covered in every plan offered inside and outside an exchange and in Medicaid. EHB are defined in relation to the classes of services and benefits covered, the level of financial protection against deductibles, and the cost-sharing protection they provide. The 10 categories are: ambulatory; emergency; hospitalization; maternity and newborn care; mental health and substance use disorders,

	including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory; preventive, wellness, and chronic disease management; and pediatric, including oral and vision care. Lifetime dollar limits on spending is prohibited and must be phased out (except for grandfathered individual policies) by 2014.
Exchange/ marketplace	See "health insurance exchange" below.
Federal poverty level (FPL)	The federal annually adjusted household income criteria used to determine eligibility for income-related programs, such as Medicaid and the CHIP, and subsidies for insurance purchased in the exchange. In 2013, these are: FPL — 1 person — Family of 4 100% — $11,490 — $23,550 133% — $15,282 — $31,321 138% — $15,856 — $32,499 150% — $17,235 — $35,325 250% — $28,725 — $58,875 400% — $45,960 — $94,200
Free choice voucher	A person who could participate in an employer-sponsored health plan with minimum essential coverage but does not because the premium is too high could be eligible for a voucher to offset the purchase of a plan in the exchange. Household income must be ≤ 400% of the federal poverty level and the premium cost between 8% and 9.8% of household income. The employer is required to provide the voucher, which is in the amount of the employer's contribution to the monthly premium had the employee enrolled in the employer's own plan. A person who uses a voucher is not eligible for tax credits or subsidies for a plan purchased in the exchange.
Full-time equivalent (FTE)	The number of full-time employees plus the number of part-time employees converted to full-time schedules. A company with 5 full-time employees who each work 40 hours per week and 6 part-time employees who each work 20 hours per week has 8 FTEs. FTE is used to determine whether an employer may be liable to face a penalty if it does not offer an affordable plan.
Grandfathered plan	A health plan or policy in which a person was enrolled as of the date of enactment of the ACA (Mar. 23, 2010). A plan with grandfathered status is exempted from meeting some of the requirements of the ACA, and may maintain that status so long as any changes in benefits or cost sharing do not surpass certain thresholds established by law. The purpose of this status is to allow people to keep plans that they like, and to allow employers to give employees the same level of coverage but under a new issuer (if individuals change plans, grandfathered status does not apply.) In general, grandfathered and non-grandfathered group health plans must comply with: • No rescissions of coverage except for fraud, misrepresentation, or non-payment • Lifetime dollar limits on essential health benefits prohibited • No annual dollar limits on essential health benefits as of Jan. 1, 2014 (also for stand-alone HSAs)

	• Dependent child coverage to age 26 as of Jan. 1, 2014 • No pre-existing condition limitations for dependents under age 19 as of Jan. 1, 2014 • No waiting periods over 90 days as of Jan. 1, 2014 Non-grandfathered plans must comply with additional requirements: • Coverage of preventive care without employee cost-sharing, including preventive care for women • Expanded claims and appeal requirements • Additional patient protections (primary care designation, OB/GYN access, and emergency services) • Coverage of routine costs associated with clinical trials as of Jan. 1, 2014 • Limitations on out-of-pocket maximums as of Jan. 1, 2014 (also deductible limitations that apply to small group plans only)
Health Care Reform Coordinating Council (HCRCC)	Maryland created the HCRCC in 2010 to advise the government on implementation of the ACA. The HCRCC makes policy recommendations and offers implementation strategies aimed at expanding quality and access while reducing waste and controlling costs. In 2011 the HCRCC authorized the Health Care Delivery Reform Subcommittee to track implementation of reform efforts that lower costs, improve patients' care experience, and improve outcomes, and to disseminate best practices in health care delivery and payment reform statewide.
Healthcare.gov	ACA mandated web-site providing information on health insurance marketplaces and consumer rights. Has a live chat feature, a blog, regulatory and policy information, resources in multiple languages, and links to state marketplaces.
Health disparities	Measurable differences in health status, care, and outcomes that are associated with race, ethnicity, income, language, place of residence, and other factors unrelated to the need for or ability to benefit from health care. Maryland law includes factors such as gender, sexual orientation and gender identity.
Health enterprise zone (HEZ)	Maryland's Health Disparities and Reduction Act of 2012 established a process for DHMH, in consultation with the Community Health Resources Commission (CHRC) to designate HEZs. The purpose of the designation is to reduce health disparities, costs, hospital admissions and readmissions, and to improve outcomes in these geographic areas, which are defined as being economically disadvantaged, contiguous communities of at least 5,000 inhabitants that demonstrate poor health outcomes. HEZs must have a comprehensive plan that shows collaboration across a range of stakeholders, and are eligible to receive incentives such as loan assistance repayment, income tax credits, priority to enter the Maryland Patient Centered Medical Home Program, grants, and priority funding to establish an electronic health records program.
Health equity	The concept that each person has the opportunity to attain his or her full health potential and that no one is disadvantaged from achieving this because of social determinants. Health inequity is evidenced by differences in life expectancy, quality of life, rates of disease and disability, severity of disease, and access to care. The Maryland Women's Coalition for Health Care Reform released an issue brief: *Health Equity. The Promise of Health Care Reform* in 2013.

