



Glossary of Health Care Terms

Health Plan Types

Health Maintenance Organizations (HMOs): Organizations that provide a wide range of comprehensive health care services for a specified group or individual for a fixed premium. Consumers generally pay a fee, known as a deductible or a co-payment, for physician services, prescriptions and other health care services. With an HMO, consumers can choose from a large selection of primary care physicians within their network. Once selected, most HMOs require that consumers' medical visits begin with the selected physician and that the consumers stay in the HMO network. These plans are licensed by the Knox-Keene Act and the Department of Managed Care.

Point of Service (POS): An HMO product that allows the enrollee to receive a service from a non-HMO provider at a higher cost to the enrollee. The higher cost can take the form of a deductible and/or a higher point-of-service charge.

Preferred Provider Organizations (PPOs): Health plans that negotiate discounted fees with their "preferred providers:" hospitals, doctors and other health care providers. These plans then encourage enrolled members to use the preferred network of providers by offering lower co-payments and other incentives. Enrolled members also have the option of visiting physicians, hospitals and other health care providers outside the network of preferred providers but usually will pay more for out-of-network providers. These plans are licensed by the Knox-Keene Act and governed by the California Department of Insurance.

Provider Types

Primary Care Physician: The physician who assumes responsibility for the comprehensive medical care of an individual on a continuing basis. The physician obtains professional assistance when needed for services he or she is not qualified to provide and coordinates the care provided by other professional personnel or specialists.

Specialty Physician: The physician who assumes responsibility for medical care of an individual for specialized services and generally on a limited basis, usually on referral from a primary care physician.

Compensation Methods

Capitation: Provider is paid a fixed, per capita amount for each person served without regard to the actual number or nature of services provided to each person. Capitation is most common in contracts between plans and medical groups.

Fee For Service (FFS): Provider is paid for each encounter of service rendered. Under fee for service arrangements, expenditures increase if the fees themselves increase, if more units of service are charged or if more expensive services are substituted for less expensive ones. Fee For Service is most common in traditional indemnity and PPO arrangements. There is no coordination through a primary physician.

Salary: A method of payment whereby an individual provider is paid a fixed salary without regard to the actual number or nature of services provided to each person. This form of payment is most common in staff model HMOs and in some medical groups. Groups and IPAs are likely to be paid by capitation. Hospital payment methodologies may vary.

Other Terms

Community Rating: Community rating differs from the current method of "underwritten" ratings for setting health insurance rates. With underwritten ratings, health status is taken into consideration in determining the rate. This helps keep costs down. With community ratings only specified factors, such as age, family status and geography and not health status, can be taken into consideration when setting rates.

Co-payment: The portion of charges the consumer pays to the provider for covered health care services in addition to any deductible.

Consolidated Omnibus Budget Reconciliation Act (COBRA): Act that gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce and other life events. Qualified individuals may be required to pay the entire premium for coverage of up to 102 percent of the cost to the plan.

Deductible: A fixed amount which is deducted from eligible expenses before benefits from the insurer are payable.

Employee Retirement Income Security Act (ERISA): Administered by the U.S. Department of Labor, Employee benefits Security Administration. ERISA regulates employer sponsored pension and insurance plans (self-insured plans) for employees.

Exclusions and/or limitations: Conditions or circumstances spelled out in an insurance policy which limits or exclude coverage benefits.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): HIPAA amended the Employee Retirement Income Security Act (ERISA), to provide new rights and protections for participants and beneficiaries in group health plans. HIPAA includes protections for coverage under group health plans and patient privacy. These protections limit exclusions for preexisting conditions, prohibit discrimination against employees and dependents based on their health status and allow a special opportunity to enroll in a new plan to individuals in certain circumstances. For individuals, HIPAA includes protections that guarantee access to individual policies for people who qualify and guarantee renewability of individual policies. HIPAA also gives consumers the right to access their health information and limits who can look at and receive a person's health information.

Guarantee Issue: A requirement that health plans issue coverage to individuals regardless of pre-existing medical conditions, age or other factors. Forced coverage without regard to medical history could lead to people dropping insurance when they're healthy and resuming coverage only when they are ill or expect to incur health expenses, thus causing medical and health care coverage costs to skyrocket.

Guaranteed Renewability: Term used to describe a provision where a consumer's health insurance cannot be cancelled if they become sick.

Healthy Families Program: A low-cost insurance that provides health, dental and vision coverage to children who do not have insurance today and do not qualify for no-cost Medi-Cal.

Health Savings Accounts (HSAs): Federal accounts created by the Medicare bill signed into law on December 8, 2003. These accounts are designed to help individuals save for future qualified medical and retiree health expenses on a tax-free basis.

Individual Mandate: Requiring all individuals to purchase or obtain some type of medical coverage.

Medicaid: A federally funded, state-run program that provides health insurance coverage to individuals and families with limited incomes and resources.

Medi-Cal: California's Medicaid health care program. This program pays for a variety of medical services for children and adults with limited income and resources. Medi-Cal is supported by federal and state taxes.

Medi-Cal Managed Care: Medi-Cal programs that have networks of providers, including doctors, pharmacies, clinics, labs and hospitals. Consumers must use the providers in the network when they need health care.

Medicare: A federal health insurance program for people age 65 and older, some disabled people younger than age 65 and people with end-stage renal disease (permanent kidney failure treated with dialysis or a transplant).

Managed Risk Medical Insurance Board (MRMIB): A California Health and Human Services Agency board that seeks to improve the health of Californians by providing and promoting access to affordable coverage for comprehensive, high quality, cost-effective health care services. It implements the California Healthy Families program.

Major Risk Medical Insurance Program (MRMIP): Program that provides health insurance for Californians unable to obtain coverage in the individual health insurance market because of their pre-existing conditions. It is administered by MRMIB.

Pre-existing condition: A medical condition a consumer has prior to enrolling in any new group health plan.

State Children's Health Insurance Program (SCHIP): A national program that provides health insurance for families who earn too much money to qualify for Medicaid, yet cannot afford to buy private insurance. The program was created to address the growing number of children in the United States without health insurance. Within broad federal guidelines, each state determines the design of its program, eligibility groups, benefit packages, payment levels for coverage and administrative and operating procedures. SCHIP is financed with state and federal funds. It is known as the Healthy Families program in California.

For more information, please visit www.calhealthplans.org or call (916) 552-2910.