Health Care Reform Glossary

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Accountable Care Organization (ACO) – These organizations coordinate patient care and provide the full range of health care services for patients. The health reform law provides incentives for providers who join together to form such organizations and who agree to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to the ACO.
Annual Benefit Limit – In the past, some insurance plans have placed a limit on the dollar amount of claims they will pay in a given year for an individual. Beginning in 2010, annual benefit limits on certain "essential health benefits" are restricted on a graduated basis, and annual limits will eventually be prohibited in 2014.
Basic Health Plan – Beginning in 2014, states will have the option of creating a basic health plan to provide coverage to individuals with incomes between 133 and 200 percent of poverty instead of enrolling in the health insurance exchange and receiving premium subsidies. The federal government will provide states that choose to offer this plan with 95 percent of what it would have paid to subsidize these enrollees in the health insurance exchange.
Benefit Package – The set of health services, such as physician visits, hospitalizations, and prescription drugs, that are covered by a member's insurance policy or group health plan.
Capitation – Under a capitation system health care providers are paid a set amount for each enrolled person assigned to that physician or group of physicians, whether or not that person seeks care.
Case Management – The coordination of medical care for patients with specific diagnoses or high health care needs, performed by case managers who can include medical directors or nurses.
Catastrophic Coverage – A coverage option with a limited benefit plan design accompanied by a high Deductible. The plan design is intended to protect primarily against the cost for unforeseen and expensive illnesses or injuries. These plans are attractive to young adults in relatively good health.
CHIP – The Children's Health Insurance Program (CHIP) is a program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to low income families with children. The program was designed with the intent to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid.
Chronic Care Management – The coordination of health care and supportive services to improve the health status of patients with chronic conditions, such as diabetes and asthma. The goals of these programs are to improve the quality of care and manage costs.
COBRA – Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) applies to employers who generally employ 20 or more full time equivalent employees. Employees who lose their jobs are able to continue their employer-sponsored coverage for a set period of time. For example, employees are typically entitled to extend coverage for 18 months, however if they are deemed disabled by the Social Security Administration, coverage may continue for up to 29 months.
Co-insurance – The amount or percentage of the reimbursed amount of covered expenses a plan member must pay for health services after the Deductible has been met.
Community Living Assistance Services and Supports (CLASS) Program – The CLASS program establishes a national voluntary long-term care insurance program for the purchase of non-medical

services and support necessary for enrollees who have paid premiums into the program and become eligible (due to disability or chronic illnesses). Enrollees would receive benefits that help pay for assistance in the home or in a facility in future years. Enrollment begins January 1, 2011 (targeting working adults who can make voluntary premium contributions through payroll deductions or directly). The first benefits will be paid out to enrollees in 2016.

Community Rating – A method of pricing health insurance plans, where all policyholders are charged the same premium, regardless of health status, age or other factors. "Modified community rating" generally refers to a method where health insurers may vary premiums based on specified demographic characteristics (e.g. age, gender, location), but cannot vary premiums based on the health status or claims history of policyholders.

Comparative Effectiveness Research – Research is federally sponsored to compare existing health care interventions to determine which work best for which patients and which pose the greatest benefits and harms. The research also aims to improve the quality of care and to control costs.

Consumer-Directed Health Plans – These 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 plans usually have a high Deductible accompanied by a savings account for health care services. There are two types of savings accounts – Health Savings Accounts (HSAs) and Health Reimbursement Accounts (HRAs).

Co-payment – A fixed dollar amount paid by an individual receiving a health care service covered by the member's plan.

Cost-Sharing – Health plan members are required to pay a portion of the costs of their care. Examples of these costs include Co-payments, Co-insurance and annual Deductibles.

Deductible – The dollar amount that a plan member must pay for health care services each year before the insurer begins to reimburse for health care services. Beginning in 2014, deductibles for small group insurance plans will be limited to $2,000 for individual policies and $4,000 for family policies.

Disease Management – The coordination of care for the entire disease treatment process, including preventive care, patient education and outpatient care in addition to inpatient and acute care. The process is intended to reduce costs and improve the quality of life for an individual with a chronic condition.

