Health Reform Glossary

This glossary is intended to serve as a resource for understanding the concepts included in the Affordable Care Act. It provides simple and straightforward definitions of key terms that are part of the health reform law.

Access: The ability to obtain needed medical care. Access to care is often affected by the availability of insurance, the cost of the care, and the geographic location of providers.

Accountable Care Organization (ACO): A network of health care providers that band together to provide the full continuum of health care services for patients. The network would receive a payment for all care provided to a patient, and would be held accountable for the quality and cost of care. Proposed pilot programs in Medicare and Medicaid would provide financial incentives for these organizations to improve quality and reduce costs by allowing them to share in any savings achieved as a result of these efforts.

Actuarial Equivalent: A health benefit plan that offers similar coverage to a standard benefit plan. Actuarially equivalent plans will not necessarily have the same premiums, cost sharing requirements, or even benefits; however, the expected spending by insurers for the different plans will be the same.

Actuarial Value: A measure of the average value of benefits in a health insurance plan. It is calculated as the percentage of benefit costs a health insurance plan expects to pay for a standard population, using standard assumptions and taking into account cost-sharing provisions. Placing an average value on health plan benefits allows different health plans to be compared. The value only includes expected benefit costs paid by the plan and not premium costs paid by the enrollee. It also represents an average for a population, and would not necessarily reflect the actual cost-sharing experience of an individual.

Adverse Selection: People with a higher than average risk of needing health care are more likely than healthier people to seek health insurance. Health coverage providers strive to maintain risk pools of people whose health, on average, is the same as that of the general population. Adverse selection results when the less healthy people disproportionately enroll in a risk pool.

Association Health Plan: Health insurance plans that are offered to members of an association. These plans are marketed to individual association members, as well as small businesses members. How these plans are structured, who they sell to, and whether they are state-based or national associations determines whether they are subject to state or federal regulation, or both, or are largely exempt from regulations.

Benefit Package: The set of services, such as physician visits, hospitalizations, prescription drugs, that are covered by an insurance policy or health plan. The benefit package will specify any cost-sharing requirements for services, limits on particular services, and annual or lifetime spending limits.

Basic Health Program: States will have the option to implement a Basic Health Program (BHP) under health reform that gives states 95% of what the federal government would have spent on subsidies for adults between 133% and 200% of the federal poverty level and legal resident immigrants with incomes below 133% who have been in the U.S. for fewer than five years (and therefore do not qualify for Medicaid).

Capitation: A method of paying for health care services under which providers receive a set payment for each person or "covered life" instead of receiving payment based on the number of services provided or the costs of the services rendered. These payments can be adjusted based on the demographic characteristics, such as age and gender, or the expected costs of the members.

Case Management: The process of coordinating medical care provided to patients with specific diagnoses or those with high health care needs. These functions are performed by case managers who can be physicians, nurses, or social workers.

Children's Health Insurance Program (CHIP): Enacted in 1997, CHIP is a federal-state program that provides health care coverage for uninsured low-income children who are not eligible for Medicaid. States have the option of administering CHIP through their Medicaid programs or through a separate program (or a combination of both). The federal government matches state spending for CHIP but federal CHIP funds are capped.

Chronic Care Management: The coordination of both health care and supportive services to improve the health status of patients with chronic conditions, such as diabetes and asthma. These programs focus on evidence-based interventions and rely on patient education to improve patients' self-management skills. The goals of these programs are to improve the quality of health care provided to these patients and to reduce costs.

COBRA: When employees lose their jobs, they are able to continue their employer-sponsored coverage for up to 18 months through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Co-insurance: A method of cost-sharing in health insurance plans in which the plan member is required to pay a defined percentage of their medical costs after the deductible has been met.

Community Rating: A method for setting premium rates for health insurance plans under which all policy holders are charged the same premium for the same coverage. "Modified community rating " generally refers to a rating method under which health insuring organizations are permitted to vary premiums based on specified demographic characteristics (e.g. age, gender, location), but cannot vary premiums based on the health status or claims history of policy holders.

