

2

HEALTHWORDS

HealthWords 2 was prepared by the Colorado Health Institute (CHI) staff to assist policymakers, state and local agency officials and others in better understanding the myriad of terms and acronyms that are part of ongoing health care reform discussions. This 2009 glossary is an update to CHI's 2007 publication with additional terms that have become part of the lexicon of health care reform's unique language used to describe state- and national-level reform options and strategies.

For additional copies, please contact info@ColoradoHealthInstitute.org or see the CHI Web site at www.coloradohealthinstitute.org/HealthWords.aspx.

Italicized words are defined in this glossary.

Accountable Care Collaboratives

(ACCs). A regional approach to health systems accountability proposed by the *Colorado Department of Health Care Policy and Financing* as part of its *Medicaid* reform efforts. This systems reform would include designation of a statewide health information exchange and data organization to be responsible for reporting quality information to regional organizations (ACCs) charged with coordinating regional health care services and ensuring local accountability for quality health care delivery through Medicaid payment reforms to health care providers.

Acute care. Medical care provided in response to an immediate illness or a serious injury related to an accident or other form of trauma. Treatment is typically short term or episodic.

Activities of Daily Living (ADLs). Basic tasks individuals perform in the course of everyday life such as eating, bathing, dressing, toileting and transferring from a bed to a chair.

Amendment 35. The 2004 voter-approved amendment to the Colorado Constitution which increased the sales tax on tobacco products to expand access to health care and fund prevention programs. SJR09-035 declared a fiscal emergency and gave the governor permission to use the tax funds for other health care expenses contained in the state budget.

American Recovery and Reinvestment Act (ARRA). Federal legislation signed into law in February 2009 intended to provide a stimulus to the U.S. economy in the wake of the current recession. In the health care sector, funds were included for an enhanced Medicaid match for states, *COBRA premium subsidies* for laid-off workers, major expansion of *health information technology* and *electronic medical records*, comparative effectiveness research, expansion of *safety net* clinic capacity and health professions workforce training including student loan repayment programs. Colorado expects to receive more than \$7 billion over three years through more than 140 programs with some funds going directly to local organizations and others allocated through state agencies.

Arveschoug-Bird. A statute that limits Colorado General Fund operating appropriations to the lesser of 5 percent of state personal income or 6 percent over total General Fund expenditures for the previous year. Recent legislation (SB09-228) eliminated the 6 percent restriction on expenditures but maintained the limit of 5 percent of personal income.

Association Health Plans. A health insurance option whereby small employers that are members of an official trade group or professional association can band together across state lines to offer health insurance coverage to employees and their dependents.

Benefit package. Medical and other related services that are included in an insurance plan such as hospitalizations, office visits and prescription drug coverage.

Business Group of One (BGI). A self-employed person or a sole proprietor who qualifies for health insurance as a small business under Colorado's small-group insurance laws. BGIs are governed by the same rules as other small businesses (2-50 employees) and

therefore are guaranteed issuance of a policy regardless of *pre-existing conditions*.

Capitation. A contractual arrangement between a purchaser (employer or the state) and a health plan in which the health plan agrees to provide a specified range of services to enrollees for a negotiated prospective per member per month (PMPM) payment as opposed to paying on a *fee-for-service* basis for individual services provided. Under a fully capitated payment contract, the health plan is at financial risk for the cost of any services provided beyond the PMPM payment received for each member. In most fully capitated health plans, a *risk adjustment* tool is used to adjust the PMPM for members with known extraordinary health care needs.

Carve-out. A set of *Medicaid* services (for example, substance abuse or mental health) exempted from the capitation rate set for *managed care* plans. Also, certain populations may be “carved out” from mandatory Medicaid managed care plan enrollment such as the aged, blind or people with disabilities.

Case (care) management. A process used by public and private health insurers and *long-term care* providers to manage the care of high-cost, high-need individuals. Care is coordinated by a case manager to ensure that needs identified by a functional assessment are in alignment with authorized supportive services.

