Glossary of Common Federal Health Policy Terms

"834": Formally called "EDI Benefit Enrollment and Maintenance Set (834)," this is the electronic file that is exchanged between a health care payer and an insurer. In the context of the Affordable Care Act, it's how health care exchanges alert insurers that someone has enrolled in a health plan. Transferring 834 information was a big obstacle in the early stages of enrollment, due to a flaw in the incomplete "back end" of HealthCare.gov. There were widespread errors, duplication and confusion. It's far better, though not perfect, for the 2016 season. The "834"s are formally called "EDI Benefit Enrollment and Maintenance Set (834)." For lots of details, see this CMS document.

Actuarial value: The average share of medical costs that a health plan will cover for a beneficiary population; the covered individual pays the rest. The exchange's metal tiers reflect different actuarial values.

Administrative services only (ASO): An arrangement in which an employer hires a third-party to provide administrative services, such as claims processing and billing; the employer bears the risk for claims.

Advanceable tax credit (or tax credit): The ACA subsidizes certain low- and middle-income people purchasing insurance in the exchanges through advance premium tax credits (APTC) that are available when the insurance premium is due, meaning the buyer doesn't have to wait to receive a tax return in the next calendar year. GOP plans to replace the ACA will rely heavily on tax credits.

Affordable Care Act (ACA): Also known as the **Patient Protection and Affordable Care Act** or **Obamacare.** It became law on March 23, 2010. The main coverage provisions — Medicaid expansion, state-based health insurance exchanges and subsidies for low- and middle-income people to buy insurance — went into effect in 2014. As of 2016, about 22 million people were covered through the exchanges or through Medicaid expansion. The law has always been politically divisive, and many states have either refused to create their own exchange or declined to expand Medicaid. The Republican Congress under the Trump Administration has vowed to dismantle it.

Age band: The ACA bans insurers from charging older people any more than three times as much as younger people in the small group and individual markets. Some groups, including major insurers, want to push it to a five to one ratio — but critics say that will push older and sicker people from the insurance markets.

Allowable charge: Sometimes known as the "allowed amount," "maximum allowable" or "usual, customary, and reasonable (UCR)" charge, this is the dollar amount a health insurance company considers reasonable for medical services or supplies based on the rates in your area.

All-payer system: A system in which all payers — state and federal health programs, private insurers, employers and individuals — pay the same rate for a given health service. Under an all payer system, health care providers can't shift costs among payers**.** (This isn't the same thing as All-Payer Claims Data Bases, which figured in a recent Supreme Court case. That involves collecting data from all the payers, and doesn't mean that all the payers use the same rate scale.)

Annual limit: Before the ACA, many health plans imposed a yearly limit on what they would pay, either in total costs or for services such as prescriptions or hospitalizations. After hitting the limit, the beneficiary must pay the costs for the rest of the year. While the ACA has deductibles and out-of-pocket costs that can be burdensome, it also ended the yearly (and lifetime) limits so that people who get a catastrophic, high-cost disease or condition don't have to worry about hitting benefit limits.

Any willing provider: Some states require a managed care organization to accept any provider, such as a doctor or hospital, into the network. This may broaden the choice of consumers facing narrow networks, but insurers say it undermines efforts to control costs.

Basic health plan (BHP): Under the ACA, people under 133 percent of the federal poverty level will be absorbed in Medicaid, and other low- to middle- income people will receive subsidies to purchase health insurance on the state insurance exchange. But states have another option — the Basic Health Plan — for covering people with incomes between 133 and 200 percent of the federal poverty level, who are above the new Medicaid limits but still quite low-income. The basic plan will be outside the state insurance exchange, include the essential benefits and be subsidized. The federal government will pay states 95 percent of what it would have paid, had those purchasers received subsidies through the exchanges.

Bending the curve: A phrase that refers to changing the trajectory of health care cost growth by making it grow more slowly. It's usually used as part of a discussion about ways of using payment and delivery system reforms to create a more efficient health care system, with more sensible incentives, that will slow spending growth.

Block grant: A lump sum usually given to a state or local government for a specific purpose. Some requirements may be attached to the grant, but — within the context of the ongoing Medicaid debate — this GOP idea generally intends to give the money to the states with few strings attached, which would change the nature of Medicaid entitlement by giving governors great flexibility in who to cover and what benefits to offer. Key details of a block grant are the base year on which it is based and any annual growth factor.

