

GLOSSARY OF HEALTH CARE TERMS

209(b) - A section of the Social Security Amendments of 1972 that allows states to set Medicaid income eligibility standards that are more restrictive than a person's eligibility for the SSI program. Generally, if a person qualifies for SSI (which covers adults who are aged, blind, or disabled), a state must offer her full Medicaid coverage. In 209(b) states, SSI eligibility does not guarantee Medicaid eligibility (*see also SSI*.)

Actuarial Equivalence - As it relates to health insurance, this means that the dollar value of one benefit, such as a health insurance policy, is equal to the dollar value of another health insurance policy.

Adjusted Community Rate (ACR) - An HMO's estimate of the premium it would charge to Medicare beneficiaries if these beneficiaries were enrolled in commercial plans and not covered by Medicare. The ACR is intended to gauge the appropriateness of reimbursements to plans by the Centers for Medicare and Medicaid Services (CMS). If the CMS payment is higher than a plan's ACR, the plan is required by law to provide the difference to Medicare enrollees in lower premiums or higher benefits or to return it to the Medicare program (*see also Medicare Advantage*).

Advanceable Tax Credit - As it relates to expanding health coverage, a tax credit provided to cover the cost of purchasing health coverage in the individual market where the monthly payments can be sent directly to a health insurance provider, and the recipient need not wait to file a tax return and receive the subsidy as a tax credit or refund.

Adverse Risk Selection - In the health insurance market, adverse selection occurs when people who are older and sicker—and therefore more likely to incur higher medical costs—join the same health plan. Adverse selection often results when one health plan offers more comprehensive

benefits than another plan and is thus more attractive to older and sicker people. At the same time, younger and healthier people are likely to pick a cheaper, less comprehensive plan. As a result, comprehensive health plans often become more expensive—and then even more people leave these plans, until only the very sickest are left in them. This cycle of adverse risk selection is called a “death spiral,” and the result is that comprehensive health insurance plans become too expensive for anyone who needs the coverage.

American Association of Health Plans (AAHP) - The trade organization that represents managed care organizations (HMOs and PPOs).

Any Willing Provider (AWP) Legislation - State laws that require managed care organizations (MCOs, e.g. HMOs and PPOs) to accept any provider willing to meet the terms and conditions in the MCO's contract, whether or not the MCO wants or needs that provider.

Association Health Plans (AHPs) - Under proposed legislation in Congress, Association Health Plans allow small employers to band together across state lines—through their membership in a trade or professional association—to purchase health coverage for their families and employees that is exempt from the consumer protections provided by many state laws, including requirements for coverage of important services and providers. This creates a situation in the small group or small employer market that, due to adverse risk selection (see above), will increase the price of health care for the majority of those who work for small employers. By eliminating state regulation of the small group market, AHPs will create fertile ground for fraud and abuse, which could leave defrauded workers with millions of dollars in unpaid medical bills.

Average Manufacturer Price (AMP) - The AMP is the price at which a pharmaceutical manufacturer sells drugs to purchasers. There is an AMP for wholesalers and an AMP for pharmacies. For sales to wholesalers, AMP represents the Wholesale Acquisition Cost after all discounts. For sales directly to pharmacies, AMP represents the price pharmacies pay for drugs after all the discounts they receive.

Average Wholesale Price (AWP) - The AWP is the price that pharmaceutical manufacturers suggest that wholesalers charge retail pharmacies. Manufacturers generally offer lower prices or rebates to favored customers that have purchasing power, such as large insurance companies or government bodies, meaning that those customers pay significantly less than the AWP.

Balanced Budget Act of 1997 (BBA) – The BBA 1) created the State Children’s Health Insurance Program (SCHIP), which expanded coverage to low-income children not covered under Medicaid; 2) added a new part to Medicare, called Medicare+Choice (now Medicare Advantage), which includes an array of private health plan options; 3) gave states greater authority to structure their Medicaid programs, including the authority to unilaterally enroll beneficiaries without a waiver from HHS; and 4) added new beneficiary protections to both Medicaid and Medicare.

Beneficiary - A person who receives benefits. The term is commonly applied to anyone receiving benefits under the Medicare or Medicaid programs or who is covered under a private health insurance plan.

Benefit Cap - A dollar limit placed on the amount of coverage that can be provided to an individual in a given time period, which is usually one year.

Benefit Package - A group of guaranteed services provided by a health plan to its members.

Block Grant – A lump sum of money given to a state or local governing agency based on a formula to be spent on services such as health care coverage. Generally, the purposes of block grants are broadly defined, with few restrictions mandated by the funding source. Restrictions can be imposed by the re-granting agency.

Brand-Name Drugs - Drugs provided by the manufacturer that held or acquired the initial

patent on the drug. Brand-name drugs may have a generic equivalent on the market (*see also Generic Drug*).

Bulk Purchasing Programs - Single or multi-state programs that combine various groups or programs—such as state employees, the Medicaid program, or state pharmacy assistance programs—to create a larger group that can negotiate better drug prices from manufacturers. Bulk purchasing programs may provide drug coverage to people without prescription drug insurance.

Carrier – As it pertains to Medicare, a private organization—usually an insurance company—that has a contract with the Centers for Medicare and Medicaid Services (CMS) to process claims under Part B of Medicare.

Carve-Out – A health care delivery and financing arrangement in which certain specific health care services that are covered benefits (e.g. mental health services) are administered and funded separately from general health care services. The carve-out is typically done through separate contracting for services to a special population. As it relates to Medicaid, a set of services (such as behavioral health services) that are provided separately, or a specific population (such as people with HIV or children with special needs) that is not required to enroll in a Medicaid managed care program. These services or populations are said to be “carved out” and handled separately, either in fee-for-service plans or through a separate managed care organization.

