Health Terms Glossary

Following is a list of common health insurance terms and definitions*.

Ambulatory Care – Health services delivered on an outpatient basis. A patient's treatment at a doctor's office or a surgical center without an overnight stay is considered ambulatory care; home treatment is not.

Authorization –The approval of care, such as hospitalization. Pre-authorization may be required before a patient is admitted or given care by a non-HMO provider.

Benefit Package – The set of health services, such as physician visits, hospitalizations and prescription drugs that are covered by a member's insurance policy or group health plan.

Cafeteria Plan – A flexible benefits plan that generally offers a choice of two or more qualified benefits or the option of cash.

Capitation – Under a capitation system health care providers are paid a set amount for each enrolled person assigned to that physician or group of physicians, whether or not that person seeks care.

Case Management – The coordination of medical care for patients with specific diagnoses or high health care needs, performed by case managers who can include medical directors or nurses.

Catastrophic Coverage – A coverage option with a limited benefit plan design accompanied by a high Deductible. The plan design is intended to protect primarily against the cost for unforeseen and expensive illnesses or injuries. These plans are attractive to young adults in relatively good health.

CHIP – The Children's Health Insurance Program (CHIP) is a program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to low income families with children. The program was designed with the intent to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid.

Chronic Care Management – The coordination of health care and supportive services to improve the health status of patients with chronic conditions, such as diabetes and asthma. The goals of these programs are to improve the quality of care and manage costs.

COBRA – Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) applies to employers who generally employ 20 or more full time equivalent employees. Employees who lose their jobs are able to continue their employer-sponsored coverage for a set period of time. For example, employees are typically entitled to extend coverage for 18 months, however if they are deemed disabled by the Social Security Administration, coverage may continue for up to 29 months.

Co-insurance – The amount or percentage of the reimbursed amount of covered expenses a plan member must pay for health services after the Deductible has been met.

Consumer-Driven Health Plans – These health plans seek to increase consumer awareness about health care costs and provide incentives for consumers to consider costs when making health care decisions. These plans usually have a high Deductible accompanied by a savings account for health care services. There are two types of savings accounts – Health Savings Accounts (HSAs) and Health Reimbursement Accounts (HRAs).

Co-payment – A fixed dollar amount paid by an individual receiving a health care service covered by the member's plan.

Cost-Sharing – Health plan members are required to pay a portion of the costs of their care. Examples of these costs include Co-payments, Co-insurance and annual Deductibles.

Credentialing – Examination of a physician or other health care provider's credentials to determine if he or she should be entitled to clinical privileges at a hospital or managed care organization.

Current Procedural Technology (CPT) – A coding system developed by the American Medical Association to categorize different medical procedures, each represented by a five-digit code. The system is used frequently for billing purposes.

Deductible – The dollar amount that a plan member must pay for health care services each year before the insurer begins to reimburse for health care services. Beginning in 2014, deductibles for small group insurance plans will be limited to $2,000 for individual policies and $4,000 for family policies.

Disease Management – The coordination of care for the entire disease treatment process, including preventive care, patient education and outpatient care in addition to inpatient and acute care. The process is intended to reduce costs and improve the quality of life for an individual with a chronic condition.

Dual Eligibles – A term used to describe an individual who is eligible for Medicare and for some Medicaid benefits.

Electronic Health Record/Electronic Medical Records – Computerized patient health records, including medical, demographic, and administrative information. These records can be created and stored within one organization or shared across multiple health care organizations and sites.

Employee Assistance Program (EAP) – A program of counseling and other forms of assistance for employees suffering from alcoholism, substance abuse, or emotional or family problems.

Episode of Care – Refers to all the health services related to the treatment of a condition. For acute conditions (such as a concussion or a broken bone), the episode includes all treatment and services from the onset of the condition to its resolution. For chronic conditions (such as diabetes), the episode refers to all services and treatments received over a given period of time. Some payment reform proposals involve basing provider payment on episodes of care instead of paying on a Fee-for-Service basis.

Exchange or Health Insurance Exchange – The health care reform law creates Health Benefit Exchanges (competitive insurance marketplaces) in each state, where individuals and employers can shop for health plans.