Budget-neutral: This is means that a waiver, demonstration or pilot program, or legislative provision can't cost more than what would have been spent without the waiver.

Budget reconciliation: A fast-track budget procedure in Congress that requires only a simple majority that can't be filibustered, but can be vetoed by the president. The measure has to follow arcane budgetary rules that are interpreted by the Senate parliamentarian. It's unlikely lawmakers could use this to repeal all of the ACA, but they could try to strike its tax- and spending-related elements, including the individual and employer mandates.

"Cadillac" health plan or "Cadillac Tax": An employee health benefit plans where coverage exceeds a certain dollar threshold. The portion above a certain annual level ($10,200 for individuals and $27,500 for self and spouse or family coverage) will be subject to a 40 percent excise tax starting in 2018.

Capitation/capitated payment: When a health care provider is paid a fixed or per capita amount for each enrolled patient, regardless of how much medical care each person actually receives.

Care coordination: The health law encourages better care coordination, so that providers work together to avoid complications, recurrences and rehospitalizations — particularly for patients with chronic diseases such as diabetes or congestive heart failure.

Catastrophic plan: A high deductible plan that kicks in when medical expenses mount. The catastrophic plans in the ACA exchanges also cover preventive care and some primary care.

Centers for Medicare & Medicaid Services (CMS): Part of the Department of Health and Human Services, this federal agency runs Medicare, Medicaid and the Children's Health Insurance programs. It now includes centers, or offices, responsible for key elements of health reform.
Center for Medicare and Medicaid Innovation (CMMI): Established under the ACA, CMMI tests new payment and service delivery models that aim to improve care, lower costs and better align payment systems to support

patient-centered practices. CMMI is an office within CMS and may undergo some changes under new leadership.

Center for Consumer Information and Insurance Oversight: The Center for Consumer Information and Insurance Oversight (CCIIO) oversees the implementation of various ACA provisions related to private health insurance, especially medical loss ratio rules and the health insurance exchanges. CCIIO is an office within CMS.

Certificate of Need laws: State Certificate of Need laws and regulations aim to prevent overbuilding of health care facilities or creating excess capacity, based on the idea that too much capacity leads to overuse and higher prices. These laws often require state approval to build a new hospital, significantly modify an existing one or expand certain services. Critics say it can lead to overregulation, monopolization and decreased competition.

Community mental health centers: These clinics, which have been around since the 1960s, are getting more attention amid greater appreciation of the inadequacy of the mental health care system. A center certified by CMS must provide outpatient services — including specialized services for children, the elderly, people with chronic mental illness and those who have been discharged from a mental health inpatient facility — as well as 24 hour a day emergency care services. Under health reform and related subsequent legislation, there has been a push to better integrate behavioral health and primary care in the community setting.

Community rating: Before the ACA's passage, insurers could charge people based on gender, their health status (pre-existing conditions), age or other factors — or they could choose not to cover them at all. Starting in 2014, "community rating" was limited. Older people can only be charged three times as much as younger people, a limit that had previously been much higher in some states, and there is no extra charge for women of child-bearing years or people who have been sick. Smokers can be charged more and participation in wellness programs can affect premiums. There will also be some geographic variation and, of course, families will pay more than individuals.

Comparative effectiveness research: Research that looks at different approaches or treatments for a condition to determine which are most likely to have the best outcomes. It does not necessarily account for cost.

Coordination of benefits: In the event of coverage from two sources (e.g., Medicare plus supplementary coverage, or two employer plans, which occurs when two people in the family have coverage) the insurers will "coordinate benefits," meaning they will determine which insurer is the primary payer and which is secondary payer.

Critical access hospital (CAH): Certain small hospitals mostly in rural areas are designated as "critical access" hospitals. They must be able to provide emergency care, but may not have all the services of a larger hospital. These hospitals follow less rigorous staffing standards than other hospitals, and are paid by Medicare based on their cost, not the usual payment scales. Not all rural hospitals are considered critical access.

Death spiral: A term to describe the insurance market when more sick people — or those who have a high chance of becoming sick — purchase insurance than healthier people. If too many sick or high-cost people buy and too few healthier ones are in the risk pool, premiums rise. Then, even more of the healthier people drop out, so premiums rise even more. This is also known as adverse selection.