Case Management - A means of coordinating care for people with multiple, often complex health care needs. As it relates to managed care, a system that requires that a single individual in the provider organization be responsible for arranging and approving all services needed. Ideally, case management should increase consumers’ access to appropriate care through specialists and ensure that full information about a consumer’s health conditions follow him or her through the health care system. In the context of private managed care, case management by a gatekeeper can be inappropriately motivated by the goal of reducing their health care costs. In the context of Medicaid, case management and managed care delivery systems must be examined carefully to determine if cost concerns are overriding the positive goal of coordinating care.

Categorically Needy – As it relates to Medicaid, a beneficiary is deemed categorically needy if she is eligible for coverage because she meets certain income requirements and falls into a specific population category: families with children; pregnant women; and people who are blind, disabled, or over 65. People who do not fall into these categories cannot qualify for Medicaid, no matter how low their incomes (unless their state has obtained a federal Section 1115 waiver to cover additional groups).

Centers for Medicare and Medicaid Services (CMS) - CMS is the name for the agency within the Department of Health and Human Services (HHS) that oversees Medicare and Medicaid. It was previously known as the Health Care Financing Administration (HCFA).

CHIP - see *State Children's Health Insurance Program (CHIP)*

Clawback- This is the colloquial term for the "state phased-down monthly contribution"—the mechanism through which states will help fund the new Medicare prescription drug benefit. Beginning in January 2006, states will make monthly payments to the federal government. These payments will be determined by a formula based on the number of dual eligibles in a state and the state's drug costs for dual eligibles in 2003, inflated by national drug price inflation. These payments amount to a large portion of the savings states would have realized by no longer having to pay for Medicaid drug coverage for dual eligibles.

COBRA – The Consolidated Omnibus Budget Reconciliation Act of 1985. A provision of this federal law requires that certain employers permit laid-off workers and their dependants to remain in the employee health plan for a specified period of time. Employees must pay the full cost of the premium (including the share formerly paid by the employer).

Co-Insurance - The portion of covered health care expenses that must be paid, in addition to the deductible, by the health plan members. The figure is usually expressed in a ratio, such as 80/20, where the insurer pays 80 percent and the client pays the remaining 20 percent of the bill (*see Cost-Sharing*).

Community Rating - A method of determining health care premiums where the premium is based on the average cost of health services used

by all customers in a specific service area. When community rating is in place, insurance companies are required to charge the same premium to all their customers for the same type and amounts of coverage. It is a way of spreading the cost of medical insurance among all the policyholders of a particular insurance company plan. Modified community rating allows some variation in premiums but limits the extent of the variation (for example, within a band no higher than 25 percent of average or lower than 25 percent of average).

"Consumer Driven" Health Plans – This term is used by different people to mean different things. One of the more common ways this term is used is to refer to a high-deductible plan that may be linked to a Health Savings Account (HSA – see below). The term is also used to refer to a defined contribution plan (see below) in which an employer offers an employee an account with a fixed dollar amount of money in it that is used to pay for health care coverage or services. Both of these kinds of plans—while purportedly giving consumers more "choice" and "control" over their health care—really shift the risk of incurring high health care costs and out-of-pocket costs from employers and insurance companies to employees.

Consumer Price Index (CPI) - A measurement of inflation at the consumer level. Many state programs use the CPI as a measure of changes in consumer buying power and increase the level of benefits provided to reflect those changes. The Bureau of Labor Statistics, which is within the U.S. Department of Labor, tracks the CPI.

Copayment - The amount a plan member has to pay each time he or she sees a doctor, fills a prescription, or receives other medical services. For example, most health plans require enrollees to pay a set dollar amount for each physician office visit or each prescription drug.

Cost-Sharing - A provision of private or public health coverage that requires the beneficiary to pay a portion of the costs of covered services.

Creditable Coverage – Drug coverage that is offered by other plans, such as coverage from a current or former union or employer, that is at least as good as the coverage offered through the standard Medicare drug benefit. People with creditable coverage may keep that coverage without being penalized for not signing up for the

new Medicare prescription drug benefit during the initial enrollment period.

Deductible - A set dollar amount that must be paid *before insurance coverage begins*. For example, many private insurance policies require payment of several hundred dollars out-of-pocket before the insurance will pay for medical care. Medicare also requires the payment of a deductible each year. In 2006, the deductible for Medicare Part A (hospitalization) is \$952, and the deductible for Medicare Part B (physician and other outpatient non-pharmacy services) is \$124. For Medicare's new drug benefit, Medicare Part D, the standard deductible is \$250, but this varies by drug plan.

Defined Benefit - A benefits scheme that guarantees coverage of certain benefits by a sponsor, such as an employer or the government, regardless of how much those benefits cost.

Defined Contribution Health Plans – A payment structure for a benefit plan in which a benefit sponsor, such as an employer or the government, pays a specified amount of a benefit's costs on behalf of each covered individual. The individual is responsible for charges above that defined amount. In employer-sponsored plans, employees receive a fixed dollar contribution from an employer to choose among various plans. Those who are sicker or older and who expect to need health care services may opt for plans with more comprehensive benefits, but they will also need to contribute significant amounts of their own money in addition to the employer's contribution. Those choosing bare-bones health plans contribute less of their own money.

Disenrollment - The process of voluntary or involuntary termination of coverage. When a health plan member quits because he or she prefers to leave, it is considered to be voluntary disenrollment. Involuntary disenrollment includes when a member leaves a plan because he or she switches jobs or when a member's coverage is terminated by the plan against the member's will.

Dispensing Fee - A transaction fee that pharmacists charge to process and fill a prescription.

Dispensing Limit- The maximum number of prescriptions for which a health plan is willing to pay in an allotted time period.

Disproportionate Share Hospital (DSH)

Adjustment (pronounced "dish") - An additional payment made through Medicaid and Medicare to hospitals that serve a relatively large volume of uninsured, Medicaid, and Medicare patients.

Doughnut Hole - The popular term for the gap in Medicare Part D prescription drug coverage. In 2006, that gap in coverage begins when an individual's drug expenses reach \$2,251. At that point, beneficiaries must pay for all of their prescription drug costs out-of-pocket until they incur \$5,100 in drug expenses. Once this threshold is reached, coverage starts again for the rest of the year (this is called catastrophic coverage).

