

GLOSSARY of Healthcare Reform Terms¹

Accountable Care Organization² is a local network of providers that can manage the full continuum of care for all patients within their provider network. They must be of sufficient size to allow accurate measurement of both quality and total costs. An ACO must have a defined administrative structure that is capable of meeting reporting requirements for the quality measures that will be expected and for receiving and distributing shared savings payments.

Essential Benefits Package³ means health benefits coverage that is equivalent to the average prevailing employer-sponsored coverage and covers at minimum: Hospitalization, outpatient hospital and outpatient clinic services, including emergency department services. Professional services of physicians and other health professionals. Services such as equipment and supplies incident to the services of a physician's or a health professional's delivery of care in institutional settings, physician offices, patients' homes or place of residence, or other settings, as appropriate. Prescription drugs. Rehabilitative and habilitative services. Mental health and substance use disorder services. Preventive services and those vaccines recommended for use by the CDC. Maternity care. Well baby and well child care and oral health, vision, and hearing services, equipment, and supplies at least for children under 21 years of age.

Guarantee Issue/Renewal⁴ (coverage): Requires insurers to offer and renew coverage, without regard to health status, use of services, or pre-existing conditions. This requirement ensures that no one will be denied coverage for any reason.

Health Insurance Exchange⁵: A purchasing arrangement through which insurers offer and smaller employers and individuals purchase health insurance. State, regional, or national exchanges could be established to set standards for what benefits would be covered, how much insurers could charge, and the rules insurers must follow in order to participate in the insurance market. Individuals and small employers would select their coverage within this organized arrangement.

Purpose and Function

- 1. Offer consumers a choice of health plans and focus competition on price.** Exchanges offer enrollees a choice of private health insurance plans. Covered services and cost sharing (i.e., deductibles, coinsurance, etc.) would be organized in ways that make easy comparisons across plans.
- 2. Provide information to consumers.** An exchange also provides consumers with transparent information about plan provisions such as premium costs and benefits, as well as a plan's performance in encouraging wellness, managing chronic illnesses, and improving consumer satisfaction.
- 3. Create an administrative mechanism for enrollment.** Similar to how employer enrollment is managed, an exchange could serve the same function for people without access, including people buying insurance on their own or who work for small businesses. The exchange could also be used to determine eligibility for and administer income-related subsidies. Alternatively, these functions could be handled by a government agency or through the tax system.
- 4. Move towards portability of coverage.** An exchange de-links coverage from employment, helping to make insurance more portable. Exchanges also could coordinate enrollment shifts between Medicaid and subsidized private coverage for people with very low and potentially changing incomes.
- 5. Help with insurance market reforms.** An exchange also facilitates changes in the rules governing how insurers sell coverage. Usually, people buying insurance in the non-group market can be denied coverage or charged a higher premium based on a pre-existing health condition. Most proposals require insurers to accept all applicants without consideration of the applicant's health, and would prohibit or limit premium variation related to health status. The exchanges could ensure these market reforms by monitoring marketing practices and administering a uniform system for enrolling in a health insurance plan.

Public Plan Option²: A proposal to create a new insurance plan administered and funded by federal or state government that would be offered along with private plans in a newly-created health insurance exchange.

¹ This abridged glossary is taken from a number of sources for purposes of the Center for Practical Bioethics Healthcare Reform 2009: Session 1. Readers seeking a more complete guide, go to <http://www.kff.org/healthreform/upload/7909.pdf>

² Skinner, J Ph.D., **The Implications of Variations in Medicare Spending for Health Care Reform.** The Dartmouth Institute for Health Policy and Clinical Practice, The National Bureau of Economic Research, [Invited Testimony, Committee on Energy and Commerce, United States House of Representatives. April 2, 2009](#), p5.

³ Adapted from HR 3200 (Section 122) (Go to Library of Congress – <http://Thomas.loc.gov> and search HR3200)

⁴ [Glossary of Key Health Reform Terms](#). Taken from Kaiser Family Foundation publication (#7909)

⁵ Adapted from [Kaiser Family Foundation's publication \(#7908\)](#).