Glossary of Cost-Related Terms [1]

This section has been reviewed and approved by the Cancer.Net Editorial Board [2], 11/2013

Americans with Disabilities Act (ADA): A federal (national) law that protects people with disabilities from discrimination. It requires employers to make reasonable accommodations in the workplace for qualified individuals with a disability. Learn more at www.dol.gov [3].

Appeal: Asking your insurance company to reconsider its decision to deny payment for a service or treatment. You have the right to ask your insurance company to conduct a full and fair review of its decision, known as an internal review. If the company still denies payment after considering your appeal, the Affordable Care Act allows you to have an independent review organization decide whether to uphold or overturn the plan?s decision, usually called an external review.

Associated costs: Costs that are related to a cancer diagnosis but not specifically due to medical care given to treat the disease; also called non-medical costs. Transportation and childcare during treatment are two common associated costs for people with cancer.

Case manager: A health care professional, often a nurse with experience in cancer, who helps coordinate the care of a person with cancer before, during, and after treatment. At a medical center, a case manager may provide a wide range of services for patients that may include managing treatment plans, coordinating health insurance approvals, and locating support services. Insurance companies also employ case managers.

Clinical trial: A research study to test a new treatment or drug.

COBRA: Consolidated Omnibus Budget Reconciliation Act. A federal law that allows employees in danger of losing health insurance under certain circumstances, such as leaving a job or reducing their hours, to pay for and keep their insurance coverage for a limited time.

Co-insurance: The percentage of health care costs an insured patient pays after meeting a health care plan's yearly deductible. For example, an 80/20 co-insurance rate means that the insurance company pays 80% of approved health care costs, and the patient pays the remaining 20% of costs out-of-pocket.

Co-pay: A set fee, in dollars, that an insurance provider requires a patient to pay each time care is received. For example, a visit to the oncologist may cost a patient $30 each time; the

insurance provider pays the rest of the visit's costs. The amount of the co-pay is set by the insurance provider, not the doctor's office.

Deductible: The amount of approved health care costs an insured patient must pay out-of-pocket each year before the health care plan begins paying any costs.

Disability insurance: Insurance that provides an income on either a short-term or a long-term basis to a person with a serious illness or injury that prevents the person from working.

Essential health benefits: A set of services that an insurance plan is required to provide to patients. There can be no dollar limits each year on the cost that insurance pays for essential health benefits. According to the Affordable Care Act, plans offered in small group and individual markets must provide items and services in at least 10 categories for the plan to be certified and offered in the health care exchanges. Benefit categories include emergency services, preventive wellness and chronic disease management, and prescription drugs. More information is available at www.HealthCare.gov [4].

Fee-for-service: This is a type of private health insurance in which a person visits a doctor, submits a claim form, and the insurance plan pays the bill using a co-insurance structure. Deductibles are common.

Family and Medical Leave Act (FMLA): This federal law offers specific protections for employees during medical leave (when the employee is ill) and family leave (when the employee must care for a spouse, child, or parent who is ill). Learn more at www.dol.gov [3].

HMO: Health Maintenance Organization; a type of private health insurance. After joining an HMO, a person chooses a primary care doctor from an approved list of doctors (called the network). Specialist care must be approved by that primary care doctor (called a referral).

HIPAA: Health Insurance Portability and Accountability Act. This is a set of national rules that help protect the privacy of a patient's individual medical information, provide patients with access to their medical records, and help people with health problems, such as cancer, get health insurance for themselves and their family members. Learn more at www.hhs.gov/ocr/privacy [5].

Insurance cap: The amount of money an insurance plan will pay in total benefits. Once a patient's medical bills reach the total, or cap, the plan will no longer provide coverage. Both lifetime and annual caps were eliminated under the Affordable Care Act. For more information read the section [6] summarizing this law or visit www.healthcare.gov [7].

Long-term care insurance: Insurance that helps people with long-lasting illnesses or disabilities pay for non-medical daily services and care that ordinary health plans don't cover, such as help with eating, bathing, and dressing. Depending on the plan, care can be given in the home or outside the home.

Medicaid: This is a type of government health insurance for people with low incomes who meet certain conditions. Medicaid is jointly funded by the federal and state governments, but each state operates its program individually (including deciding who can receive Medicaid benefits for that state). Learn more at www.cms.gov [8].