Categorically eligible. Classes of individuals eligible for the *Medicaid* program based on specific categories of eligibility including but not limited to very low-income parents, children ages 0-18 in low-income families, pregnant women, low-income aged, and blind and disabled individuals.

Centers for Medicare & Medicaid Services (CMS). The agency within the U.S. Department of Health and Human Services that is responsible for the federal administration of *Medicaid*, *Medicare* and the *State Children's Health Insurance Program*. (The Colorado Medical Society also uses "CMS" as its acronym of choice.)

CHIPRA (Children's Health Insurance Program Reauthorization Act of 2009).

Extends and expands the *State Children's Health Insurance Program* (now referred to as CHIP as opposed to SCHIP) to September 30, 2013. The act authorizes \$33 billion in federal funds to provide coverage to an additional 4.1 million children through the *Medicaid* and CHIP programs who otherwise would have been uninsured. CHIPRA also rewards states for outreach to families and enrollment of uninsured children through financial incentives and permits states to provide coverage to legal immigrant children and pregnant women who have been in the country for fewer than five years.

CHP+ (Child Health Plan Plus). The name of Colorado's *State Children's Health Insurance Program*.

CIVHC (Center for Improving Value in Health Care). Established in 2008 as part of Governor Ritter's Building Blocks to Health Care Reform. The virtual CIVHC includes a board appointed by Governor Ritter and a broad-based advisory committee including consumers, business, health care providers,

insurers, health policy experts and state agencies working together to pursue strategies for quality improvement and value purchasing in Colorado's *Medicaid* program with planned expansions into the private health care sector.

Clawback. The term used to describe the mechanism by which states pay the federal government back for prescription drugs that states formerly paid for through the *Medicaid* program but which are now paid for by Part D, the federal prescription drug benefit under *Medicare*.

COBRA (Consolidated Omnibus Budget Reconciliation Act). 1986 federal legislation containing certain health benefit provisions that amend *ERISA*, the IRS code and the Public Health Service Act to enable qualified individuals who lose their job to maintain the group coverage in which they were enrolled for an additional 18 months after leaving employment. COBRA applies to firms with more than 20 employees. Qualified individuals, which can also include retirees, spouses, former spouses and dependent children, are required to pay the full amount of the standard *premium* of the plan in which they

were enrolled while employed. The *American Recovery and Reinvestment Act of 2009* provided for premium reductions and additional election opportunities for health benefits under COBRA for a limited amount of time.

Colorado Department of Health Care Policy and Financing (HCPF). The state agency that administers the *Medicaid* and *CHP+* programs as well as a variety of other programs for Colorado's low-income families, the elderly and persons with disabilities.

Colorado Department of Human Services (DHS). The state agency that administers a broad range of social services in Colorado, including behavioral health programs, the system of services for people with developmental disabilities, aging and adult services and the coordination of early childhood programs and services.

Colorado Department of Public Health and Environment (CDPHE). The state agency responsible for administering a broad range of public health functions for the state including air and water quality, hazardous waste management, childhood immunization

programs and chronic *disease management* programs, to name a few.

Colorado Department of Regulatory Agencies (DORA). The state agency that oversees Colorado's business environment and provides consumer protection services. It houses the state's health professions licensing boards and the Division of Insurance which regulates health, auto and property insurance companies in the state.

Colorado Health Care Affordability Act (HB 1293). 2009 state law that will allow Colorado to assess a fee on hospitals that will generate additional federal funds to provide higher reimbursements to hospitals for *Medicaid* and *Colorado Indigent Care Program* patients and enable expansion of Medicaid coverage to more than 100,000 uninsured Coloradans. Colorado expects to generate an additional \$600 million annually through the hospital fee that will be matched by \$600 million in federal funds.

Colorado Household Survey. A 10,000 person telephone survey conducted in late 2008 and early 2009 of Colorado households

that focused on health insurance coverage, access to physical and oral health care, out of pocket health care costs and affordability of care.

Colorado Indigent Care Program

(CICP). A state-administered program that provides partial reimbursement to some health care providers who provide a significant amount of health care to the state's low-income *uninsured* populations up to 250 percent of the *federal poverty level*. Funds currently are provided to 46 hospitals, 15 clinics and 92 satellite facilities throughout the state. A major source of funding is the *Disproportionate Share Hospital Program*.

