



Glossary of Health Care Terms

Updated January 2010 • Families USA

209(b) - A section of the Social Security Amendments of 1972 that allows states to set Medicaid income eligibility standards that are more restrictive than those of the Supplementary Security Income (SSI) program, which covers elderly, blind, or disabled adults. Generally, if a person qualifies for SSI, a state must offer her full Medicaid coverage. In 209(b) states, SSI eligibility does not guarantee Medicaid eligibility. See also Supplementary Security Income.

1915(i) State Plan Amendment - A provision included in the Deficit Reduction Act of 2005 that allows states to provide Medicaid home- and community-based services (HCBS) as an alternative to institutional care without a waiver. Eligible individuals with incomes under 150 percent of the federal poverty level may receive HCBS under 1915(i) State Plan Amendments.

A **Accountable Care Organization** - A group of physicians (and possibly a hospital) that is responsible for the quality of care provided and for annual overall Medicare spending for their patients. Providers who are members of an accountable care organization receive bonuses for meeting quality and resource use targets, and they are penalized for not meeting quality and resource use targets.

Activities of Daily Living (ADLs) - Includes five basic activities: eating, dressing, bathing, moving from a bed to a chair, and toileting. The ability to perform these activities is used as a clinical indicator of whether an individual requires long-term services and supports, and if so, at what level.

Actuarial Equivalence - As it relates to health insurance, this means that the dollar value of one benefit, such as a health insurance policy, is equal to the dollar value of another health

insurance policy.

Actuarial Value - When used as an independent measure (as opposed to use in comparing two insurance plans), this refers to the share of medical costs that will be paid by the insurance plan for an average population. For example, in an insurance plan with an actuarial value of 80 percent, the insurer will pay 80 percent of the medical costs, and the consumer will pay 20 percent, on average.

Adjusted Community Rating - See Community Rating.

Advanceable Tax Credit - As it relates to expanding health coverage, a tax credit provided to cover the cost of purchasing health coverage in the individual market that allows monthly payments to be sent directly to a health insurance provider. The recipient need not wait to file a tax return and receive the subsidy as a tax credit or refund.

Adverse Selection - The trend wherein people purchase insurance only when they become sick and therefore incur significant expenses. If people do not purchase insurance until they are sick, the individual insurance market may become a pool only for the sick, with no healthy members. This drives up premiums in the individual market. Adverse selection can also occur when healthier individuals are siphoned into certain plans (generally with fewer benefits and lower premiums) and sicker individuals into others (which offer more benefits).

American Recovery and Reinvestment Act (ARRA) - The economic stimulus legislation that was signed into law in February 2009. ARRA has many provisions, including one that provides temporary assistance with premiums to help involuntarily unemployed workers

purchase their former employer's COBRA continuation coverage, state continuation ("mini-COBRA") coverage, or other continuation coverage. ARRA also temporarily increases states' Medicaid FMAP, so long as states maintain their eligibility levels and benefits for Medicaid enrollees. See also FMAP.

America's Health Insurance Plans (AHIP) - The trade organization that represents health insurance companies.

Annual Limit - A cap on the dollar value or number of services that an insurance plan will cover over the course of a year.

Any Willing Provider Legislation - State laws that require managed care organizations (MCOs, e.g. HMOs and PPOs) to contract with any provider willing to meet the terms and conditions in the MCO's contract, whether or not the MCO wants or needs that provider.

Association Health Plans (AHPs) - Plans that allow small employers to band together across state lines—through their membership in a trade or professional association—to purchase health coverage for their families and employees that is exempt from the consumer protections provided by many state laws, including requirements for coverage of important services and providers. This creates a situation in the small group or small employer market that, due to adverse selection, will increase the price of health care for the majority of those who work for small employers. By eliminating state regulation of the small group market, AHPs could create fertile ground for fraud and abuse, which would leave defrauded workers with millions of dollars in unpaid medical bills. See also Adverse Selection.

Average Manufacturer Price (AMP) - The price at which a pharmaceutical manufacturer sells drugs to purchasers. There is an AMP for wholesalers and an AMP for pharmacies. For sales to wholesalers, AMP represents the Wholesale Acquisition Cost after all discounts.

For sales directly to pharmacies, AMP represents the price pharmacies pay for drugs after all the discounts they receive.

Average Wholesale Price (AWP) - The price that pharmaceutical manufacturers suggest that wholesalers charge retail pharmacies. Manufacturers generally offer lower prices or rebates to favored customers that have purchasing power, such as large insurance companies or government bodies, meaning that these customers pay significantly less than the AWP.

Balance Billing - The practice of medical care providers billing an insurer for full costs, regardless of whether they exceed the rate the insurer is willing to pay, and then billing the patient for the portion of the bill that the insurer did not pay. Many managed care plans prohibit the use of balanced billing and may use sanctions against providers who balance the bill. Some states ban the practice of balance billing.

Balanced Budget Act of 1997 (BBA) - The BBA 1) created the State Children's Health Insurance Program (SCHIP, now known as CHIP), which expanded coverage to low-income children not covered under Medicaid; 2) added a new part to Medicare, called Medicare+Choice (now Medicare Advantage), which includes an array of private health plan options; 3) gave states greater authority to structure their Medicaid programs, including the authority to unilaterally enroll beneficiaries without a waiver from HHS; and 4) added new beneficiary protections to both Medicaid and Medicare.

Bayh-Dole Act (1980) - Legislation that permits grantees and contractors to retain their title to federally funded discoveries and inventions and to encourage universities to license those discoveries to the commercial sector. The purpose of the act was to encourage the commercialization of technologies that are developed with federal funds.

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Beneficiary - A person who receives benefits. The term is commonly applied to anyone receiving benefits under the Medicare, Medicaid, state Children's Health Insurance Program (CHIP) programs, or who is covered under a private health insurance plan.

Benefit Cap - A dollar limit placed on the amount of coverage that can be provided to an individual in a given time period, which is usually one year (see Annual Limit). Some health insurance plans also impose lifetime benefit caps (see Lifetime Limit).

Benefit Package - A group of guaranteed services provided by a health plan to its members.

Biologic Drug - A drug that is synthesized from living organisms or their products, rather than from traditional chemical methods. These cutting-edge drugs tend to be very expensive.

Block Grant - A lump sum of money that is given to a state or local governing agency (based on a formula) to be spent on services such as health coverage. Generally, the purposes of block grants are broadly defined with few restrictions. Restrictions can be imposed by the re-granting agency. CHIP is administered via block grants from the federal government to states.

Brand-Name Drugs - Drugs provided by the manufacturer that held or acquired the initial patent on the drug. Brand-name drugs may have a generic equivalent on the market.

Budget Neutrality - A federal government requirement that a new program or a state's coverage plan (e.g., a Medicaid waiver) introduce only new costs that are balanced by spending cuts elsewhere so that overall spending levels remain unchanged.

Built Environment - All buildings, spaces, and products that are created or modified by people. A person's built environment includes homes, schools, workplaces, parks and recreation areas, greenways, business areas,

and transportation systems, all of which can influence his or her health.

Bulk Purchasing Programs - Single or multi-state programs that combine various groups or programs—such as state employees, the Medicaid program, or state pharmacy assistance programs—to create a larger group that can negotiate better drug prices from manufacturers. Bulk purchasing programs may provide drug coverage to people without prescription drug insurance.

Bundled Payments - A system of paying physicians and hospitals (particularly in Medicare) as a group, rather than individually, to encourage coordination of care, higher quality, and better accountability.

Cafeteria Plans - See Section 125 Cafeteria Plans.

Capitation - The practice of reimbursing health care providers a fixed amount for each enrollee they treat, regardless of the actual number or nature of services provided (paying per member, per month).

Carrier - As it pertains to Medicare, a private organization—usually an insurance company—that has a contract with the Centers for Medicare and Medicaid Services (CMS) to process claims under Part B of Medicare.

Carve-Out - A health care delivery and financing arrangement in which certain specific health care services that are covered benefits (e.g. mental health services) are administered and funded separately from general health care services. The carve-out is typically done through separate contracting for services to a special population. As it relates to Medicaid, a set of services (such as behavioral health services) that are provided separately, or a specific population (such as people with HIV or children with special needs) that is not required to enroll in a Medicaid managed care program. These services or populations are said to be “carved out” and handled separately,

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either in fee-for-service plans or through a separate managed care organization.

Case Management - A means of coordinating care for people with multiple, often complex health care needs. As it relates to managed care, a system that requires that a single individual in the provider organization be responsible for arranging and approving all services needed. Ideally, case management should increase consumers' access to appropriate care through specialists and ensure that full information about a consumer's health conditions follows him or her through the health care system. In the context of private managed care, case management by a gatekeeper can be inappropriately motivated by the goal of reducing a company's health care costs. In the context of Medicaid, case management and managed care delivery systems must be examined carefully to determine if cost concerns are overriding the positive goal of coordinating care.

Cash and Counseling - An initiative within the Medicaid program pertaining to long-term services and supports (LTSS). This program allows enrollees to receive their LTSS benefits in the form of cash that they can use to pay for providers, equipment, and other services that they believe best meet their needs. In addition, the program provides informational counseling to ensure that enrollees are aware of all available options for LTSS.

Categorically Needy - As it relates to Medicaid, a beneficiary is deemed categorically needy if she is eligible for coverage because she meets certain income requirements and falls into a specific population category: families with children; pregnant women; and people who are blind, disabled, or over 65. People who do not fall into these categories cannot qualify for Medicaid, no matter how low their incomes (unless their state has obtained a federal Section 1115 waiver to cover additional groups). Medicaid expansion proposals in

federal health reform legislation would require states to cover all non-elderly citizens with income below a certain percentage of the federal poverty level, regardless of whether they are categorically eligible.

Centers for Medicare and Medicaid Services (CMS) - The agency within the Department of Health and Human Services (HHS) that oversees Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

Certificate of Need - A regulatory process that requires hospitals and other health care facilities to obtain state approval before embarking on a capital investment project or offering certain new and expanded services. Requiring a certificate of need is meant to ensure that health care expenditures and investments are equitably distributed throughout a state or region.

Children's Health Insurance Program (CHIP) - The Balanced Budget Act (BBA) of 1997 established Title XXI of the Social Security Act, which created the federal block grant program now known as CHIP. CHIP provides funds to states to establish a health insurance program for targeted low-income children. States can: (1) expand Medicaid to cover children in families with higher incomes, (2) create a new health insurance program for children, or (3) do both. The program is financed with federal and state funds, with the federal government paying a greater share than it pays for the state's regular Medicaid program. Each state has its own CHIP program.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) - Signed into law by President Obama on February 4, 2009, CHIPRA extends and expands CHIP. CHIPRA adds \$44 billion in federal funds for children's coverage and is expected to provide coverage to an additional 4.1 million children in Medicaid and CHIP by the end of September 2013. The law also improves the benefits

package for children, includes incentives for effective enrollment practices, and allows states to provide coverage to legal immigrant children and pregnant women who have been in the country for fewer than five years.

Citizenship Documentation Requirement - A federal requirement that individuals applying for or renewing Medicaid coverage must provide documentary proof of identity and citizenship as a condition of eligibility. In the past, states could decide what constituted proof of citizenship, and most allowed applicants to simply attest to their citizenship under penalty of perjury. This law was passed as part of the Deficit Reduction Act (DRA) in February 2006 and went into effect in July 2006. It has caused tens of thousands of citizens to lose or be denied Medicaid coverage due to their inability to provide the required documents. It also places a costly administrative burden on states. CHIPRA extends the documentation requirement to CHIP as well, but it allows states to conduct data matches as a way to simplify the documentation process.

CLAS Standards - The collective set of Culturally and Linguistically Appropriate Services (CLAS) mandates, guidelines, and recommendations issued by the Department of Health and Human Services (HHS) Office of Minority Health. They are intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services.

