

## HEALTHCARE POLICY TERMINOLOGY FOR THE NBNA MEMBERSHIP



### BUZZ WORDS

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**Accountable Care Organization** A group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings

**Adverse Selection** is the enrollment of a disproportionately large number of sicker-than-average people in a health plan.

**Affordable Care Act** The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law

**AHRQ:** Agency for Healthcare Research and Quality, Department of Health and Human Services. Charged with major areas of health care research such as quality improvement and patient safety, outcomes and effectiveness of care.

**Authorizing Committee** Both the Senate and the House have sitting committees that are charged with overseeing legislation dealing with specific programs. These authorizing committees hold hearings and make alterations to bills before the legislation is moved to the full Senate or House for consideration. For example, the Senate Health, Education, Labor and Pensions Committee holds hearings on bills that would set federal laws for smoking prevention.

**Balance Billing:** A bill from a health care provider for charges above the amount paid by a health plan or insurer, over and above the amount recognized as allowable by the insurer.

**Block Grant:** A lump sum of federal money given to state and local governments for specific purposes.

**Budget Reconciliation:** Under congressional budget rules, when the House and Senate draw up the budget resolution each year, they can include a budget reconciliation directive mandating that various committees change laws governing entitlement programs to save money.

**Budget Resolution:** This is a joint House and Senate blueprint of anticipated federal spending and revenues. The resolutions, which lay out the committees' spending, revenue, borrowing and economic goals, serve as the vehicle for imposing internal budget discipline. The measures go to the full House and Senate and must be reconciled to produce one budget resolution that is passed by both chambers. The budget resolution covers at least five years and contains spending limits for discretionary spending. It also includes a projection of annual budget deficits and a statement of the federal debt.

**Bundling:** A single charge for a group of related health services. For example, a bundled charge for diabetes services might cover blood tests, diagnosis and treatment.

**Byrd Rule:** This is a reference to procedures that can be used to excise portions of a bill being considered under budget reconciliation. The rule is named for Sen. Robert C. Byrd, D-W.Va., who helped design the six conditions that allow portions of the legislation to be cut from the bill.

**Cafeteria Plan:** Plan provided by employers under Section 125 of the Internal Revenue Code that allows employees to receive certain benefits on a pretax basis.

**Capitation:** A fixed payment provided to a health provider from a managed care plan for the care of a patient, regardless of the type or number of services actually provided.

**Caregiver:** Person who provides support and assistance with various activities, paid or unpaid.

**Catastrophic Health Insurance:** Coverage tends to cover an expensive, severe illness but not routine costs.

**Categorical Eligibility:** The groups of people eligible for Medicaid: children, pregnant women, adults in families with dependent children, people with disabilities and the elderly.

**Centers For Disease Control And Prevention:** HHS agency that focuses on preventing and controlling disease, injury, and disability.

**Centers For Medicare And Medicaid Services (CMS):** Agency in the U.S. Department of Health and Human Services that regulates the big public health programs.

**Children's Health Insurance Program (CHIP):** Federal-state program for children who aren't poor enough to qualify for Medicaid but whose families can't afford private

insurance.

**Chronic Care:** Medical services for people with an illness that lasts a long time or recurs.

**Community-Based Services:** Designed to help older people remain in their homes. Services may include: home health aides, home-delivered meals and visiting nurse services.

**Community Health Center:** Health centers that provide primary care to low-income people. Fees often set on a sliding-scale based on income.

**Community Rating:** Insurance premiums that are set at the same price for everyone, based on the average cost of providing health care.

**Comparative Effectiveness** means comparing two or more treatments for a given condition. Studies may compare similar treatments, such as two drugs, or it may analyze very different approaches, such as surgery and drug therapy.

Comparative effectiveness evaluations may focus only on the relative medical benefits and risks of each option, or they may also weigh both the costs and the benefits of those options. In some cases, a given treatment may prove to be more effective clinically or more cost-effective for a broad range of patients, but frequently a key issue is determining which specific types of patients would benefit most from it.