Community Health Centers (CHCs).

Federally designated and funded nonprofit health clinics that provide comprehensive *primary care* services regardless of patients' ability to pay. Also known as Federally Qualified Health Centers (FQHCs), these clinics receive cost-based reimbursement for *Medicare* and *Medicaid* patients and must use a *sliding-fee schedule*. Colorado has 15 CHCs which operate over 138 clinic sites in 35 Colorado counties and care for patients living in 55

counties. CHCs provide physical health care with some providing dental and mental health care services as well.

Community rating (pure and modified).

A method for actuarially determining health insurance *premiums* based on the average health care use and costs of a population. Pure community rating is a rate calculated on an entire population regardless of its health status, age, gender or geographic location. Modified community rating permits insurers to consider certain demographic factors in calculating rates such as age, gender, health status, geography or other factors including some combination thereof.

Consumer-driven health care. An insurance model that combines a *high-deductible health insurance plan* with a tax-preferred *health savings account* which enrollees may use to pay for routine health care expenses up to a certain amount, usually around \$2,000 per year for an individual policy. The theory behind the consumer-driven health insurance model is that when individuals are more directly responsible for the cost of routine health care

they will be more prudent purchasers and consume only what they need to stay healthy.

Consumer-directed attendant care services (CDAS). A Medicaid optional benefit that allows enrollees to hire and supervise their personal care attendants who deliver a defined set of personal care services, thus allowing *long-term care* consumers to directly purchase and manage the services they need.

Co-payment. (See *Cost-sharing*)

Cost-sharing. The portion of health care expenses that falls to an insured individual for payment, usually taking the form of a co-payment (the amount an insured individual has to pay for a service such as an office visit or a prescription) and a deductible (the dollar amount that must be paid before insurance coverage begins).

Cost-shifting. Increasing the *premium* charged to one segment of the insured population, e.g., individuals with employer-sponsored coverage, to make up the difference between the actual costs of providing care and the amount reimbursed by public programs such as *Medicare* and *Medicaid*. This term also

applies to the practice used by health care providers such as hospitals to cover the costs of *uncompensated care* provided to *uninsured* patients by passing these costs on to insured patients in the form of higher charges.

CoverColorado. (see *High-risk pool*)

Crowd out. The case in which a new or expanded public health insurance program designed to extend coverage to a previously *uninsured* population prompts otherwise eligible privately insured individuals to drop their private coverage to take advantage of the public option.

Current Population Survey (CPS). A 50-year-old monthly survey of approximately 50,000 households conducted by the U.S. Census Bureau for the Bureau of Labor Statistics. Currently, the CPS is the best source of Colorado-specific data on *uninsured* Coloradans.

Deductible. (See *Cost-sharing*)

Deficit Reduction Act (DRA) of 2005. Federal legislation that, among other provisions, requires pregnant women and parents

who apply for *Medicaid* coverage on behalf of themselves and their children to submit original or notarized forms documenting citizenship; also requires that photo identification be provided at the time of application.

Disease management. Ongoing management of chronic disease through an integrative, multi-disciplinary care model. Disease management programs are designed to be cost-effective and an alternative to the fragmented care patients receive when seeing multiple providers.

Disproportionate Share Hospital (DSH) Program. A federally funded program enacted in 1981 that provides enhanced *Medicaid* funding to hospitals that serve a significant number of low-income *Medicaid* and *uninsured* patients. In Colorado, the DSH program is a major source of funding for the *CICP* program.

Dual eligible. A low-income aged, blind or disabled *Medicare* beneficiary who also qualifies for the *Medicaid* program.

Durable Medical Equipment (DME). Medical equipment provided to individuals with functional limitations or recovering from

a hospital event. Examples include modified shower equipment, walkers, wheelchairs and hospital beds.

Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). A mandatory *benefits package* available to all children, adolescents and pregnant women under the age of 21 years enrolled in the state's *Medicaid* program that is designed to ensure access to early and comprehensive preventive health care and appropriate treatment. The state must provide these benefits under the terms set forth by the *Centers for Medicare & Medicaid Services*.

Electronic medical record (EMR). An individual medical record that has been digitized and stored electronically and moves with a patient across types of providers.

Emergency medical services (EMS). Services provided by “first responders” (ambulances, fire and police departments) in response to an emergency situation caused by an accident, natural disaster or terrorist act.

Emergency Medical Treatment and Active Labor Act (EMTALA). Federal legislation passed as part of the Omnibus Budget Reconciliation Act of 1986 that requires hospitals and ambulance services to stabilize a patient by providing immediate medical care to anyone needing emergency treatment regardless of citizenship, legal status or the ability to pay.

Employer mandate. A means of increasing health insurance coverage by requiring employers of a certain size (usually 50 or more employees) to provide health insurance to their employees or pay a penalty (often referred to as “pay or play”).

Employer-sponsored insurance (ESI). Health insurance coverage provided by an employer. ESI can be solely paid for by an employer or provided with premium *cost-sharing* between the employer and employee.

ERISA (Employment Retirement Income Security Act). Federal legislation passed in 1974 that contains a number of health benefit provisions including the setting of minimum standards for voluntarily estab-

lished private health insurance plans. ERISA prevents states from regulating *self-insured* health plans offered by employers, thus providing latitude in the benefits self-insured employers can offer to their employees.

Evidence-based medicine. The use of clinical evidence about treatment methods in medical decision-making related to individual patient care. The use of practice protocols developed through clinical research is a good example of how evidence-based medicine gets translated and diffused into medical practice.

Federal poverty level (FPL). Annually updated guidelines established by the U.S. Department of Health and Human Services to determine eligibility for various federal and state programs. In 2009, the FPL for a family of four is \$ 20,650.

Fee-for-service. A method of paying providers for health care delivered in which an insurer pays a physician or hospital for part or all of the cost of a service according to a pre-determined fee schedule.

Guaranteed issue. Health insurance for which there is a guarantee that coverage is

available to anyone regardless of health status, occupation, age or gender. Guaranteed issue is required in Colorado's *small group market* (2-50 employees) and *BGIs* but is not required in the individual market.

Health care vulnerability. The state of being at risk for not obtaining health care coverage or being unable to gain access to needed health care services by virtue of income, geographic location, health status, cultural barriers or other related socio-economic factors.

Health information technology (HIT). The automation of health information for the purpose of sharing clinical and demographic information at the patient and provider levels with the goal of improving health and health care quality. The policy goal of HIT is to automate health information at the patient level in order to reduce redundancies in testing and other diagnostic procedures and eliminate medical errors and the fragmentation of patient-level information.

Health insurance exchange. A new entity included in several national health reform proposals that would serve as a broker of health

insurance plans available to individuals and small employers for the purpose of providing more transparency in comparing available standardized, affordable benefit plans.

Health Insurance Flexibility and Accountability (HIFA) Waiver. A federal waiver program that provides states increased flexibility in tailoring their *Medicaid* and *State Child Health Insurance Programs*. States may expand eligibility in Medicaid and CHIP only if they can demonstrate budget neutrality in such expansions. States are also encouraged to use the private health insurance market, to the extent feasible, in designing coverage expansions through a HIFA waiver.

Health insurance transparency. Initiatives that enable purchasers, including employers and individual consumers, to compare the quality, outcomes and price of health care services so they can make informed choices when purchasing or selecting a health care provider or set of services.

Health Maintenance Organization (HMO). A comprehensive health insurance plan that provides a coordinated array of

preventive and treatment services for a fixed payment per member per month (PMPM), also known as a *capitation* payment. HMOs provide services through a fixed panel of health care providers that can either be employees of the HMO or provide care under contract. Enrollees receive medically necessary services regardless of whether the cost of those services exceeds the negotiated PMPM.

