Glossary of Health Care Terms

Access: The ability to obtain needed medical care. Access to care is often affected by the availability of insurance, the cost of the care, and the geographic location of providers.

Children's Health Insurance Program (CHIP): Enacted in 1997, CHIP is a federal-state program that provides health care coverage for uninsured low-income children who are not eligible for Medicaid. States have the option of administering CHIP through their Medicaid programs or through a separate program (or a combination of both). The federal government matches state spending for CHIP but federal CHIP funds are capped.

COBRA: When employees lose their jobs, they are able to continue their employer-sponsored coverage for up to 18 months through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Co-insurance: A method of cost-sharing in health insurance plans in which the plan member is required to pay a defined percentage of their medical costs after the deductible has been met.

Comparative Effectiveness: A field of research that analyzes the impact of different options for treating a given condition in a particular group of patients. These analyses may focus only on the medical risks and benefits of each treatment or may also consider the costs and benefits of particular treatment options.

Co-payment: A fixed dollar amount paid by an individual at the time of receiving a covered health care service from a participating provider. The required fee varies by the service provided and by the health plan.

Cost Containment: A set of strategies aimed at controlling the level or rate of growth of health care costs. These measures encompass a myriad of activities that focus on reducing overutilization of health services, addressing provider reimbursement issues, eliminating waste, and increasing efficiency in the health care system.

Cost-Sharing: A feature of health plans where beneficiaries are required to pay a portion of the costs of their care. Examples of costs include co-payments, coinsurance and annual deductibles.

Cost Shifting: Increasing revenues from some payers to offset losses or lower reimbursement from other payers, such as government payers and the uninsured.

Deductible: A feature of health plans in which consumers are responsible for health care costs up to a specified dollar amount. After the deductible has been paid, the health insurance plan begins to pay for health care services.

Dual Eligibles: A term used to describe an individual who is eligible for Medicare and for some level of Medicaid benefits. Most dual eligibles qualify for full Medicaid benefits including nursing home services, and Medicaid pays their Medicare premiums and cost sharing.

Employer Health Care Tax Credit: An incentive mechanism designed to encourage employers, usually small employers, to offer health insurance to their employees. The tax credit enables employers to deduct an amount, usually a percentage of the contribution they make toward their employees' premiums, from the federal taxes they owe. These tax credits are typically refundable so they are available to non-profit organizations that do not pay federal taxes.

Employer Mandate: An approach that would require all employers, or at least all employers meeting size or revenue thresholds, to offer health benefits that meet a defined standard, and pay a set portion of the cost of those benefits on behalf of their employees.

Employer Pay-or-Play: An approach that would require employers to offer and pay for health benefits on behalf of their employees, or to pay a specified dollar amount or percentage of payroll into a designated public fund. The fund would provide a source of financing for coverage for those who do not have employment-based coverage.

Fee-for-Service: A traditional method of paying for medical services under which doctors and hospitals are paid for each service they provide. Bills are either paid by the patient, who then submits them to the insurance company, or are submitted by the provider to the patient's insurance carrier for reimbursement.

Group Health Insurance: Health insurance that is offered to a group of people, such as employees of a company. The majority of Americans have group health insurance through their employer or their spouse's employer.

Health Insurance Exchange/Connector: A purchasing arrangement through which insurers offer and smaller employers and individuals purchase health insurance. State, regional, or national exchanges could be established to set standards for what benefits would be covered, how much insurers could charge, and the rules insurers must

follow in order to participate in the insurance market. Individuals and small employers would select their coverage within this organized arrangement.

Individual Insurance Market: The market where individuals who do not have group (usually employer-based) coverage purchase private health insurance. This market is also referred to as the non-group market.

Individual Mandate: A requirement that all individuals obtain health insurance. A mandate could apply to the entire population, just to children, and/or could exempt specified individuals. Massachusetts was the first state to impose an individual mandate that all adults have health insurance.

Managed Care: A health delivery system that seeks to control access to and utilization of health care services both to limit health care costs and to improve the quality of the care provided. Managed care arrangements typically rely on primary care physicians to act as "gatekeepers" and manage the care their patients receive.

Medicaid: Enacted in 1965 under Title XIX of the Social Security Act, Medicaid is a federal entitlement program that provides health and long-term care coverage to certain categories of low-income Americans. States design their own Medicaid programs within broad federal guidelines. Medicaid plays a key role in the U.S. health care system, filling large gaps in the health insurance system, financing long-term care coverage, and helping to sustain the safety-net providers that serve the uninsured.

Medical Loss Ratio: The percentage of premium dollars an insurance company spends on medical care, as opposed to administrative costs or profits.

Medicare: Enacted in 1965 under Title XVII of the Social Security Act, Medicare is a federal entitlement program that provides health insurance coverage to 45 million people, including people age 65 and older, and younger people with permanent disabilities, end-state renal disease, and Lou Gehrig's disease.

Out-of-Pocket Costs: Health care costs, such as deductibles, co-payments, and co-insurance that are not covered by insurance. Out-of-pocket costs do not include premium costs.

Out-of-Pocket Maximum: A yearly cap on the amount of money individuals are required to pay out-of-pocket for health care costs, excluding the premium cost.

Premium: The amount paid, often on a monthly basis, for health insurance. The cost of the premium may be shared between employers or government purchasers and individuals.

Premium Subsidies: A fixed amount of money or a designated percentage of the premium cost that is provided to help people purchase health coverage. Premium subsidies are usually provided on a sliding scale based on an individual's or family's income.

Public Plan Option: A proposal to create a new insurance plan administered and funded by federal or state government that would be offered along with private plans in a newly-created health insurance exchange.

Single-Payer System: A health care system in which a single entity pays for health care services. This entity collects health care fees and pays for all health care costs, but is not involved in the delivery of health care.

Socialized Medicine: A health care system in which the government operates and administers health care facilities and employs health care professionals.

Tax Credit: A tax credit is an amount that a person/family can subtract from the amount of income tax that they owe.

Tax Deduction: A deduction is an amount that a person/family can subtract from their adjusted gross income when calculating the amount of tax that they owe.

Underinsured: People who have health insurance but who face out-of-pocket health care costs or limits on benefits that may affect their ability to access or pay for health care services.

Universal Coverage: A system that provides health coverage to all Americans. A mechanism for achieving universal coverage (or near-universal coverage) under several current health reform proposals is the individual mandate. Single payer proposals would also provide universal coverage.

--adapted from Kaiser Family Foundation http://www.kff.org/healthreform/upload/7909.pdf