

# NAR Legislative Issue Brief

## Health Care Reform: Glossary of Key Health Care Terms



National Association of REALTORS® Government Affairs Division  
500 New Jersey Avenue, NW, Washington DC, 20001

**Administrative Pricing:** Reimbursement mechanisms for doctors and hospitals determined by legislative or regulatory fiat, rather than through the free market.

**Adverse Selection:** A phenomenon caused by a high proportion of sicker individuals enrolling in a particular insurance pool, often leading to higher premiums for all participants in the pool.

**Capitation:** A form of reimbursement that bases payment levels on a flat, regular (often monthly) payment, often risk-adjusted to reflect an individual's health status. Payments to Medicare Advantage plans are made on a capitated basis. Supporters of capitation believe that it removes the perverse incentives present in fee-for-service reimbursement to over-bill for care, while critics voice concerns that capitation could encourage doctors and hospitals to under-provide care to save costs.

**Comparative Effectiveness:** Research comparing the relative merits of two drugs or methods of treating an illness. Of particular concern is the distinction between clinical effectiveness—which examines the merits of various treatment options without respect to their cost—and cost-effectiveness research.

**Cost Shift:** In health care, cost shift refers to two related phenomena—doctors and hospitals charging patients with health insurance to pay for uncompensated care provided to those without coverage, and providers charging those with private coverage more to pay for below-cost reimbursement by government programs.

**Crowd Out:** A phenomenon whereby individuals drop their private health insurance to enroll in government programs.

**Delivery System Reform:** A general term for efforts to slow the growth of health costs by reforming the way health care is delivered in order to generate efficiencies. Many of these proposals would leverage the federal government's role in financing Medicare and Medicaid by linking hospital and physician reimbursement to certain behaviors or practices. Critics of these proposals caution that they may not generate significant savings to the federal government, but will further entangle federal bureaucrats in the practice of medicine.

**Employee Exclusion:** Dating from an Internal Revenue Service ruling during World War II, all health and related fringe benefits provided by an employer are excluded from income for purposes of both payroll and income taxes without limit. (Note however that for the employer, both wages and health benefits are tax-deductible business expenses.) The Joint Committee on Taxation estimates that in 2007, the exclusion resulted in more than \$246 billion in foregone income and payroll tax revenue to the federal government. Many economists of varying political stripes argue that—because a marginal dollar of cash income is taxable to employees, while a marginal dollar of health insurance is completely tax-free—the exclusion encourages the purchase of overly generous insurance policies, and in turn leads to the over-consumption of health care.

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**ERISA:** Acronym describing the Employee Retirement Income Security Act of 1974, which enacted rules regarding employee benefit plans. Section 514 of ERISA pre-empts “any and all State laws insofar as they...relate to any employee benefit plan,” permitting employers who self-insure their group health plans from complying with (potentially conflicting) State benefit mandates and other regulatory requirements. Small employers who “fully insure”—that is, purchase coverage from another company without assuming insurance risk—remain subject to State regulatory requirements.

**Exchange:** Also called a “Connector,” any of a variety of proposals designed to provide comparison shopping of health insurance products for individuals.

**Fee-for-service:** A method of reimbursement that bases payment levels on a discrete episode of care—for instance, a single office visit or procedure performed. Traditional Medicare and many forms of private insurance bill on a fee-for-service basis. Critics of fee-for-service medicine argue that reimbursement policies discourage doctors to provide more efficient care—since physicians generally receive none of the savings resulting from procedures they did not perform.

**Group Insurance:** Health coverage provided by employers—the largest source of coverage nationwide, with approximately 160 million individuals (more than 60% of the non-elderly population) enrolled. Coverage is offered to all eligible employees within a given classification and can be self-insured or fully-insured by an employer—in the latter instance, the employer purchases coverage from a carrier and assumes no insurance risk. States and the federal government also divide the group market into small and large groups, with the small groups classified as those with 2-50 employees.

**Guaranteed Issue:** A requirement that insurance carriers accept all applicants, regardless of health status. Generally coupled with community rating—a further requirement that carriers charge all individuals the same rates, with few variations. Critics argue that the two policies, particularly when enacted in concert, encourage individuals not to purchase health insurance until they encounter significant medical expenses, and likewise—by raising premiums for all individuals—discourage young and healthy individuals from buying insurance.

**High-Risk Pools:** A form of coverage for the medically uninsurable, currently offered in 34 States. Coverage is generally extended to those rejected for coverage on the individual market. Premiums are higher than rates for healthy individuals, but lower than the actual cost of most participants’ health care—State general fund appropriations, grants from the federal government, and/or surtaxes on insurance premiums finance the pools’ operating losses. Supporters of these mechanisms believe that a more robust system of State-based risk pools could offer coverage to all medically uninsurable individuals, without the adverse market effects connected with a requirement that insurance companies accept all applicants (see Guaranteed Issue above).

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**Individual Insurance:** Health coverage purchased for an individual (or family) outside the group setting. Individual insurance is subject to State regulation (including benefit mandates), and must generally be purchased with after-tax dollars.

