GLOSSARY

ACRONYMS

The following list is a guide to some of the more common acronyms and abbreviations for health care agencies, terms and programs. A number of these acronyms and abbreviations are defined in the glossary.

AAPCC - Adjusted Average Per Capita Cost

ACF - Administration for Children and Families

ADA - Americans with Disabilities Act

ADL - Activity of Daily Living

AHRQ - Agency for Healthcare Research and Quality

ALF - Assisted Living Facility

ASO - Administrative services only (agreement)

BBA - Balanced Budget Act of 1997

CBO - Congressional Budget Office

CDC - Centers for Disease Control and Prevention

CHC - Community Health Center

CHIP - See SCHIP

CMS - Centers for Medicare & Medicaid Services

COBRA - Consolidated Omnibus Budget Reconciliation Act of 1985

CPI - Consumer Price Index

CRS - Congressional Research Service

CPT - Current Procedural Terminology

DME - Direct Graduate Medical Education (sometimes DGME)

DME - Durable Medical Equipment

DRG - Diagnosis-Related Group

DSH - Disproportionate Share Hospital

ED - Emergency Department

EMS - Emergency Medical Services

EPSDT - Early and Periodic Screening, Diagnostic and Treatment Services

ERISA - Employee Retirement Income Security Act

FACCT - Foundation for Accountability

FDA - Food and Drug Administration

FEHBP - Federal Employees Health Benefits Program

FFS - Fee-for-service

FPL - Federal Poverty Level or Line

FQHC - Federally Qualified Health Center

FY - Fiscal Year

GAO - General Accounting Office

GME - Graduate Medical Education

HCFA - Health Care Financing Administration (See CMS)

HEDIS - Health Plan Employer Data and Information Set

HHA - Home Health Agency

HHS - Department of Health and Human Services

HIPAA - Health Insurance Portability and Accountability Act

HIPC - Health Insurance Purchasing Cooperative/Corporation

HMO - Health Maintenance Organization

HPSA - Health Professional Shortage Area

HRSA - Health Resources and Services Administration

ICF/MR - Intermediate Care Facility for the Mentally Retarded

IADL - Instrumental Activity of Daily Living

IHS - Indian Health Service

IME - Indirect (Graduate) Medical Education

IMG - International Medical Graduate

IPA - Independent Practice Association

JCAHO - Joint Commission on Accreditation of Healthcare Organizations

LTC - Long-term care

MCH - Maternal and Child Health

MCO - Managed Care Organization

MedPAC - Medicare Payment Advisory Commission

MEWA - Multiple Employer Welfare Association

MSA - Medical Savings Account

MUA - Medically Underserved Area

NCQA - National Committee for Quality Assurance

NHSC - National Health Services Corps

NIH- National Institutes of Health

NP/RNP - Nurse Practitioner (Registered)

OMB - Office of Management and Budget

PACE - Program of All-Inclusive Care for the Elderly

PASARR - Preadmission Screening and Annual Resident Review

PBM - Pharmacy Benefit Manager

PCCM/PCI/PCC - Primary Care Case Management, Initiative, or Clinician

PHS - (U.S.) Public Health Service

POS - Point-of-Service (plan)

PPO - Preferred Provider Organization

PPS - Prospective Payment System

PRO - Peer Review Organization

PSO - Provider-Sponsored Organization

QMB - Qualified Medicare Beneficiary

RBRVS - Resource-Based Relative Value Scale

RHC - Rural Health Clinic

RN- Registered Nurse

RVS - Relative Value Scale

SAMHSA - Substance Abuse and Mental Health Services Administration

SCHIP - State Children's Health Insurance Program (formerly CHIP, renamed in 1999)

SHIP - State Health Insurance Assistance Program

SHMO - Social Health Maintenance Organization

SLMB - Specified Low-Income Medicare Beneficiary

SSA - Social Security Administration

SNF - Skilled Nursing Facility

TANF - Temporary Assistance for Needy Families

TPA - Third Party Administrator

UR - Utilization Review

VA - (U.S. Department of) Veterans Affairs

VHA - Veterans Health Administration

GLOSSARY TERMS

ACTIVITIES OF DAILY LIVING (ADL) — An index or scale which measures a patient's degree of independence in bathing, dressing, using the toilet, eating, and transferring (moving from a bed to a chair, for example). Used to determine need for long-term care and eligibility for payments for care by insurers.

ACUTE CARE — Medical services provided to treat an illness or injury, usually for a short time. (Contrast with Chronic Care.)

ADMINISTRATIVE SERVICES ONLY (ASO) AGREEMENT — A contract typically between an insurance company and a self-funded plan or group of providers in which the insurance or management company performs only administrative services (billing, plan design, claim processing, marketing, for example) and does not assume any risk. (Also see self-insurance)

ADVANCEABLE TAX CREDIT — A subsidy to help pay for health insurance that is available when the insurance premium is due, without having to wait until a year-end tax return is filed (see TAX CREDIT).

ADVERSE SELECTION — When a disproportionately high number of individuals in poorer than average health enroll in a health plan.

AMBULATORY CARE — Medical service provided on an outpatient (non-hospitalized) basis. Services may include diagnosis, treatment, surgery, and rehabilitation.

AMYOTROPHIC LATERAL SCLEROSIS — (See LOU GEHRIG'S DISEASE)

ANCILLARY CHARGE — The fee associated with additional services performed before, or secondary to, a significant procedure such as surgery. Ancillary charges are for services such as lab work, X-ray or anesthesia. Also, an additional patient charge above the copayment and deductible amount which the covered person is required to pay by the insurer.

ANY WILLING PROVIDER — A requirement — typically a state law — that a managed care organization must accept any properly licensed provider willing to meet the terms of a plan's contract, whether the organization wants or needs that provider. Often described by managed care groups as "anti-managed care" legislation.

ASSISTED LIVING FACILITY (ALF) — A group residence offering 24-hour assistance to those who may need some help with activities of daily living such as bathing or dressing, but who do not need the level of medical and nursing care offered by skilled nursing facilities.

BALANCE BILLING — A provider's bill to a covered person for charges above the amount paid by the health plan or insurer.

BEHAVIORAL HEALTH SERVICES — Medical services encompassing mental health care and substance abuse treatment.

BLOCK GRANT — A lump sum of money given to a state or local government to be spent in eligible areas. Normally, it is based on a formula, the objectives are broadly defined and the grant's source places few limits on the money's use.