Health insurance exchange/health benefit exchange/ health insurance marketplace	The ACA mandates state health insurance "marketplaces" where individuals and small groups (SHOP) can purchase a qualified health plan (QHP) starting Jan. 1, 2014. These may be state-run, federal-state partnerships, or federally administered. In Maryland, the Maryland Health Benefit Exchange (see below) is the governing body that, in conjunction with the Maryland Insurance Administration, oversees the marketplace, called the Maryland Health Connection (see below). Exchanges are responsible for calculating premiums subsidies, enrollment, quality oversight, certification of qualified health plans that can be sold in the exchange, and other matters. They also contract with connector entities. By providing a single application process, web-based shopping that facilitates plan comparison, and oversight over the entire process, exchanges are designed to make it easier and more transparent to select and enroll in health insurance that suits individual needs.
Health literacy	Health literacy is the extent to which a person has the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. In addition to basic literacy skills, health literacy requires knowledge of health topics. People with limited health literacy often lack knowledge or have misinformation about the body as well as the nature and causes of disease.
Health Systems Infrastructure Administration (HSIA)	"In anticipation of health care reform implementation and the imperative to improve population health for all Marylanders," DHMH's administration of public health was restructured in 2012. HSIA was established with a focus on the triple aim approach: 1) access to care, 2) high-value coordinated service delivery, and 3) integration of public health and medicine to emphasize health promotion rather than an acute care approach. HSIA comes under the Deputy Secretary of Public Health Services and oversees programs including, SHIP, HEZs, and School-based health.
High-risk pools	A method provided under the ACA to insure individuals with pre-existing conditions who have been uninsured for at least six months. High-risk pool plans offer health insurance coverage that is subsidized by the state. These may be operated by states during the period prior to the implementation of health insurance exchanges as a means of providing coverage to individuals who otherwise cannot secure coverage in the individual market. In 2014, Maryland will close its federally funded program. Learn more. See Maryland Health Insurance Plan (MHIP) for information on the state program.
Immigrant eligibility	Lawfully present immigrants receive some federal coverage under the ACA, such as QHP enrollment and subsidies, but are subject to waiting periods for Medicaid and CHIP. States can choose to suspend the waiting period for children and pregnant women; if not, they must wait at least five years. Undocumented immigrants have no access to health insurance in the exchange; they may continue to seek care at safety net providers and ERs, and to qualify for Emergency Medicaid if income eligible. Lawfully present children of undocumented immigrants are eligible for all exchange benefits and Medicaid.