Comparative effectiveness is increasingly being viewed as a viable way to help drive down spiraling health care costs while continuing to provide quality care. Roughly \$700 billion each year goes to health-care spending that can't be shown to lead to better health outcomes, according to the non-partisan Congressional Budget Office. Last year legislation was introduced in Congress to establish an ambitious comparative effectiveness program created by the federal government, including establishing the Health Care Comparative Effectiveness Research Institute to review evidence and produce new information on how diseases, disorders, and other health conditions can be treated to achieve the best clinical outcome for patients.

Lawmakers and the Obama Administration are pushing to include \$1.1 billion in the economic stimulus package for comparative effectiveness. Proponents say the Institute would work with experts and stakeholders to prioritize treatments for research—including surgical procedures, pharmaceuticals, medical devices, and other measures.

The research would be carried out by public and private organizations approved by the Institute's board of directors, including doctors, patients, and pharmaceutical and

biotechnology companies. The results would then be made available to clinicians, patients, and the public.

Critics such as the Cato Institute contend such a government-created comparative effectiveness effort “will be a complete waste of time and money.” Cato says a better way to generate comparative-effectiveness information would be for Congress to eliminate government activities that it says suppress private production, including allowing workers and Medicare enrollees to control the money that purchases their health insurance. Such a laissez-faire approach would both increase comparative-effectiveness research and increase the likelihood that patients and providers would use it, according to Cato. This will all continue to play out in the months ahead and increasing scrutiny of the evidence behind medical interventions is always a good thing.

**Consolidated Omnibus Budget Reconciliation Act Of 1985 (COBRA):** Allows former employees of companies with 20 or more workers to receive coverage under their employers’ health plans, if they pay the full cost of coverage and a small administrative fee. The 2009 stimulus bill provides a 65% subsidy to the worker for nine months, if the employees lost their jobs between Sept. 1, 2008, and Dec. 31, 2009.

**Consumer-Directed Health Plans:** Health plans that typically have high deductibles and are coupled to consumer-controlled savings accounts used to pay for services not covered by the plan. The aim is to make patients more sensitive to the high cost of care.

**Continuum Of Care:** The medical, social, rehabilitative, residential and supportive needs of people who are frail or chronically ill.

**Coinsurance:** The percentage of the cost of medical services that isn’t covered by the insurer and thus must be paid by the patient.

**Copayment:** A flat amount paid by a consumer when a medical service is rendered by a participating provider in a health plan.

**Cost-Sharing:** Any contribution consumers make towards the cost of their health care as defined in their health insurance policy .

**Cost-Shifting:** Occurs when some payers are charged more for medical services to offset underpayments by other payers.

**Deductible:** Fixed amount that must be paid by a patient before a health plan begins to cover other services.

**Defined Benefit:** Plan under which health services are standardized and guaranteed, such as in Medicare.

**Defined Contribution:** Plan under which an employer or government contributes a set amount toward the purchase of a health plan; covered services may vary based on the choice of plan.

**Diagnosis Related Group (DRG):** The classification of hospital patients based on their diagnoses, treatments and other criteria. Hospitals are paid the same for each case in the same DRG, regardless of the actual treatment provided.

**Discretionary Spending:** This is the spending that Congress sets annually for federal programs and does not include entitlement program spending, such as Medicare, Medicaid and Social Security.

**Donut Hole** (or Doughnut Hole) refers to a "coverage gap" within the defined standard benefit under the Medicare Part D prescription drug program. Under the defined standard benefit package there is a gap in coverage between the initial coverage limit and the catastrophic coverage threshold. Within this gap, the beneficiary pays 100% of the cost of prescription drugs before catastrophic coverage kicks in. The term "coverage gap" is preferred by Centers for Medicare and Medicaid Services (CMS) and Prescription Drug Plans, but the "Donut Hole" has been more widely adopted in the popular media.