BUNDLING — The use of a single comprehensive charge for a group of related health services. (Contrast with Unbundling.)

CAP — (See OUT-OF-POCKET CAP)

CAPITATION — Method of payment for health services in which a health care provider is paid a fixed amount for each person on the provider's patient roster, regardless of the actual number or nature of services provided to each person.

CARRIER — An entity which may underwrite or administer a range of health benefit programs. May refer to an insurer or a managed health plan.

CARVE-OUTS — A payer strategy in which an HMO or insurance company isolates ("carves out") a benefit and hires another organization to provide this service. Common carve-outs include behavioral health and prescription drugs. The technique is intended to allow the insurer to better control its costs.

CASE MANAGEMENT — A process where a health plan identifies covered persons with specific health care needs, then devises and carries out for them a plan to achieve the best patient outcome in the most cost-effective manner.

CASE MIX — The mix of patients treated within a particular institutional setting such as a hospital, or a particular health plan. Case mix may be measured by the severity of patients' illnesses or the prospective use of care resources.

CASE MIX ADJUSTMENT — Change in payment to a health plan or provider to avoid overpaying or underpaying where health status or likely use of services varies from average.

CATASTROPHIC HEALTH INSURANCE — Health insurance which provides protection against the high cost of treating severe or lengthy illnesses. Such policies cover all, or a percentage, of medical expenses above a relatively high specified amount.

CATASTROPHIC ILLNESS — A very serious and costly condition that could be life threatening or cause life-long disability and involves severe financial hardship.

CENTERS OF EXCELLENCE — Health care facilities selected to deliver specific services, often exclusively, based on criteria such as experience, outcomes, efficiency, and effectiveness.

CERTIFICATE OF NEED — The requirement that a health care institution obtain permission from an oversight agency before making major changes to its facilities or facility-based services.

CHERRY PICKING — The practice of insurance companies taking only those businesses or individuals that are good health risks, and avoiding businesses or people that have higher health risks. Also called skimming.

CHILDREN'S HEALTH INSURANCE PROGRAM — (see STATE CHILDREN'S HEALTH INSURANCE PROGRAM)

CHRONIC CARE — Medical or long-term care services provided to those with chronic conditions. (Contrast with acute care.)

CHRONIC CONDITION — A condition that will not improve, that lasts a year or longer, or reoccurs and may result in long-term care needs. Chronic illnesses include Alzheimer's disease, arthritis, diabetes, epilepsy, and some mental illnesses. May be very serious or only moderately inconvenient.

CLOSED PANEL/CLOSED ACCESS — A term that describes health plans in which enrollees are permitted to receive non-emergency services only through specified providers. Group- and staff-model HMOs (see definitions) are examples of closed panel plans.

COBRA — The Consolidated Omnibus Budget Reconciliation Act of 1985, one part of which entitles ex-employees of companies with 20 or more workers to continue to receive coverage under the group plan for 18 months after leaving, if they pay the full cost of the coverage.

COINSURANCE (COPAYMENT) — A portion of the bill for a medical service, that is not covered by the patient's health insurance policy and therefore must be paid out of pocket by the patient. Coinsurance refers to a percentage, e.g., 10 percent of the total charge up to a specified maximum; contrast with "copayment" which is stated as a flat amount, e.g., $5 per office visit.

COMMUNITY RATING — A method for setting health insurance rates where the premium is the same for everyone within a specified geographic area and is based on the average cost of providing health services to the population of that region. The premium is not adjusted for the individual beneficiary's medical history or likelihood of using medical services. (Contrast with Experience Rating.)

CO-MORBIDITIES — Conditions that exist at the same time as the primary condition in the same patient (e.g., hypertension is a co-morbidity of many conditions such as heart disease, end-stage renal disease, and diabetes).

CONSUMER-DIRECTED OR CONSUMER-DRIVEN HEALTH PLANS — Plans in which enrollees can choose their benefit package and providers. They then pay any premium cost for their chosen coverage beyond a fixed contribution by their employers. Also includes those plans that establish health spending accounts into which employers contribute pretax dollars to be used for health care purchases. These mechanisms are designed to change employees from receivers of health care into informed consumers by participating more fully in health care and cost decisions. Also see "Health Reimbursement Arrangement" and "Health Savings Account."

CONVERSION PRIVILEGE— Right given to an insured person under a group insurance contract to change coverage, without evidence of medical insurability, to an individual policy upon termination of the group coverage. Conversion privileges are guaranteed to many workers under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and to others under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

COPAYMENT — (see COINSURANCE)

COST SHARING — Any out-of-pocket payment the patient makes for a portion of the costs of covered services. Deductibles, coinsurance, copayments, and balance bills are types of cost sharing.

COST SHIFTING — The practice by which a seller of a health service, such as a hospital, increases charges for some payers to offset losses due to uncompensated or indigent care or lower payments from other payers.

CRITICAL ACCESS HOSPITAL (CAH) — Limited-service hospitals located in a rural area and meeting certain size, location, and other requirements. CAHs are subject to less rigorous staffing standards, and receive reimbursement from Medicare based on their actual costs, rather than by the more common (and less favorable) payment tied to average costs for treating a particular diagnosis.

CROSS-SUBSIDY — The concept of certain purchasers paying more for medical services than they would otherwise cost so that others can pay less or nothing at all, or another activity can be funded. In the U.S. health system, this mechanism has been used to pay for medical services for the poor and uninsured, medical education, and research.

CROWD-OUT — A phenomenon whereby new public programs or expansions of existing public programs designed to extend coverage to the uninsured prompt some employers to drop employee health coverage, encouraging their employees instead to take advantage of the expanded public subsidy.

CUSTODIAL CARE — Medical or non-medical services which do not seek to cure, are provided during periods when the medical condition of the patient is not changing, or do not require continued delivery by medical personnel. Much long-term nursing home care is classified as custodial.

DEDUCTIBLE — A fixed amount, usually expressed in dollars, that the beneficiary of a health insurance plan must pay directly to the health care provider before a health insurance plan begins to pay for any costs associated with the insured medical service.

DEFENSIVE MEDICINE — The practice of health care providers ordering tests that may not be necessary to over-protect themselves from potential malpractice lawsuits. Said to be a major reason health care costs are so high.

