

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.

Adjust 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. *Adjusted 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).

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 Selection - The trend wherein people purchase insurance only when they become sick and have significant expenses. If people do not purchase insurance until they are sick and need it, the individual insurance market may become a pool only for the sick, with no healthy members. This drives up premiums in the individual market. Adverse selection can also occur when healthier individuals are siphoned into certain plans (generally with fewer benefits and lower premiums) and sicker individuals into other plans (which offer more benefits).

Affordable Choices – A health care initiative proposed by President Bush in 2007 that shifts federal dollars from hospitals and other health care

institutions to states to create programs to get low-income, uninsured individuals to purchase “basic” private coverage. This initiative could push low-income people into high-deductible plans that require significant out-of-pocket spending, and it is unclear what consumer protections, if any, would be incorporated, or whether the funding source is sufficient and sustainable.

America's Health Insurance Plans (AHIP) - The trade organization that represents health insurance companies.

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.

Applied Research - Systematic study done to gain the knowledge or understanding necessary to determine how to meet a recognized and specific need, such as development of a new drug to treat a disease. Applied research is designed to solve practical problems rather than to acquire knowledge for knowledge's sake.

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 (CHIP), 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.

Basic Research - Systematic study directed toward gaining more complete knowledge or understanding of a problem or issue without a specific goal or product in mind. Basic research is driven by a scientist’s interest in a question or issue rather than a desire to create or invent something, although basic research findings may have broad applications and may turn out to be the foundation for future development of specific processes or products.

Bayh-Dole Act (1980) - Legislation that permits grantees and contractors to retain their title to federally funded discoveries and inventions and to encourage universities to license those discoveries to the commercial sector. The purpose of the act was to encourage the commercialization of technologies that are developed with federal funds.

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*).

Budget Neutrality – A federal government requirement that a particular new program or a state’s coverage plan (for example, a Medicaid waiver) introduce only new costs that are balanced by spending cuts elsewhere, so that overall spending levels remain unchanged.

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).

Certificate of Need – A regulatory process that requires hospitals and other health care facilities to obtain state approval before embarking on a capital investment project or offering certain new and expanded services. Requiring a certificate of need is meant to ensure that health care expenditures and investments are equitably distributed throughout a state or region.

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

Citizenship Documentation – An onerous federal requirement that individuals applying for or renewing Medicaid coverage provide documentary proof of identity and citizenship as a condition of eligibility. (In the past, applicants could simply attest to their citizenship under penalty of perjury.) This law was passed as part of the Deficit Reduction Act (DRA) and went into effect in July 2006. It has caused tens of thousands of citizens to lose or be denied Medicaid coverage due to their failure to provide the required documents, and it also places a costly administrative burden on states.

CLAS Standards – The collective set of Culturally and Linguistically Appropriate Services (CLAS) mandates, guidelines, and recommendations issued by the U. S. Department of Health and Human Services Office of Minority Health intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services.

Clawback - The colloquial term for the "state phased-down monthly contribution"—the mechanism through which states help fund the Medicare Part D prescription drug program. States make monthly payments to the federal government. These payments are 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.

Clinical Trials - Research studies performed on human volunteers to answer specific health questions. There are two types of clinical trials: 1) *Interventional trials* determine whether experimental treatments or new ways of using known therapies are safe and effective under controlled environments. 2) *Observational trials* address health issues in large groups of people or populations in natural settings.

Clinical Trial Phases - The specific phases of clinical testing relevant to the development of new medical interventions.

Preclinical testing - Before clinical trials begin, animal testing is used to determine basic safety.

Phase I - Testing of a new drug or treatment in a small group of people (20-80) to evaluate safety, determine a safe dosage range, and identify side effects.

Phase II - Testing a larger group of participants (100 to 300) to see if the study drug or treatment is effective and to further evaluate its safety.

Phase III - Testing large groups of people (1,000-3,000) to confirm the drug's effectiveness, monitor side effects, and compare it to commonly used treatments.

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.

