

HEALTH CARE GLOSSARY

- Access to Health Care:** An individual's ability to obtain needed health care services when they need it.
- Benefit Package:** A defined set of services or benefits that an insurer provides to subscriber groups or individuals.
- Capitation:** Refers to the practice by managed care organizations to set a specific amount to be paid per member per month. Health care providers therefore know in advance how much money they can collect from their 'capitated' population, regardless of what services are actually performed.
- Consumer-Driven Plans:** Health plans that provide employees with funds that the employee, rather than the employer, uses to purchase health care services or insurance. The idea is to allow employees to make their own cost-benefit decisions, selecting those providers, services, and insurers that provide the most value to them as consumers.
- Co-payments:** Health care related costs that a consumer pays out-of-pocket. These are in addition to what is paid by other parties. Co-payments are very common with prescription drugs, and in many plans also apply to office visits and other services.
- Cost-sharing:** A health insurance policy provision that requires the insured party to pay a portion of the costs of covered services. Deductibles, co-insurance, and co-payments are all examples of cost-sharing.
- Cost-shifting:** The process of passing the costs of health care from one group to another, most commonly seen in 1) employers expecting employees to pay a greater share of their employer-provided health care expenses; and 2) insurance premiums being raised to cover the cost of caring for the uninsured.
- Deductibles:** Similar to car insurance, deductibles are health care related costs (either annually, over a lifetime, or case-specific) that an individual must pay out-of-pocket before any additional costs will be picked up by the insurance company. For example, you might be required to pay any hospitalization costs up to \$1,000. Usually, higher deductibles result in lower annual premiums.
- Defensive Medicine:** Describes physicians' practice of providing more diagnostic and therapeutic services as a means of reducing their risk of liability for negligence in medical injury malpractice suits.
- Defined Contribution:** A pre-set dollar amount representing the maximum employer contribution to health care benefits for a given period of time.
- Employer contribution:** The money that an employer pays for its employees' health plan. Employer contributions vary widely and can be based on percentage of cost, length of employment, family circumstances, or a flat fee.
- Employer Mandate:** A plan which requires that employers pay all or part of their employees' health insurance premiums, or pay into a fund that provides the required insurance.
- Health Maintenance Organization (HMO)** A managed care business that organizes health care services for its members, either on a for-profit or a not-for-profit basis. They are responsible for the financing and delivery of a comprehensive set of benefits for their enrolled members.
- Individual Mandate:** A plan that requires that individuals purchase their own health insurance, just as they do car insurance.
- Managed Care:** Managed care is a term that describes systems where the health plan attempts to control or coordinate services delivered and used by its members. The purpose of these arrangements can be to save costs, improve quality, or both.
- Medicaid:** a federal and state health insurance program for qualifying persons with low income. It also

provides coverage for acute and long term care.

Medicaid (Federal) Waivers: The Department of Health and Human Services (DHHS) can waive certain requirements of federal law and regulation in order to encourage innovation and provide states with greater flexibility in their Medicaid and State Children's Health Insurance Programs (SCHIP). These waivers can enable states to better tailor their programs to meet local needs, and they allow states to experiment with new approaches of providing health care services to Medicaid and SCHIP recipients.

Medical Savings Accounts: Savings accounts through which individuals assume their own risk for minor and major medical needs.

Medicare: a national universal health insurance program for people aged 65 and older and for people with disabilities. It is funded by payroll taxes and modest premiums paid by beneficiaries.

Means Test: The criteria by which an individual's or family's income and assets are evaluated for eligibility in a public program, such as Medicaid.

Pay or Play: A system that would guarantee health insurance for everyone by requiring employers to either play by providing insurance to employees or pay into a fund to cover the costs of the uninsured and unemployed people.

Preferred Provider Organization (PPO): A managed care plan that contracts with networks or panels of providers to provide services and to be paid on a negotiated fee schedule. Enrollees are offered a financial incentive to use providers on a preferred list, but may use non-network providers as well.

Purchasing Pool: Grouping together many small business employers, their employees, and dependents into a larger pool to offer choice of benefits and stability of rates similar to large employers.

Risk Pooling/Sharing: The idea that the greater the number of people who are insured, the more you accurately can predict claims against the pool. That is, larger groups of people allow insurers to use anticipated savings from healthier persons to balance the risks of losses in covering unhealthier persons.

Safety Net: Services and programs, government-sponsored and private, that provide health care regardless of insurance status or ability to pay. This generally includes Medicaid, community health centers, public hospitals, and hospital emergency rooms.

Single Payer Systems/Programs: A financing mechanism for health care delivery in which payers (individuals, employees) contribute to a single fund that reimburses providers of health services. The VA and Medicare are often referred to as examples of single payer within the U.S.: many consumers, many providers, and a single entity (the federal government) paying for all covered services.

Universal Coverage: Basic health insurance coverage for an entire population which is financed through taxes – either from individuals, employers, or both.

Universal Health Care: A health system designed to guarantee that everyone has access to quality health care that is comprehensive and affordable.

**The Archimedes Movement | www.WeCanDoBetter.org
1 SW Columbia, Suite 860 | Portland, Oregon 97258 | 503-709-8574**

The Archimedes Movement was established at The Foundation for Medical Excellence in January 2006 under the leadership and direction of former Oregon Governor John Kitzhaber, MD.