DEFINED BENEFIT — A health benefit model used by an employer or government program where health services covered under the plan are standardized and guaranteed. The cost of providing the standard benefits may fluctuate. One example of a defined benefit plan is Medicare. (Contrast with Defined Contribution.)

DEFINED CONTRIBUTION — A health benefit model used by employers or government programs where health services covered may fluctuate based on choice of plan, but the employer or government contributes a set amount (percentage or dollar amount) towards the purchase of the selected health plan. An example of a defined contribution plan is the Federal Employees Health Benefits Program. A defined contribution plan limits the financial liability of employers or the government, because the contribution is defined, or fixed. (Contrast with Defined Benefit.)

DIAGNOSIS-RELATED GROUP (DRG) — A way of determining payments to hospitals, used under Medicare's prospective payment system (PPS) and by some other public and private payers. The DRG system classifies patients into groups based on the principal diagnosis, treatments, and other relevant criteria. Hospitals are paid the same for each case classified in the same DRG, regardless of the actual cost of treatment.

DIRECT CONTRACTING — A method for providing health services to covered employees and their families, by group providers who contract directly with an employer, thereby cutting out "the middleman" or insurance carrier.

DIRECT MEDICAL EDUCATION (DME) ADJUSTMENT — A payment from Medicare to a teaching hospital for each resident, based on the institution's direct costs of training new doctors and the proportion of patient days paid by Medicare. Also see Graduate Medical Education and Indirect Medical Education Adjustment

DIRECT-TO-CONSUMER ADVERTISING — The use of mass media (television, newspapers, magazines, etc.), and other forms of reaching the general public, by the pharmaceutical industry, to promote their products. These advertisements must be approved by the FDA.

DISPROPORTIONATE SHARE HOSPITAL (DSH) ADJUSTMENT — An increased payment under Medicare's PPS or under Medicaid for hospitals that serve a relatively large volume of low-income patients.

DOMESTIC PARTNER — One of two individuals in a long-term committed relationship who are responsible for each other's financial and emotional well-being. Employers can set their own definitions of domestic partners when deciding how to extend benefits, but definitions frequently require, among other things, that the partners have lived together for at least six months, are responsible for each other's financial welfare, and are at least 18 years old. Domestic partners can be either same or opposite sex.

DRUG REIMPORTATION — (see REIMPORTATION)

DUAL ELIGIBLE — A Medicare beneficiary who also receives either a full range of Medicaid benefits offered in his or her state, or help with Medicare out-of-pocket expenses. Also see Qualified Medicare Beneficiary; Specified Low-Income Medicare Beneficiary.

DURABLE MEDICAL EQUIPMENT (DME) — Medical devices which can stand repeated use, such as wheelchairs, oxygen tanks, and apnea monitors.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT) — Screening/diagnostic services to determine physical or mental problems of, and provide treatment for, Medicaid beneficiaries who are under 21 years of age.

ELECTRONIC MEDICAL RECORD — A computer-based record containing health care information. It may contain some, but not necessarily all, of the information that is in an individual's paper-based medical record. The EMR may include clinical, demographic, and/or administrative data. Also known as a computerized patient record.

EMERGENCY CONTRACEPTION (EC) — Also called "the morning-after pill," prevents an egg from being fertilized, a fertilized egg from implanting in the uterus, or ovulation. The pill can be taken between 24-72 hours after intercourse to prevent a pregnancy when no other contraceptives have been used, or the initial contraceptive has failed.

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) — Enacted in 1974, ERISA was originally designed to secure workers' pension rights. The law also established federal reporting and disclosure requirements for most private employee health plans. Under ERISA, companies that pay for their workers' health benefits directly, rather than by buying insurance to pay the bills, are exempt from state insurance regulations and taxes. ERISA also limits workers' ability to sue their insurer, whether the employer is self-insured or not.

EMPLOYER CONTRIBUTION REQUIREMENT OR "EMPLOYER MANDATE" — A requirement that employers either provide health care benefits to their workers or pay a payroll tax that automatically covers their workers under a public (state) plan. Such proposals are also called "pay or play."

END-STAGE RENAL DISEASE (ESRD) — Kidney disease that is severe enough to require lifetime dialysis or a kidney transplant. People who have ESRD are eligible for Medicare.

ENTERPRISE LIABILITY — Proposal to hold hospitals or HMOs liable for negligent harm in medical malpractice cases, rather than holding individual physicians liable.

EVIDENCE-BASED MEDICINE — The conscientious and prudent use of current best clinical evidence in making decisions about the care of individual patients, often through information technology that is integrated into the provider's environment. Patient preferences should be considered along with outside-evidence and clinical expertise.

EXPERIENCE RATING — Process of determining the insurance premium for a group based wholly or partially on that particular group's past use of services, and expenses incurred. (Contrast with Community Rating.)

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (FEHBP) — System under which federal civilian employees choose among a number of approved private plans, with the federal government paying a major portion of the cost of the coverage.

FEDERAL POVERTY LEVEL (FPL) — Amount set annually by the U.S. Department of Health and Human Service as the official poverty income level. It is used to determine an individual's or family's eligibility for various federal and non-federal programs based on their income level. In 2004, in the contiguous United States, the federal poverty level is $9,310 for an individual and $12,490 for a family of two.

FEDERALLY QUALIFIED HEALTH CENTER (FQHC) — Facilities that have been approved by the government for a program to provide low cost health care. They include community health centers, tribal health clinics, migrant health centers, and health centers for the homeless.

FEE-FOR-SERVICE — A method of paying health care providers a fee for each medical service rendered, rather than paying them salaries or capitated payments.

FIRST-DOLLAR COVERAGE — Insurance plans that provide benefits without first requiring payment of a deductible.

FIRST RESPONDERS — Firefighters, police officers, ambulance crews, doctors and other local emergency officials that are the first to respond to an emergency situation.

FISCAL INTERMEDIARY — A private contractor that pays hospital bills on behalf of Medicare.

FORMULARY — A list of selected pharmaceuticals and their appropriate dosages found to be the most useful and cost-effective for patient care. Physicians are often required to prescribe from the formulary developed by the insurance plan or HMO with which they are affiliated.

GATEKEEPER/CARE MANAGER — A healthcare professional, usually a primary care physician, who coordinates, manages, and authorizes all healthcare services provided to a person covered by a health plan. Unless an emergency exists, the gatekeeper usually must pre-authorize referrals to specialists, hospitalizations, and lab and radiology tests.

