CENTER FORWARD

Health Care: A Basics Glossary

Center Forward Basics
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Overview

As the 116th Congress ramps up with Democratic control of the House, health care will certainly be at the top of the legislative agenda. In order to help our readers navigate the U.S. health care landscape, we have created the following glossary of terms. While by no means exhaustive, this Basic provides an overview of common health care terms.

Glossary

Accountable Care Organization (ACO) - group of health care providers who coordinate care to improve a patient's overall health. ACOs get paid based on how well they are able to achieve health care goals while driving down costs.

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

Alternative Payment Model (APM) - one of two tracks under the CMS Quality Payment Program, APM gives added incentive payments to providers for high-quality and cost-efficient care for patients.

Association Health Plan - health insurance purchased by a group of small businesses. These plans allow small employers to band together to buy insurance, pooling their purchasing power and granting them access to cheaper premiums often provided to large companies with more leverage. The ACA required these plans to cover all of the law's mandated benefits, such as the ten essential health benefits laid out in the legislation. The Trump Administration eased these restrictions through executive order in 2018 to make association health plans more accessible. These plans can have lower premiums in comparison to non-association health plans and cover fewer health services for beneficiaries.

Center Forward Basics

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

Biologics - created from a variety of natural sources (human, animal, or microorganisms), biologics are complex to manufacture and are used in the treatment, prevention, or diagnosis of diseases. Biologics are a diverse category of products that can range from vaccines for influenza prevention to gene therapy for cancer treatment.

Biologics Price Competition and Innovation Act (BPICA) - Congress passed BPICA as part of the Affordable Care Act in 2010 to establish an abbreviated approval process for biological products that meet the FDA's standard of being "highly similar" (biosimilar) to or "interchangeable" with an FDA-approved biologic.

Biosimilars - highly similar to biologics, biosimilars have no clinically meaningful differences from existing FDA-approved biologics. Because biological products are so complex to develop, inherent variations caused by the manufacturing process are expected; therefore, a biosimilar must meet the FDA's high standard of having "no clinically meaningful differences" in purity, safety and effectiveness from the biologic it is being modeled after.

Brand Name Drug - refers to a drug marketed under a proprietary, trademark-protected name. "Brand name drugs" or "brands" typically serve as reference products (see reference product) to which generics or biosimilars are compared by the FDA.

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 was set to take effect in 2018 but has been delayed twice and is currently delayed until 2022.

Catastrophic Health Plan - health plan that meets requirements of qualified health plans (QHPs), such as providing essential health benefits and following established limits on cost-sharing. The monthly premium is usually lower than that of other QHPs, but out-of-pocket costs for deductibles, copayments, and coinsurance are generally much higher. Only those under the age of 30 or those with a "hardship exemption" qualify for a catastrophic plan.

Centers for Disease Control and Prevention (CDC) - a major component of the Department of Health and Human Services (HHS), the CDC works to protect the U.S. from health, safety and security threats by fighting diseases and supporting communities and citizens to do the same. The CDC conducts critical research and outreach through over 25 centers, institutes and offices, such as the Office of Infectious Diseases.

Centers for Medicare and Medicaid Services (CMS) - 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 Program (CHIP) - provides low-cost health coverage for children in families that earn too much money to qualify for Medicaid but not enough to purchase private insurance. According to CMS, 9.4 million children were enrolled in 2017. The program was reauthorized in 2018 for six years, from FY 2018 through FY 2023.

Clinical Trial - research study in which people are assigned to interventions to evaluate the effects on health outcomes. Interventions can include drugs, biological products, devices, etc.

Coinsurance versus Copayment - *coinsurance* is the percentage of costs of a covered health service a beneficiary pays after the deductible has been reached. A *copayment* is a fixed amount paid by a beneficiary once the deductible has been paid.

Community Rating - rule preventing health insurers from charging beneficiaries within a geographic area different premiums based on age, gender, health status or other factors.

Consolidated Omnibus Budget Reconciliation Act (COBRA) - federal law enacted in 1986 to allow the temporary continuation of health insurance coverage after employment ends or another qualifying event occurs. A beneficiary pays 100% of the premiums, including the share an employer used to pay, plus a small administrative fee to maintain coverage.

Cost-Sharing Reductions (CSRs) - refers to the decreased amount an enrollee has to pay for deductibles, copayments and coinsurance. The Trump Administration halted the federal government's reimbursements of CSRs to insurers in October 2017. In response, several insurers have sued the federal government for these payments.

Deductible - amount a beneficiary pays for health care services before their insurance plan begins to pay. Once this amount has been paid, beneficiaries usually only pay a copayment or coinsurance while the insurance company pays the rest.

Donut Hole - refers to the Medicare prescription drug (Part D) coverage gap, commonly referred to as the "donut hole." After a beneficiary and their drug plan have spent the allotted amount for covered drugs, the beneficiary must shoulder all of the costs out-of-pocket until they reach the yearly limit. Once the yearly limit is reached, a drug plan resumes sharing part of the cost.

