Healthcare.gov

**Story**

Introduction

A Simplified HealthCare.gov Metamodel

HealthCare.gov By State

HealthCare.gov Plan Information Example

Answer a few quick questions to see the premium estimates

What type of coverage do you need?

What state do you live in?

What county do you live in?

Who will you apply for health coverage for?

Message

Most people who apply will qualify for lower costs

Plans are put into 5 categories

Results

Marketplace Application Checklist

Conclusions and Recommendations

**Slides**

Slide 1 Data Science for HealthCare.gov

Slide 2 Background

Slide 3 Healthcare.gov

Slide 4 Site Map and Glossary

Slide 5 Goals and Process

Slide 6 Knowledge Base: MindTouch

Slide 7 Knowledge Base: Spreadsheet

Slide 8 Knowledge Base: Spotfire

Slide 9 Knowledge Base: Be Informed

Slide 10 Conclusions and Recommendations

**Spotfire Dashboard**

**Story**

**Slides**
I. WITNESS

II. BACKGROUND

A. PPACA Implementation
B. Problems With the Federally Facilitated Marketplace
C. Energy and Commerce Committee’s October 24, 2013, Hearing

III. STAFF CONTACTS

Footnotes

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16

Energy and Commerce Committee Chairman Fred Upton
Preface

Improvements Already Made to HealthCare.gov

Reinforcements

Expanding Access to Affordable Coverage Through the Health Insurance Marketplace

Other Benefits of the Affordable Care Act

Conclusion

Footnotes

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16

PPACA Implementation Failures: Didn't Know or Didn't Disclose?

2013-10-24-Alexander-DEI-to-Sebelius-HHS-followup-Obamacare-Exchanges-rollout-re-10-10
What factors affect Marketplace health plan premiums?
Do I qualify for Medicaid?
Lupita’s story: I don’t have insurance
7 ways to save in the Health Insurance Marketplace
How can I see Marketplace health plans and prices before I fill out an application?
Will I qualify for lower out-of-pocket costs?
Where can I get low-cost care in my community?
What do American Indians and Alaska Natives need to know about the Marketplace?
How can I get lower costs on Marketplace coverage?
Can I buy a “catastrophic” plan?
Are my children eligible for CHIP?

Young Adults
Alejandra’s story: College students need coverage too!
3 ways to get covered if you’re under 30
Malik’s story: I’m young and I need health insurance
Jaime’s story: Life without health insurance
What are my birth control benefits?
Why should I have health coverage?
What if I’m pregnant or plan to get pregnant?
Can children stay on a parent’s plan until age 26?
Can I buy a “catastrophic” plan?

Using the Marketplace
How we’re working to improve HealthCare.gov
4 ways to apply for coverage in the Health Insurance Marketplace
How do I apply for Marketplace coverage?
Open enrollment in the Health Insurance Marketplace is here!
What income and household information do I provide when I apply for Marketplace coverage?
Can I appeal a Marketplace decision?
10 ways to get ready for the Health Insurance Marketplace
4 steps to getting covered in the Health Insurance Marketplace
Calculating your costs and savings in the Health Insurance Marketplace
How to get help with your Marketplace application
What if I want to change Marketplace plans after I enroll?
How can I get ready to apply for Marketplace coverage?
How can I apply for coverage using my mobile phone?
How to find the health insurance plan that’s right for you
Get ready for the Health Insurance Marketplace: Create an account
Questions? Call us at 1-800-318-2596
Introducing the Health Insurance Marketplace
What key dates do I need to know?
How do I get help enrolling in the Marketplace?
How do I choose Marketplace insurance?
How can I stay up-to-date about the Marketplace?
Contact Us

Rights, Protections, and the Law
Can I appeal a Marketplace decision?
How do I get an exemption from the fee for not having health coverage?
Do Marketplace insurance plans cover mental health and substance abuse services?
Howard’s story: I can’t get health insurance
Jaime’s story: Life without health insurance
2014 in 214 words
What are my birth control benefits?
Answers to your top health insurance questions
What are my breastfeeding benefits?
Introducing the Health Insurance Marketplace
Where can I read the Affordable Care Act?
What if someone doesn’t have health coverage in 2014?
What if I’m pregnant or plan to get pregnant?
What if I have a grandfathered health insurance plan?
Timeline of the health care law
How does the health care law protect me?
How do I appeal a health plan decision?

Prevention
Do Marketplace insurance plans cover mental health and substance abuse services?
4 ways the Health Insurance Marketplace keeps you healthy
What are my birth control benefits?
What are my breastfeeding benefits?
Can I get dental coverage in the Marketplace?
Where can I find provider information?
What are my preventive care benefits?
How does the Affordable Care Act help people like me?

Other Health Insurance Programs
What if I have PCIP coverage?
What do immigrant families need to know about the Marketplace?
Do I qualify for Medicaid?
What if my state is not expanding Medicaid?
What if I need coverage that starts before January 2014?
Where can I get low-cost care in my community?
What do American Indians and Alaska Natives need to know about the Marketplace?
What do military veterans need to know about the Marketplace?
What if I have Medicare?
Are my children eligible for CHIP?

If You Have Health Insurance

What if my current individual plan is changing or not being offered in 2014?
Answers to your top health insurance questions
What if I currently have COBRA coverage?
What if I want to change individual insurance plans?
What if I have job-based insurance?
What if I have a grandfathered health insurance plan?
What if I'm losing job-based insurance?
How does the health care law protect me?
How does the Affordable Care Act help people like me?
How do I appeal a health plan decision?
How can I get consumer help if I have insurance?
Can I use a Flexible Spending Account (FSA) to pay some medical expenses?
Can children stay on a parent’s plan until age 26?

Health Insurance Marketplace

We’re listening — and improving every day
4 ways to apply for coverage in the Health Insurance Marketplace
Will I qualify for lower costs on monthly premiums?
What is the Marketplace in my state?
How can I get an estimate of costs and savings on Marketplace health insurance?
Open enrollment in the Health Insurance Marketplace is here!
Get Covered: A one-page guide to the Health Insurance Marketplace
How do I get an exemption from the fee for not having health coverage?
10 ways to get ready for the Health Insurance Marketplace
4 steps to getting covered in the Health Insurance Marketplace
Alejandra’s story: College students need coverage too!
Calculating your costs and savings in the Health Insurance Marketplace
How to get help with your Marketplace application
Here’s how the Health Insurance Marketplace helps women
3 ways to get covered if you’re under 30
What do immigrant families need to know about the Marketplace?
How to find the health insurance plan that’s right for you
Do Marketplace insurance plans cover mental health and substance abuse services?

Malik's story: I'm young and I need health insurance

What if I'm retired but not eligible for Medicare?

4 ways the Health Insurance Marketplace keeps you healthy

Howard's story: I can't get health insurance

10 health care benefits covered in the Health Insurance Marketplace

Lupita's story: I don't have insurance

How can I protect myself from fraud in the Health Insurance Marketplace?

4 ways to protect yourself from fraud in the Health Insurance Marketplace

Jaime's story: Life without health insurance

2014 in 214 words

Get ready for the Health Insurance Marketplace: Create an account

7 ways to save in the Health Insurance Marketplace

Answers to your top health insurance questions

What are my health coverage options if I'm unemployed?

Questions? Call us at 1-800-318-2596

Can I get dental coverage in the Marketplace?

What if I'm a part-time employee without health coverage?

You've got questions. We've got answers.

What if I currently have COBRA coverage?

How can I see Marketplace health plans and prices before I fill out an application?

Welcome to the new HealthCare.gov!

Introducing the Health Insurance Marketplace

Can I buy health insurance outside the Health Insurance Marketplace?

What is the Health Insurance Marketplace?

What if someone doesn't have health coverage in 2014?

What if I have a pre-existing health condition?

What does Marketplace health insurance cover?

What do I do if my employer offers health insurance through the SHOP Marketplace?

What do American Indians and Alaska Natives need to know about the Marketplace?

How can I get lower costs on Marketplace coverage?

Can I keep my own doctor?

Can I buy a "catastrophic" plan?

Am I eligible for coverage in the Marketplace?

Health Insurance Basics

Open enrollment in the Health Insurance Marketplace is here!

How do I get an exemption from the fee for not having health coverage?

Howard's story: I can’t get health insurance
10 health care benefits covered in the Health Insurance Marketplace
How can I protect myself from fraud in the Health Insurance Marketplace?
4 ways to protect yourself from fraud in the Health Insurance Marketplace
2014 in 214 words
What are my health coverage options if I’m unemployed?
Questions? Call us at 1-800-318-2596
What are my breastfeeding benefits?
Can I get dental coverage in the Marketplace?
What if I’m a part-time employee without health coverage?
You’ve got questions. We’ve got answers.
What if I need coverage that starts before January 2014?
Why should I have health coverage?
What key dates do I need to know?
What if someone doesn’t have health coverage in 2014?
What if I’m self-employed?
What if I have job-based insurance?
What if I have a pre-existing health condition?
What if I'm losing job-based insurance?
What are the different types of health insurance?
How does the Affordable Care Act help people like me?
Contact Us
Can I use a Flexible Spending Account (FSA) to pay some medical expenses?
Can I keep my own doctor?
Businesses
What do I need to tell my employees about the Marketplace?
A new way to SHOP for small business coverage and get help
What is the Employer Shared Responsibility Payment?
Will I qualify for small business health care tax credits?
What is the SHOP Marketplace?
What is considered a small business?
What if I'm self-employed?
What if I already insure my employees?
What do small businesses need to know?
What if my business has 50 or more employees?
What do I do if my employer offers health insurance through the SHOP Marketplace?
How do my employees sign up for SHOP?
How do I choose coverage that’s right for my business?
How can I get ready for SHOP?
Do I have to offer health coverage to my employees?
Can I use an agent or broker to buy health insurance in the Marketplace?

Glossary

A
Accountable Care Organization
Accreditation
Actuarial Value
Advanced Premium Tax Credit
Affordable Care Act
Affordable Insurance Exchange
Affordable coverage (as it relates to APTC)
Agent
Alimony
Allowed Amount
Annual Deductible Combined
Annual Limit
Appeal
Attest/Attestation
Authorized Representative

B
Balance Billing
Benefits
Biosimilar Biological Products
Brand Name (Drugs)
Broker
Bronze Health Plan

C
COBRA
Cancelled Debts
Capital Gains
Care Coordination
Catastrophic Health Plan
Centers for Medicare & Medicaid Services (CMS)
Certified Applicant Counselor
Children's Health Insurance Program (CHIP)
Chronic Disease Management
Claim
Co-op
Coinsurance
Community Rating
Competitive Bidding
Complication of Pregnancy
Conversion
Coordination of Benefits
Copayment
Cost Sharing
Cost Sharing Reduction
Court Awards
Creditable Coverage

D
Deductible
Dental Coverage
Department of Health and Human Services (HHS)
Dependent
Dependent Coverage
Disability
Dividend
Domestic Partnership
Donut Hole, Medicare Prescription Drug
Drug List
Durable Medical Equipment (DME)

E
Early and Periodic Screening, Diagnostic, and Treatment Services, EPSDT
Eligibility Assessment
Eligible Immigration Status
Emergency Medical Condition
Emergency Medical Transportation
Emergency Room Care
Emergency Services
Employer Shared Responsibility Payment
Employer or Union Retiree Plans
Essential Health Benefits
Exchange
Excluded Services
Exclusive Provider Organization (EPO) Plan
External Review
Family and Medical Leave Act (FMLA)
Federal Poverty Level (FPL)
Federally Qualified Health Center (FQHC)
Federally Recognized Tribe
Fee
Fee For Service
Flexible Benefits Plan
Flexible Spending Account (FSA)
Formulary
Full-Time Employee
Fully Insured Job-based Plan

Generic Drugs
Gold Health Plan
Grandfathered
Grandfathered Health Plan
Grievance
Group Health Plan
Guaranteed Issue
Guaranteed Renewal

HIPAA Eligible Individual
Habilitative/Habilitation Services
Hardship Exemption
Health Care Workforce Incentive
Health Coverage
Health Insurance
Health Insurance Marketplace
Health Maintenance Organization (HMO)
Health Plan Categories
Health Reimbursement Account (HRA)
Health Savings Account (HSA)
Health Status
High Deductible Health Plan (HDHP)
High Risk Pool Plan (State)
High-Cost Excise Tax
Home Health Care
Home and Community-Based Services (HCBS)
Hospice Services
Hospital Outpatient Care
Hospital Readmissions
Hospitalization

In Person Assistance Personnel Program
In-network Coinsurance
In-network Copayment
Individual Health Insurance Policy
Inpatient Care
Insurance Co-Op
Interest
Investment Income

Job-based Health Plan

Large Group Health Plan
Lifetime Limit
Long-Term Care

Marketplace
Medicaid
Medical Loss Ratio (MLR)
Medical Underwriting
Medically Necessary
Medicare
Medicare Advantage (Medicare Part C)
Medicare Hospital Insurance Tax
Medicare Part D
Medicare Prescription Drug Donut Hole
Member Survey Results
Minimum Essential Coverage
Minimum value
Modified Adjusted Gross Income (MAGI)
Multi-Employer Plan

Navigator

http://semanticommunity.info/Healthcare.gov
Updated: Sat, 19 Sep 2015 01:00:50 GMT
Powered by mindtouch™
Net Capital Gains
Net Rental Income
Network
New Plan
Non-preferred provider
Nondiscrimination
Not Yet Accredited (Health Plan)
Notice
Open Enrollment Period
Original Medicare
Out-of-Network Coinsurance
Out-of-Network Copayment
Out-of-Pocket Costs
Out-of-Pocket Estimate
Out-of-pocket maximum/limit
Patient Protection and Affordable Care Act
Patient-Centered Outcomes Research
Payment Bundling
Penalty
Pension (Retirement Benefit)
Physician Services
Plan
Plan Year
Platinum Health Plan
Point of Service (POS) Plans
Policy Year
Pre-Existing Condition
Pre-Existing Condition (Job-based Coverage)
Pre-Existing Condition Exclusion Period (Individual Policy)
Pre-Existing Condition Exclusion Period (Job-based Coverage)
Pre-existing Condition Insurance Plan (PCIP)
Preauthorization
Preferred Provider
Preferred Provider Organization (PPO)
Premium
Premium Tax Credit
Prescription Drug Coverage
Prescription Drugs
Prevention
Preventive Services
Primary Care
Primary Care Physician
Primary Care Provider
Prior Authorization
Public Health
 Qualified Health Plan
Qualifying Life Event
Rate Review
Reconstructive Surgery
Referral
Rehabilitative/Rehabilitation Services
Reinsurance
Rental or Royalty Income
Rescission
Retirement Benefit (Pension)
Rider (exclusionary rider)
Risk Adjustment
Self-Employment Income
Self-Insured Plan
Service Area
Silver Health Plan
Skilled Nursing Care
Skilled Nursing Facility Care
Social Security
Social Security Benefits
Social Security Survivors Benefits
Special Enrollment Period
Special Health Care Need
Specialist
State Continuation Coverage
State Health Insurance Assistance Program (SHIP)
**Story**

**Data Science for HealthCare.gov**

**Introduction**

Today, the day of HHS Secretary Kathleen Sebelius's [Congressional Testimony](http://semanticommunity.info/Healthcare.gov), the message I got when I tried to Login at HealthCare.gov was: "The system is down at the moment. We are experiencing technical difficulties and hope to have them resolved soon. Please try again later. In a hurry? You might be able to apply faster at our Marketplace call center. Call 1-800-318-2596 to talk with one of our trained representatives about applying over the phone."

The other two options are: Learn and Get Insurance.

The Learn option says: "Find health coverage that works for you. Get quality coverage at a price you can afford. Open enrollment in the Health Insurance Marketplace continues until March 31, 2014." In turn it has two options: Apply Online
and Apply by Phone and 4 Ways to get Marketplace Coverage - Apply by Phone, Apply Online, Find Help Applying, and Apply by Paper.

The Get Insurance option says: "Welcome to the Marketplace. Enroll now in a plan that covers essential benefits, pre-existing conditions, and more. Open enrollment continues until March 31, 2014." In turn it has two options: Individuals and Families and Small Business Owners.

So now I am already a bit overwhelmed and there are still more things of the home page I have not even looked at. Fortunately I see: How do I apply for Marketplace coverage? which says:

"You can fill out a paper application and mail it in. You’ll find out whether you’re eligible for lower costs on private insurance, Medicaid, or the Children’s Health Insurance Program (CHIP).

Once you get your eligibility notice, you can either go online to compare, choose, and enroll in a plan or contact our call center. A customer service representative will help you.

If you or someone on your application are eligible for Medicaid or CHIP, a representative will contact you to enroll.

To get a paper application, download the application form and instructions."

So it looks like I could avoid the Web site problems altogether this way. I also found at the very bottom of that page a way to find local help which looked useful. I also got an email from the Fairfax Virginia County Government about help.

To better understand the Web site content and online application process that needs a tech surge to fix by Thanksgiving, I found a link For Developers that says the source code and content are accessible, but the link to HealthCare.gov Source Code does not work and the link to Prose does not provide much. So I decided I would have to repurpose the content myself to build a taxonomy (from the application process) and thesaurus (from the glossary), in preparation for Data Science and Be Informed knowledge bases. The background information mentions that the "Data Hub" is working well, but it is not openly exposed so developers could develop their own HealthCare.gov themselves like I am going to do.

I repurposed the Glossary and used the Site Map and application process logic to develop a metamodel taxonomy. A meta model describes a language, by introducing the types of concepts that occur in a domain, which types of relations exist between these concepts and which types of properties exist for these concepts and relations.

A Simplified HealthCare.gov Metamodel

A simplified metamodel from the above information is:

• HealthCare.gov
  ◦ Login (Not Available)
  ◦ Learn (Apply Online and Apply by Phone - 4 Ways to get Marketplace Coverage)
    • Apply by Phone
    • Apply Online
    • Find Help Applying
- Apply by Paper
  - **Get Insurance**
    - Individuals and Families
      - Choose Your State
      - Create an account
      - Apply
      - Pick a plan
      - Enroll
    - Small Business Owners
      - Choose Your State
      - Create an account
      - Apply
      - Pick a plan
      - Enroll
  - **All Topics**
    - Getting Lower Costs on Coverage
    - Young Adults
    - Using the Marketplace
    - Rights, Protections, and the Law
    - Prevention
    - Other Health Insurance Programs
    - If You Have Health Insurance
    - Health Insurance Marketplace
    - Health Insurance Basics
    - Businesses
  - **Glossary**
  - **Support**
  - **Other Things**
    - Individuals & Families
    - Small Businesses
    - All Topics
    - Get Insurance
    - Health Insurance Blog
    - Get your options & info
    - Glossary
    - Search
    - Connect With Us
    - Get Email Updates
Besides identifying yourself, the next most important step is to find What is the Marketplace in my state? so the web interface could be a map, but it would show 35 states using HealthCare.gov, 5 Territories Not Eligible, 16 states using their own marketplaces, and 3 states using both.