Drug Treatment Protocols - Documents that outline the clinical decision-making processes related to prescribing drugs. Protocols typically include a detailed clinical decision-making tree and generally recommend initiating therapy with the lowest-cost alternative.

Drug Utilization Review (DUR) - Review of physician prescribing or of an insured group's drug utilization, typically to control costs and monitor quality of care. DUR programs often result in recommendations to practitioners, including the use of generic substitutions, the use of formularies, the use of copayments, and education.

Dual Eligible - A low-income Medicare beneficiary who also receives full Medicaid benefits.

Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

- Mandatory Medicaid benefits and services for children and adolescents under age 21. State Medicaid programs are required to provide EPSDT benefits, which are designed to ensure children's access to early and comprehensive preventive health care and treatment.

Employee Retirement Income Security Act of 1974 (ERISA)

- A federal law governing employee benefit programs. As it relates to health insurance, ERISA includes general protections about benefits and about the disclosure of information to employees in the plan. ERISA also prevents states from regulating health insurance if the employer "self insures."

Entitlement Program: A government program that guarantees the provision of benefits to all individuals who meet eligibility requirements. The Medicaid and Medicare programs are entitlement programs.

Extra Help – see *Low-Income Subsidy*

Fail First – An approach to managing prescription drug use and costs that requires that lower-cost drugs be tried first and fail before more aggressive—and often more expensive—drugs will be covered.

Federal Employees Health Benefits Program (FEHBP) - The health benefits plan for employees of the federal government. The Office of Personnel Management (OPM), which administers FEHBP, approves a variety of health benefit plans from which employees may choose. All plans must offer similar core benefits, and plans can also offer additional benefits. The government pays no more than 75 percent of the cost of an employee's chosen plan, and the employee pays the rest.

Federal Poverty Level - Guidelines established by the Department of Health and Human Services that are used to determine an individual's or family's eligibility for various federal and non-federal programs. Federal poverty levels vary by family size and, to a small extent, location (Alaska and Hawaii have higher rates than the 48 contiguous states and the District of Columbia).

Federal Supply Schedule (FSS) – As it relates to prescription drugs, the price available to all federal government purchasers. FSS prices are intended to be equal to or better than the prices that manufacturers charge their “most favored” non-federal customers under comparable terms.

Fee-for-Service (or Indemnity) Insurance - 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 medicine.

Formulary - The list of drugs that a plan will cover or help pay for. Plans do not have to help with the costs of drugs that are not on their formulary, and the costs of those non-formulary drugs do not count toward a person's annual out-of-pocket expenses. Formularies vary by plan (*see also Tiered Formulary*).

Freedom of Choice - A Medicaid provision that requires states to allow beneficiaries the freedom to choose providers. States can seek Section 1915 and 1115 waivers of the freedom-of-choice requirement.

Gatekeeper Physician - A primary care physician who controls the access of his or her HMO patients to specialty medical care.

Generic Drug - A drug product that is no longer covered by patent protection and thus may be produced and/or distributed by many firms. Generic drugs are FDA reviewed and must be bio-equivalent, which means that they must have the same active ingredients and be absorbed by the body the same way as their brand-name counterparts. Generic drugs usually cost significantly less than brand-name drugs.

Generic Substitution – (1) An insurance company requirement that generic drugs, when available, be substituted for brand-name drugs unless the prescribing physician indicates in writing that the brand-name drug is required. (2) A state law governing when and how pharmacists may substitute generic for brand-name drugs. These laws, which vary widely from state to state, specify what physicians must do if they want to ensure that a prescription is filled with a brand-name drug.

Grievance Procedure - A process health plan enrollees or health care providers must use when there is disagreement about a plan's services, billing, or general procedures.

Guaranteed Issue – A requirement (usually a state law) that insurers sell a policy to anyone who seeks one.

Guaranteed Renewal – A requirement that insurers renew the policies of policyholders. Such requirements are established to prevent insurers from dropping policyholders who become ill and have high medical bills.

Guidelines – As it relates to prescribing medications, systematic sets of rules for choosing among alternate drug therapies. *Treatment* guidelines, or protocols, generally require that the drug therapy with the fewest side effects (often the oldest and cheapest drugs) be tried before more potent therapies are recommended. *Administrative* guidelines generally focus more on cost and may require that the least expensive

drug be used first; only if that fails should more expensive drugs be used.

Health Care Financing Administration (HCFA)
– see *Centers for Medicare and Medicaid Services (CMS)*

Health Insurance Flexibility and Accountability (HIFA) Initiative – Policy guidance issued by the Bush Administration in August 2000 that provides for a fast-track approval process for Section 1115 Medicaid and SCHIP waivers. HIFA gives states new flexibility to cut benefits and increase cost-sharing for some current beneficiaries. HIFA also requires states to include a private insurance component in their programs that would provide a Medicaid or SCHIP subsidy to individuals to purchase available employer-sponsored or other private insurance instead of enrolling in the state's Medicaid or SCHIP program (see *Waivers*).

Health Insurance Portability and Accountability Act (HIPAA) – A federal law that sought to improve the “portability” of benefits by making it easier for workers to move from job to job without the risk of being locked out of insurance or having to wait for coverage of preexisting medical conditions. The bill also prohibits insurers from discriminating against workers based on their medical history (or that of their dependents).

Health Maintenance Organization (HMO) - A type of managed care health plan that provides health care to insured people through a network of providers within a defined geographic area. The providers may be employees or contractors of the HMO. The HMO providers are responsible for an individual group of patients, and they generally receive a fixed amount of money per month to cover the care of each patient (this is called “capitation”). One advantage of HMO plans has been that they often did not charge deductibles and they often had lower co-insurance or copayments. HMOs were designed to control costs by limiting access to specialty care. In theory, the HMO gatekeeper or primary care provider would help the consumer avoid unnecessary specialist care, but in practice, it is argued that needed specialty care is unduly restricted. Thus traditional HMOs fell out of favor in the mid-1990s.

