



Glossary of Health Care Reform Terms



A

Access - A person's ability to obtain health care services.

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

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

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

Acute Care - Medical treatment rendered to people whose illnesses or medical problems are short-term or don't require long-term continuing care. Acute care facilities are hospitals that mainly treat people with short-term health problems.

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

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

Aggregate Indemnity - The maximum amount of payment provided by an insurer for each covered service for a group of insured people.

Aid to Families with Dependent Children (AFDC) - A state-based federal assistance program that provided cash payments to needy children (and their caretakers), who met certain income requirements. AFDC has now been replaced by a new

block grant program, but the requirements, or criteria, can still be used for determining eligibility for Medicaid.

Alliance - Large businesses, small businesses, and individuals who form a group for insurance coverage.

Allowed Charge - Discounted fees that insurers will recognize and pay for covered services. Insurers negotiate these discounts with providers in their health plan network, and network providers agree to accept the allowed charge as payment in full. Each insurer has its own schedule of allowed charges.

All-payer System - A proposed health care system in which, no matter who is paying, prices for health services and payment methods are the same. Federal or state government, a private insurance company, a self-insured employer plan, an individual, or any other payer would pay the same rates. Also called Multiple Payer system.

Ambulatory Care - All health services that are provided on an out-patient basis, that don't require overnight care. Also called out-patient care.

Ancillary Services - Supplemental services, including laboratory, radiology and physical therapy, that are provided along with medical or hospital care.

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

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

B

Beneficiary - A person who is eligible for or receiving benefits under an insurance policy or plan.

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

Biosimilar Biological Products - The generic version of more complicated medications.

Blue Cross/Blue Shield - Non-profit, tax-exempt insurance service plans that cover hospital care, physician care and related services. Blue Cross and Blue Shield are separate organizations that have different benefits, premiums and policies. These organizations are in all states, and The Blue Cross and Blue Shield Association of America is their national organization.

Board Certified - Status granted to a medical specialist who completes required training and passes an examination in his/her specialized area. Individuals who have met all requirements, but have not completed the exam are referred to as "board eligible."

Board Eligible - Reference to medical specialists who have completed all required training but have not completed the exam in his/her specialized area.

C

Cafeteria Plan - This benefit plan gives employees a set amount of funds that they can choose to spend on a different benefit options, such as health insurance or retirement savings.

Capitation - A fixed prepayment, per patient covered, to a health care provider to deliver medical services to a particular group of patients. The payment is the same no matter how many services or what type of services each patient actually gets. Under capitation, the provider is financially responsible.

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

Care Guidelines - A set of medical treatments for a particular condition or group of patients that has been reviewed and endorsed by a national organization, such as the Agency for Health care Policy Research.

Carrier - A private organization, usually an insurance company, that finances health care.

Carve-Out - Medical services that are separated out and contracted for independently from any other benefits.

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

Catastrophic Health Insurance - Currently, some insurers describe these plans as those that only cover certain types of expensive care, like hospitalizations. Other times insurers mean plans that have a high deductible, so that your plan begins to pay only after you've first paid up to a certain amount for

covered services.

CHAMPUS - (Civilian Health and Medical Program of the Uniformed Services) A health plan that serves the dependents of active duty military personnel and retired military personnel and their dependents.

Children's Health Insurance Program (CHIP) - Insurance program enacted in 1997 that is jointly funded by state and Federal government that provides health insurance to low-income children and, in some states, pregnant women in families who earn too much income to qualify for Medicaid but cannot afford to purchase private health insurance coverage. States have the option of administering CHIP through their Medicaid programs or through a separate program (or a combination of both). The federal government matches state spending for CHIP but federal CHIP funds are capped.

Chronic Care - Treatment given to people whose health problems are long-term and continuing. Nu nursing homes, mental hospitals and rehabilitation facilities are chronic care facilities.

Chronic Disease - A medical problem that will not improve, that lasts a lifetime, or recurs.

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

Claims - Bills for services. Doctors, hospitals, labs and other providers send billed claims to health insurance plans, and what the plans pay are called paid claims.