### HealthCare.gov By State

<table>
<thead>
<tr>
<th>State</th>
<th>Result</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>If you live in Alabama, <strong>you'll use this website, HealthCare.gov</strong>, to apply for coverage, compare plans, and enroll.</td>
<td>HealthCare.gov</td>
</tr>
<tr>
<td>Alaska</td>
<td>If you live in Alaska, <strong>you'll use this website, HealthCare.gov</strong>, to apply for coverage, compare plans, and enroll.</td>
<td>HealthCare.gov</td>
</tr>
<tr>
<td>American Samoa</td>
<td>If you live in the American Samoa, you're not eligible to use the Marketplace to apply for health insurance. Check with your territory’s government offices to learn about health coverage options.</td>
<td>Not Eligible</td>
</tr>
<tr>
<td>Arizona</td>
<td>If you live in Arizona, <strong>you'll use this website, HealthCare.gov</strong>, to apply for coverage, compare plans, and enroll.</td>
<td>HealthCare.gov</td>
</tr>
<tr>
<td>Arkansas</td>
<td>If you live in Arkansas, <strong>you'll use this website, HealthCare.gov</strong>, to apply for coverage, compare plans, and enroll.</td>
<td>HealthCare.gov</td>
</tr>
<tr>
<td>California</td>
<td>If you live in California, Covered California is the Health Insurance Marketplace to serve you. Instead of HealthCare.gov, you’ll use the Covered California website to apply for coverage, compare plans, and enroll. <a href="http://semanticommunity.info/Healthcare.gov"><em>Visit Covered California now to apply.</em></a></td>
<td>Covered California</td>
</tr>
<tr>
<td>Colorado</td>
<td>If you live in Colorado, Connect for Health Colorado is the Health Insurance Marketplace to serve you. Instead of HealthCare.gov, you’ll use the Connect for Health Colorado website to apply for coverage,</td>
<td>Connect for Health Colorado</td>
</tr>
<tr>
<td>State</td>
<td>Description</td>
<td>Website</td>
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</tr>
<tr>
<td>Connecticut</td>
<td>If you live in Connecticut, Access Health CT is the Health Insurance Marketplace to serve you. Instead of HealthCare.gov, you'll use the Access Health CT website to apply for coverage, compare plans, and enroll. Visit Access Health CT now to apply.</td>
<td>Access Health CT</td>
</tr>
<tr>
<td>Delaware</td>
<td>If you live in Delaware, you'll use this website, HealthCare.gov, to apply for coverage, compare plans, and enroll.</td>
<td>HealthCare.gov</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>If you live in the District of Columbia, DC Health Link is the Health Insurance Marketplace to serve you. Instead of HealthCare.gov, you'll use the DC Health Link website to apply for coverage, compare plans, and enroll. Visit DC Health Link now to apply.</td>
<td>DC Health Link</td>
</tr>
<tr>
<td>Florida</td>
<td>If you live in Florida, you'll use this website, HealthCare.gov, to apply for coverage, compare plans, and enroll.</td>
<td>HealthCare.gov</td>
</tr>
<tr>
<td>Georgia</td>
<td>If you live in Georgia, you'll use this website, HealthCare.gov, to apply for coverage, compare plans, and enroll.</td>
<td>HealthCare.gov</td>
</tr>
<tr>
<td>Guam</td>
<td>If you live in Guam, you’re not eligible to use the Marketplace to apply for health insurance. Check with your territory’s government offices to learn about health coverage options.</td>
<td>Not Eligible</td>
</tr>
<tr>
<td>Hawaii</td>
<td>If you live in Hawaii, the Hawaii Health Connector is the Health Insurance Marketplace to serve you. Instead of HealthCare.gov, you’ll use the Hawaii Health Connector website to apply for coverage, compare plans, and enroll. Visit Hawaii Health Connector</td>
<td>Hawaii Health Connector</td>
</tr>
<tr>
<td>State</td>
<td>Message</td>
<td>Website</td>
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</tr>
<tr>
<td>Hawaii</td>
<td>Hawaii Health Connector now to apply.</td>
<td>HealthCare.gov and Your Health Idaho</td>
</tr>
<tr>
<td>Idaho</td>
<td>If you live in Idaho, Your Health Idaho is the Health Insurance Marketplace to serve you. Your Health Idaho can give you information on local events and resources available in your state, including application assistance. For Open Enrollment this year, instead of the Your Health Idaho website, you'll use HealthCare.gov to apply for coverage, compare plans, and enroll.</td>
<td>HealthCare.gov</td>
</tr>
<tr>
<td>Illinois</td>
<td>If you live in Illinois, you'll use this website, HealthCare.gov, to apply for coverage, compare plans, and enroll.</td>
<td>HealthCare.gov</td>
</tr>
<tr>
<td>Indiana</td>
<td>If you live in Indiana, you'll use this website, HealthCare.gov, to apply for coverage, compare plans, and enroll.</td>
<td>HealthCare.gov</td>
</tr>
<tr>
<td>Iowa</td>
<td>If you live in Iowa, you'll use this website, HealthCare.gov, to apply for coverage, compare plans, and enroll.</td>
<td>HealthCare.gov</td>
</tr>
<tr>
<td>Kansas</td>
<td>If you live in Kansas, you'll use this website, HealthCare.gov, to apply for coverage, compare plans, and enroll.</td>
<td>HealthCare.gov</td>
</tr>
<tr>
<td>Kentucky</td>
<td>If you live in Kentucky, kynect: Kentucky’s Healthcare Connection is the Health Insurance Marketplace to serve you. Instead of HealthCare.gov, you'll use the kynect: Kentucky’s Healthcare Connection website to apply for coverage, compare plans, and enroll. Visit kynect: Kentucky’s Healthcare Connection now to apply.</td>
<td>kynect: Kentucky’s Healthcare Connection</td>
</tr>
<tr>
<td>Louisiana</td>
<td>If you live in Louisiana, you'll use this website, HealthCare.gov, to apply for coverage, compare plans, and enroll.</td>
<td>HealthCare.gov</td>
</tr>
<tr>
<td>State</td>
<td>Details</td>
<td>Website</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>Maine</td>
<td>If you live in Maine, <strong>you'll use this website, HealthCare.gov</strong>, to apply for coverage, compare plans, and enroll.</td>
<td>HealthCare.gov</td>
</tr>
<tr>
<td>Maryland</td>
<td>If you live in Maryland, the Maryland Health Connection is the Health Insurance Marketplace to serve you. Instead of HealthCare.gov, you'll use the Maryland Health Connection website to apply for coverage, compare plans, and enroll. <strong>Visit the Maryland Health Connection now to apply.</strong></td>
<td>Maryland Health Connection</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>If you live in Massachusetts, the Health Connector is the Health Insurance Marketplace to serve you. Instead of HealthCare.gov, you'll use the Health Connector website to apply for coverage, compare plans, and enroll. <strong>Visit the Health Connector now to apply.</strong></td>
<td>Massachusetts Health Connector</td>
</tr>
<tr>
<td>Michigan</td>
<td>If you live in Michigan, <strong>you'll use this website, HealthCare.gov</strong>, to apply for coverage, compare plans, and enroll.</td>
<td>HealthCare.gov</td>
</tr>
<tr>
<td>Minnesota</td>
<td>If you live in Minnesota, MNsure is the Health Insurance Marketplace to serve you. Instead of HealthCare.gov, you'll use the MNsure website to apply for coverage, compare plans, and enroll. <strong>Visit MNsure now to apply.</strong></td>
<td>MNsure</td>
</tr>
<tr>
<td>Mississippi</td>
<td>If you live in Mississippi, <strong>you'll use this website, HealthCare.gov</strong>, to apply for coverage, compare plans, and enroll. For small businesses and their employees: In Mississippi, your Small Business Health Options Program (SHOP) is OneMississippi. Instead of HealthCare.gov, you'll use the OneMississippi website to apply for coverage, compare plans, and enroll. Please</td>
<td>HealthCare.gov and OneMississippi</td>
</tr>
<tr>
<td>State</td>
<td>Information</td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------------------------------------------------------------------</td>
<td></td>
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<tr>
<td>Missouri</td>
<td>If you live in Missouri, <strong>you'll use this website, HealthCare.gov</strong>, to apply for coverage, compare plans, and enroll.</td>
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<td>Montana</td>
<td>If you live in Montana, <strong>you'll use this website, HealthCare.gov</strong>, to apply for coverage, compare plans, and enroll.</td>
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<td>If you live in Nebraska, <strong>you'll use this website, HealthCare.gov</strong>, to apply for coverage, compare plans, and enroll.</td>
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<tr>
<td>Nevada</td>
<td>If you live in Nevada, the Nevada Health Link is the Health Insurance Marketplace to serve you. Instead of HealthCare.gov, you’ll use the Nevada Health Link website to apply for coverage, compare plans, and enroll. <a href="http://semanticommunity.info/Healthcare.gov">Visit the Nevada Health Link now to apply.</a></td>
<td></td>
</tr>
<tr>
<td>New Hampshire</td>
<td>If you live in New Hampshire, <strong>you'll use this website, HealthCare.gov</strong>, to apply for coverage, compare plans, and enroll.</td>
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<td>If you live in New Jersey, <strong>you'll use this website, HealthCare.gov</strong>, to apply for coverage, compare plans, and enroll.</td>
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<tr>
<td>New Mexico</td>
<td>If you live in New Mexico, <a href="http://semanticommunity.info/Healthcare.gov">BeWellNM</a> is the Health Insurance Marketplace to serve you. The BeWellNM website can give you information on local events and resources available in your state, including application assistance. For Open Enrollment this year, instead of the BeWellNM website, <strong>you'll use HealthCare.gov</strong> to <a href="http://semanticommunity.info/Healthcare.gov">apply for coverage, compare plans, and enroll.</a></td>
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<td>North Carolina</td>
<td>If you live in North Carolina, you'll use this website, HealthCare.gov, to apply for coverage, compare plans, and enroll.</td>
<td><a href="http://semanticommunity.info/Healthcare.gov">HealthCare.gov</a></td>
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<td>North Dakota</td>
<td>If you live in North Dakota, you'll use this website, HealthCare.gov, to apply for coverage, compare plans, and enroll.</td>
<td><a href="http://semanticommunity.info/Healthcare.gov">HealthCare.gov</a></td>
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<tr>
<td>Northern Mariana Islands</td>
<td>If you live in the Northern Mariana Islands, you’re not eligible to use the Marketplace to apply for health insurance. Check with your territory’s government offices to learn about health coverage options.</td>
<td>Not Eligible</td>
</tr>
<tr>
<td>Ohio</td>
<td>If you live in Ohio, you'll use this website, HealthCare.gov, to apply for coverage, compare plans, and enroll.</td>
<td><a href="http://semanticommunity.info/Healthcare.gov">HealthCare.gov</a></td>
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<tr>
<td>Oklahoma</td>
<td>If you live in Oklahoma, you'll use this website, HealthCare.gov, to apply for coverage, compare plans, and enroll.</td>
<td><a href="http://semanticommunity.info/Healthcare.gov">HealthCare.gov</a></td>
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<tr>
<td>Oregon</td>
<td>If you live in Oregon, Cover Oregon is the Health Insurance Marketplace to serve you. Instead of HealthCare.gov, you’ll use the Cover Oregon website to apply for coverage, compare plans, and enroll. <a href="http://semanticommunity.info/Healthcare.gov">Visit Cover Oregon now to apply.</a></td>
<td><a href="http://semanticommunity.info/Healthcare.gov">Cover Oregon</a></td>
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<td>Pennsylvania</td>
<td>If you live in Pennsylvania, you'll use this website, HealthCare.gov, to apply for coverage, compare plans, and enroll.</td>
<td><a href="http://semanticommunity.info/Healthcare.gov">HealthCare.gov</a></td>
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<tr>
<td>Location</td>
<td>Information</td>
<td>Website/Program</td>
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<td>If you live in Puerto Rico, you’re not eligible to use the Marketplace to apply for health insurance. Check with your territory’s government offices to learn about health coverage options.</td>
<td>Not Eligible</td>
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<tr>
<td>Rhode Island</td>
<td>If you live in Rhode Island, HealthSource RI is the Health Insurance Marketplace to serve you. Instead of HealthCare.gov, you’ll use HealthSource RI website to apply for coverage, compare plans, and enroll. Visit HealthSource RI now to apply.</td>
<td>HealthSource RI</td>
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<td>South Carolina</td>
<td>If you live in South Carolina, you'll use this website, HealthCare.gov, to apply for coverage, compare plans, and enroll.</td>
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<td>South Dakota</td>
<td>If you live in South Dakota, you'll use this website, HealthCare.gov, to apply for coverage, compare plans, and enroll.</td>
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<td>Tennessee</td>
<td>If you live in Tennessee, you'll use this website, HealthCare.gov, to apply for coverage, compare plans, and enroll.</td>
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<tr>
<td>Texas</td>
<td>If you live in Texas, you'll use this website, HealthCare.gov, to apply for coverage, compare plans, and enroll.</td>
<td>HealthCare.gov</td>
</tr>
<tr>
<td>Utah</td>
<td>If you live in Utah, you'll use this website, HealthCare.gov, to apply for coverage, compare plans, and enroll. Here's what you need to know before you apply. You can also see if you qualify for lower costs and preview plans and prices. You’ll find out final costs and savings on Marketplace plans based on your specific situation when you apply. For small businesses and their employees: In Utah, your Small Business Health Options Program (SHOP) is Avenue H. Instead of HealthCare.gov, you’ll use HealthCare.gov and Avenue H.</td>
<td>HealthCare.gov and Avenue H</td>
</tr>
<tr>
<td>State</td>
<td>Information</td>
<td>Website/Link</td>
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<tr>
<td>---------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<td>Vermont</td>
<td>If you live in Vermont, Vermont Health Connect is the Health Insurance Marketplace to serve you. Instead of HealthCare.gov, you'll use the Vermont Health Connect website to apply for coverage, compare plans, and enroll. Visit Vermont Health Connect now to apply.</td>
<td>Vermont Health Connect</td>
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<tr>
<td>Virginia</td>
<td>If you live in Virginia, you'll use this website, HealthCare.gov, to apply for coverage, compare plans, and enroll.</td>
<td>HealthCare.gov</td>
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<td>Virgin Islands</td>
<td>If you live in the Virgin Islands, you're not eligible to use the Marketplace to apply for health insurance. Check with your territory’s government offices to learn about health coverage options.</td>
<td>Not Eligible</td>
</tr>
<tr>
<td>Washington</td>
<td>If you live in Washington, the Washington Healthplanfinder is the Health Insurance Marketplace to serve you. Instead of HealthCare.gov, you’ll use the Washington Healthplanfinder website to apply for coverage, compare plans, and enroll. Visit the Washington Healthplanfinder now to apply.</td>
<td>Washington Healthplanfinder</td>
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<tr>
<td>Wyoming</td>
<td>If you live in Wyoming, you'll use this website, HealthCare.gov, to</td>
<td>HealthCare.gov</td>
</tr>
</tbody>
</table>
Now if we had the database of Plan Information for each state, we could go from state, to county, to plans, to details very easily. I will do this for my county (Fairfax), and state (Virginia) as a specific example and skip 4 of the 5 the steps below. This will be the simple system that works and can be scaled up according to Gall’s Law.

- **Create an account**
  - First provide some basic information. Then choose a user name, password, and security questions for added protection.

- **Apply**
  - Next you’ll enter information about you and your family, including your income, household size, other coverage you’re eligible for, and more.
  - Use this checklist now to help you gather the information you’ll need.

- **Pick a plan**
  - Next you’ll see all the plans and programs you’re eligible for and compare them side-by-side.
  - You’ll also find out if you can get lower costs on monthly premiums and out-of-pocket costs.

- **Enroll**
  - Choose a plan that meets your needs and enroll!
  - Coverage starts as soon as January 1, 2014.

---

**HealthCare.gov Plan Information Example**

**Source:** [https://www.healthcare.gov/find-premium-estimates/](https://www.healthcare.gov/find-premium-estimates/)

**Answer a few quick questions to see the premium estimates**

**IMPORTANT NOTE:** The prices shown on this tool don’t reflect the lower costs you may qualify for based on household size and income.

**Which best describes you?**

- I'm looking for coverage for myself or my family **SELECTED**
- I'm looking for coverage for a small business I own or operate

**What type of coverage do you need?**

(Select one.)

- Health **SELECTED**
- Dental

Dental coverage will be included in some plans. In some cases, separate, stand-alone plans will be offered.
What state do you live in?

- Virginia SELECTED

What county do you live in?

- Fairfax SELECTED

Who will you apply for health coverage for?

(Select one.)

- Only you
- You and your spouse SELECTED
- You, your spouse, and your children
- You and your children
- Only your children

Message

All plans must offer the same essential health benefits. These benefits include coverage for things like:

- Doctor visits
- Prescription drugs
- Hospitalization
- Maternity and newborn care
- Preventive care

Plans can offer other benefits, like vision, dental, or medical management programs for a specific disease or condition. As you compare plans, you'll see what benefits each plan covers.

Most people who apply will qualify for lower costs

Most people who apply for coverage in the Marketplace will qualify for lower costs on monthly premiums based on their household size and income.

The chart on the right shows household sizes and income levels that qualify for lower costs. The lower your income within the ranges shown, the lower your premium costs will be.

Some people with lower incomes within these ranges will qualify to save money on out-of-pocket costs like deductibles and copayments.

<table>
<thead>
<tr>
<th>Number of people in your household</th>
<th>Income range to qualify for lower costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$11,490 to $45,960</td>
</tr>
<tr>
<td>2</td>
<td>$15,510 to $62,040</td>
</tr>
</tbody>
</table>
These 5 categories (catastrophic, bronze, silver, gold, and platinum) are based on how you and the plan expect to share the costs for health care.

The category you choose affects how much your premium costs each month and what portion of the bill you pay for things like hospital visits or prescription drugs.

It also affects your total out-of-pocket costs - the total amount you'll spend for the year if you need lots of care.

**Plans are put into 5 categories**

- **Catastrophic**: Covers less than 60% of the total average costs of care
- **Bronze**: Covers 60% of the total average costs of care
- **Silver**: Covers 70% of the total average costs of care
- **Gold**: Covers 80% of the total average costs of care
- **Platinum**: Covers 90% of the total average costs of care

**Results**

Source: [https://www.healthcare.gov/find-premium-estimates/#results/](https://www.healthcare.gov/find-premium-estimates/#results/)

- All plans (50):
  - Catastrophic: Covers less than 60%
  - Bronze: Covers 60% of costs
  - Silver: Covers 70% of costs
  - Gold: Covers 80% of costs
  - Platinum: Covers 90% of costs
Your answers:
- Coverage type: Individual & Family
- Coverage: Medical
- Location: VA - Fairfax
- Who needs coverage: You and your spouse
- Insurance companies:
  - CareFirst BlueChoice, Inc.
  - Innovation Health Insurance Company
  - Anthem Blue Cross and Blue Shield
  - Kaiser Permanente
  - CareFirst BlueCross BlueShield
  - Anthem Health Plans of Virginia

Their Note: All health plans and stand-alone dental plans may not be available at this time, due to technical issues. We'll update this information as soon as it's available.