Health Savings Account (HSA). A tax-sheltered account funded by an employee and/or employer into which pre-tax dollars are deposited for the purpose of paying for qualified medical expenses. Under current federal law, employees must be enrolled in a *high-deductible health plan* to establish an HSA. In 2009 the annual contribution allowed is \$3,000 for an individual and \$5,950 for a family. Additionally, individuals over 55 years of age may make a catch-up contribution of up to an additional \$1,000 per calendar year.

High-deductible health plan. A health insurance plan that requires the payment of a specified amount before the insurer begins reimbursing for services provided. The deductible is paid by the enrollee, either out

of pocket or through a *Health Savings Account*, a flexible spending account or a Section 125 cafeteria plan. For 2009, the minimum annual deductible amount established by law was \$1,150 for an individual and \$2,300 for family coverage. In most products sold in Colorado, the deductible is higher than the minimum and often is shared by the employer and employee.

High-risk pool (CoverColorado). A state-established, subsidized health insurance program designed to provide coverage to individuals who have been excluded from the individual insurance market because of a *pre-existing* medical condition and who are not eligible for public coverage. In Colorado, the high-risk pool, CoverColorado, provides subsidies to certain low-income individuals, although *premiums* are generally set at 100-150 percent of prevailing rates in the nine geographic rating regions of the state.

HIPAA (Health Insurance Portability and Accountability Act). Passed by Congress in 1996, HIPAA includes various health insurance coverage and patient privacy protections. The privacy rules were established to protect patients' privacy through

the strict enforcement of confidentiality of medical records and other health information provided to health plans, doctors, hospitals and other health care providers. Rules to implement HIPAA were developed by the U.S. Department of Health and Human Services.

Home and Community-based Services (HCBS) Waiver. An array of *long-term care* supportive services funded by *Medicaid* and provided in a community setting with the goal of meeting the health, functional and behavioral health needs of low-income elders and individuals with disabilities who otherwise would be eligible for placement in a facility such as a nursing home.

Indemnity insurance. Insurance purchased by individuals and employers that is based on a *fee-for-service* reimbursement schedule. Indemnity insurance policies assume the insurer will pay a certain percentage of charges, usually 80 percent, with a 20 percent co-payment paid by the insured. Indemnity plans provide more provider choice than *PPOs* or *HMOs*.

Individual mandate. A means of increasing health insurance coverage that requires all individuals, with few exceptions, to purchase health insurance (similar to the auto insurance mandate). The policy goal is for universal health insurance coverage and is predicated on the availability of affordable plans.

Individually purchased insurance. Health insurance products available for purchase by individuals without the involvement of an employer sponsor. Unlike insurance sold in the small group market, insurers in Colorado can deny individual coverage based on an individual's health status.

Limited benefit plan. A health insurance plan that covers fewer benefits in exchange for lower premiums relative to comprehensive health insurance plans. The benefits covered by these plans vary, but usually include doctor visits, X-rays and lab work, prescription drugs and limited hospitalization. In addition, covered benefits may be limited to specific settings, conditions or diseases. These plans are generally purchased by individuals not covered by an employer-sponsored health insurance plan.

Long-term care. Health care, personal assistance and other supportive services provided to individuals with significant functional limitations that are unable to care for themselves without the assistance of others. Long-term care services are provided in institutions, the home and other community-based settings. These services are generally paid for privately or, in the case of eligible low-income elders and people with disabilities, are covered under the *Medicaid* program.

Managed care. Insurance coverage that integrates service delivery and financing through an identified panel of providers that coordinate care with the goal of ensuring the appropriate health care is delivered at the right time by the right provider to plan members. Managed care organizations are reimbursed through a negotiated capitated monthly payment.

Medicaid. Title 19 of the Social Security Act, passed in 1965, which established a state-federal partnership to provide health care coverage to low-income children, parents, pregnant women, elders and individuals with disabilities. In 2009 in Colorado, more than

472,000 people are receiving health care coverage through Medicaid. Medicaid in Colorado complies with all federal minimum requirements for services and covered eligible groups and additionally authorizes some optional services and eligibility categories beyond those mandated by federal law.