Health Savings Accounts (HSAs) – Health Saving Accounts (HSAs) were established as part of the Medicare Prescription Drug, Improvement,

and Modernization Act of 2003 (MMA). HSAs offer tax benefits for people who purchase insurance policies with high deductibles. To qualify for the HSA tax break, the policy must have a deductible of at least \$1,000 (for an individual) or \$2,000 (for a family), but the deductibles may run as high as \$10,200. An HSA is a tax-preferred savings account. Deposits into the HSA may be deducted from income for federal income taxes. A maximum of \$2,600 (for an individual) or \$5,150 (for a family) can be deducted in one year. The tax-deductible contributions may be placed into an HSA by an individual, an employer, or both. Individuals can get a small tax advantage if they contribute to their HSAs, but the amount they save on federal taxes depends on their income, tax liability, and how much they (not their employers) contribute to their HSAs. For many people, an HSA will provide little or no tax break. Withdrawals from health savings accounts that are used to pay for out-of-pocket health care costs are tax free, while withdrawals for non-medical uses are subject to income tax and a 10 percent penalty for people under the age of 65. Money that is not used can be rolled over from one year to the next. Individuals over the age of 65 may withdraw money from their accounts—for any reason—without being taxed. Money in the accounts can be invested in stocks and bonds without incurring tax on the earnings.

HIFA - see *Health Insurance Flexibility and Accountability (HIFA) Initiative or Waivers*

High-Risk Pool – A subsidized health insurance pool organized by some states as an alternative for individuals who have been denied health insurance because of a medical condition or whose premiums are rated significantly higher than the average due to health status or claims experience. HIPAA (see above) allows states to use high-risk pools to satisfy the statutory requirements for ensuring access to health insurance coverage for certain individuals. However, even with state subsidies to help cover expected claims and lower premiums, high-risk pools often have very high premiums, and the coverage they offer may not be adequate for many of the people who do not have other sources of coverage.

HIPAA - see *Health Insurance Portability and Accountability Act*

Hospice - A public or private organization that provides pain relief, symptom management, and

supportive services to people with terminal illnesses. Medicare beneficiaries may elect to receive hospice care instead of standard Medicare benefits for a terminal illness.

Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) - A not-for-profit organization that performs accreditation reviews, primarily of hospitals, other institutional facilities, and outpatient facilities. JCAHO also accredits HMOs.

Katie Beckett Provision - Medicaid's Katie Beckett provision extends Medicaid coverage to certain disabled children living at home who are under 18 years old and who would be eligible for Medicaid if they were staying in a hospital or nursing facility. Katie Beckett was a ventilator-dependent, institutionalized child who was unable to go home, not because of medical reasons, but because she would no longer have been eligible for Medicaid because of her parents' income.

Low-Income Subsidy (LIS) – Under the new Medicare prescription drug benefit, additional financial help given to people with limited incomes or resources that greatly reduces their out-of-pocket costs. Individuals eligible for both Medicaid and Medicare automatically qualify for this assistance, as do those in Medicare buy-in programs (Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, and Qualifying Individual – 1). Others must apply. Individuals should contact their local Social Security Office, Medicaid Office, or Medicare to get more information and see if they might qualify.

Managed Care Organization (MCO) - A 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, and directs the use of medical care services. The two most common types of managed care organizations are health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

Medicaid - The federal health insurance program established in 1965 through Title XIX of the Social Security Act. Medicaid pays for health services for low-income Americans under age 65, including children, pregnant women, and people with disabilities, and for nursing home care for impoverished older adults over 65. It is financed through both federal and state funds. Each state implements its own Medicaid program, and the

amount allocated to each Medicaid program varies.

Medicaid Drug Rebate Program – Under this program, drug manufacturers are required to enter into national rebate agreements with the Department of Health and Human Services (HHS) before the government will pay for the manufacturers' drugs that are then dispensed to Medicaid patients. The rebate formula requires that pharmaceutical manufacturers rebate to the states the greater of a) 15.1 percent of the average manufacturer price (AMP) to wholesalers for brand-name drugs, or b) the manufacturer's best price, which is the lowest price offered to any other customer (excluding federal supply schedule prices and prices for state pharmacy assistance programs). For generic drugs, the rebate is 11 percent of AMP.

Medically Needy - An optional Medicaid category under which a state covers individuals and families whose incomes are too high for them to qualify for Medicaid but whose medical expenses eat up the majority of their incomes. To qualify as medically needy, an individual or family must meet the non-income eligibility criteria for Medicaid and then "spend down" their income to medically needy eligibility levels by paying for medical care. States are not required to provide the same benefit package to medically needy individuals that they provide to people who are categorically needy (*see also Spend-Down*).

Medicare - The federal health insurance program established in 1965 through Title XVIII of the Social Security Act that covers Americans who are age 65 or over, who are disabled, or who have been diagnosed with end-stage renal disease.

Medicare Advantage (MA) - Private Medicare health plans, usually managed care plans or HMOs, that have sometimes provided extra benefits that "traditional" Medicare did not cover. Plans may charge additional premiums. This program was formerly known as Medicare+Choice or Medicare Part C.

Medicare Advantage Prescription Drug Plans (MA PDPs) - Private Medicare managed care plans that include prescription drug coverage under Medicare Part D. Plans may charge an additional premium for Part D drug coverage.

Medicare Buy-In – see *Qualified Individual-1; Qualified Medicare Beneficiary; and Specified Low-Income Medicare Beneficiary*

Medicare Drug Discount Card - Any of several cards offered by private companies and approved by Medicare that provide discounts on prescription drugs. These cards offered discounts to cardholders during the period between the December 2003 passage of the new Medicare drug law (including the Medicare Part D prescription drug benefit) and its January 2006 implementation. Beneficiaries could only sign up for one card at a time and could only change cards at the end of 2004.

