NACHC Health Reform Glossary

In Washington, technical terms and acronyms get used all the time. This is especially true as part of the current health reform debate. This Glossary is intended to help make some sense of the health reform lexicon – we'll update it regularly, as new terms are entering the picture each and every day.

Have you heard a term that you'd like to know more about, but don't see it here? Email us at advocacy@nachc.com, and we'll add it here.

Accountable Care Organization or ACO: is a group of hospital, primary care physicians, specialists and other providers who work together to integrate health care services for their shared patients and bill and report on these patients together with a shared goal of improving quality. In health reform legislation, physicians could form **ACOs** to coordinate care for their shared Medicare and Medicaid patients and then jointly share the benefits and additional reimbursement for improving the health of these patients.

Authorization vs. Appropriation vs. Directed Spending: **Authorization** is when Congress tells the government it *should* spend a certain amount of money on a certain program and it is typically the necessary pre-cursor to appropriation. **Appropriation** is when Congress actually spends a certain amount of money on a certain program in a given year. **Directed spending** bypasses the annual authorization-appropriation process and it's when Congress tells the government it *must* spend a certain amount of money on a program over a given future time period.

Benchmark Plan: refers to a standard, minimum health insurance plan and sets a floor for all health insurance coverage and benefits. In health reform, the bills establish a **benchmark plan** which sets a national floor for all insurance companies – all plans they offer must *at least* meet the standards and offer the benefits of the benchmark plan.

Community-Based Residency: is a program that provides medical students the opportunity to complete residency training in a community-based setting such as a health center.

Conference Committee: is when the Senate and House come together in an "ad hoc" (aka: temporary) committee to bring together two different pieces of legislation from the House and Senate into one single bill. **Conference committee** members are appointed by leadership in both chambers and, in health reform, will probably include members of House and Senate leadership and key committee chairs.

CO-OP: is a jointly-owned commercial enterprise that produces and distributes goods and services and is run for the benefit of its owners. Although this is most common now among groups of farmers or consumers, the health reform bill under consideration in the Senate would provide seed funding for groups to form nonprofit **CO-OPs** to provide health insurance, with the profits going toward better benefits and health care for consumers.

Cost Sharing: is the practice of sharing the burden of healthcare cost with one's insurance company through the charge of a co-pay or deductible.

Deductible: is the amount of money that a patient is required to pay out of their own pocket when they receive health care services, before their insurance company pays for care. Insurance companies set a **deductible** amount and once a patient pays up to that amount and the insurance company pays providers for charges over that amount.

Deficit-Neutral: is when a bill, program or policy pays for itself over a certain budget period and does not impact (especially increase) the federal deficit. Typically, a bill or policy is **deficit-neutral** when the cost of new provisions is offset by reductions to other spending or increases in revenues.

Employer Mandate: is a policy whereby employers are made responsible for carrying and maintaining health insurance for their employees. The health reform bills include **employer mandate** for large employers although small business are exempt, meaning larger employers must provide health insurance to their employees or they must pay a certain amount of money to an employee to partially pay for the individual to purchase their own health insurance – this is also called "play-or-pay."

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 and all plans being sold in insurance Exchanges must include Essential Community Providers in their provider networks.

Federal Poverty Level or FPL: is more strictly known as the "federal poverty guidelines" and it refers to the amount of income an individual or family earns each year. 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.

Federally-qualified Behavioral Health Center or FQBHC: is a new designation established in health reform legislation that would set standards and distribute grant funds for certain provider groups to provide mental health services including screening, diagnosis and treatment. Unlike FQHC designation, FQBHC does not bring additional benefits like better Medicare/Medicaid reimbursement, or FTCA coverage.

Federal Tort Claims Act or FTCA: is the statute that grants health centers medical malpractice protection under the law protecting Federal government employees. Health reform legislation in the House would extend that medical malpractice (**FTCA**) protection to clinicians that volunteer at health centers.

Filibuster: is a way to obstruct Congress' consideration of a bill. A party that disagrees with a bill might try to filibuster it by debating the bill indefinitely, calling for it to be read out loud, or any number of other delay tactics in order to stall progress or prevent a vote from taking place. A **filibuster** can only be broken with 60 votes in support of ending the debate.

Graduate Medical Education or GME: is a funding system under Medicare and Medicaid that pays primarily teaching hospitals for the direct and indirect costs of training medical residents. As part of

health reform, policymakers have been working to encourage more residency training in community-based settings like health centers.

Individual Mandate: is a policy whereby every person is responsible for carrying and maintaining their own health insurance. Although there are exceptions for certain groups of people including Native Americans, non-US citizens, and those with religious objections, among others, the health reform bills under consideration all include an **individual mandate** for people to have health insurance. This is similar to the **individual mandate** that all people must carry their own auto insurance.

Insurance Exchange(s): is a newly-created coordinated, regulated marketplace through which individuals and certain employers can purchase private insurance. **Exchanges** could be state, nationally, or even locally-controlled, and will require all participating insurance companies to meet benefit and coverage standards, transparency standards, and 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 threshold and allowing single-childless adults (and others that meet the income level) to enroll.

Medicaid Reimbursement: is the payment made by a state to a healthcare provider for services given to Medicaid patient. Health centers receive enhanced Medicaid reimbursement according to a Prospective Payment System (PPS) rate. See Prospective Payment System.

Medicare: is a federal health insurance program that provides hospital, physician and prescription drug coverage for seniors 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. Health reform bills are paid for in part by reducing payments to Medicare Advantage plans.

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. The **Medicare cap** was established by regulation in the early 1990s, and 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).

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. Half of all **NHSC** clinicians work in health centers. Health reform seeks to expand the NHSC through additional funding.

Nurse-Managed Health Center: is a community-based clinic, managed by nurses, that provides primary care and wellness services to underserved populations regardless of insurance status or inability to pay. Health Reform would create a new grant program for **Nurse Managed Health Centers**, separate from the Health Centers program.

Premium: is the periodic (monthly, yearly, etc) 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.

Preventive Services: are primary care services geared towards preventing disease including flu shots, cancer and diabetes screenings, mammograms, pap smears and yearly physical exams.

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.

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. See **Directed Spending**.

Public Option: is a proposed health insurance plan, offered as part of the Exchanges, which would be administered by the Federal government. It would meet all of the standards and requirements that other insurance Exchange plans have to meet. In the merged Senate bill, states would be able to "opt-out" of the **public option**.

School-Based Health Clinic: is a primary care clinic based out of, or partnering with, a school to provide physical and mental health services to medically underserved children and adolescents. Health reform legislation would create a new grant program for School-based Health Clinics, separate from the Health Centers program, and would improve SBHCs ability to bill under Medicaid.

Subsidies (aka Premium Credits): generally, a subsidy is when the government pays a portion of the cost of some good or service on an individual's behalf. In health reform, the federal government will cover a part of the cost of insurance premiums for low-income individuals and families –these people will be able to purchase insurance through the Exchanges at full price and receive a **subsidy**, **or premium credit**, from the IRS to reimburse them for some of the cost.

Teaching Health Center or THC: is a health center that has incorporated a residency program in primary care. Health reform legislation creates new authority and funding for the establishment and operation of Teaching Health Centers, and FQHCs are specifically eligible. See **Community Based Residency**.