Pure community rating requires insurers to set the same premiums for everyone in a community. Plans cannot vary premiums at all based on health status, claims history, or age, but they may be allowed to vary premiums within a state based on geographical location and/or family

composition.

Adjusted community rating likewise prohibits insurers from varying premiums in a community based on health status or claims history, but it does allow them to vary rates based on more factors than geography and family composition. For example, it may allow some variation in premiums but limit that variation within a band no higher than 25 percent of average or lower than 25 percent of average.

Connector – This term originated with the Massachusetts Health Reform of 2006. A health insurance “connector” (also known as an “exchange”) is a structure that facilitates enrollment of individuals, families, and small businesses in private health coverage. It creates a common marketplace where consumers can compare their health coverage options. It may also play a central role in outreach and education about newly available coverage and assist employers in establishing Section 125 pre-tax health plans for employees.

“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.

Continuous Eligibility – A policy that states can apply to children’s Medicaid and SCHIP coverage that allows an individual to remain eligible for the program for a full 12 months regardless of changes in family income. This policy reduces the paperwork burden on families and helps prevent children from losing coverage as family situations change.

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.

Crowd-Out – A term used to describe the substitution of public coverage for private coverage. The term has also been used to convey the idea that, when expanding access to subsidized coverage in order to cover the uninsured, the expansion will prompt some privately insured individuals to drop their existing coverage and take advantage of the public subsidy. This issue has been particularly contentious in the children’s health debate, as some have argued that large numbers of families drop private coverage in favor of SCHIP or Medicaid. Studies have found varying degrees of crowd-out in these programs, but most reports have found it to be minimal.

Cultural Competence – The capacity of service providers to respect and respond to individual and cultural differences when caring for diverse populations.

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.

Deficit Reduction Act (DRA) - In February 2006, President Bush signed into law budget reconciliation legislation, known as the Deficit Reduction Act (DRA), that fundamentally alters many aspects of the Medicaid program. Some of these changes are mandatory provisions that states must enact and that will make it more difficult for people to either qualify for or enroll in Medicaid. Other changes are optional provisions that allow states to make unprecedented changes to the Medicaid program through state plan amendments.

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.

Disparities in Health – Differences in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific population groups.

Disparities in Health Care – Differences between two or more population groups in health care access, coverage, and quality of care *not due to different health needs*. This can include differences in preventive, diagnostic, and treatment services between population groups.

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 2008, that gap in coverage begins when an individual's drug expenses reach \$2,510. At that point, beneficiaries must pay for all of their prescription drug costs out-of-pocket until they incur \$5,726 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.

Executive Order (EO) 13166 – President Clinton signed, and President Bush reaffirmed, EO 13166 to improve access to federally funded programs and activities for individuals with limited English proficiency (LEP). EO 13166 requires each federal agency to develop guidance on language access to its federal fund recipients.

Express Lane – Also called "Express Lane Eligibility," this is when a state uses children's eligibility information from another means-tested program (such as Food Stamps, the National School Lunch Program, or the Women, Infants and Children (WIC) program) to determine eligibility for Medicaid or SCHIP. This simplifies the application process for families and helps get more eligible children covered.

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 Match – For the Medicaid and SCHIP programs, the federal government matches what states contribute to these programs. These match rates vary by state and program.

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.

Federal Technology Transfer Act of 1986 - This law amended previous legislation, the Stevenson-Wylder Technology Innovation Act, which required federal agencies to facilitate the transfer of technology developed by those agencies to the private sector. The Federal Technology Transfer Act authorizes cooperative research and development agreements between federal laboratories and other agencies to further facilitate the movement of federal discoveries into the private market.

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, either fully or in part. 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.

Global Fund to Fight AIDS, TB, and Malaria - An independent entity funded by government and private sources. The Global Fund was conceptualized at the July 2000 G-8 Summit and formally launched in 2001. Its primary objective is to raise new resources to fight HIV/AIDS, TB, and malaria by issuing grants to countries with the greatest need in support of prevention, care, and treatment programs. The U. S. limits its contributions to 33 percent of total donations to the fund.

