Appendix D: Acronyms and Glossary of Terms

Acronyms

AAFP —American Academy of Family Physicians
AFL-CIO —American Federation of Labor-Congress of Industrial Employees
CalPERS -California Public Employees' Retirement System (State of California)
CBO -Congressional Budget Office (U.S. Congress)
CDF -Conservative Democratic Forum (U.S. Congress)
CHAMPUS -Civilian Health and Medical Program of the Uniformed Services
DHHS —U.S. Department of Health and Human Services
ERISA —Employee Retirement Income Security Act of 1974
FICA —Federal Insurance Contributions Act
GAO -General Accounting 0ffice (U.S. Congress)
GDP -Gross domestic product
GNP -Gross national product
HBSM —Health Benefits Simulation Model (Lewin-VHI)
HCFA —Health Care Financing Administration
HI —Hospital Insurance Trust Fund (Medicare Part A)
HIAA —Health Insurance Association of America
HMO —Health maintenance organization
NHE —National health expenditures
NLCHCR —National Leadership Coalition for Health Care Reform
OASDI -Old Age, Survivors, and Disability Insurance
OTA -Office of Technology Assessment (U.S. Congress)
PPO —Preferred provider organization
VAT —Value added tax

Terms

Access to health care: Potential and actual entry of a population into the health care delivery system. Elements of access include availability, affordability, and approachability.

Accountable health plans: Organized systems of health care delivery and financing.

Actuarial cost of coverage: The expected dollar value of a health plan's benefits. The method for determining this value may be based entirely on a plan's provisions, or may adjust for the geographic location and demographic characteristics of enrollees, the actual health care utilization level by plan participants, or the type of plan under which the benefits are provided (e.g., fee-for-service plan vs. health maintenance organization).

Administrative costs: Expenses related to the management or supervision of the provision of health care coverage and services. Analyses of reform approaches, proposals or plans frequently do not share a common definition of what components constitute administrative costs but most commonly refer to insurer, including government programs and private plans, and provider, including hospital and physician, administrative costs.

Administrative costs-savings: Reductions in expenditures related to changes in the administrative costs associated with the provision of health care coverage and services.

Aid to Families With Dependent Children (AFDC): A federally-supported, State-administered program established by the Social Security Act of 1935 that provides financial support for children under the age of 18 (and their caretakers) who have been deprived of parental support or care because of the parent's death, continued absence from the home, unemployment, or physical or mental illness.

All-payer system: All insurers use the same payment schedule.

Analysis: A separation of a whole entity into its complex parts, and an examination of its elements and their relations.

Approach: An organized group of broad ideas designed to achieve specific goals with respect to reform of the health care financing and/or delivery systems.

Beneficiary: A person entitled to receive covered health care services and reimbursement for such covered services rendered under a health insurance plan.

Benefit package: In this report, benefit package refers primarily to the services and providers that are covered by a *health insurance* plan, and to the financia1 and other terms of such coverage (e.g., patient *cost-sharing,* limitations on amounts and numbers of visits or days). See also, *scope of benefits or coverage* and *depth of benefits or coverage.*

Benefits: The covered health care services and the amount payable by a health insurance plan to a beneficiary under the terms of the plan.

California Public Employees' Retirement System (CalPERS) Health Benefits Program: A health insurance program available to California's public employees and their dependents whose current strategy focuses on the maintenance of a large risk pool, the promotion of *managed care* strategies and a standard *benefit package* required to be offered by participating HMOs.

Canadian-style system: A health care financing system based upon the system in place in Canada which provides tax-financed universal coverage with the government as sole purchaser of services. Typically, in Canada, patients choose their own physicians and incur no deductibles or copayments. Physicians are paid according to a negotiated fee schedule and hospitals operate under global budgets, both of which are established by the provinces.

Cap: In this report, refers to a limit on the dollar amount an employer can deduct from its corporate income taxes or that an employee can exclude from his or her taxable income for an employer's contributions to an employee's health benefits' premiums.

Cavitation **payment:** A method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person served in a set period of time, usually a year, without regard to the actual number or nature of services provided to each person. This is the characteristic payment method in *health maintenance organizations.* Compare *fee-for-service.*

Civilian Health and Medical Program of **the** Uniformed Services (CHAMPUS): A Department of Defense program supporting private sector health care for dependents of active and retired members of the uniformed services.