Donut Hole – A gap in prescription drug coverage under Medicare Part D, where beneficiaries pay 100% of their prescription drug costs after their total drug costs exceed an initial coverage limit until they qualify for a second tier of coverage. Under the standard Part D benefit, Medicare covers 75% of drug costs below the initial coverage limit ($2,830 in 2010), and 95% of spending within the second tier level ($6,440 in 2010). The "donut hole" specifically refers to the range between these two levels. Health care reform also provides a $250 rebate for all Medicare Part D enrollees who enter the donut hole in 2010, increases discounts in subsequent years and completely closes the donut hole by 2020.

Dual Eligibles – A term used to describe an individual who is eligible for Medicare and for some Medicaid benefits.

Electronic Health Record/Electronic Medical Records – Computerized patient health records, including medical, demographic, and administrative information. These records can be created and stored within one organization or shared across multiple health care organizations and sites.

Employee Retirement Income Security Act of 1974 (ERISA) – Enacted in 1974 to provide minimum Federal standards for welfare benefit plans in private industry, and protect the interests of employee benefit plan participants and their beneficiaries by requiring the disclosure to them of financial and other information concerning the plan; by establishing standards of conduct for plan fiduciaries; and by providing for appropriate remedies and access to the Federal courts.

Employer Mandate – Beginning in 2014 pursuant to the health reform law, employers meeting size or

revenue thresholds will be required to offer minimum essential health benefit packages or pay a set portion of the cost of those benefits for use in the Exchanges.

Episode of Care – Refers to all the health services related to the treatment of a condition. For acute conditions (such as a concussion or a broken bone), the episode includes all treatment and services from the onset of the condition to its resolution. For chronic conditions (such as diabetes), the episode refers to all services and treatments received over a given period of time. Some payment reform proposals involve basing provider payment on episodes of care instead of paying on a Fee-for-Service basis.

Essential Health Benefits – The health reform law placed certain coverage requirements on essential health benefits, and provides a broad set of benefit categories that would be considered essential to a health benefits package -- including hospitalization, outpatient services, emergency care, prescription drugs, maternity care, preventive services and other benefits. The Secretary of HHS will, in the future, define what constitutes "Essential Health Benefits" and this will be guided by the current scope of benefits provided under a typical employer plan. For plan years beginning in 2010 the only requirement for "Essential Health Benefits" is that if they are included in the plan they may not be subject to a lifetime limit and until 2014 can only be subject to a "restricted annual limit".

Exchange or Health Insurance Exchange – The health care reform law creates Health Benefit Exchanges (competitive insurance marketplaces) in each state, where individuals and employers can shop for health plans.

External Review – Health care reform requires all health plans (except Grandfathered plans) to provide an external review appeal process that meets minimum standards. With the exception of a few state processes currently in existence, external review has typically been limited to appeals of clinical decisions. The health reform law has expanded the scope of external review for self-funded health plans to non-eligibility administrative appeals as well. Administrative appeals deal with such issues as benefit exclusions, benefit limits and disputes over member financial responsibility for payments such as Co-payments, Co-insurance and Deductibles.

Fee-for-Service – A traditional method of paying for medical services where doctors and hospitals are paid a fee for each service they provide.

Grandfathered Plan – A health plan that was in place on March 23, 2010, when the health reform law was enacted, is exempt from complying with some parts of the health reform law, so long as the plan does not make certain changes (such as eliminating or reducing benefits, increasing cost-sharing, or reducing the employer contribution toward the premium). Once a health plan makes such a change, it becomes subject to other health reform provisions (e.g., appeals and cost sharing restrictions on preventive services).

Group Health Plan – Health insurance that is offered by a plan sponsor, typically an employer on behalf of its employees.

Guarantee Issue/Guarantee Renewability – Beginning in 2014, the health reform law requires insurers to offer and renew coverage to non-Grandfathered plans, without regard to health status, use of services, or pre-existing conditions.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – This law sets standards for the security and privacy of personal health information. In addition, the law makes it easier for individuals to change jobs without the risk of extended waiting periods due to pre-existing conditions.

Health Maintenance Organization (HMO) – A health plan that provides coverage through a network of hospitals, physicians and other health care providers. HMOs usually require the selection of a primary care physician who is responsible for managing and coordinating all health care. Usually, referrals to specialist physicians are required, and the HMO pays only for care provided by an in-network provider.