Medicare Part A (*also known as Hospital Insurance*) - Medicare Part A covers inpatient hospital care, home health care, hospice care, and care in limited skills nursing facilities. Eligibility is normally based on prior payment of payroll taxes. Beneficiaries must pay an initial deductible each time they are ill and a copayment for some services.

Medicare Part B (*also known as Supplementary Medical Insurance*) - Medicare Part B covers physician services, medical supplies, and other outpatient treatment such as laboratory tests and x-rays. Medicare beneficiaries must pay a monthly premium for Part B coverage.

Medicare Part D (*also known as the Medicare prescription drug benefit*) - Medicare Part D provides for an outpatient prescription drug benefit that began in January 2006. Beneficiaries can remain in fee-for-service plans and enroll in a separate, freestanding, private prescription drug plan (PDP), or they can enroll in an integrated Medicare Advantage plan that includes prescription drug coverage.

Medicare+Choice - see *Medicare Part C or Medicare Advantage*

Medicare Prescription Drug Benefit- see *Medicare Part D*

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) - Commonly known as the Medicare Modernization Act (MMA), this law most notably creates a prescription drug benefit for Medicare beneficiaries, known as Medicare Part D. In addition, it increases the part B deductible and offers new preventive benefits for beneficiaries.

Medigap (or Medicare Supplemental) Policy - A privately purchased insurance policy that supplements Medicare coverage. The policy must meet requirements set by federal statute and by the National Association of Insurance Commissioners.

Medigap Plans H, I, and J - Medigap plans designated as “H,” “I,” or “J” offer some type of prescription drug coverage. With the start of the new Medicare drug benefit, these plans cannot take new enrollees. Individuals enrolled in these plans can continue their coverage. However, the drug coverage these plans offer will generally not be considered “creditable” (see *Creditable Coverage*).

Multi Employer Welfare Arrangement (MEWA) - An employee welfare benefit plan that typically provides medical, surgical, or hospital care benefits, or benefits in the event of sickness, accident, disability, death, or unemployment, to the employees of two or more employers. MEWAs, unlike single employer plans, can be subject to ERISA, state insurance laws, or both. The law applicable to a MEWA will depend upon whether the MEWA is collectively bargained, fully insured, or self-insured. MEWAs that are fully insured and certified by the Department of Labor must only meet broad state insurance laws that regulate reserves but are otherwise unregulated by the states. The inadequate regulation of MEWAs had led to many cases of fraud and insolvency and has left many consumers with large unpaid health insurance coverage claims.

National Committee for Quality Assurance (NCQA) - An independent, nonprofit organization that accredits HMOs and assesses and reports on health plan quality. The NCQA provides health plan information to consumers free of charge.

Off-Label Drug Use - The use of FDA- approved treatments for a purpose or in a manner other than the one for which it was approved.

Olmstead Decision - This Supreme Court decision interpreted the Americans with Disabilities Act to mean that federal, state, and local governments are required to provide community settings, in addition to institutions, where integrated care services are provided to individuals with disabilities. Olmstead established that state Medicaid programs, which are a major source of financing for long-term care services

and services for individuals with disabilities, must also comply with the ADA and fund more community-based long-term care, rather than the institutionally based care that it has primarily funded.

Pay or Play Legislation – Legislation designed to expand health coverage where employers have a choice of whether to "play" by providing health care benefits to their employees or "pay" by paying money into a state health plan that would cover their employees.

Pharmacy Assistance Discount Programs - State programs that give members a discount on prescription drug purchases. These programs do not provide comprehensive prescription drug coverage.

Pharmacy Assistance Programs - State-funded programs that provide prescription drug insurance coverage. Most programs focus on providing coverage to low-income seniors. Some programs are open to all Medicare beneficiaries. Generally, programs only cover individuals without any other drug insurance.

Pharmacy Benefit Managers (PBMs) - Companies that manage pharmacy benefits under contract on behalf of payers, such as state Medicaid programs, pharmacy assistance programs, or employers. PBMs can be stand-alone companies or a division of a larger insurance company. PBMs typically use a variety of clinical and administrative procedures to reduce pharmacy costs.

Point-of-Service Plans (POS) - A type of managed care health plan that permits its enrollees, at the time services are needed, to decide whether to obtain covered services through designated "in-network" participating providers or through non-participating providers. Enrollees' cost-sharing responsibilities vary depending on whether they obtain services through in-network or non-network providers. If they use in-network services, enrollees pay lower cost-sharing amounts (e.g., lower copayments). However, enrollees may seek non-network treatment and receive benefits on a fee-for-service basis, usually with substantially higher cost-sharing. Also known as an open-ended HMO.

Preexisting Condition Exclusion – A policy of excluding certain people from obtaining insurance

or treatment due to a preexisting medical condition.

Preferred Drug List (PDL) - This mechanism for health plans to control costs involves establishing a list of drugs that health plans prefer that providers prescribe to patients at the beginning of treatment. "Non-preferred" drugs may be available at a higher copayment, not reimbursed by the payer at all, or only reimbursed if treatment with the preferred drug fails. Many states use preferred drug lists to control Medicaid fee-for-service prescription drug spending. "Preferred drugs" are on a plan's formulary and generally do not require an authorization (*see also Formulary*).

Preferred Provider Organizations (PPOs) - A type of managed care plan in which enrollees can choose plan-selected providers who discount their fees. By visiting a PPO provider, a beneficiary will pay less money out-of-pocket for medical services than he or she would by visiting a non-PPO provider.

Premium - The charge (not including any deductibles or copayments) enrollees must pay for coverage under a health plan. Premiums are typically paid on a monthly basis.

Premium Assistance – The use of federal funds usually designated for public health coverage programs—especially Medicaid and SCHIP—to purchase (or subsidize the purchase of) private insurance.

Prescription Drug Plan (PDP) - As it relates to the new Medicare Part D benefit, a privately run plan that provides coverage only for prescription drugs and not for any other health care service. Also known as a stand-alone drug plan.

