Explanation of Some of the Terminology and Acronyms Used in the Medical Tourism Case

**Benefit Design:** the structure of a health insurance product, including the specific types of services that are covered and the amount that the insured person has to pay.

**Copayment:** An amount paid by the insured person to the physician, hospital or other provider of medical care each time a service is received (e.g., a $10 fee for each office visit).

**Deductible:** A fixed amount, usually per year, that an insured person must pay before the insurer provides any payment for covered services (e.g., a $500 deductible means that the insured person must pay the first $500 of medical fees each year before the insurer provides any insurance payments).

**CMS:** The Centers for Medicare and Medicaid Services, which is the U.S. federal government agency that administers the Medicare, Medicaid and Children’s Health Insurance programs, the major governmental health coverage programs in the United States. (See [www.cms.gov](http://www.cms.gov) for more information).

**FDA:** The Food and Drug Administration is an agency of the United States Department of Health and Human Services, one of the federal executive departments. Its major responsibilities are to help protect the health of the public by ensuring the safety of food, and the safety and effectiveness of drugs and vaccines, medical devices, and other biological products. (See [www.fda.gov](http://www.fda.gov)).

**Health Maintenance Organization (HMO):** a type of health insurance plan that combines the financing and delivery medical care. HMO most often contract with independent health care providers, but some directly employ physicians and/or directly own hospitals and other health care facilities.

**Health Plan:** a term commonly used in the US to refer to a health insurance company.

**Medical Malpractice:** refers to negligence or misconduct by a medical professional, generally resulting from the failure to meet the accepted standard of care and resulting in an injury or damage to the patient.

**Managed care:** A form of health insurance or health financing in which the health plan uses a variety of tools and techniques to control and/ or coordinate the use of health services in order to contain health expenditures, improve quality, or both. Among the most common tools are required pre-authorization or prior approval of certain types of services, disease management programs, managing high cost cases, and using a limited number of doctors and hospitals.

**Medicaid:** the governmental health insurance program for low-income people. The program is administered by the states, based on minimum standards set by the federal government, and jointly financed by the federal government and the states. Medicaid is available only to certain low-income individuals and families who fit into eligible categories. There is wide variability in Medicaid programs across the states.
**Medicare**: A social insurance program that provides health coverage to the elderly and certain younger people with significant disabilities. It is financed and administered by the federal government, through the Centers for Medicare and Medicaid Services, and is a uniform program throughout the United States.

**Nonprofit/Not-for-profit**: an organization is formed for the purpose of serving a public or mutual benefit rather than for the pursuit or accumulation of profits for the owners or investors. Most hospitals and many health plans in the US are structured as non-profit organizations.

**Underinsured**: an individual’s health insurance does not adequately protect them against catastrophic health care expenses. This problem can arise because: certain services are not covered by the insurance; the copayments/coinsurance and/or deductible amounts are large relative to the person’s income; and/or there are limits on the amount of coverage (e.g., an annual or lifetime limits on benefits). Although there is no universal standard for defining underinsurance, among the commonly used measures are: a person’s annual out-of-pocket medical expenses amount to 10 percent or more of their income, or, among lower income people, out-of-pocket medical expenses amount to 5 percent or more of income.

**Uninsured**: having no health insurance coverage. Fifty million people in the United States are uninsured.

**Other Useful Resources**


University of Washington School of Public Health: Glossary of Health Care and Health Management Terms (available at: http://depts.washington.edu/hsic/resource/glossary.html)