Coinsurance: A fixed percentage of covered expenses paid by a health plan and an enrollee for covered expenses after any deductible has been met; for example, 80/20 coinsurance means 80 percent is paid by the plan and 20 percent is paid by the person covered by the plan. Compare *copayment.*

Community rating: A method of determining health plan premiums by basing the premiums on the average costs of health services for all subscribers within a specific geographic area. Under community rating, the premium does not vary for different groups or subgroups of subscribers based upon their specific claims experience. Compare *experience rating.*

Competition: If not qualified by some phrase (such as **nonprice competition),** competition as used by economists means price-competition (competition based on price). Enthoven has suggested that ''value-for-money **competition**' would be a more apt phrase of what is typically meant when economists refer to price competition. In standard economics, **pure competition** is characterized by many sellers (and buyers) of a standardized product,

free entrance to the market, and no collusion or price fixing.

Consumers: In this report, individuals who fund, either through out-of-pocket expenses or indirect payments (e.g., taxes), health care coverage and/or services and/or use them.

Copayment: A fixed dollar amount that a health plan enrollee is required to pay for a covered service (e.g., $10 per office visit, $3 per prescription drug).

Cost containment: The control or reduction of inefficiencies in the consumption, allocation, or production of health services that contribute to higher than necessary costs.

Costs: Expenses incurred in the provision of services or goods. Many different kinds of costs are defined and used (e.g., allowable, direct, indirect, and operating costs). It is important not to confuse *costs* with charges which are the price of a service or the amounts billed for services rendered, which may or may not be the same as or based on costs.

Cost-sharing: The provisions of a health benefits plan that require the enrollee to pay a portion of the cost of services covered by the plan, typically exclusive of *premium cost-sharing* (sharing of the cost of a health care plan premium between the sponsor and the enrollee). Usual forms of cost-sharing include deductibles, coinsurance, and copayments. These payments are made at the time a service is received or shortly thereafter, and are only made by those insureds who seek treatment.

Cost-shifting: The condition which occurs when health care providers are not reimbursed or are not fully reimbursed for providing health care so charges to those who do pay are increased.

Coverage: Promise by a third party to pay for all or a portion of expenses incurred for specified health care services.

Covered services: Services eligible for reimbursement by a health plan. See *benefit package.*

Current dollars: The value of dollars spent or received at the time of the transaction, without adjusting for inflation or deflation since the transaction date. Compare *inflation-adjusted dollars.*

Current Population Survey: A cross-sectional survey which can provide a series of snapshots of the socioeconomic conditions that exist at different fixed points in time. The survey is conducted by the U.S. Department of Commerce, Economics and Statistics Administration, Bureau of the Census.

Deductible: A specified amount of money (e.g., $200, $500, $1,000) that must be paid during a given time period (usually a year) by the enrollee and/or his or her dependents for covered services before any payments are made by a health plan.

Depth of benefits or coverage: Refers to the level of patient *cost-sharing* required under a health insurance plan (i.e., the deductibles, copayments, coinsurance, out-of-pocket maximums, maximum liability of the insurance plan).

Direct spending on health: Includes the amount directly paid for health insurance premiums by a household, as well as other out-of-pocket expenses for health services.

Employer mandate: Refers to a requirement that employers offer health insurance to employees and, in some cases, contribute toward the cost of employees' health benefits' premiums,

Employers' share of health insurance premiums: The employers' share of health insurance premiums is the share of the premium charged by the insurer that the employer, rather than the covered employee, is on record as contributing. The term employers share can be a misnomer, however, because, according to most economists, the employers' share of the premium is part of the total employee compensation package, and thus paid, ultimately, by the individual insured. The employment setting is the most frequent form of group sponsorship of health insurance purchases.

Employment-based health insurance plan: A group health plan that is sponsored by an employer for its employees and their dependents,

Enrollee: An individual who qualifies for benefits under a health benefits plan and has taken any required action to register or otherwise signify his or her participation in the plan.

ERISA: Employee Retirement Income Security Act of 1974. Exempts companies that self-insure, or fund their own insurance plans, from State regulations. Most large companies began to self-insure in the 1980s. Now, 70 percent of firms with 5,000 or more workers do it. Only Hawaii has an ERISA waiver, allowing it to regulate such plans.

