



Glossary of Key Health Reform Terms

The complex and challenging process of implementation of the recently passed health reform law—the Patient Protection and Affordable Care Act (PPACA)—has begun. This glossary is intended to serve as a resource for understanding the concepts included in the reform legislation as well as in the debate surrounding implementation. It provides simple and straightforward definitions of key terms that were part of the health reform debate and continue to be part of the national dialogue as implementation moves forward.

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

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

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

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

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

Annual Benefit Limit: Insurers place a ceiling on the amount of claims they will pay in a given year for an individual. Individuals would then have to pay the full cost for any claims incurred above this ceiling during the course of the year. Beginning in 2010, annual benefit limits will be restricted and will be prohibited in 2014 under health reform.

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 business 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.

Basic Health Plan: Beginning in 2014, the health reform law will give states the option of creating a basic health plan to provide coverage to individuals with incomes between 133 and 200 percent of poverty in lieu of having these individuals enroll in the health insurance exchange and receive premium subsidies. The plan would exist outside of the health insurance exchange and include the essential health benefits as defined by the health reform law. Cost-sharing under this plan would also be limited. If states choose to offer this plan, the federal government will provide states 95 percent of what it would have paid to subsidize these enrollees in the health insurance exchange.

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

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

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

Catastrophic Coverage: A coverage option with limited benefits and a high deductible (the amount of health care costs that must be paid for by the consumer before the insurance plan begins to pay for services), intended to protect against medical bankruptcy due to an unforeseen illness or injury. These plans are usually geared toward young adults in relatively good health. While catastrophic plans do not generally cover preventive care, catastrophic coverage plans under health reform will be required to exempt some preventive care services from the deductible.

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

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

Community Living Assistance Services and Supports (CLASS) Program: The CLASS program establishes a national voluntary insurance program for purchasing non-medical services and supports necessary for individuals with functional limitations to maintain community residence. Enrollment will begin January 1, 2011 and will target working adults who will be able to make voluntary premium contributions either through payroll deductions through their employer or directly. The first benefits will be paid out to eligible beneficiaries in 2016.

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 May 31, 2010.

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

Community Rating: A method for setting premium rates for health insurance plans under which all policy holders are charged the same premium for the same coverage. "Modified community rating" generally refers to a rating method under which health insuring organizations are permitted to vary premiums based on specified demographic characteristics (e.g. age, gender, location), but cannot vary premiums based on the health status or claims history of policy holders. Under health reform, beginning in 2014, health plans will be required to adopt modified community rating. Variations in premiums will only be allowed for differences in geography, family structure, age (limited to a 3 to 1 ratio) and tobacco use (limited to a 1.5 to 1 ratio).

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

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

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

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

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

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

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

Deductible: A feature of health plans in which consumers are responsible for health care costs up to a specified dollar amount. After the deductible has been paid, the health insurance plan begins to pay for health care services. Under health reform, beginning in 2014, deductibles for new plans sold in the small group insurance market will be limited to \$2,000 for individual policies and \$4,000 for family policies.

Disproportionate Share Hospital (DSH) Payments: Payments made by Medicare or a state's Medicaid program to hospitals designated 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 Medicare and Medicaid beneficiaries. With respect to Medicaid DSH, states have some discretion in determining how much eligible hospitals receive, but 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. Health reform will reduce the amount of both Medicare and Medicaid DSH funds distributed by the federal government over time as more people become insured.

Doughnut Hole: A gap in prescription drug coverage under Medicare Part D, where beneficiaries enrolled in Part D plans pay 100% of their prescription drug costs after their total drug spending exceeds an initial coverage limit until they qualify for catastrophic coverage. Under the standard Part D benefit, Medicare covers 75% of total drug spending below the initial coverage limit (\$2,830 in 2010), and 95% of spending above the catastrophic level (\$6,440 in 2010). These thresholds are indexed to increase over time. The doughnut hole or coverage gap specifically refers to the range between these two levels (\$3,610 in 2010) in which beneficiaries are responsible for all costs incurred for prescription drugs. The coverage gap will be gradually phased out under health reform, so that by 2020, beneficiaries will only be responsible for 25% of all prescription drug costs up to the catastrophic level.

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, often those with slightly higher incomes (up to 120% of poverty), Medicaid provides the "Medicare Savings Programs" through which enrollees receive assistance with Medicare premiums, deductibles, and other cost sharing requirements. To promote better coordination of Medicare and Medicaid services for dual eligibles, the health reform law creates a new Federal Coordinated Health Care Office within the Centers for Medicare & Medicaid Services.