Global Health - Health problems and issues that are global in scope, that transcend national boundaries, and that may be influenced by circumstances or experiences in other countries. These problems are best addressed by cooperative actions and solutions.

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, regardless of the applicant's health status, claims history, age, or the industry in which he or she is employed. This requirement also guarantees that the coverage will be renewed as long as the premium is paid.

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 Information Technology (HIT) - The use of electronic technology, such as computerized medical records, to provide comprehensive management of medical information and its secure exchange between health care consumers and providers, as well as to streamline health care delivery.

Health Insurance Flexibility and Accountability (HIFA) Initiative – Policy guidance issued by the Bush Administration in August 2001 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 Opportunity Accounts (HOAs) - A type of Health Savings Account in the Medicaid program that

is coupled with a new deductible. A provision in the DRA permits up to 10 states to establish five-year HOA demonstration projects. An HOA is an account into which a state may deposit up to \$2,500 per adult and \$1,000 per child in a participating family. States decide how much the deductible will be, but it can be no more than 110 percent of the amount that is in the account. The money in the account is used to purchase individual health care services. Once the deductible is met, the individual will receive “regular” Medicaid coverage. Individuals may enroll on a voluntary basis, and eligibility requirements generally permit only healthy parents and children to enroll in HOAs.

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 nonprofit association created by states as an alternative for individuals who have been denied health insurance because of a preexisting 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. By law, premiums are capped, and while they are somewhat higher than premiums charged to healthy people, they are not as high as premiums for unhealthy individuals. High-risk pools are subsidized in order to keep premiums

within the state's cap.

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.

Immigrant Children's Health Improvement Act (ICHIA) - Legislation that Congress has attempted but failed to pass numerous times over the past several years that would allow states to lift the five-year bar on eligibility for public health programs for legal immigrants. If passed, states could choose to cover legal immigrant children and pregnant women in Medicaid and SCHIP.

Individual Mandate – A law requiring all state residents to obtain health insurance. Currently, Massachusetts is the only state with an individual mandate.

Interpreting – The process of understanding and analyzing a spoken or signed message and re-expressing that message faithfully, accurately, and objectively in another language, taking the cultural and social context into account. Interpreting enables communication between two or more individuals who do not speak the same language.

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 children with disabilities who live 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.

Limited English Proficiency (LEP) – Individuals who do not speak English as their primary language and have a limited ability to read, write, speak, or understand English are described as having limited English proficiency. An LEP individual has a limited ability to communicate in English at a level that permits the person to interact effectively with health care providers or social service agencies. According to the 2005 American Community Survey, more than 23 million individuals (8.3 percent of the population) speak English less than "very well."

Low-Income Subsidy (LIS) – Part of the Medicare prescription drug program, 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 Savings Programs (Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, and Qualifying Individual). 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 Benchmark Benefit Package (also known as alternative benefit package) - The DRA established a new option that allows state Medicaid programs to offer different benefit packages to different types of Medicaid enrollees, which essentially reduces services for individuals in benchmark benefit plans. States may require only parents and certain categories of children to enroll into these plans, while other Medicaid populations may enroll on a voluntarily basis. In order to establish a benchmark benefit package, a state must submit a state plan amendment to CMS.

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.

Medicaid Waiver – see *Waivers*

Medical Home – A primary care practice where a patient routinely seeks medical care and where a patient's health history is known. A medical home is a place where health care should be accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.

Medical Loss Ratio – The percentage of premium dollars that health insurance companies spend on medical care, as opposed to administrative costs or retaining for profit.

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 Part A (*also known as Hospital Insurance*) - Medicare Part A covers inpatient hospital care, home health care, hospice care, and limited skilled nursing care. 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 traditional Medicare 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 Payment Advisory Commission (MedPAC) – An independent body established by Congress to advise it on issues affecting the Medicare program.