Expenditure: In the context of health care, monies spent on the acquisition of health care coverage

and/or services. See *national health expenditures.*

Expenditure limits: With respect to health care, expenditure limits include various mechanisms which limit the maximum amounts that may be spent to acquire health care coverage and services (e.g., negotiated fee schedules, hospital global operating budgets, national health budget).

Expenditure targets: With respect to health care, established goals as to how much money may be spent on health care coverage and services.

Experience rating: A method of adjusting group health plan premiums based wholly or in part on the historical utilization data of the specific group. Compare *community rating.*

Family: As defined by the U.S. Department of Commerce, Economics and Statistics Administration, Bureau of the Census, a family is a group of two persons or more (one of whom is the householder) related by birth, marriage, or adoption and residing together, all such persons (including related subfamily members) are considered as members of one family. Beginning with the 1980 Current Population Survey (CPS), unrelated subfamilies (referred to in the past as secondary families) were no longer included in the count of families, nor are the members of unrelated subfamilies included in the count of family members. The term is often used interchangeably with *household.*

Federal poverty level: The official U.S. Government definition of poverty based on cash income levels for families of different sizes. Responsibility for changing poverty concepts and definitions rests with the Office of Management and Budget in the Executive Office of the President of the United States. The poverty thresholds for the continental United States in 1992 were $8,810 for one person, $9,190 for two persons, $11,570 for three persons, and $13,950 for four persons. Alaska and Hawaii have higher thresholds.

Fee-for-service: A method of billing for health services under which a physician or other practitioner charges separately for each patient encounter or service rendered. Under a fee-for-service payment system, expenditures increase if the fees themselves increase, if more units of services are provided or if more expensive services are substituted for less expensive ones. This system contrasts with salary, per capita or other prepayment systems, where the payment to the practitioner is not changed with the number of services actually rendered. Compare *cavitation payment.*

Fee-for-service plan: As used by the Office of Personnel Management and others, a traditional or conventional health insurance plan that permits employees to select providers of services and pays the providers according to the fees charged for such services. The term is used to distinguish such plans from HMOS, under which the enrollee generally must obtain services from the HMO providers whose payments from the HMO are not necessarily directly related to the type or quantity of services actually provided.

Financing (of health care): Refers to where the money to pay health care providers for the delivery of health care services comes from (e.g., government/taxpayers). Compare *payment.*

Fiscal year: Any accounting period of 12 successive calendar months, or 52 weeks, or 365 days, used by an organization for financial reporting. Beginning with October 1, 1977, the Federal fiscal year extends from October 1 through September 30.

Fringe benefits: Noncash benefits provided to a worker by an employer.

Global **budget:** Generally, an overall budget limit on health care services, regardless of where the funds originate. Global budgets can take the form of a State or national maximum limit on total health care expenditures, but usually imply national limits. In some contexts, global budgeting has come to mean setting a limit on spending by sector (e.g., specific allocations for physicians, hospitals).

Gross **domestic product** (GDP): Covers the goods and services produced by labor and property located in the United States.

Gross national product (GNP): Covers the goods and products produced by labor and property supplied by U.S. residents regardless of whether produced in the U.S. or in foreign countries.

Group health insurance: Health insurance purchased through a group that exists for some purpose other than buying insurance, such as a workplace, labor union, or professional association. Currently, the majority of Americans under age 65 are covered by employment-based group health insurance.

Group-model HMO: An HMO that uses a single large multispecialty group practice as the sole (or major)

source of care for an HMO's enrollees. The group may or may not have existed prior to the formation of the corporately distinct HMO, and has an exclusive contract with the HMO. Some groups also see fee-for-service or preferred provider organization patients; others are not allowed to do so.

Health Benefits Simulation Model (HBSM): An analytic model developed by the private consulting firm Lewin-VHI in 1984. The purpose of the HBSM is to estimate the cost of access proposals, the impact of access proposals, distributional impacts, and to identify unintended consequences. It is a month-by-month simulation model including a household data file from the 1987 National Medical Expenditures Survey updated to the simulation year. There is a statistical match with the Small Business Administration's survey of large and small firms.

Health Care Financing Administration (HCFA): An agency within the U.S. Department of Health and Human Services (DHHS) that oversees the Medicaid and Medicare programs, and is responsible for making payments to the States for the Medicaid program, and to providers under Medicare for care rendered to program beneficiaries. HCFA is also responsible for assuring that health care services provided to Medicare and Medicaid beneficiaries meet professionally recognized and Federal standards of care and are delivered effectively and efficiently.