Or stated more simply

Refers to a coverage gap in Medicare prescription drug coverage. The program pays 75 percent of the patient's yearly drug expenses up to given point, which is \$2,405 for 2009. Coverage starts up again when total prescription costs for an individual reach \$5,916.25 this year. After that, Medicare picks up 95% of the costs for the rest of the year.

Or even simpler

Most plans with Medicare prescription drug coverage (Part D) have a coverage gap (called a "donut hole"). This means that after you and your drug plan have spent a certain amount of money for covered drugs, you have to pay all costs out-of-pocket for your prescriptions up to a yearly limit. Once you have spent up to the yearly limit, your coverage gap ends and your drug plan helps pay for covered drugs again.

**Dual Eligible:** Lower-income Medicare beneficiaries who also are eligible for some Medicaid benefits, or help with Medicare out-of-pocket expenses.

**Electronic Medical Record:** A medical record in digital format.

**Employee Retirement Income Security Act (ERISA):** The 1974 federal law that regulates most private employee health plans.

**Employer Mandate:** Requires employers to provide health insurance benefits to their employees.

**Entitlement Spending:** This is spending for federal programs such as Medicare, Medicaid and Social Security. The funding levels are dependent on the number of people entitled to the program. A set of health care service categories that must be covered by certain plans, starting in 2014.

**Essential Health Benefits** The Affordable Care Act ensures health plans offered in the individual and small group markets, both inside and outside of the Health Insurance Marketplace, offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Insurance policies must cover these benefits in order to be certified and offered in the Health Insurance Marketplace. States expanding their Medicaid programs must provide these benefits to people newly eligible for Medicaid.

**Evidence-Based Medicine:** Use of current best clinical evidence to make decisions about care of individual patients.

**Federal Employees Health Benefits Program (FEHBP):** Health care plans offered to federal civilian employees who choose annually among a number of private health insurance plans.

**Federal Medical Assistance Percentage:** Percentage used to determine federal matching funds for state Medicaid spending.

**Federally Qualified Health Center:** Health centers approved by the government to provide low-cost health care.

**Fee-For-Service:** Method of paying for health care services based on the actual care delivered.

**First-Dollar Coverage:** Health insurance plans that don't include deductibles.

**Financing Health Care** There are generally five primary methods of funding health care systems:

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1. Direct or out of pocket payments
2. general taxation
3. social health insurance
4. voluntary or private health insurance
5. donations or community health insurance

**Fiscal Cliff** In the United States, the **fiscal cliff** is the sharp decline in the budget deficit that could have occurred beginning in 2013 due to **increased taxes and reduced spending** as required by previously enacted laws. The deficit—the amount by which government spending exceeds its revenue—was projected to be reduced by roughly half in 2013. The [Congressional Budget Office](#) (CBO) had estimated that the sharp decrease in the deficit would have likely led to a mild [recession](#) in 2013 with the unemployment rate rising to roughly 9 percent in the second half of the year.<sup>[1]</sup> The fiscal cliff was largely eliminated by the eleventh-hour passage of the [American Taxpayer Relief Act of 2012](#). **Flexible Spending Account:** Employee benefit programs that allow workers to set aside pre-tax money for certain health and dependent-care expenses.

**Formulary:** List of medications covered by a health insurance plan.

**Graduate Medical Education Payment:** Medicare payments designed to cover teaching hospital's costs of training residents.

**Group Health Insurance:** Health insurance offered to a group of people, such as employees of a company, or members of a union. The majority of Americans have group health insurance through an employer.

**Guaranteed Issue:** Requires health plans to accept applicants even if they have been sick.

**Health Care Reform** is a general rubric used for discussing major policy creation or changes—for the most part, governmental policy that affects healthcare delivery in a given place. Health care reform typically attempts to:

- Broaden the population covered by private or public health insurance
- Expand the array of health care providers consumers may choose among
- Improve the access to health care specialists
- Improve the quality of healthcare
- Decrease the cost of health care

**Healthcare Navigator** An individual or organization that's trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including completing eligibility and enrollment forms.

These individuals and organizations are required to be unbiased. Their services are free to consumers.