Health Reimbursement Account (HRA) – A tax-exempt account that can be used to pay for qualified health expenses. HRAs are usually paired with a high-Deductible health plan and are funded solely by

employer contributions.
Health Savings Account (HSA) – A tax-exempt savings account that can be used to pay for qualified medical expenses. Individuals can obtain HSAs from most financial institutions, or through their employer. Both employers and employees can contribute to the plan. To open an HSA, an individual must have health coverage under an HSA-qualified high-Deductible health plan which has Deductibles of at least $1,200 for an individual and $2,400 for a family in 2010.
High-Deductible Health Plan – These health insurance plans have higher Deductibles and lower premiums than traditional insurance plans.
High-Risk Pool – The health reform law expands upon the current state-based high-risk pool system. The law requires the government to establish or issue contracts to establish a temporary high risk pool (through 2013) to provide coverage for eligible individuals with pre-existing conditions by appropriating $5 billion to subsidize premiums. Eligibility is limited to individuals who have been uninsured for at least six months prior to applying for pool coverage, and who have a pre-existing condition.
Individual Mandate – A requirement that most individuals obtain health insurance or pay a penalty beginning in 2014. Massachusetts was the first state to impose an individual mandate that all adults have health insurance.
Interim Final Rule (IFR) – A final rule that has the full force and effect of law; thus, affected parties have an obligation to comply with its requirements. An IFR allows interested parties to submit comments during a public comment period and prior to issuing revised guidance.
Internal Review – An internal review of an adverse claim determination.
Lifetime Benefit Maximum – A limit on the amount an insurer will pay toward the cost of health care services over the lifetime of the policy. Health care reform prohibits lifetime dollar limits on "essential health benefits" effective for plan/policy years beginning on or after September 23, 2010.
Long-Term Care – Services needed for an individual to live independently in the community, such as home health and personal care, as well as services provided in institutional settings such as nursing homes. Many of these services are not covered by Medicare or private insurance (see also the Community Living Assistance Services and Supports program defined above).
Managed Care – A health care delivery system that seeks to reduce the cost of providing health benefits and improve the quality of care. These arrangements often rely on primary care physicians to manage the care their patients receive.
Mandatory Benefits – A state or federal requirement that health plans provide coverage for certain benefits, treatment or services.
Medicaid – A federal and state funded program that provides medical and health related services to certain low-income Americans. The health reform law expands Medicaid eligibility to non-Medicare eligible individuals with incomes up to 133% of the Federal poverty level, establishing uniform eligibility for adults and children across all states by 2014.
Medical Loss Ratio (MLR) – The minimum percentage of premium dollars a commercial insurance company must spend on the reimbursement of certain medical costs. The health reform law requires insurers in the large group market to have an MLR of 85% and insurers in the small group and individual markets to have an MLR of 80% (with some waivers granted to states to reduce the threshold for certain markets).
Medicare – A federal program that provides health care coverage to people age 65 and older, and to those who are under 65 and are permanently physically disabled or who have a congenital physical disability; or to those who meet other special criteria such as end-stage renal disease. Eligible individuals can receive coverage for hospital services (Medicare Part A), physician based medical services (Medicare Part B) and prescription drugs (Medicare Part D).