GRADUATE MEDICAL EDUCATION (GME) — The period following the completion of medical school when physicians, as residents, receive training in a specialty, such as internal medicine, general surgery or anaesthesiology. Medicare pays a large share of GME costs. Also see Direct Medical Education Adjustment; Indirect Medical Education Adjustment.

GROUP INSURANCE — Health insurance offered through business, union trusts or other groups and associations. The policy-holder is the employer or other entity, not the employees. This system of health insurance is the most common in the United States.

GROUP-MODEL HMO — An HMO that contracts with a single multi-specialty medical group to provide care for HMO members. The HMO compensates the group for contracted services at a negotiated rate, and that group is responsible for compensating its physicians and contracting with hospitals for care of their patients. Kaiser Permanente is one example of this kind of organization. Also see Staff-model HMO; Network-model HMO.

GUARANTEED ISSUE — A requirement that health plans cannot reject coverage for an applicant based on medical history. For example, under HIPPA, small employers which purchase health plans are covered under "guarantee issue." While plans can adjust premiums based on medical history or other factors, the plan must issue coverage to the small employer. Likewise, health plan policies that operate under a "guaranteed renewability" clause, cannot cancel coverage due to a beneficiary's health status.

GUARANTEED RENEWABILITY — (See GUARANTEED ISSUE)

HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY (HIFA) INITIATIVE — A Bush Administration initiative to encourage the approval of Section 1115 Medicaid and SCHIP waivers. It allows State approaches to increase the number of individuals with health insurance coverage within those programs' resources, often by increasing cost-sharing for current beneficiaries. HIFA encourages states to offer private health insurance coverage or employer-sponsored coverage, with subsidies, as an alternative to enrolling this population in Medicaid or SCHIP.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) — A 1996 federal law that protects employed persons and their families against possible discrimination in health coverage based on past or present health. Generally, the law guarantees the right to renew health coverage, but does not restrict the price that insurers may charge. HIPAA doesn't replace the states' role as primary regulators of insurance. HIPAA also requires the collection of certain health care information by providers and protects the privacy of that information.

HEALTH MAINTENANCE ORGANIZATION (HMO) — A managed care plan that combines the function of insurer and provider to give members comprehensive health care from a network of affiliated providers. Enrollees pay limited copayments and are usually required to select a primary care physician through which all care must be coordinated. HMOs generally will not pay for services obtained from a non-network provider or without a primary care physician's referral. HMOs often place an emphasis on prevention and careful assessment of medical necessity.

HEALTH PLAN EMPLOYER DATA AND INFORMATION SET (HEDIS) — A set of standardized measures of health plan performance allowing comparisons on quality, access, patient satisfaction, membership, utilization, finance, and health plan management. HEDIS was developed by employers, HMOs, and the National Committee on Quality Assurance (NCQA).

HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) — A geographic area determined by the U.S. Public Health Service to have a shortage of physicians and other health professionals. Physicians who provide services in HPSAs qualify for a Medicare bonus payment or student loan forgiveness.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) — A type of health insurance plan, also known as "health reimbursement account" or "personal care account," that reimburses employees for qualified medical expenses. HRAs consist of funds set aside by employers to reimburse employees for qualified medical expenses, often paired with a high-deductible health plan. An HRA provides "first-dollar" medical coverage until funds are exhausted. Once the deductible is reached, normal coverage begins. Any unused funds are rolled over at the end of the year, but normally do not follow the employee once he or she changes jobs. Compare "Health Savings Account."

HEALTH SAVINGS ACCOUNT (HSA) — A type of health insurance plan similar to Medical Savings Accounts (MSAs) but with fewer restrictions. HSAs have two components: a high-deductible health plan and a tax-preferred savings account. Any employer can offer an HSA, and both employers and employees can contribute to it. The worker must pay for all services until the amount of the deductible is reached (a minimum of $1,000 for an individual and $2,000 for family coverage). The worker can withdraw money from an HSA to cover the cost of services under the deductible. Then normal coverage begins. Any unused funds are rolled over at the end of the year. Unlike HRAs, HSAs follow an employee when he or she changes employers. Compare "Health Reimbursement Arrangement."

HIGH-RISK POOL — A subsidized health insurance pool organized by many states as a source of coverage for individuals who have been denied health insurance because of a medical condition, or whose premiums are significantly higher than the average due to health status or claims experience.

HOME HEALTH CARE — Health services rendered in the home to the aged, disabled, sick, or convalescent individuals who do not need institutional care. The most common types of home health services are nursing services, speech therapy, physical therapy, occupational therapy, rehabilitation therapy, and social services.

HOSPICE — A group providing medical, emotional, spiritual and social help, usually in the patient's own home to those expected to live less than six months. Medicare pays for hospice care including payment for non-curative prescription drugs not normally covered by Medicare.

HYDE AMENDMENT — A federal law first enacted in 1980, and attached to appropriations bills every year since, that prohibits the use of federal Medicaid funds for abortion, except for reasons of life endangerment.

INDEMNITY INSURANCE — A traditional health insurance plan which pays providers on a fee-for-service basis. Consumers face few restrictions on provider selection, but may have greater financial liability, including a deductible and coinsurance, than in many managed care plans.

INDEPENDENT PRACTICE ASSOCIATION (IPA) — A physician organization which typically contracts with an HMO to provide services to the HMO's enrollees. The HMO usually makes capitated payments to the IPA; however, the IPA may reimburse its physicians on a fee-for-service basis. Physicians are in solo practice and can contract with other HMOs and see other fee-for-service patients.

INDIRECT MEDICAL EDUCATION (IME) ADJUSTMENT — A bonus added by Medicare to its payments for inpatient stays at teaching hospitals. Medicare recognizes that it is more costly to run a teaching hospital than one that trains no new physicians. Teaching hospitals involve residents in patient care, tend to treat sicker patients with less insurance coverage, require a more costly mix of staff, and use more expensive and complex interventions. Also see Graduate Medical Education, and Direct Medical Education Adjustment.

INPATIENT — An individual who has been admitted to a hospital for at least 24 hours and is receiving services under the direction of a physician.

INSURANCE — A way of responding to the risk of an adverse event, such as having to pay large health care expenses, by spreading those risks among many people. Insurance provides a way to substitute a small, predictable payment (a premium) for the risk of having to make a large payment in the event of an uninsured accident or illness.

