

Glossary

ACRONYMS

The following list is a guide to some of the more common acronyms and abbreviations for health care agencies, terms and programs. A number of these acronyms and abbreviations are defined in the glossary.

- ACF** - Administration for Children and Families
- ADL** - Activities of Daily Living
- AHRQ** - Agency for Healthcare Research and Quality
- ALF** - Assisted Living Facility
- ALS** - Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
- ASO** - Administrative Services Only Agreement
- CAH** - Critical Access Hospital
- CBO** - Congressional Budget Office
- CCRC** - Continuing Care Retirement Community
- CDC** - Centers for Disease Control and Prevention
- CHC** - Community Health Center
- CMS** - Centers for Medicare and Medicaid Services
- COBRA** - Consolidated Omnibus Budget Reconciliation Act of 1985
- CPI** - Consumer Price Index
- CRS** - Congressional Research Service
- DME** - Durable Medical Equipment; Direct Medical Education Payment
- DRA** - Deficit Reduction Act of 2005
- DRG** - Diagnosis-Related Group
- DSH** - Disproportionate Share Hospital Adjustment
- EPSDT** - Early and Periodic Screening, Diagnostic and Treatment Services
- ERISA** - Employee Retirement Income Security Act
- ESRD** - End-Stage Renal Disease
- FDA** - Food and Drug Administration
- FEHBP** - Federal Employees Health Benefits Program
- FFS** - Fee-for-Service
- FMAP** - Federal Medical Assistance Percentage
- FPL** - Federal Poverty Level or Line
- FQHC** - Federally Qualified Health Center
- FY** - Fiscal Year
- GAO** - Government Accountability Office
- GME** - Graduate Medical Education Payment

HCBS - Home and Community-Based Services

HCFA - Health Care Financing Administration

HEDIS - Health Plan Employer Data and Information Set

HHA - Home Health Agency

HHS - Department of Health and Human Services

HI -Hospital Insurance Trust Fund

HIFA - Health Insurance Flexibility and Accountability Demonstration Initiative

HIPAA - Health Insurance Portability and Accountability Act

HMO - Health Maintenance Organization

HOA - Health Opportunity Account

HPSA - Health Professional Shortage Area

HRA - Health Reimbursement Arrangement/Account

HRSA - Health Resources and Services Administration

HSA - Health Savings Account

IADL - Instrumental Activities of Daily Living

ICF/MR - Intermediate Care Facility for the Mentally Retarded

IGT - Intergovernmental Transfer

IHS - Indian Health Service

IME - Indirect Medical Education Adjustment

IPA - Independent Practice Organization

JCAHO - Joint Commission on Accreditation of Healthcare Organizations

LTC - Long-Term Care

MA-PD - Medicare Advantage Prescription Drug

MCH - Maternal and Child Health

MCO - Managed Care Organization

MedPAC - Medicare Payment Advisory Commission

MEWA - Multiple Employer Welfare Association

MMA - Medicare Prescription Drug, Improvement and Modernization Act of 2003

MRDD - Mental Retardation and/or Developmental Disability

MSA - Medical Savings Account

MSP - Medicare Savings Program

NCQA - National Committee for Quality Assurance

NDEP - National Diabetes Education Program

NIH - National Institutes of Health

NP/RNP - Nurse Practitioner (Registered)

ONCHIT - Office of the National Coordinator for Health Information Technology

OMB - Office of Management and Budget

P4P - Pay for Performance

PACE - Program of All-Inclusive Care for the Elderly

PBM - Pharmacy Benefit Manager

PCCM/PCI/PCC - Primary Care Case Management, Initiative, or Clinician

PDP - Prescription Drug Program

PHS - U.S. Public Health Service

POS - Point-of-Service Plan

PPO - Preferred Provider Organization

PPS - Prospective Payment System

PSO - Patient Safety Organization

QALY - Quality-Adjusted Life Years

QIO - Quality Review Organization

QMB - Qualified Medicare Beneficiary

RBRVS - Resource-Based Relative Value Scale

RRB - Railroad Retirement Board

RVS - Relative Value Scale

SAMHSA - Substance Abuse and Mental Health Services Administration

SBHP - Small Business Health Plan

SCHIP - State Children's Health Insurance Program

SGR - Sustainable Growth Rate

SHIP - State Health Insurance Assistance Program

SLMB - Specified Low-Income Medicare Beneficiary

SMI - Supplementary Medical Insurance

SNF - Skilled Nursing Facility SSA - Social Security Administration

SSDI - Social Security Disability Income

SSI - Supplemental Security Income

STAR*D - Sequenced Treatment Alternatives to Relieve Depression

TANF - Temporary Assistance for Needy Families

TMA - Transitional Medical Assistance

TPA - Third Party Administrator

UPL - Upper Payment Limit

UR - Utilization Review

GLOSSARY TERMS

ACTIVITIES OF DAILY LIVING (ADL) - An index or scale which measures a patient's degree of independence in bathing, dressing, using the toilet, eating and transferring (moving from a bed to a chair, for example). Used to determine need for long-term care and eligibility for payments for care by insurers.

ACUTE CARE - Medical services provided to treat an illness or injury, usually for a short time. Contrast with Chronic Care.

ADMINISTRATIVE SERVICES ONLY (ASO) AGREEMENT - A contract typically between an insurance company and a self-funded plan or group of providers in which the insurance or management company performs only administrative services (billing, plan design, claim processing, marketing, for example) and does not assume any risk. Also see Self-Insurance.

ADVANCEABLE TAX CREDIT - A subsidy to help pay for health insurance that is available when the insurance premium is due, without having to wait until a year-end tax return is filed. Also see Tax Credit.

ADVERSE SELECTION - When a disproportionately high number of individuals in poorer than average health enroll in a health plan.

AMBULATORY CARE - Medical service provided on an outpatient basis (no overnight hospital stay, see glossary). Services may include diagnosis, treatment, surgery and rehabilitation.

AMYOTROPHIC LATERAL SCLEROSIS (ALS) - See Lou Gehrig's Disease

ANCILLARY CHARGE - The fee associated with additional services performed before, or secondary to, a significant procedure such as surgery. Ancillary charges are for services such as lab work, X-ray or anesthesia. Also, an additional patient charge above the copayment and deductible amount which the covered person is required to pay by the insurer.

ANY WILLING PROVIDER - A requirement - typically a state law - that a managed care organization must accept any properly licensed provider willing to meet the terms of a plan's contract, whether the organization wants or needs that provider. Often described by managed care groups as "anti-managed care" legislation.

APPEAL - A request for review of a denial of coverage of a particular medical service or inadequate payment for services already received. Medicare beneficiaries have the right to appeal in either of these circumstances, whether they are enrolled in traditional Medicare or in a Medicare health maintenance organization. Also see Grievance.

ASSISTED LIVING FACILITY (ALF) - A group residence offering 24-hour assistance to those who may need some help with activities of daily living (see glossary), but who do not need the level of medical and nursing care offered by skilled nursing facilities (see glossary).

ASSOCIATION HEALTH PLAN (AHP) - Health insurance arrangement sponsored by business coalitions and trade and professional associations. AHPs operate under states' insurance laws and regulations. Recent legislative proposals would regulate AHPs primarily under federal law. Also see Small Business Health Plan.

BALANCE BILLING - A provider's bill to a covered person for charges above the amount paid by the health plan or insurer.

BEHAVIORAL HEALTH SERVICES - Medical services encompassing mental health care and substance abuse treatment.

BIOSURVEILLANCE - Automated monitoring of health data sources of potential value in identifying trends that may indicate an emerging epidemic, whether naturally occurring or the result of bioterrorism.

BLOCK GRANT - A lump sum of money given to a state or local government to be spent for certain purposes. Normally, it is based on a formula, the objectives are broadly defined and the grant's source places relatively few limits on the money's use.

BUNDLING - The use of a single comprehensive charge for a group of related health services. Contrast with Unbundling.

CAP - See Out-of-Pocket Cap

CAPITATION - Method of payment for health services in which a health care provider is paid a fixed amount for each person on the provider's patient roster, regardless of the actual number or nature of services provided to each person.

CARRIER - An entity which may underwrite or administer a range of health benefit programs. May refer to an insurer or a managed health plan.

CARVE-OUTS - A payer strategy in which an HMO or insurance company isolates ("carves out") a benefit and hires another organization to provide this service. Common carve-outs include behavioral health and prescription drugs. The technique is intended to allow the insurer to better control its costs.

CASE MANAGEMENT - A process where a health plan identifies covered persons with specific health care needs, then devises and carries out for them a plan to achieve the best patient outcome in the most cost-effective manner.