Health care provider: An individual or institution that provides medical services (e.g., a physician, hospital, laboratory, etc). This term should not be confused with an insurance company which "provides" insurance.

Health insurance: In this report, the term "health insurance" is used broadly to include various types of health plans that are designed to reimburse or indemnify individuals or families for the costs of medical care, or (as in HMOs) to arrange for the delivery of that care, including traditional private indemnity fee-for-service coverage, prepaid health plans such as HMOS, self-funded employment-based health plans, Medicaid, and Medicare. Private health insurance: With respect to health insurance, refers to a plan run or sponsored by an entity other than government. Public health insurance: With respect to health insurance, refers to a government-run or -sponsored plan.

Health insurance network (HIN): An arrangement that would aggregate the purchasing power of small businesses by allowing them to make group purchases of insurance. As proposed by the Bush Administration, these would have been voluntary arrangements.

Health insurance purchasing cooperative **Or group: An arrangement** to make group purchases of health insurance that would be established under a Managed Competition approach to health care reform. It would aggregate the purchasing power of large populations and provide economies of scale to small businesses and individuals.

Health maintenance organizations (HMOS): An organization that, in return for prospective per capita ***(capitation)*** payments, acts as both insurer and provider of comprehensive but specified health care services to a voluntarily enrolled population. Prepaid group practices and individual practice associations are types of HMOS.

Hospital Insurance Trust Fund (HI): The Federal hospital insurance trust fund is a trust fund of the Treasury of the United States in which the monies collected from taxes on the annual earnings of employees, employers, and self-employed persons covered by Social Security are deposited. Disbursements from the fund are made to help pay for benefit payments and administrative expenses incurred by the hospital insurance program (Medicare Part A). See *Medicare.*

Household: As defined by the Bureau of the Census within the U.S. Department of Commerce, all the persons who occupy a housing unit (i.e., a house, an apartment or other group of rooms, or a single room occupied or intended for occupancy as separate living quarters).

Individual insurance: Policies purchased without the benefit of group sponsorship that provide protection to the policyholder and/or his or her family. Sometimes called personal insurance as distinct from group insurance.

Individual Vouchers or Tax Credits approach: Approach to health care reform that focuses on tax incentives to encourage the purchase of coverage and expand access to it. Usually combined with some insurance market reforms.

Inflation-adjusted dollars: Dollars expressed in terms of their purchasing power in a base year. They are adjusted for changes in buying power due to inflation (or deflation) between the base year and the year of measurement.

Insurance: Protection by written contract against the financial hazards (in whole or in part) of the happening of specified fortuitous events.

Insurer: An insurance company, HMO, government program, or "self-funded" group (e.g., employer) responsible for providing protection against financial loss.

Internal Revenue Code of 1986: The most recent codification of the U.S. statutes pertaining to taxation including any amendments thereto since 1986,

Jackson Hole Group: Described by the group itself as an *ad hoc* and changing group of health executives, leaders, and experts who have been meeting (over the past several years) to discuss and address the deficiencies of the health system.

Managed care: A general term applied to a range of initiatives from organized health care delivery systems (e.g., HMOS) to features of health care plans (e.g., preadmission certification programs, utilization review programs) that attempt to control or coordinate enrollees' use of (and thus to control the cost of) services.

Managed Competition approach: An approach to health care reform that would combine health insurance market reform with health care delivery system restructuring. The theory of Managed Competition is that the quality and economy of health care delivery will improve if independent groups compete with one another for consumers in a government-regulated market.

Market: In economics, an area within which buyers and sellers are in such close communication that prices of the same goods tend to equality throughout the area. Some markets are virtually worldwide, others are national, and some are local or regional. Many economists have noted that markets for health care differ from markets for most other goods. For example, the market in health care is subject to considerable problems regarding the lack of knowledge (and, sometimes, lack of rationality) among consumers, and the influences of health care providers as agents of patients.

Medicaid: A joint Federal-State program of Federal matching grants to the States to provide health insurance for categories of the poor and medically indigent. States determine eligibility, payments, and benefits consistent with Federal standards.