<table>
<thead>
<tr>
<th>Name</th>
<th>Provider</th>
<th>Type</th>
<th>Category</th>
<th>Estimated premium</th>
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<tbody>
<tr>
<td>BlueChoice Young Adult $6,350</td>
<td>CareFirst BlueChoice, Inc.</td>
<td>HMO</td>
<td>Catastrophic</td>
<td>$302.24</td>
</tr>
<tr>
<td>IH Basic</td>
<td>Innovation Health Insurance Company</td>
<td>PPO</td>
<td>Catastrophic</td>
<td>$314.00</td>
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<tr>
<td>BlueChoice HSA Bronze $6,000</td>
<td>CareFirst BlueChoice, Inc.</td>
<td>HMO</td>
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<td>BlueChoice HSA Bronze $4,000</td>
<td>CareFirst BlueChoice, Inc.</td>
<td>HMO</td>
<td>Bronze</td>
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<tr>
<td>Anthem HealthKeepers Catastrophic DirectAccess</td>
<td>Anthem Blue Cross and Blue Shield</td>
<td>HMO</td>
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<td>$384.52</td>
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<tr>
<td>IH Advantage 6350</td>
<td>Innovation Health Insurance Company</td>
<td>PPO</td>
<td>Bronze</td>
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<tr>
<td>Plan Name</td>
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<td>IH AdvantagePlus 5500 PD</td>
<td>Innovation Health Insurance Company</td>
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<td>Bronze</td>
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<td>BlueChoice Plus Bronze $5,500</td>
<td>CareFirst BlueChoice, Inc.</td>
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<td>Bronze</td>
<td>$426.24</td>
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<tr>
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<td>Kaiser Permanente</td>
<td>HMO</td>
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<td>$434.36</td>
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<tr>
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<td>$455.78</td>
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<tr>
<td>KP VA Bronze 5000/30%/HSA/Dental</td>
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<td>HMO</td>
<td>Bronze</td>
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<tr>
<td>KP VA Bronze 4500/50/HSA/Dental</td>
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<td>HMO</td>
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http://semanticommunity.info/Healthcare.gov
Updated: Sat, 19 Sep 2015 01:00:50 GMT
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<th>Provider Name</th>
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<td>Kaiser Permanente</td>
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<td>IH Classic 5000</td>
<td>Innovation Health Insurance Company</td>
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<td>HMO</td>
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<td>HMO</td>
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<td>Silver</td>
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<td><strong>BlueCross BlueShield Preferred 1500, A Multi-State Plan</strong></td>
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<td><strong>BlueChoice Gold $1,000</strong></td>
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<td>IH Classic 3500 PD: MO</td>
<td>Innovation Health Insurance Company</td>
<td>PPO</td>
<td>Silver</td>
<td>$3478.00</td>
</tr>
<tr>
<td>IH Premier 2000 PD: MO</td>
<td>Innovation Health Insurance Company</td>
<td>PPO</td>
<td>Gold</td>
<td>$3544.00</td>
</tr>
</tbody>
</table>

**Marketplace Application Checklist**


When you apply for coverage in the Health Insurance Marketplace, you’ll need to provide some information about you and your household, including income, any insurance you currently have, and some additional items.

Use the checklist below to help you gather what you need to apply for coverage. Open enrollment starts October 1, 2013 for coverage starting as early as January 1, 2014. Open enrollment ends March 31, 2014.

- Social Security Numbers (or document numbers for legal immigrants)
- Employer and income information for every member of your household who needs coverage (for example, from pay stubs or W-2 forms—Wage and Tax Statements)
- Policy numbers for any current health insurance plans covering members of your household
- A completed **Employer Coverage Tool** (see page 2 of this checklist: **My Note: See below**) for every job-based plan you or someone in your household is eligible for. (You’ll need to fill out this form even for coverage you’re eligible for but don’t enroll in.)
Conclusions and Recommendations

- Gall’s Law can be used to better understand the HealthCare.gov Web site content and online application process and to build a simple system that works.

- The background information mentions that the "Data Hub" is working well, but it is not openly exposed so developers could develop their own HealthCare.gov themselves like I am going to do.

- A simple “Data Hub” was built in a spreadsheet and could be scaled up by screen scraping code.

- My HealthCare.gov Results Costs are visualized by Provider and Category to help my decision making.

- Be Informed Be Free is being used in a series of free training events and to pilot agile HealthCare.gov without expensive software development.

Slides
Slide 1 Data Science for HealthCare.gov

http://semanticommunity.info/
http://datacommunitydc.org/blog/2013...ce-conference/
http://semanticommunity.info/Healthcare.gov

Slide 2 Background

Background

• HealthCare.gov was launched October 1st by President Obama.
• HHS Secretary Kathleen Sebelius accepted responsibility for problems with HealthCare.gov before Congress on October 30th.
• I followed Gall's Law to better understand the Web site content and online application process and to build a simple system that works.
• I repurposed the content to build a taxonomy (from the application process) and thesaurus (from the glossary), to create knowledge bases for Data Science and Be Informed Applications.

Slide 3 Healthcare.gov

https://www.healthcare.gov/
Slide 4 Site Map and Glossary

https://www.healthcare.gov/sitemap/

Slide 5 Goals and Process

http://semanticommunity.info/Army_Weapon_Systems_Handbook_2012#Gall's_Law
Goals and Process

- The goal was to build a simple system that works and can be scaled up according to Gail’s Law.
- The process was:
  - A Simplified Healthcare.gov Metamodel
  - Healthcare.gov By State
  - Healthcare.gov Plan Information Example
    - Answer a few quick questions to see the premium estimates
    - What type of coverage do you need?
    - What state do you live in?
    - What county do you live in?
    - Who will you apply for health coverage for?
    - Message
  - Most people who apply will qualify for lower costs
  - Plans are put into 5 categories
- Results

- The results are shown in MindTouch, Spreadsheet, Spotfire, and Be Informed Knowledge Bases.

Slide 6 Knowledge Base: MindTouch

http://semanticommunity.info/Healthcare.gov

Knowledge Base: MindTouch

Slide 7 Knowledge Base: Spreadsheet

http://semanticommunity.info/@api/deki/files/26890/Healthcare.gov.xlsx
Knowledge Base: Spreadsheet

My Note: All of these spreadsheets can be searched.

My Note: The Semantic Community approach is consistent with the European ISA Recommended URI Design and Management Principles.

http://semanticommunity.info/#!/api/debi/Files/26890/Healthcare.gov.xlsx

Slide 8 Knowledge Base: Spotfire

Web Player

Knowledge Base: Spotfire

https://silverspotfire.tibco.com/softlibrary/users/beiemann/Public/Healthcare.gov-Spotfire.xlsx

Slide 9 Knowledge Base: Be Informed

http://www.beinformed.com/BeInformed...yEventsArchive
http://www.beinformed.com/BeInformed...ommunityEvents
Slide 10 Conclusions and Recommendations

http://www.hhs.gov/digitalstrategy/...ov-better.html

Conclusions and Recommendations

• Gall’s Law can be used to better understand the HealthCare.gov Web site content and online application process and to build a simple system that works.
• The background information mentions that the “Data Hub” is working well, but it is not openly exposed so developers could develop their own HealthCare.gov themselves like I am going to do.
• A simple “Data Hub” was built in a spreadsheet and could be scaled up by screen scraping code.
• My HealthCare.gov Results Costs are visualized by Provider and Category to help my decision making.
• Be Informed Be Free is being used in a series of free training events and to pilot agile HealthCare.gov without expensive software development.

Spotfire Dashboard

For Internet Explorer Users and Those Wanting Full Screen Display Use: Web Player Get Spotfire for iPad App

Media, iframe, embed and object tags are not supported inside of a PDF.

Story

Be Informed for Healthcare.gov
Slides

Slide 1 Be Informed for HealthCare.gov

http://semanticommunity.info/
http://datacommunitydc.org/blog/2013...ce-conference/
https://silverspotfire.tibco.com/us/...niemann/Public
http://semanticommunity.info/Healthcare.gov

Slide 2 Background and Purpose

BPM, Semantic Medline, Data Science, YarcData, & Be Informed

http://www.informationweek.com/obama...s-bpm-adoption
http://www.youtube.com/watch?v=ShfI4SNzNO4
http://www.youtube.com/watch?v=6fNAmPD0mo
http://semanticommunity.info/Data_Science/Data_Science_Symposium_2013
http://semanticommunity.info/Healthcare.gov
Background and Purpose:
BPM, Semantic Medline, Data Science, YarcData, & Be Informed

- Obamacare Drives One Health Plan’s BPM Adoption:
  - Regulatory changes brought about by the Affordable Care Act prompted Fallon Health Plans to decide it needed a flexible framework for automating its business process management.
- The videos of our NIH Semantic Medline with YarcData Graph Appliance Data Science Team work are available on YouTube:
  - Schizo (7 minutes):
    - [http://www.youtube.com/watch?v=S3H61NlN0O](http://www.youtube.com/watch?v=S3H61NlN0O)
  - Cancer (21 minutes):
    - [http://www.youtube.com/watch?v=wDrfrApI8Ko](http://www.youtube.com/watch?v=wDrfrApI8Ko)
- Our work for the upcoming NIST Data Science Symposium is at:
- We are using Semantic Data Science to get HealthCare.gov and other HHS databases into RDF with stronger relationships for data integration:
  - [http://semanticommunity.info/HealthCare.gov](http://semanticommunity.info/HealthCare.gov)
- Be Informed for HealthCare.gov can generate a semantic data base for discovery in YarcData:
  - See the next slides.

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**Slide 3 Data Science Team Example**

Chief Technology Officer

**Data Science Team Example:**

Chief Technology Officer

- **Chief Technology Officer:**
  - Todd Park, US Federal Chief Technology Officer and Health Data Innovation
- **Data Science Team:**
  - Dr. Brand Niemann, Lead, Director and Senior Data Scientist, Semantic Community
    - Semantic Data Science on HealthCare.gov and other HHS databases
  - Damon Davis, Deputy Director, HHS Health Data Initiative
    - Enabling and incentivizing the health data ecosystem to utilize all data assets in innovative ways
  - Kees van Mansum, Be Informed Information Architect and Be Free Community Manager
    - Be Informed HealthCare.gov Modeling
  - Aaron Bossett, YarcData Federal Solution Architect
    - Managing RDF Triple Stores in YarcData
  - Dr. Eric Little, Modus Operandi Chief Scientist
    - Ontologist and Semantic Technology Applications for Health Data
  - Millis Davis, Managing Director, Project 10x
    - Cray Computer Advisor for YarcData Graph Appliance

---

**Slide 4 Data Science for HealthCare.gov**

Semantic Community

Slide 5 Be Informed HealthCare.gov

Installation Instructions
http://localhost:8080/beinformed/webui/webapp/

Be Informed HealthCare.gov:
Installation Instructions

- I have included the repository and add-on file.
- You can import and use the repository and provided add-on in your own workspace of your Be Informed Personal Edition by following this instruction:
  - Unzip the Add-on.zip file and copy the contents to the Add-ons folder in your Be Informed installation (typically: C:\Be Informed\Be Informed Studio 4.2.4. Personal Edition\addons)
  - Start Be Informed Personal Edition
  - Choose File > Import, Existing Projects into Workspace, then Select archive file and browse to the zip-file with the repository.
  - Select all projects in the file and click Finish to add them to your workspace.
- You can see the web portal on:

Slide 6 Create a New Be Informed Project

HealthCare.gov in Be Informed Studio
Slide 7 Model Overview

What is your income?

Slide 8 Model Overview

How much coverage do you want in your health plan?
Slide 9 Web Portal Example

Below Income Maximum

http://localhost:8080/beinformed/webui/webapp/

Slide 10 Next Steps

Creating a Benefit Application in Less Than 30 Minutes

http://www.beinformed.com/BeInformed...ommunityEvents
Next Steps:
Creating a Benefit Application in Less Than 30 Minutes

Research Notes

http://www.slate.com/articles/technology/bitwise/2013/10/
healthcare_gov_problems_house_committee_hearing_is_a_spectacle_of_tech_illiteracy.html

PPACA Implementation Failures: Answers from HHS

Source: http://energycommerce.house.gov/hearing/ppaca-implementation-failures-answers-hhs

Wednesday, October 30, 2013 - 9:00am
Energy and Commerce
2123 Rayburn
Background Documents and Information:

Hearing Notice My Note: See below

Background Memo My Note: See below

Opening Statements:

Energy and Commerce Committee Chairman Fred Upton My Note: See below

Energy and Commerce Committee Vice Chairman Marsha Blackburn My Note: See below
Witnesses:

The Honorable Kathleen Sebelius

- Secretary
- U.S. Department of Health and Human Services
- **Witness Testimony** My Note: See below

Congress:

113th

**Hearing Notice**

Source: [PDF]
The Committee on Energy and Commerce has scheduled a hearing on Wednesday, October 30, 2013, at 9:00 a.m. in 2123 Rayburn House Office Building. The title of the hearing is “PPACA Implementation Failures: Answers from HHS.” Witnesses will be announced and are by invitation only. The hearing webcast will be available at http://energycommerce.house.gov.

By Order of Chairman Upton

Background Memo

Source: (PDF)

THE COMMITTEE ON ENERGY AND COMMERCE
MEMORANDUM
October 28, 2013
To: Members, Full Committee
From: Majority Committee Staff
Re: Hearing Entitled “PPACA Implementation Failures: Answers from HHS”

On Wednesday, October 30, 2013, at 9:00 a.m. in 2123 Rayburn House Office Building, the Committee on Energy and Commerce will hold a hearing entitled “PPACA Implementation Failures: Answers from HHS.” This hearing will focus on the failures and issues surrounding the implementation of Patient Protection and Affordable Care Act’s (PPACA) health insurance exchanges. The following provides background on the hearing.

I. WITNESS

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services

II. BACKGROUND

A. PPACA Implementation

PPACA implementation has involved multiple government agencies and contractors. Agencies such as the Centers for Medicare and Medicaid Services (CMS), Internal Revenue Service, Social Security Administration, Department of Homeland Security, and the Office of Personnel Management are involved in the implementation of the PPACA exchanges. In addition, the Department of Health and Human Services (HHS) has entered into contracts with organizations to assist with the creation and operation of such exchanges, including the Federally facilitated marketplace (FFM). These contractors are assisting with activities such as IT buildup, eligibility verification, developing procedures for the receipt and processing of paper applications, and the creation of a data services hub to route information between agencies, contractors, and exchanges. Several of these contractors appeared before the Subcommittee on Health in September to discuss the status of their work. 1

Open enrollment in the PPACA exchanges began October 1, 2013, with coverage planned to be effective on January 1, 2014. Prior to the open enrollment start date, many questions were raised related to the readiness, testing, and functionality of the exchanges. Missed deadlines, delays, and untimely guidance raised questions regarding consumer assistance and experience, eligibility accuracy, integration with existing State programs, and interagency coordination.

In June, the Government Accountability Office (GAO) issued a report 2 raising key questions regarding the readiness of the FFM. GAO found that core functions of the FFM had yet to be completed and concluded that CMS “has many key activities remaining to be completed across the core exchange functions – eligibility and enrollment, including development and implementation of the data hub; program management; and consumer assistance.” GAO further stated
that “much remains to be accomplished within a relatively short amount of time” and the “completion of certain activities was behind schedule.”

Despite such issues, HHS officials repeatedly assured the public that implementation was progressing on time and as intended. In July, Secretary Sebelius stated that HHS was “on track to flip the switch on October 1 and say to people, ‘Come on and sign up.’”

On August 1, 2013, CMS Administrator Marilyn Tavenner’s written testimony stated “when consumers visit the Marketplace through Healthcare.gov beginning on October 1, 2013, they will experience a new way to shop for health coverage.” Administrator Tavenner further testified that “the online version of the application will be a dynamic experience that shortens the application process…”

As recently as September 19, 2013, the head of CMS’ Center for Consumer Information and Insurance Oversight testified that “Consumers will be able to go online, they will be able to get a determination of what tax subsidies they are eligible for, they’ll be able to look at the plans that are available where they live, they will be able to see the premium net of subsidy that they would have to pay, and they will be able to choose a plan and get enrolled in coverage beginning October 1.”

**B. Problems With the Federally Facilitated Marketplace**

Since the October 1 start of open enrollment, major media outlets have described the launch of PPACA’s exchange program as “plagued by problems” and “nothing short of disastrous.” The launch of the exchanges has been fraught with significant problems that are leading to major delays for Americans attempting to shop for health coverage.

Review of 47 State exchanges, particularly sites run by the Federal government, turned up “frequent error messages or traffic overload notices.”

Reports suggest these problems may be caused by inadequate server capacity, poor software coding, and system architecture.

Other reports suggest such problems stem from a design element requiring users “create accounts before shopping for insurance.” An HHS spokeswoman said the “agency wanted to ensure that users were aware of their eligibility for subsidies that could help pay for coverage, before they started seeing the prices of policies.” In addition, insurers have stated that the Federal exchange is “generating flawed data,” including “duplicate enrollments, spouses reported as children, missing data fields, and suspect eligibility determinations.”

Secretary Sebelius recently concluded after a two week review that “[w]e didn’t have enough testing, specifically for high volumes, for a very complicated project.” Furthermore, the Secretary stated that “[HHS] had two years and almost no testing.”

**C. Energy and Commerce Committee’s October 24, 2013, Hearing**

On October 24, 2013, the Energy and Commerce Committee held a hearing entitled “PPACA Implementation Failures: Didn’t Know or Didn’t Disclose?” At the hearing, the following contractors testified regarding the problems since October 1, 2013: CGI Federal, Optum/QSSI, Equifax Workforce Solutions and Serco. Wednesday’s hearing will be an opportunity to gather additional information on the problems from the HHS Secretary.

**III. STAFF CONTACTS**

Should you have any questions regarding the hearing, please contact Karen Christian, Sean Hayes, Paul Edattel, or Clay Alspach at (202) 225-2927.
Footnotes

1

2

3
Ibid.

4

5
Hearing before the Energy and Commerce Committee, “PPACA Pulse Check”, August 1, 2013.

6
Ibid.

7

8
Kelly Kennedy, Health Care Exchange Still Plagued by Problems, USA TODAY, October 16, 2013.

9
Jan Crawford, Obamacare Overload: Congress Demands Answers About Health Care Site, CBS This Morning (October 9, 2013), http://www.cbsnews.com/video/watch/?id=50156756n.
Energy and Commerce Committee Chairman Fred Upton

Opening Statement of the Honorable Fred Upton
Committee on Energy and Commerce
Hearing on “PPACA Implementation Failures: Answers from HHS”
October 30, 2013
(As Prepared for Delivery)

The Energy and Commerce Committee welcomes the president’s point person on health care, Secretary Sebelius, as part of our continuing oversight of the health care law. We look forward to a thoughtful conversation on a number of issues including transparency and fairness.

Over the months leading up to the October 1 launch, the secretary and her colleagues at HHS repeatedly looked us in the eye and testified that everything was on track. Despite the numerous red flags and lack of testing, they assured us that all systems were a go.

But something happened along the way – either those officials did not know how bad the situation was, or they did not disclose it. Sadly, here we are, now five weeks into enrollment, and the news seems to get worse by the day.
Healthcare.gov was down last night at 5:00 p.m. It was also down on Monday, and it crashed last weekend. And even this morning when we attempted to view the site before this hearing, we were hit with an error message.

But this is more than just a website problem – that was supposed to be the easy part. Americans were assured their experience would be similar to other online transactions like purchasing a flight or ordering a pizza and that their sensitive personal information would be kept secure. But after more than three years to prepare, malfunctions have become the norm and the administration has pivoted from saying they are “on track” to setting a new target date of November 30. And for those few Americans who have successfully applied, will the website glitches become provider glitches on January 1?