Clawback - The colloquial term for the “state phased-down monthly contribution”—the mechanism through which states help fund the Medicare Part D prescription drug program. States make monthly payments to the federal government. These payments are determined by a formula based on the number of dual eligibles in a state and the state’s drug costs for dual eligibles in 2003, inflated by national drug price inflation. They amount to a large portion of the savings states would

have realized by no longer having to pay for Medicaid drug coverage for dual eligibles.

Clinical Trial - A research study that is performed on human volunteers to answer specific health questions. There are two types of clinical trials: 1) Interventional trials determine whether experimental treatments or new ways of using known therapies are safe and effective under controlled environments; 2) Observational trials address health issues in large groups of people or populations in natural settings.

Clinical Trial Phases - The specific phases of clinical testing relevant to the development of new medical interventions.

- **Preclinical testing** - Animal testing used to determine basic safety before clinical trials begin.
- **Phase I** - Testing of a new drug or treatment in a small group of people (20-80) to evaluate safety, determine a safe dosage range, and identify side effects.
- **Phase II** - Testing a larger group of participants (100 to 300) to see if the study drug or treatment is effective and to further evaluate its safety.
- **Phase III** - Testing large groups of people (1,000-3,000) to confirm the drug’s effectiveness, monitor side effects, and compare it to commonly used treatments.

Co-Insurance - The portion of covered health care expenses that must be paid, in addition to the deductible, by health plan members. The figure is usually expressed as a ratio, such as 80/20, where the insurer pays 80 percent and the client pays the remaining 20 percent of the bill. See also Cost-Sharing.

Community Living Assistance Services and Supports (CLASS) Act - A bill, included in federal health reform proposals, that creates a national voluntary program to help individuals pay for community-based long-term services

and supports. Enrollment is open to working adults and adult students, but it can be maintained post-retirement. Individuals who have paid premiums into the program for at least five years and who are unable to perform a certain number of activities of daily living (ADLs) would be eligible to receive a cash benefit.

Community Rating - A method of determining health insurance premiums based on the average cost of health services used by all consumers in a specific service area. When community rating is in place, insurance companies are required to charge the same premium to all their customers for the same type and amount of coverage. It is a way of spreading the cost of medical insurance among all the policyholders of a particular insurance company plan.

- **Pure Community Rating** - A rating that requires insurers to set the same premiums for everyone in a community. Plans cannot vary premiums based on health status, claims history, or age, but they may be allowed to vary premiums within a state based on geographical location and/or family composition.
- **Adjusted Community Rating** - A rating that likewise prohibits insurers from varying premiums in a community based on health status or claims history, but does allow them to vary rates based on more factors than geography and family composition. For example, it may allow some variation in premiums but limit that variation within a band no higher or lower than 25 percent of average premiums.

Comparative Effectiveness Research - Research that examines the relative effects of different options for treating a specific health condition or problem in a particular group of patients. Such an analysis can focus on the costs and benefits of different treatments.

Congressional Budget Office (CBO) - A nonpartisan federal agency that provides Congress with economic information, including cost estimates of legislative proposals and estimates related to the federal budget and deficit.

Connector - A term that originated with the Massachusetts Health Reform legislation of 2006. A health insurance “connector” (also known as an “exchange”) is a structure that facilitates enrollment of individuals, families, and small businesses in private health coverage that meets certain standards. It creates a common marketplace where consumers can compare their health coverage options. It may also play a central role in outreach and education about newly available coverage and assist employers in establishing Section 125 pre-tax health plans for employees.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - A provision of this federal law requires that certain employers permit former workers and their dependants to remain in the employee health plan for a specified period of time. Employees must pay the full cost of the premium, including the share formerly paid by the employer.

“Consumer Driven” Health Plans - This term is used by different people to mean different things. One of the more common ways this term is used is to refer to a high-deductible plan that may be linked to a Health Savings Account (see Health Savings Accounts). The term is also used to refer to a defined contribution plan (see Defined Contribution Health Plan) in which an employer offers an employee an account with a fixed dollar amount of money in it that is used to pay for health coverage or health care. Both kinds of plans, while purportedly giving consumers more “choice” and “control” over their health care, actually shift the risk of incurring high health care costs from employers and insurance companies to consumers.

Consumer Price Index (CPI) - A measurement of inflation at the consumer level that is tracked by the Bureau of Labor Statistics, which is within the U.S. Department of Labor. Many state coverage programs use the CPI as a measure of changes in consumer buying power and increase the level of benefits provided to reflect those changes. However, health care costs generally inflate at a rate faster than the CPI.

Continuous Eligibility - A policy that states can apply to children's Medicaid and CHIP coverage that allows a child to remain eligible for the programs for a full 12 months, regardless of changes in family income. This policy reduces the paperwork burden on families and helps prevent children from losing coverage as family situations change.

Co-op - See Health Care Cooperative.

Copayment - The amount a plan member has to pay each time he or she sees a doctor, fills a prescription, or receives other medical services. For example, most health plans require enrollees to pay a set dollar amount for each physician office visit or each prescription drug.

Cost Shifting - Increasing charges for insurance coverage or health services for one group of payers (such as health plan enrollees) to offset costs for other payers (such as employers, government payers, or the uninsured). For example, an employer that is facing higher premium charges from a health insurance company may shift some of those increased costs to its employees in the form of higher deductibles, copayments, or co-insurance.

Cost-Sharing - A provision of private or public health coverage that requires the beneficiary to pay a portion of the costs of covered services (such as copayments).

Countercyclical - A program that faces increased demand during an economic downturn, when program resources are

more constrained. For instance, when people lose their jobs and their health insurance, more people become eligible for and enroll in Medicaid. Therefore, Medicaid is a countercyclical program—it faces higher enrollment and program costs at a time when funds are more scarce and private job-based insurance is contracting.

Counter-Detailing - The practice of providing health care providers with neutral educational materials about prescription drugs. Counter-detailing is intended to offset the drug industry's intensive promotion of its products directly to providers.

Creditable Coverage - In the context of Medicare, drug coverage that is offered by other plans—such as coverage from a current or former union or employer—that is at least as good as the coverage offered through the standard Medicare drug benefit. People with creditable coverage may keep that coverage without being penalized for not signing up for the new Medicare prescription drug benefit during the initial enrollment period. This term is similarly used in the context of HIPAA, under which people with creditable coverage may not be penalized through medical underwriting or other means when applying for a new insurance plan in the private market. Finally, this term is used in the context of an individual mandate to define the lowest level of coverage an individual must have to be in compliance with the mandate.

Crowd-Out - A term used to describe the substitution of public coverage for private coverage. The term has been used to convey the idea that, when expanding access to subsidized coverage in order to cover the uninsured, some privately insured individuals will drop their existing coverage and take advantage of the public subsidy, or that some employers will decide to stop offering insurance if a large number of their employees

would be eligible for the public subsidy. This issue has been particularly contentious in the children's health debate, as some have argued that large numbers of families drop private coverage in favor of CHIP or Medicaid. Studies have found varying degrees of crowd-out in these programs, but most reports have found it to be minimal.

Cultural Competence - The capacity of health care providers to respect and respond to individual and cultural differences when caring for diverse populations.

Deductible - A set dollar amount that must be paid before insurance coverage begins. For example, many private insurance policies require enrollees to spend several hundred dollars out of pocket on health care services before the insurance will pay for care. Medicare also requires the payment of a deductible each year. In 2010, the deductible for Medicare Part A (hospitalization) is \$1,100, and the deductible for Medicare Part B (physician and other outpatient, non-pharmacy services) is \$155. For the Medicare drug benefit, Medicare Part D, the standard deductible is \$310, but this varies by drug plan.

Deficit Reduction Act (DRA) - In February 2006, President Bush signed into law budget reconciliation legislation, known as the Deficit Reduction Act (DRA), that fundamentally altered many aspects of the Medicaid program. Some of these changes were mandatory provisions that states have to enact and that make it more difficult for people to either qualify for or enroll in Medicaid. Other changes are optional provisions that allow states to make unprecedented changes to the Medicaid program through state plan amendments.

Defined Benefit Health Plan - A benefits scheme that guarantees coverage of certain benefits by a sponsor, such as an employer or the government, regardless of how much those benefits cost.

Defined Contribution Health Plan - A payment structure for a benefit plan in which a benefit sponsor, such as an employer or the government, pays a specified amount of a benefit's costs on behalf of each covered individual. The individual is responsible for charges above that defined amount. In employer-sponsored plans, employees receive a fixed dollar contribution from an employer to choose among various plans. Those who are sicker or older and who expect to need health care services may opt for plans with more comprehensive benefits, but they will also need to contribute significant amounts of their own money in addition to the employer's contribution. Those choosing bare-bones health plans contribute less of their own money.

Dependent Coverage - Health insurance that is provided to an insured person's dependents, such as children and spouses. Federal law does not define who qualifies for dependent coverage under job-based coverage or in the individual market. Some states have expanded the definition beyond children and spouses to include adult children, stepchildren, disabled adult children, grandchildren, or domestic partners.

Disenrollment - The process of voluntary or involuntary termination of coverage. When a health plan member quits because he or she prefers to leave, it is considered to be voluntary disenrollment. Involuntary disenrollment occurs when a member leaves a plan because he or she has switched to a new job or when a member's coverage is terminated by the plan against the member's will.

Disparities in Health - Differences in the mortality rates and incidence, prevalence, and burden of disease and other adverse health conditions that exist between specific population groups.

Disparities in Health Care - Differences between two or more population groups in health care access, coverage, and quality that are not due to different health needs. This can include differences in preventive, diagnostic, and treatment services between population groups.

Dispensing Fee - A transaction fee that pharmacists charge to process and fill a prescription.

Dispensing Limit - The maximum number of prescriptions for which a health plan is willing to pay in an allotted time period.

Disproportionate Share Hospital (DSH) Adjustment (pronounced “dish”) - An additional payment made through Medicaid and Medicare to hospitals that serve a relatively large volume of uninsured, Medicaid, and Medicare patients.

Doughnut Hole - The popular term for the gap in Medicare Part D prescription drug coverage. In 2010, the gap will begin when an individual’s total drug expenses reach \$2,830. At that point, beneficiaries must pay for all of their prescription drug costs out-of-pocket until they incur \$6,440 in drug expenses. Once this threshold is reached, coverage starts again for the rest of the year. This is referred to as catastrophic coverage.

Drug Treatment Protocols - Documents that outline the clinical decision-making processes related to prescribing drugs. Protocols typically include a detailed clinical decision-making tree and generally recommend initiating therapy with the lowest-cost alternative.

Drug Utilization Review - Review of physician prescribing or of an insured group’s drug utilization, typically to control costs and monitor quality of care. Such programs often result in recommendations to practitioners, including the use of generic substitutions, the use of formularies, the use of copayments, and education.

Dual Eligible - A low-income Medicare beneficiary who also receives Medicaid benefits.

Durable Medical Equipment (DME) - Medical equipment, such as wheelchairs and oxygen tanks, that is used to maintain or improve the health or quality of life of individuals with chronic health needs.

Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT) - Mandatory Medicaid benefits and services for children and adolescents under age 21. State Medicaid programs are required to provide EPSDT benefits, which are designed to ensure children’s access to early and comprehensive preventive health care and treatment.

Elimination Rider - An amendment to an insurance contract limiting or excluding coverage for certain conditions. For example, an elimination rider may exclude coverage for treatment to an applicant’s knee.

Employee Retirement Income Security Act of 1974 (ERISA) - A federal law governing employee benefit programs. As it relates to health insurance, ERISA includes general protections about benefits, appeals, and the disclosure of information to employees enrolled in the plan. ERISA also prevents states from regulating health insurance if the employer “self insures.”