Exclusive Provider Organization (EPO) – A more rigid type of preferred provider organization (PPO) that requires members to use only designated providers or relinquish reimbursement altogether. PPOs, in contrast, encourage members to use "preferred" providers through more generous reimbursement but will still reimburse for non-preferred providers.

Experience Rating – A method of determining premiums that adjusts a group's rate based on the demographic characteristics and utilization experience of that particular group as opposed to using averaged data for multiple groups.

Fee-for-Service – A traditional method of paying for medical services where doctors and hospitals are paid a fee for each service they provide.

Formulary – The panel of drugs chosen by a hospital or managed care organization to treat patients. Drugs outside the formulary are not used except in specified circumstances.

Gatekeeper – An HMO physician who coordinates a patient's care and who effectively controls costs by minimizing unnecessary services.

Group Health Plan – Health insurance that is offered by a plan sponsor, typically an employer on behalf of its employees.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – This law sets standards for the security and privacy of personal health information. In addition, the law makes it easier for individuals to change jobs without the risk of extended waiting periods due to pre-existing conditions.

Health Maintenance Organization (HMO) – A health plan that provides coverage through a network of hospitals, physicians and other health care providers. HMOs usually require the selection of a primary care physician who is responsible for managing and coordinating all health care. Usually, referrals to specialist physicians are required, and the HMO pays only for care provided by an in-network provider.

Health Reimbursement Account (HRA) – A tax-exempt account that can be used to pay for qualified health expenses. HRAs are usually paired with a high-Deductible health plan and are funded solely by employer contributions.

Health Savings Account (HSA) – A tax-exempt savings account that can be used to pay for qualified medical expenses. Individuals can obtain HSAs from most financial institutions, or through their employer. Both employers and employees can contribute to the plan. To open an HSA, an individual must have health coverage under an HSA-qualified high-Deductible health plan which has Deductibles of at least $1,200 for an individual and $2,400 for a family in 2010.

High-Deductible Health Plan – These health insurance plans have higher Deductibles and lower premiums than traditional insurance plans.

Independent Practice Association (IPA) – An independent group of physicians and other health-care providers that are under contract to provide services to members of different HMOs, as well as other insurance plans, usually at a fixed fee per patient.

Individual Mandate – A requirement that most individuals obtain health insurance or pay a penalty beginning in 2014. Massachusetts was the first state to impose an individual mandate that all adults have health insurance.

Limited Fee Schedule – A comprehensive listing of fees used as a standard to reimburse physicians or other health care providers.

Long-Term Care – Services needed for an individual to live independently in the community, such as home health and personal care, as well as services provided in institutional settings such as nursing homes. Many of these services are not covered by Medicare or private insurance (see also the Community Living Assistance Services and Supports program defined above).

Managed Care – A health care delivery system that seeks to reduce the cost of providing health benefits and improve the quality of care. These arrangements often rely on primary care physicians to manage the care their patients receive.

Mandatory Benefits – A state or federal requirement that health plans provide coverage for certain benefits, treatment or services.

Medicaid – A federal and state funded program that provides medical and health related services to certain low-income Americans.

Medicare – A federal program that provides health care coverage to people age 65 and older, and to those who are under 65 and are permanently physically disabled or who have a congenital physical disability; or to those who meet other special criteria such as end-stage renal disease. Eligible individuals can receive coverage for hospital services (Medicare Part A), physician based medical services (Medicare Part B) and prescription drugs (Medicare Part D).

Medicare Advantage – Also referred to as Medicare Part C, the Medicare Advantage program allows Medicare beneficiaries to receive their Medicare benefits through a private insurance plan.

Medicare Part A – The Medicare portion that covers expenses incurred in hospitals, extended care facilities, hospices, etc.

Medicare Part B – The Medicare portion that covers physicians' services and other types of care not covered under Part A.

Member – Any individual or dependent enrolled in and covered by a managed health care plan.

Open Enrollment – A period during which the employees of an insured employer are allowed to enroll in the plan.

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

Out-of-Pocket Maximum – An annual limit on the amount of money individuals are required to pay out-of-pocket for health care costs, excluding premiums.

Participating Provider – A hospital, physician, facility or other health care provider who has entered into a written agreement with UnitedHealthcare to provide services, treatment and/or supplies for covered services.