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

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

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

Employer Health Care Tax Credit: An incentive mechanism designed to encourage employers, usually small employers, to offer health insurance to their employees. The tax credit enables employers to deduct an amount, usually a percentage of the contribution they make toward their employees' premiums, from the federal taxes they owe. These tax credits are typically refundable so they are available to non-profit organizations that do not pay federal taxes. The health reform law includes a tax credit for small employers that provide health coverage to their employees. The tax credit is available to employers with 25 or fewer employees and average annual wages of less than \$50,000.

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. Currently, Hawaii is the only state in the US to have an employer mandate.

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.

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.

Episode of Care: An episode of care refers to all the treatments and services related to the treatment of a condition. For acute conditions (such as a concussion or a bone fracture), the episode refers to all treatment and services from the onset of the condition to its resolution. For chronic conditions, the episode refers to all services and treatments received over a given period of time, commonly one year. Some payment reform proposals include basing payment on episodes of care, rather than on each service rendered. The intent is to increase the accountability of the provider for the care of the patient. The health reform law calls for pilot programs to test this method of payment reform in Medicare and Medicaid.

Essential Health Benefits: A benchmark level of benefits created by the health reform law that is meant to ensure a health plan provides a comprehensive set of services. Plans both within and outside of the health insurance exchange will be required to offer at least this level of coverage. Cost-sharing will be limited to the current HSA limits (\$5,950 for individuals and \$11,900 for families). The Secretary of Health and Human Services will be required to define and annually update the benefit package.

Experience Rating: A method of setting premiums for health insurance policies based on the claims history of an individual or group. Experience rating will be prohibited under the health reform law beginning in 2014.

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

Federal Medical Assistance Percentage (FMAP): The statutory term for the federal Medicaid matching rate—i.e., the share of the costs of Medicaid services or administration that the federal government bears. In the case of covered services, FMAP varies from 50% to 76% depending upon a state's per capita income; on average, across all states, the federal government pays 57% of the costs of Medicaid. The American Recovery and Reinvestment Act (ARRA) provides a temporary increase in the FMAP through December 31, 2010, and additional legislation partially extends this funding through June 30, 2011.

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 2009, the Census weighted average poverty threshold for a family of four was \$21,947 and HHS poverty guideline was \$22,050.

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.

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 significant changes to its policy, such as eliminating or reducing benefits to treat a specific disease or condition, significantly increasing cost-sharing, or reducing the employer contribution toward the premium, among others. Once a health plan makes such a change to their policy, it becomes subject to all the requirements of health reform.

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

Guarantee Issue/Renewal: Requires insurers to offer and renew coverage, without regard to health status, use of services, or pre-existing conditions. This requirement ensures that no one will be denied coverage for any reason. Beginning in 2014, the health reform law will require guarantee issue and renewability.

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

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

Health Insurance Exchange/Connector: An arrangement through which insurers offer smaller employers and individuals health insurance plans for purchase. Under health reform, state-based health insurance exchanges will be established to set standards for what benefits are to be covered, how much insurers can charge, and the rules insurers must follow in order to participate in the insurance market. Individuals and small employers will then be able to select their coverage within this organized arrangement. An example of this arrangement is the Commonwealth Connector, created in Massachusetts in 2006. The state-based exchanges under health reform are legislated to begin operation in 2014.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Through the Health Insurance Portability and Accountability Act of 1996, individuals can maintain coverage while changing jobs or for a temporary period of unemployment without a waiting period. Individuals in many states who lose group health coverage after a loss of employment have access to coverage through high-risk pools, with no pre-existing condition exclusion periods. HIPAA also sets standards that address the security and privacy of personal health data.

Health Reimbursement Arrangement (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 do not have to be.

Health Savings Account (HSA): A tax-exempt savings account that can be used to pay for current or future qualified medical expenses. Employers may make HSAs available to their employees or individuals can obtain HSAs from most financial institutions. Employers and employees can contribute to the plan. In order to open an HSA, an individual must have health coverage under an HSA-qualified high-deductible health plan. These HSA-qualified high-deductible health plans must have deductibles (the amount of health care costs that must be paid for by the consumer before the insurance plan begins to pay for services) of at least \$1,200 for an individual and \$2,400 for a family in 2010.

High-Deductible Health Plan: Health insurance plans that have higher deductibles (the amount of health care costs that must be paid for by the consumer before the insurance plan begins to pay for services), but lower premiums than traditional plans. Qualified high-deductible plans that may be combined with a health savings account must have a deductible of at least \$1,200 for single coverage and \$2,400 for family coverage in 2010.