LOCK-IN — Lock-in refers to the period of time an individual is required to, or agrees to, remain registered with a particular provider, group of providers, or health care organization.

LONG-TERM CARE (LTC) — Ongoing health and social services provided for individuals who need continuing assistance with activities of daily living (ADLs) because of physical or mental disability. Services can be provided in an institution, the home or the community, and include informal services provided by family and friends as well as formal services provided by professionals or agencies (although those providing informal services are typically not paid for doing so).

LOSS RATIO — The ratio of money paid out by an insurer for claims divided by premiums collected for a particular type of insurance policy. Low loss ratios indicate that a small proportion of premium dollars was paid out for benefits, while a high loss ratio indicates that a high percentage of the premium dollars was paid out.

LOU GEHRIG'S DISEASE (AMYOTROPHIC LATERAL SCLEROSIS -ALS) — A fatal neurological disease that attacks the nerve cells, gradually causing them to degenerate, and leads to a loss of muscle control. Most patients lose their ability to breathe on their own within 3-5 years of the onset of symptoms. Persons found to be eligible for social security disability benefits because of this disease can qualify for Medicare without waiting the usual two years.

MANDATE — Used in two senses in health policy discussions. (1) Employer or individual mandate, in which the government imposes a requirement on some or all employers to help pay for insurance coverage for their workers (and perhaps their families), or on individuals to obtain coverage. (2) State mandate, a requirement imposed by states on insurance companies to include, as part of any health insurance policy they sell, coverage for a specific service, such as well baby care, or provider, such as psychologists or optometrists.

MARKET BASKET INDEX — An index of the annual change in the prices of a selection of goods and services providers used to produce health services. Also referred to as an input price index.

MEDICAID — Public health insurance program that provides coverage for some low-income persons and families for acute and long-term care. It is financed by state and federal funds (the federal government pays at least 50 percent of the total cost in each state), and is administered by states within broad federal guidelines.

MEDICAID 1115 WAIVER — Special permission granted to states under section 1115(a) of the Social Security Act, which allows the waiver of any provision of Medicaid law for demonstrations "likely to assist in promoting the objectives" of the program. Demonstration waivers are granted for research purposes, to test a program improvement, or investigate an issue of interest to HCFA.

MEDICAL IRA — (See MEDICAL SAVINGS ACCOUNT)

MEDICAL SAVINGS ACCOUNT (MSA) — A health insurance option consisting of a high-deductible insurance policy and a tax-advantaged savings account. Individuals pay for their own health care up to the annual deductible by withdrawing from the savings account or paying out of pocket. The insurance policy pays for most or all costs of covered services once the deductible is met. Laws allowing limited demonstrations of MSAs were enacted in 1996 for the general population, and in 1997 for Medicare beneficiaries. (Compare to Health Savings Account.)

MEDICAL UNDERWRITING — (See UNDERWRITING)

MEDICALLY NECESSARY — Description of services or supplies required to preserve and maintain the health status of a patient in accordance with the area standards of medical practice. Whether or not medically necessary services are being denied to patients enrolled in managed care plans is an issue of contention.

MEDICALLY NEEDY — An optional Medicaid category in which states can cover individuals and families whose incomes minus accumulated medical bills are below state income limits for the Medicaid program. This allows Medicaid coverage for people who have extensive health care needs, but with too much income to be eligible for Medicaid.

MEDICARE — Federal health insurance program for virtually all persons age 65 and older, and some severely disabled persons under age 65. It consists mainly of Part A, hospital insurance (HI) and Part B, supplemental medical insurance (SMI).

MEDICARE ADVANTAGE — Formerly known as Medicare+Choice, a part of Medicare designed to offer beneficiaries a choice of managed care plan options. Also called Part C of Medicare, it encompasses health maintenance organizations (HMOs), preferred provider organizations (PPOs), Medicare medical savings accounts (MSAs), provider-sponsored organizations (PSOs) and other options. Not all options are available in all areas.

MEDICARE+CHOICE — (See MEDICARE ADVANTAGE)

MEDIGAP INSURANCE/MEDICARE SUPPLEMENTAL INSURANCE — Medigap policies are sold by private insurance companies to fill "gaps" in fee-for-service Medicare. Except in Minnesota, Massachusetts, and Wisconsin, there are 10 standardized policy designs, known as Plans A through J. Plans H, I, and J include limited drug coverage. As of January 2006, when the new Medicare prescription drug benefit begins (Medicare Part D), no new Medigap policies that include drug coverage can be sold. Beneficiaries with existing Medigap policies that include drug coverage may maintain them if they wish. However, they may be subject to penalties if they later want to get Part D drug benefits.

MORBIDITY — A determination of the incidence and severity of sicknesses and accidents in a well defined class of persons.

MORNING-AFTER PILL — (See EMERGENCY CONTRACEPTION)

Glossary

MORTALITY — An actuarial determination of the death rate at each age as determined from prior experience.

MULTIPLE EMPLOYER WELFARE ASSOCIATION (MEWA) — A group of employers who band together for purposes of purchasing group health insurance, often through a self-funded approach, to avoid state mandates, taxes and insurance regulation. Some states prohibit MEWAs.

NETWORK-MODEL HMO — An HMO that contracts with more than one independent physician group to provide health services. The providers may see patients who are not members of the HMO. Also see Group-Model HMO, Staff-Model HMO.

NURSE PRACTITIONER (NP/RNP) — A registered nurse with advanced academic and clinical experience enabling her or him to diagnose and manage most common and many chronic illnesses, either independently or as part of a health care team. A nurse practitioner provides some care previously offered only by physicians and in most states has the ability to prescribe medications.

ON LOK PROJECT — A San Francisco project that uses the HMO model to provide all acute care and long-term care services needed by a frail elderly population at risk of nursing home placement. Also see Program of All-Inclusive Care for the Elderly.

OPEN ENROLLMENT — The period of time during which health insurance coverage is offered regardless of health status and without medical screening. Open enrollment periods are characteristic of some Blue Cross-Blue Shield plans and HMOs, and all plans in the Federal Employees Health Benefits Program.

OPEN PANEL/OPEN ACCESS — A self-referral arrangement allowing health plan enrollees to see participating providers for specialty care without a referral from another doctor.