Defined benefit: Specified benefits promised by a health plan, whether through a private employer or a government program like Medicare or Medicaid, that are considered an entitlement. Under Medicare and Medicaid, the government by law has to spend the money to provide benefits for everyone eligible for — or entitled to — these programs. Beneficiaries may have cost sharing, but the benefit is not capped or limited.

Most private health plans are still defined benefits — the employer pays a certain percentage of the premium, and the employee pays the rest.

Defined contribution: The shift toward a defined contribution — which is what many Republicans want to see happen for Medicare and Medicaid — is a limited, set, fixed amount toward health coverage, whether through a voucher or another form of payment. Beneficiaries may have their choice of health plans, but the contribution is fixed. That means the government or employer has fixed financial liability. In the world of employer-sponsored insurance, it means that the employer gives the employee a fixed amount and the employee then goes and buys insurance. This is how the small business exchange works in Utah.

Disproportionate share hospital (DSH): This refers to a hospital that has a disproportionate share of low-income payments as defined by standards set in Medicare and Medicaid. Hospitals receive DSH payments to help compensate for the cost and the health status of patients.

Doughnut hole (or donut hole): A coverage gap in the Medicare drug benefit, during which beneficiaries pay all the costs until another level of coverage kicks in. The health law gradually fills it in.

Dually eligible individuals: The health reform law created a new Federal Coordinated Health Care Office (aka "Office of Duals") at the Centers for Medicare & Medicaid Services to improve quality and efficiency of care for this population, defined as low-income people who qualify for both Medicare and Medicaid, also referred to as “Medi-medis.” They tend to be poorer and sicker than the rest of the population and use more health care resources.

Durable medical equipment (DME): Items that may be prescribed such as ventilators, wheelchairs, hospital beds or home oxygen systems.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services: States must cover these services for all Medicaid-eligible children under age 21. They include screening for vision, hearing, dental problems, as well as physical and mental health conditions. Services must include follow-up and treatment for identified problems or conditions.

Effectuate: Insurers use this word to describe finalizing enrollment. Coverage has been effectuated once someone signs up, selects a plan on the ACA exchange, pays the premium and has the policy finalized.

Employee choice: Rather than choosing the health plan themselves, small businesses using the SHOP exchange are supposed to decide how much they will contribute to workers’ health coverage then let the employees choose from a menu of plan choices through the exchange. But that “employee choice” option was delayed — and then delayed again in 18 states until at least 2016. Most of the state-run exchanges have gone ahead with it. Without employee choice, there is less incentive for small businesses to switch to the exchange.

Employer mandate: The requirement that businesses with more than 50 workers offer affordable coverage. The deadline, originally in 2014, has changed and the requirement is being phased in more slowly.

Employee Retirement Income Security Act (ERISA): The federal Employee Retirement Income Security Act sets requirements for employer-sponsored health plans, both self-insured and fully insured. ERISA plans are overseen by the Department of Labor and generally are not covered by state insurance regulations, such as coverage mandates. The act went into effect in 1974.

Essential health benefits: A set of benefits created by the ACA that will ensure that a plan covers comprehensive services. All plans, inside and outside of the state-based exchanges, will have to offer at least this much coverage. For more information, see the Institute of Medicine's report on defining essential health benefits.

Exchanges: See HEALTH INSURANCE EXCHANGES.

Exclusive provider organization (EPO) plan: A more restrictive type of preferred provider organization plan under which employees must use providers from the specified network of physicians and hospitals to receive coverage; there is no coverage for care received from a non-network provider except in an emergency situation.

Federal Medical Assistance Percentage (FMAP): How the federal government matches state contributions to Medicaid. Under the ACA, the match for the expansion population is 100 percent from 2014 through 2016, then it gradually drops down to 90 percent. That's a higher match than for traditional Medicaid. California's Medi-Cal match is 50 percent.

Flexible benefits plan (Cafeteria plan or IRS 125 Plan): A benefit program under Section 125 of the Internal Revenue Code that offers employees a choice between permissible taxable benefits, including cash, and nontaxable benefits such as life and health insurance, vacations, retirement plans and child care. Although a common core of benefits may be required, the employee can determine how his or her remaining benefit dollars are to be allocated for each type of benefit from the total amount promised by the employer. Sometimes employee contributions may be made for additional coverage.

