

Glossary of Health System Terms

A *verse Selection* – Adverse selection is a phenomenon where those with higher risk are more inclined to purchase insurance than those who have a lower risk. The fact that this occurs is understandable since those who will likely utilize a service are much more inclined to pay for it than those who will not. This poses a problem for the insurer because this selection means that they will have an insurance pool in which they will have to pay out benefits on a majority of individuals, which can easily create an unsustainable situation. In order to overcome this problem, insurers must utilize price discrimination to entice low risk individuals to purchase coverage or lobby the government to force individuals to have compulsory coverage.

Annual or Lifetime Benefit Caps – Benefit caps are the maximum dollar amount of coverage provided under a given insurance plan for a given benefit. These can either be for overall expenditures, or for expenditures on specific benefits like prescription medications. The caps are usually delineated over a given unit of time, such as a calendar or benefit year, or for the lifetime of the insurance plan.

Association Health Plan – Association health plans are insurance plans offered to an association that exists for purposes other than the sale of insurance. This allows individuals who are uninsured due to lack of employer provided insurance or are self-employed to join with others to form a group to negotiate lower premiums for health insurance. Examples of associations that offer health insurance as a benefit of membership include the National Association for the Self-Employed.

B *ad debt (as opposed to charitable care)* – Both bad debt and charitable care together account for services provided for which the provider will not receive payment. The difference between bad debt and charitable care is the expectation of payment. Bad debt is accrued when the provider either does not receive or only receives a portion of the payment expected for services provided. Charitable care, on the other hand, consists of services that are provided for which no payment is either demanded or expected. The costs of covering these expenses translates to an estimated increase of \$1000 to each family insurance policy.

Benefit Buy Down – In order to combat high health insurance costs, many small businesses who wish to provide health insurance to their employees have utilized a method of essentially paying their employees to accept plans with reduced benefits. For example, an employer can decide to purchase a health plan for his employees with a high deductible of \$1500 as opposed to providing a plan with a deductible of \$750. This move will save the employer a significant amount of money each month on health insurance costs. Now, he passes some of this savings on to his employees by providing them with an account administered by a third party who will reimburse them for health care costs incurred after the employee spends \$750 until their deductible is met. This in essence creates a situation where the employee still realizes a \$750 deductible and the employer realizes a reduction in health insurance costs, literally by buying down the deductible. This term can also be used to describe a policy where the employer reduces the richness of the benefit package (eliminates portions of coverage such as physical therapy, prescriptions or mental health services) to reduce the costs associated with purchase of the plan.

C *apitation* – Capitation is a fixed payment made to a medical provider based on a unit of time rather than the complexity or number of services provided. A provider (physician or health organization) is paid a set amount of money for the year with the understanding that they will provide services to the patients covered under their plan regardless of the number of services utilized. Managed care organizations have used this method of reimbursement as a means of risk sharing with the physician or other entity. In order to prevent the physician from providing substandard care, managed care organizations police the quality and utilization of services provided by the physician and often link what they deem appropriate behavior to financial incentives

paid to the. The intent of capitation is to incentivize the provider to reduce the costs associated with providing care to a pool of patients.

COBRA—COBRA allows an employee to purchase insurance for himself and family at 102% of the cost of coverage (average \$10,000 for family of four). Employees must have had a "qualifying event" that causes them to lose coverage including involuntary layoffs or termination. A qualifying employer is one with 20 or more employees. The American Recovery and Reinvestment Act (ARRA) includes a 65% subsidy for COBRA premiums after involuntary termination. COBRA is named for the Consolidated Omnibus Budget Reconciliation Act of 1985.

Coinsurance – Coinsurance is the practice of splitting the cost of medical services between the insurer and the insured. A common ratio is 20% borne by the insured and 80% by the health plan. However, more health plans are shifting the co-insurance to a 50:50 ratio. The co-insurance begins after the deductible has been paid. This percentage is in effect until a maximum dollar amount is reached at which time the insurer will assume 100% of costs.