Medicare: A Federally administered health insurance program covering the cost of services for people who are 65 years of age or older, receiving Social Security Disability Insurance payments for at least 2 years, or have end-stage renal disease. Medicare consists of two separate but coordinated programs--hospital insurance (Part A) and supplementary medical insurance (Part B). Health insurance protection is available to insured persons without regard to income.

Medigap: A private health insurance policy (also called a Medicare supplemental policy) designed to pay for services not covered by the Medicare program. Medigap policies generally cover some or all of Medicare's cost-sharing requirements and may also cover other costs or services not covered by Medicare (such as dental services).

Minimum benefit package: A health insurance benefit package consisting of specified benefits which must be offered.

National health budget: Establishes a dollar amount to be spent on health care nationally, usually geared to a limitation on the percent increase in the rate of growth of national health expenditures.

National health care: A system in which government both finances and delivers health care (e.g., the system in place in the United Kingdom). This term is sometimes used as a synonym for the Canadian-style system, even though the Canadian Government does not deliver care.

National health expenditures: An estimate of national spending on health care made up of two broad categories: 1) health services and supplies, which, in turn, consist of personal health care expenditures (the direct provision of health care), program administration and the net cost of private health insurance, and government public health activities; and 2) research and construction of medical facilities.

Negotiated fee schedule: Fees set through an organized bargaining process, Usually used to help determine a global budget. Also called negotiated payment schedule.

Out-of-pocket expenses or spending: Payments made by a plan enrollee, beneficiary or insured for medical services that are not reimbursed by the health plan. These may include payments for deductibles and coinsurance for covered services, for services not covered by the plan, for provider charges in excess of the plan's limits, and for enrollee premium payments.

Payer: The person (e.g., patient) or organization (e.g., self-funded employer, insurance company, government) that makes full or partial payments for health care services rendered to and/or for health commodities received by a patient.

Payment **(for health care): The** amounts and methods used to pay for health care that is supplied. Compare *financing.*

Payroll tax: A tax which is a direct function of the size of an employer's payroll.

Per-capita: On an individual basis.

Plan: In this report, used to refer to a specific variant of an *approach* to health care reform. Distinct from a health benefit or health insurance plan. Also called a *proposal.*

Play-or-Pay approach: Approach to health care reform that would provide employment-based health benefits coverage combined with public programs to cover the uninsured. Employers can either "play" (provide coverage for their employees in the private market) or "pay" (pay into the public health insurance program), most often through a *payroll tax* which sets a maximum limit on employers' liability for coverage, as a percent of payroll.

Preexisting condition: A physical and/or mental condition of an insured which first manifested itself prior to the issuance of the insured 's policy or which existed prior to issuance and for which treatment was received.

Preferred provider organization (PPO): A term that refers to a variety of different insurance arrangements under which plan enrollees who choose to obtain medical care from a specified group of participating providers receive certain advantages, such as reduced cost-sharing charges. Providers usually furnish services at lower than usual fees in return for prompt payment by the health insurance plan and a certain assured volume of patients.

Premium: The price or amount which must be paid periodically (e.g., monthly, biweekly) to purchase insurance coverage or to keep an insurance policy in force. Virtually all health insurance programs require the payment of a premium by the enrollee, insured or beneficiary and/or by someone else (such as the employer) on the individual's behalf. Premiums paid to *health maintenance organizations* or similar organizations are often called *cavitation* payments.

Premium cost-sharing: The sharing of the cost of the health plan premium between the employer or other group sponsor and the enrollee.

Price-competition: See *competition.*

Proposal: In this report, used to refer to a specific variant of an *approach* to health care reform. Also called a *plan.*

Prospective payment system: A payment system under which health care providers are paid for their services according to a predetermined fixed amount. Although prospective payment rates may be related to the costs providers incur in providing services, the amount a provider is paid for a service under a prospective payment system is unrelated to the provider's actual cost of providing that specific service. Medicare and CHAMPUS use prospective payment systems to pay for inpatient hospital services,

Provider: See *health care provider.*

Quality of (medical) care: Evaluation of the performance of health care providers according to the degree to which the process of care increases the probability of outcomes desired by the patients and reduces the probability of undesired outcomes, given the state of medical knowledge. Which elements of patient outcomes predominate depends on the patient condition.

Revenue: As used in an accounting sense, the increase in assets (or decrease in liabilities) that results from operation. Revenues result from: 1) services performed by the Federal Government and 2) goods and other property delivered to purchasers.