Americans are scared and frustrated, and this situation should rise above politics. Many folks at home watching us today have spent hours or even days trying to sign up. They continue to take time away from work or loved ones but have made little progress, and soon they may worry about being on the wrong side of their government, facing potential penalties. I recently spoke to a woman from Buchanan, Michigan, who was excited to sign up, but has since become disillusioned after spending hours on the phone and website with little success. There are also millions of Americans coast to coast who no doubt believed the president’s repeated promise that if they liked their plan, they’d be able to keep it “no matter what.” They are now receiving termination notices, and for those who lose the coverage they like, they may also be losing faith in their government.

Today’s hearing is about fairness for the American people who are losing their coverage or seeing their premiums skyrocket as high as 400 percent. This hearing is also about transparency. While the administration continues to boast the number of Americans that have “applied,” they intentionally withhold precise enrollment numbers. Why? These numbers are critical to fully understanding the status and gauging progress of implementation. Lead contractor CGI testified last week that they had the data, but needed the administration’s permission to release it. We asked the Secretary on October 8 for those figures, but still have not received a response. We hope to get one today.

The American people deserve answers as well as the peace of mind that promises will be kept. The secretary has an opportunity today to embrace transparency and start restoring the public’s faith in the administration and government.

Energy and Commerce Committee Vice Chairman Marsha Blackburn

Opening Statement of the Honorable Marsha Blackburn
Committee on Energy and Commerce
Hearing on “PPACA Implementation Failures: Answers from HHS”
October 30, 2013
(As Prepared for Delivery)

For four years, the president told Americans that if they like the health insurance plan they have, they can keep it. The facts today show this is not the case. Everyday, my office gets letters from constituents letting us know they have been thrown off their current plan. Adding insult to injury, the website to buy one of the president’s plans doesn’t even work. For those that are able to get through, many are finding their premiums going up, not down. The botched rollout of this law simply confirms everyone’s worst fears about government run health care. If they government can’t figure out how to run a website, how will they be able to figure out how to take care of us. Today we continue our investigation into these issues of behalf of all Americans whose lives are affected by this law.

Witness Testimony

Source: (PDF)
Preface

Good morning, Chairman Upton, Ranking Member Waxman, and members of the Committee. On October 1st, we launched one of the key provisions of the Affordable Care Act—the new Health Insurance Marketplace, where people without health insurance, including those who cannot afford health insurance, and those who are not part of a group plan, can go to get affordable coverage. Consumers can access the Marketplace in several ways—through a call center, by filling out a paper application, with the help of in-person assistance, or by going online and filling out an application on HealthCare.gov.

Over the past few weeks, millions of Americans have visited HealthCare.gov to look at their new health coverage options under the Affordable Care Act. In that time, nearly 700,000 applications have been submitted to the Federal and state marketplaces from across the Nation. This tremendous interest—with over 20 million unique visits to date to HealthCare.gov—confirms that the American people are looking for quality, affordable health coverage. Unfortunately, the experience on HealthCare.gov has been frustrating for many Americans. Some have had trouble creating accounts and logging in to the site, while others have received confusing error messages, or had to wait for slow page loads or forms that failed to respond in a timely fashion. The initial consumer experience of HealthCare.gov has not lived up to the expectations of the American people and is not acceptable. We are committed to fixing these problems as soon as possible.

Improvements Already Made to HealthCare.gov

To build the Marketplace, CMS used private sector contractors, just as it does to administer aspects of Medicare. CMS has a track record of successfully overseeing the many contractors our programs depend on to function. Unfortunately, a subset of those contracts for HealthCare.gov have not met expectations. Among other issues, the initial wave of interest stressed the account service, resulting in many consumers experiencing difficulty signing up, while those who were able to sign up sometimes had problems logging in.
In response, we have made a number of improvements to the account service. We have updated the site several times with new code that includes bug fixes that have improved the HealthCare.gov experience. We continue to add more capacity in order to meet demand and execute software fixes to address the sign up and log in issues, stabilizing those parts of the service and allowing us to remove the virtual “waiting room.” Today, more individuals are successfully creating accounts, logging in, and moving on to apply for coverage and shop for plans. We are pleased with these quick improvements, but we know there is still significant, additional work to be done. We continue to conduct regular maintenance nearly every night to improve the consumer experience.

Reinforcements

To address the technical challenges with HealthCare.gov, we are putting in place tools and processes to aggressively monitor and identify parts of HealthCare.gov where individuals are encountering errors or having difficulty using the site, so we can prioritize and address them. We are also working to prevent new issues from cropping up as we improve the overall service and deploy fixes to the site during off-peak hours on a regular basis.

To ensure that we make swift progress, and that the consumer experience continues to improve, our team has called in additional help to solve some of the more complex technical issues we are encountering. We are bringing in people from both inside and outside government to scrub in with the team and help improve HealthCare.gov. Specifically, we are bringing on board management expert and former CEO and Chairman of two publicly traded companies, Jeff Zients, to work in close cooperation with our HHS team to provide management advice and counsel to the project. Mr. Zients has led some of the country’s top management firms, providing private sector companies around the world with best practices in management, strategy, and operations. He has a proven track record as Acting Director at the Office of Management and Budget and as the Nation’s first Chief Performance Officer. Working alongside our team and using his rich expertise and management acumen, Mr. Zients will provide advice, assessments, and recommendations.

Our team has also brought in additional experts and specialists drawn from within government, our contractors, and industry, including veterans of top Silicon Valley companies. These reinforcements include several Presidential Innovation Fellows. This new infusion of talent will bring a powerful array of subject matter expertise and skills, including extensive experience scaling major IT systems. They are part of a cross-functional team that is working aggressively to diagnose the parts of HealthCare.gov that are experiencing problems, learn from successful states, prioritize issues, and fix them.

As part of our team’s efforts to ramp up capacity and expertise with the country’s leading innovators and problem solvers, our contractors—including CGI, the lead firm responsible for the Federally-Facilitated Marketplace technology—have secured additional staff and made additional staffing commitments. They are providing and directing the additional resources needed for this project.

Expanding Access to Affordable Coverage Through the Health Insurance Marketplace

We are committed to improving the consumer experience with HealthCare.gov, which serves as an important entry point to the new Marketplace. The new Marketplace is a place that enables people without health insurance, including those who cannot afford health insurance, and those who are not part of a group plan, to finally start getting affordable coverage.

Just a few weeks into a six-month open enrollment period, while some consumers have had to wait too long to access the Marketplace via HealthCare.gov, the Marketplace is working for others and consumers are also utilizing the call center, paper applications and in-person assistance to apply for coverage.

The idea of the Marketplace is simple. By enrolling in private health insurance through the Marketplace, consumers effectively become part of a form of statewide group coverage that spreads risk between sick people and healthy people, between young and old, and then bargains on their behalf for the best deal on health insurance. Because we have created competition where there was not competition before, insurers are now eager for new business, and have created new health care plans with more choices.
The bids submitted by insurers provide clear evidence that the Marketplace is encouraging plans to compete for consumers, resulting in more affordable rates. The weighted average premium for the second-lowest-cost silver plan, looking across 47 states and DC, is 16 percent below the premium level implied by earlier Congressional Budget Office estimates. Outside analysts have reached similar conclusions. A recent Kaiser Family Foundation report found that, “while premiums will vary significantly across the country, they are generally lower than expected,” and that fifteen of the eighteen states examined would have premiums below the CBO-projected national average of $320 per month for a 40-year-old in a silver plan.

This is good news for consumers. In fact, some insurers lowered their proposed rates when they were finalized. In Washington, D.C., some issuers have reduced their rates by as much as 10 percent. In Oregon, two plans requested to lower their rates by 15 percent or more. New York State has said, on average, the approved 2014 rates for even the highest coverage levels of plans individual consumers can purchase through its Marketplace (gold and platinum) represent a 53 percent reduction compared to last year’s direct-pay individual market rates. Furthermore, states are using their rate review powers to review and adjust rates accordingly. In Oregon, the state has reduced rates for some plans by as much as 35 percent, and in Maryland, the state has reduced some rates for coverage offered through the Marketplace by almost 30 percent, offering consumers an even better deal on their coverage for the 2014 plan year.

In addition to the more affordable rates resulting from competition among insurers, insurance affordability programs, including premium tax credits and cost-sharing reductions, will help many eligible individuals and families, significantly reducing the monthly premiums and cost-sharing paid by consumers. Premium tax credits may be paid in advance and applied to the purchase of a qualified health plan through the Marketplace, enabling consumers to reduce the upfront cost of purchasing insurance. In addition, cost-sharing reductions will lower out-of-pocket payments for deductibles, coinsurance, and copayments for eligible individuals and families. A recent RAND report indicated that, for the average Marketplace participant nationwide, the premium tax credits will reduce out-of-pocket premium costs by 35 percent from their unsubsidized levels.

CBO has projected that about 8 in 10 Americans who obtain coverage through the Marketplace will qualify for assistance to make their insurance more affordable, an estimated 20 million Americans by 2017. A family’s eligibility for these affordability programs depends on its family size, household income, and access to other types of health coverage.

The fact is that the Affordable Care Act delivered on its product: quality, affordable health insurance. The tremendous interest shown in HealthCare.gov shows that people want to buy this product. We know the initial consumer experience at HealthCare.gov has not been adequate. We will address these initial and any ongoing problems, and build a website that fully delivers on this promise of the Affordable Care Act.

Other Benefits of the Affordable Care Act

While we are working around the clock to address problems with HealthCare.gov, it is important to remember that the Affordable Care Act is much more than purchasing insurance through HealthCare.gov. Most Americans—85 percent—already have health coverage through an employer-based plan, or health benefit, such as Medicare, Medicaid, or the Children’s Health Insurance Program (CHIP). For these Americans, the Affordable Care Act provides new benefits and protections, many of which have been in place for some time. For example, because of the Affordable Care Act, millions of young adults have been able to stay on their parents’ plans until they are 26. Because of the Affordable Care Act, seniors on Medicare receive greater coverage of their prescription medicine, saving them billions. Because of the Affordable Care Act, for millions of Americans, recommended preventive care like mammograms is free through employer-sponsored health coverage. And in states where governors and legislatures have allowed it, the Affordable Care Act provides the opportunity for many Americans to get covered under Medicaid for the first time. In Oregon, for example, a Medicaid eligibility expansion will help cut the number of uninsured people by 10 percent, as a result of enrollment efforts over the last few weeks, resulting in 56,000 more Americans who will now have access to affordable health care.
The Affordable Care Act is also holding insurers accountable for the rates they charge consumers. For example, insurance companies are now required to justify a rate increase of 10 percent or more, shedding light on unnecessary costs. Since this rule was implemented, the proportion of rate filings requesting insurance premium increases of 10 percent or more has plummeted from 75 percent in 2010 to an estimated 14 percent in the first quarter of 2013, saving Americans an estimated $1.2 billion on their health insurance premiums. These figures strongly suggest the effectiveness of review of rate increases.

The rate review program works in conjunction with the so-called 80/20 rule (or Medical Loss Ratio rule), which generally requires insurance companies in the individual and small group markets to spend at least 80 percent of premiums on health care and quality improvement activities and no more than 20 percent on administrative costs (such as executive salaries and marketing) and profits. In the large group market (generally coverage sold to employers with more than 50 employees), insurers must spend at least 85 percent of premiums on medical care and quality improvement activities. If insurers fail to meet their medical loss ratio requirement, they must provide rebates to their customers.

New rules will help make health insurance even more affordable for more Americans beginning next year. Marketplace health insurance plans will be prohibited from charging higher premiums to applicants because of their current or past health problems or gender, and will be limited in how much more they can charge Americans based on their age.

Conclusion
The Affordable Care Act has already provided new benefits and protections to Americans with health insurance, and we are committed to improving the experience for consumers using HealthCare.gov so that Americans can easily access the quality, affordable health coverage they need. By enlisting additional technical help, aggressively monitoring errors, testing to prevent new issues from cropping up, and regularly deploying fixes to the site, we are working to ensure consumers’ interaction with HealthCare.gov is a positive one, and that the Affordable Care Act fully delivers on its promise.

Footnotes

1 http://aspe.hhs.gov/health/reports/2...cfm#_ftnref18

2 http://kaiserfamilyfoundation.files...rketplaces.pdf


4 http://www.oregonlive.com/health/ind...econsider.html

5 http://www.governor.ny.gov/press/071...efit-exchange
This is a simple calculation based on Figure 6 of the RAND study, available at the link above.


Medical Loss Ratio Final Rule: https://www.federalregister.gov/arti...dable-care-act


PPACA Implementation Failures: Didn’t Know or Didn’t Disclose?

Source: http://energycommerce.house.gov/hearing/ppaca-implementation-failures-didn%E2%80%99t-know-or-didn%E2%80%99t-disclose
My Note: Add these linked documents below?

Thursday, October 24, 2013 - 9:00am
Energy and Commerce
2123 Rayburn
Background Documents and Information:

Hearing Notice

Background Memo

Media, iframe, embed and object tags are not supported inside of a PDF.

Opening Statements:

Energy and Commerce Committee Chairman Fred Upton

Energy and Commerce Committee Vice Chairman Marsha Blackburn

Witnesses:

Cheryl Campbell
  • Senior Vice President
  • CGI Federal
  • Witness Testimony (Truth in Testimony and CV)

Andrew Slavitt
  • Group Executive Vice President
  • Optum/QSSI
  • Witness Testimony (Truth in Testimony and CV)

Lynn Spellecy
  • Corporate Counsel
  • Equifax Workforce Solutions
  • Witness Testimony (Truth in Testimony and CV)

John Lau
  • Program Director
  • Serco
  • Witness Testimony (Truth in Testimony and CV)

Congress:
113th
The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, NW
Washington, DC 20201

Dear Secretary Sebelius:

On October 10, 2013, we wrote you asking for information related to the multitude of problems associated with the Administration’s implementation of HealthCare.gov, particularly the causes of problems related to the development and operation of the federal exchange HealthCare.gov. On numerous occasions over the last few weeks, Committee staff provided HHS staff with a list of priority areas for the Department’s response and answered numerous questions from HHS staff; so the Department should plan its response accordingly and transmit information to the Committee as quickly as possible. Despite the importance of this issue and the Committee’s willingness to accommodate the Department, notwithstanding staff reforms Committee staff you would not be able to provide the response by the requested date. While you have refused to provide information to Congress, you have been a frequent guest on numerous news and television programs subsequent to October 1, 2013. It is unacceptable that you are providing information to numerous other outlets, but not to Congress.

According to Committee sources, the federal government spent more than was needed to establish HealthCare.gov. While similar IT projects in the private sector would likely have cost far less, the implementation of HealthCare.gov and its related components have cost taxpayers between $400 and $500 million. Despite the huge amount of extraordinary spending on HealthCare.gov, the site has been a huge failure. Most visitors to HealthCare.gov are unable to create accounts and shop for coverage, and

1 Letter from Rep. G. K. Butterfield, Jr., to Kathleen Sebelius, Secretary, Department of Health and Human Services (Oct. 10, 2013).
2 Email between Committee staff and HHS (Oct. 10, 2013, October 21, 2013, October 22, 2013).
3 Email from SEIS and HHS Committee staff (October 22, 2013).
5 Email between Committee staff and CMS (Oct. 17, 2013).
6 Email between Committee staff and CMS (Sept. 16, 2013).
even if they are successful, their information may be of no use as insurance companies are getting new data from the exchange." Even many supervises of Obamacare, such as Ezra Klein, a Washington Post reporter and columnist who urged Democrats in Congress in March 2010 to pass Obamacare and wrote that the bill was a victory for Democrats, have admitted that the Affordable Care Act’s launch has been a failure. Not ‘troubled.’ Not ‘glitchy.’ A failure.”

As another example of a major problem with implementation that the Affordable Care Act presently denies consumers to contact application assistance personnel that have not yet completed the federal certification requirements. When Committee staff visited www.healthcare.gov last Thursday morning in Virginia, one of the 34 states with a federal exchange, the website warned that “Application Assistants based on this page may still be completing training and state certification requirements.”

The website also stated that “We continue to add new organizations that can help—please check back regularly.”

Navigators and other assistance personnel are required to successfully complete HHS’s online training program before they are certified to assist consumers. If a navigator or an assistance personnel is required to successfully complete HHS’s online training program before they are certified to assist consumers. If a navigator or an assistance personnel is supposed to certify or verify, then the navigator or the assistance personnel is required to accurately certify or verify. This is troubling that the website advises consumers to contact some organizations that are not certified, and raise serious concerns about fraud and misinformation as unscreamed and unscrutinized assistance personnel are apparently advising consumers about Obamacare. The Oversight and Government Reform Committee conducted a thorough review of the navigators and assistance programs in its report entitled, “Rules of Fraud and Misinformation with Obamacare Outreach Campaign: How Navigator and Assister Program Mismanagement Endangers Consumers,” and found serious deficiencies that place consumers at high risk of misinformation and identity theft.

During the months prior to October 1, 2013, the Administration and many HHS officials assured the American people that the health insurance exchange would be ready to successfully launch on October 1, 2013. For example, on July 17, 2013, Marilyn Tavenner, Administrator for the Centers for Medicare and Medicaid Services, testified, “I


Christopher Wrenn and Louise Rutherford, Health Policy Wire (Written by Andrew G. Lampman), 40 J. Wholesale, 39, 1 (Oct. 8, 2013), http://www.jwholesale.com/article/S0308-0462(13)00004-5/40JHEALTHCARE/1.0


The Honorable Kathleen Sebelius  
October 24, 2013 
Page 2

Dear Secretary Sebelius,

I want to assure you that on October 1, 2013, the health insurance marketplace will be open for business. Consumers will be able to log onto HealthCare.gov, fill out an application and find out what coverage and benefits they qualify for. At a hearing on May 21, 2013, before the Committee on Oversight and Government Reform, Gary Cohen, Director of the Office of Consumer Information and Insurance Oversight also testified, “I think we are very much on schedule. We are moving forward. We are going to be ready October 1st for open enrollment to begin.” You provided similar assurances to other Committees of Congress as well.

It is clear that you and other high-ranking HHS officials either provided false testimony to Congress or did not know how badly the development of the HealthCare.gov website was proceeding. Either scenario, if true, is unacceptable and demands accountability from your department. Your failure to provide Congress information that would shed additional light on these problems is a troubling indication that you are refusing to hold people accountable for this costly and failed enterprise.

Attached to this letter is a copy of the request made by our Committee on October 10, 2013, which was due today, and to which you have not replied. If you do not comply with this Committee’s requests by 5:00 p.m. on October 18, 2013, the Committee on Oversight and Government Reform will be forced to consider the use of compulsory process.

The Committee on Oversight and Government Reform is the principal oversight committee of the House of Representatives and every day “any time” investigation “any router” as set forth in House Rule X. An attachment to this letter provides additional information about responding to the Committee’s request.

In preparing your answers to these questions, please answer each question individually and include the text of each question in your response. When producing documents to the Committee on Oversight and Government Reform, please deliver production onto a single drive to the Majority Staff in Room 2137 of the Rayburn House Office Building and the Minority Staff in Room 2131 of the Rayburn House Office Building. The Committee prefers to receive documents in electronic format.