COBRA - When employees lose their jobs, they are able to continue their employer-sponsored coverage for up to 18 months through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under the original legislation, individuals were required to pay the full premium to continue their insurance through COBRA. The American Recovery and Reinvestment Act (ARRA) provides a temporary subsidy of 65% of the premium cost for the purchase of COBRA coverage to people who have lost their job between September 1, 2008 and December 31, 2009.

Co-Insurance - The percentage of allowed charges for covered services that you're required to pay. For example, the health insurance may cover 80% of charges for a covered hospitalization, leaving you responsible for the other 20%. This 20% is known as the coinsurance.

Community Rating - A rule that prevents health insurers from varying premiums within a geographic area based on age, gender, health status or other factors.

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Comparative Effectiveness Research - A field of research that analyzes the impact of different options for treating a given condition in a particular group of patients. These analyses may focus only on the medical risks and benefits of each treatment or may also consider the costs and benefits of particular treatment options.

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

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

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

Cooperatives/Co-ops - HMOs that are managed by the members of the health plan or insurance purchasing arrangements in which businesses or other groups join together to gain the buying power of large employers or groups.

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

Cost Containment - The method of preventing health care costs from increasing beyond a set level by controlling or reducing inefficiency and waste in the health care system.

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

Cost Shifting - When one group of patients does not pay for services, such as uninsured or Medicare patients, health care providers pass on the costs for these health services to other groups of patients.

Countercyclical - Medicaid is a countercyclical program in that it expands to meet increasing need when the economy is in decline. During an economic downturn, more people become

eligible for and enroll in the Medicaid program when they lose their jobs and their access to health insurance. As enrollment grows, program costs also rise.

Coverage - A person's health care costs are paid by their insurance or by the government.

Covered Services - Treatments or other services for which a health plan pays at least part of the charge.

Creditable Coverage - Health insurance coverage under any of the following: a group health plan; individual health insurance; student health insurance; Medicare; Medicaid; CHAMPUS and TRICARE; the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps; Public Health Plan (any plan established or maintained by a State, the U.S. government, a foreign country); Children's Health Insurance Program (CHIP) or a state health insurance high risk pool. If you have prior creditable coverage, it will reduce the length of a pre-existing condition exclusion period under new job-based coverage.

D

Deductible - The amount of money, or value of certain services (such as one physician visit), a patient or family must pay before costs (or percentages of costs) are covered by the health plan or insurance company, usually per year.

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

Diagnostic Related Groups (DRGs) - A system for classifying hospital stays according to the diagnosis of the medical problem being treated, for the purposes of payment.

Direct Access - The ability to see a doctor or receive a medical service without a referral from your primary care physician.

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

Disease Management - Programs for people who have chronic illnesses, such as asthma or diabetes, that try to encourage them to have a healthy lifestyle, to take medications as prescribed, and that coordinate care.

Disposable Personal Income - The amount of a person's income that is left over after money has been spent on basic necessities such as rent, food, and clothing.

Disproportionate Share Hospital (DSH) Payments - Payments made by a state's Medicaid program to hospitals that the state designates as serving a "disproportionate share" of low-income

or uninsured patients. These payments are in addition to the regular payments such hospitals receive for providing inpatient care to Medicaid beneficiaries. States have some discretion in determining how much eligible hospitals receive. The amount of federal matching funds that a state can use to make payments to DSH hospitals in any given year is capped at an amount specified in the federal Medicaid statute.

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

Dual Eligibles - A term used to describe an individual who is eligible for Medicare and for some level of Medicaid benefits. Most dual eligibles qualify for full Medicaid benefits including nursing home services, and Medicaid pays their Medicare premiums and cost sharing. For other duals Medicaid provides the "Medicare Savings Programs" through which enrollees receive assistance with Medicare premiums, deductibles, and other cost sharing requirements.

E

Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) - As part of the Medicaid program, the law requires that all states have a program for eligible children under age 21 to receive a medical assessment, medical treatments and other measures to correct any problems and treat chronic conditions.

Elective - A health care procedure that is not an emergency and that the patient and doctor plan in advance.

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

Emergency - A medical condition that starts suddenly and requires immediate care.

Emergency Room Services - Evaluation and treatment of an illness, injury, or condition that needs immediate medical attention in an emergency room.

