



Glossary of Key Health Reform Terms

Access: The ability to obtain needed medical care. Access to care is often affected by the availability of insurance, the cost of the care, and the geographic location of providers.

Case Management: The process of coordinating care medical care provided to patients with specific diagnoses of those with high health care needs.

Community Rating: A method for setting premium rates for health insurance plans under which all policy holders are charged the same premium for the same coverage.

Disproportionate Share Hospital (DSH) Payments: Payments made by a state's Medicaid program to hospitals that the state designates as serving a "disproportionate share" of low-income or uninsured patients.

Dual Eligibles: A term used to describe an individual who is eligible for Medicare and for some level of Medicaid benefits.

Employer Mandate: An approach that would require all employers, or at least all employers meeting size and revenue thresholds, to offer health benefits that meet a defined standard, and pay a set portion of the cost of those benefits on behalf of their employees.

Federal Medical Assistance Percentage (FMAP): The share of the costs of Medicaid services or administration that the federal government bears.

Federal Poverty Level (FPL): The federal government's working definition of poverty that is used as the reference point to determine the number of people with income below poverty and the income standard for eligibility for public programs.

Health Care Cooperative (Co-op): A non-profit, member-run health insurance organization, governed by a board of directors elected by its members.

Individual Mandate: A requirement that all individuals obtain health insurance. A mandate could apply to the entire population, just to children, and/or could exempt specified individuals.

Long-Term Care: Services that include those needed by people to live independently in the community, such as home health and personal care, as well as services provided in

institutional settings such as nursing homes. Medicaid is the primary payer for long-term care. Many of these services are not covered by Medicare or private insurance.

Medicaid: The federal entitlement program that provides health and long-term care coverage to certain categories of low-income Americans.

Medical Home: A health care setting where patients receive comprehensive primary care services, have an ongoing relationship with a primary care provider who directs and coordinates their care; have enhanced access to non-emergent primary, secondary, and tertiary care.

Medicare: The federal entitlement program that provides health insurance coverage to 45 million people, the vast majority of which are age 65 and older, and younger people with particular diseases.

Pay for Performance: A health care payment system in which providers receive incentives for meeting or exceeding quality, cost, or other benchmarks. Some systems penalize providers who do not meet established benchmarks. The goal of pay for performance is to improve the quality of care over time.

Payment Bundling: A mechanism of provider payment where providers or hospitals receive a single payment for all of the care provided for an episode of illness, rather than per service.

Public Plan Option: A proposal to create a new insurance plan administered and funded by federal or state government that would be offered along with private plans in a newly-created health insurance exchange.

Uncompensated Care: A measure of the costs of health care services that are provided but not paid for by the patient or by insurance. Health care providers incur some of this cost along with the federal government.

Underinsured: People who have health insurance but who face out-of-pocket health care costs or limits on benefits that may affect their ability to access or pay for health care services.

Universal Coverage: A system that provides health coverage to all Americans. A mechanism for achieving universal coverage (or near-universal coverage) under several current health reform proposals is the individual mandate.

Wellness Plan/Program: Employment-based program to promote health and prevent chronic disease. Goals of these programs include, reducing health care costs, sustaining and improving employee productivity, and reducing absences due to illness.

Special thanks to the Henry J. Kaiser Family Foundation for their assistance with these definitions.