Medical home. A regular source of medical care that is continuous and comprehensive in its approach. The goal of medical homes is to promote wellness, prevention and early intervention for health care problems and health *care management* in the presence of chronic disease. SB 130, which passed in the 2007 legislative session, established state policy that all children enrolled in the *Medicaid* program in Colorado should have access to a medical home to ensure continuous access to preventive, developmental and *acute care* services.

Medical Services Premium. The term used by *HCPF* to represent the payments made on behalf of *Medicaid* enrollees in Colorado for the physical health services they receive from authorized Medicaid providers.

Medical underwriting. The use of medical or health status information in setting health insurance premiums. In Colorado, medical underwriting is not permitted in the small group insurance market but can be used to set rates for individual health policies.

Medically indigent. Low-income, *uninsured* individuals who do not qualify for government-sponsored coverage such as *Medicaid* and *Medicare* or for whom *employer-sponsored insurance* is not an option.

Medically Needy. An optional eligibility category under the *Medicaid* program that establishes eligibility for low-income individuals who are over the income eligibility threshold in a state but who have extraordinary medical expenses that can be used to “spend down” into Medicaid eligibility. Colorado is one of a minority of states that does not have a Medically Needy program.

Medicare. Title 18 of the Social Security Act, passed in 1965, which created an entitlement to health care coverage for individuals age 65 and older and eligible individuals with permanent and significant disabilities. Medicare

Part A covers inpatient hospital care, some skilled nursing facility care and hospice care. Part B covers physician care, diagnostic X-rays, laboratory tests and *durable medical equipment*. Part C, originally Medicare + Choice and now Medicare Advantage, allows private insurers to offer a Medicare plan. Part D, the most recent addition to the Medicare program, offers a subsidized prescription drug benefit to Medicare beneficiaries.

Medicare supplemental insurance (Medigap). Health insurance sold by private insurance companies to fill some of the payment and benefit “gaps” in *Medicare* coverage.

Moral hazard. Prospect that when individuals are insulated from risk through insurance coverage they may behave differently than they would if they were fully exposed to the risk. For example, an insured individual with a comprehensive health insurance policy may be less conscientious about certain risky behaviors with the knowledge that the insurance policy will pay for the consequences of these behaviors (e.g., smoking).

Out-of-network providers. Services provided by health care providers who are not employed by or under contract with a *managed care* plan or specified *preferred provider organization (PPO)* network. Health plan enrollees generally pay an additional co-payment for using out-of-network providers.

Out-of-pocket payments. Direct spending by consumers for health care goods and services including *cost-sharing* for monthly *premiums*, deductibles and co-payments.

Pay for performance (P4P). A reimbursement system currently used by Medicare and some states' Medicaid programs that rewards health care providers based on measurable improvements in specified health care outcomes of their patients.

Pay or play. (See *Employer mandate*)

Pharmacy benefit managers (PBMs). Companies that manage the drug benefit coverage offered by *employer-sponsored insurance*.

Pre-existing condition. A medical condition developed prior to an individual's enrolling in or purchasing a health insurance policy; may

be used to deny coverage in some instances, such as in Colorado's individual insurance market.

Preferred Drug List (PDL). A list of prescription drugs covered by a particular health plan or public program that have been selected for their efficacy, safety and cost-effectiveness. Ideally, the list is based on documented scientific evidence.

Preferred provider organization (PPO). A defined benefit health insurance plan in which health care providers agree to provide services to members at a negotiated price (usually a discounted fee).

Premium. Amount paid to an insurance company for providing health care coverage to an individual for specified benefits contained in a contract between an insurer and purchaser (either an employer or individual purchaser).

Premium subsidy. Publicly financed assistance available to help certain low-income individuals and families purchase an affordable health insurance policy. The subsidy is usually calculated based on a sliding scale according to income.

Presumptive eligibility. Preliminary determination of eligibility for certain *Medicaid* eligibility categories made so a person can receive health care benefits before a final eligibility determination is made. In Colorado, low-income pregnant women, women applying to the breast and cervical cancer Medicaid program, children under the age of 19 and individuals applying for long-term care services qualify for presumptive eligibility.