Employer Firewall - See Firewall.

Employer Mandate - A requirement that employers offer their employees health coverage, which usually must meet a defined standard, or face a penalty. Massachusetts and Hawaii have employer mandates, and some federal health reform proposals include an employer mandate.

Entitlement Program - A government program that guarantees the provision of benefits to all individuals who meet eligibility requirements. The Medicaid and Medicare programs are entitlement programs.

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Evidence-Based Medicine - A term that refers to the practice of choosing treatment methods (or choosing not to treat a condition) based on what scientific evidence indicates will have the best outcome, given all the risks and benefits of various options.

Exchange - A structure that facilitates enrollment of individuals, families, and businesses in private health coverage that meets certain standards, creating a common marketplace where consumers can compare their health coverage options. It may also play a central role in outreach and education about newly available coverage. Exchanges play a key role in federal health reform proposals. Massachusetts is the model state with an Exchange, known there as a “connector.”

Excise Tax - As it relates to federal health reform proposals, a provision that would subject health insurance plans with a value that exceeds a certain amount (such as \$8,500 for an individual or \$23,000 for a family) to income taxes.

Executive Order 13166 - An order that President Clinton signed and President Bush reaffirmed. EO 13166 improves access to federally funded programs and activities for individuals with Limited English Proficiency (LEP). It requires each federal agency to develop guidance on language access to its federal fund recipients. See also Limited English Proficiency.

Experience Rating - The process of determining insurance rates for a group based on the group’s previous health care costs and service utilization.

Express Lane Eligibility - The process of using eligibility information from another means-tested program (such as food stamps; the National School Lunch Program; or the Women, Infants and Children [WIC] program) to determine children’s eligibility for Medicaid or CHIP. This simplifies the application process for families and helps get more eligible children covered.

External Appeal - A process in which insured people may appeal to an entity outside of their health plan, such as a government agency and/or an independent panel of medical providers, for a review of denied insurance claims or denied requests for coverage of medical care.

Extra Help - See Low-Income Subsidy.

Fail First - An approach to managing prescription drug use and costs that requires lower-cost drugs to be tried first and to fail before an insurer will pay for more aggressive—and often more expensive—drugs.

Failsafe - As it relates to federal health reform proposals, a provision to modify the subsidies that are provided to middle-income Americans for the purchase of health coverage if such subsidies increase the deficit.

Federal Employees Health Benefits Program (FEHBP) - The health insurance plan for employees of the federal government. The Office of Personnel Management (OPM), which administers the FEHBP, approves a variety of health benefit plans from which employees may choose. All plans must offer similar core benefits and can also offer additional benefits. The government pays no more than 75 percent of the cost of an employee’s chosen plan and the employee pays the rest.

Federal Match - Also known as the Federal Medical Assistance Percentage (FMAP), the federal government matches the funds that states contribute to their Medicaid and CHIP programs. These matching rates vary by state and program, but states with more low-income residents have higher matching rates. On average, the federal government pays 57 percent of the cost of Medicaid. The minimum match is 50 percent; the maximum is 78 percent.

Federal Poverty Level - Guidelines established by the Department of Health and Human Services (HHS) that are used to determine an individual’s or family’s eligibility for various federal and non-federal programs. Federal

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poverty levels vary by family size and, to a small extent, location (Alaska and Hawaii have higher rates than the 48 contiguous states and the District of Columbia).

Federal Supply Schedule - As it relates to prescription drugs, the price available to all federal government purchasers. FSS prices are intended to be equal to or better than the prices that manufacturers charge their “most favored” non-federal customers under comparable terms.

Federal Technology Transfer Act of 1986 - This law amended previous legislation, the Stevenson-Wylder Technology Innovation Act, which required federal agencies to facilitate the transfer of technology developed by those agencies to the private sector. The Federal Technology Transfer Act authorizes cooperative research and development agreements between federal laboratories and other agencies to further facilitate the movement of federal discoveries into the private market.

Federally Qualified Health Center (FQHC) - Health centers that provide comprehensive primary care to the medically underserved, regardless of their ability to pay. They are public, nonprofit entities that receive funding from the federal government and include community health centers, tribal health clinics, migrant health centers, rural health centers, and health centers for the homeless.

Fee-for-Service (or Indemnity) Insurance - Health insurance plans that reimburse physicians and hospitals for each individual service they provide. These plans allow clients to choose any physician or hospital. Managed care is an alternative to fee-for-service medicine.

Firewall - As it relates to federal health reform proposals, a provision that prevents individuals who have affordable job-based insurance from dropping that coverage and seeking coverage from other sources, such as in an Exchange. An exception would be made for individuals whose employer coverage is considered

“unaffordable.” (Unaffordable is defined as when employees have to spend more than a specified percent of their income on their share of the premium [not including the employer contribution].)

Follow-on Biologic Drug - Similar to a generic drug, a biologic drug that is comparable to a brand-name biologic whose patent has expired. It is sometimes called a biosimilar or a biogeneric. Under current U.S. law there is no regulatory pathway for the FDA to approve the manufacture of follow-on biologic drugs. Few, if any, follow-on biologics are available in the U.S. See also Biologic Drug.

Formulary - The list of drugs that a plan will cover or help pay for, either fully or in part. Plans do not have to help with the costs of drugs that are not on their formulary and the costs of those non-formulary drugs do not count toward a person’s annual out-of-pocket expenses. Formularies vary by plan. See also Tiered Formulary.

Freedom of Choice - A Medicaid provision that requires states to allow beneficiaries the freedom to choose providers. States can seek Section 1915 and 1115 waivers of the freedom-of-choice requirement.

Fully Insured Plan - An insurance plan in which an insurance company bears the full risk of health care costs for an employer group.

Gatekeeper Physician - A primary care physician who controls the access of his or her HMO patients to specialty medical care.

Generic Drug - A drug product that is no longer covered by patent protection and thus may be produced and/or distributed by many firms. Generic drugs are FDA reviewed and must be bio-equivalent, which means that they must have the same active ingredients and be absorbed by the body the same way as their brand-name counterparts. Generic drugs usually cost significantly less than brand-name drugs.

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Generic Substitution - (1) An insurance company requirement that generic drugs, when available, be substituted for brand-name drugs unless the prescribing physician indicates in writing that the brand-name drug is required; (2) A state law governing when and how pharmacists may substitute generic for brand-name drugs. These laws, which vary widely from state to state, specify what physicians must do if they want to ensure that a prescription is filled with a brand-name drug.

Grandfathered Plan - As it relates to federal health reform proposals, a term that describes insurance plans that were in existence prior to the passage of reform and therefore would not immediately be subject to the new requirements for health insurance plans.

Grievance Procedure - A process health plan enrollees or health care providers must use when there is disagreement about a plan's services, billing, or general procedures.

Guaranteed Issue - A requirement (usually a state law) that insurers sell a policy to any person who seeks one, regardless of the applicant's health status, claims history, age, or the industry in which he or she is employed.

Guaranteed Renewal - A requirement that insurers renew the policies of enrollees as long as they pay their premiums. Such requirements are established to prevent insurers from dropping policy holders who become ill and have high medical bills.

Guidelines - As it relates to prescribing medications, systematic sets of rules for choosing among alternate drug therapies. Treatment guidelines, or protocols, generally require that the drug therapy with the fewest side effects (often the oldest and cheapest drugs) be tried before more potent therapies are recommended. Administrative guidelines generally focus more on cost and may require that the least expensive drug be used first; only if that fails should more expensive drugs be used.

Health Care Cooperative (Co-op) - An insurance provider that is owned by the enrollees it insures. In the context of federal health reform, supporters often envision co-ops as alternatives to both private insurance and a public plan option.

Health Inequity - Unfair, unjust, preventable, and unnecessary differences in health that exist between different groups of people, such as people of different racial and ethnic backgrounds.

Health Information Technology (HIT) - The use of electronic technology, such as computerized medical records, to provide comprehensive management of medical information and its secure exchange between health care consumers and providers, as well as to streamline health care delivery.

Health Insurance Flexibility and Accountability (HIFA) Waiver Initiative - Policy guidance issued by the Bush Administration in August 2001 that provides for a fast-track approval process for Section 1115 Medicaid and CHIP waivers. HIFA gave states new flexibility to cut benefits and increase cost-sharing for some current beneficiaries. These policies were subsequently included in the Deficit Reduction Act. HIFA also included an emphasis on incorporating subsidies for individuals to purchase available employer-sponsored or other private insurance instead of enrolling in the state's Medicaid or CHIP program. See also Waivers.

Health Insurance Portability and Accountability Act (HIPAA) - A federal law that sought to improve the "portability" of benefits by making it easier for workers to move from job to job without the risk of being locked out of insurance or having to wait for coverage of pre-existing medical conditions. The bill also prohibits insurers from discriminating against workers based on their medical history (or that of their dependents). Finally, it includes standards for privacy of medical information and for patients' access to their medical records.

H

Health Maintenance Organization

(HMO) - A type of managed care health plan that provides health care to insured people through a network of providers within a defined geographic area. The providers may be employees or contractors of the HMO. The HMO providers are responsible for an individual group of patients, and they generally receive a fixed amount of money per month to cover the care of each patient (see Capitation). One advantage of HMO plans has been that they often do not charge deductibles and they often have lower co-insurance or copayments than other plans. HMOs were designed to control costs by limiting access to specialty care. In theory, the HMO gatekeeper or primary care provider would help the consumer avoid unnecessary specialist care, but in practice, it is argued that needed specialty care is unduly restricted. Thus, traditional HMOs fell out of favor in the 1990s.

Health Opportunity Accounts (HOAs) - A type of Health Savings Account in the Medicaid program that is coupled with a new deductible. An HOA is an account into which a state may deposit up to \$2,500 per adult and \$1,000 per child for a participating family. States decide how much the deductible will be but it cannot exceed 110 percent of the amount that is in the account. The money in the account is used to purchase individual health care services. Once the deductible is met, the individual will receive "regular" Medicaid coverage. Individuals may enroll on a voluntary basis. Eligibility requirements generally permit only healthy parents and children to enroll in HOAs. A provision in the Deficit Reduction Act permits up to 10 states to establish five-year HOA demonstration projects. See also Deficit Reduction Act.

Health Savings Accounts (HSAs) - Tax-preferred savings accounts that were established as part of the Medicare Prescription Drug, Improvement, and Modernization Act of

2003 (MMA). HSAs offer tax benefits for people who purchase insurance policies with high deductibles. To qualify for the HSA tax break, the policy must have a deductible of at least \$1,200 (for an individual) or \$2,400 (for a family). Deposits into the HSA may be excluded from income for federal income taxes. A maximum of \$3,050 (for an individual) or \$6,150 (for a family) can be deducted in one year. The contributions may be placed into an HSA by an individual, employer, or both. Individuals can get a small tax advantage if they contribute to their HSAs, but the amount they save on federal taxes depends on their income, tax liability, and how much they (not their employers) contribute to their HSAs. For many people, an HSA will provide little or no tax break. Money that is not used can be rolled over from one year to the next. Money in the accounts can be invested in stocks and bonds without incurring tax on the earnings. Individuals over the age of 65 may withdraw money from their accounts for any reason without being taxed.

High-Deductible Health Plan (HDHP) - Health insurance plans that have higher amounts of health care costs that must be paid for by the consumer before the insurance plan begins to pay for services, but that come with lower premiums than traditional plans. These plans may be paired with Health Savings Accounts (HSAs).