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

Medicare Prescription Drug Benefit - *see Medicare Part D*

Medicare Savings Programs (MSPs) – A group of three programs for Medicare beneficiaries with low incomes. These programs (Qualified Medicare Beneficiary or QMB, Specified Low-Income Medicare Beneficiary or SLMB, and Qualified Individual or QI) pay some or all of an individual's Medicare premiums and may also pay an individual's Medicare deductibles and co-insurance. The programs are administered through state Medicaid agencies. *See Qualified Individual-1; Qualified Medicare Beneficiary; and Specified Low-Income Medicare Beneficiary*

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) - Commonly known as the Medicare Modernization Act (MMA), this law most notably created a prescription drug program for Medicare beneficiaries, known as Medicare Part D. In addition, it increased the part B deductible, expanded private Medicare Advantage plans, and added 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*).

Microbicide - Any compound or substance whose purpose is to reduce the infectivity of microbes, such as viruses or bacteria. A major effort is currently

underway to develop topical microbicides that might be applied to condoms or directly to the genitals to block sexually transmitted diseases (STDs) such as HIV.

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.

National Institutes of Health (NIH) - A U. S. government-funded research agency that is part of the Department of Health and Human Services. The NIH is the largest research body in the world; it has 27 different institutes or centers, each with its own clinical focus. NIH uses about 80 percent of its budget to fund external research conducted by universities, research institutes, or other entities. These awards are made on a competitive basis.

Nonprofit Plans – Insurance plans that cannot sell stock shares and that must operate in the interest of the public good. In return, they may receive a tax break, although this varies from state to state.

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.

Out-of-Pocket Maximum – The upper limit of how much individuals or families must pay out of pocket in

deductibles and coinsurance for covered medical services during a benefit period.

Patient Assistance Programs (PAPs) – Private programs, generally sponsored by pharmaceutical manufacturers, that provide free or low-cost supplies of the sponsor's products to consumers with limited or no health coverage. Many of these programs are being restructured to coordinate with the Medicare Part D drug program.

Pay-for-Performance (P4P) - The idea that there should be a direct link, based on accepted measures, between what is paid for health services and the value of the services provided. Pay-for-performance uses payment methods and other incentives to encourage physicians and other health care personnel to provide higher quality and efficiency, rather than higher volume.

Pay or Play – Legislation designed to expand health coverage that requires employers (within certain parameters) to either "play" by contributing to their employees' health coverage or "pay" an assessment to the state which the state, in turn, uses to fund health coverage.

PEPFAR—President's Emergency Plan for AIDS Relief - A 2003 Bush Administration initiative that pledged \$15 billion in U. S. Funds over five years to fight HIV/AIDS. The plan targets countries with a high prevalence of HIV/AIDS. It has drawn criticism because of the requirement that one-third of the funds earmarked for prevention be used for abstinence until marriage education. PEPFAR is currently authorized from fiscal years (FY) 2004 to 2008.

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.

Presumptive Eligibility - A policy that states can use in their Medicaid or SCHIP programs for children or pregnant women. This policy allows states to provide these individuals with immediate but temporary enrollment in Medicaid or SCHIP if they appear to meet program eligibility standards.

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.

Private Fee-for-Service (PFFS) – A type of Medicare Advantage plan that does not have a formal network of providers. Members can go to any doctor that accepts their plan. Costs to beneficiaries may be higher or lower than they are for traditional Medicare.

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

Public-Private Product Development Partnerships (PDPs) - Organizations formed to address the challenge of developing products for diseases that predominantly affect developing countries. PDPs receive funding from private donors, governments, international organizations, and industry. While PDPs follow a nonprofit business model, many outsource certain development aspects to for-profit partners. PDPs address a void in medical product development left by for-profit biotech and pharmaceutical companies.

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.

Rate Bands – The variation in insurance premiums that is allowed by state regulations, expressed as a ratio or as a percentage of the index rate or average rate. Rate bands are used to limit the variation in premiums among individuals.

Rate Regulation – The process of overseeing and regulating the premiums—or rates—that insurance companies charge to their customers. States and the

federal government regulate different kinds of insurance.

Regional Preferred Provider Organizations

(Regional PPOs) – A type of Medicare Advantage plan created by the 2003 Medicare Modernization Act. Regional PPOs operate like other PPOs, but they must serve a large geographic region, typically one or more states.