Community Rating – Laws have been enacted in several states that require insurers to accept all applicants for coverage regardless of health status and charge the same premium for a given community. These premiums are based on a community rating of the region's health and demographic profile. This eliminates the practice of utilizing risk assessment to determine the premiums charged to enrollees.

Connector or Health Insurance Exchange – Connectors are purchasing pools that work to allow private insurance plans to compete for the individual's business. They allow people to compare multiple insurance plans directly, purchase a plan that fits their particular needs, and to bring several sources of funding to the table for purchase of insurance products (employer contribution, state supplemental payment and personal assets). It is a way for the state to streamline asset tests if they are needed for benefit determination.

Excellent resource to understand the Massachusetts Health Plan through the Commonwealth Fund:

<http://www.commonwealthfund.org/Publications/View-All.aspx?topic=Health+Insurance&sort=date&page=1>

Co-pay – A co-pay, or copayment, is a means of cost sharing utilized by insurance companies. This is a flat dollar amount paid directly to the provider by the insured individual for medical services rendered at the time of their visit.

Crowd-Out – Crowd-out is a situation that occurs when individuals who have been privately insured drop their coverage in favor of government provided public programs that are created to extend coverage to the underinsured or uninsured. This can either be through individual choice, or through employer reduction in their contribution toward employees' health insurance which will prompt individuals to seek these subsidized government programs. This can create a situation where private insurers have less of a coverage pool to draw from when paying out claims and therefore must increase premiums, thereby pricing themselves out of the market. In this case, the government is "crowding-out" private insurers as more individuals opt for taxpayer subsidized insurance. This was seen with the advent of Medicare Part D.

DSH (Disproportionate Share Hospital) Funding – Disproportionate Share Hospital Funding was designed to assist hospitals who had a disproportionate number of low-income patients due to serving a low income population. This funding has become a significant source of income for hospitals that serve the United States' poorest regions. In order to qualify for assistance, the hospital's disproportionate patient percentage is calculated, and if the hospital is above a given threshold, they qualify for a Medicare DSH adjustment. Another method for eligibility is to get an alternate special exemption by having more than 100

beds and 30% of inpatient revenue derived from state and local government sources other than Medicare or Medicaid.

Dual Eligibles – Dual Eligibles are individuals who are able to receive Medicare Part A and/or B benefits in addition to Medicaid benefits. State Medicaid pays the deductible, premiums, and co-insurance for Part A/B and sometimes Part D. When people are dual eligible, benefits derived from Medicaid supplement those covered by Medicare. Services that are covered by both programs are first paid by Medicare with the remainder paid by Medicaid, up to the state limit.

EMTALA – This piece of legislation was designed to prevent hospitals from transferring, discharging, or refusing to see patients because of high costs or inability to pay. This act requires Medicare participating hospitals that provide emergency services to give a medical screening exam to individuals seeking medical care, to treat and stabilize the emergency medical problem, and prevents transfer until either the patient is stabilized or several conditions are met to ensure appropriate transfer.

Federal Match or Federal Drawdown (FMAP) – The federal government provides matching funds for state expenditures on assistance payments for social services like Medicaid and SCHIP. The formula takes into account the personal income of state residents (states like Mississippi have lower personal income and get a higher match from the Federal government). This has been adjusted up recently to provide more income to the states. The FMAP for Missouri has recently been adjusted from 63% to 74% based on our unemployment rates. This allows states to reduce the percentage of each enrollee’s costs and makes it possible for states to maintain their Medicaid coverage in difficult times.

Federal Poverty Level - The federal poverty levels are used primarily for statistical purposes and are updated each year by the Census Bureau. The poverty guidelines are issued yearly by the Department of Health and Human Services and are used for administrative purposes, like the determination of eligibility of individuals for federal programs like Medicaid and SCHIP. Often eligibility determinations are expressed as a percentage of the FPL. For example, In Missouri, custodial parents are covered up to a family income of 19% of the FPL or \$350 of income per month. To calculate your income go to <http://www.safetyweb.org/tools/fplcalc2009.asp>

2009	
Persons in family	Annual income to equal 100% of Federal Poverty Guideline
1	\$10,830
2	14,570
3	18,310
4	22,050

Federally Qualified Health Centers (FQHC) or Community Health Centers – These are non-profit corporations whose mission is to provide quality health care and cost effective treatment to underserved areas of the U.S. and to the uninsured. These entities are funded via state and federal grants, Medicare/Medicaid payments, and private insurance. Uninsured patients are charged on a sliding scale. Swope Health Services and Samuel Rodgers are FQHC clinics serving Kansas City.