CASE MIX - The mix of patients treated within a particular institutional setting such as a hospital or under a particular health plan. Case mix may be measured by the severity of patients' illnesses or the prospective use of care resources.

CASE MIX ADJUSTMENT - Change in payment to a health plan or provider to avoid overpaying or underpaying where health status or likely use of services varies from average.

CASH AND COUNSELING - A Medicaid long-term care waiver demonstration program that allows certain Medicaid beneficiaries to purchase their own personal care and related services. Medicaid provides a monthly allowance, the amount of which is determined after assessing the beneficiary's need for community-based long-term care services. Starting in 2007, states may implement similar capped programs covering costs of self-directed personal care services without a waiver. For more information, see Chapter 7, Long-Term Care.

CATASTROPHIC HEALTH INSURANCE - Health insurance which provides protection against the high cost of treating severe or lengthy illnesses. Such policies cover all or most of medical expenses above a relatively high specified amount.

CATASTROPHIC ILLNESS - A very serious and costly condition that could be life threatening or cause life-long disability and which often involves severe financial hardship.

CATEGORICAL ELIGIBILITY - Medicaid's eligibility pathway for individuals who can be covered. The program's 25+ categories can be organized into five broad groups - children, pregnant women, adults in families with dependent children, individuals with disabilities and the elderly. Certain individuals, notably single adults without children, cannot qualify for Medicaid, even if their incomes are low enough to meet financial eligibility standards. For more information, see Chapter 6, Medicaid.

CENTERS OF EXCELLENCE - Health care facilities selected to deliver specific services, often exclusively, based on criteria such as experience, outcomes, efficiency and effectiveness.

CERTIFICATE OF NEED - The requirement that a health care institution obtain permission from an oversight agency before making major changes to its facilities or facility-based services.

CHERRY PICKING - The practice of insurance companies taking only those businesses or individuals that are good health risks, and avoiding businesses or people that have higher health risks. Also called skimming.

CHRONIC CARE - Medical services provided to those with chronic conditions. Contrast with Acute Care.

CHRONIC CONDITION - A condition that is not expected to improve, that lasts a year or longer or recurs, and may result in long-term care needs. Chronic illnesses include Alzheimer's disease, arthritis, diabetes, epilepsy and some mental illnesses.

CLAWBACK - Popular term for "phased-down state contribution" that describes how the federal government is recovering (or "clawing" back, from the states' perspective) money spent on Medicare-covered drugs for persons dually eligible for Medicare and Medicaid. Since January 2006, states have made monthly payments to the federal Medicare program, reflecting the amount of money they spent on prescription drugs for Medicaid-eligible seniors (known as dual eligibles, see glossary) before the enactment of Medicare Part D. Payments were set at 90% of costs in FY 2006, decreasing to 75% by FY 2015.

CLOSED PANEL/CLOSED ACCESS - A term that describes health plans in which enrollees are permitted to receive non-emergency services only through specified providers. Group- and Staff-Model HMOs (see glossary) are examples of closed panel plans.

COINSURANCE - A portion of the bill for a medical service, that is not covered by the patient's health insurance policy and therefore must be paid out of pocket by the patient. Coinsurance refers to a percentage, e.g., 10 percent of the total charge up to a specified maximum. Contrast with copayment, which is stated as a flat amount, e.g., \$5 per office visit.

COMMUNITY HEALTH CENTER (CHC) - Organization providing comprehensive primary care to medically underserved populations, regardless of their ability to pay. These public and non-profit entities receive federal funding under Section 330 of the Public Health Service Act, as amended.

COMMUNITY RATING - A method for setting premiums at the same price for everyone, based on the average cost of providing health services to all. The premium is not adjusted for the individual beneficiary's medical history or likelihood of using medical services. Contrast with Experience Rating.

CO-MORBIDITIES - Medical conditions that exist at the same time as the primary condition in the same patient (e.g., hypertension is a co-morbidity of many conditions such as heart disease, end-stage renal disease and diabetes).

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA) - This law includes one part which entitles former employees of companies with 20 or more workers to continue to receive coverage under the group plan for up to 18 months after leaving, if they pay the full cost of the coverage. For more information, see www.dol.gov/ebsa/newsroom/fscobra.html.

CONSUMER-DIRECTED OR CONSUMER-DRIVEN HEALTH PLAN - Includes plans that establish health spending accounts into which employers or individuals contribute pre-tax dollars to be used for health care purchases. These mechanisms aim to change employees from receivers of health care into purchasers by participating more fully in health care and cost decisions. Also see Health Reimbursement Arrangement and Health Savings Account.

CONSUMER PRICE INDEX (CPI) - A statistical measure of the annual change in cost to workers of purchasing a market basket of goods and services. It is expressed as a percentage of the cost of these goods and services during a base period. CPI is also known as retail price index or cost-of-living index.

CONTINUING CARE RETIREMENT COMMUNITY (CCRC) - Housing community designed to provide different levels of long-term care under contract. Services usually include home help, support in an assisted living facility and care in a nursing home.

CONVERSION PRIVILEGE - Right given to an insured person under a group insurance contract to change coverage, without evidence of medical insurability, to an individual policy upon termination of the group coverage. Conversion privileges are guaranteed to many workers under the Consolidated Omnibus Budget Reconciliation Act of 1985 (see glossary), and to others under the Health Insurance Portability and Accountability Act of 1996 (see glossary).

COPAYMENT - See Coinsurance

COST SHARING - Any out-of-pocket payment the patient makes for a portion of the costs of covered services. Deductibles, coinsurance, copayments and balance bills are types of cost sharing.

COST SHIFTING - The practice by which a seller of a health service, such as a hospital, increases charges for some payers to offset losses due to uncompensated or indigent care or lower payments from other payers.

CRITICAL ACCESS HOSPITAL (CAH) - Limited-service hospital located in rural areas and meeting certain size, location and other requirements. CAHs are subject to less rigorous staffing standards and receive reimbursement from Medicare based on their actual costs, rather than by the more common (and less favorable) payment tied to average costs for treating a particular diagnosis.

CROSS-SUBSIDY - The concept of certain purchasers paying more for medical services than they otherwise would so that others can pay less (or nothing at all), or another activity can be funded. In the U.S. health system, this mechanism has been used to pay for medical services for the poor and uninsured, medical education and research.

CROWD-OUT - A phenomenon whereby public programs or expansions of public programs designed to extend coverage to the uninsured encourage some employers to drop health coverage, urging their employees instead to take advantage of the expanded public subsidy.

CUSTODIAL CARE - Long-term care services which do not seek to cure, provided during periods when the medical condition of the patient is not changing or does not require continued delivery by medical personnel.

DEDUCTIBLE - A fixed amount, usually expressed in dollars in the form of an annual fee, that the beneficiary of a health insurance plan must pay directly to the health care provider before a health insurance plan begins to pay for any costs associated with the insured medical service.

DEFENSIVE MEDICINE - The practice of health care providers ordering tests that may not be necessary to over-protect themselves from potential malpractice lawsuits. Said to be a major cause of high health care costs.

DEFICIT REDUCTION ACT OF 2005 (DRA) - The DRA made significant changes to the Medicaid program - for example, allowing states to increase premiums and cost-sharing for families and to base benefits on private plans. The law also tightened long-term care asset transfers and capped home equity at \$500,000. A DRA provision effective July 1, 2006, requires Medicaid beneficiaries to show proof of citizenship upon applying for or renewing their benefits. For more information, see www.kff.org/medicaid/7465.cfm.

DEFINED BENEFIT - A health insurance model used by an employer or government program where specified health services covered under the plan are standardized and guaranteed. The cost of providing the standard benefits may fluctuate. One example of a defined benefit plan is Medicare. Contrast with Defined Contribution.

DEFINED CONTRIBUTION - A health benefit model used by employers or government programs where health services covered may fluctuate based on choice of plan, but the employer or government contributes a set amount (percentage or dollar amount) towards the purchase of the selected health plan. A defined contribution plan limits the financial liability of employers or the government, because the contribution is defined, or fixed. An example of a defined contribution plan is the State Children's Health Insurance Program (see glossary). Contrast with Defined Benefit.

DIAGNOSIS-RELATED GROUP (DRG) - A way of determining payments to hospitals, used under Medicare's prospective payment system (PPS) and by some other public and private payers. The DRG system classifies patients into groups based on the principal diagnosis, treatments and other relevant criteria. Hospitals are paid the same for each case classified in the same DRG, regardless of the actual cost of treatment.

DIRECT CONTRACTING - A method for providing health services to covered employees and their families, by group providers who contract directly with an employer, thereby cutting out "the middleman" or insurance carrier.