Employee Retirement Income Security Act (ERISA) - A Federal act, passed in 1974, that established new standards for

employer-funded health benefit and pension programs. Companies that have self-funded health benefit plans operating under ERISA are not subject to state insurance regulations and health care legislation.

Employer Contribution - The contribution is the money a company pays for its employees' health care. Exclusions- Health conditions that are explicitly not covered in an insurance package and that your insurance will not pay for.

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

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

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

Employer Responsibility - Under the Affordable Care Act starting in 2014, if an employer with at least 50 full-time equivalent employees doesn't provide affordable health insurance and an employee uses a tax credit to help pay for insurance through an Exchange, the employer must pay a fee to help cover the cost of the tax credits.

Entitlement Program - Federal programs, such as Medicare and Medicaid, for which people who meet eligibility criteria have a federal right to benefits. Changes to eligibility criteria and benefits require legislation. The Federal government is required to spend the funds necessary to provide benefits for individuals in these programs, unlike discretionary programs for which spending is set by Congress through the appropriations process. Enrollment in these programs cannot be capped and neither states nor the federal government may establish waiting lists.

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

The Affordable Care Act defines essential health benefits to "include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care."

Insurance policies must cover these benefits in order to be certified and offered in Exchanges, and all Medicaid State plans must cover these services by 2014.

Starting with plan years or policy years that began on or after September 23, 2010, health plans can no longer impose a lifetime dollar limit on spending for these services. All plans, except grandfathered individual health insurance policies, must phase out annual dollar spending limits for these services by 2014.

The Department of Health and Human Services is working with a number of partners to develop the essential health benefits package. In the fall of 2011, HHS will launch an effort to collect public comment and hear directly from all Americans who are interested in sharing their thoughts on this important issue.

Exchange - A new transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Affordable Insurance Exchanges will offer you a choice of health plans that meet certain benefits and cost standards. Starting in 2014, Members of Congress will be getting their health care insurance through Exchanges and you will be able buy your insurance through Exchanges too.

Exclusions - Items or services that aren't covered under your contract for insurance and for which an insurance company won't pay. For example, your policy may not cover pregnancy care or any services related to a pre-existing condition.

Exclusive Provider Organizations (EPO)/Exclusive Provider Arrangement (EPA) - An indemnity or service plan that provides benefits only if those hospitals or doctors with which it contracts provide the medical services, with some exceptions for emergency and out-of-area services.

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

F

Family and Medical Leave Act (FMLA) - A Federal law that guarantees up to 12 weeks of job protected leave for certain

employees when they need to take time off due to serious illness or disability, to have or adopt a child, or to care for another family member. When on leave under FMLA, you can continue coverage under your job-based plan.

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

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

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

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

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

First Dollar Coverage - A system in which the insurer pays for all employee out-of-pocket health care costs. Under first dollar

coverage, the beneficiary has no deductible and no co-payments.

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

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

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

Formulary - A list of medications that a managed care company encourages or requires physicians to prescribe as necessary in order to reduce costs.

Fully Insured Job-Based Plan - A health plan purchased by an employer from an insurance company.

G

Gag Clause - A contractual agreement between a managed care organization and a provider that restricts what the provider can say about the managed care company

Gatekeeper - The person in a managed care organization, often a primary care provider, who controls a patient's access to health care services and whose approval is required for referrals to other services or other specialists.

General Practice - Physicians without specialty training who provide a wide range of primary health care services to patients.

Global Budgeting - A way of containing hospital costs in which participating hospitals share a budget, agreeing together to set the maximum amount of money that will be paid for health care.

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

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

Group Insurance - Health insurance offered through business, union trusts or other groups and associations. The most common system of health insurance in the United States, in which the cost of insurance is based on the age, sex, health status and occupation of the people in the group.

Group Model HMO - An HMO that contracts with an independent group practice to provide medical services

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

H

Health Care Benefits - The specific services and procedures covered by a health plan or insurer.

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

Health Care Financing Administration (HCFA) - The federal government agency within the Department of Health and Human Services that directs the Medicare and Medicaid programs. HCFA also does research to support these programs and oversees more than a quarter of all health care costs in the United States.