Comparative Effectiveness Research: A field of research that analyzes the impact of different options for treating a given condition in a particular group of patients. These analyses may focus only

on the medical risks and benefits of each treatment or may also consider the costs and benefits of particular treatment options.

Consumer-Directed Health Plans: Consumer-directed health plans seek to increase consumer awareness about health care costs and provide incentives for consumers to consider costs when making health care decisions. These health plans usually have a high deductible accompanied by a consumer-controlled savings account for health care services. There are two types of savings accounts: Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs).

Consumer Operated and Oriented Plans (CO-OP): Qualified non-profit, customer-governed, private health insurers that will offer qualified health plans in the exchanges.

Co-payment: A fixed dollar amount paid by an individual at the time of receiving a covered health care service from a participating provider. The required fee varies by the service provided and by the health plan.

Cost Containment: A set of strategies aimed at controlling the level or rate of growth of health care costs. These measures encompass a myriad of activities that focus on reducing overutilization of health services, addressing provider reimbursement issues, eliminating waste, and increasing efficiency in the health care system.

Cost-Sharing: A feature of health plans where beneficiaries are required to pay a portion of the costs of their care. Examples of costs include co-payments, coinsurance and annual deductibles.

Cost Shifting: Increasing revenues from some payers to offset losses or lower reimbursement from other payers, such as government payers and the uninsured.

Countercyclical: Medicaid is a countercyclical program in that it expands to meet increasing need when the economy is in decline. During an economic downturn, more people become eligible for and enroll in the Medicaid program when they lose their jobs and their access to health insurance. As enrollment grows, program costs also rise.

Deductible: A feature of health plans in which consumers are responsible for health care costs up to a specified dollar amount. After the deductible has been paid, the health insurance plan begins to pay for health care services.

Disproportionate Share Hospital (DSH) Payments: Payments made by a state's Medicaid program to hospitals that the state designates as serving a "disproportionate share" of low-income or uninsured patients. These payments are in addition to the regular payments such hospitals receive for providing inpatient care to Medicaid beneficiaries. States have some discretion in determining how much eligible hospitals receive. The amount of federal matching funds that a state can use to make payments to DSH hospitals in any given year is capped at an amount specified in the federal Medicaid statute.

Dual Eligibles: A term used to describe an individual who is eligible for Medicare and for some level of Medicaid benefits. Most dual eligibles qualify for full Medicaid benefits including nursing home

services, and Medicaid pays their Medicare premiums and cost sharing. For other duals Medicaid provides the "Medicare Savings Programs" through which enrollees receive assistance with Medicare premiums, deductibles, and other cost sharing requirements.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services: One of the services that states are required to include in their basic benefits package for all Medicaid-eligible children under age 21. EPSDT services include periodic screenings to identify physical and mental conditions, as well as vision, hearing, and dental problems. Services also include follow-up diagnostic and treatment services to correct conditions identified during a screening, without regard to whether the state Medicaid plan covers those services for adult beneficiaries.

Electronic Health Record/Electronic Medical Records: Computerized records of a patient's health information including medical, demographic, and administrative data. This record can be created and stored within one health care organization or it can be shared across health care organizations and delivery sites.

Employee Retirement Income Security Act of 1974 (ERISA): Legislation enacted in 1974 to protect workers from the loss of benefits provided through the workplace. ERISA does not require employers to establish any type of employee benefit plan, but contains requirements applicable to the administration of the plan when a plan is established. The requirements of ERISA apply to most private employee benefit plans established or maintained by an employer, an employee organization, or both.

Employer Health Care Tax Credit: An incentive mechanism designed to encourage employers, usually small employers, to offer health insurance to their employees. The tax credit enables employers to deduct an amount, usually a percentage of the contribution they make toward their employees' premiums, from the federal taxes they owe. These tax credits are typically refundable so they are available to non-profit organizations that do not pay federal taxes.