DIRECT GRADUATE MEDICAL EDUCATION PAYMENT - Medicare payment to approved teaching hospitals to help cover the direct costs of training residents to become board-eligible in their field. Hospitals receive full payments to help cover resident salaries, fringe benefits and compensation for attending physicians, for residents in their initial residency period (the minimum number of years required to qualify for board certification in that specialty for 5 years) and half payments for residents who have completed their initial training and are sub-specializing. Direct GME payments, which totaled approximately \$2.5 billion in fiscal year 2006, vary significantly among hospitals and depend on the number of residents at the hospital, the hospital specific per resident amount and the size of the hospital's inpatient Medicare population. For more information, see www.cogme.org. Also see Graduate Medical Education Payment and Indirect Medical Education Adjustment.

DIRECT-TO-CONSUMER (DTC) ADVERTISING - The use of mass media (television, newspapers, magazines, etc.) and other forms of reaching the general public. DTC advertising is often used by the pharmaceutical industry to promote their products. These advertisements must meet certain standards under federal regulations.

DISPROPORTIONATE SHARE HOSPITAL (DSH) ADJUSTMENT - An increased payment under Medicare's prospective payment system or under Medicaid for hospitals that serve a relatively large number of low-income uninsured patients.

DOUGHNUT HOLE - Coverage gap in Medicare Part D prescription drug coverage. Medicare pays 75 percent of the beneficiary's yearly drug expenses up to \$2,250, after which there is a gap in coverage - the doughnut hole. The coverage resumes when total prescription drug expenses reach \$5,100, after which Medicare pays for 95 percent of the beneficiary's prescription drug costs through the end of the year (See Chapter 5, Medicare Prescription Drugs, for details).

DRUG REIMPORTATION - See Reimportation

DUAL ELIGIBLE - A Medicare beneficiary who also receives either a full range of Medicaid benefits offered in his or her state, or help with Medicare out-of-pocket expenses. For more information, see www.cms.hhs.gov/DualEligible. Also see Qualified Medicare Beneficiary and Specified Low-Income Medicare Beneficiary in glossary.

DURABLE MEDICAL EQUIPMENT (DME) - Medical devices such as wheelchairs, oxygen tanks and apnea monitors.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT) - Comprehensive services states are required to provide to Medicaid-enrolled children who need them, including extensive services for children with disabilities. The Deficit Reduction Act allows states to restructure children's benefits to provide a narrower array of services for healthy children; however, states must continue to provide wrap-around EPSDT benefits. For more information, see www.cms.hhs.gov/MedicaidEarlyPeriodicScrn.

ELECTRONIC MEDICAL RECORD - A computer-based record containing health care information. EMRs may include clinical, demographic and/or administrative data. Also known as a computerized patient record.

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) - Enacted in 1974, ERISA was primarily designed to secure workers' pension rights. The law established federal reporting and disclosure requirements for most private employee health plans. Under ERISA, companies that pay for their workers' health benefits directly (e.g. by self-insuring and assuming all or most financial risk) are exempt from state insurance regulations and taxes. ERISA also limits workers' ability to sue their insurer. For more information, see www.dol.gov/dol/topic/health-plans/erisa.htm.

EMPLOYER CONTRIBUTION REQUIREMENT OR "EMPLOYER MANDATE" - A requirement that employers either provide health care benefits to their workers or pay a fee that contributes to the cost of covering their workers under a public (state) plan. Such proposals are also called "pay or play."

END-STAGE RENAL DISEASE (ESRD) - Kidney disease that is severe enough to require lifetime dialysis or a kidney transplant. People of all ages who have ESRD are eligible for Medicare.

ENTERPRISE LIABILITY - Proposal to hold hospitals or health maintenance organizations liable for negligent harm in medical malpractice cases, rather than holding individual physicians liable.

EVIDENCE-BASED MEDICINE - The use of current best clinical evidence in making decisions about the care of individual patients, often with the assistance of information technology. Patient preferences are considered along with clinical expertise.

EXPERIENCE RATING - Process of determining insurance premiums for a group that is based wholly or partially on that particular group's past use of services and expenses incurred. Contrast with Community Rating.

FAMILY CAREGIVER - Spouses, daughters and daughters-in-law, sons and other relatives and friends who volunteer to help with personal care, medication management and a range of household and financial matters. Sometimes referred to as "informal caregivers," they provide long-term care worth an estimated \$77 billion each year.

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (FEHBP) - Health care plans offered to federal civilian employees who can annually choose among a number of approved, community-rated private health insurance plans. The federal government pays a major portion of the cost of the coverage (on average 72 percent). For more information, see www.opm.gov/insure/health.

FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) - Percentage used to determine the amount of federal matching funds for state Medicaid expenditures. By law, FMAP cannot be less than 50 percent or exceed 80 percent. Slightly higher Enhanced Federal Medical Assistance Percentages are used to determine matching payments for SCHIP (see glossary). These payments cannot exceed 85 percent of the state's SCHIP expenditures. For more information, see <http://aspe.hhs.gov/health/fmap07.htm>.

FEDERAL POVERTY GUIDELINES - Income amounts set each February by the U.S. Department of Health and Human Services used to determine an individual's or family's eligibility for various public programs, including Medicaid and the State Children's Health Insurance Program. Sometimes called Federal Poverty Level/Line (FPL). (The poverty guidelines are different from the U.S. Census Bureau's "poverty thresholds," which are used for Census statistical purposes.) For the 2006 poverty guidelines, see <http://aspe.hhs.gov/poverty/06poverty.shtml>.

FEDERALLY QUALIFIED HEALTH CENTER (FQHC) - Facilities that have been approved by the government for a program to provide low cost health care. They include community health centers, tribal health clinics, migrant health centers, rural health centers and health centers for the homeless.

FEE-FOR-SERVICE (FFS) - A method of paying health care providers a fee for each medical service rendered, rather than - paying them salaries or capitated payments.

FIRST-DOLLAR COVERAGE - Insurance plans that provide benefits without first requiring payment of a deductible.

FIRST RESPONDERS - Firefighters, police officers, ambulance crews, doctors and other local emergency officials who are the first to respond to an emergency situation.

FISCAL INTERMEDIARY - A private contractor that pays hospital bills on behalf of Medicare.

FISCAL YEAR (FY) - The 12-month period used for calculating annual fiscal spending, which parallels the federal government's annual budget cycle. The U.S. government fiscal year runs from October 1 of the previous year to September 30 of the calendar year for which the fiscal year is numbered. States' fiscal years do not always correspond to the federal fiscal year.

FORMULARY - A list of selected pharmaceuticals and their appropriate dosages created by health insurance plans, which are usually intended to include a broad array of prescription drugs that are also cost-effective for patient care. Physicians are often required or urged to prescribe from the formulary developed by the insurance plans, pharmacy benefit managers or health maintenance organizations with which they are affiliated.

GATEKEEPER/CARE MANAGER - A healthcare professional, usually a primary care physician, who coordinates, manages, and authorizes all health services provided to a person covered by a health plan. Unless an emergency exists, the gatekeeper generally must pre-authorize referrals to specialists, hospitalizations and lab and radiology tests.

GRADUATE MEDICAL EDUCATION (GME) PAYMENT - Medicare payment to approved teaching hospitals to cover the costs of training residents. The GME payment comprises both the direct GME payment (see glossary), which pays for the direct costs of training residents, and the Indirect Medical Education Adjustment (IME, see glossary), which pays for the increased operating costs of a teaching hospital. Although IME and direct GME refer to Medicare payments, Medicaid is also a major funder of graduate medical education. For more information about GME, see www.cogme.org.

GRIEVANCE - A complaint filed because of dissatisfaction with the quality of care or customer service of a health plan. Medicare fee-for-service, Medicare health maintenance organizations (see glossary) and Medicare Part D prescription drug plans, as well as Medicaid and most other health plans, have formal procedures for handling and responding to grievances. If a Medicare beneficiary files a grievance against a hospital, a Quality Improvement Organization (see glossary) will review the case and guarantee the patient's stay, possibly free-of-charge, until the review has been completed. Also see Appeal.

GROUP INSURANCE - Health insurance offered through business, union trusts or other groups and associations. The policy holder is generally the employer or other entity. This system of health insurance is the most common in the United States.

GROUP-MODEL HMO - A health maintenance organization (HMO) that contracts with a single multi-specialty medical group to provide care for HMO members. The HMO compensates the group for contracted services at a negotiated rate, and that group is responsible for compensating its physicians and contracting with hospitals for care of their patients. Also see HMO, staff-model HMO and network-model HMO.

