

## Glossary

### A

**Acute Care:** Medical treatment given to individuals whose illnesses are short-term or episodic.

**Acute Condition:** An illness or condition that is short-term or episodic. Examples would include a case of bronchitis or a broken arm.

**Aid to Families with Dependent Children (AFDC):** A state-based federal assistance program that provided cash payments to needy children (and their caretakers), who met certain income requirements. AFDC has now been replaced by a new block grant program.

### B

**Beneficiary:** A person who is eligible for or receiving benefits under an insurance policy or plan.

### C

**Cafeteria Plan:** Health benefits that are excludable for income and employment tax purposes. Under a cafeteria plan, an employee is provided a fixed budget to purchase various benefits such as health, life and disability.

**Catastrophic Health Insurance:** Health insurance that provides fairly complete coverage against the high cost of treating severe or lengthy illnesses or disability, usually with little or no coverage for relatively minor expenses.

**Centers for Medicare and Medicaid Services (CMS):** Formerly known as the Health Care Financing Administration (HCFA), the Centers for Medicare and Medicaid Services is the federal agency that administers Medicare and works in conjunction with state governments to oversee the federal-state Medicaid and the State Children's Health Insurance Program (SCHIP).

**CHAMPUS:** (Civilian Health and Medical Program of the Uniformed Services) A health plan that serves the dependents of active duty military personnel and retired military personnel and their dependents.

**CHIP:** (Children's Health Insurance Program) A

federal-state program enrolling children from families that earn too much to qualify for Medicaid but not enough to afford private health insurance. *[Note: formerly called SCHIP.]*

**Chronic Care:** Treatment or services necessary to treat a medical condition that lasts a lifetime or recur.

**Chronic Condition:** A medical problem that will not improve, that lasts a lifetime, or recurs and usually requires a long period of supervision, observation or care. Examples include diabetes, asthma and high blood pressure. *[NOTE: many say "chronic" means it will last a year or more.]*

**Co-insurance:** The percentage of a medical bill that is not covered by a patient's health policy and must therefore be covered out-of-pocket by the patient.

**Co-payment:** The part of the medical bill that is not covered by a patient's health insurance policy and must be covered out of pocket by the patient. It is usually a flat amount, such as \$10 for an office visit.

**COBRA:** (Consolidated Omnibus Budget Reconciliation Act of 1985) A federal law that allows individuals leaving a company with 20 or more workers to continue the health insurance policy they had when employed. COBRA applies when individuals lose or leave a job. The individual pays the entire group premium, not just the worker's share, plus a set administrative fee, usually for up to 18 months.

**Collectively Bargained Health Plan:** An employer provided benefit, pension or annuity plan that is established through a union-negotiated contract.

**Community Rating:** A method for setting health insurance rates in which everyone in a specific area is charged the same premium rather than having it adjusted individually according to a person's health history. The rate is usually based on the average cost of delivering health care to people living in that area.

**Coverage:** A person has coverage if all or part of his

health care costs is paid either by insurance or by the government.

## D

**Deductible:** The amount of money, or value of certain services (such as one physician visit) a patient or family must pay before costs are covered by the health plan or insurance company, usually per year.

**Diversion:** The routing of patients to other hospitals because an emergency room is full.

## E

**Employment Retirement Income Security Act (ERISA):** A law enacted in 1974 that sets federal reporting and disclosure rules for employer-sponsored health plans. Under ERISA law, companies that self-insure and pay for workers' health benefits directly are exempt from state insurance regulation and taxes.

**Exclusion Period:** A period during which a health insurance plan will not pay for a new enrollee's health care relating to a previous medical condition.

**Experience Rating:** A practice in which premium rates for health insurance are based on the past cost experiences of the enrolled individual or group.

## F

**Federal Employees Health Benefit Program (FEHBP):** The health benefit system for federal civilian employees. Under the FEHBP, employees choose from among multiple health plans approved by the federal government. The federal government picks up a large portion of the cost of coverage.

**Federal Poverty Guidelines:** The official annual income level for poverty is defined by the federal government. Under the 2003 guidelines, the federal poverty level for a family of four was \$18,400.

**Fee-for-service:** An approach in which physicians or other providers bill separately for each patient encounter or service they provide, rather than receiving a salary or a set payment per patient

enrolled.

**Flexible Spending Account:** Also Flexible Spending Arrangements. Benefit plans in which an employer reduces an employee's earnings, before income tax is taken out, to pay for medical expenses not covered by insurance. These plans also can be used to pay for child care services.

## G

**Group Insurance:** Health insurance offered through business, union trusts or other groups and associations. This system of health insurance is the most common in the United States.

**Guarantee Issue:** A requirement in which health plans must enroll people regardless of health status, age, gender or other factors predicting use of health services. However, plans that provide guaranteed issue can turn enrollees away for other reasons.

**Guarantee Renewability:** When a health plan has a guaranteed renewability clause, it prevents coverage from being discontinued because a person gets sick.