Employer Mandate: An approach that would require all employers, or at least all employers meeting size or revenue thresholds, to offer health benefits that meet a defined standard, and pay a set portion of the cost of those benefits on behalf of their employees.

Employer Pay-or-Play: An approach that requires employers to offer and pay for health benefits on behalf of their employees, or pay a specified dollar amount or percentage of payroll into a designated public fund. The fund would provide a source of financing for coverage for those who do not have employment-based coverage. Currently, two states, Massachusetts and Vermont, and the City of San Francisco impose pay-or play requirements on employers.

Employer-Sponsored Insurance: Insurance coverage provided to employees, and, in some cases, their spouses and children, through an employer.

Entitlement Program: Federal programs, such as Medicare and Medicaid, for which people who meet eligibility criteria have a federal right to benefits. Changes to eligibility criteria and benefits require legislation. The Federal government is required to spend the funds necessary to provide benefits for individuals in these programs, unlike discretionary programs for which spending is set by

Congress through the appropriations process. Enrollment in these programs cannot be capped and neither states nor the federal government may establish waiting lists.

Essential Health Benefits: A package of benefits set by the Secretary of Health and Human Services that insurers will be required to offer under the exchanges.

Experience Rating: A method of setting premiums for health insurance policies based on the claims history of an individual or group.

Federal Employee Health Benefits Program (FEHBP): A program that provides health insurance to employees of the U.S. federal government. Federal employees choose from a menu of plans that include fee-for-service plans, plans with a point of service option, and health maintenance organization plans. There are more than 170 plans offered; a combination of national plans, agency-specific plans, and more than 150 HMOs serving only specific geographic regions. The various plans compete for enrollment as employees can compare the costs, benefits, and features of different plans.

Federal Medical Assistance Percentage (FMAP): The statutory term for the federal Medicaid matching rate—i.e., the share of the costs of Medicaid services or administration that the federal government bears. In the case of covered services, FMAP varies from 50 to 76 percent depending upon a state's per capita income; on average, across all states, the federal government pays 57 percent of the costs of Medicaid. The American Recovery and Reinvestment Act (ARRA) provides a temporary increase in the FMAP through December 31, 2010.

Federal Poverty Level (FPL): The federal government's working definition of poverty that is used as the reference point to determine the number of people with income below poverty and the income standard for eligibility for public programs. The federal government uses two different definitions of poverty. The U.S. Census poverty threshold is used as the basis for official poverty population statistics, such as the percentage of people living in poverty. The poverty guidelines, released by the U.S. Department of Health and Human Services (HHS), are used to determine eligibility for public programs and subsidies. For 2008, the Census weighted average poverty threshold for a family of four was $22,025 and HHS poverty guideline was $21,200.

Federally Qualified Health Centers (FQHC): Safety net providers such as community health clinics and public housing centers that provide health services regardless of the ability to pay and are funded by the federal government.

Fee-for-Service: A traditional method of paying for medical services under which doctors and hospitals are paid for each service they provide. Bills are either paid by the patient, who then submits them to the insurance company, or are submitted by the provider to the patient's insurance carrier for reimbursement.

Group Health Insurance: Health insurance that is offered to a group of people, such as employees of a company. The majority of Americans have group health insurance through their employer or their spouse's employer.

Guarantee Issue/Renewal: Requires insurers to offer and renew coverage, without regard to health status, use of services, or pre-existing conditions. This requirement ensures that no one will be denied coverage for any reason.

Health Care Cooperative (CO-OP): A non-profit, member-run health insurance organization, governed by a board of directors elected by its members. Co-ops provide insurance coverage to individuals and small businesses and can operate at state, regional, and national levels.

Health Information Technology: Systems and technologies that enable health care organizations and providers to gather, store, and share information electronically.