GUARANTEE ISSUE - A requirement that health plans cannot reject coverage for an applicant based on medical history. For example, under federal law, small employers that purchase health insurance cannot be denied coverage for sick workers. However, plans can adjust premiums based on medical history or other factors. Health plan policies that operate under a "guaranteed renewability" clause cannot cancel coverage due to a beneficiary's health status.

GUARANTEED RENEWABILITY - See Guarantee Issue -

HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY (HIFA) DEMONSTRATION INITIATIVE - A Bush Administration initiative to encourage states to apply for certain Section 1115 Medicaid (see glossary) and SCHIP waivers. HIFA waivers make it possible for states to offer private health insurance coverage or employer-sponsored coverage, with subsidies, as an alternative to enrolling beneficiaries in traditional Medicaid or SCHIP. For more information, see www.cms.hhs.gov/HIFA.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) - A 1996 federal law that provides some protection for employed persons and their families against discrimination in health coverage based on past or present health. Generally, the law guarantees the right to renew health coverage, but does not restrict the premiums that insurers may charge. HIPAA does not replace the states' role as primary regulators of insurance. HIPAA also requires the collection of certain health care information by providers and sets rules designed to protect the privacy of that information. For more information, see www.hhs.gov/ocr/hipaa/.

HEALTH MAINTENANCE ORGANIZATION (HMO) - A managed care plan that combines the function of insurer and provider to give members comprehensive health care from a network of affiliated providers. Enrollees typically pay limited copayments and are usually required to select a primary care physician through whom all care must be coordinated. HMOs generally will not reimburse all costs for services obtained from a non-network provider or without a primary care physician's referral. HMOs often emphasize prevention and careful assessment of medical necessity. See Group-Model HMO, Network-Model HMO and Staff-Model HMO.

HEALTH OPPORTUNITY ACCOUNT (HOA) - A type of health savings account for Medicaid beneficiaries created by the Deficit Reduction Act of 2005 (see glossary). States may deposit annual sums of up to \$2,500 per adult and \$1,000 per child into the account, to be used to pay for medical expenses not covered by the high deductible health plan with which the account is coupled. Beginning January 1, 2007, as many as 10 states can initiate HOA demonstration projects. Compare to Health Savings Account and Health Reimbursement Arrangement.

HEALTH PLAN EMPLOYER DATA AND INFORMATION SET (HEDIS) - A set of standardized measures of health plan performance allowing comparisons on quality, access, patient satisfaction, membership, utilization, finance and health plan management. HEDIS was developed by employers, health maintenance organizations (see glossary) and the National Committee on Quality Assurance.

HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) - A geographic area determined by the U.S. Public Health Service to have a shortage of physicians and other health professionals. Physicians who provide services in HPSAs qualify for a Medicare bonus payment or student loan forgiveness.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) - A type of health insurance plan also known as "health reimbursement account" or "personal care account," HRAs are tax-preferred accounts with funds established by employers to reimburse employees for qualified medical expenses; often HRAs are paired with a high-deductible health plan. An HRA may be used by an employee to pay for medical coverage until funds are exhausted. Once the deductible is reached, normal coverage begins. Any unused funds are rolled over at the end of the year, but do not follow the employee once he or she changes jobs. Compare to Health Savings Account.

HEALTH SAVINGS ACCOUNT (HSA) - A type of health insurance plan similar to HRAs (see above), but which is owned by workers. An HSA is a tax-preferred savings account and is paired with a high-deductible health plan. Any employer can offer an HSA (or a self-employed individual can set one up on his or her own), and both employers and employees can contribute to it. The worker must pay for all services until the amount of the deductible is reached (in 2006, a minimum of \$1,050 for an individual and \$2,100 for family coverage). The worker can withdraw money from the HSA to pay for medical services under the deductible. Once the deductible is reached, normal coverage begins. Any unused funds are rolled over at the end of the year. Unlike HRAs, HSAs follow an employee when he or she changes jobs. Also see Health Reimbursement Arrangement and Medical Savings Account.

HIGH-RISK POOL - A subsidized health insurance pool organized by many states as a source of coverage for individuals who have been denied health insurance because of a medical condition, or whose premiums are significantly higher than the average due to health status or claims experience.

HOME AND COMMUNITY-BASED SERVICES (HCBS) - State-designed HCBS encompass case management, adult day care, home health aide assistance, personal care, assisted living services and respite care. Section 1915(c) of the Social Security Act permits the HHS Secretary to approve Medicaid waivers that allow for long-term care services to be delivered in community instead of institutional settings. The Deficit Reduction Act also created a new capped HCBS option that allows states to offer these services without having to obtain administrative waiver approval. See PACE program and Medicaid Section 1915 Waiver.

HOMEBOUND - Condition required to receive home health care services under Medicare and generally interpreted to mean that the beneficiary cannot leave home without excessive effort and does so only infrequently, for no more than 16 hours per month for non-medical reasons. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (see glossary) authorizes a demonstration project involving as many as 15,000 beneficiaries in three states, that aims to clarify and standardize the definition of homebound. For more information, see <http://aspe.hhs.gov/MITS/text/titleVII/702.html>.

HOME HEALTH CARE - Health services rendered in the home, including skilled nursing care, speech therapy, physical therapy, occupational therapy, rehabilitation therapy and social services. Medicare covers some home health care services if the beneficiary is homebound (see glossary) but does not require more than 35 hours of services per week. Medicaid pays for home health care services in 12 states.

HOME HEALTH AGENCY (HHA) - Health care provider organization that renders skilled nursing and health care services in the home. See Home Health Care and Homebound.

HOSPICE - An organization providing medical, emotional, spiritual and social help, often in the patient's own home, for those expected to live less than six months. Medicare pays for hospice care, including payment for non-curative prescription drugs not normally covered by Medicare.

HOSPITAL INSURANCE (HI) TRUST FUND

The Part A Medicare trust fund that pays for inpatient hospital services; skilled nursing facility care for up to 100 days following hospitalization; and some care from home health providers, hospices and rehabilitation facilities for the elderly and permanently disabled. Financed with a dedicated payroll tax, HI trust fund spending is projected to exceed incoming revenues in 2006, with cash flow deficits growing rapidly after 2010 as baby boomers retire. Also see Trust Fund.

HYDE AMENDMENT - A federal law first enacted in 1980, and attached to appropriations bills every year since, that prohibits the use of federal Medicaid funds for abortion, except for reasons of life endangerment.

INDEMNITY INSURANCE - A health insurance plan that pays providers on a fee-for-service basis for delivering health care. Consumers face very few restrictions on provider selection, but may have greater financial liability in the form of deductibles and coinsurance than in many managed care plans.

INDEPENDENT PRACTICE ASSOCIATION (IPA) - A physician organization which typically contracts with a health maintenance organization (HMO, see glossary) to provide services to the HMO's enrollees. The HMO usually makes capitated payments to the IPA, but the IPA may choose to reimburse its physicians on a fee-for-service basis. Physicians can contract with other HMOs and see other fee-for-service patients.

INDIRECT MEDICAL EDUCATION (IME) ADJUSTMENT - A Medicare payment supplemental to diagnosis-related group (DRG) payments for each beneficiary inpatient stay that is intended to compensate teaching hospitals for the various costs associated with running an academic health center that trains and employs large numbers of medical residents. Many teaching hospitals tend to treat sicker patients with less insurance coverage, requiring a more costly mix of staff, and may use more expensive and complex interventions. For more information, see www.cogme.org. Also see Graduate Medical Education Payment and Direct Medical Education Payment.

INPATIENT - A person who is admitted to a hospital, usually for 24 hours or more.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs) - Activities relating to independent living, which include preparing meals, keeping a budget, purchasing groceries, performing housework and using a telephone. IADLs refer to skills beyond basic self care, or activities of daily living (see glossary).

INSURANCE - A way of responding to the risk of an adverse event, such as having to pay large health care expenses, by spreading those risks among many people. Insurance provides a way to substitute a small, predictable payment (a premium) for the risk of having to make a large payment in the event of an uninsured accident or illness.

INTERGOVERNMENTAL TRANSFER (IGT) - Transfer of funds among or between different levels of government, including state-owned or operated facilities and local governments. The term is most often used in Medicaid, where transfers of non-federal public funds to the state Medicaid agency are used to draw down federal matching funds. States also use IGTs to draw down federal Disproportionate Share Hospital Adjustment and Upper Payment Limit funds (see glossary).

INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (ICF/MR) - An institution providing diagnosis, treatment or rehabilitation of individuals with mental retardation or related conditions. ICF/MRs provide a protected residential setting, ongoing evaluations, 24-hour supervision and health services. Under Medicaid, states may cover ICF/MR services.