ORGANIZED DELIVERY SYSTEMS — Networks of providers and payers which would provide care and compete with other systems for enrollees. Systems could include hospitals, physicians, and other providers and sites that could offer a full range of preventive and treatment services. Also known as accountable health plans, coordinated care networks, community care networks, integrated health systems.

OUT-OF-POCKET CAP/MAXIMUM — An annual limit on how much in deductibles and copayments the patient has to pay. Also called a "stop-loss" provision.

OUTCOMES RESEARCH — Research that attempts to evaluate particular health services by identifying and recording the clinical results (death, illness, ability to function, etc.) of those treatments.

OUTPATIENT — A person receiving medical services who has not been admitted to a hospital.

PARTIAL-BIRTH ABORTION — A non-medical term that generally refers to a late-term abortion procedure known as intact dilation and extraction (intact D&X, or D&X), in which the patient's uterus is dilated and the fetus extracted to its neck.

PARTIAL CAPITATION — An insurance arrangement where the payment made to a health plan is a combination of a capitated premium and a payment based on actual use of services; the proportions specified for these components determine the insurance risk faced by the plan. Sometimes called "ambulatory capitation."

PAY OR PLAY — (See Employer Contribution Requirement)

PAYROLL TAX — A flat percentage tax collected on salaries and wages. The Social Security tax that finances both cash benefits and Medicare Part A is a payroll tax of 7.65 percent each on employers and employees. Of that, 1.45 percent each, a total of 2.9 percent of payroll, is allocated for Medicare.

PEER REVIEW — Evaluation of the quality of a health care provider's work, provided by professional staff members with equivalent training.

PHARMACY BENEFIT MANAGER (PBM) — A company that contracts with insurers and employers to manage the prescription drug benefit for enrollees or employees. The vast majority of managed care plans use PBMs.

POINT-OF-SERVICE PLAN (POS) — A managed care plan that combines features of both prepaid and fee-for-service insurance. POS plan enrollees decide whether to use network or non-network providers at the time care is needed, but usually are subject to reduced coverage and larger copayments for using non-network providers.

PRACTICE GUIDELINES/PARAMETERS — A statement of the known benefits, risks, and costs of particular courses of medical action, developed to give physicians information about treatment alternatives.

PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASARR) — Federal requirement (OBRA `87) for the process of evaluating, reviewing, and establishing a person's need for nursing facility services and for specialized services for mental illness, mental retardation or a related condition.

PRE-EXISTING CONDITION — A physical or mental condition of an individual which is known to the individual before an insurance policy is issued. Insurers may choose not to cover treatment for such a condition, at least for a period, may raise rates because of it, or may deny coverage altogether.

PREFERRED PROVIDER ORGANIZATION (PPO) — A health care delivery system through which a number of providers contract to serve health plan enrollees on a fee-for-service basis at discounted fees. Providers agree to PPO discounts in the hope of gaining more patients. Patients may use any provider without a referral, in network or out, but have a financial incentive - for example, lower coinsurance payments - to use doctors on the preferred list.

PREMIUM — The cost of health plan coverage, not including any required deductibles or copayments.

PREMIUM SUPPORT — A health benefit model that is considered by its designers to be a hybrid of the defined contribution and defined benefit approaches (see definitions). This model would require general categories of health services be covered, but benefits could be added or deleted within limits. The employer or government would then contribute a set amount of the premium for the purchased plan. Plans could set premiums at whatever level they choose, with beneficiaries liable for any costs above the employer or government contribution. A demonstration designed to test a model similar to premium support in Medicare is scheduled to begin in 2010.

PREVENTIVE HEALTH SERVICES — Services aimed at preventing a disease from occurring, or preventing or minimizing its consequences. This includes care aimed at warding off illnesses (immunizations), at early detection of disease (Pap smears), and at stopping further deterioration (exercise).

PRIMARY CARE — Care at "first contact" with the health care system, including an array of non-specialist services provided by physicians, nurse practitioners, or physician's assistants - more simply, the care that most people receive for most of their problems that bother them most of the time.

PRIMARY CARE CASE MANAGEMENT, INITIATIVE, OR CLINICIAN (PCCM/PCI/PCC) — A Medicaid managed care program in which an eligible individual may use services only with authorization from his or her assigned primary care provider. That provider is responsible for locating, coordinating, and monitoring all primary and other medical services for enrollees. Those services are usually paid on a fee-for-service basis.

PRIMARY CARE PHYSICIAN — A physician — general practitioner, family physician, pediatrician, some internists and OB/GYNs — who serves as the patient's first point of contact with the health care system and coordinates the patient's medical care.

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) — Originally a Medicare demonstration project that replicated the model of managed care developed by On Lok Senior Health Services. The Balanced Budget Act of 1997 expanded PACE into a national, permanent program and created a Medicaid PACE option. PACE targets very frail community-dwelling elderly, most of whom are dually eligible for Medicare and Medicaid. Core services include adult day care, social support, home health, hospital care, nursing home care, and case management for the integration of acute and long-term care services. PACE is financed through both Medicare and Medicaid capitated payments to the provider. Also see On Lok Project.

PROSPECTIVE PAYMENT SYSTEM (PPS) — A method used by Medicare to pay for some services, like inpatient and outpatient hospital services, skilled nursing facilities, and rehabilitation facilities. Payment rates are determined before services are rendered, and not based on actual costs or charges of a specific facility. Rates are intended to cover treatment costs for a typical patient with a given diagnosis and are adjusted for factors like wages and indigent care.

PROVIDER — Any health care professional or institution that renders a health service or provides a health care product. The most important providers are hospitals, nursing homes, physicians, and nurses.

PROVIDER-SPONSORED ORGANIZATION (PSO) — Any organization created through the formal affiliation of health care providers that seeks to act as insurer for an enrolled population. PSOs can be physician-based, hospital-based, or a combination of both; typically, they are local health delivery systems.

PUBLIC CHARGE — A term used by immigration officials to describe someone who is primarily dependent on the government for subsistence. Being classified as a public charge can damage an immigrant's ability to become a permanent resident, to leave and reenter the USA, or even to remain in the country. Many immigrants are afraid to enroll themselves or their children into health care programs such as Medicaid and SCHIP for fear of being labeled as a "public charge," although receipt of SCHIP and most Medicaid services is not considered in determining public charge status.