Flexible spending accounts or arrangements (FSA): Accounts offered and administered by employers that provide a way for employees to set aside, out of their paycheck, pre-tax dollars to pay for the employee's share of insurance premiums or medical expenses not covered by the employer's health plan. The employer may also make contributions to a FSA. Typically, benefits or cash must be used within the given benefit year or the employee loses the money. Flexible spending accounts can also be provided to cover child care expenses, but those accounts must be established separately from medical FSAs.

Fully insured plan: A plan where the employer contracts with another organization to assume financial responsibility for the enrollees' medical claims and for all incurred administrative costs.

Habilitation services: The essential benefits requirements of the health law include both habilitation and rehabilitation services. Rehabilitation helps a patient regain a lost ability; habilitation helps them develop an ability that they never had (i.e. a child with developmental delays who isn't walking or talking when expected). It can include physical and occupational therapy, as well as speech and language pathology. It can be inpatient or outpatient.

Health insurance exchanges/marketplaces: New marketplaces where individuals and small businesses can purchase health insurance, with new rules and consumer protections laid out in health reform legislation. States have some leeway in how they design their exchanges, but if a state does not set up the exchange, the federal government will run the state marketplace. States can have one exchange for small business and another for individuals, or they can merge the two.

Health insurance tax: A tax on health insurance plans, which helped offset ACA costs, was suspended for one year (2017) as part of a budget deal Congress enacted at the end of 2015. The IRS estimated that the tax had brought in $8 billion in 2014, and would have hit $14.3 billion in 2018. The health insurance industry had fought for its repeal.

Health savings account (HSA): A personal savings account that allows participants to pay for medical expenses with pre-tax dollars. GOP replacement plans are likely to rely on expansion of HSAs.

High risk pool: A source of funds used to purchase insurance for individuals with high cost health conditions. Can be funded by the state, private sources or federal sources. The GOP ACA replacement plans contemplate grants to states for high risk pools as a way of stabilizing the insurance market and helping cover folks with pre-existing conditions.

Hospital fee/ provider tax: States and the federal government share in the financing of the Medicaid program. One of the ways states raise funds for their share of Medicaid spending is through provider taxes/fees. Provider taxes (in California, the hospital fee) are an integral source of Medicaid financing governed by long-standing regulations. Unless states are able to find additional funds to replace provider tax funding with other sources, limits on provider taxes could result in program cuts with implications for Medicaid providers and beneficiaries.

Individual mandate: A provision in the ACA that requires individuals to have health insurance or face a penalty, though there are many federal exemptions.

In-network provider: A health care professional, hospital or pharmacy that is part of a health plan's network of preferred providers. You will generally pay less for services received from in-network providers because they have negotiated a discount for their services in exchange for the insurance company sending more patients their way.

Inter-governmental transfer (IGT): A transfer of public funds between governmental entities, which may take place from one level of government to another (i.e. counties to states) or within the same level of government (i.e. from a state university hospital to the state Medicaid agency). The federal Medicaid statute explicitly recognizes the legitimacy of IGTs involving tax revenues.

Medicaid: Created in 1965, joint state-federal program provides health care for the low-income and disabled. It also covers long-term care, such as nursing homes, for low-income elderly people. It was expanded under the Affordable Care Act to cover more people right around and just above the poverty line — including those who had no children and were previously ineligible. The Supreme Court made that expansion optional for states; so far, 32 have done so.

Medicaid and CHIP Payment and Access Commission (MACPAC): An advisory committee on Medicaid and the Children's Health Insurance Program, MACPAC was established in a 2009 law and expanded and funded in the health reform law. It reviews state and federal policies and makes recommendations to Congress, HHS and the states on matters related to Medicaid and children's access to care.

Medicaid Section 1115 Demonstration Waiver: States can negotiate these waivers with the U.S. Health and Human Services Agency (HHS) to modify their Medicaid and Children's Health Insurance (CHIP) programs to expand eligibility, provide services not always covered by Medicaid, or test new delivery systems that attempt to improve care while cutting or slowing spending growth. Demonstrations must also be "budget neutral" to the federal government, meaning that federal Medicaid expenditures during the demonstration must not be more than they would have otherwise been. Under the Trump Administration, conservative states are likely to receive approval for Medicaid modifications — such as charging beneficiaries small co-pays or adding work requirements — that they could not get under former President Obama.