LOCK-IN - Lock-in refers to the period of time an individual is required to, or agrees to, remain registered with a particular provider or group of providers, or remain enrolled in a particular health care plan.

LONG-TERM CARE (LTC) - Ongoing health and social services provided for individuals who need continuing assistance with activities of daily living and/or instrumental activities of daily living (see glossary). Services can be provided in an institution, the home or the community, and include informal services provided by family and friends as well as formal services provided by professionals or agencies. Medicaid is the primary payer of LTC services in nursing homes.

LOSS RATIO - The ratio of money paid out by an insurer for claims divided by premiums collected for a particular type of insurance policy. Low loss ratios indicate that a small proportion of premium dollars was paid out for benefits, while a high loss ratio indicates that a high percentage of the premium dollars was paid out.

LOU GEHRIG'S DISEASE - A fatal neurological disease also called Amyotrophic Lateral Sclerosis, that attacks the nerve cells, gradually causing them to degenerate, and leads to a loss of muscle control. Most patients lose their ability to breathe on their own within 3-5 years of the onset of symptoms. Persons found to be eligible for Social Security cash disability benefits (SSDI, see glossary) because of this disease can qualify for Medicare services immediately, without waiting the usual two years following receipt of SSDI.

MANAGED CARE ORGANIZATION (MCO) - A health care organization, such as a health maintenance organization (HMO) or preferred provider organization (PPO), that contracts to provide medical services to a group of enrollees in exchange for capitated monthly premiums. Payments to physicians and other practitioners in HMOs are often lower than fee-for-service payments. Medicare Advantage includes HMOs, preferred provider organizations (PPO) and regional PPOs (see glossary).

MANDATE - Used in two senses in health policy discussions. (1) Employer or individual mandate, in which the government imposes a requirement on some or all employers to help pay for insurance coverage for their workers (and perhaps their families), or on individuals to obtain coverage. (2) State mandate, a requirement imposed by states on insurance companies to include, as part of any health insurance policy they sell, coverage for a specific service, such as well baby care, or provider, such as psychologists or optometrists.

MARKET BASKET INDEX - An index of the annual change in the prices of a selection of goods and services providers used to produce health services. Also referred to as an input price index.

MEANS-TESTING - Determining eligibility for government benefits based on an individual's lack of means, as measured by income and/or assets. Under Medicaid, means-testing differs for different eligibility groups (see Categorical Eligibility). The Medicare Prescription Drug Improvement and Modernization Act of 2003 (see glossary) introduced means-testing in Medicare, which now sets higher premiums for higher-income seniors and provides more generous drug benefits to lower-income beneficiaries.

MEDICAID - Public health insurance program that provides coverage for an estimated 60 million low-income persons for acute and long-term care. It is financed jointly by state and federal funds (the federal government pays at least 50 percent of the total cost in each state), and is administered by states within broad federal guidelines.

MEDICAID 1115 WAIVER - Under Section 1115(a) of the Social Security Act, the Secretary of Health and Human Services may waive most provisions of Medicaid law for demonstrations "likely to assist in promoting the objectives" of the program. Under long-standing policy, these waivers must be cost-neutral. Demonstration waivers may be granted for research purposes, to test a program improvement, or investigate a new way of delivering services.

MEDICAID 1915 (b) AND (c) WAIVER - Under Section 1915(b) of the Social Security Act, the Secretary of Health and Human Services may waive any provision of Medicaid law that prevent states from limiting beneficiaries' ability to choose providers. Section 1915(b) waivers are often sought by states that hope to control costs through managed care. Under Section 1915(c), the Secretary can allow states to obtain matching funds for long-term care services provided to Medicaid beneficiaries in home and community-based settings. Waivers are effective for two years.

MEDICAL IRA - See Medical Savings Account

MEDICAL SAVINGS ACCOUNT (MSA) - A health insurance option consisting of a high-deductible insurance policy coupled with a - tax-preferred savings account. MSA policies, enacted in 1996, have been largely replaced by health savings accounts (see glossary).

MEDICAL UNDERWRITING - See Underwriting

MEDICALLY NECESSARY - Description of services or supplies required to preserve and maintain the health status of a patient in accordance with the area standards of medical practice. Whether or not medically necessary services are being denied to patients enrolled in some public and private managed care plans can be an issue of contention. To resolve these issues, many plans have appeals and grievance processes (see glossary).

MEDICALLY NEEDY - An optional Medicaid category in which states can cover individuals and families who qualify for coverage because of high medical expenses, usually hospital or nursing home care. To qualify, individuals must be categorically eligible and their monthly incomes minus accumulated medical bills must be below state income limits for the Medicaid program. This allows Medicaid coverage for people who have extensive health care needs but too much income to be eligible for Medicaid. Also see Spend-Down.

MEDICARE - Federal health insurance program for virtually all persons age 65 and older, and permanently disabled persons under age 65, who qualify by receiving Social Security Disability Insurance (see glossary).

MEDICARE ADVANTAGE - A part of Medicare designed to offer beneficiaries a choice of managed care and other private plan options, such as Medicare health savings accounts (see glossary). Also called Part C of Medicare (and formerly known as Medicare+Choice), Medicare Advantage encompasses health maintenance organizations (HMOs), preferred provider organizations (PPOs), Medicare HSAs, regional PPOs, and other options. Not all options are available in all areas.

MEDICARE ADVANTAGE PRESCRIPTION DRUG PLAN (MA-PD) - Medicare Part D prescription drug coverage that is sponsored by a Medicare Advantage plan.

MEDICARE+CHOICE - See MEDICARE ADVANTAGE

MEDICARE PRESCRIPTION DRUG, IMPROVEMENT & MODERNIZATION ACT OF 2003 (MMA) - Legislation signed into law in December 2003, that provides seniors and disabled individuals on Medicare with a prescription drug benefit, delivered through private stand-alone prescription drug plans or managed care plans integrating Part A and B benefits (Medicare Advantage, see glossary). The law expanded the array of Medicare managed care plans and changed payment methodologies. It also provided for an interim prescription drug discount card program to help pay for prescription drugs until Part D began operations in January 2006. For more information, see www.kff.org/medicare/med011604pkg.cfm.

MEDICARE SAVINGS PROGRAM (MSP) - The program provides assistance through Medicaid with Medicare premiums - and sometimes cost-sharing requirements - to Medicare beneficiaries of limited income and resources who do not qualify for full Medicaid benefits. The program encompasses QMBs, SLMBs (see glossary) and other groups of beneficiaries who need help with cost-sharing to access services. For more information, see www.cms.hhs.gov/DualEligible.

MEDIGAP INSURANCE/MEDICARE SUPPLEMENTAL INSURANCE - Medigap policies are sold by private insurance companies to fill "gaps" in fee-for-service Medicare. Except in Minnesota, Massachusetts and Wisconsin, there are 10 standardized policy designs, known as Plans A through J. Plans H, I and J include limited drug coverage. No new Medigap policies that include drug coverage are now being sold. Beneficiaries with existing Medigap policies that include drug coverage may maintain them if they wish. However, they may be subject to late enrollment penalties if they later want Part D drug benefits. For more information, see www.cms.hhs.gov/Medigap.

MORBIDITY - A determination of the incidence and severity of sicknesses and accidents in a well-defined class of persons.

MORTALITY - An actuarial determination of the death rate at each age as determined from prior experience.

MULTIPLE EMPLOYER WELFARE ASSOCIATION (MEWA) - A group of employers who band together for purposes of purchasing group health insurance, often through a self-funded approach. MEWAs are sometimes exempt from state benefit mandates, taxes and other regulations.

NATIONAL DIABETES EDUCATION PROGRAM (NDEP) - A joint effort of the CDC and the National Institutes of Health, NDEP supports communities, providers and worksites in educating individuals and families about pre-diabetes and diabetes prevention. For more information, see <http://ndep.nih.gov> or www.cdc.gov/diabetes/ndep.

NETWORK-MODEL HMO - A health maintenance organization (HMO) that contracts with more than one independent physician group to provide health services. The providers may see patients who are not members of the HMO. Also see HMO, Group-Model HMO and Staff-Model HMO.

NURSE PRACTITIONER (NP/RNP) - A registered nurse with advanced academic and clinical experience who diagnoses and manages most common and many chronic illnesses, either independently or as part of a health care team. A nurse practitioner provides some care previously offered only by physicians and in most states has the ability to prescribe medications.

ON LOK PROGRAM - A San Francisco project that uses an HMO model to provide all acute care and long-term care services needed by a frail elderly population at risk of nursing home placement. For more information, see www.dhs.ca.gov/director/OLTC/html/PACE.htm. Also see Program of All-Inclusive Care for the Elderly.