Health Insurance Exchange/Connector: A purchasing arrangement through which insurers offer and smaller employers and individuals purchase health insurance. State, regional, or national exchanges could be established to set standards for what benefits would be covered, how much insurers could charge, and the rules insurers must follow in order to participate in the insurance market. Individuals and small employers would select their coverage within this organized arrangement. An example of this arrangement is the Commonwealth Connector, created in Massachusetts in 2006.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Through The Health Insurance Portability and Accountability Act of 1996, individuals in many states who lose group health coverage after a loss of employment have access to coverage through high-risk pools, with no pre-existing condition exclusion periods. HIPAA also sets standards that address the security and privacy of personal health data.

Health Reimbursement Account (HRA): A tax-exempt account that can be used to pay for current or future qualified health expenses. HRAs are established benefit plans funded solely by employer contributions, with no limits on the amount an employer can contribute. HRAs are often paired with a high-deductible health plan, but are not required to do so.

Health Savings Account (HSA): A tax-exempt savings account that can be used to pay for current or future qualified medical expenses. Employers may make HSAs available to their employees or individuals can obtain HSAs from most financial institutions. In order to open an HSA, an individual must have health coverage under an HSA-qualified high deductible health plan. These HSA-qualified high-deductible health plans must have deductibles of at least $1,150 for an individual and $2,300 for a family in 2009.

High-Deductible Health Plan: Health insurance plans that have higher deductibles (the amount of health care costs that must be paid for by the consumer before the insurance plan begins to pay for services), but lower premiums than traditional plans. Qualified high-deductible plans that may be combined with a health savings account must have a deductible of at least $1,150 for single coverage and $2,300 for family coverage in 2009.

High-Risk Pool: State programs designed to provide health insurance to residents who are considered medically uninsurable and are unable to buy coverage in the individual market.

Individual Insurance Market: The market where individuals who do not have group (usually employer-based) coverage purchase private health insurance. This market is also referred to as the non-group market.

Individual Mandate: A requirement that all individuals obtain health insurance. A mandate could apply to the entire population, just to children, and/or could exempt specified individuals. Massachusetts was the first state to impose an individual mandate that all adults have health insurance.

Lifetime Benefit Maximum: A cap on the amount of money insurers will pay toward the cost of health care services over the lifetime of the insurance policy.

Long-Term Care: Services that include those needed by people to live independently in the community, such as home health and personal care, as well as services provided in institutional settings such as nursing homes. Medicaid is the primary payer for long-term care. Many of these services are not covered by Medicare or private insurance.

Modified Adjusted Gross Income (MAGI): A definition of income from the tax system that will be used under the Affordable Care Act to determine eligibility for Medicaid in all states and for tax credits available to people buying insurance in exchanges. The income calculations will take into account family size and income from all family members.

Managed Care: A health delivery system that seeks to control access to and utilization of health care services both to limit health care costs and to improve the quality of the care provided. Managed care arrangements typically rely on primary care physicians to act as "gatekeepers" and manage the care their patients receive.

Mandatory Benefits: Certain benefits or services, such as mental health services, substance abuse treatment, and breast reconstruction following a mastectomy, that state-licensed health insuring organizations are required to cover in their health insurance plans. The number and type of these mandatory benefits vary across states.

Medicaid: Enacted in 1965 under Title XIX of the Social Security Act, Medicaid is a federal entitlement program that provides health and long-term care coverage to certain categories of low-income Americans. States design their own Medicaid programs within broad federal guidelines. Medicaid plays a key role in the U.S. health care system, filling large gaps in the health insurance system, financing long-term care coverage, and helping to sustain the safety-net providers that serve the uninsured. Learn more with this primer on Medicaid.

Medicaid Waivers: Authority granted by the Secretary of Health and Human Services to allow a state to continue receiving federal Medicaid matching funds even though it is no longer in compliance with certain requirements of the Medicaid statute. States can use waivers to implement home and community-based services programs, managed care, and to expand coverage to populations, such as adults without dependent children, who are not otherwise eligible for Medicaid.