**Health Coverage Tax Credits:** Refundable tax credit designed to help certain individuals pay for premiums.

**Health Disparities** (also called **healthcare inequality** in some countries) refer to gaps in the quality of health and health care across racial, ethnic, and socioeconomic groups. The Health Resources and Services Administration defines health disparities as "population-specific differences in the presence of disease, health outcomes, or access to health care." Among the disease-specific examples of racial and ethnic disparities in the United States is the cancer incidence rate among African Americans, which is 10% higher than among whites. In addition, adult African Americans and Latinos have approximately twice the risk as whites of developing diabetes. Minorities also have higher rates of cardiovascular disease, HIV/AIDS, and infant mortality than whites

**Health Insurance Marketplace or Exchange:** A resource where individuals, families, and small businesses can: learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The Marketplace also provides information on programs that help people with low to moderate income and resources pay for coverage. This includes ways to save on the monthly premiums and out-of-pocket costs of coverage available through the Marketplace, and information about other programs, including Medicaid and the Children's Health Insurance Program (CHIP). The Marketplace encourages competition among private health plans, and is accessible through websites, call centers, and in-person assistance. In some states, the Marketplace is run by the state. In others it is run by the federal government.

**Health Insurance Portability And Accountability Act (HIPAA):** Federal law that provides some protection for employees and their dependents to renew health insurance. The law also spells out rules to protect the privacy of health care information.

**Health Maintenance Organization (HMO)** - a legal entity that accepts responsibility and financial risk for providing specified services to a defined population during a defined period at a fixed price. It is an organized system of health care delivery that provides comprehensive care to enrollees through designated providers. Enrollees are generally assessed a monthly payment for health care services and may be required to remain in the program for a specified amount of time

Or more simply

**Health Maintenance Organization (HMO):** Managed care plan that gives members comprehensive health care services through a network of providers.

**Health Plan Categories** Plans in the Marketplace are primarily separated into 4 health plan categories — Bronze, Silver, Gold, or Platinum — based on the percentage the plan pays of the average overall cost of providing essential health benefits to members. The plan category you choose affects the total amount you'll likely spend for essential health benefits during the year. The percentages the plans will spend, on average, are 60% (Bronze), 70% (Silver), 80% (Gold), and 90% (Platinum). This isn't the same as coinsurance, in which you pay a specific percentage of the cost of a specific service.

**Health Plan Employer Data And Information Set (HEDIS):** Standardized health plan measures that allow people to compare plans on such factors as patient satisfaction and quality.

**Health Policy** broadly describes the actions taken by governments---national, state, and local---to advance the public's health. It is a set of authoritative decisions made within government that pertain to health and the pursuit of health.<sup>1</sup> It is not a single action but requires a range of legislative and regulatory efforts ranging from ensuring air and water quality to supporting cancer research. Health care policy is that piece of health policy that deals with the organization, financing and delivery of health care services. This includes training of health professionals, overseeing the safety of drugs and medical devices, administering public programs like Medicare and regulating private health insurance. The obligation of governments to promote and protect the public's health is grounded in the U.S. Constitution.

**Health Reimbursement Arrangement:** Tax-preferred accounts that are typically paired with a high-deductible plan. Employers contribute funds for qualified medical expenses.

**Health Savings Account:** Tax-preferred savings, paired with a high deductible health plan. Both employees and employers can contribute to the accounts. Worker must pay for all services until the deductible is reached. Money left in the account at the end of the year can be rolled over to the next. Unlike a health reimbursement arrangement, money left in the account isn't lost if an employee changes jobs

**High-Risk Pool:** Health insurance pool created by many states to cover individuals who can't get coverage because of medical conditions.

**HIMSS:** Healthcare Information Management Systems Society. A nonprofit that promotes the adoption of health information technology.

**HIPPA:** Health insurance Portability and Accountability Act, enacted in 1996, is

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<sup>1</sup> Longest, BB. (2010.)Health Policymaking in the United States, Fifth Edition.,pg.5

designed to protect health insurance coverage when workers change jobs. It also set rules to protect the privacy of medical information.