Health Care Workforce Development - The use of incentives and recruiting to encourage people to enter into health care

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professions such as primary care and to encourage providers to practice in underserved areas.

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

Health Insurance - Financial protection against the health care costs caused by treating disease or accidental injury.

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

Health Insurance Portability and Accountability Act (HIPAA) - Also known as Kennedy-Kassebaum law, this guarantees that people who lose their group health insurance will have access to individual insurance, regardless of pre-existing medical problems. The law also allows employees to secure health insurance from their new employer when they switch jobs even if they have a pre-existing medical condition.

Health Insurance Purchasing Cooperatives (HIPCs) - Public or private organizations that get health insurance coverage for certain populations of people, combining everyone in a specific geographic region and basing insurance rates on the people in that area.

Health Maintenance Organization (HMO) - A health plan provides comprehensive medical services to its members for a fixed, prepaid premium. Members must use participating providers and are enrolled for a fixed period of time. HMOs can do business either on a for-profit or not-for-profit basis.

Health Plan Employer Data and Information Set (HEDIS) - Performance measures designed by the National Committee for Quality Assurance to give participating managed health plans and employers to information about the value of their health care and trends in their health plan performance compared with other health plans.

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

Health Savings Account (HSA) - A medical savings account available to taxpayers who are enrolled in a High Deductible

Health Plan. The funds contributed to the account aren't subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses. Unlike a Flexible Spending Account (FSA), funds roll over year to year if you don't spend them.

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

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

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

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

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

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

Home Health Care - Skilled nurses and trained aides who provide nursing services and related care to someone at home.

Hospice Care - Care given to terminally ill patients. Hospital Alliances- Groups of hospitals that join together to cut their costs by purchasing services and equipment in volume.

Hospital Acquired Condition (HAC)—A health condition that was acquired during hospitalization (i.e. was not present upon admission to the hospital), and generally is high cost, high volume or both, that results in a higher payment when present as a secondary diagnosis, and could reasonably have been prevented through application of evidence-based guidelines.

HCAHPS—The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS, pronounced "H-caps") survey is a standardized, publicly reported survey of patients' perceptions of their hospital experience. Three broad goals have shaped HCAHPS. First, the survey is designed to produce data about patients' perspectives of care that allow objective and meaningful comparisons of hospitals on topics that are important to consumers. Second, public reporting of the survey results creates new incentives for hospitals to improve quality of care. Third, public reporting serves to enhance accountability in health care by increasing transparency of the quality of hospital care provided in return for the public investment.

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

I

Indemnity Insurance - A system of health insurance in which the insurer pays for the costs of covered services after care has been given, and which usually defines the maximum amounts which will be paid for covered services. This is the most common type of insurance in the United States.

Independent Practice Association (IPA) - A group of private physicians who join together in an association to contract with a managed care organization.

Indigent Care - Care provided, at no cost, to people who do not have health insurance or are not covered by Medicare, Medicaid, or other public programs.

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

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

Individual Responsibility - Under the Affordable Care Act, starting in 2014, you must be enrolled in a health insurance plan that meets basic minimum standards. If you aren't, you may be

required to pay an assessment. You won't have to pay an assessment if you have very low income and coverage is unaffordable to you, or for other reasons including your religious beliefs. You can also apply for a waiver asking not to pay an assessment if you don't qualify automatically.

Inpatient - A person who has been admitted to a hospital or other health facility, for a period of at least 24 hours. Under Medicare, a hospital admission is generally considered inpatient when a patient is expected to need two or more midnights of medically necessary hospital care. The admission must be ordered by the physician and the hospital must formally admit the patient. (www.medicare.gov/Pubs/pdf/11435.pdf)

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

Integrated Delivery System (IDS) - An organization that usually includes a hospital, a large medical group, and an insurer such as an HMO or PPO.

Integrated Provider (IP) - A group of providers that offer comprehensive and coordinated care, and usually provides a range of medical care facilities and service plans including hospitals, group practices, a health plan and other related health care services.

J

Job-Based Health Plan - Coverage that is offered to an employee (and often his or her family) by an employer.

Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) - A national private, non-profit organization that accredits health care organizations and agencies and sets guidelines for operation for these facilities.

