



Health Care Glossary¹

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HMO - Health Maintenance Organization. A state-licensed health plan that offers prepaid, comprehensive coverage for both hospital and physician services, and also manages care and restricts members to using only healthcare providers affiliated with the plan.

Network - The group of physicians, hospitals, and other medical care professionals that a managed care plan has contracted with to deliver medical services to its members².

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Individual Insurance - Policies purchased by individuals directly from an insurance company, not through the auspices of another organization such as an employer or association.

Job-Lock - The inability of individuals to change jobs because they would lose crucial health benefits.

Managed Care -Any system of health payment or delivery arrangements where the health plan attempts to control or coordinate use of health services by its enrolled members in order to contain health expenditures, improve quality, or both. Arrangements often involve a defined delivery system of providers with some form of contractual arrangement with the plan.

Medical Savings Account (MSA) - A health insurance option consisting of a high-deductible insurance policy and a tax-advantaged savings account. Individuals would pay for their own health care up to the annual deductible by withdrawing from the savings account or paying out of pocket. The insurance policy would pay for most or all costs of covered services once the deductible is met.

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Underwriting - The process by which an insurer determines whether and on what basis it will accept an application for insurance. Some insurers use medical underwriting to exclude individuals, groups, or coverage for certain health conditions that are expected to incur high costs.



Health Care Glossary¹

Benefit Package - Services covered by a health insurance plan and the financial terms of such coverage, including cost sharing and limitations on amounts of services.

Copay - A fixed dollar amount paid for a covered service by a health insurance enrollee. Amount that a member of a health plan has to pay for specific health services, such as visits to a physician

Deductible - A type of cost sharing where the insured party pays a specified amount of approved charges for covered medical services before the insurer will assume liability for all or part of the remaining covered services.

Defensive Medicine - Physician practices just to reduce risk of a liability claim, e.g., performing diagnostic tests of marginal value.

Experience Rating - A system used by insurers to set premium levels based on the insured's past loss experience. For example, rating may be based on service utilization for health insurance or on liability experience for professional liability insurance.

Gatekeeper - The person in a managed care organization who decides whether or not a patient will be referred to a specialist for further care. Physicians, nurses and physician assistants all function as gatekeepers.

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

HMO - Health Maintenance Organization. A state-licensed health plan that offers prepaid, comprehensive coverage for both hospital and physician services, and also manages care and restricts members to using only healthcare providers affiliated with the plan.

Network - The group of physicians, hospitals, and other medical care professionals that a managed care plan has contracted with to deliver medical services to its members².

¹ All definitions taken from the University of Washington School of Public Health and Community Medicine Health Services Library website at <http://depts.washington.edu/hsic/resource/glossary.html>, unless otherwise noted. The glossary pulls definitions from academic publications.

² <http://www.bcbs.com/coverage/glossary/>

Health Risk Behaviors - Behaviors, such as smoking, lack of exercise, and overeating, that increase the potential for an individual to experience disease, or injury.

Health Risk Factors – In addition to "health risks behaviors" defined above, risk factors include genetic factor such as a family history of heart disease, or environmental factors such as living in a polluted area.

Individual Insurance - Policies purchased by individuals directly from an insurance company, not through the auspices of another organization such as an employer or association.

Job-Lock - The inability of individuals to change jobs because they would lose crucial health benefits.

Managed Care -Any system of health payment or delivery arrangements where the health plan attempts to control or coordinate use of health services by its enrolled members in order to contain health expenditures, improve quality, or both. Arrangements often involve a defined delivery system of providers with some form of contractual arrangement with the plan.

Medical Savings Account (MSA) - A health insurance option consisting of a high-deductible insurance policy and a tax-advantaged savings account. Individuals would pay for their own health care up to the annual deductible by withdrawing from the savings account or paying out of pocket. The insurance policy would pay for most or all costs of covered services once the deductible is met.

Out-of-Pocket Expense - Payments made by an individual for medical services. These may include direct payments to providers as well as 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.

Preexisting Condition Limitations - A provision in insurance policies that excludes health conditions existing prior to coverage sign up. These limitations exclude specified conditions entirely or for a specified period. When an individual changes jobs and enrolls in a new insurance plan, these limitations can cause a critical gap in health benefits.

Preferred Provider Organization (PPO) - A health plan with a network of providers whose services are available to enrollees at lower cost than the services of non-network providers. PPO enrollees may self-refer to any network provider at any time.

Premium - An amount paid periodically to purchase health insurance benefits.

Preventive Services - Services intended to prevent the occurrence of a disease or its consequences.

Point of Service Plans (POs) - A managed-care plan that combines features of both prepaid and fee-for-service insurance. Health plan enrollees decide whether to use network or non-network providers at the time care is needed and usually are charged sizable copayments for selecting the latter.

Risk Pools - Legislatively created programs that group together individuals who cannot get insurance in the private market. Funding for the pool is subsidized through assessments on insurers or through government revenues. Maximum rates are tied to the rest of the market.

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