

Health Reform Glossary

Adverse Selection

People not covered by employer based plans tend to purchase insurance when they are sick and have mounting medical expenses. When this happens, it drives up premiums because healthy people are underrepresented in the insurance pool. Adverse selection also happens when healthy individuals opt for high deductible or low benefit plans, thereby leading to rising premiums for the sicker people in traditional plans. Insurance is affordable when there are large risk pools with both sick and healthy policyholders.

Community Rating

A method of setting health care premiums based on the average cost of health care services by all customers in a specific region. Everyone in the area is charged the same premium for the same type of policy. This is in contrast to experience rating where people's premiums are based on the medical history and past use of medical services. Community rating spreads the cost of insurance among all the policy holders of that company's plan.

Consumer-Driven Health Plan

This term typically refers to a health insurance policy with a very high deductible. Consumer driven health plans supposedly motivate consumers to make wise choices about their use of health care. What these plans actually do is shift the risk of incurring high health care costs away from insurers and employers and onto consumers. Health Savings Accounts are an example of consumer driven health plans. A fixed contribution plan, where an employer contributes a specified amount on money into a health care account that the employee controls is another example. Research demonstrates high-deductible policies cause people to cut back on medical care, including necessary services. If a health care crisis happens, people almost universally abandon HSAs in favor of traditional comprehensive plans.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)

A provision of federal law that requires employers to permit laid off workers to remain in the employer based health plan for a specified length of time. The employee must pay the full cost of coverage.

Cost Sharing

The portion of covered health services under a plan that the insured person is required to pay.

Deductible

A set dollar amount that must be paid by the patient before insurance coverage begins paying for care.

Disease Management- or Case Management

This refers to the coordination of care for people with chronic disease and complex medical needs. Often case management implies a specified individual responsible for arranging and approving health care services for the patient. Ideally case management ensures that patients have access to appropriate care and that all of their providers have full information about the patient. Unfortunately in managed care, case management has often led to efforts to minimize expenses rather than assure appropriate care.

Electronic Medical Records

These are patient medical records maintained on computers. A minority, but growing number of providers have switched from paper records to electronic medical records (EMRs). "Interoperable" EMRs are EMRs that can share data across regions or systems. There is potential for EMRs to decrease or eliminate common errors due to illegible handwriting and can speed sharing of critical patient information in

emergencies. The current research on EMRs is mixed. There is no conclusive evidence that EMRs lower costs, start up costs are considerable. .

ERISA (Employee Retirement Income Security Act of 1974)

This law took from the states their authority to tell employers that they had to offer insurance to their employees, and their authority to tell self-insured employers what benefits they had to cover. ERISA has been interpreted by the courts to mean states may not force employers to finance insurance for their employees by the more indirect route of taxing employers if they do not. ERISA is often said to prohibit “reform” at the state level. This is misleading. ERISA only prohibits states from financing universal or expanded coverage with taxes on employers (including a mandate that employers pay premiums for their employees). ERISA has no bearing on whether states may enact universal coverage with a single- or a multiple-payer system.

Evidence-Based Medicine

This phrase first appeared around 1990. It refers to medical decision-making that is based on scientific evidence as opposed to anecdotal evidence: experience, habit, personal preference, and tradition. Most people believe that health care is based on scientific evidence; this is unfortunately far from true. One small example from the field of obstetrics: episiotomy is the most common surgical procedure in the country, yet scientific evidence has shown it increases blood loss, slows healing and actually worsens muscle tone; continuous monitoring of fetal heart rate during labor increases the c/section rate and cost of childbirth, but does not improve outcomes for babies- yet both episiotomy and continuous monitoring are standard practice. Expensive new technologies and medications, both drivers of health care inflation are frequently adopted without proof they improves outcomes. If adopted as standard of care, evidence based practice can improve quality and decrease costs.

Federal Employee Health Benefits Program (FEHBP)

The health benefit plan for employees of the federal government. Employees can choose from a variety of plans but they all plans must offer similar core benefits. The employee pays a percentage of the cost.

Federal Health Board

This is a health reform proposal currently being considered. The FHB would resemble our current Federal Reserve Board for the banking industry. The Board would ensure consistency of “health-care protocols, benefits, and transparency” across public programs and would set evidence based standards for benefits and quality for federal programs in the hopes of assuring quality care and ultimately lowering costs. These standards would legally apply to federal health programs and contractors, but serve only as a model for private insurers.

Fee-For-Service

This refers to private and public plans that pay doctors and hospitals for each individual service they provide. These plans allow patients to choose any provider or hospital. Fee for service is in contrast to “managed care”. Managed-care advocates assert that overuse of the health care system is the primary cause of high health care costs, and that the fee-for-service payment method is the primary cause of overuse.

The facts are: (1) Underuse (not getting needed health care or taking prescribed medication) is a more common problem than overuse in the U.S. and (2) although common sense tells us the fee-for-service method does create an incentive to order unnecessary services, empirical research has not established that the fee-for-service method causes overuse.