High-Risk Pool: State programs designed to provide health insurance to residents who are considered medically uninsurable and are unable to buy coverage in the individual market. As of early 2009, high-risk pools operated in 34 states but varied by eligibility requirements, cost-sharing requirements, availability of premium subsidies, and funding sources. The health reform law creates temporary high risk pools in each state (referred to as the Pre-existing Condition Insurance Plan) to provide coverage for those with pre-existing conditions who are uninsured. These temporary pools will provide coverage until 2014.

Income-Related Premium: Premiums for Medicare Part B and Part D that apply to higher-income Medicare beneficiaries. The Medicare Modernization Act of 2003 established an income-related Part B premium that took effect in 2007, requiring higher-income Medicare beneficiaries to pay a greater share of average Part B costs (35% to 80%, depending on their income). Beneficiaries are required to pay the income-related Part B premium if their income is equal to or greater than \$85,000 for an individual and \$170,000 for a couple in 2010. The health reform law freezes the threshold for the income-related Part B premium at 2010 levels through 2019, effective in 2011. The health reform law also creates an income-related Part D premium, effective in 2011, using the same surcharge percentages (35% to 80%) and income thresholds (\$85,000 for an individual and \$170,000 for a couple in 2010) as for Part B. Similar to the Part B premium provision, the income thresholds for the Part D income-related premium are not indexed to increase annually.

Independent Payment Advisory Board: A board of 15 members appointed by the President and confirmed by the Senate for six year terms. The board is tasked with submitting proposals to Congress to reduce Medicare spending by specified amounts if the projected per beneficiary spending exceeds the target growth rate. If the Board fails to submit a proposal, the Secretary of the Department of Health and Human Services is required to develop a detailed proposal to achieve the required level of Medicare savings. The Secretary is required to implement the Board's (or Secretary's) proposals, unless Congress adopts alternative proposals that result in the same amount of savings. The Board is prohibited from submitting proposals that would ration care, increase taxes, change Medicare benefits or eligibility, increase beneficiary premiums and cost-sharing requirements, or reduce low-income subsidies under Part D.

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

Individual Mandate: A requirement that all individuals obtain health insurance. Massachusetts was the first state to impose an individual mandate that all adults have health insurance. There is an individual mandate to obtain health insurance in the health reform law that applies to all Americans with some hardship and income-based exemptions beginning in 2014.

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

Long-Term Care: Services that include those needed by people to live independently in the community, such as home health and personal care, as well as services provided in institutional settings such as nursing homes. Medicaid is the primary payer for long-term care. Many of these services are not covered by Medicare or private insurance. The health reform law includes several new options in Medicaid for states to expand the availability of home and community-based long-term care services and creates the new Community Living Assistance Services and Supports (CLASS) program to assist individuals with functional limitations in purchasing supportive services so they can maintain community residence.

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

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

Medicaid: Enacted in 1965 under Title XIX of the Social Security Act, Medicaid is a federal entitlement program that provides health and long-term care coverage to certain categories of low-income Americans. States design their own Medicaid programs within broad federal guidelines including setting eligibility levels. 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. The health reform law expands Medicaid eligibility to non-elderly individuals (children pregnant women, parents, and adults without dependent children) with incomes up to 133% of poverty, establishing uniform eligibility for adults and children across all states by 2014.

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 who are not otherwise eligible for Medicaid.

Medical Home or Health 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 non-emergent primary, secondary, and tertiary care; and have access to linguistically and culturally appropriate care.

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

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. Medical underwriting will be prohibited under health reform beginning in 2014.

