FamiliesUSA
The Voice for Health Care Consumers

GLOSSARY OF HEALTH CARE TERMS [*]

Adjusted Community Rating - A method of determining health care premiums where the premium is based on the average cost of health services used by all customers in a specific service area. When community rating is in place, insurance companies are required to charge the same premium to all their customers for the same type and amounts of coverage. It is a way of spreading the cost of medical insurance among all the policyholders of a particular insurance company plan. *Adjusted community rating* allows some variation in premiums but limits the extent of the variation (for example, within a band no higher than 25 percent of average or lower than 25 percent of average).

Advanceable Tax Credit - As it relates to expanding health coverage, a tax credit provided to cover the cost of purchasing health coverage in the individual market where the monthly payments can be sent directly to a health insurance provider, and the recipient need not wait to file a tax return and receive the subsidy as a tax credit or refund.

Adverse Selection - The trend wherein people purchase insurance only when they become sick and have significant expenses. If people do not purchase insurance until they are sick and need it, the individual insurance market may become a pool only for the sick, with no healthy members. This drives up premiums in the individual market. Adverse selection can also occur when healthier individuals are siphoned into certain plans (generally with fewer benefits and lower premiums) and sicker individuals into other plans (which offer more benefits).

Beneficiary - A person who receives benefits. The term is commonly applied to anyone receiving benefits under the Medicare or Medicaid programs or who is covered under a private health insurance plan.

Benefit Cap - A dollar limit placed on the amount of coverage that can be provided to an individual in a given time period, which is usually one year.

Benefit Package - A group of guaranteed services provided by a health plan to its members.

Block Grant – A lump sum of money given to a state or local governing agency based on a formula to be spent on services such as health care coverage. Generally, the purposes of block grants are broadly defined, with few restrictions mandated by the funding source. Restrictions can be imposed by the re-granting agency.

Carve-Out – A health care delivery and financing arrangement in which certain specific health care services that are covered benefits (e.g. mental health services) are administered and funded separately from general health care services. The carve-out is typically done through separate contracting for services to a special population. As it relates to Medicaid, a set of services (such as behavioral health services) that are provided separately, or a specific population (such as people with HIV or children with special needs) that is not required to enroll in a Medicaid managed care program. These services or populations are said to be "carved out" and handled separately, either in fee-for-service plans or through a separate managed care organization.

Case Management - A means of coordinating care for people with multiple, often complex health care needs. As it relates to managed care, a system that requires that a single individual in the provider organization be responsible for arranging and approving all services needed. Ideally, case management should increase consumers' access to appropriate care through specialists and ensure that full information about a consumer's health conditions follow him or her through the health care system. In the context of private managed care, case management by a gatekeeper can be inappropriately motivated by the goal of reducing their health care costs. In the context of Medicaid, case management and managed care delivery systems must be examined carefully to determine if cost concerns are overriding the positive goal of coordinating care.

Categorically Needy – As it relates to Medicaid, a beneficiary is deemed categorically needy if she is eligible for coverage because she meets certain income requirements and falls into a specific population category: families with children: pregnant women; and people who are blind, disabled, or over 65. People who do not fall into these categories cannot qualify for Medicaid, no matter how low their incomes (unless their state has obtained a federal Section 1115 waiver to cover additional groups).

[*] The National Women's Law Center thanks Families USA for sharing this glossary of health care terms for inclusion in the *Reform Matters Toolkit*. This glossary is an excerpt of the full Families USA "Glossary of Health Care Terms" which can be found at: http://www.familiesusa.org/resources/tools-for-advocates/kits/glossary-health-care.html.

Centers for Medicare and Medicaid Services (CMS) - CMS is the name for the agency within the Department of Health and Human Services (HHS) that oversees Medicare and Medicaid. It was previously known as the Health Care Financing Administration (HCFA).

CHIP - see *State Children's Health Insurance Program (SCHIP)*

COBRA – *See Consolidated Omnibus Budget Reconciliation Act of 1985.*

Co-Insurance - The portion of covered health care expenses that must be paid, in addition to the deductible, by the health plan members. The figure is usually expressed in a ratio, such as 80/20, where the insurer pays 80 percent and the client pays the remaining 20 percent of the bill *(see Cost-Sharing)*.