**Mandates, Benefit:** Laws requiring all insurance policies sold to offer coverage for a particular treatment (e.g., in vitro fertilization, hair prostheses) or access to a particular type of medical provider (e.g., dentists, massage therapists). One [survey](#) found that as of 2008, States had enacted nearly 2,000 discrete benefit mandates. Critics of benefit mandates argue that mandates both individually and collectively raise the cost of health insurance, making coverage less accessible to individuals. Federal group policies regulated under ERISA are exempt from State benefit mandates.

**Mandates, Employer:** Proposals requiring employers to provide health insurance benefits to their employees, and/or pay a tax to finance their workers' health coverage. Also commonly called "pay-or-play," after a requirement instituted as part of the Massachusetts health reforms that employers must "play" by offering health coverage to their workers or "pay" a tax to cover the costs of their employees' uncompensated care.

**Mandates, Individual:** A requirement that all individuals have health insurance, subject to some type of enforcement by the State. Massachusetts' health reform law required individuals to purchase health insurance or face penalties on their tax returns.

**Medicaid:** A State-federal partnership providing health coverage to certain vulnerable populations. Eligibility requirements vary by State, but often include low-income women and children as well as elderly and disabled populations. The federal government finances Medicaid through the Federal Medical Assistance Percentage (FMAP), a match rate linked to States' relative income level that has averaged 57% of total Medicaid spending in recent years. While low-income individuals and children constitute the majority of Medicaid beneficiaries, most Medicaid spending funds long-term and related care to elderly and disabled enrollees.

**Medical Loss Ratio:** A requirement that insurance carriers dedicate a minimum percentage of premiums to paying medical claims, in an attempt to restrict "excessive" administrative costs or profits by insurance companies.

**Medicare:** A single-payer (i.e. government-funded) health insurance plan that offers coverage to seniors over age 65, Social Security disability recipients (after a two-year waiting period) and individuals with end-stage renal disease. Part A (hospital services) is mandatory for all seniors, while Part B (physician and outpatient services) and Part D (prescription drug coverage) are voluntary. (Medicare Part C is Medicare Advantage, an alternative to traditional Medicare described below.) Medicare generally pays doctors and hospitals on a fee-for-service basis, reimbursing based on a discrete office visit, procedure performed, or hospital stay.

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**Medicare Advantage:** Health coverage provided by private insurance companies and regulated by the federal government, in lieu of the traditional Medicare benefit. Plans receive capitated (per-beneficiary) payments from the federal government that are adjusted according to enrollees' risk and based on their bids against a statutorily-defined benchmark. Plans which bid below the benchmark may use the savings to provide extra benefits—reduced cost-sharing, lower premiums, and/or vision and dental coverage—to beneficiaries.

**Medigap:** Insurance products designed to supplement the traditional Medicare benefit, offered by private companies according to standardized benefit designs implemented and regulated by the federal government. Many economic analysts—including the Congressional Budget Office—have concluded that, by insulating beneficiaries from financial exposure to deductibles and co-payments, Medigap policies encourage seniors to over-consume health care, resulting in higher costs for the Medicare program.

**Pay-for-Performance:** Proposals designed to increase or decrease Medicare or Medicaid reimbursement levels to quality outcomes. Several programs exist linking incentive payments to reporting of selected quality measures, but reimbursement has yet to be directly linked with outcomes. Critics of this approach argue that pay-for-performance could discourage providers from accepting patients with complications that could lead to poor outcomes.

**“Public Option”:** An insurance plan run and/or funded by a governmental entity. Democrats have proposed several different ideas as to how such a plan may be structured—a Medicare-like insurance plan operated by the Department of Health and Human Services, a more independent entity where a third-party administrator makes operational decisions, or State-based governmental plans, perhaps including a buy-in to State employee health insurance offerings. Independent actuaries at the non-partisan Lewin Group found that a government-run plan reimbursing at Medicare rates would cause about 120 million Americans to lose their current health coverage. Regardless of the particulars of its structure, opponents may echo the concerns of CBO Director Elmendorf, who testified that it would be “extremely difficult” to have a “public plan compete on a level playing field,” such that Democrats would create inherent biases in favor of the government-run plan. Some may also be concerned that such a plan could exercise increasing control over patients' health decisions, leading to delays in obtaining critical treatments or outright denials of care.

**Sustainable Growth Rate:** A mechanism instituted as part of the Balanced Budget Act of 1997 regarding physician reimbursements, which calls for reductions in future years' reimbursement levels if physician spending exceeds the SGR target. Critics note that, because the target applies to aggregate levels of spending, individual physicians have a micro-level incentive to increase the number of services they perform in order to overcome a lower per-service payment under the SGR. On the other hand, supporters of entitlement reform argue that while imperfect, the mechanism has forced Congress to find offsets to finance increases in the SGR, resulting in a higher level of scrutiny of the Medicare program than would otherwise have been the case.

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**Tax Treatment of Health Insurance:** Health insurance provided through an employer is not taxable, while health insurance outside the employer group market generally must be purchased with after-tax dollars. Three exceptions to this rule exist: 1) self-employed individuals may deduct health insurance premiums from their income (but not payroll) taxes; 2) Health Savings Account contributions may be deducted from income (but not payroll) taxes; and 3) health insurance expenses may be taken as an itemized deduction for income tax purposes, but only to the extent that total health expenses exceed 7.5% of adjusted gross income. Critics of the current policy argue that individuals without access to employer-sponsored insurance have to pay 30-50% more for their coverage, resulting in more uninsured individuals.