



Common Terms Used in the Health Reform Debate

The debate on health reform has produced many terms and acronyms that, outside of the wonky world of Washington, are not always easy to understand. We hope this Glossary will help make you some sense of the health reform word list – we will update it regularly in response to new terms that may be used and to answer questions we receive from you. If you hear a term that you'd like to know more about, but don't see here, email us at grassroots@nachc.com.

Conference Committee: because both the Senate and House have to pass the SAME bill for it to become law, representatives of both Houses must come together in temporary committee to bring the two different pieces of legislation passed by each into one single bill. *When the Senate finally passes its health reform bill, the House and Senate will need to merge their two different bills in a **Conference committee**. That is the bill that must ultimately be passed and that the President could sign into law.*

Cost Sharing: is when you share part of the cost of your health care with your insurance company by paying a co-pay or deductible.

Deductible: is the amount of money that a patient is required to pay for health care out of their own pocket before the insurance company pays anything. *Each insurance policy has a **deductible** amount and after the patient has paid up to that amount, the insurance company will pay all or part of the rest of the bill.*

Deficit-Neutral: is when a federal program or policy pays for itself over time so that it does not impact (or increase) the federal deficit. Typically, a policy is **deficit-neutral** when the cost of any new provisions is offset either by reducing spending on something else or by increasing revenues. *Under health reform, the President has asked that any health care reform bill be deficit-neutral so as not to add anything to the federal deficit.*

Employer Mandate: refers to a requirement that employers must offer and maintain health insurance for their employees. *The health reform bills currently include **employer mandates** for large employers (small businesses are currently exempt). This means larger employers must provide health insurance to their employees or they will have to provide money to help an employee pay to purchase their own health insurance – this is also called “play-or-pay.”*

Federal Poverty Level or FPL: refers to the level of income the federal government determines is sufficient for an individual or family to meet basic living requirements. Eligibility for federal programs such as Medicaid is based on a percentage of **FPL**. The current **FPL** is roughly \$11,000 for an individual or \$22,000 for a family of four. *A key element of health reform is how much to expand health care programs like Medicaid, or to provide assistance to individuals or families to buy insurance based on need under FPL guidelines.*

Filibuster: is a way to stop or delay the Senate's consideration of a bill. Any Senator who disagrees with a bill or simply wants to delay action, but does not have enough votes to defeat the bill may **filibuster** by speaking on the Senate floor as long as they want. *A **filibuster** can only be stopped when 60 Senators vote to end the debate. Some Senators may try to filibuster the health reform bill to prevent progress or final passage.*

Individual Mandate: is a requirement that every person must buy and maintain their own health insurance if it is not provided by a government program or their employer. *The health reform bills under consideration all include an **individual mandate** for people to have health insurance, although there are exceptions for certain groups of people including Native Americans, non-US citizens, and those with religious objections.*

Insurance Exchange(s): refers to a proposed newly-created marketplace that would allow individuals and certain employers to purchase private insurance. ***Insurance Exchanges** could be controlled by states, the federal government, or even locally, and would require all participating insurance companies to meet standards including; minimum benefits and coverage, transparency, and a requirement to include many types of providers (including health centers) in their networks.*

Medicaid: is a state-federal health insurance program that provides coverage for low-income Americans, and covers 36% of health center patients. *Health reform aims to expand **Medicaid** to provide coverage for up to an additional 15 million people by raising the minimum income level and allowing single-childless adults (and others that meet the income level) to enroll.*

Medicare: is a federal health insurance program that provides hospital, physician and prescription drug coverage for seniors (over age 65) and younger adults with disabilities.

Medicare Advantage: A plan offered by private companies which contract with Medicare to provide Medicare benefits. **Medicare Advantage** typically provides services to beneficiaries that are not covered and paid for under traditional Medicare. *Current proposals on how to pay for health reform could include in part, the savings yielded by reducing payments to Medicare Advantage plans.*

Premium: is the periodic payment an individual, family or employer makes to pay for an insurance policy. The **premium** and deductible are connected – typically, the lower your deductible is, the higher your premium, and vice versa. *Under health reform, Congress is working to make sure the cost of premiums and deductibles are fair and manageable for individuals and families.*

Public Health Investment Fund: is a fund proposed in the House health reform bill that would be a dedicated funding stream for public health and prevention. *Health centers are guaranteed funding from this fund currently in the amount of \$12 billion.*

Public Option: is a proposed health insurance plan, offered as part of an Insurance Exchange, which would be administered by the Federal government. *Any public option would have to meet all of the standards and requirements that other Insurance Exchange plans have to meet and compete with private insurance plans on an equal business footing. In the current Senate bill, states would be able to "opt-out" of (not offer its residents) the **public option**.*

Subsidies (aka Premium Credits): a subsidy is when the government provides assistance to pay a portion of the cost of some good or service for an individual or family. *In health reform, the federal*

government would cover a part of the cost of insurance premiums for low-income individuals and families who have to buy private insurance. Subsidy recipients will be able to purchase insurance through Insurance Exchanges at full price and receive a **subsidy, or premium credit**, from the IRS to reimburse them for some of the cost.

Important Health Reform Terms to Know for Health Centers

Essential Community Provider or ECP: is a health care provider that serves high-risk, special needs, and underserved individuals. *In health reform legislation, **Essential Community Providers** are defined as all entities that are eligible for the Medicare 340B discount (a prescription drug program). Currently, the health reform bills require all plans being sold in insurance Exchanges to include Essential Community Providers in their provider networks – health centers are defined as Essential Community Providers.*

Medicare Cap: refers to the maximum amount that Medicare will pay health centers for services to Medicare patients, regardless of how much care they provide or how much that care costs. Currently three-quarters of all health centers lose money serving Medicare beneficiaries because of this cap (it's an average loss of \$85,000 per health center each year). *Under health reform we hope to pass a health center provision – sometimes referred to as the MATCH Act - that would forever fix the outdated Medicare Cap by establishing a fair payment system for health centers.*

National Health Service Corps or NHSC: is a program administered by HRSA that helps medically underserved areas recruit and retain primary care physicians – and other health professionals - through loan repayment and scholarship funding. *A critical program for health centers, half of all **NHSC** clinicians work in health centers. Health reform seeks to expand the NHSC through additional funding.*

Prospective Payment System or PPS: is the way health centers are reimbursed by Medicaid and, as of October 2009, by the Children's Health Insurance Program (CHIP). *Under the health center **PPS**, health centers are paid reliably and adequately for all of the critically important and federally-approved services provided to patients enrolled in these programs.*