Community Rating - A method of determining health care premiums where the premium is based on the average cost of health services used by all customers in a specific service area. When community rating is in place, insurance companies are required to charge the same premium to all their customers for the same type and amounts of coverage. It is a way of spreading the cost of medical insurance among all the policyholders of a particular insurance company plan.

> **Pure community rating** requires insurers to set the same premiums for everyone in a community. Plans cannot vary premiums at all based on health status, claims history, or age, but they may be allowed to vary premiums within a state based on geographical location and/or family composition.
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> **Adjusted community** rating likewise prohibits insurers from varying premiums in a community based on health status or claims history, but it does allow them to vary rates based on more factors than geography and family composition. For example, it may allow some variation in premiums but limit that variation within a band no higher than 25 percent of average or lower than 25 percent of average.

Connector – This term originated with the Massachusetts Health Reform of 2006. A health insurance "connector" (also known as an "exchange") is a structure that facilitates enrollment of individuals, families, and small businesses in private health coverage. It creates a common marketplace where consumers can compare their health coverage options. It may also play a central role in outreach and education about newly available coverage and assist employers in establishing Section 125 pre-tax health plans for employees.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - A provision of this federal law requires that certain employers permit laid-off workers and their dependants to remain in the employee health plan for a specified period of time. Employees must pay the full cost of the premium (including the share formerly paid by the employer).

"Consumer Driven" Health Plans – This term is used by different people to mean different things. One of the more common ways this term is used is to refer to a high-deductible plan that may be linked to a Health Savings Account (HSA – see below). The term is also used to refer to a defined contribution plan (see below) in which an employer offers an employee an account with a fixed dollar amount of money in it that is used to pay for health care coverage or services. Both of these kinds of plans—while purportedly giving consumers more "choice" and "control" over their health care—really shift the risk of incurring high health care costs and out-of-pocket costs from employers and insurance companies to employees.

Continuous Eligibility – A policy that states can apply to children's Medicaid and SCHIP coverage that allows an individual to remain eligible for the program for a full 12 months regardless of changes in family income. This policy reduces the paperwork burden on families and helps prevent children from losing coverage as family situations change.

Copayment - The amount a plan member has to pay each time he or she sees a doctor, fills a prescription, or receives other medical services. For example, most health plans require enrollees to pay a set dollar amount for each physician office visit or each prescription drug. *(see Cost-Sharing)*

Cost-Sharing - A provision of private or public health coverage that requires the beneficiary to pay a portion of the costs of covered services.

Crowd-Out – A term used to describe the substitution of public coverage for private coverage. The term has also been used to convey the idea that, when expanding access to subsidized coverage in order to cover the uninsured, the expansion will prompt some privately insured individuals to drop their existing coverage and take advantage of the public subsidy. This issue has been particularly contentious in the children's health debate, as some have argued that large numbers of families drop private coverage in favor of SCHIP or Medicaid. Studies have found varying degrees of crowd-out in these programs, but most reports have found it to be minimal.

Cultural Competence – The capacity of service providers to respect and respond to individual and cultural differences when caring for diverse

populations.

Deductible - A set dollar amount that must be paid *before insurance coverage begins*. For example, many private insurance policies require payment of several hundred dollars out-of-pocket before the insurance will pay for medical care. Medicare also requires the payment of a deductible each year. In 2006, the deductible for Medicare Part A (hospitalization) is $952, and the deductible for Medicare Part B (physician and other outpatient non-pharmacy services) is $124. For Medicare's new drug benefit, Medicare Part D, the standard deductible is $250, but this varies by drug plan.

Deficit Reduction Act (DRA) - In February 2006, President Bush signed into law budget reconciliation legislation, known as the Deficit Reduction Act (DRA), that fundamentally alters many aspects of the Medicaid program. Some of these changes are mandatory provisions that states must enact and that will make it more difficult for people to either qualify for or enroll in Medicaid. Other changes are optional provisions that allow states to make unprecedented changes to the Medicaid program through state plan amendments.

Disparities in Health – Differences in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific population groups.

Disparities in Health Care – Differences between two or more population groups in health care access, coverage, and quality of care *not due to different health needs*. This can include differences in preventive, diagnostic, and treatment services between population groups.