Individual mandate/ responsibility	The ACA requires all individuals to obtain health insurance that meets minimum coverage standards or pay a penalty, starting Jan. 1, 2014. This is referred to as the "individual mandate." There are some exceptions, such as for people with very low income where coverage is unaffordable or those for whom this would violate religious belief. Individuals can also apply for a waiver if they do not automatically qualify. The penalty is 1% of household income in 2014, 2% of household income in 2015, and 2.5% of household income in 2016 and beyond.
Insurance broker/agent	See Producer or Captive Producer.
Local Health Improvement Coalition (LHIC)	Under Maryland's State Health Improvement Process (SHIP), 18 active Local Health Improvement Coalitions (LHIC) across all state jurisdictions, have been formed or strengthened to coordinate the actions of public health, hospitals, community health providers, schools, senior centers and other faith-based and community organizations to improve health in Maryland communities. Most coalitions are co-chaired by public health and hospital leaders and include a cross section of health and human service leaders.
Maryland Health Benefit Exchange (MHBE)	The Maryland Health Benefit Exchange (MHBE) is a public corporation and independent unit of the State government established by the Maryland Health Benefit Exchange Act of 2011 and in accordance with the ACA. The MHBE has a nine-member Board of Trustees that includes the Secretary of Health and Mental Hygiene, Maryland Insurance Commissioner and Executive Director of the Maryland Health Care Commission. The MHBE is responsible for the design and administration of Maryland Health Connection.
Maryland Health Care Commission (MHCC)	The MHCC is an independent regulatory agency whose mission is to plan for health system needs, promote informed decision-making, increase accountability, and improve access by providing timely and accurate information on availability, cost, and quality of services to policy makers, purchasers, providers and the public. Its Center for Healthcare Financing and Health Policy (CSHBP) has regulatory responsibility for the small group market for health insurance and broad responsibility for the analysis of public policy options related to organization and financing of health care. The CSHBP publishes a guide that rates HMO clinical performance and consumer satisfaction, and will soon expand this to PPOs.
Maryland Health Connection	The public online marketplace for individuals, families, and small businesses to compare and enroll in health insurance, as well as determine eligibility for Medicaid and other assistance programs, federal tax credits and cost-sharing reductions. It is a state-based health insurance exchange that will have its first open enrollment period from Oct. 1, 2013 to Mar. 31, 2014.
Maryland Health Insurance Plan (MHIP)	The state plan established prior to the ACA and administered by CareFirst that serves people who are unable to obtain coverage because of pre-existing conditions. It will be phased out because the ACA prohibits denial of insurance for pre-existing conditions, so it will no longer be necessary. Starting in October 2013, the Exchange will provide notice to MHIP members of new protections under the ACA and their options for coverage through the Exchange. The transition of MHIP enrollees into QHPs will be done gradually to ensure the stability of the risk pool with a closure of MHIP completed by January 2020.

Maryland Insurance Administration (MIA)	The independent state regulatory agency with oversight of the insurance industry. The MIA reviews and approves qualified health plan (QHP) premium rates, certifies QHPs for sale in the exchange (in conjunction with the Maryland Health Benefit Exchange), licenses producers (see below), and investigates complaints regarding illegal insurance practices.
Medicaid benchmark	The benefit package a state may select in place of the standard Medicaid mandatory and optional benefits. Starting Jan. 1, 2014, all newly eligible and existing Medicaid beneficiaries must receive this coverage. The benchmark must cover all 10 EHB categories and anything else the HHS Secretary deems appropriate for the covered population. The benchmark must use as a reference: 1) the standard Federal Employees Health Benefit BCBS HMO Plan, 2) the state employee health plan, 3) the largest HMO plan generally available in the state.
Medicaid expansion	A key ACA provision that gives states the opportunity to expand Medicaid eligibility those aged 19-65 with incomes ≤ 133% of federal poverty level (up from 116% FPL). The Maryland Health Progress Act 2013 puts this provision in statute. When the 5% mandatory income disregard is taken into account, all Maryland adults up to age 65 with incomes ≤ 138% of the federal poverty level will be eligible for Medicaid. Eligibility for adults aged 65 and older is unchanged. Medicaid also provides for comprehensive medical and other health care services for former foster care adolescents under 26 years of age who on their 18th birthday were in foster care under the responsibility of the Maryland, D.C. or any other state, and are not otherwise eligible for Medicaid benefits. The federal government pays 100% of the cost of expansion for 2014-2016, after which the match gradually drops to 90% by 2020, where it stays. Not all states have chosen to expand their Medicaid programs.
Medicare "Part D" donut hole	Part D is an optional outpatient prescription drug benefit in Medicare that, in return for a premium, pays a portion of a participant's prescription drug costs. What is referred to as the "donut hole" is an inadvertent gap that leaves people with Part D without any coverage after the total retail cost of their prescription drugs reaches $2,970 (2013). When that occurs they must pay 100% of their prescription drug costs out of pocket, until they hit the "catastrophic coverage" spending level when Medicare picks up 95% of the cost. The ACA gradually reduces the donut hole through brand name and generic drug discounts and completely closes it by 2020.
Mental health parity	The federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires that health insurance plans with mental health and substance use disorder benefits provide them on the same—and no more restrictive—financial and treatment terms as medical/surgical benefits. The ACA expands already existing federal mental health parity protections by 1) requiring all new individual and small group QHPs to include mental health and substance use disorder benefits among the 10 EHBs; and 2) applying federal parity protections to mental health and substance use disorder benefits in the individual market and Medicaid fee-for-service. Maryland mental health parity law contains consumer protections such as notice, disclosure, and complaint provisions, as well as giving the MIA enforcement authority to ensure compliance with utilization review standards for medical necessity.