High-Risk Pool - A nonprofit association that is created by states as an alternative for individuals who have been denied health insurance because of a pre-existing condition or whose premiums are significantly higher than the average due to health status or claims experience. The Health Insurance Portability and Accountability Act (HIPAA) allows states to use high-risk pools to satisfy the statutory requirements for ensuring access to health coverage for certain individuals. By law, premiums are capped, and while they are

somewhat higher than the premiums that are charged to healthy people, they are not as high as premiums for unhealthy individuals in the individual market. High-risk pools are subsidized in order to keep premiums within the state's cap. See also Health Insurance Portability and Accountability Act.

Home- and Community-Based Services (HCBS) - Services and supports that are provided to people with disabilities or older people with functional limitations that make it possible for them to continue living in their homes and communities, as opposed to in institutional settings such as nursing facilities.

Hospice - A public or private organization that provides pain relief, symptom management, and supportive services to people with terminal illnesses. Medicare beneficiaries may elect to receive hospice care instead of standard Medicare benefits for a terminal illness.

Hospital-Acquired Conditions - Health conditions that are caused by health care services, such as an infection that a patient acquires while being treated in a hospital. Some health insurance plans and programs have recently adopted policies to refuse payment for health care or hospital-acquired conditions, based on the theory that refusing to pay for such conditions will decrease their incidence.

I **Immigrant Children's Health Improvement Act (ICHIA)** - A provision that was included in the Children's Health Insurance Program Reauthorization Act (CHIPRA) that grants states the option of eliminating the five-year waiting period for legal immigrant children and pregnant women who are otherwise eligible for Medicaid or CHIP. States that take up this option will receive federal matching funds for these individuals. See also Children's Health Insurance Program Reauthorization Act.

Income Disregards - Income that is excluded and expenses that are deducted from a family's gross earnings, such as child care and child support. When determining eligibility for Medicaid and CHIP, disregards help make health coverage more widely available and affordable and ensure that a family's work-related expenses are taken into account when determining eligibility for public health coverage programs.

Independent Medicare Commission - A proposed entity within the executive branch that would have the authority to adjust Medicare payment rates. In federal health reform legislation that is under consideration, Congress would have a limited ability to replace the Commission's proposals with its own payment adjustments. Proposals differ as to the scope of the Commission's authority, governance, and mandate to reduce Medicare expenditures.

Individual Insurance Market - The market in which individuals who do not have group coverage (such as coverage through a job) purchase private health insurance for themselves and their families.

Individual Mandate - A requirement that all individuals obtain health insurance. Federal health reform proposals include an individual mandate. Massachusetts is the only state that enforces an individual mandate.

In-Network - A term used to describe a medical provider or facility that has a contract to serve members of a certain insurance plan at a negotiated rate. Generally, enrollees in an insurance plan will have the lowest cost-sharing if they receive their care from an "in-network" provider or facility.

Instrumental Activities of Daily Living (IADLs) - Activities that are necessary for independent living, including housekeeping, cooking, shopping, laundry, medication management,

money management, and communication. The degree to which a person has difficulty performing these functions is used as an indicator to determine whether he or she requires personal assistance services.

Internal Appeal - A process in which an insurance plan reviews its denial of a claim or a denial of coverage for a medical service at the request of a plan enrollee, which may result in the plan reversing its initial decision.

Interpreting - The process of understanding and analyzing a spoken or signed message; taking the cultural and social context into account; and re-expressing that message faithfully, accurately, and objectively in another language. Interpreting enables communication between two or more individuals who do not speak the same language.

J **Joint Commission (formerly the Joint Commission for the Accreditation of Healthcare Organizations, or JCAHO)** - A not-for-profit organization that performs accreditation reviews of health care facilities, primarily for hospitals, other institutional facilities, and outpatient facilities.

K **Katie Beckett Provision** - A provision that extends Medicaid coverage to certain children with disabilities who live at home, are under 18 years old, and would be eligible for Medicaid if they were staying in a hospital or nursing facility. Katie Beckett was a ventilator-dependent, institutionalized child who was unable to go home, not because of medical reasons but because she would no longer have been eligible for Medicaid due to of the level of her parents' income.

L **Lifetime Limit** - A cap on the total dollar amount that an insurer will pay for an enrollee's health care costs over the course of the insurance policy. If an enrollee's health costs exceed the lifetime limit, the enrollee will not receive any further benefits from the insurance policy.

Limited English Proficiency (LEP) - Individuals who do not speak English as their primary language and have a limited ability to read, write, speak, or understand English. An LEP individual has a limited ability to communicate in English at a level that permits the person to interact effectively with health care providers or social service agencies. According to the 2005 American Community Survey, more than 23 million individuals (8.3 percent of the population) speak English less than "very well."

Long-Term Care Insurance Partnership Policies - A provision of the Deficit Reduction Act of 2005 that gives states the option to partner with private long-term care insurance plans that meet certain consumer protection standards. Individuals who purchase long-term care insurance through these programs are allowed to protect assets equal to the value of their long-term care insurance policy and still qualify for Medicaid, if they reach the point where they have exhausted policy benefits and are paying for long term services out of pocket.

Long-Term Services and Supports (LTSS) - The medical and personal services and supports that are provided to individuals with chronic needs, such as those with disabilities and older adults with physical or cognitive needs. LTSS can be provided in the home, in the community (such as at an adult day care center), or in an institutional facility such as a nursing home.

Low-Income Subsidy (LIS) - Part of the Medicare Part D prescription drug program, this additional financial help is available to people with limited incomes or resources that greatly reduces their out-of-pocket costs. Individuals who are eligible for both Medicaid and Medicare automatically qualify for this assistance, as do those in Medicare Savings Programs (Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, and Qualifying Individual). Others must apply.

M Managed Care Organization - A system of health service delivery and financing that coordinates the use of health services by its members, designates covered health services, provides a specific provider network, and directs the use of medical care services. The two most common types of managed care organizations are health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

Managed Competition - A system in which the government certifies insurance carriers that meet specific standards to sell their plans in a government-sponsored arrangement. A “Connector” is one example of managed competition. See also Connector.

Mandated Benefit - A service for which insurance companies are legally obligated to provide coverage in an insurance policy. A few benefits are federally mandated, and states have also established their own sets of mandated benefits.

Medicaid - The federal health insurance program established in 1965 through Title XIX of the Social Security Act. Medicaid pays for health services for many low-income Americans under age 65, including children, pregnant women, and people with disabilities, and it pays for nursing home care for impoverished older adults over 65. It is financed through both federal and state funds. Each state administers its own Medicaid program and has significant flexibility to determine who is eligible, what benefits to cover, and how care is provided. See also Federal Match or FMAP.

Medicaid and CHIP Payment and Access Commission (MACPAC) - A commission that was established by the Children’s Health Insurance Program Reauthorization Act (CHIPRA) to review policies that affect children’s access to health care services and other issues that affect Medicaid and CHIP, and to make recommendations to Congress on provider payment rates for both Medicaid and

CHIP. MACPAC is scheduled to begin operating in early 2010.

Medicaid Benchmark Benefit Package (also known as an Alternative Benefit Package) - The Deficit Reduction Act of 2005 established a new option that allows state Medicaid programs to offer different benefit packages to different types of Medicaid enrollees without a waiver, which essentially reduces services for individuals in benchmark benefit plans. States may require only parents and certain categories of children to enroll in these plans, while other Medicaid populations may enroll voluntarily. In order to establish a benchmark benefit package, a state must submit a state plan amendment to CMS.

Medicaid Drug Rebate Program - Under this program, drug manufacturers are required to enter into national rebate agreements with the Department of Health and Human Services (HHS) before the government will pay for the manufacturers’ drugs that are then dispensed to Medicaid patients. The rebate formula requires that pharmaceutical manufacturers rebate to the states the greater of a) 15.1 percent of the average manufacturer price (AMP) to wholesalers for brand-name drugs, or b) the manufacturer’s best price, which is the lowest price offered to any other customer (excluding federal supply schedule prices and prices for state pharmacy assistance programs). For generic drugs, the rebate is 11 percent of AMP.

Medicaid Waiver - See Waivers.

Medical Home - A primary care practice where a patient routinely seeks medical care and the patient’s health history is known. A medical home is a place where health care should be accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally appropriate.

Medical Loss Ratio - The percentage of premium dollars that health insurance companies spend on medical care, as opposed to administrative costs or amounts retained for profit.

Medically Necessary - A standard used by insurers to determine whether or not to cover or provide reimbursement for a particular treatment.

Medically Needy - An optional Medicaid category under which a state covers individuals and families whose incomes are too high for them to qualify for Medicaid but whose medical expenses eat up the majority of their incomes. To qualify as medically needy, an individual or family must meet the non-income eligibility criteria for Medicaid and then “spend down” their income to medically needy eligibility levels by paying for medical care. States are not required to provide the same benefit package to medically needy individuals that they provide to people who are categorically needy. See also Spend-Down.

Medicare - The federal health insurance program that was established in 1965 through Title XVIII of the Social Security Act that covers Americans who are age 65 or over, disabled, or who have been diagnosed with end-stage renal disease.

Medicare Advantage (MA) - Private Medicare health plans, primarily HMOs, PPOs, and Private Fee-for-Service plans, that contract with Medicare to deliver Medicare benefits to beneficiaries. On average, the plans are paid more than it costs traditional Medicare to provide care. Plans may charge additional premiums or provide additional benefits. This program was formerly known as Medicare+Choice or Medicare Part C.

Medicare Advantage Prescription Drug Plans - Private Medicare plans that include prescription drug coverage under Medicare Part D, as well as coverage for Part A and Part B services. Plans may charge an additional premium for Part D drug coverage.

Medicare Commission - See Independent Medicare Commission.

Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) - Legislation that was enacted over President Bush’s veto that increases Medicare physician payments and restricts some Medicare Advantage plans. The law also makes substantial improvements to programs for low-income Medicare beneficiaries, including increasing asset limits and requiring Social Security and states to share data about eligible beneficiaries. It also includes several provisions that address health disparities in Medicare.

Medicare Medical Savings Accounts - A type of Medicare Advantage plan in which the traditional Medicare cost-sharing arrangements are replaced by a high-deductible plan. Beneficiaries receive a deposit to use toward their initial deductible, but they must pay for the balance of their deductible out of their own pockets.

Medicare Part A (also known as hospital insurance) - Coverage for inpatient hospital care, home health care, hospice care, and limited skilled nursing care. Eligibility is normally based on prior payment of payroll taxes. Beneficiaries must pay an initial deductible each time they are ill and a copayment for some services.

Medicare Part B - Coverage for physician services, medical supplies, and other outpatient treatment such as laboratory tests and x-rays. Medicare beneficiaries must pay a monthly premium for Part B coverage.

Medicare Part D (also known as the Medicare prescription drug benefit) - An outpatient prescription drug benefit that began in January 2006. Beneficiaries can remain in traditional Medicare and enroll in a separate, freestanding, private prescription drug plan (PDP), or they can enroll in an integrated Medicare Advantage plan that includes prescription drug coverage.

Medicare Payment Advisory Commission (MedPAC) - An independent body established by Congress to advise it on issues affecting the Medicare program.

Medicare Prescription Drug Benefit - See Medicare Part D.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) - Commonly known as the Medicare Modernization Act (MMA), this law most notably created a prescription drug program for Medicare beneficiaries, known as Medicare Part D. In addition, it increased the Part B deductible, expanded private Medicare Advantage plans, and expanded Health Savings Accounts.

Medicare Savings Programs (MSPs) - A group of three programs for Medicare beneficiaries with low incomes. These programs, Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualified Individual (QI), pay some or all of an individual's Medicare premiums and may also pay an individual's Medicare deductibles and co-insurance. The programs are administered through state Medicaid agencies. See also Qualified Individual, Qualified Medicare Beneficiary, and Specified Low-Income Medicare Beneficiary.

Medigap (or Medicare Supplemental) Policy - A privately purchased insurance policy that supplements Medicare coverage. The policy must meet requirements set by federal statute and by the National Association of Insurance Commissioners.