**Home Health Care:** Care delivered at home that includes such services as skilled nursing, social services and occupational therapy.

**Hospice:** Services designed for people expected to live less than six months. Goal is to provide emotional and spiritual care to the patients and their family. Medical care is typically palliative, not aimed at a cure.

**Hospital Insurance Trust Fund:** Medicare trust fund that pays for hospital inpatient services (known as Medicare Part A).

**Individual Insurance Market:** Where individuals who aren't covered by an employer or government agency purchase health insurance on their own.

**Individual Mandate:** Law requiring individuals to have health insurance or face a possible penalty.

**Long-Term Care:** Health and social services for people with permanent disabilities or chronic illnesses. Care may be provided in a residential facility, at home or elsewhere in the community.

**Managed Care Organization:** Health care organizations that contract with an insurer to provide medical services to a group of enrollees. They include health maintenance organizations and preferred provider organizations.

**Means-Testing:** The use of income and/or assets to determining eligibility for programs.

**Medicaid:** State-federal health program for the low-income and disabled. Provides acute and long-term care to about 60 million people.

**Medicaid Waivers:** Issued by the Department of Health and Human Services, waivers allow the states to experiment with the design of their programs. For example, the states may get federal funds to provide coverage to certain categories of people for which federal funds wouldn't normally be eligible.

**Medical Underwriting:** Insurers' process of scrutinizing individuals, and their medical histories, to determine whether and how to cover them. People with past illnesses may be rejected, charged more or have certain conditions excluded from coverage.

**Medical Home:** An approach in which patients, especially those with chronic illnesses, are cared for by a primary care physician heading a team that might include behavioral experts and dieticians.

**Medically Necessary:** Services required to preserve a patient's health status, in accordance with the standards of medical practice.

**Medicare:** Federal health program for people 65 and older and the disabled. Part A provides inpatient-hospital coverage; Part B, outpatient coverage, including doctors' visits; Part C, hospital and doctors' expenses, administered through private plans called Medicare Advantage, and Part D, stand-alone prescription drug coverage.

**Medicare Advantage:** Medicare benefits offered through private plans rather than through the traditional fee-for-service plan.

**Medicare Prescription Drug, Improvement And Modernization Act Of 2003:** The law that established the prescription drug benefit.

**Medicare Supplemental Insurance (MEDIGAP):** Sold by private insurance firms, these policies fill in the "gaps" of Medicare fee-for-service coverage, such as co-pays.

**Mental Health Parity Act:** Federal law that prohibits employer plans with more than 50 employees from imposing caps or limits on mental health or substance abuse treatment that are more restrictive than those on medical or surgical benefits.

**National Health System:** Publicly funded health care systems, as in England and Germany, in which all individuals have health insurance.

**Never Event:** Medical errors that can be prevented and should never happen in a hospital, as determined by the National Quality Forum. The group lists 28 such events, including, for example, operating on the wrong body part. CMS has said it won't pay for certain "never events."

**Nursing Home:** Facilities licensed by states to provide personal and skilled nursing care on a 24-hour a day basis.

**Open Enrollment:** Time of year that most employees sign up for health coverage.

**Pay For Performance:** System under which providers are rewarded for high-quality services.

**Pay Or Play:** Requirement that employers either provide health benefits to their employees or pay a fee to help cover the uninsured.

**Point-Of-Service Plan:** Managed-care plan that allows users, at the time care is needed, to choose whether to use providers who are in the network or out of the network. Out-of-network care is typically more costly.

**Post-Acute Care:** Short-term care provided by many long-term care facilities such as rehabilitation, post-surgical care or specialized care for chronic conditions like diabetes.

**Pre-Existing Conditions Exclusions:** Insurers may exclude benefits for an illness or condition for specific period of time--if the patient was diagnosed before being insured under the policy.

