Health Insurance in Kansas: A Primer

Glossary of Health Insurance Terms

INTRODUCTION

To fully understand health insurance, it is helpful to be familiar with its terminology. This glossary lists some of the most commonly used health insurance terms and includes succinct definitions and explanations of them. It is provided to help answer any questions that you may have while viewing the primer presentation on the enclosed compact disc.

Our hope is that the primer and accompanying glossary will provide you with the information you need to better understand health insurance so that you can contribute to the public policy discussion that surrounds it and make informed choices about your own coverage and care.

This primer is just part of the Kansas Health Institute’s ongoing effort to provide information about health insurance in the state. More information on this and other health issues is available on our Web site at www.khi.org.

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GLOSSARY

**Adverse Selection**
The tendency of those at higher risk to seek more insurance coverage than those at lower risk.

**Benefit Design**
(or Benefit Package)
The services and other items that are covered by an insurance policy and the terms of the coverage.

**Capitation**
A method of paying health care providers in which a set payment per patient per unit of time (usually per month) is made to cover a specified set of services, without regard to the actual number of services provided. Capitation is often used as the method of payment for providers who participate in managed care plans.

**Case Management**
Coordinating care for people with certain illnesses among a group of providers.

**COBRA**
The Consolidated Omnibus Budget Reconciliation Act, a federal law that allows former employees of companies with 20 or more workers to continue in their employer’s group health insurance plan for 18 months following the loss of their job.
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Composition of the Risk Pool
The characteristics of the members of the risk pool, such as age and health status.

Cost-Sharing
A requirement that a portion of the cost of covered services be paid by the policyholder. Deductibles, copayments, and coinsurance are examples of cost-sharing.

Consumer-Directed Plan
A health insurance plan that is characterized by lower premiums and higher cost-sharing than other types of plans.

Coinsurance
The percentage of each covered service, above the deductible, that must be paid by the policyholder. For example, a policyholder may be required to pay coinsurance of 20 percent of the cost of a service while the insurer pays 80 percent.

Copayment
A predetermined flat fee that a policyholder pays for services, in addition to what insurance covers. For example, a policyholder may be required to make a $15 copayment for each physician office visit.

Deductible
The amount that must be paid by the policyholder before insurance coverage starts. For example, a policyholder may be required to pay the first $500 per year for covered services.

Employer-Sponsored Health Plan
A health insurance policy provided by an employer as a job benefit.

ERISA
The Employee Retirement Income Security Act sets federal standards for employer-sponsored health insurance policies and is the chief regulatory mechanism for self-insured plans.

Fee-for-Service
A method of paying health care providers in which the provider receives a separate payment for each service that is delivered.

Fully-Insured Health Plan
An employer-sponsored health insurance plan that is purchased from an insurance company. The insurer is then responsible for paying for covered services used by policyholders.

Gatekeeping
Requiring approval from a primary care provider before a policyholder may see a specialist.

Group Policy
An insurance policy that is sold to a group of two or more people who are covered under the terms of a single insurance contract.

Guaranteed Issue
A requirement that an insurer offer a health insurance policy to any eligible individual or group.

Health Savings Account (HSA)
An account into which the owner deposits pre-tax income to cover the high cost-sharing requirements of a consumer-directed health plan. HSA owners typically must be enrolled in such a high-deductible health plan.

HealthWave
A shared federal-state program that provides health insurance for low-income children and children in families that cannot afford to purchase insurance but earn too much money to qualify for Medicaid (also see SCHIP).

HIPAA
The Health Insurance Portability and Accountability Act, a federal law best known for rules regarding the privacy of medical information, also provides certain protections for participants of employer-sponsored health plans.

HMO (Health Maintenance Organization)
A type of managed care organization that employs or contracts with health care providers and requires policyholders to use these providers for all covered health services.

Indemnity Insurance
The traditional insurance model, in which the policyholder decides when and from whom to seek services and providers are paid on a fee-for-service basis.
Individual Policy (or Non-Group Policy)
An insurance policy that is sold to individuals and families who are not part of a larger group for insurance purposes.

Kansas Insurance Department
The state agency responsible for the regulation of companies and agents that sell insurance in Kansas.

Managed Care
A type of insurance plan that integrates service delivery and financing; the insurer has some control over payment for services, the volume of services provided, and who provides the services.

Mandated Benefits
A set of benefits that are required by state or federal law to be included in all health insurance policies. In Kansas, mandated benefits include coverage for newborns, mental health and substance abuse treatment, and some preventive services, such as mammograms and prostate cancer screening. Services provided by certain types of providers, such as psychologists, are also mandated in Kansas.

Medicaid
The shared federal-state program that provides health insurance for low income Kansans.

Medical Debt
Debt incurred due to out-of-pocket health care expenses.

Medicare
The federal program that provides health insurance for elderly (age 65 and above) and disabled Americans.

Out-of-Pocket Expenses
Costs that are not covered by a health insurance policy and are paid by the policyholder with his/her own funds.

Point of Service (POS) Plan
A type of managed care plan that combines characteristics of the HMO and PPO. Members of a POS plan may choose, at the time that services are needed, whether to use a provider who is a member of the plan’s network or one who is not a member.

PPO (Preferred Provider Organization)
A type of managed care organization that contracts with health care providers to furnish services to its members at lower than usual fees. In return, the PPO provides a certain volume of patients and other amenities, such as prompt payment. Use of providers who are not members of the PPO typically requires the policyholder to pay a higher cost-sharing amount.

Pre-Certification
Requiring approval from the insurer before certain services, such as inpatient hospital care, may be provided.

Pre-Existing Condition
An illness or health problem that was diagnosed before the purchase of a health insurance policy.

Premium
The amount paid to the insurance company to purchase an insurance policy.

Provider Network
The physicians, hospitals, and other health care providers that an insurer has contracted with to provide services to its policyholders.

Risk-Based Rating
Setting premiums based on the insured person’s likely use of covered services.

Risk Pool
A group of insured individuals.

Risk Spreading
The distribution of costs generated by a few people across a large group.
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**SCHIP (State Children’s Health Insurance Program)**
The shared federal-state program that provides health insurance for children in families that cannot afford to purchase insurance but earn too much money to qualify for Medicaid. In Kansas, the SCHIP program is known as HealthWave.

**Self-Insured Health Plan**
An employer-sponsored health insurance plan in which the employer, rather than an insurance company, is responsible for paying for covered services used by policyholders. Self-insured plans are typically held by large companies with many employees.

**Solvency**
The insurance companies’ ability to pay the claims of policyholders.

**Underinsured**
People with public or private health insurance policies that do not cover all necessary health costs, resulting in out-of-pocket expenses that exceed their ability to pay.

**Underwriting**
The process of evaluating risk to determine whether to provide insurance coverage.

**Uninsured**
People who are not covered by a public or private health insurance policy.

**Waiting Period**
A period of time that must pass before insurance coverage is provided.