Medicare: This is a type of health insurance provided by the federal government for people 65 or older, as well as for some people with disabilities. Medicare is divided into four parts: Parts A, B, C, and D. Part A covers in-patient hospital care. Part B provides financial coverage using premiums, deductibles, and a co-insurance structure for other medical expenses, such as doctor visits. Medicare Advantage plans, or Part C, are insurance plans managed by private, approved companies. Part D provides prescription drug coverage. Learn more at www.medicare.gov [9].

Non-essential benefits: Services provided by an insurance plan that are outside the ?essential benefits? category. Patients may be responsible for some or all of these costs.

Open enrollment: Specific dates where eligible individuals are able to select or change to a new health care plan. Once this time ends, you may need to wait until the next open enrollment period, usually a year later, to join a health care plan, unless you qualify for a special enrollment period. Find additional information at www.HealthCare.gov [10]. Medicare participants can go to www.medicare.gov [11] to learn about Medicare open enrollment. If you have private insurance, talk with a health insurance plan representative to learn more.

Out-of-network care: Health care providers or facilities that are not part of an HMO or PPO plan's approved list or network are considered ?out of network? (as opposed to being on an approved list or ?in network?). Out-of-network care often costs patients more than in-network care and may involve a deductible and require pre-approval for certain services.

Out-of-pocket costs: Expenses that must be paid from a patient's personal financial resources; any expense not covered by insurance.

Patient navigator: A person, often a nurse or social worker, who helps guide patients, survivors, families, and caregivers through the health care system. Navigators offer numerous services including arranging financial support, transportation, and childcare during treatment; coordinating care among several doctors; and providing emotional support.

Patient Protection and Affordable Care Act: Often called ?health care reform,? this is a 2010 federal law that changed certain rules regarding health insurance coverage in the United States. Learn more at www.HealthCare.gov [10].

PPO: Preferred Provider Organization. This is a type of private health insurance in which a person has access to a network of approved doctors, called in-network doctors. In PPOs, patients typically do not need a referral for specialist care.

Precertification: The process of requesting approval from an insurance plan for specific services before they happen, such as a treatment, procedure, or hospital stay; also called pre-approval. Many hospitals and clinics have precertification coordinators, patient navigators, or case managers who help patients with cancer through this process.

Pre-existing condition: A medical condition that a person already has when enrolling in a new health plan. Starting in 2014, under the Affordable Care Act, insurance plans are not allowed to deny coverage or charge extra to individuals with a pre-existing condition. Learn more at www.HealthCare.gov [10].

Premium: The amount a person or company pays each month to keep insurance coverage.

Reasonable and customary fees: The average cost for health services in a geographic area that insurance plans use to decide how much they will pay for those services. If a doctor's fees for a service are higher than average, the patient must pay the difference.

Social Security Disability Insurance and Supplemental Security Income: These are two national programs that assist people with disabilities. Each has specific medical requirements that a person must meet before getting these benefits. Both programs are administered by the Social Security Administration. Learn more at www.ssa.gov/disability [12].

Social worker: A professional who helps patients with cancer and their family members cope with everyday tasks and challenges before, during, and after treatment. Social workers, who may work for a hospital, a service agency, or a local government, can help address financial problems, explain insurance benefits, provide access to counseling, and more.

Specialist care: Health care given by a doctor who has been trained in treating a specific type of health problem or specific group of people. For instance, an oncologist is a doctor who specializes in treating cancer.

More Information

Medical Dictionary Resources [13]

Understanding the Costs Related to Cancer Care [14]

Health Insurance [15]

Links:
[1] http://www.cancer.net/navigating-cancer-care/financial-considerations/glossary-cost-related-terms
[2] http://www.cancer.net/about-us
[3] http://www.dol.gov
[4] http://www.HealthCare.gov
[5] http://www.hhs.gov/ocr/privacy
[6] http://www.cancer.net/node/24921
[7] http://www.healthcare.gov
[8] http://www.cms.gov/
[9] http://www.medicare.gov/

[10] https://www.healthcare.gov/
[11] http://www.medicare.gov
[12] http://www.ssa.gov/disability/
[13] http://www.cancer.net/node/24925
[14] http://www.cancer.net/node/24922
[15] http://www.cancer.net/node/24918