Metal plans	The four tiers of qualified health plans (QHPs) that can be sold in the exchange, distinguished by their actuarial value – the percentage of benefit costs that will be paid for by the plan. The higher the actuarial value, the lower the out-of-pocket cost for the enrollee. Generally a bronze plan will have lower premiums than a platinum plan. They all have to offer the essential health benefits, and could offer more. The four metal tiers are: • Bronze – 60% of medical expenses covered • Silver – 70% of medical expenses covered • Gold – 80% of medical expenses covered • Platinum – 90% of medical expenses covered
Modified Adjusted Gross Income (MAGI)	The income calculation to determine Medicaid eligibility and health benefit subsidies for insurance purchased through the health benefit exchange. It is the total of all earned and unearned income without considering any possible tax deductions (e.g., student loan payments, IRA contributions, gifts, etc.). There are special MAGI income counting rules that are generally aligned with rules for federal assistance programs. For Medicaid eligibility there is a mandatory 5% income disregard, which extends eligibility to those with a MAGI of 138% of federal poverty level.
Navigator	In Maryland, a navigator must acquire training and certification to provide outreach and education on health benefits and subsidies; assist with application submissions for initial and renewed eligibility for APTC, cost sharing reduction, Medicaid and MCHP; and provide ongoing support for agency referrals, the selection of MCOs, application submission, enrollment, and disenrollment for Medicaid and MCHP. Importantly, navigators—unlike assisters—can provide advice on and facilitate enrollment into QHPs offered for sale through the individual and/or SHOP exchange. Navigators must be employed by, or engaged with the Maryland Connector Program. A navigator is responsible for agency referrals, as necessary, including the Attorney General's Health Education and Advocacy Unit (HEAU), Maryland Insurance Administration (MIA), Department of Health and Mental Hygiene (DHMH), and the Department of Human Resources (social services). http://marylandhbe.com/navigator-program/
Network adequacy	The HHS standard requires that a qualified health plan (QHP) have "a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay." QHPs must also contract with "a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area."
Newly eligible	Those adults aged 19-65 who will become eligible for Medicaid coverage for the first time when Medicaid expansion becomes effective on Jan. 1, 2014. As a result of a 2012 Supreme Court ruling on the constitutionality of the state mandate to expand Medicaid, states have the option of whether or not to do so. As of end June 2013, 26 states including Maryland are expanding their Medicaid programs.

No wrong door	The ACA requires state exchanges to adopt a streamlined application process that allows people to apply for whichever type of assistance they are eligible using a single form. The applicant is screened for eligibility for Medicaid, CHIP, and APTCs (coverage through the exchange) and referred to the appropriate program for enrollment. In addition, people must be able to apply online, in person, by mail, or by phone and file with the state insurance exchange or with the state Medicaid or CHIP agency. No wrong door, no wrong form, no wrong way to apply.
Partner organization	Within the context of a connector entity, this is a public or private organization that contracts with it to provide outreach and/or enrollment services as part of the navigator program. In Maryland, partners of connector entities are subject to oversight by the MIA.
Patient-centered medical home (PCMH)	A model for delivering services in which a team of health professionals, guided by a primary care provider, provides continuous, comprehensive, and coordinated care in a culturally and linguistically sensitive manner to patients throughout their lives. The PCMH provides for all of a patient's health care needs, or collaborates with other qualified professionals to meet those needs. The hallmarks of a PCMH are evidence-based practice, expanded access and communication, care coordination and integration, improved outcomes, and lower health care costs. Maryland's Multipayer Patient-Centered Medical Home Program (MMPP) has 52 multispecialty and primary care practices and FQHCs statewide; Maryland law requires the five major fully insured health benefit products in the state to participate, and other federal and state plans are doing so voluntarily. CareFirst also launched a PCMH model in Maryland that now has 300 medical panels participating.
Patient's Bill of Rights	The health insurance coverage protections established to begin six months after enactment of the ACA, on Sept. 23, 2010. They prohibit limitations for pre-existing conditions, end lifetime caps on coverage, and protect choice of health care provider. These protections are all subsumed in the ACA as of Jan. 1, 2014.
Pre-existing condition	A health condition that exists prior to enrollment into a health plan, regardless of whether the condition has been formally diagnosed. The ACA prohibits insurers and employer-sponsored health plans from denying or limiting coverage to children with pre-existing conditions; this protection will extend to all children and adults starting Jan. 1, 2014.
Qualified health plan (QHP)	Under the ACA, starting Jan. 1, 2014, an insurance plan that is certified by an exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. In the individual market, the Maryland Health Benefit Exchange (MHBE) has three corporations and a CO-OP offering QHPs, some with embedded dental (CareFirst, Evergreen (CO-OP), Kaiser, and UnitedHealthcare). There are also five stand-alone dental plans (CareFirst, Delta, DentaQuest, Dominion, United Concordia). The SHOP exchange has an additional two large commercial insurers—Aetna and Coventry offering QHPs, some with embedded dental and nine stand-alone dental plans (Alpha Dental, BEST, CareFirst, Coventry, Delta Dental of PA, DentaQuest, Dominion, Guardian, Metropolitan Life, United Concordia)