L

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

Limitations - A "cap" or limit on the amount of services that may be provided. It may be the maximum cost or number of days that a service or treatment is covered.

Limited Service Hospital - A hospital, often located in a rural area, that provides a limited set of medical and surgical services.

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

M

Malpractice Insurance - Coverage for medical professionals which pays the costs of legal fees and/or any damages assessed by the court in a lawsuit brought against a professional who has been charged with negligence.

Managed Care - This term describes many types of health insurance, including HMOs and PPOs. They control the use of health services by their members so that they can contain health care costs and/or improve the quality of care.

Mandate - Law requiring that a health plan or insurance carrier must offer a particular procedure or type of coverage.

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

Means Test - An assessment of a person's or family's income or assets so that it can be determined if they are eligible to receive public support, such as Medicaid.

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

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

Medical Home - A health care setting where patients receive comprehensive primary care services; have an ongoing relationship with a primary care provider who directs and coordinates their care; have enhanced access to nonemergent primary, secondary, and tertiary care; and have access to linguistically and culturally appropriate care.

Medical IRAs - Personal accounts which, like individual retirement plans, allow a person to accumulate funds for future use. The money in these accounts must be used to pay for medical services. The employee decides how much money he or she will spend on health care.

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

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

Medically Indigent - A person who does not have insurance and is not covered by Medicaid, Medicare or other public programs.

Medically Necessary - Services or supplies that are needed for the diagnosis or treatment of your health condition and meet accepted standards of medical practice.

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

Medicare - A federal program of medical care benefits created in 1965 designed for those over age 65 or permanently disabled. Medicare consists of two separate programs: A and B. Medicare Part A, which is automatic at age 65, covers hospital costs and is financed largely by employer payroll taxes. Medicare Part B covers outpatient care and is financed through taxes and individual payments toward a premium.

Medicare Advantage (Medicare Part C) - A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B

benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

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

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

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

Medicare Supplements or Medigap - A privately-purchased health insurance policy available to Medicare beneficiaries to cover costs of care that Medicare does not pay. Some policies cover additional costs, such as preventive care, prescription drugs, or at-home care.

Member - The person enrolled in a health plan.

Minimum Essential Coverage - The type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

N

National Committee on Quality Assurance (NCQA) - An independent national organization that reviews and accredits managed care plans and measures the quality of care offered by managed care plans.

New Plan - As used in connection with the Affordable Care Act: A health plan that is not a grandfathered health plan and therefore subject to all of the reforms in the Affordable Care Act.

In the individual health insurance market, a plan that your family

is purchasing for the first time will generally be a new plan.

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

In both the individual and group markets, a plan that loses its grandfathered status will be considered a new plan. A plan loses its grandfathered status when it makes significant changes to the plan, such as reducing benefits or increasing cost-sharing for enrollees.

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

Network - A group of affiliated contracted health care providers (physicians, hospitals, testing centers, rehabilitation centers etc.), such as an HMO, PPO, or Point of Service plan.

Non-Contributory Plan - A group insurance plan that requires no payment from employees for their health care coverage.

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

Non-Participating Provider - A health care provider who is not part of a health plan. Usually patients must pay their own health care costs to see a non-participating provider.

Nurse Practitioner - A nurse specialist who provides primary and/or specialty care to patients. In some states nurse practitioners do not have to be supervised by a doctor.

O

Open Enrollment Period - A specified period of time during which people are allowed to change health plans, usually once a year.

Open Panel - A right included in an HMO, which allows the covered person to get non-emergency covered services from a specialist without getting a referral from the primary care physician or gatekeeper.

Out of Pocket Costs or Expenditures (OOP) - The amount of money that a person must pay for his or her health care, including: deductibles, co-pays, payments for services that are not covered, and/or health insurance premiums that are not paid by his or her employer.

Out-of-Pocket Limit - The maximum amount you will have to pay for covered services in a year.

Outcomes - Measures of the effectiveness of particular kinds of medical treatment. This refers to what is quantified to determine if a specific treatment or type of service works.

Out of Pocket Maximum - The maximum amount that a person must pay under a plan or insurance contract.

