Glossary of Health Care Terms and Acronyms

The Walker Company
HEALTHCARE CONSULTING

A

Access - A person's ability to obtain health care services.

Accountable Care Organization (ACO) - A network of health care providers that band together to provide the full continuum of health care services for patients. The network would receive a payment for all care provided to a patient, and would be held accountable for the quality and cost of care. Proposed pilot programs in Medicare and Medicaid would provide financial incentives for these organizations to improve quality and reduce costs by allowing them to share in any savings achieved as a result of these efforts.

Actuarial Equivalent - A health benefit plan that offers similar coverage to a standard benefit plan. Actuarially equivalent plans will not necessarily have the same premiums, cost sharing requirements, or even benefits; however, the expected spending by insurers for the different plans will be the same.

Actuarial Value - The percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, you would be responsible for 30% of the costs of all covered benefits. However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual health care needs and the terms of your insurance policy.

Acute Care - Medical treatment rendered to people whose illnesses or medical problems are short-term or don't require long-term continuing care. Acute care facilities are hospitals that mainly treat people with short-term health problems.

Adverse Selection - People with a higher than average risk of needing health care are more likely than healthier people to seek health insurance. Health coverage providers strive to maintain risk pools of people whose health, on average, is the same as that of the general population. Adverse selection results when the less healthy people disproportionately enroll in a risk pool.

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.

Aggregate Indemnity - The maximum amount of payment provided by an insurer for each covered service for a group of insured people.

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, but the requirements, or criteria, can still be used for determining eligibility for Medicaid.

Alliance - Large businesses, small businesses, and individuals who form a group for insurance coverage.

Allowed Charge - Discounted fees that insurers will recognize and pay for covered services. Insurers negotiate these discounts with providers in their health plan network, and network providers agree to accept the allowed charge as payment in full. Each insurer has its own schedule of allowed charges.

All-payer System - A proposed health care system in which, no matter who is paying, prices for health services and payment methods are the same. Federal or state government, a private insurance company, a self-insured employer plan, an individual, or any other payer would pay the same rates. Also called Multiple Payer system.

Ambulatory Care - All health services that are provided on an out-patient basis, that don't require overnight care. Also called out-patient care.

Ancillary Services - Supplemental services, including laboratory, radiology and physical therapy, that are provided along with medical or hospital care.

Annual Limit - A cap on the benefits your insurance company will pay in a year while you're enrolled in a particular health insurance plan. These caps are sometimes placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.

Association Health Plan - Health insurance plans that are offered to members of an association. These plans are marketed to individual association members, as well as small businesses members. How these plans are structured, who they sell to, and whether they are state-based or national associations determines whether they are subject to state or federal regulation, or both, or are largely exempt from regulations. Recent Congressional proposals would have loosened regulations on these insurance plans.

B

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

Benefits - The health care items or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents. In Medicaid or CHIP, covered benefits and excluded services are defined in state program rules.

Biosimilar Biological Products - The generic version of more complicated medications.

Blue Cross/Blue Shield - Non-profit, tax-exempt insurance service plans that cover hospital care, physician care and related services. Blue Cross and Blue Shield are separate organizations that have different benefits, premiums and policies. These organizations are in all states, and The Blue Cross and Blue Shield Association of America is their national organization.

Board Certified - Status granted to a medical specialist who completes required training and passes and examination in his/her specialized area. Individuals who have met all requirements, but have not completed the exam are referred to as "board eligible."

Board Eligible - Reference to medical specialists who have completed all required training but have not completed the exam in his/her specialized area.

C

Cafeteria Plan -This benefit plan gives employees a set amount of funds that they can choose to spend on a different benefit options, such as health insurance or retirement savings.

Capitation - A fixed prepayment, per patient covered, to a health care provider to deliver medical services to a particular group of patients. The payment is the same no matter how many services or what type of services each patient actually gets. Under capitation, the provider is financially responsible.

Care Coordination - The organization of your treatment across several health care providers. Medical homes and Accountable Care Organizations are two common ways to coordinate care.

Care Guidelines - A set of medical treatments for a particular condition or group of patients that has been reviewed and endorsed by a national organization, such as the Agency for Health care Policy Research.

Carrier - A private organization, usually an insurance company, that finances health care.

Carve-Out - Medical services that are separated out and contracted for independently from any other benefits.

Case Management - The process of coordinating medical care provided to patients with specific diagnoses or those with high health care needs. These functions are performed by case managers who can be physicians, nurses, or social workers.

Catastrophic Health Insurance - Currently, some insurers describe these plans as those that only cover certain types of expensive care, like hospitalizations. Other times insurers mean plans that have a high deductible, so that your plan begins to pay only after you've first paid up to a certain amount for covered services.

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.

Children's Health Insurance Program (CHIP) - Insurance program enacted in 1997 that is jointly funded by state and Federal government that provides health insurance to low-income children and, in some states, pregnant women in families who earn too much income to qualify for Medicaid but cannot afford to purchase private health insurance coverage. 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.

Chronic Care - Treatment given to people whose health problems are long-term and continuing. Nu nursing homes, mental hospitals and rehabilitation facilities are chronic care facilities.

Chronic Disease - A medical problem that will not improve, that lasts a lifetime, or recurs.

Chronic Disease Management - An integrated care approach to managing illness which includes screenings, check-ups, monitoring and coordinating treatment, and patient education. It can improve your quality of life while reducing your health care costs if you have a chronic disease by preventing or minimizing the effects of a disease.

Claims - Bills for services. Doctors, hospitals, labs and other providers send billed claims to health insurance plans, and what the plans pay are called paid claims.

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). Under the original legislation, individuals were required to pay the full premium to continue their insurance through COBRA. The American Recovery and Reinvestment Act (ARRA) provides a temporary subsidy of 65% of the premium cost for the purchase of COBRA coverage to people who have lost their job between September 1, 2008 and December 31, 2009.

Co-Insurance - The percentage of allowed charges for covered services that you're required to pay. For example, the health insurance may cover 80% of charges for a covered hospitalization, leaving you responsible for the other 20%. This 20% is known as the coinsurance.

Community Rating - A rule that prevents health insurers from