Fee-for-Service – Fee for service plans are insurance plan in which the physician or hospitals are reimbursed by the company for each service rendered to the patient. These types of plans often allow patients a great deal of flexibility in choosing their physician or hospital, however, they are often the most expensive plans available. **Bundling** is the approach to charge for a diagnostic unit of care (entire costs associated with an episode of pneumonia that requires hospitalization) rather than each visit or charge associated with it (hospital room fee, each doctor visit, physical therapy visit, medication, supplies etc).

Go-Bare Period – The go-bare period is a fixed duration of time during which an individual must remain uninsured before enrolling in a public insurance. This is often a period required by law in certain states unless the individual has recently lost a job where they have had employer-sponsored health insurance. These rules were created to prevent people from dropping their individual coverage in order to use governmental coverage.

Guaranteed Issue – Guaranteed issue plans must be issued to an individual, regardless of their health. This type of insurance is often strictly governed by law, requiring components like a fixed price or coverage of specific procedures. This type of coverage is issued by companies that specialize in high-risk plans or it is mandated to be provided by state laws.

Health Insurance Exchange – See *Connector*.

High-Risk Pool – High Risk Pools are programs created by the states to serve individuals who are medically uninsurable due to high risk. These people have been denied health care due to a serious health condition, are ineligible for Medicare/Medicaid, or cannot afford the high premiums associated with private coverage. The states create a pool which charges premiums to individuals; however, these premiums cannot cover the high level of claims that are leveled against the pool. The difference is made up by public or private industry in order to keep the pool viable. The High Risk Pools may have waiting lists and individual premiums may still be quite high. Some states have a lifetime benefit for High Risk Pools. <http://www.mhip.org/>

Individual Mandate – The individual mandate has been proposed as a potential solution for dealing with the uninsured in the United States. Individual mandates require that an individual have a minimum level of health insurance either through an employer, an individual plan, a purchasing pool, or a public program like Medicare/Medicaid. The idea behind this policy is that everyone would have a base insurance coverage and risk would be spread across a larger pool of healthy individuals. The other intent is to remove the cost sharing for uninsured individuals.

Medicaid Spend Down – Medicaid spend down is a means to allow individuals who have an annual income in excess of the maximum allowed to participate in Medicaid to participate in the program. For Missouri, those who are determined to be disabled are eligible for Medicaid benefit but it does not “turn on” unless they have an income of less than 85% of the Federal Poverty level. For a single person this is \$770 per month. For those above that level, they can either take whatever amount of money they make above that level and pay it to the State in the form of a premium or can spend that amount on medical related expenses and submit these receipts every month to the State. When a patient has been disabled for 24 months, they qualify for Medicare benefits.

Medical Home – A medical home is a concept that focuses on developing a personalized relationship between the patient’s chosen personal physician and the patient to provide patient-centered care. In this system, the patient can choose whatever physician or specialist they wish, but their primary physician will have a comprehensive knowledge of the patient’s medical conditions and will facilitate and coordinate among providers.

**Very good description at the American Academy of Family Practice website http://www.aafp.org/online/etc/medialib/aafp_org/documents/about/pcmh.Par.0001.File.dat/PCMH.pdf

Medical Loss Ratio – The medical loss ratio is the fraction of revenue generated by insurance companies that goes to pay for medical services. This is often used as a measure of the firm’s profitability and competitive place

in the market. It ranges from 75% for efficient, profitable companies to 100% for money-losing plans for firms that are not going to be viable in the long term .