98 This data, which includes all names and addresses, was released to all members of Congress on April 10, 2013, http://tinyurl.com/healthcare.gov, and was released to the public on April 18, 2013. See also HealthCare.gov, May 29, 2013, http://tinyurl.com/healthcare.gov.
The Honorable Kathleen Sebelius
October 23, 2013

If you have any questions about this request, please have your staff contact Stacy Childs of the Senate Health, Education, Labor and Pensions Committee Staff at 202-224-6779 or Brian Shafe of the House Committee on Oversight and Government Reform Staff at 202-225-9674. Thank you for your attention to this matter.

Sincerely,

[Signature]

[Signature]

Larry Alexander
Ranking Member
Health, Education, Labor and Pensions Committee
U.S. Senate

[Signature]

G. K. Butterfield
Chairman
Committee on Oversight and Government Reform
U.S. House of Representatives

Endorsements

c: The Honorable Tom Harkin, Chairman
Committee on Health, Education, Labor and Pensions
U.S. Senate

The Honorable Elijah Cummings, Ranking Minority Member
Committee on Oversight and Government Reform
U.S. House of Representatives
October 10, 2013

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Sebelius:

We are writing to seek information about the federal health insurance exchanges established by the Department of Health and Human Services (HHS). We are concerned by recent comments by the media that the system suffers from technical problems that need design changes. We seek information about these problems as well as whether you still expect individuals to suffer a tax penalty if they do not purchase government-approved health insurance.

Obamacare requires millions of individuals to enroll in government-mandated insurance or else face a tax penalty. The law requires an online exchange to be available by October 1, 2013, for individuals to compare plans and prices. For the 36 states that are not operating their own exchange websites, HHS-established healthcare.gov for individuals to shop for insurance that would meet the law’s mandated insurance coverage requirements. A Government Accountability Office report from June detailed that HHS spent almost $3.9 billion over three years in contracts to establish the exchange and its related functions.

Two top HHS officials, Marilyn Tavenner, the Administrator of the Centers for Medicare and Medicaid Services (CMS), and Gary Cohen, the Director for the Center for Consumer Information and Insurance Oversight, provided testimony to the House Committee on Oversight and Government Reform within the past few months suggesting that HHS would be ready for implementation on October 1, 2013. On July 17, 2013, Ms. Tavenner testified that she was “feeling pretty comfortable about the ability of CMS to be ready on October 1.” She further stated that “I want to assure you that [on] October 1, 2013, the health insurance marketplace will be open for business. Consumers will be able to log onto healthcare.gov, fill out an application and find out what coverage and benefits they qualify for.” At a hearing on May 21, 2013, Mr. Cohen testified “I think we are very much on

1 John S. Doden, Future Provision and Affordable Care Act: Status of HHS Efforts to Establish Federally Facilitated Health Insurance Exchanges, CHRI Report (Congressional Budget Office 2010)

The Novoheath Kathleen Sebelius  
October 16, 2013  
Page 2

schedule, we are moving forward. We are going to be ready October 1, for open enrollment to begin. 18 Mr. Culos also testified that there would not be "any problems with [the] massive amount of data sharing." 19

HHS launched healthcare.gov on October 1, 2013, as required by law. From day one, however, healthcare.gov has been plagued by what Administration officials initially referred to as technical glitches. After six days the Administration finally admitted the glitches were "design and software problems that have kept customers from applying online for coverage." 20 News reports detailed stories of people waiting as long as 16 hours to enroll for insurance, many waiting for hours only to give up. As many as 89 of every 100 applications are not able to be processed, and experts are concerned that "federal officials could face a situation in January in which relatively large numbers of people believe they have coverage starting that month, but whose enrollment applications have not been processed." 21

Among the many problems that have been identified in the media, many tens of thousands of people have started the application process but have been unable to create accounts, 22 the system that determines whether people are eligible for federal subsidies or Medicaid has made inaccurate determinations, 23 the exchange will not be able to communicate with state Medicaid agencies until November, 24 drop down tools and identity checking systems have not properly functioned, 25 the website is down at the account creation stage, 26 issues arise over incorrect or computed applications, 27 and insufficient capacity has been allocated for the website. 28 The website was shut down for periods on October 5th, October 6th, and on October 8th in order for HHS to attempt to make changes.

To help us evaluate the extent of the problems with ObamaCare’s clumsy and for us to better determine whether any substantive legislative actions are necessary, please provide the Committees with the following information by October 24, 2013:

1. As of October 4, 2013, at midnight, how many people had successfully enrolled for insurance through the federal exchange? How many people attempted to submit applications?

2. Please describe, in detail, all technical problems (including software and design defects) that are preventing people from successfully creating accounts, applying for insurance, and enrolling in plans. Please describe in detail the administration’s plans to address those problems and what has already been done to fix them. Please include which contractors were

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18 Hearing Before the House Oversight and Government Reform, Subcommittee on Economic Growth, Job Creation, and Full Investment, "The Screwup:" The Troubles of the Affordable Care Act (July 16, 2015).
19 Novoheath Kathleen Sebelius  
October 16, 2013  
Page 2

22 "The website is down: What’s going on with ObamaCare?" The New York Times (October 5, 2013).
The Honorable Kathleen Sebelius

October 16, 2013

involved in the design and operation of those aspects of the exchange and which contractors are involved in correcting the problems.

3. How much has it already cost and will it cost to address the technical problems with the exchange? Does HHS need additional appropriations to solve the technical problems and if so, how will HHS pay for the changes? Please be specific about the numbers involved.

4. According to several news reports, the system that determines when people are eligible for subsidies to buy insurance or Medicaid appears to be malfunctioning, and thus many people may not be eligible for plans in which they are enrolled. What is your timeline for determining when people may have received inaccurate information about eligibility and for notifying affected individuals? How will individuals be notified?

5. According to a USA Today interview with HHS’s Chief Technology Officer Todd Park, the Administration has said it hopes as many as 7 million people will eventually sign up for health insurance through the federal exchange. Yet, the administration only designed HealthCare.gov to handle 50,000 to 60,000 simultaneous users.

a. Why did the Administration build the site to accommodate so few people at a time when it expected many more to apply for insurance?

b. How much lead time of the exchange was done? What is the maximum number of simultaneous users the exchange was tested to accommodate?

6. According to some reports, the Administration was repeatedly warned that the federal exchange had significant problems. Insurers complained that during test of the exchange there were difficulties with transmissions to issuers, with issuers not receiving all necessary data about individuals enrolling in plans during tests.

a. Did HHS go live with HealthCare.gov knowing there were problems with transmitting data to issuers?

b. If those problems were resolved during testing, how were they resolved?

7. For the first five days of open enrollment, the administration assisted enrollment problems were a matter of conjecture and volume. In an on the record interview with USA Today published October 6, Todd Park said “These bugs were functions of volume.” Take away the volume and it works.” On the same day, the Administration admitted to The Wall Street Journal that capacity was not the only problem, but the exchange suffered from design problems as well.

a. When did HHS first learn of the design and software problems with the exchange?

b. Please provide all documents, including emails, referring or relating to the design, software, and capacity problems with the exchange.

8. Will individuals who attempted to enrol in insurance through the federal exchange but who ultimately were unsuccessful due to the system’s failures still face a tax penalty if they do not enrol for 2014? What about individuals who believe they successfully enrol but later find out they were ineligible?

7
8 See http://www.healthcare.gov for more information.

9 See e.g., Juliet Eilperin, et al., More Robust Looked For at Federal Health Care Website, Wash. Post (Oct. 8, 2013).
9. Please provide all documents referring or relating to the testing of the exchange and the federal data hub, including but not limited to contractual terms, reports or other data that were submitted by contractors, internal testing, internal emails, memos, power point presentations, and any communications from third parties such as insurers or other stakeholders on the performance of the exchange.

The Committee on Oversight and Government Reform is the principal oversight committee of the House of Representatives and may at “any time” investigate “any matter” as set forth in House Rule X. An attachment to this letter provides additional information about responding to the Committee’s request.

In preparing your answers to these questions, please answer each question individually and include the text of each question in your response. When providing documents to the Committee on Oversight and Government Reform, please deliver production sets to the Majority Staff in Room 2157 of the Rayburn House Office Building and the Minority Staff in Room 2471 of the Rayburn House Office Building. The Committee prefers to receive documents in electronic format.

If you have any questions about this request, please have your staff contact Stacy Cline of the Senate Health, Education, Labor and Pensions Committee at 202-224-2596 or Brian Blake of the House Committee on Oversight and Government Reform Staff at 202-225-5074. Thank you for your attention to this matter.

Sincerely,

[Signatures]

Sen. Lamar Alexander
Ranking Member
Senate Health, Education, Labor and Pensions Committee

Rep. Darrell Issa
Chairman
House Committee on Oversight and Government Reform

Enclosure

cc: The Honorable Tom Harkin, Chairman, Senate Committee on Health, Education, Labor and Pensions
The Honorable Elijah Cummings, Ranking Minority Member, Committee on Oversight and Government Reform
Responding to Committee Document Requests

1. In complying with this request, you are required to produce all responsive documents that are in your possession, custody, or control, whether held by you or your past or present agents, employees, and representatives acting on your behalf. You should also produce documents that you have a legal right to obtain, that you have a right to copy or to which you have access, as well as documents that you have placed in the temporary possession, custody, or control of any third party. Requested records, documents, data or information should not be destroyed, modified, removed, transferred or otherwise made inaccessible to the Committee.

2. In the event that any entity, organization or individual denied in this request has been, or is also known by any other name than that hereinafter denoted, the request shall be read also to include that alternative identification.

3. The Committee’s preference is to receive documents in electronic form (i.e., CD, memory stick, or thumb drive) in lieu of paper productions.

4. Documents produced in electronic format should also be organized, identified, and indexed electronically.

5. Electronic document productions should be prepared according to the following standards:

(a) The production should consist of single page Tagged Image File (“TIFF”), files, accompanied by a Consistency-View (Load) file, an Opinion reference file, and a file defining the fields and character lengths of the load file.

(b) Document numbers in the load file should match document Bates numbers and TIFF file names.

(c) If the production is completed through a series of multiple partial productions, field search and file order in all load files should match.

(d) All electronic documents produced to the Committee should include the following fields of metadata specific to each document:

BEGIDOC, ENDOCD, TEXT, BEGATTACH, ENDATTACH, PAGECOUNT, Custodial, Rectorytype, Date, Time, SENTDATE, SENTTIME, BEGINDATE, BEGINTIME, ENDOCTIME, ENDTIMEl, AUTHOR, FROM,
6. Documents produced to the Committee should include an index describing the contents of the production. To the extent more than one CD, hard drive, memory stick, thumb drive, box or folder is produced, each CD, hard drive, memory stick, thumb drive, box or folder should contain an index describing its contents.

7. Documents produced in response to this request shall be produced together with copies of file labels, dividers or identifying markers with which they were associated when the request was served.

8. When you produce documents, you should identify the paragraph in the Committee’s schedule to which the documents respond.

9. It shall not be a basis for refusal to produce documents that any other person or entity also possesses non-identical or identical copies of the same documents.

10. If any of the requested information is only reasonably available in machine-readable form (such as on a computer server, hard drive, or computer backup tape), you should consult with the Committee staff to determine the appropriate format in which to produce the information.

11. If compliance with the request cannot be made in full by the specified return date, compliance shall be made to the extent possible by that date. An explanation of why full compliance is not possible shall be provided along with any partial production.

12. In the event that a document is withheld on the basis of privilege, provide a privilege log containing the following information concerning any such document: (a) the privilege asserted; (b) the type of document; (c) the general subject matter; (d) the date, author and addressee; and (e) the relationship of the author and addressee to each other.

13. If any documents responsive to this request was, but no longer is, in your possession, custody, or control, identify the document (stating its date, author, subject and recipient) and explain the circumstances under which the document ceased to be in your possession, custody, or control.

14. If a date or other descriptive detail set forth in this request referring to a document is incorrect, but the actual date or other descriptive detail is known to you or is otherwise apparent from the context of the request, you are required to produce all documents which would be responsive as if the date or other descriptive detail were correct.

15. Unless otherwise specified, the time period covered by this request is from January 1, 2009 to the present.

16. This request is continuing in nature and applies to any newly-discovered information. Any record, document, compilation of data or information, not produced because it has not been
located or discovered by the return date, shall be produced immediately upon subsequent location or discovery.

17. All documents shall be Bates-numbered sequentially and produced sequentially.

18. Two sets of documents shall be delivered, one set to the Majority Staff and one set to the Minority Staff. When documents are produced to the Committee, production sets shall be delivered to the Majority Staff in Room 2377 of the Rayburn House Office Building and the Minority Staff in Room 3409 of the Rayburn House Office Building.

19. Upon completion of the document production, you should submit a written certification, signed by you or your counsel, stating that: (1) a diligent search has been completed of all documents in your possession, custody, or control which reasonably could contain responsive documents; and (2) all documents located during the search that are responsive have been produced to the Committee.

Schedule Definitions

1. The term “document” means any written, recorded, or graphic matter of any nature whatsoever, regardless of how recorded, and whether original or copy, including, but not limited to, the following: memoranda, reports, expense reports, books, manuals, instructions, financial reports, working papers, records, notes, letters, notices, confirmations, telecommunications, receipts, agreements, pamphlets, magazines, newspapers, prospectuses, inter-office and intra-office communications, electronic mail (e-mail), contracts, cables, notations of any type of conversations, teleconference call, meeting or other communication, bulletins, printed matter, computer printouts, tapes, envelopes, transcriptions, diaries, analyses, returns, summaries, interviews, bills, accounts, estimates, projections, comparisons, messages, correspondence, press releases, circulars, financial statements, reviews, opinions, offers, studies and investigations, questionnaires and surveys, and work sheets (and all drafts, preliminary versions, statements, modifications, revisions, changes, and commitments of any of the foregoing, as well as any attachments or appendices thereto), and graphic or oral records or representations of any kind (including without limitation, photographs, charts, graphs, microfilms, microfilm, videocassette, and motion pictures), and electronic, mechanical, and optical records or representations of any kind (including, without limitation, tapes, cassette, disks, and recordings) and written, printed, typed, or other graphic or recorded matter of any kind or nature, however produced or reproduced, and whether preserved in writing, film, tape, disk, videocassette or otherwise. A document bearing any notation not a part of the original text is to be considered a separate document. A draft or non-identical copy is a separate document within the meaning of this term.

2. The term “communication” means each manner or means of disclosure or exchange of information, regardless of means utilized, whether oral, electronic, by document or otherwise, and whether in a meeting, by telephone, facsimile, email (desktop or mobile device), text message, instant message, MMS or SMS message, regular mail, telecon, relayed, or otherwise.
WILLIAMSBURG, Va. – The development problems of healthcare.gov are a "teachable moment," said Federal Chief Information Officer Steven VanRoekel.

"It's often notable risk taking or notable failures that teach us how to do things differently in the future," he told an audience at the annual ACT-IAC Executive Leadership Conference.

"Our goal is to definitively fix this thing, make sure it's working," he also said, stating President Obama "reminds us every day to get this fixed."

The beleaguered health insurance exchange for the 36 states that refused to build their own continues to suffer technical problems into its fifth week. Administration officials have said a majority of users will experience difficulties through the end of next month. In a problem unrelated to its development woes, the site was unavailable for most of Sunday after the Verizon data center hosting the website crashed, reportedly after workers attempted to replace a broken networking component.
Nonetheless, the federal government should "be proud of the boldness by which we approach this," VanRoekel told the audience, a mix of government and private sector information technology executives.

"The fact that we're moving transactions around securely, with respect to privacy and controlling tons of things, there is incredible complexity out there," he added. Signing up for health insurance through the exchange doesn't require individuals to disclose medical information apart from smoking status. *Time* also reported Monday that the system had a password reset security flaw that enabled social hacking of individual accounts through the unintentional disclosure of security questions and users' email in browsers. Administration officials told the magazine the flaw has been removed.

VanRoekel renewed an administration call for more modular development, a development he said would reduce the "risk surface" of federal IT projects. "Monolithic failure cannot be the norm in government," he said.

Meanwhile in Congress, two senior Republicans threatened Friday to subpoena Health and Human Services Secretary Kathleen Sebelius over what they say is HHS's unresponsiveness to document requests. The *letter* (My Note: I downloaded this locked PDF - See above.), signed by Sen. Lamar Alexander (R-Tenn.) and Rep. Darrell Issa (R-Calif.)--the ranking member of the Senate Health, Education, Labor and Pensions Committee and the chairman of the House Oversight and Government Reform Committee, respectively--gave Sebelius a 5 p.m. Oct. 28 deadline.

CNN reports that the HHS secretary didn't comply with it. Issa, who has a history of hunting for Obama administration scandal, has already said Sebelius should resign if healthcare.gov problems aren't quickly fixed. The secretary is set to testify before the House Energy and Commerce Committee on Oct. 30

**Contractors point fingers at each other and CMS during healthcare.gov hearing**

*October 27, 2013 | By David Perera*


*My Note: See links in this article*

Problems plaguing healthcare.gov should be fixed for most users by the end of next month, former White House official Jeffrey Zients told reporters days into his role as head of the "tech surge" the Obama administration says will resolve the system's technical issues.

A review of the system shows that "the HealthCare.gov site is fixable," Zients said. The Centers for Medicare & Medicaid Services says that more than 700,000 people have filled out applications for health insurance at state websites and healthcare.gov, the healthcare insurance exchange for the 36 states that refused to build their own.
Existing healthcare.gov contractor QSSI of Columbia, Md., is overseeing the system overhaul. QSSI is also the contractor hired to develop the system's data hub, functionality that routes applicants' information to various government databases for purposes of verification, such as checking Social Security number validity with the Social Security Administration or verifying income with the Internal Revenue Service. QSSI became a subsidiary of the insurer UnitedHealth Group in September 2012.

Zients' comment came after a four hour Oct. 24 hearing of the House Energy and Commerce Committee during which system contractors were witnesses.

During it, contractor officials testified that their parts of the system mostly worked and pointed fingers at each other and CMS.

The eligibility, plan management and financial management portion of the system, known as the Federally-Facilitated Marketplace, "passed eight technical reviews before going live on Oct. 1," said Cheryl Campbell, a senior vice president of CGI Federal of Fairfax, Va.

CGI Federal, a subsidiary of Canadian company CGI Group, has received $112 million so far for the building of the FFM, a figure that will likely grow $196 million this year with options to reach $293 million, Campbell said.

"Our portion of the system that CGI was responsible for...our functionality worked," she said. The FFM did crash in a test with a load of only a few hundred users days before healthcare.gov's Oct. 1 unveiling, Campbell acknowledged.

But problems experienced by the public during the initial rollout of the website were due to the enrollment function, Campbell said, the data hub functionality developed by QSSI. A decision not to allow anonymous browsing of health insurance plans, reportedly out of fear that individuals would see insurance quotes without knowing their eligibility for government subsidies, which would have distorted sign-up decisions, means that all users must first go through a verification module, known as the Enterprise Identity Management function. "The EIDM created a bottleneck, preventing the vast majority of consumers from accessing the FFM," Campbell said.