OPEN ENROLLMENT - The period of time during which health insurance coverage options are offered to a specified population, regardless of health status and without medical screening. Open enrollment periods are characteristic of some Blue Cross-Blue Shield plans and health maintenance organizations (see glossary), and all plans in the Federal Employees Health Benefits Program.

OPEN PANEL/OPEN ACCESS - A self-referral arrangement allowing health plan enrollees to see participating providers for specialty care without a referral from a primary care physician or other doctor.

ORGANIZED DELIVERY SYSTEMS - Networks of providers and payers that provide care and compete with other systems for enrollees. Systems may include hospitals, physicians and other providers and sites offering a full range of preventive and treatment services. Also known as coordinated care networks, community care networks and integrated health systems.

OUT-OF-POCKET CAP/MAXIMUM - An annual limit on how much the patient has to pay in deductibles, coinsurance and copayments. Medicare Parts A, B and C do not have an out-of-pocket cap, while Part D does: when total out-of-pocket prescription drug expenses reach \$5,100, Medicare begins to pay 95 percent of the beneficiary's drug costs through the end of the year. Also called a "stop-loss" provision.

OUTCOMES RESEARCH - Research that attempts to evaluate particular health services by tracking and analyzing clinical results (e.g., death, illness, ability to function) of various treatments.

OUTPATIENT - A person receiving medical services who has not been admitted to a hospital.

OUTPATIENT HOSPITAL SERVICES - Services provided to a hospital outpatient. They are covered by Part B for Medicare beneficiaries. For more information, see Chapter 4, Medicaid.

PARTIAL CAPITATION - An insurance arrangement where the payment made to a health plan is a combination of a capitated premium and a payment based on actual use of services. The proportions specified for these components determine the insurance risk faced by the plan. Sometimes called "ambulatory capitation."

PATIENT SAFETY ORGANIZATION (PSO) - An organization that works to improve patients' safety and quality of care, by developing and disseminating patient safety data. PSOs can be public, such as state health agencies that collect hospital data, or private, such as the Joint Commission on Accreditation of Healthcare Organizations, which evaluates and accredits nearly 15,000 health care organizations across the U.S.

PAY FOR PERFORMANCE (P4P) - A method of paying health care providers differing amounts based on their performance on measures of quality and efficiency. Payment incentives can be in the form of bonuses or financial penalties.

PAY OR PLAY - See Employer Contribution Requirement

PAYROLL TAX - A flat percentage tax collected on salaries and wages. A payroll tax of 7.65 percent on both employers and employees finances Social Security cash benefits and Medicare Part A hospital services. Of that 7.65 percent, 1.45 percent each, or a total of 2.9 percent of payroll with both employer and employee contributions, is allocated for Medicare.

PEER REVIEW ORGANIZATION (PRO) - See Quality Improvement Organization

PHARMACY BENEFIT MANAGER (PBM) - A company that contracts with insurers and employers to manage the prescription drug benefit for enrollees or employees. The vast majority of managed care plans (see glossary) use PBMs.

POINT-OF-SERVICE PLAN (POS) - A managed care plan (see glossary) that combines features of both prepaid and fee-for-service insurance. POS plan enrollees decide whether to use network or non-network providers at the time care is needed, but usually are subject to reduced coverage and larger copayments for using non-network providers.

POVERTY LEVEL - See Federal Poverty Guidelines

PRACTICE GUIDELINES/PARAMETERS - A statement of the known benefits, risks and costs of particular courses of medical action, developed to give physicians information about treatment alternatives.

PRE-EXISTING CONDITION - A physical or mental condition of an individual which is known to the individual before an insurance policy is issued. Insurers may choose not to cover treatment for such a condition, at least for a period, may raise rates because of it, or may deny coverage altogether.

PREFERRED PROVIDER ORGANIZATION (PPO) - A health care delivery system through which a number of providers contract to serve health plan enrollees on a fee-for-service basis at discounted fees. Providers agree to PPO discounts in the hope of gaining more patients. Patients may use any provider without a referral, in network or out, but have a financial incentive - for example, lower coinsurance payments - to use doctors on the preferred list.

PREMIUM - The cost of health plan coverage, not including any required deductibles or copayments.

PREMIUM ASSISTANCE - The use of federal funds available through public health coverage programs - especially Medicaid and SCHIP (see glossary) - to purchase or help purchase private insurance.

PREMIUM SUPPORT - A health benefit model that is considered by its designers to be a hybrid of the defined contribution and defined benefit approaches (see glossary). This model would require general categories of health services to be covered, but benefits could be added or deleted within limits. The employer or government would then contribute a set amount of the premium for the purchased plan. Plans could set premiums at whatever dollar level they choose, with beneficiaries liable for any costs above the employer or government contribution. A Medicare demonstration designed to test a model similar to premium support is scheduled to begin in 2010.

PREVENTIVE HEALTH SERVICES - Services aimed at preventing a disease from occurring, or preventing or minimizing its consequences. This includes care aimed at warding off illnesses (immunizations), at early detection of disease (Pap smears), and at stopping further deterioration (cholesterol-lowering medication).

PRIMARY CARE - Care at "first contact" with the health care system, including an array of non-specialist services provided by physicians, nurse practitioners, or physician's assistants - more simply, the care that most people receive for most of their problems that bother them most of the time.

PRIMARY CARE CASE MANAGEMENT, INITIATIVE, OR CLINICIAN - (PCCM/PCI/PCC) - A Medicaid managed care program in which an eligible individual may use services only with authorization from his or her assigned primary care provider. That provider is responsible for locating, coordinating, and monitoring all primary and other medical services for enrollees. Those services are usually paid on a fee-for-service basis.

PRIMARY CARE PHYSICIAN - A physician - general practitioner, family physician, pediatrician, some internists or OB/GYNs - who serves as the patient's first point of contact with the health care system and coordinates the patient's medical care.

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) - Originally a Medicare demonstration project that replicated the model of managed care developed by On Lok Senior Health Services in San Francisco, California. The Balanced Budget Act of 1997 expanded PACE into a national, permanent program and created a Medicaid PACE option. PACE targets frail community-dwelling elderly, most of whom are dually eligible for Medicare and Medicaid. Core services include adult day care, social support, home health, hospital care, nursing home care, and case management that integrates acute and long-term care services. PACE is financed through capitated Medicare and Medicaid payments to the provider. For more information, see www.cms.hhs.gov/PACE/. Also see On Lok Program.

PROSPECTIVE PAYMENT SYSTEM (PPS) - A method used by Medicare to pay for many services, including inpatient and outpatient hospital services as well as services provided at skilled nursing and rehabilitation facilities. Payment rates are linked to diagnosis and determined before services are rendered, rather than being based on actual costs or charges of a specific facility. Rates are intended to cover treatment costs for a typical patient with a given diagnosis and are adjusted for factors like wages and indigent care.

PROVIDER - Any health care professional or institution that renders a health service or provides a health care product. Major providers are hospitals, nursing homes, physicians and nurses.

PUBLIC CHARGE - A term used by immigration officials to describe someone who is dependent on the government for subsistence. Being classified as a public charge can damage an immigrant's ability to become a permanent resident, to leave and reenter the U.S., or even to remain in the country. Some immigrants do not enroll themselves or their children into health care programs such as Medicaid and SCHIP for fear of being labeled a "public charge," although receipt of SCHIP and most Medicaid services is not considered in determining public charge status.

PUBLIC HEALTH - The protection and improvement of population health by organized community effort. Public health activities are very broad and include immunization, sanitation, preventive medicine, disease control, education about reducing personal risks, occupational health and safety, pollution control, water safety, food safety, epidemiology, etc.

PURCHASING POOL - A group of people, businesses or associations who come together to enhance their bargaining power and negotiate lower premiums from health insurance plans than they could on their own, while also pooling risks across sick and healthy individuals.

QUALIFIED MEDICARE BENEFICIARY (QMB) - A person who is eligible for Medicare, has an income below 100 percent of the federal poverty level and has limited assets, is eligible to receive cost-sharing assistance if enrolled in the Qualified Medicare Beneficiary program. Under the QMB program, state Medicaid agencies are required to pay the cost of Medicare Part A and B premiums, deductibles, and coinsurance. For more information, see www.cms.hhs.gov/DualEligible.

QUALITY-ADJUSTED LIFE YEARS (QALYs) - Years of life saved by a medical technology or service, adjusted to reflect the health quality of those years (as determined by some evaluative measure). QALYs are the most commonly used unit to express results in certain cost-effectiveness analyses. A year of perfect health is considered equal to 1.0 QALY.

