

Note, this is a work in process - corrections and clarifications are welcome!
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Blue Cross and Blue Shield

The Blue Cross Blue Shield Association (BCBSA) is a American federation of 39 independent, community-based and locally operated Blue Cross and Blue Shield healthcare coverage companies, in total covering over 97 million Americans. Blue Cross and/or Blue Shield insurance companies are franchisees, independent of the association, and offer insurance plans within defined regions under one or both of the association's brands. BC/BS insurers offer health insurance coverage in every US state. In addition, they are the administrators of Medicare in many states and provide group coverage to many state government employees, as well as the Federal Employees Health Benefit Plan (FEHBP).

Historically, "Blue Cross" was used for hospital coverage while "Blue Shield" was used for medical coverage, today that split only exists for traditional health insurance plans in parts of Pennsylvania. Most of the BC/BS companies, cover most of their customers under managed care plans such as HMOs and PPOs which provide hospital and medical care in one policy. In most of the country, one insurer operates under both brands; in the remaining places (including California), the Blue Cross and Blue Shield brands belong to competing insurers. Many plans are administered by not-for-profit organizations, while others are for-profit companies. (Though all Blue Cross Blue Shield plans must pay Federal income tax under the Tax Reform Act of 1986, some plans are still considered not-for-profit at the state level).

Since its 2004 purchase by Wellpoint, an Indiana Company, Blue Cross California's has come under increasing criticism for its business practices. Blue Cross California's HMO plans pay the *least* on patient care of any of the five largest health insurers, while earning the most profit. In an annual report, the California Medical Association found Blue Cross spends 78.9 cents per premium dollar on health care. Meanwhile, their profits are about twice as much (or more) than any other large health plan.

ERISA

The Employee Retirement Income Security Act of 1974. The federal law, that established legal guidelines for private pension plan administration and investment practices. This federal statute shields businesses from state and local regulation of the benefits they offer workers, including health insurance. Essentially, this law limits the abilities of state legislatures to serve as laboratories for healthcare solutions. Courts have applied ERISA to strike down efforts in Maryland and Suffolk County, N.Y. that would have compelled employers to cover more people.

In December, a San Francisco law passed in 2006 that would have required businesses with more than 20 employees to pay a minimum health care contribution for each employee, was struck down as in violation of ERISA. Early in 2008, the circuit court said that the city had a “strong likelihood” to prevail in the case, and granted a temporary stay of the district court order to suspend the law while the full appeal is heard.

Federal Poverty Level

Guidelines established by the Department of Health and Human Services which are used to determine whether a person or family is eligible for assistance through various federal programs. In general a poverty level is defined as the threshold below which families or individuals are considered to be lacking the resources to meet the basic needs for healthy living; having insufficient income to provide the food, shelter and clothing needed to preserve health. For 2007 they are:

| Persons in Family or Household | 48 Contiguous States and D.C. | Alaska | Hawaii |
|---------------------------------------|--------------------------------------|---------------|---------------|
| 1 | \$10,210 | \$12,770 | \$11,750 |
| 2 | 13,690 | 17,120 | 15,750 |
| 3 | 17,170 | 21,470 | 19,750 |
| 4 | 20,650 | 25,820 | 23,750 |
| 5 | 24,130 | 30,170 | 27,750 |
| 6 | 27,610 | 34,520 | 31,750 |
| 7 | 31,090 | 38,870 | 35,750 |
| 8 | 34,570 | 43,220 | 39,750 |
| For each additional person, add | 3,480 | 4,350 | 4,000 |

The poverty thresholds were originally developed in 1963-1964 by the Social Security Administration. They were calculated by taking the dollar costs of the U.S. Department of Agriculture’s economy food plan for families of three or more persons and multiplied the costs by a factor of three. The factor of three was used because the Agriculture Department’s 1955 Household Food Consumption Survey found that for families of three or more persons, the average dollar value of all food used during a week (both at home and away from home) accounted for about one third of their total money income after taxes. The “three-times-the-cost-of-the-food-plan” calculation was done only once, for the 1963 base year poverty thresholds, using the Agriculture Department’s economy food plan. Poverty thresholds for years since 1963 have been updated for price changes only using the Consumer Price Index, therefore assuming that the relationship of all other costs to that of food have remained constant since the 1955 study cited above. Many experts feel that the official poverty measure is flawed and does not adequately disclose the number of people who are poor in the United States. In 1995, a research panel organized by the National Research Council's Committee on National Statistics recommended that the poverty level calculations should be overhauled to reflect changes in families and regional differences in the cost of living.

The panel's recommended measure uses both a more accurate definition of income and a different concept of basic needs. The recommended measure of disposable income reflects the income actually available to the nation's families for purchasing basic needs. It is interesting to note that if the EU standard of "relative poverty" (defined as an income below 60% of the national median equalized disposable income) was applied in the US, the number of Americans that live in poverty would rise from 12% to 17%.

