Health Care: A Basics Glossary

Center Forward Basics
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Overview

The Affordable Care Act, also called "Obamacare," is one of the number one legislative priorities this Congress. Other health care issues, like the reauthorization of the Children's Health Insurance Program, are also up for discussion in the months ahead. Health care, however, can be a complicated policy world. To help navigate this world, we have created the following glossary of some important health care terms especially relevant for the 115th Congress. This list is by no means exhaustive but is meant to be a basic overview as the process unfolds.

The Glossary

Advance Premium Tax Credit- is a tax credit people can apply for and take in advance to help lower their monthly health care premium. People estimate what their annual income will be and if it is higher than expected, they are required to pay back the difference at tax time; if less, they will get a refund.

Age Rating- refers to the practice of segmenting the health care eligible population by age in an effort pool risk. Under the ACA, there is a 3 to 1 ration, meaning that an older person can only be charged 3 times more than a younger enrollee for a comparable plan. Many experts advocate for upping this ratio to 5:1 to better contain costs.

Association Health Plan (AHP)- a is health insurance coverage offered to collections of individuals and/or employers through entities that may be called associations, trusts, multiple employer welfare arrangements ("MEWAs"), purchasing alliances or purchasing cooperatives. AHP health insurance coverage is currently regulated when sold to an individual as individual health insurance, and when sold to an employer, as group coverage.

Cadillac Tax- refers to a provision in the ACA called the "High-cost Plan Tax" (HCPT), which is a 40 percent tax on employer plans that exceed certain costs: $10,200 for an individual and $27,500 for a family. This tax is set to come into effect in 2020 and includes premium contributions from both employees and employers and includes contributions to saving mechanisms like Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs).

Center Forward brings together members of Congress, not-for profits, academic experts, trade associations, corporations and unions to find common ground. Our mission: to give centrist allies the information they need to craft common sense solutions, and provide those allies the support they need to turn those ideas into results.

In order to meet our challenges we need to put aside the partisan bickering that has gridlocked Washington and come together to find common sense solutions.

For more information, please visit www.center-forward.org

Center for Disease Control and Prevention (CDC)- the mission of the CDC is to serve "as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and health education activities designed to improve the health of the people of the United States." The CDC comprises 25 centers, institutes and offices, including the Center for Global Health, National Institute for Occupational Safety and Health, Office of Infectious Diseases and the Office of Noncommunicable Diseases.

Center for Medicare and Medicaid Services (CMS)- is the federal agency, in partnership with states, that covers over 100 million people through Medicare, Medicaid, Children's Health Insurance Program (CHIP) and the Health Insurance Marketplace.

Children's Health Insurance Plan (CHIP)- provides low-income children with health insurance coverage through states. According to the CMS Office of the Actuary, 8.9 million individuals CHIP in 2015. CHIP is up for reauthorization in 2017.

Cost-sharing Reductions (CSRs)- refers to the decreased amount an enrollee has to pay for deductibles, copayments and coinsurance.

Dual Eligibles- refers to those who are eligible for both Medicare and Medicaid.

Essential Health Benefits (EHBs)- according to the ACA, as of 2014, all Health Insurance Marketplace plans, non-marketplace and small group plans, as well as Medicaid and Medicare must offer ten "Essential Health Benefits", which include: outpatient care, emergency services, hospitalization, maternity and newborn care, mental health and addiction services, prescriptions drugs, rehabilitation services, laboratory services, preventive and well treatment, as well as pediatric care.

Evidence Based Medicine (EBM)- is an approach to medicine and medical care that looks to scientific data procured from rigorous research.

Fee for Service- method of payment for medical services where the provider is paid for specific service performed, i.e. office visit, blood work taken, tests administered.

Food and Drug Administration (FDA)- the FDA's mission is to protect the "public health by ensuring the safety, efficacy, and security of human and veterinary drugs, biological products, and medical devices; and by ensuring the safety of our nation's food supply, cosmetics, and products that emit radiation." They work to accomplish this by overseeing major regulatory infrastructure that approves new products and monitors existing ones.

Fully-insured versus Self-insured Health Plans- these terms generally apply to employer-sponsored plans. Fully-insured plans are those purchased by employers to provide health care coverage to their employees and administered by an outside health insurance company. Self-insured plans are usually plans operated by the employer themselves.

Generic Drug User Fee Agreement (GDUFA)- is a result of the Generic Drug User Fee Amendments to the Food and Drug Administration Safety and Innovation Act of 2012. The intention is to get generic drugs to the public in a timely manner. It also requires drug companies to pay fees for the FDA to review generic drug applications as well as inspect their production facilities.

Grace Periods- if an individual misses a payment of their health care coverage premium, they have a 90-day grace period before their coverage can be dropped if they have a marketplace plan and concurrently qualify for an Advance Premium Tax Credit (APTC) AND paid at least one full month's premium during a benefit year. If an enrollee does not qualify for an APTC, grace periods may differ by state.

Health Exchanges- set up by the ACA, these are health insurance marketplaces created to help with the purchase of health care coverage insurance in states.

Health Insurance Tax (HIT)- is an annual tax on health care insurance companies included in the ACA. The total HIT is divided among insurers based on a formula regarding each insurer's net premiums.