Drug Price Competition and Patent Term Restoration Act - also known as the Hatch-Waxman Amendments and passed in 1984, Congress passed legislation to establish an abbreviated pathway for generic drug approval.

Essential Health Benefits - 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" that include: outpatient care, emergency services, hospitalization, maternity and newborn care, mental health and addiction services, prescriptions drugs, rehabilitation services, laboratory services, preventive and wellness treatment, as well as pediatric care.

Excepted Benefits - benefits offered separately from major medical health coverage, such as accident insurance. Since these benefits are "excepted," they generally do not have to meet the same requirements of traditional health insurance plans, such as the ACA requirement on covering essential health benefits.

Exclusive Provider Organization (EPO) - insurance plan where services are only covered if received from doctors, specialists or hospitals in the plan's network, except in cases of emergency.

Family and Medical Leave Act (FMLA) - guarantees up to 12 weeks of job-protected leave for eligible employees due to serious illness or disability, to give birth or adopt a child, or to care for a family member.

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

Flexible Spending Account (FSA) - set up through an employer, an FSA allows employees to pay for many out-of-pocket medical expenses with tax-free funds. Employers set a limit on the amount an employee can put in an FSA, and employees can use the funds on expenses like copayments, deductibles and medical devices.

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.

Formulary - sometimes referred to as a drug list, a formulary is a list of prescription drugs covered by a prescription drug plan or an insurance plan, including prescription drug benefits.

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 operated by employers themselves and are most common in large companies.

Generic - medication deemed by the FDA to be the same as already marketed brand-name drugs in dosage form, safety, strength, and other factors. These similarities demonstrate bioequivalence, or prove that a generic medicine works in the same way and provides the same clinical benefit as the brand version.

Generic Drug User Fee Agreement (GDUFA) - result of the Generic Drug User Fee Amendments to the *Food and Drug Administration Safety and Innovation Act of 2012*. Congress enacted GDUFA to ensure patients have access to safe, high-quality, and affordable generic drugs. GDUFA requires generic drug manufacturers to pay fees to the FDA for review of generic drug applications as well as inspection of production facilities.

Group Health Plan - health plan offered by an employer that provides health coverage for employees and their families.

Health Insurance Tax (HIT) - annual tax on health insurance companies included in the ACA. The total HIT is divided among insurers based on each insurer's net premiums. The tax took effect in 2014 and Congress subsequently suspended the tax for years 2017 and 2019 to avoid premium increases for beneficiaries.

Health Maintenance Organization (HMO) - type of insurance plan that limits coverage to care from doctors who work for or contract with the HMO, and typically does not cover out-of-network care except in cases of emergency. HMOs usually focus on prevention and wellness by providing integrated care for patients.

Health Reimbursement Account (HRA) - employer-funded group health plans that reimburse employees for qualified medical expenses tax-free up to a certain limit per year.

Health Savings Account (HSA) - available to those enrolled in a high-deductible health insurance plan, an HSA is a savings account used to set aside pre-tax funds to pay for qualified medical expenses, such as deductibles and copayments. The IRS sets a limit each year on the tax-deductible dollar amount that may be contributed to an HSA, which is indexed to inflation.

High-risk Pool - 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.

Individual Mandate - key part of the ACA meant to offset the requirement that insurers cover beneficiaries with pre-existing conditions, the individual mandate requires everyone to obtain health care or face a tax penalty, sometimes referred to as the "Shared Responsibility Fee." Congress repealed the mandate in 2017.

Interchangeable Product - biosimilar product that meets additional requirements by FDA, demonstrating: it can produce the same clinical result as the reference product in any given patient and that switching back and forth between the reference product and the biosimilar does not reduce safety or effectiveness. An interchangeable product may be substituted for the reference product without consulting the prescriber.

Medicaid - federal and state health coverage program that covers low-income families, qualified pregnant women and children and the elderly, as well as people with disabilities. In FY2016, 76 million Americans received health care coverage through Medicaid. As of 2018, 34 states including D.C. have expanded 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 states to use federal Medicaid funds in innovative ways, such as changes to eligibility, benefits, cost sharing arrangements and provider payments. Under the ACA, many states have used this waiver to expand Medicaid coverage to low-income adults.

Medicaid Managed Care - refers to when states contract with Managed Care Organizations (MCOs) 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 plans to submit data to CMS on the proportion of premium revenues spent on patient care versus administrative costs, otherwise known as the Medical Loss Ratio. The *SUPPORT for Patients and Communities Act*, Congress' 2018 opioid package, includes a financial incentive for states to mandate a MLR of 85 percent for Medicaid MCOs, which means health plans must spend at least 85 percent of revenues on patients. Those that do not meet this threshold would have to pay some money back to the state.