Guaranteed Issue

The requirement that insurance companies offer healthcare insurance regardless of prior existing conditions in applicants (many believe that in order to have guaranteed issue, there is a need for an individual mandate, otherwise people will wait till they get sick to get insurance).

Health Savings Account

These are plans that are established under the auspices of IRS Sec.125 by employers or the governmental bodies (as in the case of ABX 1 1) and are referred to by some as Cafeteria Plans. They allow employees to put aside pre-tax dollars to spend as they choose to purchase qualified benefits such as health insurance premiums, out of pocket costs, prescriptions, qualified over the counter medications or dependent care expenses. The value of these benefits are not included in gross income, making them **not** subject to social security, Medicare or Federal income tax.

Healthy Families This publicly-funded program pays for health services for low-income citizens or legally resident children under 19 years old who can't get health insurance. Uninsured children whose families make between 100% and 250% of FPL and are enrolled in or ineligible for MediCal may enroll in the program. Under ABX 1 1, the upper limit would rise to 300% of FPL. Families have to pay a monthly premium for Healthy Families (\$4-\$15 per child, \$45 family maximum) and co-payments, usually \$5, for some services. Healthy Families is jointly funded by the state and the federal government with the federal government providing \$2 through the SCHIP program for every one dollar spent by the state. As of late 2007, the program covers more than 1 million children in California.

High-Deductible Healthcare Plan

A high-deductible health plan requires enrollees to spend a certain amount on healthcare before insurance benefits kick in. In 2006 a high deductible plan was defined as one where the deductible was more than \$1,000 for individuals and \$2,000 for families. Some plans have deductibles as high as \$5,100 for individuals and \$10,200 for families.

Individual mandate

| The requirement that everyone purchase health insurance.

Kaiser Permanente

The largest managed care organization in the U.S., serving 8.6 million members in 9 states and the District of Columbia. Kaiser Permanente is a consortium of three distinct groups of entities: the Kaiser Foundation Health Plan, Inc. and its regional operating

organizations, Kaiser Foundation Hospitals, and the Permanente Medical Groups. It is an health maintenance organization (HMO), which means that it provides and coordinates the entire scope of care for its members, including: preventive care, well-baby and prenatal care, immunizations, emergency care, screening diagnostics, hospital and medical services and pharmacy services

Medi-Cal A state- and federally-funded program that pays for medically necessary treatment, medicines and devices for very low-income people who are also either (1) children, (2) adults with dependent children (almost always single mothers, as two-parent families are seldom poor enough to qualify), (3) low-income seniors whose Medicare coverage does not meet all their needs or (4) people with disabilities. “Medi-Cal” is the name California gives its Medicaid Program. Medicaid is the term the federal government and most states use.

Medi-Cal is provided free for adults who meet certain criteria (eg: disabled, eligible for SSI) or whose incomes are below 100% FPL poverty, pregnant women and babies whose incomes are under 200% FPL and children under 5 whose families earn 133% FPL or less. Medi-Cal may be available to certain higher income individuals with a “share of cost” agreement wherein they agree to share a percentage of their medical costs. Under ABX1 1 this coverage would be expanded to cover adults without children up to 250% FPL and 300% FPL for families with children.

California is 47th in Medi-Cal reimbursements (dollar amount for covered services) A 1998 study determined that in CA, Medi-Cal reimbursement rates were 40% of all other plans average reimbursement. In 1995, Medi-Cal spent \$1,959 per enrollee, 39 percent below the national average of \$3,202.

Medicare

A single payer health insurance program administered by the U.S. government covering people who are either 65 and over or who have particular disabilities.

Out-of-pocket expenses

Refers to costs other than premiums paid by the enrollee, including co-pays, the share of expenses once the deductible is met and any amounts paid for medical expenses not covered by insurance. Need to use the word co-pay somewhere

Purchasing Pools

Where a group of consumers is grouped together in order to qualify for affordable group insurance policies that are underwritten by a private insurance company. In general, membership in the pool is limited to individuals or families whose incomes are linked to a standard percentage of poverty level. AB X1 1 would establish such a program, the California Cooperative Health Insurance Purchasing Program (Cal-CHIPPP) which would cover individuals between 0-250% of FPL.

SCHIP

The State Children's Health Insurance Program, is a program funded by a federal/state partnership and administered at the state level, providing health care to low-income children who do not have health insurance. SCHIP funded programs are known by different names in different states. Funding for this program has been provided by Congress through March 30, 2009.

Single Payer

An approach to health care financing with only one source of money for paying health care providers. The scope may be national, state-wide, or community-based. The payer may be a governmental unit or other entity such as an insurance company. Medicare and the Veterans Administration Hospitals are examples of single payer systems in operation in the United States today. California single payer proposal is embodied in SB840 (Kuehl).

Universal Coverage

An explicit government policy backed by adequate funding and systemic change that guarantees access to health care for everyone in a given jurisdiction.