Gatekeeper

A primary care doctor (in a managed care system) who must approve a patient’s access to medical specialists.

Guaranteed Issue

A requirement (usually at the state level) that insurers must sell a policy to anyone who seeks one, regardless of age, health status or risk based on vocation. The plan must be renewed as long as the premium is paid.

Health Maintenance Organization

The legal definition describes HMOs as insurance companies that agree to provide comprehensive services for a set fee per person per year. This is called “capitation”. The fee does not change based on the person’s medical needs. The plan limits patient choice of provider to a closed panel of providers. HMOs usually don’t charge deductibles. They were designed to control costs by limiting access to specialists (see gatekeeper). Research indicates that HMOs decrease the use of medical services, especially hospital and mental health services, but, despite that, HMOs did not contain health care spending because they were unable to improve health (they damaged quality of care on balance) and they drove up administrative costs.

Health Savings Account- see consumer driven health plan

Managed Care

Refers collectively to the cost-containment tools pioneered by HMOs, including: financial incentives (sometimes linked with performance on “report cards”) to induce doctors to provide fewer expensive services and to provide more preventive and evidence-based services; “utilization review,” which refers to review of physician-patient decisions by insurance company employees for the purpose of authorizing, amending, or vetoing the decision; and limiting choice of provider through proscribed networks. HMOs and Preferred Provider networks (PPOs) are examples. Drug formularies are generally considered to be a managed care method, as well. These techniques are responsible for much of the frustration and expensive overhead in our system. Research demonstrates that managed care neither cut costs nor improved quality.

Medical Home

A primary care clinic or facility where a patient receives most or all of his/her medical care. The goal is for care coordination and continuity appropriate to the patient’s need.

Pay for Performance

Pay for performance uses financial incentives to induce providers to provide “efficient high quality care” rather than performing “high volume care” (lots of tests, for example). This type of system is based on the premise that there is a direct link between care provided and outcome; and that we can standardize all measures of quality.

Pay or Play

A requirement that employers either contribute to their employees’ health coverage or pay the state, which then funds coverage.

Preemption

This usually means a federal law supersedes a state law on a certain topic and states no longer have authority to pass laws on that subject. So, ERISA preempts states from passing laws telling employers what benefits they have to offer employees. I think you could say the Constitution of the US preempts states from signing treaties with foreign countries. Preemption in this context is another way of saying the power to legislate lies only with the federal government.

Presumptive Eligibility

Allows states to provide children and pregnant women with immediate (but temporary) Medicaid or SCHIP (State Children’s Health Insurance Program) benefits, while eligibility is being determined.

Prior Authorization

A requirement to seek the insurer's approval before providing a specific medication or medical service, in order to have it covered by the plan.

Self-Insured Plan

This refers to health insurance in which an employer acts as the insurer for its own employees. In other words, the employer bypasses insurance companies and pays providers directly for services that the providers render to the employees of the firm. Forty percent of Minnesotans are in self-insured plans. Self-insured firms are essentially acting like single-payers for their employees.

Like single-payer programs or systems administered by public agencies, self-insured programs administered by employers cut administrative costs.

Single-Payer System

Refers to a system in which one payer or insurer reimburses doctors, hospitals and other providers. The single payer has the authority to negotiate limits on what providers, drug companies and equipment manufacturers can charge. Because Medicare's traditional program is a rough approximation of a single-payer system, an American single-payer system is often called a Medicare-for-all system. Medicare's traditional program (as opposed to the portion of the program that enrolls 20 percent of beneficiaries in private-sector plans for clinic and hospital services and the Part D program that provides completely privatized coverage for drugs) is a single-payer system because it is the sole insurer for its beneficiaries.

Because single-payer systems are much more efficient than multiple-payer systems, only the single-payer proposal can claim to achieve universal coverage for less or no more than we pay now. A Minnesota single-payer system would restore to patients their freedom to choose their own doctors and hospitals.

Subrogation

This is a legal term meaning one group or individual gets legal rights held by someone else. In the Minnesota Health Act, we talk about the single-payer board being granted the same right to sue an insurance company that the person insured by the company would have. The purpose, obviously, is to make sure a state or country isn't burdened with the expenses of people from other states or countries. In theory, the single-payer board could sue the National Health System of the UK if a London resident got sick while on business here and refused to help file the necessary papers with the British National Health Service.

Underinsured

People whose insurance doesn't cover their needed health care services or leaves them with medical expenses they can't afford.

Waiver

A waiver is just formal permission granted by an authority for a state or other party to do something that is ordinarily prevented by law. According to the Social Security Act (which is where the Medicare and Medicaid laws are), states have to follow certain rules in administering Medicaid. If they don't want to follow those rules, they have to ask for a waiver before they can disobey them. Similarly, if a state wanted to finance universal health insurance with a tax on employers, it would probably have to get a waiver from ERISA.

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