PUBLIC HEALTH — The protection and improvement of community health by organized community effort. Public health activities include immunization, sanitation, preventive medicine, disease control, occupational health and safety, air safety, water safety, food safety, epidemiology, etc.

PURCHASING POOL — A group of people, businesses, or associations who come together to enhance their bargaining power and negotiate lower premiums from health insurance plans than they could on their own, while also pooling risks across sick and healthy individuals.

QUALIFIED MEDICARE BENEFICIARY (QMB) — A person who has Medicare, income under 100 percent of the poverty line, and limited resources is eligible to be a Qualified Medicare Beneficiary. State Medicaid agencies are required to pay the cost of Medicare Part A and B premiums, deductibles, and coinsurance for such individuals.

QUALITY-ADJUSTED LIFE YEARS (QALYs) — Years of life saved by a medical technology or service, adjusted according to the quality of those years (as determined by some evaluative measure). QALYs are the most commonly used unit to express results in some types of cost-effectiveness analysis. A year of perfect health is considered equal to 1.0 QALY.

RATING — The process of evaluating a group or individual to determine a health insurance premium rate relative to the type of risk it presents. Key components of the rating formula include age, sex, location, and plan design.

RATING BANDS — Amounts by which insurance rates for a specific class of those insured may vary. Many small group market reform proposals restrict or eliminate these allowable variations.

REFERRAL — A primary care doctor's written permission for a patient to see a certain specialist or to receive certain services. Required by some managed care health plans.

REFUNDABLE TAX CREDIT — A way of providing a tax subsidy to an individual or business, even if no taxes are owed. (See Tax Credit) If a person owes no tax, the government sends the person (or a third party) a check for the amount of the refundable tax credit.

REIMPORTATION — The process by which individuals or groups purchase in or from other countries pharmaceuticals that were originally produced in the United States and exported for consumption abroad. Because the other countries usually have lower drug prices than in the US, this process can save consumers money on drugs for personal use. Reimportation can occur either by traveling to another country to purchase drugs, for example, driving to Canada, or by purchasing drugs over the Internet or by mail from foreign pharmacies. Though usually not the subject of law enforcement, most reimportation is a violation of federal drug safety laws.

REINSURANCE/RISK CONTROL INSURANCE (see STOP-LOSS)

RELATIVE VALUE SCALE (RVS) — An index that assigns weights to each medical service; the weights represent the relative amount to be paid for each service. To calculate a fee for a particular service, the index for that service is multiplied by a constant dollar amount (known as the conversion factor). Medicare uses an RVS to calculate payments to physicians.

RESPITE CARE — Short-term care given to a patient by another care giver, so that the usual care giver can rest.

REPORT CARD ON HEALTH CARE — A tool for use by policymakers and health care purchasers to compare and understand the actual performance of health plans or providers. Provides data in major areas of accountability, such as quality and utilization, consumer satisfaction, administrative efficiencies, financial stability, and cost control.

RISK — The probability of financial loss, based on the probability of having to provide services to a patient or patient population at a cost that exceeds the payments received. Under capitation payment systems, providers share the risk that is born by insurers. Also, an insured person may be referred to as a risk.

RISK ADJUSTMENT — Increases or reductions in payment made to a health plan on behalf of a group of enrollees to compensate for health care expenditures that are expected to be higher or lower than average.

RISK CONTRACT — An agreement between the federal government and a health maintenance organization or competitive medical plan requiring the HMO to furnish services to Medicare enrollees for an annually determined, fixed monthly payment rate from the government and a monthly premium paid by the enrollee.

RISK SELECTION — Enrollment choices made by health plans - or by enrollees - on the basis of perceived risk relative to the premium to be paid.

RISK SHARING — A method by which the risk of inaccurate rate adjustment is shared by plan sponsors and purchasers, typically managed care organizations and states. Contrast to traditional indemnity plans, in which the insurance company assumes all risk of providing the care paid for by insurance premiums, and those premiums belong solely to the insurance company.

ROE V. WADE — A 1973 US Supreme Court case that effectively legalized abortion by holding that most state laws prohibiting abortion infringed on a woman's constitutional right to privacy.

RU-486 — A drug approved by the FDA to induce an abortion without surgery. It consists of the drug mifepristone, taken in combination with another drug, misoprostol, to terminate a pregnancy up to seven weeks in duration.

SAFETY NET PROVIDERS — Those providers in the health system that have a primary focus of servicing the indigent or uninsured population, such as community or migrant health centers and public hospitals.

SECTION 1115 WAIVER — (See MEDICAID 1115 WAIVER)

SELF-EMPLOYED DEDUCTION FOR HEALTH INSURANCE — As of 2003, self-employed taxpayers can deduct all their payments for health insurance when figuring their annual income for tax purposes. By contrast, employees and their families may deduct only insurance premiums and other health expenses to the extent they exceed 7.5 percent of income.

SELF-INSURANCE — The practice of an employer providing employees with health benefits financed entirely through the internal means of the company, as opposed to purchasing insurance coverage from commercial carriers. Claims processing is often handled through an administrative services contract with an independent organization, often an insurance company.

SINGLE PAYER SYSTEM — A proposed health plan that would designate one entity (usually the government) to function as the only purchaser of health care services. Canadian provinces operate insurance coverage for residents under this system.

SKILLED NURSING FACILITY (SNF) — An institution that offers nursing services similar to those given in a hospital, to aid rehabilitation of former hospital inpatients who are seriously ill. SNFs must meet specific Medicare certification requirements and differ from custodial care facilities, which are intended primarily to support elderly and disabled individuals in the tasks of daily living.

SMALL GROUP MARKET REFORM — A series of changes to improve the way the health insurance market functions for small employers buying coverage for their workers, with the aim of making coverage more affordable and accessible. Most states have enacted one or more of these changes, and federal reforms were contained in the 1996 Health Insurance Portability and Accountability Act.

SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (SLMB) — A Medicare beneficiary who has low monthly income (between 100-120 percent of the poverty line) and limited resources is eligible. State Medicaid agencies are required to pay the person's Part B premium, but not deductibles or copayments. Also see Qualified Medicare Beneficiary.

SPEND-DOWN — Process by which individuals qualify for Medicaid by incurring medical bills until their income, minus the expenses for medical care, falls below the state-prescribed income level to qualify for Medicaid. The amount they must "spend down" each period is determined at the time eligibility is determined. Also see Medically Needy.