Dual Eligible - A low-income Medicare beneficiary who also receives full Medicaid benefits.

Employee Retirement Income Security Act of 1974 (**ERISA)** - A federal law governing employee benefit programs. As it relates to health insurance, ERISA includes general protections about benefits and about the disclosure of information to employees in the plan. ERISA also prevents states from regulating health insurance if the employer "self insures."

ERISA – *See Employment Retirement Income Security Act of 1974.*

Federal Employees Health Benefits Program (FEHBP) - The health benefits plan for employees of the federal government. The Office of Personnel Management (OPM), which administers FEHBP, approves a variety of health benefit plans from which employees may choose. All plans must offer similar core benefits, and plans can also offer additional benefits. The government pays no more than 75 percent of the cost of an employee's chosen plan, and the employee pays the rest.

Federal Match – For the Medicaid and SCHIP programs, the federal government matches what states contribute to these programs. These match rates vary by state and program.

Federal Poverty Level - Guidelines established by the Department of Health and Human Services that are used to determine an individual's or family's eligibility for various federal and non-federal programs. Federal poverty levels vary by family size and, to a small extent, location (Alaska and Hawaii have higher rates than the 48 contiguous states and the District of Columbia).

Fee-for-Service (or Indemnity) Insurance - Health insurance plans that reimburse physicians and hospitals for each individual service they provide. These plans allow clients to choose any physician or hospital. Managed care is an alternative to fee-for-service medicine.

FEHBP – *See Federal Employees Health Benefits Program.*

Freedom of Choice - A Medicaid provision that requires states to allow beneficiaries the freedom to choose providers. States can seek Section 1915 and 1115 waivers of the freedom-of-choice requirement.

Gatekeeper Physician - A primary care physician who controls the access of his or her HMO patients to specialty medical care.

Generic Drug – A drug product that is no longer covered by patent protection and thus may be produced and/or distributed by many firms. Generic drugs are FDA reviewed and must be bio-equivalent, which means that they must have the same active ingredients and be absorbed by the body the same way as their brand-name counterparts. Generic drugs usually cost significantly less than their brand-name counterparts.

Guaranteed Issue – A requirement (usually a state law) that insurers sell a policy to anyone who seeks one, regardless of the applicant's health status, claims history, age, or the industry in which he or she is employed. This requirement also guarantees that the coverage will be renewed as long as the premium is paid.

Guaranteed Renewal – A requirement that insurers renew the policies of policyholders. Such requirements are established to prevent insurers from dropping policyholders who become ill and have high medical bills.

Health Information Technology (HIT) - The use of electronic technology, such as computerized medical records, to provide comprehensive management of medical information and its secure exchange

between health care consumers and providers, as well as to streamline health care delivery.

Health Insurance Portability and Accountability Act (HIPAA) – A federal law that sought to improve the "portability" of benefits by making it easier for workers to move from job to job without the risk of being locked out of insurance or having to wait for coverage of preexisting medical conditions. The bill also prohibits insurers from discriminating against workers based on their medical history (or that of their dependents).

Health Maintenance Organization (HMO) - A type of managed care health plan that provides health care to insured people through a network of providers within a defined geographic area. The providers may be employees or contractors of the HMO. The HMO providers are responsible for an individual group of patients, and they generally receive a fixed amount of money per month to cover the care of each patient (this is called "capitation"). One advantage of HMO plans has been that they often did not charge deductibles and they often had lower co-insurance or copayments. HMOs were designed to control costs by limiting access to specialty care. In theory, the HMO gatekeeper or primary care provider would help the consumer avoid unnecessary specialist care, but in practice, it is argued that needed specialty care is unduly restricted. Thus traditional HMOs fell out of favor in the mid-1990s.