Reinsurance – Reinsurance is insurance for insurance companies. Its basic structure involves a primary insurance company that transfers, or cedes, the risk of high-cost claims to another private carrier or to a government-sponsored program. The insurer or government-sponsored program then assumes this risk and pays for some or all of these high-cost claims. There are two major types of government-sponsored reinsurance programs: 1) the government pays for some or all of the claims through general revenues; or 2) state law establishes an association of insurance companies that may want to cede risk and requires these companies to pool their resources to pay high-cost claims.

Resource Gap - In the field of global health, the gap between the percent of total medical research and development spending that targets diseases that affect the developed world versus the percent that targets diseases that predominantly affect the developing world, roughly a ratio of 10/90.

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 125 Cafeteria Plans – Plans that allow employees to set aside pre-tax dollars for a variety of benefits, including flexible spending accounts (FSAs) and health insurance. These plans are named after Section 125 of the Internal Revenue Service code. Some states encourage or require certain businesses

to establish cafeteria plans so that their workers will be able to pay for their share of health premiums with pre-tax dollars.

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.

Special Needs Plans (SNPs) – A type of Medicare Advantage plan designed to serve beneficiaries with special health care needs, including dual eligibles, institutionalized beneficiaries, or those with several or disabling chronic conditions.

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 BBA of 1997 established Title XXI of the Social Security Act, which created the federal block grant program known as SCHIP. 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 (SPAP) – A state-run program that provides drug coverage to select enrollees, most often low-income seniors. Starting in 2006, most programs coordinate coverage with the Medicare Part D prescription drug program.

State Plan Amendment - A Medicaid state plan is the document that defines how each state operates its Medicaid program. Making any major change to a state's Medicaid program usually requires an amendment to the Medicaid state plan. Amendments to the state plan must be filed and approved by the Centers for Medicare and Medicaid Services (CMS) before changes can be implemented.

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.

Tax Credits – A dollar-for-dollar reduction in the amount of taxes an individual owes. Some tax credits are “refundable,” meaning that if an individual owes less in taxes than the amount of the credit, he or she receives a refund and benefits from the full amount of the credit. The Earned Income Tax Credit is an example of a well-known federal program that works in such a manner.

Technology Transfer - The process of converting scientific findings into products that can be used in the commercial sector. The goal of both the Bayh-Dole Act and the Federal Technology Transfer Act is to move the results of federally funded research into public use through commercialization.

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.

Translational Research (also called “translational medicine”) - A branch of medical research that attempts to more directly connect basic research to patient care. Although there is some debate within the medical community regarding the scope of the term, in the area of discoveries of medical interventions, it typically refers to the movement of basic research into real therapies for real patients, emphasizing the link between the lab and the patient's bedside.

TRGOP - “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.

Uncompensated Care Funds - Funds used to pay for physician or hospital services when no payment is received from the patient or from insurance. Some states have established further guidelines for uncompensated care funds.

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

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

Waivers - Sections 1115 and 1915 of the Social Security Act define specific circumstances under which the federal government may, at a state's request, “waive” certain provisions of the federal Medicaid laws. The “waiver” is the agreement between the federal government and the state that exempts the state from these provisions, and it includes special terms and conditions that define to whom and when these exemptions apply. For example, some states use Medicaid waivers to extend Medicaid coverage to childless adults who are not blind or disabled, a group that does not ordinarily qualify for Medicaid under federal laws.

Home- and Community-Based Care (*also known as 1915 (c) or 1915 (d)*) - A home- or community-based care 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 type of 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.

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.

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.

Health Insurance Flexibility and Accountability (HIFA) Waiver – This type of waiver is based on policy guidance issued by the Bush Administration in August 2001 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.

Working Disabled – People who meet the Social Security Administration’s criteria for receiving disability income, but who still work despite their disabling condition. States must provide Medicaid coverage to working disabled individuals unless they have high enough earnings to provide a “reasonable equivalent” of the combination of Social Security

Income (SSI) benefits, Medicaid benefits, and publicly funded attendant care services.