Mental Health Parity - A requirement that mental health coverage be subject to the same limits as physical health coverage in insurance plans. Congress enacted a new federal Mental Health Parity law in October 2008. It bars insurers from setting higher copayments, deductibles, and other cost-sharing for mental health and substance abuse services than

for physical health services. It also requires identical out-of-network coverage for mental health services as for physical health services. The law will take effect January 1, 2010, for most plans.

Mini-COBRA - Laws that allow workers in businesses with fewer than 20 workers to continue their health coverage if they leave or lose their jobs. Also called state continuation laws, they require small group health plans to provide continued coverage to former workers for a specified period of time as long as the workers pay both the employer and employee share of the premium. In some states, these laws mirror the 18-month federal COBRA law. In other states, they provide shorter periods of continued coverage or fewer benefits. Some states do not have mini-COBRA laws, and workers who leave or lose jobs at small business in those states are not guaranteed a right to continue coverage under their former health plans.

Minimum Creditable Coverage - A minimum set of benefits and cost-sharing protections that must be included in a person's health insurance plan in order for that person to be considered truly insured. For example, in Massachusetts, which has an individual mandate (everyone is required to have health coverage), residents must have minimum creditable coverage in order to avoid paying a penalty.

Modified Gross Income (MGI) - A provision in federal health reform proposals that would require states to use MGI to determine an individual's eligibility for premium credit assistance and the amount of that assistance, as well as an individual's eligibility for Medicaid. States would no longer be able to use any income disregards, which currently reduce total reportable income. An exemption to the rule would be made for the elderly and those who are eligible for Medicaid through another program, including foster children,

low-income Medicare beneficiaries, and individuals receiving SSI, for whom existing income counting rules would continue to apply.

Money Follows the Person - Part of the Deficit Reduction Act, this is a five-year federal program that was designed to help states move Medicaid enrollees from institutions such as nursing homes back into the community, where they will receive home-based care. For each individual who is transitioned to the community through the program, the state receives extra federal funding for 12 months. Individuals must have resided in an institutional setting for at least six months to qualify for the program.

Multi Employer Welfare Arrangement (MEWA) - An employee welfare benefit plan that typically provides medical, surgical, or hospital care benefits; or benefits in the event of sickness, accident, disability, death, or unemployment, to the employees of two or more employers. MEWAs can be subject to ERISA, state insurance laws, or both. The law applicable to a MEWA will depend upon whether the MEWA is collectively bargained, fully insured, or self-insured. MEWAs that are fully insured and certified by the Department of Labor must only meet broad state insurance laws that regulate reserves but are otherwise unregulated by the states. The inadequate regulation of MEWAs has led to many cases of fraud and insolvency and has left many consumers with large unpaid health insurance claims. See also ERISA.

N **National Association of Insurance Commissioners (NAIC)** - The organization for insurance commissioners of all 50 states, the District of Columbia, and the U.S. territories, that serves as an entity for creating uniform policies for insurance regulation where standardization across states is appropriate. In the context of federal health reform proposals, NAIC is tasked to assist with the development of new insurance market policies and regulations that are created by reform legislation.

National Committee for Quality Assurance (NCQA) - An independent, nonprofit organization that accredits HMOs and assesses and reports on health plan quality. The NCQA provides health plan information to consumers free of charge.

Network Providers - Medical providers that have a contractual agreement with an insurance company to serve the company's enrollees for a negotiated price. Enrollees may be required to use only network providers, or they may be allowed to seek care from out-of-network providers as well. See also In-Network.

Nonprofit Plans - Insurance plans that cannot sell stock shares and that must operate in the interest of the public good. In return, they may receive a tax break, although the amount of this tax break varies from state to state.

Office of Management and Budget (OMB) - The federal executive office that is charged with assisting with the preparation of the President's annual budget. The agency also evaluates the effectiveness of federal agency policies, procedures, and programs and sets their funding priorities.

Off-Label Drug Use - The use of FDA-approved treatments for a purpose or in a manner other than the one for which it was approved.

Olmstead Decision - This Supreme Court decision interpreted the Americans with Disabilities Act to mean that federal, state, and local governments are required to provide community settings, in addition to institutions, where integrated care services are provided to individuals with disabilities. Olmstead established that state Medicaid programs, which are a major source of financing for long-term care services and services for individuals with disabilities, must also comply with the ADA and fund more community-based long-term care in addition to the institutionally-based care that it has primarily funded.

O

Ombudsman - An entity that is charged with educating consumers about their rights and assisting consumers in getting their complaints resolved. Some states have created health care ombudsmen that have varying roles: in some states, ombudsmen serve as advocates for consumers and assist consumers in making their case in health insurance appeals; in other states, ombudsmen serve as neutral mediators in health care disputes. Federal health reform proposals create an Ombudsman position that would serve as an advocate for consumers.

Open Enrollment Period - The period of time when a specified group can enroll in health insurance. For example, some employers, insurers, and Medicare offer annual periods when people can switch plans or elect to enroll if they have not done so before. A few states require certain insurers in the individual market to accept everyone who applies, regardless of health status, during designated open enrollment periods.

Out-of-Network - A term that describes a provider or facility that does not have a contract with a given insurance company for reimbursement. Some health plans do not reimburse out-of-network providers, so the patient must pay the full amount that is charged for care received from a provider or facility that is not in his or her network. Other health plans offer coverage for out-of-network providers, but they may require higher cost-sharing when enrollees use out-of-network providers. Further, if an out-of-network provider's fees are higher than a health plan's reimbursement rate, the provider may be permitted to bill the patient for the remaining amount (this is known as balance billing).

Out-of-Pocket Costs - Health care costs that are not covered by insurance that consumers must pay for out of their own wallets. These costs include deductibles, copayments, and co-insurance.

Out-of-Pocket Maximum - The upper limit of how much individuals or families must pay out of pocket in deductibles and other cost sharing for covered medical services during a benefit period.

Patient Assistance Programs - Private programs, generally sponsored by pharmaceutical manufacturers, that provide free or low-cost supplies of the sponsor's products to consumers with limited or no health coverage. Many of these programs are being restructured to coordinate with the Medicare Part D drug program.

Pay for Performance (P4P) - The idea that there should be a direct link, based on accepted measures, between what is paid for health services and the value of the services provided. Pay-for-performance uses payment methods and other incentives to encourage physicians and other health care personnel to provide higher quality and more efficient services.

Pay or Play - Legislation that is designed to expand health coverage that requires employers (within certain parameters) to either "play" by contributing to their employees' health care or coverage or "pay" an assessment that is used to fund health coverage. This may also be known as an "employer mandate."

Payer of Last Resort - A term that refers to the insurer or program that pays for an enrollee's health care services only after other entities, such as a primary insurance plan or Medicare, have paid for the services that they cover. For example, a private insurance plan may be the payer of last resort for a Medicare enrollee who has a private plan that supplements the coverage that Medicare provides.

Pay-Go (Pay-as-You-Go) - A term that is used in government budgeting that requires any new spending to be offset by other savings or revenues.

Personal Assistance Services - Assistance that is provided to people who need help with Activities of Daily Living (ADLs) or Instrumental

P

Activities of Daily Living (IADLs) to maintain their quality of life.

Pharmacy Benefit Managers (PBMs) - Companies that manage pharmacy benefits under contract on behalf of payers, such as state Medicaid programs, pharmacy assistance programs, or employers. PBMs can be stand-alone companies or divisions of larger insurance companies. PBMs typically use a variety of clinical and administrative procedures to reduce pharmacy costs.

Point-of-Service Plan (POS) - A type of managed care health plan that permits its enrollees, at the time services are needed, to decide whether to obtain covered services through designated “in-network” participating providers or through non-participating providers. Enrollees’ cost-sharing responsibilities vary depending on whether they obtain services through in-network or non-network providers. If they use in-network services, enrollees pay lower cost-sharing amounts (e.g., lower copayments). However, enrollees may seek non-network treatment and receive benefits on a fee-for-service basis, usually with substantially higher cost-sharing. Also known as an open-ended HMO.

Portability - A characteristic of health insurance that ensures continuity so that the insured person does not lose coverage due to any change in health or personal status, such as marriage, divorce, or changes in employment.

Preauthorization - A requirement that enrollees or their medical providers obtain previous approval from an insurance company before a health care service is delivered in order to receive reimbursement.

Pre-existing Condition Exclusion - In private insurance, a policy that excludes coverage of, or treatment for, a pre-existing medical condition, either permanently or for a certain period of time.

Preferred Drug List - A mechanism for health plans to control costs. It involves establishing a list of drugs that health plans prefer that providers prescribe to patients at the beginning of treatment. “Non-preferred” drugs may be available at a higher copayment, may not be reimbursed by the payer at all, or only reimbursed if treatment with the preferred drug fails. Many states use preferred drug lists to control Medicaid fee-for-service prescription drug spending. “Preferred drugs” are on a plan’s formulary and generally do not require an authorization. See also Formulary.

Preferred Provider Organization (PPO) - A type of managed care plan in which enrollees can choose plan-selected providers who discount their fees. By visiting a PPO provider, a beneficiary will pay less money out-of-pocket for medical services than he or she would by visiting a non-PPO provider.

Premium - The charge (not including any deductibles or cost-sharing) that enrollees must pay for coverage under a health plan. Premiums are typically paid on a monthly basis.

Premium Assistance - The use of federal funds that are usually designated for public health coverage programs, especially Medicaid and CHIP, to purchase (or subsidize the purchase of) private insurance.

Prescription Drug Plan (PDP) - As it relates to Medicare Part D, a privately run plan that provides coverage only for prescription drugs and not for any other health care service. Also known as a stand-alone drug plan.

Presumptive Eligibility - A policy that states can use in their Medicaid or CHIP programs for children or pregnant women. This policy allows states to provide these individuals with immediate but temporary enrollment in Medicaid or CHIP if they appear to meet program eligibility standards.

Preventive Care - Health care that emphasizes the early detection and treatment of diseases.

Prior Authorization - A requirement that an enrollee's physician or insurance plan (or Medicaid) give approval before a particular drug or service will be covered.

Private Fee-for-Service (PFFS) - A type of Medicare Advantage plan that does not have a formal network of providers and is not required to coordinate patient care. Members can go to any doctor that accepts their plan. Costs to beneficiaries may be higher or lower than they are for traditional Medicare. Under the 2008 Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), many PFFS plans will have to adopt networks by 2011.

Profiling - The process of comparing a pattern of practice, utilization (costs or services), or outcome (functional status, morbidity, or mortality) for a defined population of patients with other practice patterns. HMOs often profile contracting physicians' practices to compare them.

Prospective Payment System - The Medicare system used to pay hospitals for inpatient hospital services based on the Diagnosis-Related Group classification system.

Provider Network - A set of providers that has contracted with a health insurance plan to provide services to those enrolled in the plan at negotiated rates.

Public Plan Option - In the context of federal health reform, a proposal to create a new insurance plan that would be operated (and may be administered) by the government and funded by enrollee premiums. It would be offered in an Exchange to give groups and individuals an alternative to private health insurance plans. See also Exchange.

Purchasing Pool - As it relates to health coverage, a group of people brought together to enhance their bargaining power as well as to pool risks across individuals from the

sickest to the healthiest. All purchasing pool members pay the same premium for a given plan regardless of their health status, although some pools do vary premiums by age or other factors.

Qualified Individual (QI) Program - A federally funded program that helps Medicare beneficiaries who have incomes between 120 and 135 percent of the federal poverty level and who meet applicable resource limits. The program is administered through state Medicaid agencies and covers the cost of Medicare Part A and Part B premiums for QIs. The program differs from the SLMB program because it is not an entitlement—there is a limit to the amount of funding that is provided each year. See also SLMB.