Outpatient Care - Outpatient care is generally health care services that do not require a patient to receive overnight care in a hospital. Under Medicare, outpatient services include emergency department services, observations services, outpatient surgery, lab tests, X-rays or any other hospital services when the doctor hasn't written an order to admit the patient, even if the patient spends the night in the hospital.

P

Participating Physician or Provider - Health care providers who have contracted with a managed care plan to provide eligible health care services to members of that plan.

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

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

Payer - The organization responsible for the costs of health care services. A payer may be private insurance, the government, or an employer's self-funded plan.

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

Peer Review Organization (PRO or PSRO) - An agency that monitors the quality and appropriateness of medical care delivered to Medicare and Medicaid patients. Health care professionals in these agencies review other professionals with similar training and experience. [See Quality Improvement Organizations]

Percent of Poverty - A term that describes the income level a person or family must have to be eligible for Medicaid.

Physician Assistant - A health professional who provides primary and/or specialty care to patients under the supervision of a physician.

Physician Hospital Organizations (PHOs) - An organization that contracts with payers on behalf of one or more hospitals and affiliated physicians. Physicians still own their practices.

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

Play or Pay - This system would provide coverage for all people by requiring employers either to provide health insurance for their employees and dependents (play) or pay a contribution to a publicly-provided system that covers uninsured or unemployed people without private insurance (pay).

Point of Service (POS) - A type of insurance where each time health care services are needed, the patient can choose from different types of provider systems (indemnity plan, PPO or HMO). Usually, members are required to pay more to see PPO or non-participating providers than to see HMO providers.

Portability - A person's ability to keep his or her health coverage during times of change in health status or personal situation (such as change in employment or unemployment, marriage or divorce) or while moving between health plans.

Postnatal Care - Health care services received by a woman immediately following the delivery of her child.

Pre-Authorization - The process where, before a patient can be admitted to the hospital or receive other types of specialty services, the managed care company must approve of the proposed service in order to cover it.

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

Pre-Existing Condition (Individual Policy) - A condition, disability or illness (either physical or mental) that you have

before you're enrolled in a health plan. Genetic information, without a diagnosis of a disease or a condition, cannot be treated as a pre-existing condition. This term is defined under state law and varies significantly by state.

Pre-Existing Condition Exclusion Period (Job-Based Coverage) - The time period during which a health plan won't pay for care relating to a pre-existing condition. Under a job-based plan, this cannot exceed 12 months for a regular enrollee or 18 months for a late-enrollee.

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

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

Preferred Provider Organization (PPO) - A type of insurance in which the managed care company pays a higher percentage of the costs when a preferred (in-plan) provider is used. The participating providers have agreed to provide their services at negotiated discount fees.

Premium - The amount paid periodically to buy health insurance coverage. Employers and employees usually share the cost of premiums.

Premium Cap - The maximum amount of money an insurance company can charge for coverage.

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

Premium Tax - A state tax on insurance premiums.

Prepaid Group Practice - A type of HMO where participating providers receive a fixed payment in advance for providing particular health care services.

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

Preventive Care - Health care services that prevent disease or

its consequences. It includes primary prevention to keep people from getting sick (such as immunizations), secondary prevention to detect early disease (such as Pap smears) and tertiary prevention to keep ill people or those at high risk of disease from getting sicker (such as helping someone with lung disease to quit smoking).

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

Primary Care Provider (PCP) - The health professional who provides basic health care services. The PCP may control patients' access to the rest of the health care system through referrals.

Private Insurance - Health insurance that is provided by insurance companies such as commercial insurers and Blue Cross plans, self-funded plans sponsored by employers, HMOs or other managed care arrangements.

Provider - An individual or institution who provides medical care, including a physician, hospital, skilled nursing facility, or intensive care facility.

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

Provider-Sponsored Organization (PSO) - Health care providers (physicians and/or hospitals) who form an affiliation to act as insurer for an enrolled population.

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

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

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

Q

Qualified Health Plan - Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Exchange in which it is sold.

Quality Assessment - Measurement of the quality of care.

Quality Assurance and Quality Improvement - A systematic process to improve quality of health care by monitoring quality, finding out what is not working, and fixing the problems of health care delivery.

Quality Improvement Organization (QIO) - An organization contracting with HCFA to review the medical necessity and quality of care provided to Medicare beneficiaries.