- Medicare:** Enacted in 1965 under Title XVIII of the Social Security Act, Medicare is a federal entitlement program that provides health insurance coverage to 45 million people, including people age 65 and older, and younger people with permanent disabilities, end-stage renal disease, and Lou Gehrig's disease.
- Medicare Advantage:** Also referred to as Medicare Part C, the Medicare Advantage program allows Medicare beneficiaries to choose to receive their Medicare benefits through a private insurance plan rather than the traditional fee-for-service program. Payments to Medicare Advantage plans made by Medicare, which were on average 9% higher than the costs of the traditional fee-for-service program in 2010, will be reduced under health reform, bringing them closer to the average costs of care under the traditional fee-for-service program.
- Minimum Creditable Coverage:** The minimum level of benefits that must be included in a health insurance plan in order for an individual to be considered insured. Minimum creditable coverage standards have been established in Massachusetts as part of that state's health reform law.
- Out-of-Pocket Costs:** Health care costs, such as deductibles, co-payments, and co-insurance that are not covered by insurance. Out-of-pocket costs do not include premium costs.
- Out-of-Pocket Maximum:** A yearly cap on the amount of money individuals are required to pay out-of-pocket for health care costs, excluding the premium. The health reform law requires new plans offered beginning in 2014 to include an out-of-pocket maximum set at the current HSA level or \$5,950 for an individual policy or \$11,900 for a family policy in 2010.
- Pay for Performance:** A health care payment system in which 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.
- Payment Bundling:** A form of provider payment where providers or hospitals receive a single payment for all of the care provided for an episode of illness, rather than per service rendered. Total care provided for an episode of illness may include both acute and post-acute care. The health reform law establishes pilot programs in Medicare and Medicaid to pay a bundled payment for episodes of care involving hospitalizations.
- Portability of Coverage:** Rules created by the Health Insurance Portability and Accountability Act (HIPAA) allowing people to obtain coverage as they move from job to job or in and out of employment. Individuals changing jobs are guaranteed coverage with the new employer without a waiting period. In addition, insurers must waive any pre-existing condition exclusions for individuals who were previously covered within a specified time period. Portable coverage can also be health coverage that is not connected to an employer, allowing individuals to keep their coverage when they have a change in employment.
- Pre-existing Condition Exclusions:** An exclusion from coverage of an illness or medical condition for which a person had received a diagnosis or treatment within a specified period of time prior to becoming insured. Health care providers can exclude benefits for a defined period of time for the treatment of medical conditions that they determine to have existed within a specific period prior to the beginning of coverage. Pre-existing condition exclusions are prohibited by the health reform law beginning in 2010 for children and in 2014 for adults.
- Premium:** The amount paid, often on a monthly basis, for health insurance. The cost of the premium may be shared between employers or government purchasers and individuals.
- Premium Subsidies:** A fixed amount of money or a designated percentage of the premium cost that is provided to help people purchase health coverage. Premium subsidies are usually provided on a sliding scale based on an individual's or family's income. The health reform law provides premium subsidies through refundable pre-tax credits 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:** Health care that emphasizes the early detection and treatment of diseases. The focus on prevention is intended to keep people healthier for longer, thus reducing health care costs over the long term. The health reform law requires new qualified health plans and Medicare to provide coverage without cost-sharing for certain preventive services. The law also includes incentives for states to offer the same coverage in their Medicaid programs.
- Primary Care Provider:** A provider, usually a physician specializing in internal medicine, family practice, or pediatrics (but can also be a nurse practitioner, physician assistant or even a health care clinic), who is responsible for providing primary care and coordinating other necessary health care services for patients.
- Provider Payment Rates:** The total payment a provider, hospital, or community health center receives when they provide medical services to a patient. Providers are compensated for patient care using a set of defined rates based on illness category and the type of service administered.

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

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

Qualified Health Plan: Refers to insurance plans that have been certified as meeting a minimum benchmark of benefits (i.e. the essential health benefits) under health reform. This will allow consumers to verify that the plan they have purchased will meet at least the minimum requirements of the individual mandate.

Reinsurance: Reinsurance is insurance for insurance companies and employers that self-insure their employees' medical costs. Through government-funded reinsurance programs, federal or state governments pay for a portion of the high costs experienced by insurers. By limiting insurers' exposure to very high health costs, reinsurance programs enable insurers to lower the premiums they charge to employers and individuals. This type of program is a form of subsidy to the insurer that lowers the premium cost for all purchasers. The Healthy New York program and the Healthcare Group of Arizona are examples of state reinsurance programs. The health reform law provides for a temporary federal reinsurance program for employers that insure early retirees over age 55 who are not eligible for Medicare.

Rescission: Also referred to as "post-claims underwriting," this is a practice in the individual insurance market where an approved policy is rescinded by the insurer, often after a large claim has been filed, on the grounds that the individual misrepresented their health history on their initial application. The condition not disclosed to the insurer can be unrelated to the current claim. This practice occurs in the individual market because, unlike the large group/ employer market, until the passage of health reform, there were no restrictions against insurers for underwriting or denying coverage based on pre-existing conditions. Under health reform, insurers will only be able to rescind policies in cases of fraud.

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

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

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

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

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

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

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

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

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

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 currently who do not receive health insurance through an employer may only deduct the amount of their total health care expenses that exceeds 7.5% of their adjusted gross income.

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

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

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

Value-Based Purchasing: A payment reform under which hospitals and other providers are provided bonuses based upon their performance against quality measures. The health reform law establishes a value-based purchasing program in Medicare for hospitals and requires the development of similar programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers, and the testing of pilot programs for other providers, including psychiatric hospitals, long-term care hospitals, rehabilitation hospitals, and hospice programs.

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

For additional information on the implementation of health reform, please see:

Summary of New Health Reform Law. April 2010. Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation. Available at: www.kff.org/healthreform/upload/8061.pdf

Health Reform Implementation Timeline. April 2010. Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation. Available at: www.kff.org/healthreform/upload/8060.pdf .

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