**Preferred Provider Organization:** Network of providers who contract to deliver care to health plan enrollees on a fee-for-service basis, but at discounted rate.

**Primary Care:** Non-specialty care provided by doctors, nurses and others.

**Prospective Payment System (PPS):** Used by Medicare to pay for several types of services including inpatient, outpatient and skilled nursing services. Rates are linked to diagnoses rather than the actual costs of the care given.

**Qualified Medicare Beneficiary (QMB):** Medicare beneficiaries with limited assets and income who are eligible for Medicaid assistance in paying Medicare costs, such as premiums, deductibles and coinsurance.

**Rating:** Evaluating an individual or group to determine the appropriate premium, based on the financial risk of providing health care. Key characteristics include age, sex, past use of health services, location and plan design.

**REFUNDABLE TAX CREDIT:** A way to provide a cash subsidy to an individual or business even if no tax is owed.

**Resource-Based Relative Value Scale (RBRVS):** Method used by Medicare to reimburse physicians. The cost of providing service is divided into three categories—physician work, practice expense and professional insurance. The payment is determined by multiplying the costs by a conversion factor set by the CMS.

**Risk Adjustment:** Increases or reductions in payments made to health plans to

compensate for health care expenditures that are expected to be higher or lower than average.

**Risk Selection:** Enrollment choices made by health plans or by enrollees on the basis of perceived risk relative to the premium to be paid.

**Self-Employed Deduction For Health Insurance:** Self-employed taxpayers and their families can deduct their health insurance expenses.

**Self-Insured Plan:** A group plan in which employers assume the financial risk (although many buy reinsurance) for covering employees, rather than buying insurance from a commercial carrier. A third-party administrator or insurer typically provides administrative services.

**Sequestration** is an automatic reduction of a specific amount of the federal budget, evenly split between defense and domestic programs over a 10-year period.

**Single –payer health care** -A public service financing the delivery of [universal health care](#) to a given population as defined by age, citizenship, residency, or any other demographic. Single-payer health insurance collects all medical fees and then pays for all services through a single government (or government-related) source.

[Medicare in the United States](#) is an example of a single-payer system for a specified, limited group of persons within a country. Australia's [Medicare](#), Canada's [Medicare](#), the United Kingdom's [National Health Service](#), and Taiwan's [National Health Insurance](#) are examples of single-payer universal health care systems.

Single-payer systems may contract for healthcare services from private organizations (as is the case in Canada) or may own and employ healthcare resources and personnel (as is the case in the United Kingdom).

The term single-payer thus only describes the funding mechanism—referring to health care being paid for by a single public body from a single fund—and does not specify the type of delivery, or who doctors work for. Although the fund holder is usually the government, some forms of single-payer employ a public-private system.

### Or more simply

**Single-Payer System:** A system under which a single entity, usually the government, collects health care fees and pays the bills, but isn't involved in the delivery of care.

**Skilled Nursing Facility:** A facility that offers skilled services similar to those of a hospital, to aid rehabilitation.

**Small Group Market:** Firms with fewer than 50 employees can buy health coverage

through this state-regulated market. The rules vary from state to state.

**Social Security Disability Insurance:** Government assistance, financed through Social Security taxes, to people permanently disabled and unable to work, and who previously paid Social Security taxes.

**Social Health Maintenance Organization:** A single provider that takes care of a full range of services including medical and personal care for the elderly, including for short and long-term care.

**Staff Model HMO:** A health maintenance organization that delivers health services through salaried physicians employed by the HMO.

**State Mandate:** State coverage laws requiring private insurers to cover specific services or reimbursement for specific providers.

**Sustainable Growth Rate:** Formula that's intended to control Medicare spending by restraining doctors' fees. But numerous problems have led the formula to require repeated fee cuts—a requirement that Congress has overridden.

**Tax Credit:** Flat amount that can be deducted from owed taxes. Under some health care reform proposals, tax credits would be given to moderate-income individuals and families to subsidize health insurance premiums.