Wraparound Benefits – Benefits that Medicaid provides when it acts as a secondary insurer to Medicaid-eligible individuals who are enrolled in private plans (such as employer-based coverage) that do not cover all of the services that Medicaid covers.

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.

DRA – Deficit Reduction Act. In February 2006, President Bush signed into law budget reconciliation legislation, known as the Deficit Reduction Act (DRA), that fundamentally alters many aspects of the Medicaid program. Some of these changes are mandatory provisions that states must enact and that will make it more difficult for people to either qualify for or enroll in Medicaid. Other changes are optional provisions that allow states to make unprecedented changes to the Medicaid program through state plan amendments.

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.

HIFA Waiver - Health Insurance Flexibility and Accountability 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.

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).

HIT - Health Information Technology. The use of electronic technology, such as computerized medical records, to provide comprehensive management of medical information and its secure exchange between health care consumers and providers, as well as to streamline health care delivery.

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.

HOAs - Health Opportunity Accounts. A type of Health Savings Account in the Medicaid program that is coupled with a new deductible. A provision in the DRA permits up to 10 states to establish five-year HOA demonstration projects. An HOA is an account into which a state may deposit up to \$2,500 per adult and \$1,000 per child in a participating family. States decide how much the deductible will be, but it can be no more than 110 percent of the amount that is in the account. The money in the account is used to purchase individual health care services. Once the deductible is met, the individual will receive “regular” Medicaid coverage. Individuals may enroll on a voluntary basis, and eligibility requirements generally permit only healthy parents and children to enroll in HOAs.

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.

ICHIA - Immigrant Children's Health Improvement Act. Legislation that Congress has attempted but failed to pass numerous times over the past several years that would allow states to lift the five-year bar on eligibility for public health programs for legal immigrants. If passed, states could choose to cover legal immigrant children and pregnant women in Medicaid and SCHIP.

JCAHO - Joint Commission for the Accreditation of Healthcare Organizations, now known as the Joint Commission. A not-for-profit organization that performs accreditation reviews, primarily of hospitals, other institutional facilities, and outpatient facilities.

LEP – Limited English Proficiency. Individuals who do not speak English as their primary language and have a limited ability to read, write, speak, or understand English are described as having limited English proficiency. An LEP individual has a limited ability to communicate in English at a level that permits the person to interact effectively with health care providers or social service agencies. According to the 2005 American Community Survey, more than 23 million individuals (8.3 percent of the population) speak English less than “very well.”

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.

MedPAC – Medicare Payment Advisory Commission. An independent body established by Congress to advise it on issues affecting the Medicare program.

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.

MSPs – Medicare Savings Programs. See *Qualified Individual-1 (QI-1)*; *Qualified Medicare Beneficiary (QMB)*; and *Specified Low-Income Medicare Beneficiary (SLMB)*.

P4P - Pay-for-Performance. The idea that there should be a direct link, based on accepted measures, between what is paid for health services and the value of the services provided. Pay-for-performance uses payment methods and other incentives to encourage physicians and other health care personnel to provide higher quality and efficiency, rather than higher volume.

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.

PDPs - Public-Private Product Development

Partnerships. Organizations formed to address the challenge of developing products for diseases that predominantly affect developing countries. PDPs receive funding from private donors, governments, international organizations, and industry. While PDPs follow a nonprofit business model, many outsource certain development aspects to for-profit partners. PDPs address a void in medical product development left by for-profit biotech and pharmaceutical companies.

PEPFAR - President’s Emergency Plan for AIDS Relief. A 2003 Bush Administration initiative that pledged \$15 billion in U. S. Funds over five years to fight HIV/AIDS. The plan targets countries with a high prevalence of HIV/AIDS. It has drawn criticism because of the requirement that one-third of the funds earmarked for prevention be used for abstinence until marriage education. PEPFAR is currently authorized from fiscal years (FY) 2004 to 2008.

QI - Qualified Individual (QI) 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 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.

QMB - 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.

SCHIP - 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.

SLMB - 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.

SSDI - Social Security Disability Insurance. 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.

SSI – 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.

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

TMA - Transitional Medical Assistance. 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. These 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.