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Multiple Sclerosis
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Health Reform Principles Glossary

Assistive technology: Products and services that allow people with disabilities and the elderly to do activities that otherwise might not be possible. Some examples are wheelchairs and walkers, as well as computer technology like screen magnifiers and speech recognition programs.

Care coordination – Generally, methods designed to link patients, especially those with special health care needs and their families, to health care services and resources in a coordinated effort to reduce confusion and duplication of efforts, as well as maximize communication, fully-informed decision-making and optimal outcomes in care.

Centers of excellence – While centers of excellence are defined in many ways, the basic idea is that it is a healthcare organization that has an integrated program of care that surpasses normal expectations. This includes being able and committed to measuring the quality of care regularly and improving quality of care, health outcomes and cost.

Co-insurance - The portion of covered health care expenses that must be paid, in addition to the deductible, by the health plan members. The figure is usually expressed in a ratio, such as 80/20, where the insurer pays 80 percent and the client pays the remaining 20 percent of the bill.

Comparative efficacy – A term used to describe efforts to compare the effectiveness of two or more treatments used to treat the same condition or symptom.

Co-pay- The amount an insured patient pays toward the cost of a particular service. For example, a $10 co-pay may be required for each visit to the doctor.

Distribution of risk (see 'risk') – Because people with chronic health conditions like MS are considered poor risks by insurance companies, methods used to determine the amounts to be charged to them – in premiums and other out-of-pocket costs – are more affordable when averaged or 'distributed' along with individuals considered better risks.

National
Multiple Sclerosis
Society

Claims history (or claims experience) – Generally refers to the insurance industry practice of assessing an insured person's or group's risk based on their past claims.

Community rating - A method of determining health care premiums where the premium is based on the average cost of health services used by all members in a specific service area. When community rating is in place, insurance companies are required to charge the same premium to all their customers for the same type and amount of coverage. It is a way of spreading the cost of medical insurance among all the policyholders of a particular insurance company plan, and is therefore the opposite of experience rating.

Disease management - Is the concept of improving quality of life for people with chronic disease and/or reducing their health care costs through efforts to support the adherence to treatment, the prevention of secondary conditions or the prevention of avoidable complications, and the practice of other methods of integrated care.

Experience rating- A process in which premium rates are set by examining previous claims experience for a certain group of people. Each group has a different rate for their premium, based on the estimated need for healthcare of that group. Experience rating is not allowed for federally qualified HMOs, but is allowed in other healthcare plans.

Full population coverage – Another term for truly universal coverage when everyone is covered by a health plan.

Guaranteed renewable – A clause in an insurance policy, sometimes mandated by law, which assures the policyholder that the policy will be renewed on a yearly basis. Generally, policies that are guaranteed renewable cannot be cancelled unless the policyholder has committed fraud or failed to pay the premium.

High deductible health plans – Generally refers to health insurance policies with higher annual deductibles than typical health plans, sometimes called catastrophic coverage. They can be used along with a healthcare savings account that may have tax benefits. To qualify for a tax break under federal law, high deductible health plans with health savings accounts must have an

National
Multiple Sclerosis
Society

annual deductible of at least $1000 for an individual or $2000 for a family, although some run as high as $10,000.

Inter-operable electronic records: Secure, current patient-centric records that contain electronic copies of a patient's medical record including diagnostic images and forms signed by the patient. Records from many different locations and sources can be accessed from the patient's current place of care.

Life time caps – The maximum amount of coverage provided by a health plan under the terms of the policy.

Medical home - A primary care practice where a patient routinely seeks medical care and where a patient's health history is known. A medical home is a place where health care should be accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.

Medical loss ratio - The percentage of premium dollars that health insurance plans spend on medical care, as opposed to administrative costs or retaining for profit.

Medical underwriting – The common and legal practice among insurance companies of determining whether to sell a person a policy and how much to charge them based on the applicant's health status, claims history or perceived risk.

Olmstead Principles- The 1999 Supreme Court *Olmstead* decision is the impetus of the movement towards home and community-based care. States must provide services to people with disabilities in the most integrated setting appropriate to the needs of the individual, and the state should make reasonable modifications to its programs and policies for care in a community setting to occur.

Part D 'donut hole' - The popular term for the gap in Medicare Part D prescription drug coverage. In 2008, that gap in coverage begins when an individual's drug expenses reach $2,510. During the gap, the individual is responsible for meeting all costs of their prescription drugs.

Patient care costs of clinical trials – Typically, the 'patient care costs' refer to the doctors', hospital and/or lab fees incurred by an insured person

National
Multiple Sclerosis
Society

participating in a clinical trial that would otherwise be covered by their health insurance plan if they were receiving treatment that was not the subject of a clinical trial. In a typical clinical trial, the manufacturer of the drug or device being studied provides the drug or device at no cost and the institution conducting the study provides the data-collection and other administrative requirements of the trial.

Portable – One's continued eligibility for coverage after leaving a health plan. Federal law (HIPAA) currently guarantees portability of coverage for anyone enrolling in a *group* health plan (one providing coverage to employees, former employees, and their families that supported by an employer or employee organization), but not an *individual* health policy (insurance plan for individuals and their dependents who are not eligible for employer group coverage).

Pre-existing condition – As defined in federal (HIPAA) law, a pre-existing condition is any physical or mental condition for which a person obtained medical opinion or treatment in the six months prior to their enrollment in a group health plan.

Pre-existing condition exclusion – A legal clause appearing in virtually every health plan that allows the plan to exclude from coverage the costs of treatment for a pre-existing condition for a certain period of time after a new member first enrolls in the plan.

Pre-existing condition exclusion period – The maximum amount of time that a pre-existing condition exclusion period can be imposed on a plan member.

Re-insurance - Reinsurance is insurance for insurance companies. Its basic structure involves a primary insurance company that transfers, or cedes, the risk of high-cost claims to another private carrier or to a government-sponsored program. The insurer or government-sponsored program then assumes this risk and pays for some or all of these high-cost claims. There are two major types of government-sponsored reinsurance programs: 1) the government pays for some or all of the claims through general revenues; or 2) state law establishes an association of insurance companies that may want to cede risk and requires these companies to pool their resources to pay high-cost claims.

National
Multiple Sclerosis
Society

Respite care: Patient care given either at home or in an institution that is designed to give periodic relief to a home caregiver.

Risk – For insurance companies, risk is the likelihood that an insured person or group will incur costs to the insurer for covered medical expenses. Therefore, a person with a diagnosis of MS will always be considered a poor risk, even if they are not currently using many drugs or health services.

Sliding scales: A method of cost sharing in which the poorest people get the highest subsidies toward their premium payment and the people with higher incomes pay more.

Standards of evidence – Generally refers to methods used by clinicians and others to help define and promote optimal treatment and care based on the best available clinical evidence from high quality research studies.

Stop loss provision – A clause in an in insurance policy that defines the maximum annual out-of-pocket amount. When the patient reaches that maximum amount, the insurance company starts to pay 100% of the individual's healthcare costs through the end of the year.

Telemedicine - Application of clinical medicine where medical information is transferred via telephone, the Internet or other networks for the purpose of consulting or sometimes for remote medical procedures or examinations.

Under-insured - People whose insurance does not cover their necessary health care services, leaving them with out-of-pocket expenses that exceed their ability to pay. A growing body of research on the under-insured defines the term as any insured person whose annual out-of-pocket health care expenses exceed 10% of their household income, or 5% if household income is $40,000 or below.

Waiting periods --The period after a person has been enrolled in a health plan before their benefits become effective.