Medical Home: A health care setting where patients receive comprehensive primary care services;

have an ongoing relationship with a primary care provider who directs and coordinates their care; have enhanced access to nonemergent primary, secondary, and tertiary care; and have access to linguistically and culturally appropriate care.

Medical Loss Ratio: The percentage of premium dollars an insurance company spends on medical care, as opposed to administrative costs or profits.

Medical Underwriting: The process of determining whether or not to accept an applicant for health care coverage based on their medical history. This process determines what the terms of coverage will be, including the premium cost, and any pre-existing condition exclusions.

Medicare: Enacted in 1965 under Title XVII of the Social Security Act, Medicare is a federal entitlement program that provides health insurance coverage to 45 million people, including people age 65 and older, and younger people with permanent disabilities, end-state renal disease, and Lou Gehrig's disease. Learn more with this primer on Medicare.

Minimum Creditable Coverage: The minimum level of benefits that must be included in a health insurance plan in order for an individual to be considered insured. Minimum creditable coverage standards have been established in Massachusetts as part of that state's health reform law.

Out-of-Pocket Costs: Health care costs, such as deductibles, co-payments, and co-insurance that are not covered by insurance. Out-of-pocket costs do not include premium costs.

Out-of-Pocket Maximum: A yearly cap on the amount of money individuals are required to pay out-of-pocket for health care costs, excluding the premium cost.

Pay for Performance: A health care payment system in which providers receive incentives for meeting or exceeding quality, and sometimes cost, benchmarks. Some systems also penalize providers who do not meet established benchmarks. The goal of pay for performance programs is to improve the quality of care over time.

Payment Bundling: A mechanism of provider payment where providers or hospitals receive a single payment for all of the care provided for an episode of illness, rather than per service. Total care provided for an episode of illness may include both acute and post-acute care.

Portability of Coverage: Rules allowing people to obtain coverage as they move from job to job or in and out of employment. Individuals changing jobs are guaranteed coverage with the new employer without a waiting period. In addition, insurers must waive any pre-existing condition exclusions for individuals who were previously covered within a specified time period. Portable coverage can also be health coverage that is not connected to an employer, allowing individuals to keep their coverage when they have a change in employment.

Pre-existing Condition Exclusions: An illness or medical condition for which a person received a diagnosis or treatment within a specified period of time prior to becoming insured. Health care providers can exclude benefits for a defined period of time for the treatment of medical conditions that they determine to have existed within a specific period prior to the beginning of coverage.

Pre-Existing Condition Insurance Plan (PCIP): High-risk pool operated by the states and the federal government that provides coverage for individuals who have been denied coverage for a pre-existing condition or have a pre-existing condition. Individuals must have been without health insurance for at least six months.

Premium: The amount paid, often on a monthly basis, for health insurance. The cost of the premium may be shared between employers or government purchasers and individuals.

Premium Subsidies: A fixed amount of money or a designated percentage of the premium cost that is provided to help people purchase health coverage. Premium subsidies are usually provided on a sliding scale based on an individual's or family's income.

Preventive Care: Health care that emphasizes the early detection and treatment of diseases. The focus on prevention is intended to keep people healthier for longer, thus reducing health care costs over the long term.

Primary Care Provider: A provider, usually a physician specializing in internal medicine, family practice, or pediatrics (but can also be a nurse practitioner, physician assistant or even a health care clinic), who is responsible for providing primary care and coordinating other necessary health care services for patients.

Provider Payment Rates: The total payment a provider, hospital, or community health center receives when they provide medical services to a patient. Providers are compensated for patient care using a set of defined rates based on illness category and the type of service administered.

Public Plan Option: A proposal to create a new insurance plan administered and funded by federal or state government that would be offered along with private plans in a newly-created health insurance exchange.