Health Savings Accounts (HSAs) – Health Saving Accounts (HSAs) were established as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). HSAs offer tax benefits for people who purchase insurance policies with high deductibles. To qualify for the HSA tax break, the policy must have a deductible of at least $1,000 (for an individual) or $2,000 (for a family), but the deductibles may run as high as $10,200. An HSA is a tax-preferred savings account. Deposits into the HSA may be deducted from income for federal income taxes. A maximum of $2,600 (for an individual) or $5,150 (for a family) can be deducted in one year. The tax-deductible contributions may be placed into an HSA by an individual, an employer, or both. Individuals can get a small tax advantage if they contribute to their HSAs, but the amount they save on federal taxes depends on their income, tax liability, and how much they (not their employers) contribute to their HSAs. For many people, an HSA will provide little or no tax break. Withdrawals from health savings accounts that are used to pay for out-of-pocket health care costs are tax free, while withdrawals for non-medical uses are subject to income tax and a 10 percent penalty for people under the age of 65. Money that is not used can be rolled over from one year to the next. Individuals over the age of 65 may withdraw money from their accounts—for any reason—without being taxed. Money in the accounts can be invested in stocks and bonds without incurring tax on the earnings.

High-Risk Pool – A nonprofit association created by states as an alternative for individuals who have been denied health insurance because of a preexisting condition or whose premiums are rated significantly higher than the average due to health status or claims experience. HIPAA (see above) allows states to use high-risk pools to satisfy the statutory requirements for ensuring access to health insurance coverage for certain individuals. By law, premiums are capped, and while they are somewhat higher than premiums charged to healthy people, they are not as high as premiums for unhealthy individuals. High-risk pools are subsidized in order to keep premiums within the state's cap.

HIPAA - *see Health Insurance Portability and Accountability Act.*

HSAs – *See Health Savings Accounts.*

Individual Mandate – A law requiring all state residents to obtain health insurance. Currently, Massachusetts is the only state with an individual mandate.

Limited English Proficiency (LEP) – Individuals who do not speak English as their primary language and have a limited ability to read, write, speak, or understand English are described as having limited English proficiency. An LEP individual has a limited ability to communicate in English at a level that permits the person to interact effectively with health care providers or social service agencies. According to the 2005 American Community Survey, more than 23 million individuals (8.3 percent of the population) speak English less than "very well."

Managed Care Organization (MCO) - A system of health service delivery and financing that coordinates the use of health services by its members, designates covered health services, provides a specific provider network, and directs the use of medical care services. The two most common types of managed care organizations are health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

Medicaid - The federal health insurance program established in 1965 through Title XIX of the Social Security Act. Medicaid pays for health services for low-income Americans under age 65, including children, pregnant women, and people with disabilities, and for nursing home care for impoverished older adults over 65. It is financed through both federal and state funds. Each state implements its own Medicaid program, and the amount allocated to each Medicaid program varies.

Medicaid Waiver – *see Waivers*

Medical Home – A primary care practice where a patient routinely seeks medical care and where a patient's health history is known. A medical home is a

place where health care should be accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.

Medical Loss Ratio – The percentage of premium dollars that health insurance companies spend on medical care, as opposed to administrative costs or retaining for profit.

Medicare - The federal health insurance program established in 1965 through Title XVIII of the Social Security Act that covers Americans who are age 65 or over, who are disabled, or who have been diagnosed with end-stage renal disease.

Medicare Advantage (MA) - Private Medicare health plans, usually managed care plans or HMOs, that have sometimes provided extra benefits that "traditional" Medicare did not cover. Plans may charge additional premiums. This program was formerly known as Medicare+Choice or Medicare Part C.

Medicare Part A (*also known as Hospital Insurance*) - Medicare Part A covers inpatient hospital care, home health care, hospice care, and limited skilled nursing care. Eligibility is normally based on prior payment of payroll taxes. Beneficiaries must pay an initial deductible each time they are ill and a copayment for some services.

Medicare Part B (*also known as Supplementary Medical Insurance*) - Medicare Part B covers physician services, medical supplies, and other outpatient treatment such as laboratory tests and x-rays. Medicare beneficiaries must pay a monthly premium for Part B coverage.

Medicare Part D (*also known as the Medicare prescription drug benefit*) - Medicare Part D provides for an outpatient prescription drug benefit that began in January 2006. Beneficiaries can remain in traditional Medicare and enroll in a separate, freestanding, private prescription drug plan (PDP), or they can enroll in an integrated Medicare Advantage plan that includes prescription drug coverage.

Medicare Payment Advisory Commission (MedPAC) – An independent body established by Congress to advise it on issues affecting the Medicare program.