Andrew Slavitt, group executive vice president of QSSI, told the committee that "the data services hub was tested, tested well, and tested adequately." QSSI received $85 million for the EIDM. Among the company's duties was also to test CGI Federal code, Slavitt said, and "we found problems in the code," he testified. "We informed CMS and informed the contractor responsible for the code."

The entity responsible for ensuring that all the pieces worked together, Campbell and Slavitt said, was CMS itself, which didn't perform an end-to-end test until the last two weeks in September, Campbell said.

Slavitt said QSSI "informed CMS that more testing was necessary. We informed CMS of the pieces of the system that had--that we had tested that had issues."

The responsibility for CMS versus contractors for system integration has been a matter of some debate. "CMS had the ultimate decision for a live or no-go decision, not CGI. We were not in a position--we're there to support our client. It is not our position to tell our client whether they should go live or not go live," Campbell said.
"To say that 'our portion of the system would work' is akin to saying that you know a computer will work before you've hooked a monitor up to it, just because it turns on. There's no half-credit in these cases," wrote Slate columnist and programmer David Auerbach in reaction to the hearing.

In response to questions from Rep. G.K. Butterfield (D-N.C.), Campbell also said company officials quoted in a Oct. 21 letter from House Oversight and Government Reform Chairman Darrell Issa (R-Calif.) "may have been taken out of context."

The letter alleged that political interference from the White House contributed to system failures. Campbell said that to her knowledge, "no, the White House has not given us direct instructions."

The hearing was at time contentious, with Rep. Frank Pallone (D-N.J.), calling it a "monkey court."

Rep. Diana DeGette (D-Colo.) disputed an assertion by Rep. Joe Barton (R-Texas) that the system endangers individual privacy since it doesn't conform to the Health Insurance Portability and Accountability Act. Submitting medical information isn't a prerequisite to enrollment, she noted, other than attesting to smoking status. "People aren't putting confidential medical information onto the Internet and so, therefore, they wouldn't be violating HIPAA," she said.

For more:
- go to the hearing webpage
- watch an archived copy of the hearing on Ustream

**Obama administration says 'tech surge' will fix healthcare.gov**

October 21, 2013 | By David Perera

The Obama administration is promising to fix problems on healthcare.gov.

The federal website for residents of 36 states whose governments declined to build their own healthcare exchanges has performed mediocrely since it's Oct. 1 rollout, offering ammunition to Republicans who say the mandate for individual healthcare insurance should be postponed.

In an Oct. 20 statement (My Note: See below) on the Health and Human Services Department website, administration officials say the website has received more than 19 million unique visits so far, and acknowledges problems such as difficulty logging in, error messages and slow page loads.

As a result, the statement says HHS "has called in additional help to solve some of the more complex technical issues we are encountering" in what the administration dubs a "tech surge."
"We're also putting in place tools and processes to aggressively monitor and identify parts of healthcare.gov where individuals are encountering errors or having difficulty using the site," the statement says.

Some contractor officials working on the website—there are 55 companies contributing to some aspect of its development—told the New York Times that an administration goal to fix all the problems by Nov. 1 may be unrealistic. Rather, the problems might continue until after the Dec. 15 deadline for individuals to sign up for coverage that starts in January, "although that view is not universally shared."

The open enrollment period for individuals attaining health insurance through the exchanges ends (My Note: Healthcare.gov) March 31; afterward, individuals and families face tax penalties for going without.

The HHS statement also states that the department "is bringing in some of the best and brightest from both inside and outside government to scrub in with the team," an approach that may or may not pay dividends, since it's a truism (My Note: Book at Amazon.com) in software development that throwing more staff at a problem doesn't always result in better development. Actually, it's a truism, known as Brooks' Law (My Note: Wikipedia article), that "adding manpower to a late software project makes it later."

"More software projects have gone awry for lack of calendar time than for all other causes combined," wrote computer scientist Fred Brooks in The Mythical Man-Month, a touchstone book about programming.

For more:
- go to the HHS statement (My Note: See below)

Related Articles:
Healthcare.gov problems spark federal IT recriminations (My Note: See below)
HHS fixing Healthcare.gov glitches (My Note: See below)
Affordable Care Act online marketplaces open (My Note: See above)

Read more about: healthcare.gov, Fred Brooks (My Note: See Latest Headlines below)

Doing Better: Making Improvements to HealthCare.gov
Sunday, October 20, 2013

Source: http://www.hhs.gov/digitalstrategy/blog/2013/10/making-healthcare-gov-better.html

My Note: Quote: "Aside from the difficulties since launching the site, there are parts of the overall system that have proved up to the task. The “Data Hub,” component, which provides HealthCare.gov with information that aids in determining eligibility for qualified health plans, is working. Individuals have been able to verify their eligibility for credits, enabling them to shop for and enroll in low or even no-cost health plans." What is the "Data Hub" component? What Mark Logic did?

Over the past two and a half weeks, millions of Americans visited HealthCare.gov to look at their new health care options under the Affordable Care Act. In that time, nearly half a million applications for coverage have been submitted
from across the nation. This tremendous interest – with over 19 million unique visits to date to HealthCare.gov– confirms that the American people are looking for quality, affordable health coverage, and want to find it online.

Unfortunately, the experience on HealthCare.gov has been frustrating for many Americans. Some have had trouble creating accounts and logging in to the site, while others have received confusing error messages, or had to wait for slow page loads or forms that failed to respond in a timely fashion. The initial consumer experience of HealthCare.gov has not lived up to the expectations of the American people. We are committed to doing better.

Aside from the difficulties since launching the site, there are parts of the overall system that have proved up to the task. The “Data Hub,” component, which provides HealthCare.gov with information that aids in determining eligibility for qualified health plans, is working. Individuals have been able to verify their eligibility for credits, enabling them to shop for and enroll in low or even no-cost health plans.

WHAT HAPPENED – WHAT WE ARE WORKING ON

Since launch, when we first recognized these issues, we have been working around the clock to make improvements. We have updated the site several times with new code that includes bug fixes that have greatly improved the HealthCare.gov experience. The initial wave of interest stressed the account service, resulting in many consumers experiencing trouble signing up, while those that were able to sign up sometimes had problems logging in.

In response, we have made a number of improvements to the account service. Initially, we implemented a virtual “waiting room,” but many found this experience to be confusing. We continued to add more capacity in order to meet demand and execute software fixes to address the sign up and log in issues, stabilizing those parts of the service and allowing us to remove the virtual “waiting room.” Today, more and more individuals are successfully creating accounts, logging in, and moving on to apply for coverage and shop for plans. We’re proud of these quick improvements, but we know there’s still more work to be done. We will continue to conduct regular maintenance nearly every night to improve the experience.

TECH SURGE

To ensure that we make swift progress, and that the consumer experience continues to improve, our team has called in additional help to solve some of the more complex technical issues we are encountering.

Our team is bringing in some of the best and brightest from both inside and outside government to scrub in with the team and help improve HealthCare.gov. We're also putting in place tools and processes to aggressively monitor and identify parts of HealthCare.gov where individuals are encountering errors or having difficulty using the site, so we can prioritize and fix them. We are also defining new test processes to prevent new issues from cropping up as we improve the overall service and deploying fixes to the site during off-peak hours on a regular basis.

Most importantly, we want to hear from you, and make sure that your experience with HealthCare.gov is a positive one. If you have any comments, either complimentary or critical, please let us know by sharing your feedback at https://www.healthcare.gov/connect/. We've already heard so many stories of individuals getting health insurance for the first time, and we are dedicated to making that possible for all Americans.
The long-awaited online marketplaces to buy health insurance that were created under the Affordable Care Act went live Oct. 1.

Americans can use the marketplaces to purchase private coverage, with subsidies for some, that will start Jan. 1, 2014.

Speaking at the White House today, President Obama acknowledged that the rollout was flawed.

"There are going to be some glitches in the signup process along the way that we will fix," he said. "There have been times this morning where the site has been running more slowly than it normally will." Some users also received error messages.

Obama noted that the federally run marketplace, HealthCare.gov, received five times more visitors the morning of Oct. 1 than have ever visited Medicare.gov at once. On Tuesday afternoon, administration officials said some 2.8 million people visited HealthCare.gov since midnight, reports the Wall Street Journal.

Sixteen states and the District of Columbia set up their own exchanges. Each has its own name, such as Connect for Health Colorado, Hawaii Health Connector, Your Health Idaho, kynect (for Kentucky), MNsure (for Minnesota) and Cover Oregon.

The majority of states opted to let HHS run an online marketplace on their behalf, and their residents can use HealthCare.gov to sign up for coverage. They may decide in future years to set up their own exchanges.

While the budget impasse in Congress has largely centered around the Affordable Care Act, the resulting government shutdown has relatively little effect on the law’s implementation.

A Congressional Research Service report (.pdf), posted online by Secrecy News, explains that agencies have other sources of funding they can rely on in the absence of fiscal 2014 appropriations, such as multi-year and no-year discretionary funds that they received in prior years, along with mandatory funds.

HHS's contingency plan (.pdf) for staffing during the government shutdown notes a few Affordable Care Act activities that it spared from the shutdown, including coordination between Medicaid and the new exchanges.

For more:
- visit HealthCare.gov
- watch Obama's remarks on YouTube
- download the CRS report, R43246, from Secrecy News (.pdf)

### LATEST HEADLINES


**VanRoekel: Healthcare.gov failure a 'teachable moment'**

October 29, 2013 | By David Perera

WILLIAMSBURG, Va. – The development problems of healthcare.gov are a "teachable moment," said Federal Chief Information Officer Steven VanRoekel. "It's often notable risk taking or notable failures that teach us how to do things differently in the future," he told an audience at the annual ACT-IAC Executive Leadership Conference.

**Spotlight: HHS touts insurance affordability in marketplace**

FierceGovernment | October 29, 2013

Forty-six percent of uninsured, single young adults eligible for coverage in the Health Insurance Marketplace--or 1.3 million people--could obtain "bronze" plan coverage at a cost of $50 or less per month, finds a Health and Human Services Department report published Oct. 28.

**Contractors point fingers at each other and CMS during healthcare.gov hearing**

October 27, 2013 | By David Perera

Problems plaguing healthcare.gov should be fixed for most users by the end of next month, former White House official Jeffrey Zients told reporters days into his role as head of the "tech surge" the Obama administration says will resolve the system's technical issues. Zients's comment came after a four hour Oct. 24 hearing of the House Energy and Commerce Committee during which system contractors were witnesses.

**Damage control and political fire-fanning over healthcare.gov**

October 23, 2013 | By David Perera

Damage control and political fire-fanning dominate the fourth week of healthcare.gov's existence, making the federal healthcare insurance website for the 36 states that refused to build their own insurance exchange the locus for partisan divide and continuing criticism of federal information technology management. A poll shows that a majority of Americans may already believe that website problems are part of a broader problem with the health insurance law's implementation.

**Obama vows to fix healthcare site, focus on product and not problems**

FierceGovernment | October 22, 2013

As developers scramble to fix problems with healthcare.gov, the federal website for healthcare insurance exchanges, President Obama vowed to improve the website. He also said the product was good, even if the delivery system was flawed.

**Obama administration says 'tech surge' will fix healthcare.gov**

October 21, 2013 | By David Perera

In an Oct. 20 statement on the Health and Human Services Department website, administration officials say the website has received more than 19 million unique visits so far, and acknowledges problems such as difficulty logging in, error messages and slow page loads.
Healthcare.gov problems spark federal IT recriminations

October 16, 2013 | By David Perera
Problems with healthcare.gov, the federal website for residents of 36 states whose governments declined to build their own healthcare exchanges, have set off a round of recriminations against federal information technology management and acquisition. Military open source software advocate John Scott, writing on this blog, faults the acquisition process, but concentrates more on what he says is a lack of technological skills within government. Scott, who has libertarian tendencies, says anybody working in a large bureaucracy is likely to have their technical skills degrade over time.

HHS fixing Healthcare.gov glitches

October 7, 2013 | By David Perera
Information technology workers behind Healthcare.gov spent the weekend fixing coding errors that resulted in customers finding difficulties with the federal online insurance marketplace, reports the Wall Street Journal. The Health and Human Services Department website serves as the health insurance exchange for 36 states that opted out from building their own healthcare exchange to permit Americans to buy health insurance as mandated under the Affordable Care Act.
Getting Lower Costs on Coverage

- Will I qualify for lower costs on monthly premiums?
- How can I get an estimate of costs and savings on Marketplace health insurance?
- What income and household information do I provide when I apply for Marketplace coverage?
- Calculating your costs and savings in the Health Insurance Marketplace
- What factors affect Marketplace health plan premiums?
- Do I qualify for Medicaid?
- Lupita’s story: I don’t have insurance
- 7 ways to save in the Health Insurance Marketplace
- How can I see Marketplace health plans and prices before I fill out an application?
- Will I qualify for lower out-of-pocket costs?
Where can I get low-cost care in my community?

- What do American Indians and Alaska Natives need to know about the Marketplace?
- How can I get lower costs on Marketplace coverage?
- Can I buy a “catastrophic” plan?
- Are my children eligible for CHIP?

Young Adults

- Alejandra’s story: College students need coverage too!
- 3 ways to get covered if you’re under 30
- Malik’s story: I’m young and I need health insurance
- Jaime’s story: Life without health insurance
- What are my birth control benefits?
- Why should I have health coverage?
- What if I'm pregnant or plan to get pregnant?
- Can children stay on a parent’s plan until age 26?
- Can I buy a “catastrophic” plan?

Using the Marketplace

- How we’re working to improve HealthCare.gov
- 4 ways to apply for coverage in the Health Insurance Marketplace
- How do I apply for Marketplace coverage?
Open enrollment in the Health Insurance Marketplace is here!

• What income and household information do I provide when I apply for Marketplace coverage?

• Can I appeal a Marketplace decision?

• 10 ways to get ready for the Health Insurance Marketplace

• 4 steps to getting covered in the Health Insurance Marketplace

• Calculating your costs and savings in the Health Insurance Marketplace

• How to get help with your Marketplace application

• What if I want to change Marketplace plans after I enroll?

• How can I get ready to apply for Marketplace coverage?

• How can I apply for coverage using my mobile phone?

• How to find the health insurance plan that’s right for you

• Get ready for the Health Insurance Marketplace: Create an account

• Questions? Call us at 1-800-318-2596

• Introducing the Health Insurance Marketplace

• What key dates do I need to know?

• How do I get help enrolling in the Marketplace?

• How do I choose Marketplace insurance?

• How can I stay up-to-date about the Marketplace?

• Contact Us
Rights, Protections, and the Law

- Can I appeal a Marketplace decision?
- How do I get an exemption from the fee for not having health coverage?
- Do Marketplace insurance plans cover mental health and substance abuse services?
- Howard’s story: I can’t get health insurance
- Jaime’s story: Life without health insurance
- 2014 in 214 words
- What are my birth control benefits?
- Answers to your top health insurance questions
- What are my breastfeeding benefits?
- Introducing the Health Insurance Marketplace
- Where can I read the Affordable Care Act?
- What if someone doesn't have health coverage in 2014?
- What if I'm pregnant or plan to get pregnant?
- What if I have a grandfathered health insurance plan?
- Timeline of the health care law
- How does the health care law protect me?
- How do I appeal a health plan decision?

Prevention
Do Marketplace insurance plans cover mental health and substance abuse services?

- 4 ways the Health Insurance Marketplace keeps you healthy

- What are my birth control benefits?

- What are my breastfeeding benefits?

- Can I get dental coverage in the Marketplace?

- Where can I find provider information?

- What are my preventive care benefits?

- How does the Affordable Care Act help people like me?

Other Health Insurance Programs

- What if I have PCIP coverage?

- What do immigrant families need to know about the Marketplace?

- Do I qualify for Medicaid?

- What if my state is not expanding Medicaid?

- What if I need coverage that starts before January 2014?

- Where can I get low-cost care in my community?

- What do American Indians and Alaska Natives need to know about the Marketplace?

- What do military veterans need to know about the Marketplace?

- What if I have Medicare?

- Are my children eligible for CHIP?
If You Have Health Insurance

• **What if my current individual plan is changing or not being offered in 2014?**

• **Answers to your top health insurance questions**

• **What if I currently have COBRA coverage?**

• **What if I want to change individual insurance plans?**

• **What if I have job-based insurance?**

• **What if I have a grandfathered health insurance plan?**

• **What if I'm losing job-based insurance?**

• **How does the health care law protect me?**

• **How does the Affordable Care Act help people like me?**

• **How do I appeal a health plan decision?**

• **How can I get consumer help if I have insurance?**

• **Can I use a Flexible Spending Account (FSA) to pay some medical expenses?**

• **Can children stay on a parent’s plan until age 26?**

Health Insurance Marketplace

• **We’re listening — and improving every day**

• **4 ways to apply for coverage in the Health Insurance Marketplace**

• **Will I qualify for lower costs on monthly premiums?**

• **What is the Marketplace in my state?**
How can I get an estimate of costs and savings on Marketplace health insurance?

- Open enrollment in the Health Insurance Marketplace is here!
- Get Covered: A one-page guide to the Health Insurance Marketplace
- How do I get an exemption from the fee for not having health coverage?
- 10 ways to get ready for the Health Insurance Marketplace
- 4 steps to getting covered in the Health Insurance Marketplace
- Alejandra’s story: College students need coverage too!
- Calculating your costs and savings in the Health Insurance Marketplace
- How to get help with your Marketplace application
- Here’s how the Health Insurance Marketplace helps women
- 3 ways to get covered if you’re under 30
- What do immigrant families need to know about the Marketplace?
- How to find the health insurance plan that’s right for you
- Do Marketplace insurance plans cover mental health and substance abuse services?
- Malik’s story: I’m young and I need health insurance
- What if I’m retired but not eligible for Medicare?
- 4 ways the Health Insurance Marketplace keeps you healthy
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• How can I protect myself from fraud in the Health Insurance Marketplace?

• 4 ways to protect yourself from fraud in the Health Insurance Marketplace

• Jaime's story: Life without health insurance

• 2014 in 214 words

• Get ready for the Health Insurance Marketplace: Create an account

• 7 ways to save in the Health Insurance Marketplace

• Answers to your top health insurance questions

• What are my health coverage options if I’m unemployed?

• Questions? Call us at 1-800-318-2596

• Can I get dental coverage in the Marketplace?

• What if I’m a part-time employee without health coverage?

• You’ve got questions. We’ve got answers.

• What if I currently have COBRA coverage?

• How can I see Marketplace health plans and prices before I fill out an application?

• Welcome to the new HealthCare.gov!

• Introducing the Health Insurance Marketplace

• Can I buy health insurance outside the Health Insurance Marketplace?

• What is the Health Insurance Marketplace?

• What if someone doesn't have health coverage in 2014?
What if I have a pre-existing health condition?

- What does Marketplace health insurance cover?
- What do I do if my employer offers health insurance through the SHOP Marketplace?
- What do American Indians and Alaska Natives need to know about the Marketplace?
- How can I get lower costs on Marketplace coverage?
- Can I keep my own doctor?
- Can I buy a “catastrophic” plan?
- Am I eligible for coverage in the Marketplace?

Health Insurance Basics

- Open enrollment in the Health Insurance Marketplace is here!
- How do I get an exemption from the fee for not having health coverage?
- Howard’s story: I can’t get health insurance
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- How can I protect myself from fraud in the Health Insurance Marketplace?
- 4 ways to protect yourself from fraud in the Health Insurance Marketplace
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Can I get dental coverage in the Marketplace?