Medical device excise tax: To help offset costs, the ACA included a 2.3 percent sales tax on medical devices that went into effect on January 1, 2013. The device industry steadily fought for its repeal — and won a partial but

significant victory in late 2015, when Congress voted to suspend the tax for the next two years. The manufacturer, not the consumer, pays the tax. Most simple devices that a consumer would buy at a retail store (i.e. a thermometer) are exempt, along with glasses, hearing aids and wheelchairs. The device industry had argued that the levy was a "job killer."

Medical loss ratio (MLR): Portion of the insurance premium that goes to pay medical costs, versus administrative overhead (and profit). Under the ACA, its 80 cents on the dollar for individual and small-business plans, which have higher overhead and marketing costs. For larger businesses, it's 85 cents on the dollar. A few states are seeking waivers, and a handful has received them because it was likely that insurers would flee the state if forced to meet the new rules too quickly. Plans that don't meet the threshold would be required to give customers rebates.

Medical savings accounts (MSA): Savings accounts designated for out-of-pocket medical expenses. In an MSA, employers and individuals are allowed to contribute to a savings account on a pre-tax basis and carry over the unused funds at the end of the year. One major difference between a Flexible Spending Account (FSA) and a Medical Savings Account (MSA) is the ability under an MSA to carry over the unused funds for use in a future year, instead of losing unused funds at the end of the year. Most MSAs allow unused balances and earnings to accumulate. Unlike FSAs, most MSAs are combined with a high deductible or catastrophic health insurance plan.

Medicare: Federal health program for all Americans starting at age 65, and some of the disabled. Part A covers hospital care; Part B covers doctors, labs and other outpatient treatment; Part C covers those who choose to get covered in private Medicare Advantage Plans; and Part D is prescription drug coverage.

Medicare Payment Advisory Commission (MEDPAC): MEDPAC is an independent congressional agency established in 1997 to advise Congress on Medicare payment issues, including physicians, hospitals and Medicare Advantage plans.

Minimum essential coverage: A health plan that meets the individual mandate requirement, including exchange plans, employer-sponsored insurance or a government plan like Medicaid. See this IRS fact sheet for more information.

Minimum premium plan (MPP): A plan where the employer and the insurer agree that the employer will be responsible for paying all claims up to an agreed-upon aggregate level, with the insurer responsible for the excess. The insurer usually is also responsible for processing claims and administrative services.

Navigators: Navigators help educate people about their options under the health law, including what subsidies they can get, and help people enroll in a qualified health plan. Navigators also can connect them to ombudsmen or other resources when problems arise. They have to meet certain conflict of interest and training/certification rules.

Patient Protection and Affordable Care Act: See AFFORDABLE CARE ACT.

Per capita cap: Often discussed as an alternative method of paying states under the Medicaid program, this would allow the federal government to set a specific payment amount per covered individual. The amounts could vary based on the person's age. Like a block grant, the base year and growth rates are key factors.

Physician-hospital organization (PHO): Alliances between physicians and hospitals to help providers attain market share, improve bargaining power and reduce administrative costs. These entities sell their services to managed care organizations or directly to employers.

Post-claims underwriting: When an insurer investigates someone's health history after a health plan has been sold — and usually after a claim has been filed. This can lead to cancellation of a policy or "rescission." The ACA makes rescission illegal, except in cases of fraud or intentional misrepresentation. Also see RESCISSION.

Premium equivalent: For self-insured plans, the cost per covered employee, or the amount the firm would expect to reflect the cost of claims paid, administration and stop-loss premiums.

Premium shock: This is a term critics of the ACA use to describe rising insurance prices, or anticipated rises in premiums, particularly for younger, healthier people.

Premium stabilization: The ACA has three tools — risk adjustment, risk corridors and reinsurance (see separate glossary entries) — to try to encourage health plan participation in the new state-based exchanges, to discourage insurers from trying to find ways of avoiding covering people in poor health, and to try to stabilize premiums and spread risk in case some health plans do end up with more high-cost beneficiaries than others. Reinsurance and the risk corridors pertain to the first three years of the exchanges (2014-16), while risk adjustment is a permanent tool.

Premium support: Proposal to give people a voucher or coupon to help pay for health insurance. At the moment, it's most often used in the context of Medicare. There are several variants of premium support. Some would make it an alternative to traditional Medicare, while others would make it a substitute for traditional Medicare. The House-passed budget would make it a substitute, with the voucher unlikely to keep up with the rising health care costs. Premium support lets the federal government cap its Medicare spending, but the costs could shift to individuals.