Health Savings Accounts (HSAs)- are available to those enrolled in a high-deductible health insurance plan. People contribute pre-tax dollars to these accounts to pay for deductibles and co-payments. The funds in these accounts roll over year to year. Annually the IRS sets a limit on the tax-deductible dollar amount that may be contributed to an HSA, which is indexed to inflation.

High-risk Pool- is a mechanism to provide insurance coverage to individuals who have medical conditions resulting in high health care costs. Prior to the ACA, high-risk pools were administered by states to offer coverage to individuals who were locked out of the individual market because of their pre-existing conditions. Medical underwriting effectively excludes a large proportion of total health care spending from the insurance pool. This allows for less expensive policies for healthier individuals.

Individual Mandate- a key part of the ACA is that everyone obtain health care or face a tax penalty, sometimes referred to as the "Shared Responsibility Fee."

Medicaid Managed Care- refers to when states contract with Managed Care Organizations to provide health and additional services to beneficiaries on a pre-determined and accepted per person, per month payment. 55 million people are enrolled in this kind of care.

Medical Loss Ratio (MLR)- the ACA requires health care companies to submit data to CMS "on the proportion of premium revenues spent on clinical services and quality improvement," otherwise known as the Medical Loss Ratio. The ACA requires that at least 80 to 85 percent of payments from premiums be spent on medical care. If this MLR is not met health care companies are required to issue a rebate to the consumer.

Medicaid- is a federal and state health coverage program that covers low-income families, qualified pregnant women and children and individuals receiving SSI, as well as some other at-risk populations. 72.5 million Americans receive health care coverage through Medicaid.

Medicaid Demonstration Waivers- Section 1115 of the Social Security Act allows for the Secretary of Health and Human Services to grant waivers to states for certain Medicaid provisions in an effort to allow them to use federal Medicaid funds in innovative ways, such as changes to eligibility, benefits, cost sharing arrangements and provider payments. Under ACA, many states have used this waiver to expand Medicaid coverage to low-income adults.

Medicare- is the federally funded and state administered health insurance program for people that are 65 years old and older, some younger people with specific disabilities and those with End-Stage Renal Disease. Medicare is divided into 4 "parts": Part A, which is insurance for hospital stays; Part B, which is for medical

insurance which covers doctor services, outpatient care, medical supplies and preventive services; Part C, or Medicare Advantage plans (see definition in this glossary); and, Part D, or prescription drug coverage.

Medicare Advantage- is a private health care option for seniors eligible for Medicare. These plans have the flexibility to pioneer the implementation of innovative care coordination and preventive care programs tailored to patients' needs. MA plans provide all traditional Medicare-covered benefits to enrollees, but also provide extra benefits such as lower premiums or reduced cost sharing, enhanced prescription drug coverage, eyeglasses, and nutritional counseling. MA plans also design programs to improve care coordination and quality of care.

National Institute of Health (NIH)-, the NIH's goal "is to acquire new knowledge to help prevent, detect, diagnose, and treat disease and disability, from the rarest genetic disorder to the common cold." A part of the U.S. Department of Health and Human Services, the NIH conducts it's own research through various centers and also doles out grants to research institutions across the country.

Network Adequacy- a term used to determine if a health care network has the appropriate amount and types of providers available to consumers in a timely manner

Prescription Drug User Fee Act (PDUFA)- was passed in 1992 and gave the FDA authority to collect fees from pharmaceutical companies for a new drug approval process.

Pharmacy Benefit Manager (PBM)- is a third-party vendor who administrates prescription drug programs for the varied government and private health care programs available.

Reconciliation- the House and Senate often use annual budget bills to communicate their broad visions for the size and role of the federal government. Even so, the rules governing the budget process can remove some of the procedural obstacles that stand in the way of significant changes to tax policy and entitlement spending. One of these rules –called "reconciliation" –has a history of helping the passage of milestone legislation, including historic legislation like the Bush tax cuts and health care reform.

Reinsurance- in health care, reinsurance refers to a reimbursement system for health care companies to cover claims once they reach a certain financial threshold. It is meant to be a way to protect health care companies from high claims and is generally provided by a third party.

Risk Adjustment- refers to a statistical process that looks at health status and spending of insured individuals in relation to their health care outcomes or costs.

Risk Corridors- were established in the ACA to offset insurance company losses during the first three years of implementation. Designed in part to deal with coverage of high-risk enrollees, insurers who made higher profits pay into the program while those with more costly claims receive, in theory, an offset. However, many insurers are owed money from this program.

State Innovation Waivers- Section 1332 of the ACA allows for a state to apply for a waiver that permits them to offer different ways of implementing the basic tenants of the ACA. They must provide the same coverage absent the waiver and cannot increase the federal deficit. Waiver can come into effect as of January 2017.

Special Needs Plan (SNP)- is a type of Medicare Advantage Plan that specializes coverage to a subset of the sickest and most expensive Medicare beneficiaries.

Transitional Plans- often called "grandmothered" plans, these are plans that were sold to individuals and small groups in the period between ACA passage and its implementation. Currently, these plans are set to expire in December 2017.

Wellness Programs- many workplaces and insurance plans offer different programs to promote "wellness," including smoking cessation, weight management, diabetes management and overall physical health maintenance.

Value-based Reimbursement (VBR)- payment mechanisms whereby providers get paid or incentivized not necessarily by each individual service they provide (see fee for service) but rather for a broader treatment plan. This is a key part of the ACA and mechanisms like bundled payments and increased care coordination are examples of VBR.