Primary care. Medical care provided by physicians and other health professionals such as advanced practice nurses, physician assistants and certified nurse midwives who are licensed to provide preventive, early intervention and continuous care for basic health care services. Primary care is ongoing and can involve the establishment of a *medical home* for individuals at all stages of the life course from pregnancy and childbirth through old age. Primary care includes pediatrics; general, internal and family medicine; and obstetrics and gynecology.

Primary Care Fund. (see *Amendment 35*)

Purchasing pool. A group of purchasers such as small firms and individuals that join

together to leverage their bargaining power when purchasing health insurance. Purchasing pools have the advantage of spreading risk across a greater number of individuals and eliminating pre-existing condition clauses for individuals.

Qualified Medicare Beneficiary (QMB).

One of several eligibility categories for which the *Medicaid* program assists low-income *Medicare* beneficiaries to pay for all or some of Medicare's *cost-sharing* amounts. Specifically, Medicaid pays the Medicare Part A monthly *premiums* (when applicable), Medicare Part B monthly premiums and annual deductible, co-insurance and deductible amounts for services covered under both Parts A and B.

Referendum C. A voter-approved measure that provides Colorado state government a five-year hiatus (FY 2005-06 through FY 2009-10) from the revenue retention limits of the *Taxpayer's Bill of Rights (TABOR)* Amendment. Additional revenues that are retained due to passage of Referendum C are required to be appropriated for public K-12 education, higher education, health care and transportation.

Reinsurance. Insurance for insurance companies in which a third-party insurer, sometimes the state, assumes responsibility for high-cost, low-frequency claims, thus lowering the average risk of a group and resulting in lower *premiums* for an insured group.

Retail clinic. Health clinics usually located in a shopping mall or discount store such as Wal-Mart that provide a limited range of primary care services on a *fee-for-service* basis. Services are usually provided by nurse practitioners or physician assistants.

Risk adjustment. A process by which PMPM payments made to a health plan are adjusted to compensate for spending that is expected to be higher than average depending on the health status of its enrollees. Risk adjustment tools have been designed to discourage health plans from avoiding less healthy individuals, particularly in the *Medicaid* program.

Rural Health Clinic. A clinic certified by the *Centers for Medicare & Medicaid Services* to receive cost-based reimbursement for *Medicare* and *Medicaid* patients in order to

improve access to *primary care* in underserved rural areas.

Safety net. A largely nonprofit and public array of providers including community clinics, school-based health centers, hospitals and others that provide health care for low-income, *uninsured* and *underinsured* Coloradans and those enrolled in publicly funded health care programs such as *Medicaid* and *CHP+*.

School-based Health Centers (SBHCs). Health clinics housed in schools that receive federal, state and local funds in addition to patient revenues and in-kind contributions to provide primary health care services in K-12 schools with a high concentration of low-income children. Some SBHCs also provide dental and behavioral health services.

Section 330 of the Public Health Service Act. Federal 330 grants are provided to migrant and *community health centers*, Health Care for the Homeless programs and Public Housing Primary Care Programs to serve low-income, *uninsured*, *underinsured*, *Medicaid* and otherwise vulnerable populations.

Self-insured or self-funded employers.

Employers that set aside funds to pay for the health care costs of employees and their dependents. A self-insured/self-funded employer assumes financial responsibility for the health care costs of its enrolled employees and dependents based on a defined benefit plan. Self-funded health insurance is not regulated by states' insurance commissioners but rather by federal legislation known as *ERISA*. A self-funded employer may use the services of a third-party administrator, often an insurance company, to administer the benefit plan.

Single-payer system. The term used to describe a health insurance financing system in which one entity—public (state agency) or private (an insurance company)—is responsible for collecting health insurance *premiums* and negotiating rates paid to providers for a defined *benefit package* available to all covered individuals.

Sliding-fee schedule. Discounted prices charged for health care services provided to low-income, uninsured patients usually based on family size and household income.

Small group market. The insurance market for products sold to firms with 1-50 employees in Colorado. The state's small-group market includes qualified self-employed individuals or sole proprietors who meet the criteria of the *Business Group of One* designation specified in state regulations.