QUALITY REVIEW ORGANIZATION (QIO) PROGRAM - Under the Quality Review Organization Program, Medicare contracts with 53 QIOs, each responsible for each state, territory and the District of Columbia, to monitor hospital use and the quality of care received by Medicare patients. For example, QIOs examine and analyze hospital admissions of Medicare patients to assess the appropriateness of services, based on the severity of the patients' illness and the intensity of the services needed and received. For more information, see www.cms.hhs.gov/QualityImprovementOrgs.

RATING - The process of evaluating, or underwriting, a group or individual to determine a health insurance premium rate relative to the financial risk of needing healthcare the person or group presents. Key components of the rating formula include age, sex, location and plan design.

RATING BANDS - Amounts by which insurance rates for a specific class of insured individuals may vary. All states have laws regulating insurer rating practices, and many states periodically update these laws with small group market reform proposals to restrict or loosen allowable variations.

REFERRAL - A primary care doctor's written permission for a patient to see a certain specialist or to receive certain services. Required by some managed care health plans.

REFUNDABLE TAX CREDIT - A way of providing a tax subsidy to an individual or business, even if no taxes are owed (see glossary, tax credit). If a person owes no tax, the government sends the person (or a third party) a check for the amount of the refundable tax credit.

REIMPORTATION - The process by which individuals or groups purchase pharmaceuticals from other countries that were originally produced in the U.S. and exported for consumption abroad. Because many other countries have lower drug prices than the U.S., this process can save consumers money on drugs for personal use. Reimportation can occur either by traveling to another country to purchase drugs (e.g., driving to Canada), or by purchasing drugs over the Internet or by mail from foreign pharmacies. Though traditionally not the subject of law enforcement, most reimportation violates U.S. federal drug safety laws.

REINSURANCE/RISK CONTROL INSURANCE - See Stop-Loss

RELATIVE VALUE SCALE (RVS) - An index that assigns weights to each medical service; the weights represent the relative amount to be paid for each service. To calculate a fee for a particular service, the index for that service is multiplied by a constant dollar amount (known as the conversion factor). Medicare uses an RVS to calculate payments to physicians.

REPORT CARD ON HEALTH CARE - A tool for use by policymakers and health care purchasers to compare and understand the actual performance of health plans or providers. Provides data in major areas of accountability, such as quality and utilization, consumer satisfaction, administrative efficiencies, financial stability, and cost control.

RESOURCE-BASED RELATIVE VALUE SCALE (RBRVS) - The way Medicare determines how much it will pay physicians, based on the resource costs needed to provide a Medicare-covered service. The RBRVS divides the cost of providing services into three components: physician work, practice expense and professional insurance. The Medicare payment to physicians is determined by multiplying the combined costs by a conversion factor set by the Centers for Medicare and Medicaid Services, adjusted for geographical differences in the cost of resources. Physician work typically accounts for 50 percent of the value while practice expense accounts for 45 percent.

RESPIRE CARE - Short-term personal care given to a frail elder or person with disabilities to substitute for assistance usually provided by a family caregiver.

RISK - The probability of financial loss, relative to the probability of having to provide services to a patient or patient population at a cost that exceeds the payments received. Under capitation payment systems, providers share the risk that is borne by insurers.

RISK ADJUSTMENT - Increases or reductions in payment made to a health plan on behalf of a group of enrollees to compensate for health care expenditures that are expected to be higher or lower than average.

RISK SELECTION - Enrollment choices made by health plans - or by enrollees - on the basis of perceived risk relative to the premium to be paid.

RISK SHARING - A method by which the financial risk of covering a group of enrollees is shared by plan sponsors and purchasers, typically managed care organizations and states. In contrast, indemnity plans assume all risk of providing care paid for through insurance premiums which belong solely to the insurance company.

SAFETY NET PROVIDERS - Providers that have a primary focus of servicing low-income and uninsured people. They include community and migrant health centers and public hospitals. See community health center.

SECTION 1115 WAIVER - See Medicaid 1115 Waiver

SECTION 1915 (a) AND (b) WAIVER - See Medicaid 1915 (a) and (b) Waiver

SELF-EMPLOYED DEDUCTION FOR HEALTH INSURANCE - Self-employed taxpayers and their families can deduct all their payments for health insurance, including insurance premiums, when figuring their annual income for tax purposes, to the extent these payments exceed 7.5 percent of adjusted gross income.

SELF-INSURANCE - Large and medium-size companies often assume all or most financial risks of providing health insurance to their workers, as opposed to purchasing insurance coverage from commercial carriers (and having the carrier assume all risk). Claims processing is often handled through an administrative services contract with an independent organization, often an insurance company.

SEQUENCED TREATMENT ALTERNATIVES TO RELIEVE DEPRESSION (STAR*D) - Funded by the National Institute of Mental Health, STAR*D is the largest depression study in the U.S. and examines outcomes of a range of treatments aimed at helping depressed patients become symptom-free. For more information, see www.nmha.org/research/star/faqs.cfm.

SINGLE PAYER SYSTEM - A proposed reorganization of the health care system, either at the national or state level, which would designate one entity (usually the government) to function as the central purchaser of health care services. Canadian provinces operate health insurance coverage for residents under this system.

SKILLED NURSING FACILITY (SNF) - An institution that offers skilled services similar to those given in a hospital, such as intravenous injections and physical therapy given by professional staff, to aid rehabilitation following hospitalization of patients who have been discharged. SNFs differ from nursing homes or nursing facilities, which are intended primarily to support elderly and disabled individuals in the tasks of daily living (custodial care, see glossary). Medicare does not cover custodial care in nursing homes; however, Medicare does cover skilled nursing care, rehabilitation and associated custodial care in SNFs. Medicaid covers care in all Medicaid-certified nursing facilities.

SMALL BUSINESS HEALTH PLAN (SBHP) - Purchasing pools for small employers that have frequently been the subject of congressional proposals, SBHPs would include trade, industry and professional associations as well as 'cooperative' corporations or chambers of commerce. Known in other proposals as association health plans (see glossary), SBHPs have generated controversy because they would be exempt from some state laws regulating health insurance.

SMALL GROUP MARKET REFORM - Generally refers to laws, regulations and proposals that are designed to simplify rules for small employers (50 workers or fewer) purchasing health insurance. While most regulation of health insurance is done at the state level, the 1996 Health Insurance Portability and Accountability Act made some key reforms (see glossary).

SOCIAL SECURITY DISABILITY INSURANCE (SSDI) - Financed with Social Security taxes, SSDI provides assistance to people who are permanently disabled and unable to work, and who previously worked and paid Social Security payroll taxes. Although the number of work credits required to qualify for SSDI depends on the age of disability onset, one must typically have 40 credits, of which 20 must be from the last 10 years (four work credits can be earned per year). The size of the monthly benefit depends on the beneficiary's earnings record. Widows, widowers and adults who are blind or disabled since childhood are also eligible for SSDI.

SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (SLMB) - A person who is eligible for Medicare, has an income of between 100 to 120 percent of the federal poverty level and has limited assets, is eligible to receive cost-sharing assistance if enrolled in the Specified Low-Income Medicare Beneficiary program. Under the SLMB program, state Medicaid agencies are required to pay the beneficiary's Part B premiums, but not deductibles or copayments. Also see Qualified Medicare Beneficiary. For more information, see www.cms.hhs.gov/DualEligible.

SPEND-DOWN - Process by which individuals in many states can qualify for Medicaid because high medical expenses, usually hospital or nursing home care, reduce their monthly income to below state income limits for the Medicaid program. The amount that each individual must "spend down" is determined at the time eligibility is determined. Also see Medically Needy.

STAFF-MODEL HMO - A health maintenance organization (HMO) that delivers health services through salaried physicians who are employed by the HMO exclusively to care for HMO enrollees. Also see HMO, Group-Model HMO and Network-Model HMO.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) - A program enacted by Congress in 1997 that provides up to \$40 billion in federal matching funds for states to spend on health coverage for uninsured kids through September 2007. The program is designed to reach uninsured children whose families earn too much money to qualify for Medicaid but are too poor to afford private coverage. SCHIP reauthorization will be considered by the 110th Congress. For more information, see Chapter, Children's Coverage.

STATE HEALTH INSURANCE ASSISTANCE PROGRAM (SHIP) - A federal program that provides funding to states to provide Medicare beneficiaries and other consumers with free health insurance counseling and assistance. For more information, see www.cms.hhs.gov/Partnerships/10_SHIPS.asp.