Qualified Medicare Beneficiary (QMB) (pronounced “quimby”) Program - A program that helps Medicare beneficiaries who have incomes at or below the federal poverty level and who meet other eligibility criteria. State Medicaid agencies are required to pay the cost of Medicare Part A and Part B premiums, deductibles, and co-insurance for QMBs.

Quality Assurance Plan - A formal set of managed care plan activities used to review and upgrade the quality of services provided. Quality assurance includes quality assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative, and support services.

Rate Bands - The variation in insurance premiums that is allowed by state regulations, expressed as a ratio or percentage of the index rate or average rate. Rate bands are used to limit the variation in premiums among individuals.

Rate Regulation - The process of overseeing and regulating the premiums—or rates—that insurance companies charge to their customers. States and the federal government regulate different kinds of insurance.

Q

R

Regional Preferred Provider Organizations (Regional PPOs) - A type of Medicare Advantage plan created by the 2003 Medicare Modernization Act. Regional PPOs operate like other PPOs but are required to serve a large geographic region, typically one or more states.

Reinsurance - Insurance for insurance companies. Its basic structure involves a primary insurance company that transfers, or cedes, the risk of high-cost claims to another private carrier or to a government-sponsored program. The insurer or government-sponsored program then assumes this risk and pays for some or all of these high-cost claims. There are two major types of government-sponsored reinsurance programs: 1) the government pays for some or all of the claims through general revenues; or 2) state law establishes an association of insurance companies that may want to cede risk and requires these companies to pool their resources to pay high-cost claims.

Reserves - An amount of money set aside by an insurer to assure adequate funds to cover future claims. Both insurance companies and self-insured employers must keep a “reserve” in order to protect their solvency.

Reunderwriting - The process of adjusting premiums based on changes in a policy holder’s health status or claims the policy holder has made in the past year. Sometimes, insurance companies will double or triple the premiums for individuals who have become ill (or for the small group to which the individual belongs), which forces the insured person or group to drop the policy.

Risk Adjuster - A measure used to adjust payments made to a health plan on behalf of a group of enrollees in order to compensate for spending that is expected to be lower or higher than average. Calculation of this measure is based on the health status or demographic characteristics of the enrollees.

Risk Pooling - The process by which risk for all individuals—including the healthy and the sick—is combined into one risk pool or group, and the group’s total expected claims are evaluated. This figure is used to estimate the required funding (raised through premiums and/or other subsidies) to support the payment of all expected claims for all members of the risk pool.

Safety Net - Health care providers, such as public hospitals or community health centers, and public coverage programs, such as Medicaid, that provide health care or health coverage to low-income patients.

Section 125 Cafeteria Plans - Plans that allow employees to set aside pre-tax dollars for a variety of benefits, including flexible spending accounts (FSAs) and health insurance. These plans are named after Section 125 of the Internal Revenue Service code. Some states encourage or require certain businesses to establish cafeteria plans so that their workers will be able to pay for their share of health premiums with pre-tax dollars.

Section 1931 - Established in 1996 as part of the federal welfare reform law, the category of Medicaid that covers low-income families. Section 1931 provides Medicaid eligibility for families that, in the past, had been eligible for Medicaid as a result of their eligibility for the Aid to Families with Dependent Children (AFDC) program, as well as for other families that meet income and resource limits established by states. Section 1931 also allows states to define income and resources in ways that increase Medicaid eligibility levels for families.

Self-Insured Health Plan - A health plan in which the employer assumes the financial risk of covering its employees, paying medical claims from its own resources.

S

Service Area - The geographic area served by a health plan, as approved by state regulatory agencies and/or detailed in a certificate of authority.

Single Payer System - A health care system in which a single entity, usually the federal government, pays for all health care services.

Small Group Market - The health insurance market where small businesses (with the number of employees defined by the state) purchase health insurance for their employees. Small group markets are regulated by the states.

Social Determinants of Health - The economic and social conditions in which people live, work, and play that can influence their health.

Social Security Disability Insurance (SSDI) - The portion of Social Security that pays monthly benefits to disabled workers under the age of 65 and their dependents. To be eligible for SSDI, individuals must have contributed a minimum of 40 quarters into the Security System. SSDI recipients (but not their dependents) automatically become eligible for Medicare after a two-year waiting period.

Special Needs Plan (SNP) - A type of Medicare Advantage plan that primarily enrolls beneficiaries with special health care needs, including dual eligibles, institutionalized beneficiaries, or those with several or disabling chronic conditions.

Specialty Drugs - See Tier 4/5 Drugs.

Specified Low-Income Medicare Beneficiary (SLMB) (pronounced “slim-bee”) Program - A program that helps Medicare beneficiaries with incomes between 100 and 120 percent of the federal poverty level and whose resources meet applicable limits. This is an entitlement program—state Medicaid agencies are required to pay the cost of Medicare Part A and Part B premiums for all eligible SLMBs.

Spend-Down - The process by which an individual qualifies for Medicaid by exhausting his or her income and assets. Individuals in 209(b) states or those eligible under a medically needy program must make payments on medical bills (“spend down”) until their income—minus medical expenses—falls to or below the state-prescribed income level to qualify for Medicaid.

Stand-Alone Drug Plan - See Prescription Drug Plan or PDP.

State Health Insurance Assistance Programs (SHIPs) - Federally funded programs that work at the state, county, and local levels to assist Medicare beneficiaries in navigating the Medicare program. They provide free and individualized information and counseling on all aspects of Medicare, including Medicare Advantage (MA) plans and Part D prescription drug plans, as well as information on Medicaid, long-term care insurance, and other public benefits. SHIPs also assist with the resolution of claims and billing problems. The names of these programs vary from state to state.

State Pharmacy Assistance Program (SPAP) - A state-run program that provides drug coverage to select enrollees, most often low-income seniors. Since 2006, most programs coordinate coverage with the Medicare Part D prescription drug program.

State Plan Amendment - A Medicaid state plan is the document that defines how each state operates its Medicaid program. Making any major change to a state’s Medicaid program usually requires an amendment to the Medicaid state plan. Amendments to the state plan must be filed and approved by the Centers for Medicare and Medicaid Services (CMS) before changes can be implemented.

Step Therapy - A strategy used by health plans, particularly pharmacy benefit managers (PBMs), to manage costs. Step therapy requires that a particular therapy—generally one that is less

costly—be tried first. Approval for coverage of a more costly therapy is only provided if the patient fails to respond to the first therapy.

Stop-Loss Insurance - A form of health insurance for a health plan or self-funded employer that provides protection from high medical expenses (usually those incurred by a few high-cost beneficiaries) by covering all claims over a certain limit each year.

Supplementary Security Income (SSI) - A federal entitlement income support program for low-income disabled, aged, or blind individuals. SSI provides an additional cash supplement for people who are not fully qualified for Social Security or who receive only minimal Social Security payments. In most states, people who are eligible for SSI are automatically eligible for Medicaid.

Sustainable Growth Rate (SGR) - As part of the 1997 Balanced Budget Act, Congress adopted the SGR formula, which established Medicare physician payment rates. The formula has not worked well, and in most years, Congress has temporarily increased physician payments over what they would have been under the SGR. This legislation is often called the “doctors’ fix.” However, the SGR remains in effect for future years, leading to projections of substantial cuts in physician payments in the future.

Tax Credits - A dollar-for-dollar reduction in the amount of taxes an individual owes. Some tax credits are “refundable,” meaning that if an individual owes less in taxes than the amount of the credit, he or she receives a refund and benefits from the full amount of the credit. The Earned Income Tax Credit is an example of a well-known federal program that works in such a manner.

Tax Deduction - As it relates to the health benefits provided by employers, a tax deduction allows employers to “write off” the cost of providing health insurance to their

employees when paying taxes. This means that the cost of employee health insurance is subtracted from an employer’s gross income when calculating its income tax liability. As it relates to insured individuals and families, it is the amount that an individual or family is able to subtract from their adjusted gross income when calculating the amount of tax that they owe. Individuals may be able to subtract medical expenses, including health insurance premiums, that exceed 7.5 percent of their adjusted gross income, from federal taxes.

Tax Exclusion - As it relates to health benefits, the exemption of the value of an employer-sponsored insurance plan from an employee’s taxable income. This means that when workers pay their income taxes, they do not have to include the value of their health coverage as compensation.

Technology Transfer - The process of converting scientific findings into products that can be used in the commercial sector. The goal of both the Bayh-Dole Act and the Federal Technology Transfer Act is to move the results of federally funded research into public use through commercialization.

Therapeutic Substitution - Replacement of one drug with another drug from the same therapeutic class that the Food and Drug Administration (FDA) has determined to be “bio-equivalent” (meaning it has the same active ingredient and the same absorption rate). This includes substitution of one brand-name drug for another brand-name or substitution of a generic drug for a brand-name drug. Generally, this practice results in prescribing the less expensive drug.

Tier - The level of cost-sharing that applies to specific drugs on a plan’s formulary. Plans generally have multiple cost-sharing tiers; tiers designated by smaller numbers (e.g. tiers 1 or 2) generally have lower cost-sharing than those designated by larger numbers (e.g. tiers 3 or 4).

Tier 4/5 Drugs - Expensive prescription drugs, often called specialty drugs, that insurers place in the tier with the highest cost-sharing. These drugs are typically biologic drugs that can cost thousands of dollars a year. Cost-sharing is often a percentage co-insurance of up to 33 percent, rather than a flat copayment.

Tiered Formulary - A formulary is a list of drugs covered by a health plan or government program. A tiered formulary divides those drugs into categories and assigns a different copayment (or co-insurance amount) to each tier. Tiered formularies have two, three, or four copayment tiers. A three-tiered formulary generally features a tier for generic drugs, which usually has the lowest copayment, a tier for preferred brand-name drugs with a somewhat higher copayment, and a tier for non-preferred brand-name or off-formulary drugs with the highest copayment. Four-tiered formularies add a tier for very costly specialty drugs.

Title XVIII of the Social Security Act - The law that created the Medicare program.

Title XIX of the Social Security Act - The law that created the Medicaid program.

Trade Adjustment Assistance Reform Act of 2002 (TAARA) Health Insurance Subsidy - A subsidy geared toward helping retirees, their families, and other workers who have lost their employer-sponsored health coverage as a consequence of trade practices or bankruptcies. This legislation provides a subsidy, via the tax system, that covers 80 percent of the cost of purchasing health insurance from certain specified sources.

Transitional Medical Assistance (TMA) - A federal program that permits low-income families to continue receiving Medicaid coverage for six or 12 months if they have earnings that raise the family income above Medicaid eligibility levels.

Translational Research (also called “translational medicine”) - A branch of medical research that attempts to more directly connect basic research to patient care. Although there is some debate within the medical community regarding the scope of the term, in the area of discoveries of medical interventions, it typically refers to the movement of basic research into real therapies for real patients, emphasizing the link between the lab and the patient’s bedside.

True Out-of-Pocket (TrOOP) Costs - Prescription drug costs that are truly paid for by the beneficiary, not by an insurer or other third party that pays the costs directly or reimburses the beneficiary. The Medicare Part D program requires that these costs be tracked for beneficiaries in order to determine when catastrophic drug coverage will begin.

Uncompensated Care Funds - Funds that are used to pay for physician or hospital services when no payment is received from the patient or from insurance. Some states have established further guidelines for the use of uncompensated care funds.

Underinsured - People whose insurance does not cover their necessary health care services, leaving them with out-of-pocket expenses that exceed their ability to pay.

Underwriting - An insurer’s process of determining if and on what basis to accept an application for insurance. Based on age, health problems, weight, height, and a number of other criteria, insurers determine whether to offer a policy, exclude certain conditions from a policy, increase the price of a policy, or place other limitations on coverage for a given applicant.