Medicare Prescription Drug Benefit - *see Medicare Part D.*

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) - Commonly known as the Medicare Modernization Act (MMA), this law most notably created a prescription drug program for Medicare beneficiaries, known as Medicare Part D. In addition, it increased the part B deductible, expanded private Medicare Advantage plans, and added new preventive benefits for beneficiaries.

Medigap (or Medicare Supplemental) Policy - A privately purchased insurance policy that supplements Medicare coverage. The policy must meet requirements set by federal statute and by the National Association of Insurance Commissioners.

Modified Community Rating – *see Adjusted Community Rating.*

Out-of-Pocket Maximum – The upper limit of how much individuals or families must pay out of pocket in deductibles and coinsurance for covered medical services during a benefit period.

Pay-for-Performance (P4P) - The idea that there should be a direct link, based on accepted measures, between what is paid for health services and the value of the services provided. Pay-for-performance uses payment methods and other incentives to encourage physicians and other health care personnel to provide higher quality and efficiency, rather than higher volume.

Pay or Play – Legislation designed to expand health coverage that requires employers (within certain parameters) to either "play" by contributing to their employees' health coverage or "pay" an assessment to the state which the state, in turn, uses to fund health coverage.

Preexisting Condition Exclusion – A policy of excluding certain people from obtaining insurance or treatment due to a preexisting medical condition.

Preferred Provider Organizations (PPOs) – A type of managed care plan in which enrollees can choose plan-selected providers who discount their fees. By visiting a PPO provider, a beneficiary will pay less money out-of-pocket for medical services than he or she would by visiting a non-PPO provider.

Premium - The charge (not including any deductibles or copayments) enrollees must pay for coverage under a health plan. Premiums are typically paid on a monthly basis.

Premium Assistance – The use of federal funds usually designated for public health coverage programs—especially Medicaid and SCHIP—to purchase (or subsidize the purchase of) private insurance.

Presumptive Eligibility - A policy that states can use in their Medicaid or SCHIP programs for children or pregnant women. This policy allows states to provide these individuals with immediate but temporary enrollment in Medicaid or SCHIP if they appear to meet program eligibility standards.

Prior Authorization - A requirement that an enrollee's physician or insurance plan (or Medicaid

program) give approval in advance before a particular drug or service will be covered.

Purchasing Pool – As it relates to health coverage, a group of people brought together to enhance their bargaining power as well as to pool risks across individuals—the sickest to the healthiest. All purchasing pool members pay the same premium for a given plan, regardless of their health status.

Rate Bands – The variation in insurance premiums that is allowed by state regulations, expressed as a ratio or as a percentage of the index rate or average rate. Rate bands are used to limit the variation in premiums among individuals.

Rate Regulation – The process of overseeing and regulating the premiums—or rates—that insurance companies charge to their customers. States and the federal government regulate different kinds of insurance.

Reinsurance – Reinsurance is insurance for insurance companies. Its basic structure involves a primary insurance company that transfers, or cedes, the risk of high-cost claims to another private carrier or to a government-sponsored program. The insurer or government-sponsored program then assumes this risk and pays for some or all of these high-cost claims. There are two major types of government-sponsored reinsurance programs: 1) the government pays for some or all of the claims through general revenues; or 2) state law establishes an association of insurance companies that may want to cede risk and requires these companies to pool their resources to pay high-cost claims.

Risk Pooling – Under this process, risk for all individuals—including the healthy and the sick—is combined into one risk pool or group, and the group's total expected claims are evaluated. This is used to try to calculate the required funding (raised through premiums and/or other subsidies) to support the payment of all expected claims for all members of the risk pool.

SCHIP – *See State Children's Health Insurance.*

Section 125 Cafeteria Plans – Plans that allow employees to set aside pre-tax dollars for a variety of benefits, including flexible spending accounts (FSAs) and health insurance. These plans are named after Section 125 of the Internal Revenue Service code. Some states encourage or require certain businesses to establish cafeteria plans so that their workers will be able to pay for their share of health premiums with pre-tax dollars.

Self-Insured Health Plan – A health plan in which the employer assumes the financial risk of covering its employees, paying medical claims from its own resources.