Medical Underwriting – Medical underwriting is a practice used by insurance companies to predict how likely a covered individual will be to file a claim. Insurance firms will utilize information provided by you in an application, past medical and family history, or information garnered from private companies like the Medical Information Bureau to assess risk. Based on this information, the insurance companies will modify benefits, exclude coverage for a specific problem, change premium costs, or deny coverage entirely.

Medicaid – Medicaid is a program that funds health care services for low income special populations (children, pregnant women, aged, blind and disabled). It does not generally cover “able bodied” adults who have medical illness. It is jointly funded by state and federal contributions. There are some co-payments required of patients. Medicaid is the largest funder of nursing home services in the United States. In Missouri, Medicaid is called MO Healthnet. Missouri Medicaid Basics Brief: <http://www.mffh.org/medicaidbasics09.pdf>

Medicare – Medicare was created with the Social Security Act of 1965. Medicare is available to those who have paid into the system for a defined period of time (40 quarters of employment) or have been married to someone who has done so. Medicare benefits are available to those declared permanently disabled after a waiting period of 24 months (unless in need of dialysis or with a diagnosis of Lou Gehrig’s disease). The program is administered by the Centers for Medicare and Medicaid (CMS). 25% of the costs of the program must be covered by beneficiary premiums.

Medicare Part A – Medicare Part A is governmentally provided insurance that covers inpatient care in hospitals, critical access hospitals, nursing homes, and skilled nursing facilities. Because taxes were paid to Medicare while working (at least 40 quarters), most individuals are not charged a premium for Part A services. If worked less than 40 quarters, there is a premium. Patients are still responsible for a portion of hospitalization which goes up the longer the stay lasts. There is a lifetime cap on the number of days in hospital.

Medicare Part B – Medicare Part B is governmentally provided insurance that covers many of the services that Part A does not, such as preventative care, outpatient care, and medically necessary doctor’s services. Most individuals have to pay a premium for Part B (2008 \$96 per month which will go up to \$120 per month in 2011, usually taken out of the person’s Social Security check); however there are state programs that will help pay for premiums and deductibles for low income individuals (Missouri aged qualify when income is less than 100% Federal Poverty level).

Medicare Part C (Medicare Advantage) – As a part of the Balanced Budget Act of 1997, Medicare Part C was created as an alternative to Parts A & B. These plans are provided by private insurance companies and must at a minimum provide for what is covered under Parts A & B. Since these plans are provided by private firms and must remain competitive, they often offer extra benefits as well as Part D prescription drug coverage. Some plans charge additional premium for the expanded benefits. When this plan was created in the Medicare Modernization Act of 2005, Congress agreed to pay for-profit insurers 12 percent more per beneficiary than regular Medicare would spend to cover the same people. This enhanced payment system is currently being examined in Congress.

Medicare Part D – As a part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Medicare Part D was created to assist individuals in paying for prescription drug benefits. This portion of the Medicare program is optional and individuals who decide to participate can choose from hundreds of Part D plans provided by private insurers. The plan pays for 75% of the costs of medications from \$295-\$2700. All costs above the \$2700 are covered by the beneficiary and referred to as the “doughnut hole.” Coverage resumes

when medication costs exceed \$6154. There are considerations of making the Medicare Part D benefit subject to means testing.

Minimal Creditable Coverage—In several proposals regarding health reform, insurance companies must provide “basic” coverage as defined by a governing body. In Massachusetts, this is the Connector Oversight Board. Insurance companies are required to provide information about their products that allow direct comparison to coverage and cost to other insurance products.

Non-group market (individual market) – The non-group market consists of individuals purchasing health insurance for themselves. These people are often self-employed and, since coverage is not subsidized by employers, their purchases are highly sensitive to price. The benefits and premium ratings for this market are regulated by the states. Premiums in the non-group market are considerably higher than the group market.

Pay-or-Play – Pay or Play is a policy in which the government mandates that employers either provide health insurance to their employees or pay a penalty. The penalty is assumed to offset the costs incurred to the government in order to provide healthcare for the uninsured individuals and to maintain employer-based coverage.