Private option: Some conservative states are pursuing what's been dubbed the "private option," which seeks to use federal expansion money to buy low-income people private health insurance, rather than putting them in traditional Medicaid. They have to do so in ways that are acceptable to HHS.

Reinsurance: This is what it sounds like — insurance for the insurers. Reinsurance provides a backstop so an insurer doesn't end up with deep losses. To make the exchanges work, the government has an interest in reinsuring the health plans and limiting their financial exposure so that they are willing to participate in the exchanges — and don't try to game the system and avoid covering people with preexisting conditions or health risks. CMS has projected reinsurance will keep premiums in the exchanges 10 percent to 15 percent lower.

Rescission: Retroactive cancellation of health insurance policy, usually after someone files a claim. The health law outlaws this, except in cases of fraud or intentional misrepresentation. Also see POST-CLAIMS UNDERWRITING.

Risk Corridors: Given the uncertainty for insurers in the exchanges the first few years, risk corridors were established to enable the federal government to share the risk with the health plans from 2014-16. A health plan with costs at least 3 percent lower than expected turns some of the money over to HHS, while those with higher costs than expected will receive offsetting payments from HHS. If it's in between — within that corridor — no money is transferred. However, Congress has required risk corridor payments to be revenue neutral, meaning taxpayer funds couldn't supplement payments from the health plans themselves. That created a significant shortfall — for 2014, plans got 12.6 cents on the dollar. It is unclear how Congress, the courts or the new administration will resolve this.

Section 1332 Waiver: ACA Section 1332 allows a state to apply for the waiver of certain ACA requirements for plan years beginning on or after January 1, 2017. State Innovation Waivers allow states to implement innovative ways to provide access to quality health care that is at least as comprehensive and affordable as would be provided absent the waiver, provides coverage to a comparable number of residents of the state as would be provided coverage absent a waiver, and does not increase the federal deficit.

Sequestration: Automatic federal budget cuts that can be across the board, or can exempt or partially shield some programs or agencies.

SHOP exchanges: The Small Business Health Options Program (SHOP) provides health and/or dental insurance coverage for businesses in every state. These exchanges are open to businesses with fewer than 50 full-time equivalent employees (i.e. those businesses and nonprofit organizations that are not covered by the employer mandate) and are supposed to offer a variety of plan options, although choices have been limited in some states.

Stop-loss coverage: A form of reinsurance for self-insured employers that limits the amount the employers will have to pay for each person's health care (individual limit) or for the total expenses of the employer (group limit).

Superuser (or super utilizer): This refers to a patient who uses a lot of health care, particularly a lot of avoidable expensive health care in hospitals and emergency departments. The term is usually used to describe low-income patients with multiple chronic conditions, often including a mental health problem.

Tax reporting: Beginning with the W-2s for 2012, the year-end income tax forms include the value of the employer's contribution to the worker's health plan. This does not mean the payment is taxable — that hasn't changed. But the disclosure rule aims to give people more information about the true cost of health insurance.

Tricare: This federal health care program has almost 9.5 million members worldwide. It covers active duty service members, National Guard and Reserve members and military retirees. Tricare also serves the families of armed-service members, survivors, certain former spouses and others registered in the Defense Enrollment Eligibility Reporting System (DEERS) (for family members and dependents). People who have Tricare coverage do meet the individual mandate requirement. People who lose Tricare coverage eligibility generally can move into the exchanges.

Uncompensated care: When clinics, hospitals or doctors provide care without pay from an insurer, the patient or a government program such as Medicaid. This can include charity care or bad debt, which applies when the provider tries and fails to collect the payment due.

Value-based hospital purchasing: A Medicare initiative that rewards hospitals with incentive payments for the quality of care they provide.

Wrap-around benefits: Low-income people who qualify for various government programs may also qualify for wrap-around benefits, which provide extra help to compensate for coverage gaps or pick up costs so the individual is not required to pay out of pocket. These extra benefits "wrap around" the individual's health plan.

For more information about the terms included in this glossary, visit:
www.bls.gov/ncs/ebs/sp/healthterms.pdf
healthjournalism.org/core-topic.php?id=1&page=glossary