Medicare Advantage – Also referred to as Medicare Part C, the Medicare Advantage program allows Medicare beneficiaries to receive their Medicare benefits through a private insurance plan.
Out-of-Pocket Costs – Health care costs that are not covered by insurance, such as Deductibles, Co-payments, and Co-insurance. Out-of-pocket costs do not include premium costs.
Out-of-Pocket Maximum – An annual limit on the amount of money individuals are required to pay out-of-pocket for health care costs, excluding premiums. The health reform law, beginning in 2014, prevents an employer from imposing cost sharing in amounts greater than the current out-of-pocket limits for high-Deductible health plans ($5,950 for an individual policy or $11,900 for a family policy in 2010). These amounts will be adjusted annually.
Patient Centered Medical Home – A term defining 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; and have enhanced access to non-emergent care.
Patient Protection and Affordable Care Act (PPACA) – Also referred to as the "health reform law," this Act begins the implementation of a staged set of rules with an initial effective date of March 23, 2010. The law is intended to increase access to health care for more Americans, and includes many changes that impact the commercial health insurance market, Medicare and Medicaid.
Pay for Performance – A payment system where health care providers receive incentives for meeting or exceeding quality and 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.
Pre-existing Condition – An illness or medical condition for which a person is diagnosed or treated within a specified period of time prior to becoming insured in a new plan. The heath reform law prohibits the denial of coverage due to a pre-existing condition for plan and policy years beginning after September 23, 2010 for children under 19, and for all others beginning in 2014.
Preferred Provider Organization (PPO) – A type of managed care organization that provides health care coverage through a network of providers. Plan members typically pay higher costs when they seek care from out-of-network providers.
Premium – The amount paid, often on a monthly basis, for health insurance. The cost of the premium may be shared between employers or government purchasers, and individuals.
Premium Subsidies – A fixed amount of money, or a designated percentage of the premium cost, that is provided to help people purchase health insurance. The health reform law provides premium subsidies to individuals with incomes between 133% and 400% of the federal poverty level who purchase policies through the health insurance Exchanges, beginning in 2014.
Preventive Care Services – Health care that emphasizes the early detection and treatment of disease. The health reform law requires certain health plans (excludes Grandfathered plans) to provide coverage without member cost-sharing for certain preventive services.
Primary Care Provider – A provider, usually a physician, specializing in internal medicine, family practice, or pediatrics, who is responsible for providing primary care and coordinating other necessary health care services for patients.
Qualified Health Plan – Insurance plans that are sold through a Health Insurance Exchange must have been certified as meeting a minimum benchmark of benefits (i.e., essential health benefits) under the health reform law.
Rate Review – Review by insurance regulators of a health plan's proposed premium and premium increases. Rates are reviewed to ensure they are sufficient to pay claims, are not unreasonably high in relation to the medical claim costs and the benefits provided, and are not discriminatorily applied.
Reinsurance – Insurance purchased by insurance companies and employers that self-insure their

employees' medical costs, to limit liability or exposure to high claims or increased cost trends. The health reform law includes a temporary federal reinsurance program for employers that insure early retirees over age 55 who are not eligible for Medicare.

Rescission – Refers to a practice where an approved policy is voided from its inception by the insurer, usually on the grounds of material misrepresentation or omission on the initial application. Under health reform, rescissions are prohibited except in cases of fraud or intentional misrepresentation.

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 a sicker population as a way to discourage plans from selecting only healthier individuals.

Section 125 Plan – These plans are otherwise known as a "cafeteria plan" offered pursuant to Section 125 of the Internal Revenue Code. Its name comes from a set of benefit plans that allows employees to choose between different types of benefits, similar to the ability of a customer to choose among available items in a cafeteria, and the employees' pretax contributions are not subject to federal, state, or Social Security taxes.

Self-Insured Plan – The employer assumes the financial responsibility of health care benefits for its employees in a self-insured or self-funded plan. Employer sponsored self-insured plans typically contract with a third-party administrator to provide administrative services for the plan.

Small Business Tax Credit – The health reform law includes a tax credit equal to 50 percent (35 percent in the case of tax-exempt eligible small employers) for qualified small employers that provide health coverage to their employees. The tax credit is available to employers with 25 or fewer employees with average annual wages of less than $50,000.

Small Group Market – Businesses with typically 2-50 employees, or eligible employees depending on applicable state law, can purchase health insurance for their employees through this market, which is regulated by states.

Tax Credit – An amount that a person or business can subtract from the 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 credit is greater than the amount of tax they would otherwise owe.

Tax Deduction – An amount that a person can subtract from adjusted gross income when calculating the taxes that they owe. Generally, people who itemize deductions can deduct the portion of medical expenses, including health insurance premiums, that exceeds 7.5% of their adjusted gross income. Under health reform, the threshold for deducting medical expenses increases to 10% in 2013 (this increase is waived for individuals 65 and older for tax years 2013-2016).

Value-Based Purchasing – A payment reform which provides bonuses to hospitals and other providers based upon their performance against quality measures.

Wellness Plan/Program – An employer program to improve health and prevent disease

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