Medicare - federally funded and state administered health insurance program for people that are 65 years old and older, some younger people with 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 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 Access and CHIP Reauthorization Act (MACRA) - MACRA was passed in 2015 to extend funding for the Children's Health Insurance Program and Community Health Centers, along with other public programs. Additionally, MACRA created the Quality Payment Program (QPP) to reform how physicians are reimbursed through Medicare. QPP incentivizes quality of care for patients instead of the volume of care provided by repealing the Sustainable Growth Rate, creating the Merit-Based Incentive Payments System (MIPS) and giving bonus payments for participation in eligible alternative payment models (APMs).

Medicare Advantage (MA) - private health care option for seniors eligible for Medicare. MA plans cover all Medicare services, but can also offer extra coverage such as vision, hearing and dental coverage. More than a third of Medicare beneficiaries are enrolled in a MA plan. Beginning in 2019, MA plans will be allowed to offer coverage for certain non-medical supportive services to beneficiaries, such as transportation and home meal delivery.

Merit-based Incentive Payment System (MIPS) - one of two tracks under the CMS Quality Payment Program that moves Medicare Part B providers to a performance-based system. MIPS consolidates three Medicare programs - the Physician Quality Reporting System (PQRS), the Value-based Payment Modifier (VM) Program, and the Medicare Electronic Health Record (EHR) Incentive Program into a single payment program.

National Institutes of Health (NIH) - the NIH is part of the Department of Health and Human Services (HHS) and serves as the nation's medical research agency. Twenty-seven different Institutes and Centers make up the NIH, each with a particular research agenda, such as the National Cancer Institute (NCI) and the Center for Scientific Review.

Orphan Drug - drug used to treat, prevent or diagnose an orphan disease. Orphan diseases are rare diseases or conditions that affect fewer than 200,000 people in the United States.

Payment Bundling - payment structure that focuses on care coordination rather than payment for each individual service provided. Different health care providers are paid an overall sum to care for a patient, which reduces unnecessary or duplicative treatment, reduces complications and lowers costs.

Pharmacy Benefit Managers (PBMs) - administer prescription drug benefits on behalf of health plans, employers, unions, and consumers. PBMs negotiate discounts with drug manufacturers and pharmacies for consumers by leveraging extensive pharmacy networks as well as offering home-delivery of medications.

Physician Fee Schedule (PFS) - complete listing of fees used by Medicare to pay doctors and other providers. This comprehensive list of fee maximums is used to reimburse physicians on a fee-for-service basis.

Point of Service (POS) - type of health insurance plan where a beneficiary pays less for using doctors, hospitals and other health care providers that belong to the plan's network. POS plans require a referral from a primary physician to see a specialist.

Preferred Provider Organization (PPO) - type of insurance plan that contracts with doctors and hospitals to create a network of participating providers. A beneficiary pays less for using providers in the plan's network, but can still consult providers outside of network without a referral for an additional cost.

Prescription Drug User Fee Act (PDUFA) - passed in 1992 and authorized the FDA to collect fees from pharmaceutical companies for a new drug approval process. PDUFA must be reauthorized every five years and was most recently renewed in 2017.

Reference Product - brand name drug product, already approved by FDA, against which a proposed generic or biosimilar product is compared for purposes of safety and efficacy.

Reinsurance - reimbursement system for health insurers to help cover costs for the most expensive patients, with the goal of allowing insurers to lower overall monthly premiums for beneficiaries. As of 2018, seven states have received permission from CMS to move some federal dollars from insurance subsidies to cover reinsurance. Along with risk adjustment and risk corridors, reinsurance is one of the ACA's three premium stabilization programs.

Risk Adjustment - program intended to prevent risk selection by insurers, or discrimination against beneficiaries with high-cost conditions. The program transfers funds from plans with lower-risk enrollees to plans with higher-risk enrollees to encourage competition based on value rather than by enrolling a greater number of low-risk beneficiaries. Along with reinsurance and risk corridors, risk adjustment is one of the ACA's three premium stabilization programs.

Risk Corridors - were established by the ACA to offset insurance company losses during the first three years of ACA implementation. Designed in part to deal with coverage of high-risk enrollees, insurers who made higher profits paid into the program while those with more costly claims received, in theory, an offset. However, many insurers are owed money from this program and litigation is ongoing between the federal government and insurers who believe they are owed outstanding risk corridor payments. Risk corridors are the third of the ACA's premium stabilization programs.

Specialty Pharmaceutical - drugs and biologics that are generally complex to manufacture, can be difficult to administer, and may require special patient monitoring. Because they can also require specialized shipping and storage for temperature control, they are usually dispensed at specialty pharmacies that have these capabilities.

State Innovation Waivers (Section 1332 Waivers) - Section 1332 of the ACA allows states to apply for a waiver that permits them to offer different ways of implementing the basic tenants of the ACA. States can implement innovative ways to provide access to care, but it must be as comprehensive and affordable as it would be without the waiver, provide coverage to a comparable number of residents and cannot increase the federal deficit. Waivers became available in January 2017.

Value-based Purchasing (VBP) - payment mechanism 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 VBP.