## H

**Health Insurance Portability & Accountability Act: HIPAA.** A federal law enacted in 1996, offering limited protections to ensure continuity of health care coverage. Under HIPAA, insured individuals who have a health condition cannot be denied benefits when they change jobs. It also prevents health plans from refusing coverage on the basis of pre-existing conditions. But HIPAA puts no limits on premiums that may be charged.

**Health Maintenance Organization (HMO):** A health plan, either for-profit or not-for-profit, that provides comprehensive medical services to its members for a fixed, prepaid premium. Members must use participating providers and are enrolled for a fixed period of time.

## I

**Indemnity Insurance:** A system of health insurance in which the insurer pays for the costs of covered services after care has been given, on a fee-for-service basis. It usually defines the maximum amounts that will be paid for covered services.

**Individual Health Plan:** Health policies for people not connected to an employer or other group. This term also refers to coverage purchased by self-employed persons who have no other employees. (Sometimes called “non-group.”)

## M

**Managed Care:** Any health insurance that controls the use of health services by its enrolled members in order to contain health care costs, improve the quality of care or both. Examples are health maintenance organizations (HMOs) and Preferred Provider Organizations (PPOs).

**Medicaid:** The federal-state program for certain categories of low-income people that covered health and long-term care services for 51 million Americans in 2002, including children, the aged, blind, disabled and people who are eligible to receive federally-assisted income maintenance payments.

**Medical Savings Accounts (MSAs):** A tax-exempt account, similar to an Individual Retirement Account, that is used to pay for routine medical expenses. These are used to pay for health care not covered by insurance, including deductible and co-payments.

**Medicare:** The federal health insurance program for people age 65 and older, persons with disabilities and people with end-stage renal disease, with about 41 million beneficiaries in 2003.

**Multiple Employer Welfare Arrangement (MEWA):** A type of employee benefit plan that is established or maintained for the purpose of offering or providing certain types of benefits, including health benefits, to the employees of two or more employers. As provided under ERISA, states may regulate fully-insured MEWAs. They also may regulate self-insured MEWAs to the extent not inconsistent with federal law.

## O

**Out-of-pocket Expenditures:** The portion of medical expenses a patient is responsible for paying.

**Outpatient Care:** Health care services that do not require a patient to receive overnight care in a hospital.

## P

**Pre-existing Condition:** A medical condition a person develops before applying for a particular health insurance policy that could affect their ability to get coverage or how much they have to pay for it.

**Preferred Provider Organization (PPO):** A managed care plan that contracts with networks or panels of providers, which furnish services and are paid according to a negotiated fee schedule. Enrollees are offered a financial incentive to use providers on the preferred list, but may use non-network providers as well.

**Premium:** An amount paid periodically (usually monthly) to buy health insurance coverage.

**Purchasing Pools:** Through these pools, businesses and associations band together to negotiate lower premiums from health insurance plans than they could on their own.

## R

**Refundable Tax Credit:** A type of tax credit sometimes used to help people purchase insurance. It is used to offset other taxes or is paid to a household even if there is no tax liability.

## S

**Safety Net Providers:** Providers who have a mandate or mission to deliver large amounts of care to uninsured and other vulnerable patients. Examples include community health centers, clinics, public hospitals and some teaching hospitals.

**SCHIP:** (State Children's Health Insurance Program) A federal-state program enrolling children from families that earn too much to qualify for Medicaid but not enough to afford private health insurance. *[Note: Renamed CHIP in 2009.]*

**Self-employed Deduction for Health Insurance:** Self-employed taxpayers can deduct portions of their payments for health insurance when figuring their annual income for tax purposes. As of 2003, self-employed persons are able to deduct the full cost of insurance payments.

**Self-insured Health Plan:** Employer-provided health insurance in which the employer, rather than an

insurer, is at risk for its employees' medical expenses.

**Stop-loss:** An annual limit or cap on how much in deductibles and co-payments the patient has to pay.

T

**Tax Credit:** Under some health care reform proposals, an amount subtracted from one's tax liability to help them buy health insurance in the private market. The amount of the credit could vary according to age, health status or income. It could be paid even to those who owe no taxes ("refundable") and could be paid even before the person files a tax return ("advanceable").

**Tax-favored Fringe Benefit:** Under federal tax law, employer-paid health benefits are treated as a deductible business expense for the employer and not as taxable income for the worker.

**Temporary Assistance to Needy Families (TANF):** Block grant program that replaced Aid to Families with Dependent Children.

U

**Uncompensated Care:** Health care provided to persons unable to pay and not covered by private or governmental health insurance plans; includes both unbilled charity care and bad debts (services billed but not paid).

**Underinsured:** Refers to people who have some type of health insurance, such as catastrophic care, but not enough insurance to cover all their health care costs.

**Uninsured:** People who lack health insurance of any kind.

V

**Veterans Health Care:** Health care provided by the Department of Veterans Affairs to eligible veterans and to members of veterans' families and survivors of deceased veterans.

W

**Waiting Period:** The period from which a person is deemed eligible for health insurance coverage to the date that coverage becomes effective.