State Children's Health Insurance Program (SCHIP) - The BBA of 1997 established Title XXI of the Social Security Act, which created the federal block grant program known as SCHIP. SCHIP provides funds to states to establish a health insurance program for targeted low-income children in families with incomes below 200 percent of the federal poverty level. States can: (1) expand Medicaid to cover children in families with higher incomes, (2) create a new health insurance program for children, or (3) do both. The program is financed with federal and state funds, with the federal government paying a greater share than it pays for the state's regular Medicaid program. Each state has a different SCHIP program.

State Plan Amendment - A Medicaid state plan is the document that defines how each state operates its Medicaid program. Making any major change to a state's Medicaid program usually requires an amendment to the Medicaid state plan. Amendments to the state plan must be filed and approved by the Centers for Medicare and Medicaid Services (CMS) before changes can be implemented.

Tax Credits – A dollar-for-dollar reduction in the amount of taxes an individual owes. Some tax credits are "refundable," meaning that if an individual owes less in taxes than the amount of the credit, he or she receives a refund and benefits from the full amount of the credit. The Earned Income Tax Credit is an example of a well-known federal program that works in such a manner.

Trade Adjustment Assistance Reform Act of 2002 (TAARA) Health Insurance Subsidy - The TAARA is geared toward helping retirees, their families, and other workers who have lost their employer-sponsored health coverage as a consequence of trade practices or bankruptcies. This legislation provides a subsidy, via the tax system, that covers 65 percent of the cost of purchasing health insurance from certain specified sources.

Underinsured – People whose insurance does not cover their necessary health care services, leaving them with out-of-pocket expenses that exceed their ability to pay.

Waivers - Sections 1115 and 1915 of the Social Security Act define specific circumstances under which the federal government may, at a state's request, "waive" certain provisions of the federal Medicaid laws. The "waiver" is the agreement between the federal government and the state that exempts the state from these provisions, and it includes special terms and conditions that define to whom and when these exemptions apply. For example, some states use Medicaid waivers to extend Medicaid coverage to childless adults who are not blind or disabled, a group that does not ordinarily qualify for Medicaid under federal laws.

Home- and Community-Based Care *(also known as* 1915 *(c) or* 1915 *(d)*) - A home- or community-based care waiver allows states to offer community-based long-term care services to Medicaid beneficiaries who would otherwise require nursing home care or other types of institutionalized care. Under this type of waiver, states provide a broad range of home- and community-based services to people who are older than 65, developmentally disabled, or chronically ill. States must apply to the Department of Health and Human Services (HHS) for each specific program.

Section 1115 - Section 1115 of the Social Security Act allows the Secretary of the Department of Health and Human Services (HHS) to waive certain Medicaid requirements in order to allow states to establish demonstration projects that are "likely to further the goals of the Medicaid program." One major goal of Medicaid is to provide health care to people with low incomes. States submit a waiver application to HHS, which must approve the application before the waiver can take effect. Recent Section 1115 waiver proposals have largely sought to reduce the health care services available in Medicaid and to eliminate certain rights that people in Medicaid have to get care.

Section 1915 (b) - A Section 1915(b) waiver allows states to waive Medicaid rules regarding the freedom to choose a provider, the establishment of statewide programs, and the comparability of Medicaid benefits to different covered groups. Thus, states can require all or some categories of Medicaid beneficiaries to enroll in managed care, either throughout the state or in limited geographical areas. Since passage of the Balanced Budget Act of 1997, states can mandate managed care enrollment for many Medicaid beneficiaries without a Section 1915(b) waiver. A state must still, however, obtain such a waiver to mandate managed care enrollment for children with special needs, dual eligibles (people who are eligible for both Medicaid and Medicare), and Native Americans.

Health Insurance Flexibility and Accountability (HIFA) Waiver – This type of waiver is based on policy guidance issued by the Bush Administration in August 2001 that provides for fast-track approval of Section 1115 Medicaid and SCHIP waivers. HIFA gives states new flexibility to cut benefits and increase cost-sharing for some current beneficiaries. HIFA also requires states to include a private insurance component to their programs that would provide a subsidy to individuals for the purchase of available employer-sponsored or other private insurance instead of enrolling in the state's Medicaid or SCHIP program.

Wraparound Benefits – Benefits that Medicaid provides when it acts as a secondary insurer to Medicaid-eligible individuals who are enrolled in private plans (such as employer-based coverage) that do not cover all of the services that Medicaid covers.