Prior Authorization - A requirement that an enrollee's physician or insurance plan (or Medicaid program) give approval in advance before a particular drug or service will be covered.

Profiling – The process of comparing a pattern of practice, utilization (costs or services), or outcome (functional status, morbidity, or mortality) for a defined population of patients with other practice patterns. HMOs often profile contracting physicians' practices to compare them.

Prospective Payment Assessment Commission (ProPAC) - An independent body established by Congress to advise it on issues

related to Medicare's hospital payment system.

Prospective Payment System (PPS) - The Medicare system used to pay hospitals for inpatient hospital services based on the Diagnosis-Related Group classification system.

Purchasing Pool – As it relates to health coverage, a group of people brought together to enhance their bargaining power as well as to pool risks across individuals—the sickest to the healthiest. All purchasing pool members pay the same premium for a given plan, regardless of their health status.

Qualified Individual-1 (QI-1) program – A program that helps Medicare beneficiaries who have incomes between 120 and 135 percent of the federal poverty level and whose resources do not exceed twice the level allowed under SSI. State Medicaid agencies are required to pay the cost of Medicare Part A and Part B premiums for QI-1s. The program differs from the SLMB program (*see below*) because it is not an entitlement—there is a limit to the number of people who can enroll, and beneficiaries have to re-apply each year.

Qualified Medicare Beneficiary (QMB) program – A program that helps Medicare beneficiaries who have incomes at or below the federal poverty level and whose resources do not exceed twice the level allowed under SSI. State Medicaid agencies are required to pay the cost of Medicare Part A and Part B premiums, deductibles, and co-insurance for Qualified Medicare Beneficiaries.

Quality Assurance Plan - A formal set of managed care plan activities used to review and upgrade the quality of services provided. Quality assurance includes quality assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative, and support services.

Reunderwriting – The process of adjusting premiums based on changes in a policyholder's health status or claims the policyholder has made in the past year. Sometimes, insurance companies will double or triple the premiums for individuals who have become ill (or for the small group to which the individual belongs), which forces the insured person or group to drop the policy.

Risk Adjuster - A measure used to adjust payments made to a health plan on behalf of a group of enrollees in order to compensate for spending that is expected to be lower or higher than average, based on the health status or demographic characteristics of the enrollees.

Risk Pooling – Under this process, risk for all individuals—including the healthy and the sick—is combined into one risk pool or group, and the group's total expected claims are evaluated. This is used to try to calculate the required funding (raised through premiums and/or other subsidies) to support the payment of all expected claims for all members of the risk pool.

Section 1931 - Established in 1996 as part of the federal welfare reform law, the category of Medicaid that covers low-income families. Section 1931 provides Medicaid eligibility for families that, in the past, have been eligible for Medicaid as a result of their eligibility for the Aid to Families with Dependent Children (AFDC) program, as well as for other families that meet income and resource limits established by states. Section 1931 also allows states to define income and resources in ways that, in effect, increase Medicaid eligibility levels for families.

Self-Insured Health Plan – A health plan in which the employer assumes the financial risk of covering its employees, paying medical claims from its own resources.

Service Area - The geographic area served by a health plan, as approved by state regulatory agencies and/or detailed in a certificate of authority.

Social Security Disability Insurance (SSDI) - The portion of Social Security that pays monthly benefits to disabled workers under the age of 65 and their dependents. To be eligible for SSDI, individuals must have contributed a minimum of 40 quarters into the Security System. SSDI recipients (but not their dependents) automatically become eligible for Medicare after a two-year waiting period.

Specified Low-Income Medicare Beneficiary (SLMB) (*pronounced "slim-bee"*) program - A program that helps Medicare beneficiaries with incomes between 100 and 120 percent of the federal poverty level and whose resources do not exceed twice the level allowed under SSI. This is an entitlement program—state Medicaid agencies

are required to pay the cost of Medicare Part A and Part B premiums for all eligible SLMBs.

Spend-Down – The process by which an individual qualifies for Medicaid by exhausting his or her income and assets. Individuals in 209(b) states or those eligible under a medically needy program must make payments on medical bills (“spend down”) until their income—minus medical expenses—falls to or below the state-prescribed income level to qualify for Medicaid.

Stand-Alone Drug Plan - *see Prescription Drug Plan (PDP)*

State Children’s Health Insurance Program (SCHIP) - The federal block grant program established by Title XXI of the Balanced Budget Act of 1997. SCHIP provides funds to states to establish a health insurance program for targeted low-income children in families with incomes below 200 percent of the federal poverty level. States can: (1) expand Medicaid to cover children in families with higher incomes, (2) create a new health insurance program for children, or (3) do both. The program is financed with federal and state funds, with the federal government paying a greater share than it pays for the state’s regular Medicaid program. Each state has a different SCHIP program.

State Health Insurance Assistance Programs (SHIPs) – State programs that offer one-on-one counseling and assistance to people with Medicare and their families. The names of these programs vary from state to state.

State Pharmacy Assistance Program – A state-run program that provides drug coverage to select enrollees, most often low-income seniors. Starting in 2006, these programs may coordinate coverage with the new Medicare Part D prescription drug benefit.

Step Therapy - A strategy used by health plans, particularly pharmacy benefit managers (PBMs), to manage costs. Step therapy requires that a particular therapy—generally one that is less costly—be tried first. Approval for coverage of a more costly therapy is only provided if the patient does not respond to (fails) the first therapy.

Stop-Loss Insurance - A form of health insurance for a health plan or self-funded employer that provides protection from high medical expenses (usually those incurred by a

few high-cost beneficiaries) by covering all claims over a certain limit each year.

Supplementary Medical Insurance (*also known as Medicare Part B*) - The Medicare program that covers the cost of physician services, outpatient laboratory and x-ray tests, durable medical equipment, and outpatient hospital care (*see Medicare Part B*).