Voucher - A payment worth a specific dollar amount given to an individual toward the purchase of a specific benefit, for example, health coverage.

U

V

W-Z

Waivers - Sections 1115 and 1915 of the Social Security Act define specific circumstances under which the federal government may, at a state's request, "waive" certain provisions of the federal Medicaid laws. The "waiver" is the agreement between the federal government and the state that exempts the state from these provisions, and it includes special terms and conditions that define to whom and when these exemptions apply. For example, some states use Medicaid waivers to extend Medicaid coverage to childless adults who are not blind or disabled, a group that does not ordinarily qualify for Medicaid under federal laws.

- **Health Insurance Flexibility and Accountability (HIFA)** - This type of waiver is based on policy guidance issued by the Bush Administration in August 2001 that provides for fast-track approval of Section 1115 Medicaid and CHIP waivers. HIFA gives states new flexibility to cut benefits and increase cost-sharing for some current beneficiaries. HIFA also requires states to include a private insurance component to their programs that would provide a subsidy to individuals for the purchase of available employer-sponsored or other private insurance instead of enrolling in the state's Medicaid or CHIP program.
- **Home- and Community-Based Care**, also known as 1915(c) or 1915(d) - See Section 1915(c).
- **Section 1115** - A section of the Social Security Act that allows the Secretary of the Department of Health and Human Services (HHS) to waive certain Medicaid requirements in order to allow states to establish demonstration projects that are "likely to further the goals of the Medicaid program." One major goal of Medicaid is to provide health care to people with low incomes. States submit a waiver application to HHS, which must approve the application before the waiver can

take effect. Recent Section 1115 waiver proposals have largely sought to reduce the health care services available in Medicaid and to eliminate certain rights that people in Medicaid have to get care, which has not furthered the goal of providing health care to people with low incomes.

- **Section 1915 (b)** - A Section 1915(b) waiver allows states to waive Medicaid rules regarding the freedom to choose a provider, the establishment of statewide programs, and the comparability of Medicaid benefits to different covered groups. Thus, states can require all or some categories of Medicaid beneficiaries to enroll in managed care, either throughout the state or in limited geographical areas. Since passage of the Balanced Budget Act in 1997, states can mandate managed care enrollment for many Medicaid beneficiaries without a Section 1915(b) waiver. A state must still, however, obtain such a waiver to mandate managed care enrollment for children with special needs, dual eligibles (people who are eligible for both Medicaid and Medicare), and Native Americans.
- **Section 1915(c) Waiver** - Medicaid waivers that exempt states from certain federal requirements in order to encourage the development of home- and community-based long-term services and supports (LTSS) as an alternative to institutional services, such as nursing home care. States may provide home- and community-based care for enrollees under 1915(c) waivers as long as such services do not exceed the costs of delivering LTSS in an institutional setting.

Wellness Plan/Program - A plan or program, usually sponsored by an employer, that is designed to promote health and prevent chronic disease. The goals of these programs are to improve the health of employees, reduce health care costs, and reduce absenteeism due to illness. When not properly designed,

however, such programs can act as loopholes for shifting costs to employees and even discriminating against less healthy workers.

Working Disabled - People who meet the Social Security Administration's criteria for receiving disability income but continue to work despite their condition. States must provide Medicaid coverage to working disabled individuals unless they have high enough earnings to provide a "reasonable equivalent" of the combination of Social Security Income (SSI) benefits, Medicaid benefits, and publicly funded attendant care services.

Wraparound Benefits - Benefits that Medicaid provides when it acts as a secondary insurer to Medicaid-eligible individuals who are enrolled in private plans (such as employer-based coverage) that do not cover all of the services that Medicaid covers.

ACRONYMS

ACO - Accountable Care Organization. A group of physicians (and possibly a hospital) that is responsible for the quality of the care provided and for annual overall Medicare spending for their patients. Providers who are members of an accountable care organization receive bonuses for meeting quality and resource use targets, and they are penalized for not meeting quality and resource use targets.

ADLs - Activities of Daily Living. Includes five basic activities: eating, dressing, bathing, moving from a bed to a chair, and toileting. The ability to perform these activities is used as a clinical indicator of whether an individual requires long-term services and supports, and if so, at what level.

AHP - Association Health Plan. Association Health Plans allow small employers to band together across state lines—through their membership in a trade or professional association—to purchase health coverage for their families and employees that is exempt from the consumer protections provided by many state laws, including requirements for coverage of important services and providers. This creates a situation in the small group or small employer market that, due to adverse selection, will increase the price of health care for the majority of those who work for small employers. By

eliminating state regulation of the small group market, AHPs will create fertile ground for fraud and abuse, which could leave defrauded workers with millions of dollars in unpaid medical bills. See also Adverse Selection.

AMP - Average Manufacturer Price. The AMP is the price at which a pharmaceutical manufacturer sells drugs to purchasers. There is an AMP for wholesalers and an AMP for pharmacies. For sales to wholesalers, AMP represents the Wholesale Acquisition Cost after all discounts. For sales directly to pharmacies, AMP represents the price pharmacies pay for drugs after all the discounts they receive.

ARRA - American Recovery and Reinvestment Act. The economic stimulus legislation that was signed into law in February 2009. ARRA has many provisions, including one that provides temporary assistance with premiums to help involuntarily unemployed workers purchase their former employer's COBRA continuation coverage, state continuation ("mini-COBRA") coverage, or other continuation coverage. ARRA also temporarily increases states' Medicaid FMAP, so long as the states maintain their eligibility levels and benefits for Medicaid enrollees. See also FMAP.

AWP - Average Wholesale Price. The price that pharmaceutical manufacturers suggest that wholesalers charge retail pharmacies. Manufacturers generally offer lower prices or rebates to favored customers that have purchasing power, such as large insurance companies or government bodies, meaning that those customers pay significantly less than the AWP.

BBA - Balanced Budget Act of 1997. The BBA 1) created the State Children's Health Insurance Program (SCHIP, now known as CHIP), which expanded coverage to low-income children not covered under Medicaid; 2) added a new part to Medicare, called Medicare+Choice (now Medicare Advantage), which includes an array of private health plan options; 3) gave states greater authority to structure their Medicaid programs, including the authority to unilaterally enroll beneficiaries without a waiver from HHS; and 4) added new beneficiary protections to both Medicaid and Medicare.

CBO - Congressional Budget Office. A nonpartisan federal agency that provides Congress with economic information, including cost estimates of legislative proposals and estimates related to the federal budget and deficit.

CHIP - Children's Health Insurance Program. The Balanced Budget Act (BBA) of 1997 established Title XXI of the Social Security Act, which created the federal block grant program now known as CHIP. CHIP provides funds to states to establish a health insurance program for targeted low-income children. States can: (1) expand Medicaid to cover children in families with higher incomes, (2) create a new health insurance program for children, or (3) do both. The program is financed with federal and state funds, with the federal government paying a greater share than it pays for the state's regular Medicaid program. Each state has its own CHIP program

CHIPRA - Children's Health Insurance Program Reauthorization Act of 2009. Signed into law by President Obama on February 4, 2009, CHIPRA extends and expands CHIP. CHIPRA adds \$44 billion in federal funds for children's coverage and is expected to provide coverage to an additional 4.1 million children in Medicaid and CHIP by the end of September 2013. The law also improves the benefits package for children, includes incentives for effective enrollment practices, and allows states to provide coverage to legal immigrant children and pregnant women who have been in the country for fewer than five years.

CLASS - Community Living Assistance Services and Supports Act. A bill, included in federal health reform proposals, that creates a national voluntary program to help individuals pay for community-based long-term services and supports. Enrollment is open to working adults and adult students, but it can be maintained post-retirement. Individuals who have paid premiums into the program for at least five years and who are unable to perform a certain number of activities of daily living (ADLs) would be eligible to receive a cash benefit.

CMS - Centers for Medicare and Medicaid Services. The agency within the Department of Health and Human Services (HHS) that oversees Medicare, Medicaid, and the state Children's Health Insurance Program (CHIP).

COBRA - The Consolidated Omnibus Budget Reconciliation Act of 1985. A provision of this federal law requires that certain employers permit former workers and their dependents to remain in the employee health plan for a specified period of time. Employees must pay the full cost of the premium, including the share formerly paid by the employer.

CPI - Consumer Price Index. A measurement of inflation at the consumer level. Many state coverage programs use the CPI as a measure of changes in consumer buying power and

increase the level of benefits provided to reflect those changes. However, health care costs generally inflate at a rate faster than the CPI. The Bureau of Labor Statistics, which is within the U.S. Department of Labor, tracks the CPI.

DME - Durable Medical Equipment. Medical equipment, such as wheelchairs and oxygen tanks, that is used to maintain or improve the health or quality of life of individuals with chronic health needs.

DRA - Deficit Reduction Act. In February 2006, President Bush signed into law budget reconciliation legislation, known as the Deficit Reduction Act (DRA), that fundamentally altered many aspects of the Medicaid program. Some of these changes were mandatory provisions that states have to enact and that make it more difficult for people to either qualify for or enroll in Medicaid. Other changes are optional provisions that allow states to make unprecedented changes to the Medicaid program through state plan amendments.

DSH - Disproportionate Share Hospital Adjustment (pronounced “dish”). An additional payment made through Medicaid and Medicare to hospitals that serve a relatively large volume of uninsured, Medicaid, and Medicare patients.

EPSDT - Early and Periodic Screening, Diagnosis, and Treatment Program. Mandatory Medicaid benefits and services for children and adolescents under age 21. State Medicaid programs are required to provide EPSDT benefits, which are designed to ensure children’s access to early and comprehensive preventive health care and treatment.

ERISA - Employee Retirement Income Security Act of 1974. A federal law governing employee benefit programs. As it relates to health insurance, ERISA includes general protections about benefits, appeals, and the disclosure of information to employees in the plan. ERISA also prevents states from regulating health insurance if the employer “self insures.”

FEHBP - Federal Employees Health Benefits Program. The health insurance plan for employees of the federal government. The Office of Personnel Management (OPM), which administers the FEHBP, approves a variety of health benefit plans from which employees may choose. All plans must offer similar core benefits but may also offer additional benefits. The government pays no more than 75 percent of the cost of an employee’s chosen plan; the employee pays the rest.

FMAP - Federal Medical Assistance Percentage. The federal government matches the funds that states contribute to their Medicaid and CHIP programs. These matching rates vary by state and program, but states with more low-income residents have higher matching rates. On average, the federal government pays 57 percent of the cost of Medicaid. The minimum match is 50 percent; the maximum is 78 percent.

FQHC - Federally Qualified Health Center. Health centers that provide comprehensive primary care to the medically underserved, regardless of their ability to pay. They are public, nonprofit entities that receive funding from the federal government and include community health centers, tribal health clinics, migrant health centers, rural health centers, and health centers for the homeless.

HCBS - Home- and Community-Based Services. Services and supports that are provided to people with disabilities or older people with functional limitations that make it possible for them to continue living in their homes and communities, as opposed to in institutional settings such as nursing facilities.

HIFA Waiver - Health Insurance Flexibility and Accountability Waiver. This type of waiver is based on policy guidance issued by the Bush Administration in August 2001 that provides for fast-track approval of Section 1115 Medicaid and CHIP waivers. HIFA gave states new flexibility to cut benefits and increase

cost-sharing for some current beneficiaries. These policies were subsequently included in the Deficit Reduction Act. HIFA also included an emphasis on incorporating subsidies for individuals to purchase available employer-sponsored or other private insurance instead of enrolling in the state's Medicaid or CHIP program.