Scope of benefits or coverage: Refers to the range of services, providers, and settings covered by a health benefit plan.

Self-insurance: Payment of employees' health care expenses through the use of a special fund established by an employer rather than by arranging for

an insurer to provide such coverage. The employer directly assumes the functions, responsibilities, and liabilities of an insurer, although an employer may arrange for another entity (e.g. insurer) to handle the administrative tasks associated with running the plan.

Single Payer approach: Approach to health care reform that would provide tax-financed universal coverage with government as the sole purchaser of services. A single entity, usually government-run, reimburses all medical claims. Consumers typically pay a uniform tax rather than premiums. Money goes to a single health care trust fund, used only for health care expenditures.

Small group market reform: In the context of U.S. health care financing reform, these are measures aimed at alleviating problem areas in the private insurance marketplace. Typically, they include: guaranteed issuance of policies, regardless of health status; limitations or prohibitions on benefit plan limitations or exclusions for preexisting health conditions; and an end to experience-rating (although some form of risk-adjusted community rating is often proposed).

Sponsors: The employers (or sometimes unions) who offer group health benefit plans.

Staff-model HMO: An HMO in which physicians practice solely as employees of the HMO and are paid a salary.

State-mandated benefits: Certain minimum benefits that health insurers (but not self-insured groups which are exempt under ERISA) are required by State law to offer in their insurance policies.

Tax credit: An amount that offsets or reduces tax liability. It is subtracted directly from the tax liability that would otherwise accrue, and thus, it is not contingent upon the marginal tax rate. When the allowable tax credit amount exceeds the tax liability, and the difference is paid to the taxpayer, the credit is considered refundable. Otherwise, the difference can be: 1) allowed as a carryforward against future tax liability, 2) allowed as a carryback against past taxes paid, or 3) lost as a tax benefit. See also tax *deduction* and tax *expenditure.*

Tax deduction: An amount that is subtracted from the tax base before tax liability is calculated.

Tax expenditure: Defined as reductions in individual and corporate income tax liabilities that result from special tax provisions or regulations that provide tax benefits to particular taxpayers. Further defined as a revenue loss attributable to a provision of the Federal tax laws that: 1) allows a special exclusion, exemption, or deduction from gross income or 2) provides a special credit, preferential tax rate, or deferral of tax liability. Examples of tax expenditures include the personal income tax exclusion for health insurance premiums paid by employers on behalf of employees, and the personal tax deduction for unreimbursed medical expenses.

Third-party administrator (TPA): A private firm that administers a group health plan on behalf of the insurer or policyholder. TPAs are responsible for at least some (if not all) administrative functions, but a TPA bears no financial risk associated with the insurance function.

Third-party payer: An organization (private or public) that pays for or insures the health care expenses of its beneficiaries. Third parties include Blue Cross/Blue Shield, commercial health insurers, Medicare, and Medicaid. The individual receiving the health care services is the first party, and the individual or institution providing the service is the second party.

Third-party payment: Payment by a private insurer or government program to a health care provider for care given to a patient.

Total compensation **package: The** total amount of compensation received by a worker for services rendered including wages or salary and fringe benefits.

Underinsured: People with *public* or *private insurance* policies that do not coverall necessary medical services, resulting in *out-of-pocket expenses* that exceed their ability to pay.

Uninsured: People who lack private *or public* health insurance coverage.

- **Universal coverage: An** all encompassing plan which would provide all 37 million uninsured Americans with health insurance.
- Utilization: Use; commonly examined in terms of patterns or rates of use of a single service or type of service (e.g., hospital care, physician visits, prescription drugs). Measurement of utilization of all medical services in any given period is sometimes done in terms of dollar expenditures. Use is also expressed in rates per unit of population at risk for

a given period (e.g., number of admissions to a hospital per 1,000 persons over age 65 per year or number of visits to a physician per person).

Utilization management: A set of techniques used on the behalf of purchasers of health benefits to manage health care costs by influencing patient care decisionmaking through case-by-case assessments of the appropriateness of care prior to, or sometimes following, its provision. See *utilization review.*

Utilization review: The review of services delivered by a health care provider or supplier to determine whether those services were medically necessary.

Value added tax: A tax which accumulates on goods as they move from raw materials through the production process. Each processor pays a tax according to the amount by which he has increased the value of items that were raw materials to him.

Voucher: A form or check indicating a credit against future purchases or expenditures.