Producer	A broker or agent who is licensed by the Maryland Insurance Administration to sell insurance. Licensed producers must be specially trained and authorized by the Maryland Health Benefit Exchange to sell QHPs on Maryland Health Connection. Producers are paid by insurance carriers, not by those who purchase insurance.
Safety net provider	A health care entity that offers primary care services to people regardless of ability to pay. These may be public hospitals, community health centers, FQHCs, local health departments, and others that serve a disproportionate share of uninsured, underserved, and low-income populations.
State Health Improvement Process (SHIP)	DHMH launched SHIP in Sept. 2011 as a framework to improve Maryland's national health ranking and to reduce persistent health disparities. The SHIP provides baselines, targets and annual updates for 39 health measures at the state and county levels. The goal is to use a data-driven approach to propel and direct coordinated, collective local action to improve health through coalitions that bring together health departments, hospitals, and community-based health supports. (See also, LHIC.)
Small Business Health Care Tax Credit	A tax credit that helps small (≤ 25 full-time equivalent employees) businesses and tax-exempt organizations cover the cost of health insurance for their employees. Only available to entities that pay at least half the cost of single coverage for an employee enrolled in a QHP offered through the SHOP; it is only available for two consecutive taxable years. For tax years beginning in 2014 or later, the maximum credit is 50% of premiums paid by a business and 35% of premiums paid by a tax-exempt entity.
Small Business Health Option Program (SHOP)	The state-based insurance exchanges created by the ACA through which small employers will be able to purchase health insurance for their employees starting Jan. 1, 2014. Learn more about the establishment of the SHOP and how to sign up.
Stakeholder	Anyone with an interest in health insurance coverage: consumers, health care systems, providers, payers, pharmacies, and others. The Maryland Health Benefit Exchange Acts of 2011 and 2012 established the precedent for stakeholder involvement in MHBE decision-making. The Maryland Health Progress Act of 2013 continues it with the establishment of a permanent standing committee, starting Mar. 14, 2014, with a diverse membership across a broad range of expertise and experience. The Committee will have a Board liaison, and be charged with addressing a range of policy issues on which the Board may seek input and advice, and that may be proposed by the liaison to the Board and in consultation with the Committee chair and members.
State Innovation Model (SIM)	A grant program established by CMS Center for Medicare and Medicaid Innovation to develop, implement, and test new health care payment and service delivery models at the state level. (See CIMH above for information on Maryland's proposal.)
Streamlined, simplified application and enrollment	The ACA creates a "one-stop shop" concept for accessing and switching coverage between Medicaid, the Children's Health Insurance Program (CHIP), and the QHPs that creates a single application (using MAGI to determine income and no asset test) to obtain 1) eligibility determination for all insurance affordability programs at the same time, and 2) enrollment.

Third party administrator (TPA)	In Maryland, a number of TPAs provide health coverage/insurance services that include directly or indirectly underwriting coverage, collecting charges or premiums from, or adjustments or settlements claims on residents of the state. TPAs certified as business partners with the Maryland Health Benefit Exchange under the SHOP, will help small employers and employees 1) compare and select qualified health plans, 2) administer enrollment and eligibility changes, and 3) bill and collect premiums.
Underinsured	People who have health insurance with high out-of-pocket costs or limits on benefits that impair their ability to access services.
Wellness program	A program intended to improve and promote health and fitness. These are usually offered through the work place, although insurance plans can offer them directly to enrollees. It can be in the form of premium discounts, cash rewards, gym memberships, and other incentives to participate. Some examples of wellness programs are programs for smoking cessation, diabetes management, weight loss, and preventive health screenings.
Young adult	People between the ages of 22-26 who, under the ACA, can remain covered under a parent's employer-sponsored or individual health benefit plan.