Supplementary Security Income (SSI) - A federal entitlement income support program for low-income disabled, aged, or blind individuals. SSI provides an additional cash supplement for people who are not fully qualified for Social Security or who receive only minimal Social Security payments. In most states, people who are eligible for SSI are automatically eligible for Medicaid.

Therapeutic Substitution - Replacement of one drug with another drug from the same therapeutic class that the Food and Drug Administration (FDA) has determined to be “bio-equivalent” (meaning it has the same active ingredient and the same absorption rate). This includes substitution of one brand-name drug for another brand-name or substitution of a generic drug for a brand-name drug. Generally, this practice results in prescribing the less expensive drug.

Tier – Level of cost-sharing that applies to specific drugs on a plan’s formulary. Plans generally have multiple cost-sharing tiers; tiers designated by smaller numbers (e.g. tiers 1 or 2) generally have lower cost-sharing than those designated by larger numbers (e.g. tiers 3 or 4).

Tiered Formulary – A formulary is a list of drugs covered by a health plan or government program. A tiered formulary divides those drugs into categories and assigns a different copayment (or co-insurance amount) to each tier. Typically, tiered formularies have either two or three copayment tiers. A three-tiered formulary generally features a tier for generic drugs, which usually has the lowest copayment, a tier for preferred brand-name drugs with a somewhat higher copayment, and a tier for non-preferred brand-name or off-formulary drugs with the highest copayment. Tiered formularies are designed to encourage use of the least expensive medication.

Title XVIII of the Social Security Act - The law that created the Medicare program.

Title XIX of the Social Security Act - The law that created the Medicaid program.

Trade Adjustment Assistance Reform Act of 2002 (TAARA) Health Insurance Subsidy - The TAARA is geared toward helping retirees, their families, and other workers who have lost their employer-sponsored health coverage as a consequence of trade practices or bankruptcies. This legislation provides a subsidy, via the tax system, that covers 65 percent of the cost of purchasing health insurance from certain specified sources.

Transitional Medical Assistance (TMA) – A federal program that permits low-income families to continue receiving Medicaid coverage for six or 12 months if they have earnings that raise the family income above Medicaid-eligibility levels.

TrOOP - “True out-of-pocket” costs are prescription drug costs that are truly paid for by the beneficiary—not by an insurer or other third party—either directly or by reimbursement. The new Medicare drug law (MMA) requires that these costs be tracked for beneficiaries in order to determine when catastrophic drug coverage will begin.

Voucher - A payment worth a specific dollar amount given to an individual toward the purchase of a specific benefit, for example, health coverage.

Waivers

Section 1115 - Section 1115 of the Social Security Act allows the Secretary of the Department of Health and Human Services (HHS) to waive certain Medicaid requirements in order to allow states to establish demonstration projects that are “likely to further the goals of the Medicaid program.” One major goal of Medicaid is to provide health care to people with low incomes. States submit a waiver application to HHS, which must approve the application before the waiver can take effect. Recent Section 1115 waiver proposals have largely sought to reduce the health care services available in Medicaid and to eliminate certain rights that people in Medicaid have to get care.

Pharmacy Plus Waiver – A demonstration program providing for a Section 1115 Medicaid waiver for

pharmacy services only. These waivers can extend pharmacy services to Medicare beneficiaries with incomes up to 200 percent of the federal poverty level. The waiver must be “budget neutral,” which means that the federal government’s costs under the waiver cannot be greater than they would have been without the waiver. After the start of the Medicare Part D drug benefit on January 1, 2006, existing Pharmacy Plus waivers may continue to operate, but no new waivers will be issued.

Section 1915 (b) - A Section 1915(b) waiver allows states to waive Medicaid rules regarding the freedom to choose a provider, the establishment of statewide programs, and the comparability of Medicaid benefits to different covered groups. Thus, states can require all or some categories of Medicaid beneficiaries to enroll in managed care, either throughout the state or in limited geographical areas. Since passage of the Balanced Budget Act of 1997, states can mandate managed care enrollment for many Medicaid beneficiaries without a Section 1915(b) waiver. A state must still, however, obtain such a waiver to mandate managed care enrollment for children with special needs, dual eligibles (people who are eligible for both Medicaid and Medicare), and Native Americans.

Section 2176 (*also known as 1915 (c) or 1915 (d)*) - A Section 2176 waiver allows states to offer community-based long-term care services to Medicaid beneficiaries who would otherwise require nursing home care or other types of institutionalized care. Under this waiver, states provide a broad range of home- and community-based services to people who are older than 65, developmentally disabled, or chronically ill. States must apply to the Department of Health and Human Services (HHS) for each specific program.

Health Insurance Flexibility and Accountability (HIFA) Waiver – This type of waiver is based on policy guidance issued by the Bush Administration in August 2000 that provides for fast-track approval of Section 1115 Medicaid and SCHIP waivers. HIFA gives states new flexibility to cut benefits and increase cost-sharing for some current beneficiaries. HIFA also requires states to

include a private insurance component to their programs that would provide a subsidy to individuals for the purchase of available employer-sponsored or other private insurance instead of enrolling in the state's Medicaid or SCHIP program.

Wholesale Acquisition Price - The factory charge for a prescription drug, before discounts to wholesalers.

ACRONYMS

AHPs – Association Health Plans. Under proposed legislation in Congress, Association Health Plans allow small employers to band together across state lines—through their membership in a trade or professional association—to purchase health coverage for their families and employees that is exempt from the consumer protections provided by many state laws, including requirements for coverage of important services and providers. This creates a situation in the small group or small employer market that, due to adverse risk selection (see above), will increase the price of health care for the majority of those who work for small employers. By eliminating state regulation of the small group market, AHPs will create fertile ground for fraud and abuse, which could leave defrauded workers with millions of dollars in unpaid medical bills.

AMP - Average Manufacturer Price. The AMP is the price at which a pharmaceutical manufacturer sells drugs to purchasers. There is an AMP for wholesalers and an AMP for pharmacies. For sales to wholesalers, AMP represents the Wholesale Acquisition Cost after all discounts. For sales directly to pharmacies, AMP represents the price pharmacies pay for drugs after all the discounts they receive.

