



Advocate's Health Care Glossary

❖ **Adverse selection**

Trend of people only purchasing insurance when they are sick and have significant expenses. Or, the separation of healthier individuals into some plans & sicker individuals into other plans; the result being that those with impaired health status and/or prone to higher benefit utilization may increased costs and/or reduced benefits.

Annual or lifetime benefit caps

The maximum amount health insurance plans cover claims for plan members during a one-year period (annual benefit cap) or throughout that individual's membership (lifetime benefit cap).

Community rating

Pure community rating requires insurers to set the same premiums for everyone, regardless of age, health, gender or other factors. Adjusted community rating likewise prohibits insurers from varying premiums based on health status or claims history, but does allow insurers to vary rates based on factors such as geography, age & family composition.

Connector

Common marketplace of health insurance options for individuals.

❖ **Consumer Driven Health Plans** a.k.a. Consumer Directed

Slick marketing term for high-deductible plans and (possibly) tax-advantaged employer contributions to health reimbursement or savings accounts, may create serious problems for the U.S. health care system. HSA's penalize the sick, discourage needed care (especially primary and preventive care), direct tax subsidies towards the wealthiest, add further bureaucratic costs & complexity to health care financing.

Crowd-out

The idea that publicly financed health coverage prompts employers and individuals to drop private insurance in order to enroll in public programs.

Cycle of Burden

Without access to care the sick get sicker. It's hard to care for one's self and family when you can't work due to illness. Families are forced to seek assistance.

DSH (Disproportionate Share Hospital) Funding

Funding (mainly from federal government, through Medicaid) to hospitals that serve a relatively large volume of uninsured & low-income patients.

❖ **Direct-to-consumer advertising (DTCA)**

Marketing of prescription drugs directly to the public, especially via TV. US and New Zealand are only countries that do DTCA and there is concern such practice adversely impacts doctor-patient relationship and leads to over- and unnecessary prescribing of brand drugs.

ERISA (Employee Retirement Income Security Act of 1974)

Fed law governs employee benefit programs. General protections about benefits & disclosure of info. Prevents states from making laws that

directly regulate employer's health plans if the employer "self insures." Prohibits states from requiring employers to provide health benefits.

Federal match

Federal government "matches" states' contributions to Medicaid and SCHIP by at least 50%.

Fee-for-service

Health insurance plans that reimburse physicians and hospitals for each individual service they provide. These plans allow clients to choose any physician or hospital. Managed care is an alternative to fee-for-service.

Financial Assistance Policy (a.k.a. Charity Care)

Refers to medical facility policy to provide services to people who are unable to pay, particularly low-income and uninsured.

Formulary (or PDL, Preferred Drug List)

The list of drugs that a health plan will cover, either fully or in part. Formularies vary by health plan.

Fully insured plan

An employer that is "fully insured" enters into a contract with a health insurance company to handle health benefits for its workers. The employer pays premiums to an insurer, and, in exchange, the insurer pays health care claims and bears the risk for claims.

❖ **Generic Drug**

A chemically equivalent copy designed from a brand-name drug whose patent has expired, typically less expensive.

❖ **Go-bare Period**

Requirement that people remain uninsured for a period of time before they enroll in a public health insurance program, unless they have recently lost a job w/ employer-sponsored coverage.

❖ **Guaranteed issue**

Requirement that insurers sell insurance policies to anyone who seeks one, regardless of health, income, age or other factors.

❖ **Health Savings Accounts (HSA)**

Tax sheltered savings accounts coupled with high-deductible health insurance policies. Serious drawbacks: HSAs will increase out-of-pocket costs—and complexity.

Health Insurance

Financial protection against the medical care costs arising from disease or accidental bodily injury, with the greater good concept of that losses of a few are made good by contribution from many.

Health Insurance Portability and Accountability Act (HIPAA)

A federal law that prevents workers from being locked out of insurance or having to wait for coverage due to preexisting medical conditions. The law also prohibits insurers from discriminating against workers based on their medical history.