**Tax Deduction:** Amount that can be subtracted from adjusted gross income when calculating tax owed. Families can deduct the portion of their medical expenses that exceed 7.5% of their adjusted gross incomes.

**Tax Preference For Health Benefits:** Employer-paid health benefits are treated under federal tax law as a deductible business expense for the employer and excluded from taxable income for the employee.

**Title VIII** is the Act that covers nursing education and practice. Originally referred to as the Nurse Training Act, Title VIII was added to the Public Health Service Act in 1964. In recent years, programs under Title VIII have focused on the preparation of the basic and advanced nursing workforce and on increasing diversity within the nursing workforce.

The Nurse Reinvestment Act, commonly referred to as the NRA, is legislation that amends the existing Title VIII of the Public Health Service Act – the nursing education legislation. This legislation was passed to address the growing nursing shortage resulting from the aging nursing workforce, retention problems due to a stressful work environment, and problems recruiting young people into nursing.

The NRA added six new provisions to the Title VIII legislation resulting in a broad, comprehensive and flexible legislative authority by which the Federal government could help address the nursing shortage. Specifically, the NRA includes a nurse scholarship program and a nurse faculty loan program – both providing support to individuals for nursing education with a payback provision following graduation. At the institution/organization level, the NRA supports grants for career ladder programs, internship and residency programs, retention programs tied to quality patient care and geriatric education programs. The NRA also addresses support for public service announcements to promote the nursing profession.

**Title VIII of the Civil Rights Act of 1968** (Fair Housing Act) prohibits discrimination in the sale, rental and financing of dwellings based on race, color, religion, sex or national origin.] Title VIII was amended in 1988 (effective March 12, 1989) by the Fair Housing Amendments Act

**Tricare:** Program that provides medical care to the dependents of active-duty members of the military and to retired members of the military.

**Uncompensated Care:** Health care that is provided but not paid for by the patients or by insurance. Providers and the federal government generally incur the costs.

**Underinsured:** People who are insured but nevertheless face big costs or limits on benefits.

**Universal Coverage:** Health insurance for an entire population, through private or public programs.

**Utilization Review:** Review by an insurer of health care services to evaluate the appropriateness, necessity and quality of a requested service.

**Workers' Compensation Programs:** Program designed to ensure that employees who are injured or disabled on the job are provided with medical care, rehabilitative services, and fixed monetary awards.

**[Are You Internet Ready for NBNA Day on the Hill?: Key Websites for NBNA members for NBNA Day on the Hill](#)**

<http://www.whitehouse.gov/> This website will directly link you to the President's Plan for Health Insurance Reform. You will be able to read the key issues of the President's plan, and watch the latest video highlights of his messages to Congress. This website provides the latest legislation!

[http://www.house.gov/house/MemberWWW\\_by\\_State.shtml](http://www.house.gov/house/MemberWWW_by_State.shtml) This link will provide you with all of the Representatives of the U.S. House of Representatives. It provides a map of the United States and all you have to do is click your area. You can also find information on the Speaker of the House, the schedule for the House meetings and learn who is on what committees.

[http://www.senate.gov/general/contact\\_information/senators\\_cfm.cfm](http://www.senate.gov/general/contact_information/senators_cfm.cfm) -Do you know your Senator and how to contact them? This website is a direct link to communicate NBNA's stance on health care reform. This link provides the latest legislation and will inform you how your Senator voted!

<https://writerep.house.gov/writerep/welcome.shtml> -This link gets to the heart of the matter of writing your representative. You will be able to inform your representative of your viewpoint and receive an acknowledgement of your communication.

<http://www.healthreform.gov/> - If all you really want to concentrate on is health reform then this is the link for you! You can see how your state ranks in health care, hear from the U.S. Department of health and Human Services Secretary – Dr. Kathleen Sebelius, and submit your personal story or your chapter's experience with health care issues.

<http://www.whitehouse.gov/realitycheck/quiz> - Here's an interactive site that gives you a personal quiz on your own personal health care. This quiz is about health care reform and you. Take the quiz and see how this transformation will affect you.