STAFF-MODEL HMO — An HMO that delivers health services through salaried physicians who are employed by the HMO exclusively to care for HMO enrollees. Also see Group-model HMO, Network-model HMO.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (S-CHIP) — A program enacted by Congress in 1997 that provides up to $48 billion in federal matching funds for states to spend on health coverage for uninsured kids over ten years. The program is designed to reach uninsured children whose families earn too much money to qualify for Medicaid but are too poor to afford private coverage.

STATE HEALTH INSURANCE ASSISTANCE PROGRAM (SHIP) — A federally funded program that enables states through their own agencies or non-profit organizations to give Medicare beneficiaries free health insurance counseling and assistance.

STATE MANDATE — State laws requiring private insurers to cover specific services (such as well-baby care) or providers (such as psychologists). ERISA exempts self-insured companies from these requirements.

STEM CELLS — Primitive cells derived from human embryos (embryonic stem cells) and adult tissue (adult stem cells) They are undifferentiated cells, meaning they have the capacity to develop specialized functions when grown in the appropriate laboratory environment. Scientist create stem cell "lines", or cell cultures, that can grow indefinitely and which are currently used for disease research.

STOP-LOSS — An annual limit on how much in deductibles and copayments the patient has to pay. Also called a "cap" or "out-of-pocket cap." Large employers who self-insure may purchase "reinsurance" for stop-loss purposes.

SUPPLEMENTAL INSURANCE — Any private health insurance plan held by a Medicare beneficiary that is purchased to fill in "gaps" in traditional Medicare coverage, or to finance cost-sharing requirements, e.g., Medicare's hospital deductible. Among the most common types of supplemental insurance are some employer-sponsored retiree coverage and Medigap insurance (see "Medigap").

SUPPLEMENTAL SECURITY INCOME (SSI) — A federal income support program for low-income disabled, aged, or blind individuals. Eligibility for the monthly cash payments does not depend on previous work or contributions to a trust fund. Eligibility for SSI usually translates into eligibility for Medicaid.

TAX CREDIT — An amount that can be subtracted from the actual tax owed; under some health care reform proposals, tax credits given to moderate-income individuals/families can subsidize health plan purchases. A tax credit is much more valuable than a tax deduction of the same amount, since the deduction simply reduces the income on which a person or business pays taxes.

TAX DEDUCTION — An amount that can be subtracted from taxable income if spent on a specific purpose. Currently, businesses and the self-employed can deduct the cost of health insurance provided to employees, but health insurance premiums and other health expenses are a deduction for families only after they reach 7.5 percent of income.

TAX PREFERENCE (FOR HEALTH BENEFITS) — Employer-paid health benefits are treated under federal tax law as a deductible business expense for the employer, and excluded from taxable income for the worker. This creates incentives for workers to prefer extra compensation in the form of more health coverage rather than wages.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) — The "Workfare" program that, in 1996, replaced categorical welfare assistance such as Aid to Families with Dependent Children (AFDC). Under TANF, time limits are set for cash benefits, and recipients are expected to accept work or be enrolled in training programs.

TERTIARY CARE — Health care services provided by highly specialized providers such as neurosurgeons, thoracic surgeons, and intensive care units. These services often require highly sophisticated technologies and facilities.

THERAPEUTIC SUBSTITUTION — Replacement of one drug with another drug from the same therapeutic class that the Food and Drug Administration has determined to be equivalent - the substitute has the same active ingredient with the same absorption rate as the original drug. Generally, this results in prescribing the less costly compound.

THIRD PARTY ADMINISTRATOR (TPA) — A professional firm that provides administrative services to employers who want to self-insure their employees. The TPA does not underwrite the risk.

THIRD PARTY PAYER— Any organization, public or private, that pays or insures health or medical expenses on behalf of beneficiaries or recipients. An individual pays a premium for such coverage in all private and in some public programs; the payer organization then pays bills on the individual's behalf. Such payments are called third-party payments and are distinguished by the separation among the individual receiving the service (the first party), the individual or institution providing it (the second party), and the organization paying for it (third party).

TRADE ACT HEALTH INSURANCE SUBSIDY — Subsidy covering 65 percent of the cost of health insurance purchased from certain specified sources (automatic coverage, COBRA, state coverage etc.) for retirees, their families, and other workers who have lost their employer-sponsored health coverage as a consequence of trade practices or bankruptcies.

TRANSITIONAL MEDICAL ASSISTANCE (TMA) — Medicaid coverage for families leaving welfare to become self-supporting through work. States are required to continue Medicaid benefits to families with children who lose their cash assistance due to an increase in earnings. The transitional coverage extends for up to 12 months as long as the family continues to report earnings.

TRIAGE — The classification of sick or injured persons according to severity in order to direct care and ensure the efficient use of medical and nursing staff and facilities.

TRICARE — Program providing medical care to the dependents of active duty members of the military and to retired members of the military. Formerly known as the Civilian Health and Medical Program (CHAMPUS), the program is run by the Department of Defense.

UNBUNDLING — Separately billing for units of service that might otherwise be priced together ("bundling"). For claims processing, this includes providers billing separately for health care services that should be combined according to industry standards or accepted coding practices.

UNCOMPENSATED CARE — Care rendered by hospitals or other providers without payment from the patient or a government-sponsored or private insurance program. It includes both charity care, which is provided without the expectation of payment, and bad debts, for which the provider has made an unsuccessful effort to collect payment due from the patient.

UNDERINSURED — People with public or private insurance policies that do not cover all necessary health care services, resulting in out-of-pocket expenses that often exceed their ability to pay.

UNDERSERVED — Persons who have insufficient access to care either because they have insurance that does not cover all necessary care or because needed services are not available in their locality.

UNDERWRITING — The process by which insurers decide whether or not to accept an application for insurance, and, if the applicant is accepted, what conditions to apply. If the insurer decides that a particular individual or group poses greater than normal risks, it might charge higher premiums, offer more limited benefits, or refuse to pay for services relating to a particular "pre-existing" condition.

UTILIZATION REVIEW (UR) — Examination of delivered health care services — particularly specialist referrals, emergency room use and hospitalizations — to evaluate their appropriateness, necessity, and quality. The review can be performed before, during, or after care delivery.

VOUCHER — In various health reform proposals, a certificate given usually to a low-income or moderate-income person that can be used to pay all or part of the cost of an insurance plan.