Purchasing Pool: Health insurance providers pool the health care risks of a group of people in order to make the individual costs predictable and manageable. For health coverage arrangements to perform well, the risk pooling should balance low and high risk individuals such that expected costs for the pool are reasonably predictable for the insurer and relatively stable over time.

Reinsurance: Reinsurance is insurance for insurance companies and employers that self-insure their employees' medical costs. Through government-funded reinsurance programs, federal or state governments pay for a portion of the high costs experienced by insurers. By limiting insurers' exposure to very high health costs, reinsurance programs enable insurers to lower the premiums they charge to employers and individuals. This type of program is a form of subsidy to the insurer that lowers the premium cost for all purchasers. The Healthy New York program and the Healthcare Group of Arizona are examples of state reinsurance programs.

Risk Adjustment: The process of increasing or reducing payments to health plans to reflect higher or lower than expected spending. Risk adjusting is designed to compensate health plans that enroll an older and sicker population as a way to discourage plans from selecting only healthier enrollees.

Safety Net: Health care providers who deliver health care services to patients regardless of their ability to pay. These providers may consist of public hospital systems, community health centers, local health departments, and other providers who serve a disproportionate share of uninsured and low-income patients.

Section 125 Plan: A section 125 plan allows employees to receive specified benefits, including health benefits, on a pre-tax basis. Section 125 plans enable employees to pay for health insurance premiums on a pre-tax basis, whether the insurance is provided by the employer or purchased directly in the individual market.

Self-Insured Plan: A plan where the employer assumes direct financial responsibility for the costs of enrollees' medical claims. Employer sponsored self-insured plans typically contract with a third-party administrator or insurer to provide administrative services for the plan.

Single-Payer System: A health care system in which a single entity pays for health care services. This entity collects health care fees and pays for all health care costs, but is not involved in the delivery of health care.

Small Group Market: Firms with 2-50 employees can purchase health insurance for their employees through this market, which is regulated by states.

Small Business Health Options Program (SHOP): State health insurance exchanges that will be open to small businesses up to 100 employees.

Socialized Medicine: A health care system in which the government operates and administers health care facilities and employs health care professionals.

Tax Credit: A tax credit is an amount that a person/family can subtract from the amount of income tax that they owe. If a tax credit is refundable, the taxpayer can receive a payment from the government to the extent that the amount of the credit is greater than the amount of tax they would otherwise owe.

Tax Deduction: A deduction is an amount that a person/family can subtract from their adjusted gross income when calculating the amount of tax that they owe. Generally, people who itemize their deductions can deduct the portion of their medical expenses, including health insurance premiums, that exceed 7.5% of their adjusted gross income.

Tax Preference for Employer-Sponsored Insurance: Under the current tax code the amount that employers contribute to health benefits are excluded, without limit, from most workers' taxable income and any contributions made by employees toward the premium cost for health insurance are made on a tax-free basis. In contrast, individuals who do not receive health insurance through an employer may only deduct the amount of their total health care expenses that exceeds 7.5% of their adjusted gross income.

Uncompensated Care: A measure of the costs of health care services that are provided but not paid for by the patient or by insurance. Health care providers incur some of this cost along with the

federal government.

Underinsured: People who have health insurance but who face out-of-pocket health care costs or limits on benefits that may affect their ability to access or pay for health care services.

Universal Coverage: A system that provides health coverage to all Americans. A mechanism for achieving universal coverage (or near-universal coverage) under several current health reform proposals is the individual mandate. Single payer proposals would also provide universal coverage.

Wellness Plan/Program: Employment-based program to promote health and prevent chronic disease. Goals of these programs include: reducing health care costs, sustaining and improving employee health and productivity, and reducing absenteeism due to illness.

Young Adult Health Plan: Health plans designed to meet the needs of young adults. These plans tend to offer lower premiums in exchange for high deductibles and/or limited benefit packages.

Source:
The Henry J Kasier Family Foundation
http://healthreform.kff.org/health-reform-glossary.aspx?source=QL#p