Patient Centered Medical Home – A term defining a health care setting where patients receive comprehensive primary care services, have an ongoing relationship with a primary care provider who directs and coordinates their care; and have enhanced access to non-emergent care.

Patient Protection and Affordable Care Act (PPACA) – Also referred to as the "health reform law," this Act begins the implementation of a staged set of rules with an initial effective date of March 23, 2010. The law is intended to increase access to health care for more Americans, and includes many changes that impact the commercial health insurance market, Medicare and Medicaid.

Pay for Performance – A payment system where health care providers receive incentives for meeting or exceeding quality and cost benchmarks. Some systems also penalize providers who do not meet established benchmarks. The goal of pay for performance programs is to improve the quality of care over time.

Pre-existing Condition – An illness or medical condition for which a person is diagnosed or treated within a specified period of time prior to becoming insured in a new plan.

Preferred Provider Organization (PPO) – A type of managed care organization that provides health care coverage through a network of providers. Plan members typically pay higher costs when they seek care from out-of-network providers.

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.

Preventive Care Services – Health care that emphasizes the early detection and treatment of disease.

Primary Care Provider – A provider, usually a physician, specializing in internal medicine, family practice, or pediatrics, who is responsible for providing primary care and coordinating other necessary health care services for patients.

Qualified Health Plan – Insurance plans that are sold through a Health Insurance Exchange must have been certified as meeting a minimum benchmark of benefits (i.e., essential health benefits) under the health reform law.

Rate Review – Review by insurance regulators of a health plan's proposed premium and premium increases. Rates are reviewed to ensure they are sufficient to pay claims, are not unreasonably high in relation to the medical claim costs and the benefits provided, and are not discriminatorily applied.

Respite Care – Temporary care provided in a patient's home to give the primary caregiver, usually a family member, time off from a demanding job.

Section 125 Plan – These plans are otherwise known as a "cafeteria plan" offered pursuant to Section 125 of the Internal Revenue Code. Its name comes from a set of benefit plans that allows employees to choose between different types of benefits, similar to the ability of a customer to choose among available items in a cafeteria, and the employees' pretax contributions are not subject to federal, state, or Social Security taxes.

Skilled nursing facility (SNF) – A facility, either part of a hospital or a separate nursing home, that provides inpatient services for persons requiring skilled nursing care.

Stop-loss Insurance – Insurance that reimburses a plan, plan sponsor or medical group/IPA for losses that exceed a certain limit. The limit is usually expressed as a percentage of expected claims or specified dollar amount.

Tax Credit – An amount that a person or business can subtract from the income tax that they owe. If a tax credit is refundable, the taxpayer can receive a payment from the government to the extent that the credit is greater than the amount of tax they would otherwise owe.

Tax Deduction – An amount that a person can subtract from adjusted gross income when calculating the taxes that they owe. Generally, people who itemize deductions can deduct the portion of medical expenses, including health insurance premiums, that exceeds 7.5% of their adjusted gross income.

Tertiary Care – The aspect of inpatient care dealing with illnesses or conditions that require the costly services of a highly specialized medical center.

Third-party Administrator (TPA) – A person or organization that provides certain administrative services to group benefits plans, including premium accounting, claims review and payment, claims utilization review, maintenance of employee eligibility records and negotiation with insurers that provide stop-loss protection for large claims.

Triage – A term that originated on the battlefield, triage is the evaluation of the urgency and seriousness of a patient's condition and the establishment of a priority list for multiple patients.

Usual, Customary and Reasonable (UCR) – The maximum reimbursement, which is based upon historical fee patterns and is sometimes referred to as U&C.

Utilization Review – A cost-control method used by some insurers and employers in recent years to evaluate health care on the basis of appropriateness, necessity and quality. For hospital review, it can include pre- admission certification, concurrent review with discharge, planning and retrospective review.

Value-Based Purchasing – A payment reform which provides bonuses to hospitals and other providers based upon their performance against quality measures.

Wellness Plan/Program – An employer program to help improve health and prevent disease. The goals of these programs include reducing health care costs, maintaining and improving employee health and productivity, and reducing absenteeism due to illness.

* These definitions are offered for informational purposes only. In the event of a conflict of terms/definition, your plan document language will always prevail.