Pent-up Demand – Pent-up demand is an exceptionally strong market force that develops after a period of time in which conditions have suppressed the availability of product or service. In states that have expanded health coverage like Massachusetts, they see a higher cost for the first few years of coverage to satisfy the delayed care. Medicare sees high utilization in the first 2 years of coverage because of delayed care.

Premium Assistance – Premium assistance is financial help for low-income families to pay the individual contribution needed to enroll or stay enrolled in employer sponsored coverage.

Public Option—The public option refers to an insurance product that is offered by the government. This could be a specially designed insurance product or allowing the public the option to buy in to existing government programs such as Medicaid or Medicare.

Reinsurance – Insurance companies purchase reinsurance from other insurers to offset the risk assumed by the firm. Reinsurers do not pay policyholder’s claims, but rather reimburse insurers for claims that are paid. Self-insured companies keep in reserve what they think would be a reasonable amount to cover the needs of the employees. The reinsurance covers costs in excess of the reserves. States are considering regional or state wide Reinsurance plans to help small businesses control the amount of expenditures they may have.

State Children’s Health Insurance Program (SCHIP) -SCHIP was created by the Federal government to expand access to insurance for children. States administer the plan and can design it to be a part of the existing Medicaid system (with the same benefits) or a separate program to serve children above 100% of Federal Poverty Level (Medicaid eligible). States determine the benefit package. In Missouri, children are eligible up to 300% of the Federal Poverty level. Families must pay a premium that is based on income and have additional co-pays. <http://www.mffh.org/SCHIP.pdf>

Safety Net Provider – Safety Net Providers are health care providers whose mission is to deliver health care to individuals without regard to their ability to pay. These individuals are specifically the uninsured, Medicaid, or other patients who are considered vulnerable. Safety Net Providers are typically federal, state, and local community health centers/clinics; public hospital systems; and local health departments.

Small Group Insurance Market – The small group insurance market consists of firms with roughly 2-50 employees that purchase health insurance for the group as a benefit. These small groups are regulated by the state and subject to state benefit mandates and premium taxes.

Tax Credit—A tax credit can be either a recognition of early/partial payment of taxes due (only affects those who will pay taxes) or a state benefit that is paid to workers through the tax system. This can be designated for particular purpose such as purchasing health insurance. The tax credit is non-refundable meaning that it cannot reduce the tax rate to less than zero (requiring a net balance due to the tax payer). A tax credit is more valuable than a tax deduction because it is realized at its full value. A tax deduction will only reduce the amount of taxable income which translates to a benefit equal to the marginal tax rate (tax credit = 100% of the designated benefit amount whereas tax deduction is the amount X tax rate or \$100 x 35% or \$35).

Tiered Benefits – Tiered benefit programs are designed so that a base plan with minimal coverage can be purchased at a low cost. Then, several tiers of coverage are available for additional premiums and can be purchased at the individual's discretion. These plans were designed to help expand employer provided coverage. Critics of these plans feel that having this sort of tiered structure will, while working to expand base coverage, decrease the depth of coverage overall, especially with regard to chronic, expensive diseases.

Underinsured – This ambiguous term best describes individuals who are exposed to significant financial risk due to insurance coverage that is deemed inadequate. The problem with this notion is the fact that significant financial risk and inadequate coverage are determined arbitrarily, which can artificially inflate or deflate the number of people who can be considered underinsured.

Wrap-Around Benefits – Wrap-around benefits are provided via insurance plans that are purchased by individuals in order to cover premiums, co-pays, and services not provided for within their central plan. With regard to Medicare, wrap around policies provide not only the deductibles and co-pay sums that are not covered, but also for hospital and nursing home expenses once the Medicare pay-out limit has been attained.

www.kclinc.org



Learn about important community issues by visiting the LINC website! Here are some of the features that make it easier for you to keep track of what LINC is doing to help make your community a better place to live.

- **Video Library**
- **What's New**
- **Get Involved**
- **LINC Calendar**
- **Data and Maps**
- **E-News Sign up**
- **Caring Communities Sites**