• What if I'm a part-time employee without health coverage?

• You've got questions. We've got answers.

• What if I need coverage that starts before January 2014?

• Why should I have health coverage?

• What key dates do I need to know?

• What if someone doesn't have health coverage in 2014?

• What if I'm self-employed?

• What if I have job-based insurance?

• What if I have a pre-existing health condition?

• What if I'm losing job-based insurance?

• What are the different types of health insurance?

• How does the Affordable Care Act help people like me?

• Contact Us

• Can I use a Flexible Spending Account (FSA) to pay some medical expenses?

• Can I keep my own doctor?

Businesses

• What do I need to tell my employees about the Marketplace?

• A new way to SHOP for small business coverage and get help
What is the Employer Shared Responsibility Payment?

• Will I qualify for small business health care tax credits?

• What is the SHOP Marketplace?

• What is considered a small business?

• What if I'm self-employed?

• What if I already insure my employees?

• What do small businesses need to know?

• What if my business has 50 or more employees?

• What do I do if my employer offers health insurance through the SHOP Marketplace?

• How do my employees sign up for SHOP?

• How do I choose coverage that's right for my business?

• How can I get ready for SHOP?

• Do I have to offer health coverage to my employees?

• Can I use an agent or broker to buy health insurance in the Marketplace?

Glossary
Source: https://www.healthcare.gov/glossary/

Accountable Care Organization
A group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings.
Accreditation
If a Marketplace health plan is approved, this is the “seal of approval” given to the plan by an independent organization to show that the plan meets national quality standards.

Actuarial Value
The percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, you would be responsible for 30% of the costs of all covered benefits. However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual health care needs and the terms of your insurance policy.

Advanced Premium Tax Credit
The Affordable Care Act provides a new 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. Also called premium tax credit.

Affordable Care Act
The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is used to refer to the final, amended version of the law.

Affordable Insurance Exchange
See Health Insurance Marketplace

Affordable coverage (as it relates to APTC)
Employer coverage is considered affordable - as it relates to the Advanced Premium Tax Credit (APTC)- if the employee’s share of the annual premium for self-only coverage is no greater than 9.5% of annual household income. Starting in 2014, individuals offered employer-sponsored coverage that’s affordable and provides minimum value won’t be eligible for a premium tax credit.

Agent
An agent or broker is a person or business who can help you apply for help paying for coverage and enroll you in a Qualified Health Plan (QHP) through the Marketplace. They can make specific recommendations about which plan you should enroll in. They’re also licensed and regulated by states and typically get payments, or commissions, from health insurers for enrolling a consumer into an issuer’s plans. Some agents and brokers may only be able to sell plans from specific health insurers.
Alimony

Alimony is money you get from a spouse with whom you no longer live, or a former spouse, if paid to you as part of a divorce agreement, separation agreement, or court order. Payments designated in the agreement or order as child support or as a non-taxable property settlement aren't alimony.

For more information, see IRS Pub 504, pg. 12.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing)

Annual Deductible Combined

Usually in Health Savings Account (HSA) eligible plans, the total amount that family members on a plan must pay out-of-pocket for health care or prescription drugs before the health plan begins to pay.

Annual Limit

A cap on the benefits your insurance company will pay in a year while you're enrolled in a particular health insurance plan. These caps are sometimes placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.

Appeal

A request for your health insurer or plan to review a decision or a grievance again.

Attest/Attestation

When you apply for health coverage through the Marketplace, you"re required to agree (or "attest") to the truth of the information provided by signing the application.

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.

Balance Billing

When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.
Benefits

The health care items or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents. In Medicaid or CHIP, covered benefits and excluded services are defined in state program rules.

Biosimilar Biological Products

The generic version of more complicated medications.

Brand Name (Drugs)

A drug sold by a drug company under a specific name or trademark and is protected by a patent. Brand name drugs may be available by prescription or over the counter.

Broker

An agent or broker is a person or business who can help you apply for help paying for coverage and enroll in a Qualified Health Plan (QHP) through the Marketplace. They can make specific recommendations about which plan you should enroll in. They’re also licensed and regulated by states and typically get payments, or commissions, from health insurers for enrolling a consumer into an issuer's plans. Some brokers may only be able to sell plans from specific health insurers.

Bronze Health Plan

See Health Plan Categories

C

COBRA

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.

Cancelled Debts

If you incurred a debt from a loan or from buying something on credit and a portion of the amount you owe is discharged or forgiven ("cancelled"), the amount of the forgiven debt is generally counted as income to you.

For more information, see IRS Pub 17, ch. 12.

Capital Gains

A capital gain is the amount you get from selling property, like stock or a house. For example, if you buy stock for $1,000 and sell it for $1,250, you have capital gain of $250. You don't need to include a capital gain if it's from the sale of your main home you owned for at least 5 years (and the profit is less than $250,000).

For more information see IRS Pub 17, ch. 14, pg. 104 or IRS Pub 544.
**Care Coordination**

The organization of your treatment across several health care providers. Medical homes and Accountable Care Organizations are two common ways to coordinate care.

**Catastrophic Health Plan**

Health plans that meet all of the requirements applicable to other Qualified Health Plans (QHPs) but that don't cover any benefits other than 3 primary care visits per year before the plan's deductible is met. The premium amount you pay each month for health care is generally lower than for other QHPs, but the out-of-pocket costs for deductibles, copayments, and coinsurance are generally higher. 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.

**Centers for Medicare & Medicaid Services (CMS)**

The federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Programs, and the federally facilitated Marketplace. For more information, visit [cms.gov](http://cms.gov).

**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.

**Children's Health Insurance Program (CHIP)**

Insurance program jointly funded by state and federal government that provides health coverage to low-income children and, in some states, pregnant women in families who earn too much income to qualify for Medicaid but can’t afford to purchase private health insurance coverage.

**Chronic Disease Management**

An integrated care approach to managing illness which includes screenings, check-ups, monitoring and coordinating treatment, and patient education. It can improve your quality of life while reducing your health care costs if you have a chronic disease by preventing or minimizing the effects of a disease.

**Claim**

A request for payment that you or your health care provider submits to your health insurer when you get items or services you think are covered.

**Co-op**

A non-profit organization in which the same people who own the company are insured by the company. Cooperatives can be formed at a national, state, or local level and can include doctors, hospitals, and businesses as member-owners. Co-ops will offer insurance through the Marketplace.

**Coinsurance**

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan’s allowed amount for an office visit is $100 and you’ve met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.
Community Rating
A rule that prevents health insurers from varying premiums within a geographic area based on age, gender, health status or other factors.

Competitive Bidding
Open bidding for federal contracts between independent groups that compete for the contract by providing the best bid.

Complication of Pregnancy
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Conversion
The ability, in some states, to switch your job-based coverage to an individual policy when you lose eligibility for job-based coverage. Family members not covered under a job-based policy may also be able to convert to an individual policy if they lose dependent status (for example, after a divorce).

Coordination of Benefits
A way to figure out who pays first when 2 or more health insurance plans are responsible for paying the same medical claim.

Copayment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you get the service. The amount can vary by the type of covered health care service.

Cost Sharing
The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost sharing in Medicaid and CHIP also includes premiums.

Cost Sharing Reduction
A discount that lowers the amount you have to pay out-of-pocket for deductibles, coinsurance, and copayments. You can get this reduction if you get health insurance through the Marketplace, your income is below a certain level, and you choose a health plan from the Silver plan category (See Health Plan Categories). If you're a member of a federally recognized tribe, you may qualify for additional cost-sharing benefits.

Court Awards
Money that's due to you as the result of a lawsuit. This money may be taxable. Examples of lawsuit proceeds that aren't taxable are amounts awarded to you for personal physical injury or sickness and an amount you get as compensation for damages to your property if the payment is less than the amount you paid for the property. Payments to compensate you for lost wages or punitive damages awards are examples of taxable court awards.

For more information, see IRS Pub 17, ch. 12.
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.

Dental Coverage

Benefits that help pay for the cost of visits to a dentist for basic or preventive services, like teeth cleaning, X-rays, and fillings. In the Marketplace, dental coverage is available either as part of a comprehensive medical plan, or by itself through a "stand-alone" dental plan.

Department of Health and Human Services (HHS)

The federal agency that oversees CMS, which administers programs for protecting the health of all Americans, including Medicare, the Marketplace, Medicaid, and the Children’s Health Insurance Program (CHIP). For more information, visit hhs.gov.

Dependent Coverage

Insurance coverage for family members of the policyholder, such as spouses, children, or partners.

Disability

A limit in a range of major life activities. This includes activities like seeing, hearing, walking and tasks like thinking and working. Because different programs may have different disability standards, please check the program you’re interested in for its disability standards.

The list of activities mentioned above isn't exhaustive. A legal definition of disability can be found here: http://www.ada.gov/pubs/ada.htm. For the proposed EEOC ADA Amendments Act regulations, and related resources, see http://edocket.access.gpo.gov/2009/E9-22840.htm.
**Dividend**

A payment made by a for-profit corporation to its shareholders. This payment is a portion of the corporate earnings and may be paid a certain number of times each year (like each quarter).

**Domestic Partnership**

Two people of the same or opposite sex who live together and share a domestic life, but aren't married or joined by a civil union. In some states, domestic partners are guaranteed some legal rights, like hospital visitation.

**Donut Hole, Medicare Prescription Drug**

Most plans with Medicare prescription drug coverage (Part D) have a coverage gap (called a "donut hole"). This means that after you and your drug plan have spent a certain amount of money for covered drugs, you have to pay all costs out-of-pocket for your prescriptions up to a yearly limit. Once you have spent up to the yearly limit, your coverage gap ends and your drug plan helps pay for covered drugs again.

**Drug List**

A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a formulary.

**Durable Medical Equipment (DME)**

Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

**Early and Periodic Screening, Diagnostic, and Treatment Services, EPSDT**

A term used to refer to the comprehensive set of benefits covered for children in Medicaid.

**Eligibility Assessment**

In certain states, the Marketplace doesn't provide the final decision on Medicaid eligibility. Instead, the Marketplace conducts an assessment and passes the application to the State Medicaid agency to conduct a final eligibility determination.

**Eligible Immigration Status**

An immigration status that's considered eligible for getting health coverage through the Marketplace. The rules for eligible immigration status may be different in each insurance affordability program.

*Immigration status and the Marketplace*

**Emergency Medical Condition**

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.
**Emergency Medical Transportation**
Ambulance services for an emergency medical condition.

**Emergency Room Care**
Emergency services you get in an emergency room.

**Emergency Services**
Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

**Employer Shared Responsibility Payment**
The Affordable Care Act requires certain employers with at least 50 full-time employees (or equivalents) to offer health insurance coverage to its full-time employees (and their dependents) that meets certain minimum standards set by the Affordable Care Act or to make a tax payment called the ESRP.

**Employer or Union Retiree Plans**
Plans that provide health and/or drug coverage to former employees or members, and, in some cases, their families. These plans are offered to people through their (or a spouse's) former employer or employee organization. Many of these plans aren't legally required to meet many of the provisions of the Affordable Care Act, including providing coverage for children up to age 26.

**Essential Health Benefits**
A set of health care service categories that must be covered by certain plans, starting in 2014.

The Affordable Care Act ensures health plans offered in the individual and small 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.

Insurance policies must cover these benefits in order to be certified and offered in the Health Insurance Marketplace. States expanding their Medicaid programs must provide these benefits to people newly eligible for Medicaid.

**Exchange**
See Health Insurance Marketplace

**Excluded Services**
Health care services that your health insurance or plan doesn't pay for or cover.

**Exclusive Provider Organization (EPO) Plan**
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).
External Review

A review of a plan's decision to deny coverage for or payment of a service by an independent third-party not related to the plan. If the plan denies an appeal, an external review can be requested. In urgent situations, an external review may be requested even if the internal appeals process isn't yet completed. External review is available when the plan denies treatment based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, when the plan determines that the care is experimental and/or investigational, or for rescissions of coverage. An external review either upholds the plan's decision or overturns all or some of the plan's decision. The plan must accept this decision.

Family and Medical Leave Act (FMLA)

A Federal law that guarantees up to 12 weeks of job protected leave for certain employees when they need to take time off due to serious illness or disability, to have or adopt a child, or to care for another family member. When on leave under FMLA, you can continue coverage under your job-based plan.

Federal Poverty Level (FPL)

A measure 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.

(The amounts below are based on 2013 numbers and are likely to be slightly higher in 2014.)
- $11,490 to $45,960 for individuals
- $15,510 to $62,040 for a family of 2
- $19,530 to $78,120 for a family of 3
- $23,550 to $94,200 for a family of 4
- $27,570 to $110,280 for a family of 5
- $31,590 to $126,360 for a family of 6
- $35,610 to $142,440 for a family of 7
- $39,630 to $158,520 for a family of 8

Federally Qualified Health Center (FQHC)

Federally funded nonprofit health centers or clinics that serve medically underserved areas and populations. Federally qualified health centers provide primary care services regardless of your ability to pay. Services are provided on a sliding scale fee based on your ability to pay.

Federally Recognized Tribe

Any Indian or Alaska Native tribe, band, nation, pueblo, village or community that the Department of the Interior acknowledges to exist as an Indian tribe.

Read the current list of federally recognized tribes (PDF - 6.3 MB).
**Fee**

Starting January 1, 2014, if someone doesn't have a health plan that qualifies as **minimum essential coverage**, he or she may have to pay a fee that increases every year: from 1% of income (or $95 per adult, whichever is higher) in 2014 to 2.5% of income (or $695 per adult) in 2016. The fee for children is half the adult amount. The fee is paid on the 2014 federal income tax form, which is completed in 2015. People with very low incomes and others may be eligible for waivers. See "What if someone doesn't have health coverage in insurance in 2014?" for more information.

**Fee For Service**

A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.

**Flexible Benefits Plan**

A benefit program that offers employees a choice between various benefits including cash, life insurance, health insurance, vacations, retirement plans, and child care. Although a common core of benefits may be required, you can choose how your remaining benefit dollars are to be allocated for each type of benefit from the total amount promised by the employer. Sometimes you can contribute more for additional coverage. Also known as a Cafeteria plan or IRS 125 Plan.

**Flexible Spending Account (FSA)**

An arrangement you set up through your employer to pay for many of your out-of-pocket medical expenses with tax-free dollars. These expenses include insurance copayments and deductibles, and qualified prescription drugs, insulin and medical devices. You decide how much of your pre-tax wages you want taken out of your paycheck and put into an FSA. You don’t have to pay taxes on this money. Your employer’s plan sets a limit on the amount you can put into an FSA each year.

There is no carry-over of FSA funds. This means that FSA funds you don’t spend by the end of the plan year can’t be used for expenses in the next year. An exception is if your employer’s FSA plan permits you to use unused FSA funds for expenses incurred during a grace period of up to 2.5 months after the end of the FSA plan year.

(Nota: Flexible Spending Accounts are sometimes called Flexible Spending Arrangements.)

**Formulary**

A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

**Full-Time Employee**

An employee who works an average of at least 30 hours per week (so part-time would be less than 30 hours per week).

**Fully Insured Job-based Plan**

A health plan purchased by an employer from an insurance company.
Generic Drugs
A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as brand-name drugs.

Gold Health Plan
See Health Plan Categories

Grandfathered
As used in connection with the Affordable Care Act: Exempt from certain provisions of this law.

Grandfathered Health Plan
As used in connection with the Affordable Care Act: A group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the Affordable Care Act. Plans or policies may lose their “grandfathered” status if they make certain significant changes that reduce benefits or increase costs to consumers. A health plan must disclose in its plan materials whether it considers itself to be a grandfathered plan and must also advise consumers how to contact the U.S. Department of Labor or the U.S. Department of Health and Human Services with questions. (Note: If you are in a group health plan, the date you joined may not reflect the date the plan was created. New employees and new family members may be added to grandfathered group plans after March 23, 2010).

Grievance
A complaint that you communicate to your health insurer or plan.

Group Health Plan
In general, a health plan offered by an employer or employee organization that provides health coverage to employees and their families.

Guaranteed Issue
A requirement that health plans must permit you to enroll regardless of health status, age, gender, or other factors that might predict the use of health services. Except in some states, guaranteed issue doesn't limit how much you can be charged if you enroll.

Guaranteed Renewal
A requirement that your health insurance issuer must offer to renew your policy as long as you continue to pay premiums. Except in some states, guaranteed renewal doesn't limit how much you can be charged if you renew your coverage.

HIPAA Eligible Individual
Your status once you have had 18 months of continuous creditable health coverage. To be HIPAA eligible, at least the last day of your creditable coverage must have been under a group health plan; you also must have used up any COBRA or state continuation coverage; you must not be eligible for Medicare or Medicaid; you must not have other health insurance; and you must apply for individual health insurance within 63 days of losing your prior creditable
coverage. When you're buying individual health insurance, HIPAA eligibility gives you greater protections than you would otherwise have under state law.

**Habilitation/Habilitation Services**

Health care services that help you keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

**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. More information will be available later in 2013.

**Health Care Workforce Incentive**

The use of incentives and recruiting to encourage people to enter into health care professions like primary care and to encourage providers to practice in underserved areas.

**Health Coverage**

Legal entitlement to payment or reimbursement for your health care costs, generally under a contract with a health insurance company, a group health plan offered in connection with employment, or a government program like Medicare, Medicaid, or the Children’s Health Insurance Program (CHIP).

**Health Insurance**

A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

**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 some states, the Marketplace is run by the state. In others it is run by the federal government.

**Health Maintenance Organization (HMO)**

A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

**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 Reimbursement Account (HRA)

Health Reimbursement Accounts (HRAs) are employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year. Unused amounts may be rolled over to be used in subsequent years. The employer funds and owns the account. Health Reimbursement Accounts are sometimes called Health Reimbursement Arrangements.

Health Savings Account (HSA)

A medical savings account available to taxpayers who are enrolled in a High Deductible Health Plan. The funds contributed to the account aren’t subject to federal income tax at the time of deposit.

Funds must be used to pay for qualified medical expenses. Unlike a Flexible Spending Account (FSA), funds roll over year to year if you don’t spend them.

Health Status

Refers to your medical conditions (both physical and mental health), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

High Deductible Health Plan (HDHP)

A plan that features higher deductibles than traditional insurance plans. High deductible health plans (HDHPs) can be combined with a health savings account or a health reimbursement arrangement to allow you to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

High Risk Pool Plan (State)

Similar to the Pre-Existing Condition Insurance Plan under the Affordable Care Act, for years many states have offered plans that provide coverage if you have been locked out of the individual insurance market because of a pre-existing condition. High-risk pool plans may also offer coverage if you’re HIPAA eligible or meet other requirements. High-risk pool plans offer health insurance coverage that is subsidized by a state government. Typically, your premium is up to twice as much as you would pay for individual coverage if you were healthy.

High-Cost Excise Tax

Under the Affordable Care Act starting in 2018, a tax on insurance companies that provide high-cost plans. This tax encourages streamlining of health plans to make premiums more affordable.

Home Health Care

Health care services a person receives at home.