Social Security Disability Insurance

(SSDI). Federal cash payments to individuals who have worked for a specified number of quarters and paid into the Social Security Trust Fund through payroll taxes and who have a disability severe enough to keep them from working in any regular paying job for at least 12 consecutive months.

Specified Low-Income Medicare

Beneficiary (SLMB). One of the several *Medicaid* eligibility categories for which *Medicaid* pays the Part B *premium* for low-income (below 120 percent of the *federal poverty level*) *Medicare* beneficiaries who are otherwise not eligible for *Medicaid* coverage.

Stair step. The situation where children in the same family are eligible for different public programs, either *Medicaid* or *CHP+*, because

they have differing eligibility standards based on the child's age in combination with the family's income. Efforts to eliminate Colorado's Medicaid stair step failed in 2008.

State Children's Health Insurance Program (CHIP). A federal-state partnership program administered by the states in which the federal government provides a block grant to Colorado based on a 65/35 *cost-sharing* ratio to assist the state in offering health care coverage to low-income children and other family members who do not qualify for *Medicaid* based on income. Colorado's program, the Child Health Plan Plus (CHP+), provides coverage to children and pregnant women with incomes up to 200 percent of the *federal poverty level*.

Stop-loss insurance. An insurance policy designed to protect self-insured employers from unpredictable and/or catastrophic losses. These policies pay claims after the employer has paid a predetermined amount in claims. Colorado law requires self-insured employers to cover a minimum of \$15,000 per employee before stop-loss coverage pays claims. In addition, Colorado law requires each stop-loss

policy to protect employers from catastrophic losses. If total claims exceed the minimum of 120 percent of an employer's total expected claims, the stop-loss insurance carrier reimburses the employer.

Supplemental Security Income (SSI).

A federally funded cash assistance program designed to help low-income elders, blind and disabled individuals who have little or no income to purchase goods and services to meet their basic needs of food, clothing and shelter. Once eligible for SSI, these low-income individuals are also eligible for *Medicaid* coverage.

TABOR (Taxpayer's Bill of Rights)

Amendment. Constitutional amendment passed in 1992 by Colorado voters to restrain the growth of all levels of government (state, local, city, county, school and special districts) by limiting annual revenue increases to the prior year's revenue limit plus population growth and inflation. TABOR requires that any state or local tax increase must be approved by voters of the affected level of government.

Take-up rate. The rate at which people entitled to a benefit sign up for the benefit.

Trauma care system. The organized and coordinated efforts of local and state policy-makers and providers to deliver a full range of *emergency medical services*. Included in these systems are first responders, hospital emergency departments and Level I, II and III trauma units.

Uncompensated care. Services provided by health care providers for which no payment is received from the patient or a third-party payer. Uncompensated care can result in accumulated bad debt for providers or may be counted toward a nonprofit hospital's annual charity care obligation under rules established by the Internal Revenue Service.

Underinsured. Individuals and families with public or private insurance that does not cover all necessary health care services, resulting in out-of-pocket expenses that may affect their ability to pay for or gain access to health care.

Uninsurable. An individual who does not have health care coverage through private insurance because he or she falls outside the parameters of standard health insurance

underwriting practices. CoverColorado is the state's high-risk insurance program, a quasi-governmental agency that offers health insurance coverage to individuals who have been underwritten out of the individual insurance market because of a *pre-existing health condition*. (Also see *High-risk pool*.)

Uninsured. People who lack public or private health insurance coverage.

Wellness benefits. A set of benefits covered by a health insurance plan that promote wellness behaviors and may reward a plan enrollee who participates in physical exercise, stress reduction, smoking cessation, nutrition education and weight loss programs that enhance health through reductions in co-payments and deductibles.

The Colorado Health Institute (CHI) is an independent, nonprofit health policy and research organization based in Denver. It was established in 2002 by Caring for Colorado Foundation, The Colorado Trust and Rose Community Foundation. CHI's mission is to advance the overall health of the people of Colorado by serving as an independent and impartial source of reliable and relevant data for informed decisionmaking.



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