Quality of Care - How well health services result in desired health outcomes.

R

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

Rate Setting - These programs were developed by several states in the 1970's to establish in advance the amount that hospitals would be paid no matter how high or low their costs actually were in any particular year. (Also known as hospital rate setting or prospective reimbursement programs)

Referral System - The process through which a primary care provider authorizes a patient to see a specialist to receive additional care.

Reimbursement - The amount paid to providers for services they provide to patients.

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

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

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

Risk - The responsibility for profiting or losing money based on the cost of health care services provided. Traditionally, health insurance companies have carried the risk. Under capitation, health care providers bear risk.

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

S

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

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

Self-Insured - A type of insurance arrangement where employers, usually large employers, pay for medical claims out of their own funds rather than contracting with an insurance company for coverage. This puts the employer at risk for its employees' medical expenses rather than an insurance company.

Single Payer System - A health care reform proposal in which health care costs are paid by taxes rather than by the employer and employee. All people would have coverage paid by the government.

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

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

Socialized Medicine - A health care system in which providers are paid by the government, and health care facilities are run by the government.

Special Enrollment Period - A time outside of the open enrollment period during which you and your family have a right to sign up for job-based health coverage. Job-based plans must provide a special enrollment period of 30 days following certain life events that involve a change in family status (for example, marriage or birth of a child) or loss of other job-based health coverage.

Special Health Care Need - The health care and related needs of children who have chronic physical, developmental, behavioral or emotional conditions. Such needs are of a type or amount beyond that required by children generally.

Staff Model HMO - A type of managed care where physicians are employees of the health plan, usually in the health plan's own health center or facility.

Standard Benefit Package - A defined set of benefits provided to all people covered under a health plan.

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

T

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

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

Tax Preference for Employer-Sponsored Insurance - Under the current tax code the amount that employers contribute to health benefits are excluded, without limit, from most workers' taxable income and any contributions made by employees

toward the premium cost for health insurance are made on a tax-free basis. In contrast, individuals who do not receive health insurance through an employer may only deduct the amount of their total health care expenses that exceeds 7.5% of their adjusted gross income.

Third Party Administrator (TPA) - An organization that processes health plan claims but does not carry any insurance risk.

Third Party Payer - An organization other than the patient or health care provider involved in the financing of personal health services.

U

Uncompensated Care - Health care provided to people who cannot pay for it and who are not covered by any insurance. This includes both charity care which is not billed and the cost of services that were billed but never paid.

Underinsured - People who have some type of health insurance but not enough insurance to cover their the cost of necessary health care. This includes people who have very high deductibles of \$1000 to \$5000 per year, or insurance policies that have specific exclusions for costly services.

Underwriting - This process is the basis of insurance. It analyzes the health status and history, claims experience (cost), age and general health risks of the individual or group who is applying for insurance coverage.

Uninsured - People who do not have health insurance of any type. Over 80 percent of the uninsured are working adults and their family members.

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

Utilization Review - A program designed to help reduce unnecessary medical expenses by studying the appropriateness of when certain services are used and by how many patients they are used.

Utilization - How many times people use particular health care services during particular periods of time.

V

Value-Based Purchasing (VBP) - Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce

inappropriate care and to identify and reward the best-performing providers.

Vertical Integration - A health care system that includes the entire range of health care services from out-patient to hospital and long-term care.

W

Waiting Period - The amount of time a person must wait from the date he or she is accepted into a health plan (or from when he or she applies) until the insurance becomes effective and he or she can receive benefits.

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

Wellness Programs - A program intended to improve and promote health and fitness that's usually offered through the work place, although insurance plans can offer them directly to their enrollees. The program allows your employer or plan to offer

you premium discounts, cash rewards, gym memberships, and other incentives to participate. Some examples of wellness programs include programs to help you stop smoking, diabetes management programs, weight loss programs, and preventative health screenings.

Withhold - A percentage of providers' fees that managed care companies hold back from providers which is only given to them if the amount of care they provide (or that the entire plan provides) is under a budgeted amount for each quarter or the whole year.

Worker's Compensation Coverage - States require employers to provide coverage to compensate employees for work-related injuries or disabilities.

Y

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