Home and Community-Based Services (HCBS)

Services and support provided by most state Medicaid programs in your home or community that gives help with such daily tasks as bathing or dressing. This care is covered when provided by care workers or, if your state permits it, by your family.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.
**Hospital Outpatient Care**
Care in a hospital that usually doesn't require an overnight stay.

**Hospital Readmissions**
A situation where you were discharged from the hospital and wind up going back in for the same or related care within 30, 60 or 90 days. The number of hospital readmissions is often used in part to measure the quality of hospital care, since it can mean that your follow-up care wasn't properly organized, or that you weren't fully treated before discharge.

**Hospitalization**
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

**In Person Assistance Personnel Program**
Individual or organizations that are trained and able to provide help to consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including helping them complete eligibility and enrollment forms. These individuals and organizations are required to be unbiased. Their services are free to consumers.

**In-network Coinsurance**
The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network coinsurance usually costs you less than out-of-network coinsurance.

**In-network Copayment**
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

**Individual Health Insurance Policy**
Policies for people that aren't connected to job-based coverage. Individual health insurance policies are regulated under state law.

**Inpatient Care**
Health care that you get when you're admitted as an inpatient to a health care facility, like a hospital or skilled nursing facility.

**Insurance Co-Op**
A non-profit entity in which the same people who own the company are insured by the company. Cooperatives can be formed at a national, state or local level, and can include doctors, hospitals and businesses as member-owners.

**Interest**
The charge for the use of borrowed money.
Interest you get from a bank or dividends from a stock you own are examples of investment income, which you should tell us about if you apply for help paying for health coverage.

**Investment Income**

The income you get from an investment, like interest you get from a bank or dividends you get from a stock you own.

For more information, see IRS Pub 550.

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**Job-based Health Plan**

Coverage that is offered to an employee (and often his or her family) by an employer.

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**Large Group Health Plan**

In general, a group health plan that covers employees of an employer that has 101 or more employees. Until 2016, in some states large groups are defined as 51 or more.

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**Lifetime Limit**

A cap on the total lifetime benefits you may get from your insurance company. An insurance company may impose a total lifetime dollar limit on benefits (like a $1 million lifetime cap) or limits on specific benefits (like a $200,000 lifetime cap on organ transplants or one gastric bypass per lifetime) or a combination of the two. After a lifetime limit is reached, the insurance plan will no longer pay for covered services.

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**Long-Term Care**

Services that include medical and non-medical care provided to people who are unable to perform basic activities of daily living such as dressing or bathing. Long-term supports and services can be provided at home, in the community, in assisted living or in nursing homes. Individuals may need long-term supports and services at any age. Medicare and most health insurance plans don’t pay for long-term care.

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**Marketplace**

See [Health Insurance Marketplace](http://semanticommunity.info/Healthcare.gov)

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**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.
Medical Loss Ratio (MLR)

A basic financial measurement used in the Affordable Care Act to encourage health plans to provide value to enrollees. If an insurer uses 80 cents out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care, the company has a medical loss ratio of 80%. A medical loss ratio of 80% indicates that the insurer is using the remaining 20 cents of each premium dollar to pay overhead expenses, such as marketing, profits, salaries, administrative costs, and agent commissions. The Affordable Care Act sets minimum medical loss ratios for different markets, as do some state laws.

Medical Underwriting

A process used by insurance companies to try to figure out your health status when you're applying for health insurance coverage to determine whether to offer you coverage, at what price, and with what exclusions or limits.

Medically Necessary

Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Medicare

A Federal health insurance program for people who are age 65 or older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Medicare Advantage (Medicare Part C)

A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren’t paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare Hospital Insurance Tax

A tax under the Federal Insurance Contributions Act (FICA) that is a United States payroll tax imposed by the Federal government on both employees and employers to fund Medicare.

Medicare Part D

A program that helps pay for prescription drugs for people with Medicare who join a plan that includes Medicare prescription drug coverage. There are two ways to get Medicare prescription drug coverage: through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that includes drug coverage. These plans are offered by insurance companies and other private companies approved by Medicare.

Medicare Prescription Drug Donut Hole

Most plans with Medicare prescription drug coverage (Part D) have a coverage gap (called a "donut hole"). This means that after you and your drug plan have spent a certain amount of money for covered drugs, you have to pay all costs out-of-pocket for your prescriptions up to a yearly limit. Once you have spent up to the yearly limit, your coverage gap ends and your drug plan helps pay for covered drugs again.

Member Survey Results

A survey conducted by the Consumer Assessment of Healthcare Providers and Systems (CAHPS) which asks health plan members to rate the care their experiences with their health plan and its services.
**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.

**Minimum value**

A health plan meets this standard if it’s designed to pay at least 60% of the total cost of medical services for a standard population. Starting in 2014, individuals offered employer-sponsored coverage that provides minimum value and that’s affordable won’t be eligible for a premium tax credit.

**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.

**Multi-Employer Plan**

In general, a group health plan that's sponsored jointly by 2 or more employers.

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**Navigator**

An individual or organization that's 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. Their services are free to consumers.

**Net Capital Gains**

The amount by which your total long-term capital gain for the year is more than your short-term capital loss for the year.


**Net Rental Income**

The amount someone pays you to use your property, after you subtract the expenses you have for the property. Royalty income includes any payments you get from a patent, a copyright, or some natural resource that you own.

For more information, see IRS Pub 17, ch. 9, pg. 67-74.

**Network**

The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

**New Plan**

As used in connection with the Affordable Care Act: A health plan that is not a grandfathered health plan and therefore subject to all of the reforms in the Affordable Care Act.
In the individual health insurance market, a plan that your family is purchasing for the first time will generally be a new plan.

In the group health insurance market, a plan that your employer is offering for the first time will generally be a new plan. Please note that new employees and new family members may be added to existing grandfathered group plans – so a plan that is “new to you” and your family may still be a grandfathered plan.

In both the individual and group markets, a plan that loses its grandfathered status will be considered a new plan.

A plan loses its grandfathered status when it makes significant changes to the plan, such as reducing benefits or increasing cost-sharing for enrollees.

A health plan must disclose in its plan materials whether it considers itself to be a grandfathered plan and must also advise consumers how to contact the U.S. Department of Labor or the U.S. Department of Health and Human Services with questions.

**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.

**Nondiscrimination**

A requirement that job-based coverage not discriminate based on health status. Coverage under job-based plans cannot be denied or restricted. You also can’t be charged more because of your health status. Job-based plans can restrict coverage based on other factors such as part-time employment that aren’t related to health status.

**Not Yet Accredited (Health Plan)**

A plan that hasn’t been given a "seal of approval" by an independent company to show it meets national quality standards for health plans. There are many reasons why a health plan may not be accredited. For example, some plans have never gone through the accreditation process or have gone through the process with a different accrediting organization. Other plans are too new to be accredited or have started but not finished the accreditation process. Not being accredited doesn't mean that a plan is lower quality than a plan that's accredited.

**Notice**

An official form of communication that informs individuals about the status of their applications, their eligibility for programs, or other important information. Notices may be sent by the Marketplace or by health insurers.

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**Open Enrollment Period**

The period of time during which individuals who are eligible to enroll in a Qualified Health Plan can enroll in a plan in the Marketplace. For 2014, the Open Enrollment Period is October 1, 2013–March 31, 2014. For 2015 and later years, the Open Enrollment Period is October 15 to December 7 of the previous year. Individuals may also qualify for Special
Enrollment Periods outside of Open Enrollment if they experience certain events. (See Special Enrollment Period and Qualifying Life Event)

You can submit an application for health coverage outside of the Marketplace, or apply for Medicaid or CHIP, at any time of the year.

**Original Medicare**

Original Medicare is fee-for-service coverage under which the government pays your health care providers directly for your Part A (Hospital Insurance) and/or Part B (Medical Insurance) benefits.

**Out-of-Network Coinsurance**

The percentage (for example, 40%) you pay of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

**Out-of-Network Copayment**

A fixed amount (for example, $30) you pay for covered health care services from providers who don't contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

**Out-of-Pocket Costs**

Your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.

**Out-of-Pocket Estimate**

An estimate of the amount that you may have to pay on your own for health care or prescription drug costs. The estimate is made before your health plan has processed a claim for that service.

**Out-of-pocket maximum/limit**

The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges, or health care your health insurance or plan doesn’t cover. Some health insurance or plans don’t count your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit. In Medicaid and CHIP, the limit includes premiums. The maximum out-of-pocket costs for any Marketplace plan for 2014 are $6,350 for an individual plan and $12,700 for a family plan.

**Patient Protection and Affordable Care Act**

See Affordable Care Act

**Patient-Centered Outcomes Research**

Research that compares different medical treatments and interventions to provide evidence on which strategies are most effective in different populations and situations. The goal is to empower you and your doctor with additional information to make sound health care decisions.
Payment Bundling

A payment structure in which different health care providers who are treating you for the same or related conditions are paid an overall sum for taking care of your condition rather than being paid for each individual treatment, test, or procedure. In doing so, providers are rewarded for coordinating care, preventing complications and errors, and reducing unnecessary or duplicative tests and treatments.

Penalty

See Fee

Pension (Retirement Benefit)

A payment or series of payments made to you after you retire from work. Generally, the amount of your income from a pension or retirement account distribution depends on the type of pension or retirement account, how much you contributed to the pension or retirement account, and whether you were already taxed on the amounts you contributed.

For additional information, see IRS Pub 575.

Physician Services

Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan

A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Plan Year

A 12-month period of benefits coverage under a group health plan. This 12-month period may not be the same as the calendar year. To find out when your plan year begins, you can check your plan documents or ask your employer. (Note: For individual health insurance policies this 12-month period is called a "policy year").

Platinum Health Plan

See Health Plan Categories

Point of Service (POS) Plans

A type of 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.

Policy Year

A 12-month period of benefits coverage under an individual health insurance plan. This 12-month period may not be the same as the calendar year. To find out when your policy year begins, you can check your policy documents or contact your insurer. (Note: In group health plans, this 12-month period is called a "plan year").

Pre-Existing Condition

A health problem you had before the date that new health coverage starts.
Pre-Existing Condition (Job-based Coverage)
Any condition (either physical or mental) including a disability for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on your enrollment date in a health insurance plan. Genetic information, without a diagnosis of a disease or a condition, cannot be treated as a pre-existing condition. Pregnancy cannot be considered a pre-existing condition and newborns, newly adopted children and children placed for adoption who are enrolled within 30 days cannot be subject to pre-existing condition exclusions.

Pre-Existing Condition Exclusion Period (Individual Policy)
The time period during which an individual policy won’t pay for care relating to a pre-existing condition. Under an individual policy, conditions may be excluded permanently (known as an "exclusionary rider"). Rules on pre-existing condition exclusion periods in individual policies vary widely by state.

Pre-Existing Condition Exclusion Period (Job-based Coverage)
Any condition (either physical or mental) including a disability for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on your enrollment date in a health insurance plan. Genetic information, without a diagnosis of a disease or a condition, cannot be treated as a pre-existing condition. Pregnancy cannot be considered a pre-existing condition and newborns, newly adopted children and children placed for adoption who are enrolled within 30 days cannot be subject to pre-existing condition exclusions.

Pre-existing Condition Insurance Plan (PCIP)
A program that will provide a health coverage option for you if you have been uninsured for at least six months, you have a pre-existing condition, and you have been denied coverage (or offered insurance without coverage of the pre-existing condition) by a private insurance company. This program will provide coverage until 2014 when you will have access to affordable health insurance choices through the Health Insurance Marketplace, and you can no longer be discriminated against based on a pre-existing condition.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn’t a promise your health insurance or plan will cover the cost.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a “tiered” network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also “participating” providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Preferred Provider Organization (PPO)
A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan’s network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.
**Premium Tax Credit**

The Affordable Care Act provides a new 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.

**Prescription Drug Coverage**

Health insurance or plan that helps pay for prescription drugs and medications.

**Prescription Drugs**

Drugs and medications that by law require a prescription.

**Prevention**

Activities to prevent illness such as routine check-ups, immunizations, patient counseling, and screenings.

**Preventive Services**

Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

**Primary Care**

Health services that cover a range of prevention, wellness, and treatment for common illnesses. Primary care providers include doctors, nurses, nurse practitioners, and physician assistants. They often maintain long-term relationships with you and advise and treat you on a range of health related issues. They may also coordinate your care with specialists.

**Primary Care Physician**

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

**Primary Care Provider**

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), 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.

**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.

**Public Health**

A field that seeks to improve lives and the health of communities through the prevention and treatment of disease and the promotion of healthy behaviors such as healthy eating and exercise.
**Qualified Health Plan**

Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by the 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 qualified health plan will have a certification by each Marketplace in which it is sold.

**Qualifying Life Event**

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).

**Rate Review**

A process that allows state insurance departments to review rate increases before insurance companies can apply them to you.

**Reconstructive Surgery**

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

**Referral**

A written order from your primary care doctor 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.

**Rehabilitative/Rehabilitation Services**

Health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

**Reinsurance**

A reimbursement system that protects insurers from very high claims. It usually involves a third party paying part of an insurance company’s claims once they pass a certain amount. Reinsurance is a way to stabilize an insurance market and make coverage more available and affordable.

**Rental or Royalty Income**

The amount someone pays you to use your property, after you subtract the expenses you have for the property. Royalty income includes any payments you get from a patent, a copyright, or some natural resource that you own.

For more information, see IRS Pub 17, ch. 9, pg. 67-74.
**Rescission**

The retroactive cancellation of a health insurance policy. Insurance companies will sometimes retroactively cancel your entire policy if you made a mistake on your initial application when you buy an individual market insurance policy. Under the Affordable Care Act, rescission is illegal except in cases of fraud or intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.

**Retirement Benefit (Pension)**

A payment or series of payments made to you after you retire from work. Generally, the amount of your income from a pension or retirement account distribution depends on the type of pension or retirement account, how much you contributed to the pension or retirement account, and whether you were already taxed on the amounts you contributed. A qualified distribution from a designated Roth account isn't required to be included in your income.

For additional information, see IRS Pub 575.

**Rider (exclusionary rider)**

A rider is an amendment to an insurance policy. Some riders will add coverage (for example, if you buy a maternity rider to add coverage for pregnancy to your policy.) In most states today, an exclusionary rider is an amendment, permitted in individual health insurance policies that permanently excludes coverage for a health condition, body part, or body system. Starting in September 2010, under the Affordable Care Act, exclusionary riders cannot be applied to coverage for children. Starting in 2014, no exclusionary riders will be permitted in any health insurance.

**Risk Adjustment**

A statistical process that takes into account the underlying health status and health spending of the enrollees in an insurance plan when looking at their health care outcomes or health care costs.

**Self-Employment Income**

The net income you earn from your own trade or business. For example, any net income (profit) you earn from goods you sell or services you provide to others counts as self-employment income.

Self-employment income could also come from a distributive share from a partnership.

**Self-Insured Plan**

Type of plan usually present in larger companies where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees’ and dependents’ medical claims. These employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third party administrator, or they can be self-administered.

**Service Area**

A geographic area where a health insurance plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you move out of the plan's service area.
Silver Health Plan

See Health Plan Categories

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Skilled Nursing Facility Care

Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Social Security

A system that distributes financial benefits to retired or disabled people, their spouses, and their dependent children based on their reported earnings. While you work, you may pay taxes into the Social Security system. When you retire or become disabled, you, your spouse, and your dependent children may get monthly benefits that are based on your reported earnings. Your survivors may be able to collect Social Security benefits if you die.

Social Security Benefits

The amount you get from Social Security Disability, Retirement (including Railroad retirement), or Survivor's Benefits each month.

Social Security Survivors Benefits

Social Security benefits based on your record (if you should die) that are paid to your:

- Widow/widower age 60 or older, 50 or older if disabled, or any age if caring for a child under age 16 or disabled before age 22
- Children, if they are unmarried and under age 18, under 19 but still in school, or 18 or older but disabled before age 22; and
- Parents if you provided at least one-half of their support.

An ex-spouse could also be eligible for a widow/widower's benefit on your record. A special one-time lump sum payment of $255 may be made to your spouse or minor children.

Special Enrollment Period

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.

Special Health Care Need

The health care and related needs of children who have chronic physical, developmental, behavioral or emotional conditions. Such needs are of a type or amount beyond that required by children generally.
Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

State Continuation Coverage
A state-based requirement similar to COBRA that applies to group health insurance policies of employers with fewer than 20 employees. In some states, state continuation coverage rules also apply to larger group insurance policies and add to COBRA protections. For example, in some states, if you’re leaving a job-based plan, you must be allowed to continue your coverage until you reach the age of Medicare eligibility.

State Health Insurance Assistance Program (SHIP)
A state program that gets funding from the federal government to provide free local health coverage counseling to people with Medicare.

State Insurance Department
A state agency that regulates insurance and can provide information about health coverage in its state.

State Medical Assistance Office
A state agency in charge of the state’s Medicaid program and can give information about programs in its state that help pay medical bills for people with limited income and resources.

Subsidized Coverage
Health coverage that's obtained through financial assistance from programs to help people with low and middle incomes.

Summary of Benefits and Coverage (SBC)
An easy-to-read summary that lets you make apples-to-apples comparisons of costs and coverage between health plans. You can compare options based on price, benefits, and other features that may be important to you. You'll get the "Summary of Benefits and Coverage" (SBC) when you shop for coverage on your own or through your job, renew or change coverage, or request an SBC from the health insurance company.

Supplemental Security Income (SSI)
A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or 65 or older. SSI benefits aren't the same as Social Security retirement or disability benefits.

TTY
A TTY (teletypewriter) is a communication device used by people who are deaf, hard-of-hearing, or have severe speech impairment. People who don't have a TTY can communicate with a TTY user through a message relay center (MRC). An MRC has TTY operators available to send and interpret TTY messages.
**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.

**Total Cost Estimate (for health coverage)**

The total amount you may have to pay for health plan coverage, which is estimated before you actually have the coverage and have health expenses under the coverage.

**UCR (Usual, Customary, and Reasonable)**

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

**Uncompensated Care**

Health care or services provided by hospitals or health care providers that don't get reimbursed. Often uncompensated care arises when people don't have insurance and cannot afford to pay the cost of care.

**Urgent Care**

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

**Value-Based Purchasing (VBP)**

Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.

**Vision or Vision Coverage**

A type of health benefit that at least partially covers vision care, like eye exams and glasses. This coverage can be offered either as part of a comprehensive medical plan, or by itself through a “stand-alone” vision plan. However, stand-alone vision plans may not be offered through the Marketplaces.

**Waiting Period (Job-based coverage)**

The time that must pass before coverage can become effective for an employee or dependent, who is otherwise eligible for coverage under a job-based health plan.
**Well-baby and Well-child Visits**

Routine doctor visits for comprehensive preventive health services that occur when a baby is young and annual visits until a child reaches age 21. Services include physical exam and measurements, vision and hearing screening, and oral health risk assessments.

**Wellness Programs**

A program intended to improve and promote health and fitness that's usually offered through the work place, although insurance plans can offer them directly to their enrollees. The program allows your employer or plan to offer you premium discounts, cash rewards, gym memberships, and other incentives to participate. Some examples of wellness programs include programs to help you stop smoking, diabetes management programs, weight loss programs, and preventative health screenings.

**Worker's Compensation**

An insurance plan that employers are required to have to cover employees who get sick or injured on the job.