HIPAA - Health Insurance Portability and Accountability Act. A federal law that sought to improve the "portability" of benefits by making it easier for workers to move from job to job without the risk of being locked out of insurance or having to wait for coverage of pre-existing medical conditions. The bill also prohibits insurers from discriminating against workers based on their medical history (or that of their dependents). Finally, it includes standards for privacy of medical information and for patients' access to their medical records.

HIT - Health Information Technology. The use of electronic technology, such as computerized medical records, to provide comprehensive management of medical information and its secure exchange between health care consumers and providers, as well as to streamline health care delivery.

HMO - Health Maintenance Organization. A type of managed care health plan that provides health care to insured people through a network of providers within a defined geographic area. The providers may be employees or contractors of the HMO. The HMO providers are responsible for an individual group of patients and generally receive a fixed amount of money per month to cover the care of each patient (see Capitation). One advantage of HMO plans has been that they often do not charge deductibles and often have lower co-insurance or copayments than other plans. HMOs were designed to control costs by limiting access to specialty care. In theory, the HMO gatekeeper or primary care

provider would help the consumer avoid unnecessary specialist care. In practice, however, it is argued that needed specialty care is unduly restricted. Thus, traditional HMOs fell out of favor in the 1990s.

HOAs - Health Opportunity Accounts. A type of Health Savings Account in the Medicaid program that is coupled with a new deductible. An HOA is an account into which a state may deposit up to \$2,500 per adult and \$1,000 per child for a participating family. States decide how much the deductible will be, but it may not exceed 110 percent of the amount that is in the account. The money in the account is used to purchase individual health care services. Once the deductible is met, the individual will receive "regular" Medicaid coverage. Individuals may enroll on a voluntary basis. Eligibility requirements generally permit only healthy parents and children to enroll in HOAs. A provision in the Deficit Reduction Act (DRA) permits up to 10 states to establish five-year HOA demonstration projects. See also Deficit Reduction Act.

HSAs - Health Savings Accounts. Tax-preferred savings accounts that were established as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). HSAs offer tax benefits for people who purchase insurance policies with high deductibles. To qualify for the HSA tax break, the policy must have a deductible of at least \$1,150 for an individual or \$2,300 for a family. Deposits into the HSA may be excluded from income for federal income taxes. A maximum of \$3,000 for an individual or \$5,950 for a family can be deducted in one year. The contributions may be placed into an HSA by an individual, employer, or both. Individuals will receive a small tax advantage if they contribute to their HSAs but the amount they save on federal taxes depends on their income, tax liability, and how much they contribute. For many people, an HSA will provide little or no tax break. Money that is not used can be rolled over from one

year to the next. Money in the accounts can be invested in stocks and bonds without incurring tax on the earnings. Individuals over the age of 65 may withdraw money from their accounts for any reason without being taxed.

IADLs - Instrumental Activities of Daily Living. Activities that are necessary for independent living, including housekeeping, cooking, shopping, laundry, medication management, money management, and communication. The degree to which a person has difficulty performing these functions is used as an indicator to determine whether he or she requires personal assistance services.

ICHIA - Immigrant Children's Health Improvement Act. A provision that was included in the Children's Health Insurance Program Reauthorization Act (CHIPRA) that grants states the option of eliminating the five-year waiting period for legal immigrant children and pregnant women who are otherwise eligible for Medicaid or CHIP. States that take up this option will receive federal matching funds for these individuals. See also Children's Health Insurance Program Reauthorization Act.

LEP - Limited English Proficiency. Individuals who do not speak English as their primary language and have a limited ability to read, write, speak, or understand English. An LEP individual has a limited ability to communicate in English at a level that permits the person to interact effectively with health care providers or social service agencies. According to the 2005 American Community Survey, more than 23 million individuals (8.3 percent of the population) speak English less than "very well."

LIS - Low-Income Subsidy. Part of the Medicare Part D prescription drug program, this additional financial help is available to people with limited incomes or resources that greatly reduces their out-of-pocket costs. Individuals who are eligible for both Medicaid

and Medicare automatically qualify for this assistance, as do those in Medicare Savings Programs (Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, and Qualifying Individual). Others must apply.

LTSS - Long-Term Services and Supports. The medical and personal services and supports that are provided to individuals with chronic needs, such as those with disabilities and older adults with physical or cognitive needs. LTSS can be provided in the home, in the community (such as at an adult day care center), or in an institutional facility such as a nursing home.

MA - Medicare Advantage. Private Medicare health plans, primarily HMOs, PPOs, and Private Fee-for-Service plans, that contract with Medicare to deliver Medicare benefits to beneficiaries. On average, the plans are paid more than it costs traditional Medicare to provide care. Plans may charge additional premiums or provide additional benefits. This program was formerly known as Medicare+Choice or Medicare Part C.

MACPAC - Medicaid and CHIP Payment Access Commission. A commission that was established by CHIPRA to review policies that affect children's access to health care services and other issues that affect Medicaid and CHIP, and to make recommendations to Congress on provider payment rates for both Medicaid and CHIP. MACPAC is scheduled to begin operating in early 2010.

MedPAC - Medicare Payment Advisory Commission. An independent body established by Congress to advise it on issues affecting the Medicare program.

MGI - Modified Gross Income. A provision in federal health reform proposals that would require states to use MGI to determine an individual's eligibility for premium credit assistance and the amount of that assistance, as well as an individual's eligibility for Medicaid. States would no longer be able to

use any income disregards, which currently reduce total reportable income. An exemption to the rule would be made for the elderly and those who are eligible for Medicaid through another program, including foster children, low-income Medicare beneficiaries, and individuals receiving SSI, for whom existing income counting rules would continue to apply.

MIPPA - Medicare Improvements for Patients and Providers Act of 2008. Legislation that was enacted over President Bush's veto that increases Medicare physician payments and restricts some Medicare Advantage plans. The law also makes substantial improvements to programs for low-income Medicare beneficiaries, including increasing asset limits and requiring Social Security and states to share data about eligible beneficiaries. It also includes several provisions that address health disparities in Medicare.

MMA - Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Commonly known as the Medicare Modernization Act (MMA), this law most notably created a prescription drug benefit for Medicare beneficiaries, known as Medicare Part D. It also increased the Part B deductible, expanded private Medicare Advantage plans, and expanded Health Savings Accounts.

MSPs - Medicare Savings Programs. A group of three programs for Medicare beneficiaries with low incomes. These programs, Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualified Individual (QI), pay some or all of an individual's Medicare premiums and may also pay an individual's Medicare deductibles and co-insurance. The programs are administered through state Medicaid agencies. See also Qualified Individual (QI), Qualified Medicare Beneficiary (QMB), and Specified Low-Income Medicare Beneficiary (SLMB).

NAIC - National Association of Insurance Commissioners. The organization for insurance commissioners of all 50 states, the District of Columbia, and the U.S. territories, that serves as an entity for creating uniform policies for insurance regulation where standardization across states is appropriate. In the context of federal health reform proposals, NAIC is tasked to assist with the development of new insurance market policies and regulations that are created by reform legislation.

NCQA - National Committee for Quality Assurance. An independent, nonprofit organization that accredits HMOs and assesses and reports on health plan quality. The NCQA provides health plan information to consumers free of charge.

OMB - Office of Management and Budget. The federal executive office that is charged with assisting with the preparation of the President's annual budget. The agency also evaluates the effectiveness of federal agency policies, procedures, and programs and sets their funding priorities.

P4P - Pay for Performance. The idea that there should be a direct link, based on accepted measures, between what is paid for health services and the value of the services provided. Pay-for-performance uses payment methods and other incentives to encourage physicians and other health care personnel to provide higher quality and efficiency of services.

PBM - Pharmacy Benefit Manager. A company that manages pharmacy benefits under contract on behalf of payers, such as state Medicaid programs, pharmacy assistance programs, or employers. PBMs can be stand-alone companies or divisions of larger insurance companies. PBMs typically use a variety of clinical and administrative procedures to reduce pharmacy costs.

PDP - Prescription Drug Plan. As it relates to Medicare Part D, a privately run plan that provides coverage only for prescription drugs and not for any other health care service. Also known as a stand-alone drug plan.

PPO - Preferred Provider Organization. A type of managed care plan in which enrollees can choose plan-selected providers who discount their fees. By visiting a PPO provider, a beneficiary will pay less money out-of-pocket for medical services than he or she would by visiting a non-PPO provider.

QI - Qualified Individual (QI) program. A federally funded program that helps Medicare beneficiaries who have incomes between 120 and 135 percent of the federal poverty level and who meet applicable resource limits. The program is administered through state Medicaid agencies and covers the cost of Medicare Part A and Part B premiums for QIs. The program differs from the SLMB program because it is not an entitlement—there is a limit to the amount of funding that is provided each year. See also SLMB.

QMB - Qualified Medicare Beneficiary (QMB) (pronounced “quimby”) program. A program that helps Medicare beneficiaries who have incomes at or below the federal poverty level and who meet other eligibility criteria. State Medicaid agencies are required to pay the cost of Medicare Part A and Part B premiums, deductibles, and co-insurance for QMBs.

SGR - Sustainable Growth Rate. As part of the Balanced Budget Act of 1997, Congress adopted the SGR formula, which established Medicare physician payment rates. The formula has not worked well, and in most years, Congress has temporarily increased physician payments over what they would have been under the SGR. This legislation is often called the “doctors’ fix.” However, the SGR remains in effect for future years, leading to projections of substantial cuts in physician payments in the future.

SHIPs - State Health Insurance Assistance Programs. Federally funded programs that work at the state, county, and local levels to assist Medicare beneficiaries in navigating the Medicare program. They provide free and individualized information and counseling on all aspects of Medicare, including Medicare Advantage (MA) plans and Part D prescription drug plans, as well as information on Medicaid, long-term care insurance, and other public benefits. SHIPs also assist with the resolution of claims and billing problems. The names of these programs vary from state to state.

SLMB - Specified Low-Income Medicare Beneficiary (SLMB) (pronounced “slim-bee”) program. A program that helps Medicare beneficiaries with incomes between 100 and 120 percent of the federal poverty level and whose resources meet applicable limits. This is an entitlement program—state Medicaid agencies are required to pay the cost of Medicare Part A and Part B premiums for all eligible SLMBs.

SNP - Special Needs Plans. A type of Medicare Advantage plan that primarily enrolls beneficiaries with special health care needs, including dual eligibles, institutionalized beneficiaries, or those with several or disabling chronic conditions.

SSDI - Social Security Disability Insurance. The portion of Social Security that pays monthly benefits to disabled workers under the age of 65 and their dependents. To be eligible for SSDI, individuals must have contributed a minimum of 40 quarters into the Security System. SSDI recipients (but not their dependents) automatically become eligible for Medicare after a two-year waiting period.

SSI - Supplementary Security Income. A federal entitlement income support program for low-income disabled, aged, or blind individuals. SSI provides an additional cash supplement for people who are not fully qualified for Social

Security or who receive only minimal Social Security payments. In most states, people who are eligible for SSI are automatically eligible for Medicaid.

TAARA - Trade Adjustment Assistance Reform Act of 2002 Health Insurance Subsidy. A subsidy geared toward helping retirees, their families, and workers who have lost their employer-sponsored health coverage as a consequence of trade practices or bankruptcies. This act provides a subsidy, via the tax system, that covers 80 percent of the cost of purchasing health insurance from certain specified sources.

TMA - Transitional Medical Assistance. A federal program that permits low-income families to continue receiving Medicaid coverage for six or 12 months if they have earnings that raise the family income above Medicaid eligibility levels.

TrOOP - “True out-of-pocket” costs. Prescription drug costs that are truly paid for by the beneficiary, not by an insurer or other third party that pays the costs directly or reimburses the beneficiary. The Medicare Part D program requires that these costs be tracked for beneficiaries in order to determine when catastrophic drug coverage will begin.-