AWP - Average Wholesale Price. The AWP is the price that pharmaceutical manufacturers suggest that wholesalers charge retail pharmacies. Manufacturers generally offer lower prices or rebates to favored customers that have purchasing power, such as large insurance companies or government bodies, meaning that those customers pay significantly less than the AWP.

BBA - Balanced Budget Act of 1997. The BBA 1) created the State Children's Health Insurance

Program (SCHIP), which expanded coverage to low-income children not covered under Medicaid; 2) added a new part to Medicare, called Medicare+Choice (now Medicare Advantage), which includes an array of private health plan options; 3) gave states greater authority to structure their Medicaid programs, including the authority to unilaterally enroll beneficiaries without a waiver from HHS; and 4) added new beneficiary protections to both Medicaid and Medicare.

CMS - Centers for Medicare and Medicaid Services. The agency within the Department of Health and Human Services (HHS) that oversees Medicare and Medicaid. It was previously known as the Health Care Financing Administration (HCFA).

COBRA – The Consolidated Omnibus Budget Reconciliation Act of 1985. A provision of this federal law requires that certain employers permit laid-off workers and their dependants to remain in the employee health plan for a specified period of time. Employees must pay the full cost of the premium (including the share formerly paid by the employer).

CPI - Consumer Price Index. A measurement of inflation at the consumer level. Many state programs use the CPI as a measure of changes in consumer buying power and increase the level of benefits provided to reflect those changes. The Bureau of Labor Statistics, which is within the U.S. Department of Labor, tracks the CPI.

DSH - Disproportionate Share Hospital Adjustment (pronounced "dish"). An additional payment made through Medicaid and Medicare to hospitals that serve a relatively large volume of uninsured, Medicaid, and Medicare patients.

EPSDT - Early and Periodic Screening, Diagnosis, and Treatment Program.

Mandatory Medicaid benefits and services for children and adolescents under age 21. State Medicaid programs are required to provide EPSDT benefits, which are designed to ensure children's access to early and comprehensive preventive health care and treatment.

ERISA - Employee Retirement Income Security Act of 1974.

A federal law governing employee benefit programs. As it relates to health insurance, ERISA includes general protections about benefits and about the disclosure of information to employees in the plan. ERISA also prevents states from regulating health insurance if the employer "self insures."

FEHBP - Federal Employees Health Benefits Program.

The health benefits plan for employees of the federal government. The Office of Personnel Management (OPM), which administers FEHBP, approves a variety of health benefit plans from which employees may choose. All plans must offer similar core benefits, and plans can also offer additional benefits. The government pays no more than 75 percent of the cost of an employee's chosen plan, and the employee pays the rest.

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HIPPA - Health Insurance Portability and Accountability Act.

A federal law that sought to improve the "portability" of benefits by making it easier for workers to move from job to job without the risk of being locked out of insurance or having to wait for coverage of preexisting medical conditions. The bill also prohibits insurers from discriminating against workers based on their medical history (or that of their dependents).

HMO - Health Maintenance Organization.

A type of managed care health plan that provides health care to insured people through a network of providers within a defined geographic area. The providers may be employees or contractors of the HMO. The HMO providers are responsible for an individual group of patients, and they generally receive a fixed amount of money per month to cover the care of each patient (this is called "capitation"). One advantage of HMO plans has been that they often did not charge deductibles and they often had lower co-insurance or copayments. HMOs were designed to control costs by limiting access to specialty care. In theory, the HMO gatekeeper or primary care provider would help the consumer avoid unnecessary specialist care, but in practice, it is argued that needed specialty care is unduly restricted. Thus traditional HMOs fell out of favor in the 1990s.

HSAs - Health Savings Accounts.

Health Saving Accounts (HSAs) were established as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). HSAs offer tax benefits for people who purchase insurance policies with high deductibles. To qualify for the HSA tax break, the policy must have a deductible of at least \$1,000 (for an individual) or \$2,000 (for a family), but the deductibles may run as high as \$10,200. An HSA is a tax-preferred savings account. Deposits into the HSA may be deducted from income for federal income taxes. A maximum of \$2,600 (for an individual) or \$5,150 (for a family) can be deducted in one year. The tax-deductible contributions may be placed into an HSA by an individual, an employer, or both. Individuals can get a small tax advantage if they contribute to their HSAs, but the amount they save on federal taxes depends on their income, tax liability, and how much they (not their employers) contribute to their HSAs. For many people, an HSA will provide little or no tax break. Withdrawals from health savings accounts that are used to pay for out-of-pocket health care costs are tax free, while withdrawals for non-medical uses are subject to income tax and a 10 percent penalty for people under the age of 65. Money that is not used can be rolled over from one year to the next. Individuals over the age of 65 may withdraw money from their accounts—for any reason—without being taxed. Money in the accounts can be invested in stocks and bonds without incurring tax on the earnings.

JCAHO - Joint Commission for the Accreditation of Healthcare Organizations (JCAHO).

A not-for-profit organization that performs accreditation reviews, primarily of hospitals, other institutional facilities, and outpatient facilities. JCAHO also accredits HMOs.

MA - Medicare Advantage. Private Medicare health plans, usually managed care plans or HMOs, that have sometimes provided extra benefits that “traditional” Medicare did not cover. Plans may charge additional premiums. This program was formerly known as Medicare+Choice or Medicare Part C.

MMA - Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Commonly known as the Medicare Modernization Act (MMA), this law most notably creates a prescription drug benefit for Medicare beneficiaries, known as Medicare Part D. In addition, it increases the part B deductible and offers new preventive benefits for beneficiaries.

PBM - Pharmacy Benefit Manager. A company that manages pharmacy benefits under contract on behalf of payers, such as state Medicaid programs, pharmacy assistance programs, or employers. PBMs can be stand-alone companies or a division of a larger insurance company. PBMs typically use a variety of clinical and administrative procedures to reduce pharmacy costs.

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