Tennessee Health Care Campaign (THCC)

1103 Chapel Ave., Nashville, TN 37206

Toll-free: 1-877-431-7083 • (615) 227-7500 • Fax: (615) 846-1946 • Web site: www.thcc2.org

Susan McKay, Director of Communications & Development, Email: smckay@thcc2.org



Tennessee Health Care Campaign

Working for Guaranteed Affordable Choices

High-risk pool

Usually, a nonprofit association created by a state to provide health insurance for people with preexisting health conditions.

Home & community based care (HCBC)

Formal services provided in home or community-based settings and paid for from either private and/or public funds.

Hospital Accountability

Concept that hospitals receiving tax breaks and/or public funding should have open (transparent) & standard policies concerning such things as type financial assistance & care provided to the uninsured & under-insured & easy public access to such info.

Mandate, Individual and/or Employer

Law requiring all residents to obtain health insurance, either individuals to get it for themselves, or employers to provide it, or a combo of both.

Managed care organizations (MCOs)

System of health service delivery and financing that coordinates the use of health services by its members, designates covered health services, provides a specific provider network, directs use of medical care services using a monthly captivated payment.

Medical home

A primary care practice where a patient's health history is known, and where a patient routinely seeks medical care.

Medically indigent

People who cannot afford needed care because of insufficient income or lack of health insurance.

Never Events

New term for preventable disease, such as measles.

Non-group market (individual market)

Health insurance market that can be bought directly from an insurer, rather than through a group (such as an employer).

Non-profit plans

Insurance plans which cannot sell shares of stock and which must operate in the interest of the public good. In return, they often receive a tax benefit.

👉 Pay for Performance

Pay-for-performance changes reimbursement methods to reward providers for providing higher quality and efficient care.

👉 Pay or play

Policy that provides employers the choice of whether to "play" by providing health care benefits to their employees or "pay" by paying money to the state.

👉 Premium assistance

The use of public funds to purchase (or subsidize the purchase of) private insurance.

👉 Public good

Benefits of the good are indivisible and individuals cannot be excluded. A good or service whose benefit may be provided to a group at no more cost than required to provide for one person. Example, small pox vaccine for all, not just those who can pay.

Reinsurance

Insurance for insurance companies. A primary insurance company transfers risks of high cost claims to another private carrier or to a government-sponsored program, which assumes risk.

Section 125 Cafeteria plans

Allow employees to set aside pre-tax dollars for health benefits even if the employer does not contribute to the employee's premium. Some states require certain businesses to establish cafeteria plans so that workers will be able to pay for premiums with pre-tax dollars.

Self-insured plan

Employer assumes the financial risk of covering its employees, paying medical claims from its own resources.

👉 Self-pay patients

Uninsured or under-insured who must pay out-of-pocket for services.

State-mandated benefits

In order to sell health insurance, insurers must cover certain services and providers, which vary by state.

👉 TEFRA (a.k.a. "Katie Beckett option")

Allows states to cover home and community based care for disabled children who are not in residential programs. Eligibility depends upon the level of disability and care needed by the child, rather than the family's income. Under this option, states can avoid institutionalizing children in skilled nursing facilities.

Uncompensated care

Funds used to pay for physician or hospital services when no payment is received from the patient or from insurance. Sometimes, uncompensated care is defined to include costs that come from cost-shifting or bad debt, as well as charity care; other times, uncompensated care is defined to exclude bad debt and only refer to care for people who are determined in advance to be in need of care at no charge.

👉 Underinsured

People whose insurance does not cover essential health care services, leaving them with out-of-pocket expenses that exceed their ability to pay.

Wrap-around benefits

Medicaid, as a secondary insurer, is able to pay for benefits not covered by a private plan. This is often utilized in premium-assistance programs.

More terms @

www.communitycatalyst.org/projects/schap/glossary
www.uic.edu/sph/cade/abcmco/basics/gloss.html

Tennessee Health Care Campaign (THCC)
1103 Chapel Ave., Nashville, TN 37206

Toll-free: 1-877-431-7083 • (615) 227-7500 • Fax: (615) 846-1946 • Web site: www.thcc2.org
Susan McKay, Director of Communications & Development, Email: smckay@thcc2.org