STATE MANDATE - State coverage laws requiring private insurers to cover specific services (such as well-baby care) or reimbursement for specific providers (such as psychologists). The Employee Retirement Income Security Act generally exempts self-insured companies from these requirements.

STATE PHARMACY ASSISTANCE PROGRAM (SPAP) - State-funded program providing pharmacy benefits to seniors and other low-income groups. Before the enactment of Medicare Part D, 22 states funded SPAPs while 6 states operated waiver programs funded jointly by state and federal governments through Medicaid (see Medicaid 1115 Waiver). With Part D in operation, most states have begun providing wrap-around benefits to coordinate and ease the enrollment of their Medicare beneficiaries by, for example, covering deductibles, co-insurance or the gap in Medicare Part D coverage. For more information, see www.ncsl.org/programs/health/SPAPCoordination.htm.

STEM CELLS - Primitive cells derived from human embryos (embryonic stem cells) and some adult tissue (adult stem cells). They are undifferentiated cells, meaning they have the capacity to develop specialized functions when grown in the appropriate laboratory environment. Scientists create stem cell "lines," or cell cultures, used in disease research.

STOP-LOSS - See Out-of-Pocket Cap

SUPPLEMENTAL MEDICAL INSURANCE - Any private health insurance plan held by a Medicare beneficiary that is purchased to fill in "gaps" in traditional Medicare coverage, or to finance cost-sharing requirements, e.g., Medicare's hospital deductible. Among the most common types of supplemental insurance are some employer-sponsored retiree coverage and Medigap insurance (see glossary).

SUPPLEMENTAL SECURITY INCOME (SSI) - A federal income support program for low-income disabled, aged and blind individuals. Eligibility for SSI monthly cash payments does not depend on previous employment or contributions to a trust fund. Eligibility for SSI usually confers eligibility for Medicaid.

SUPPLEMENTARY MEDICAL INSURANCE (SMI) TRUST FUND - The Medicare trust fund that pays for physician procedures and treatments delivered in hospital outpatient departments, ambulatory surgical centers, and other non-hospital facilities; most home health care services; durable medical equipment such as wheelchairs; and the new prescription drug benefit. The SMI account is financed with beneficiary premiums (25 percent) and general revenues (75 percent).

SUSTAINABLE GROWTH RATE (SGR) - The Balanced Budget Act of 1997 established the formula for determining annual SGR targets for physicians' services under Medicare. The SGR is intended to control growth in total Medicare expenditures for physician services. If expenditures exceed the SGR target, the fee schedule update is decreased. Four factors are used to calculate the SGR: (1) average percent change in physician fees; (2) change in the average number of fee-for-service beneficiaries; (3) 10-year average annual growth in GDP per capita; and (4) change in expenditures due to new laws or regulations.

TAX CREDIT - A flat amount that can be subtracted from taxes owed. Under some health care reform proposals, tax credits would be given to moderate-income individuals/families to subsidize health insurance premiums. A tax credit is more progressive in its impact than a tax deduction of the same amount, since the value of a deduction is greater for those whose tax rates (and usually incomes) are higher.

TAX DEDUCTION - An amount that can be subtracted from taxable income if spent on a specific purpose. Currently, businesses and the self-employed can deduct the cost of health insurance provided to employees, but health expenses (including insurance) are a deduction for families with group health insurance only after they reach 7.5 percent of income.

TAX PREFERENCE (FOR HEALTH BENEFITS) - Employer-paid health benefits are treated under federal tax law as a deductible business expense for the employer, and excluded from taxable income for the worker. This creates incentives for some employers and workers to prefer extra compensation in the form of more health coverage rather than wages.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) - The block grant program that, in 1996, replaced categorical welfare assistance such as Aid to Families with Dependent Children. Under TANF, time limits are set for cash benefits, and recipients are expected to accept work or be enrolled in training programs. TANF was reauthorized in 2005 as part of the DRA with \$16.4 billion in annual funding through FY 2010. For more information, see www.acf.hhs.gov/programs/ofa/.

TERTIARY CARE - Health care services provided by highly specialized providers such as neurosurgeons, thoracic surgeons, and intensive care units. These services often require highly sophisticated technologies and facilities.

THERAPEUTIC SUBSTITUTION - Replacement of one drug with another drug from the same therapeutic class that the Food and Drug Administration has determined to be equivalent - the substitute has the same active ingredient with the same absorption rate as the original drug. Often, this results in prescribing the less costly compound.

THIRD PARTY ADMINISTRATOR (TPA) - A professional firm that provides administrative services to employers who want to self-insure their employees. The TPA does not underwrite the financial risk of providing coverage.

THIRD PARTY PAYER - Organization, public or private, that pays or insures medical expenses on behalf of enrollees. An individual pays a premium, and the payer organization pays providers' actual medical bills on the individual's behalf. Such payments are called third-party payments and are distinguished by the separation among the individual receiving the service (the first party), the individual or institution providing it (the second party), and the organization paying for it (third party).

TRADE ACT HEALTH INSURANCE SUBSIDY - Premium subsidy program that covers 65 percent of the cost of health insurance for early retirees, their families and other workers who have lost their employer-sponsored health coverage as a consequence of company failure due to trade practices or bankruptcy. The subsidy to former workers is provided in the form of a federal tax credit either to be claimed when the income tax return is filed, or sent directly to the beneficiary's health insurance provider each month, in which case he/she is responsible for paying only 35 percent of the monthly premium. For more information, see www.familiesusa.org/assets/pdfs/TAARA_Implement_Nov_2003.pdf.

TRANSITIONAL MEDICAL ASSISTANCE (TMA) - Medicaid coverage for up to one year for families leaving welfare to become self-supporting through work. During this transition period, states are required to continue Medicaid benefits even if earnings increase. For more information, see <http://openncrs.cdt.org/document/RL31698/>.

TRIAGE - The classification of sick or injured persons according to severity in order to direct care and ensure the efficient use of medical and nursing staff and facilities.

TRICARE - Program providing medical care to the dependents of active duty members of the military and to retired members of the military. Formerly known as the Civilian Health and Medical Program (CHAMPUS), the program is run by the Department of Defense. For more information, see www.tricare.org.

TRUST FUNDS - Federal trust funds are created in the U.S. Treasury to account for all program income, such as Social Security and Medicare taxes, and disbursements, such as benefit payments and program administrative costs. Revenues not needed in a particular year are invested in special non-marketable government securities; therefore, the trust funds represent the total value, including interest, of all prior program annual surpluses and deficits. There are two Social Security trust funds: the Old-Age and Survivors Insurance Trust Fund, which pays retirement and survivors benefits, and the Disability Insurance Trust Fund, which pays for disability benefits. There are also two Medicare trust funds: the Hospital Insurance (HI) Trust Fund, which pays for inpatient hospital and related care, and the Supplementary Medical Insurance (SMI) Trust Fund, which pays for physician and outpatient services. Medicare Part D prescription drug expenditures are paid out of the SMI Trust Fund. See HI Trust Fund and SMI Trust Fund in glossary.

UNBUNDLING - Separately billing for medical services that might otherwise be priced together ("bundling"). For claims processing, this includes providers billing separately for health care services that should be combined according to industry standards or accepted coding practices.

UNCOMPENSATED CARE - Care rendered by hospitals or other providers without payment from the patient or a government-sponsored or private insurance program. It includes both charity care, which is provided without the expectation of payment, and bad debt, for which the provider has made an unsuccessful effort to collect payment due from the patient.

UNDERINSURED - People with public or private insurance policies that do not cover all necessary health services, resulting in out-of-pocket expenses that often exceed their ability to pay.

UNDERWRITING - The process by which health insurers decide whether or not to accept an individual's application for insurance, and, if the applicant is accepted, what conditions to apply. Underwriting is also applied to small employers. If the insurer decides that a particular individual or group poses greater than normal financial risks, it might charge higher premiums, offer more limited benefits, or refuse to pay for services relating to a particular "pre-existing" condition.

UPPER PAYMENT LIMIT (UPL) - Federal regulatory payment limit governing what states can pay eligible public facilities for Medicaid services. The UPL is usually the rate Medicare would pay for the same service. In some cases, states request federal matching funds in amounts that exceed the state's standard Medicaid reimbursement rate, and use the new revenues generated for other goods or services. Also see Intergovernmental Transfer.

UTILIZATION REVIEW (UR) - An insurer's review of health care services - particularly specialist referrals, emergency room use and hospitalizations - to evaluate their appropriateness, necessity, and quality. The review can be performed before, during, or after care is delivered.

VOUCHER - In various health reform proposals, a certificate or fixed dollar amount that is provided to low- or moderate-income persons, which is used to pay all or part of the cost of health insurance or services.

