SJR 35: Health Care

Federal Health Care Reform: A Glossary of Common Terms

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Following are explanations of some of the commonly used terms in the federal health care reform discussions.

Blue Dog Coalition: Fifty-two fiscally conservative House Democrats who are advocating for certain requirements in any health care reform bill, including patient choice, continued competition in the market, and no increase in the federal deficit. Because the coalition may vote as a bloc, the group could be influential in passing any health care reform bill out of the House.

Capitation: A system in which health care providers are paid a fixed amount for each patient in their care, as an incentive to contain costs. A capitated system differs from a fee-for-service system in which health care providers bill for each service a patient receives.

CBO Scoring: The process in which the nonpartisan Congressional Budget Office (CBO) reviews and reports on the financial effects of a piece of legislation.

Comparative Effectiveness Research: Scientific research that examines the relative cost and effectiveness of medical procedures.

COBRA: The acronym for a requirement under the Consolidated Omnibus Budget Reconciliation Act of 1985 that allows a person to continue receiving insurance coverage through his or her former employer's policy for a period of time after losing or changing jobs. The individual must pay the full cost of the policy.

Co-op: A nonprofit cooperative that could be set up to compete with private insurers without creating a government-run insurance plan, or "public option." A co-op is owned and governed by its members, so the organization would be operated by the people it insures.

Crowd Out: The term used to describe a reduction in private insurance coverage that is caused by expansion of government-funded coverage.

Disproportionate Share Hospital (DSH) Payments: Payments provided by the federal government to hospitals that serve a higher-than-average number of low-income patients.

Employer Exclusion: The tax break that people with employer-offered insurance coverage

receive because their share of the insurance premium is deducted from their paychecks before taxes are taken out. This practices reduces a person's taxable income.

Employer Mandate: A requirement that employers of a certain size offer health insurance coverage to their employees.

Fee-for-Service: A payment system in which a health care provider bills the insurer for each service provided to a patient.

Guaranteed Access/Issue: The requirement that an insurance company provides or renews health insurance coverage for anyone who applies, regardless of a person's existing medical conditions.

Health Insurance Exchange: A clearinghouse that would offer a range of insurance options for people who are buying insurance on their own. Policies offered through the exchange would offer a minimum level of benefits and would remain in effect even if people changed jobs or, depending on the way in which the exchange is organized, if they moved.

Individual Mandate: A requirement that people buy insurance, either by joining an employer-offered plan or by buying a policy through a health insurance exchange. People who failed to buy insurance are expected to be subject to a tax penalty.

Mark Up: The process in which a congressional committee amends a piece of draft legislation.

Medicaid: The federal-state program that provides insurance coverage to low-income children, families, and some adults, as well as disabled individuals of all ages and low-income adults over the age of 65.

Medicare: The federal program that pays for medical care for adults age 65 and older, using a combination of payroll taxes that have been paid into the system and monthly premium fees for enrolled individuals.

Medicare Buy-In: An option in which certain individuals can make payments and become eligible for Medicare benefits before reaching the age of 65.

Medicare Payment Advisory Commission (MedPAC): An independent panel of doctors and others who make recommendations to Congress on provider reimbursement and other issues involving Medicare, such as access to and quality of care.

Out-of-Pocket Expenses: The money that people with insurance spend on health care services because the expenses are not covered by their insurance policies. These expenses may include a deductible that must be met before benefits are paid, co-insurance for medical procedures or hospital stays, co-payments for physician office visits, or the full cost of services or goods that are not covered at all by the policy.

Pay-or-Play: The requirement that an employer provide health insurance for employees or pay a penalty to the federal government for each employee who buys health insurance through an exchange or obtains it through the Medicaid program.

Pre-Existing Condition: A medical condition with which a person was diagnosed or that existed before the person bought a health insurance policy.

Public Option: A government-run health insurance program.

Reconciliation: The parliamentary process used in the U.S. Senate to enact a bill by a simple majority, rather than the 60-vote majority needed to avoid a filibuster. The process may be used only for bills that affect government spending and revenues.

Shared Responsibility: The philosophy that everyone has a role to play in ensuring that all Americans have health insurance coverage. This means that individuals must buy insurance, most employers must offer insurance coverage to their employees, and insurance companies cannot deny coverage because a person has a medical condition.

Single-Payer Plan: An insurance plan in which one "payer" – typically the government – funds all health care costs billed by health care providers.

Sustainable Growth Rate (SGR): One feature of the process used by Medicare to set fees for physicians' services. The rate is updated annually to reflect inflation, the current number of Medicare enrollees, and other factors.

Uncompensated Care: Medical care for which a health care facility or provider is not paid because the patient does not have insurance and/or cannot afford to pay the bill.

Underinsured: People who have health insurance but still face high medical costs because their coverage has high out-of-pocket medical expenses. Some groups consider people to be underinsured if these expenses total 10% or more of their incomes.

Universal Coverage: A health insurance system in which all people are covered by health insurance.