Health Care Reform: A Brief Glossary

Benefit package - The list of services and products that a health plan covers. Typically, the more expansive the benefit package is, the more expensive the health insurance coverage is.

Cherry-picking - A process where an insurer tries to cover only the healthiest people with the lowest risk of using health services.

Community rating - This rule would require insurance companies to set premium rates based only on geography and not health status. Sometimes gender and age also are considered in rate setting.

Guaranteed issue - This rule would require insurance companies to offer health coverage to any one willing and able to pay regardless of health status or pre-existing conditions.

Comparative effectiveness research - Research that compares two or more drugs, treatments or medical interventions to see which is most effective for which type of patient. In theory, insurance providers, whether it is the government or a private company, would use this research to guide decisions on which medical treatments to cover.

Employer mandate - A requirement that businesses offer their employees health insurance. It may only pertain to businesses of a certain size.

Fee-for-service - The traditional and most widespread method of paying doctors and health care providers for each service provided.

Free Rider – A penalty structure under which employers who do not offer health insurance to their employees would pay a fine based on the value of subsidies the government provides to their employees.

Hardship Waiver – This rule would exempt low-income individuals and families from having to obtain health insurance, if it was determined that the cost of coverage would provide financial hardship.

Health insurance cooperative - A nonprofit health plan owned and operated by a collection of small businesses or individuals that group together to purchase health insurance so they have greater negotiating power.

Health insurance exchange - A marketplace where people can buy insurance. An exchange could be set up in many ways at the state, regional or national level. The government could regulate what plans are offered, how much insurers charge and set other rules insurers must follow. Sometimes called a "connector," it often is compared to a menu of insurance options people can choose among similar to what is available to federal government employees. Its primary users likely would be small businesses and people buying individual insurance.

High-risk pool - Some states have insurance pools for people who insurance companies will not cover due to pre-existing conditions or poor health status.

Individual mandate - A requirement that all individuals purchase health insurance coverage. Proponents say an individual mandate is necessary to achieve universal coverage and to avoid a system where only the elderly and unhealthy purchase insurance. Opponents say it infringes on personal freedoms and is unenforceable.

Medicaid - The government health insurance program for the poor. The $333-billion program is paid for through a combination of federal and state funding, but administered by states. In 2007, about one in five people in the U.S. were enrolled in Medicaid.

Medicare - The government health insurance program for people who are 65 and older, blind or permanently disabled. In 2008, the $460-billion program provided health coverage to about 45 million people.

Medicare Advantage - This program allows Medicare beneficiaries to enroll in a private HMO or other health plan to receive their benefits.

Pay for performance - A system that would pay doctors, hospitals and health care providers based on how well they take care of patients and not just on how much care they provide to patients.

Pay or Play – A penalty structure under which employers who do not offer health insurance to their employees would pay a fine based on the total size of the company. Current proposals include a set fine per employee or a penalty based on total payroll.

Pre-existing condition - A prior health condition that may make people ineligible for health insurance coverage in the individual market.

Premium - The amount an insurance company charges to provide coverage. In 2008, the average annual premium for a family was $12,680 – more than twice the cost in 1999.

Public plan - The government could offer a public plan similar to Medicare as one of choice in the health insurance exchange to compete with private insurers. Republicans strongly oppose creating a public plan.

Purchasing pool - Health insurers lump the premiums people pay together to pay for health care services. In this pool, people who use few health services subsidize the costs of people who use many. This ability to "spread risk" gives large employers an advantage over small employers when buying health insurance.

SCHIP - The State Children's Health Insurance Program was created in 1997 to provide health coverage to children not poor enough to qualify for Medicaid. The program is funded by the federal and state governments, but each state operates its program differently. In 2008, the $10-billion program provided health coverage to about 4.5 million children.

Single-payer system - A health care system in which all the funding comes from one source, usually the government. Private insurance, however, can and does exist in countries with a single-payer system, such as Canada and the UK.

Socialized medicine - A health system in which the government provides the health insurance coverage, owns the hospitals, and employs the doctors. The Veterans' Administration health system is an example of socialized health care.

Uncompensated care - Care that doctors and hospitals provide to patients for which they never receive payment.

Underinsured - A term describing people who have insurance but are still considered financially vulnerable to high health expenses because of the limitations or cost-sharing of their plans.