Appendix E: Abbreviations and Glossary of Terms

Abbreviations

FFS —Fee-for-service
GHC -Group Health Cooperative of Puget Sound
HIE —Health Insurance Experiment (Rand Corporation)
HMO —Health maintenance organization
IPA —Independent Practice Association
OTA -Office of Technology Assessment
PAMC —Palo Alto Medical Clinic
POS —Point of service plan
PPO —Preferred provider organization
UMWA —United Mine Workers of America

Terms

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

Balance billing: In fee-for-service health insurance, refers to the practice of billing patients in excess of the amount approved by the health plan.

Benefit design: The determination of the terms of the benefit package.

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 financial and other terms of such coverage (e.g., patient cost-sharing, limitations on amounts and numbers of visits or days). However, a benefit package can be said to consist in total of the terms of the contract between the subscriber or enrollee and the insurer. The terms of payment to health care providers may also be part of the terms of a benefit package.

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

Chronic condition: A problem or disease that is lingering and lasting, as opposed to acute. For purposes of DHHS's *National Health Interview* **Survey, a** condition is considered "chronic" if: 1) the respondent indicates it was first noticed more than 3 months before the reference date of the interview and it exists at the time of the interview, or 2) it is a type of condition that ordinarily has a duration of more than 3 months. Examples of conditions that are considered chronic regardless of their time of onset are Alzheimer's disease, osteoarthritis, diabetes, heart conditions, emphysema, and arthritis.

Clinical Preventive **Services:** Interventions comprising medical procedures, tests, or visits with health care providers that are undertaken for the purpose of promoting health or preventing disease or unwanted health conditions (e.g., pregnancy), not for responding to patient signs, symptoms, or complaints.

Coinsurance: A requirement that insured individuals pay a fried percentage of covered expenses usually after any deductible has been met. For example, an 80-20 coinsurance arrangement means that, after the deductible is reached, 80 percent of covered expenses are paid by the plan and 20 percent are paid by the person covered by the plan. Compare copayment.

Congenital anomalies: Any abnormality, whether genetic or not, that is present at birth.

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

Deductible: The amount of covered health care expenses (e.g., $200, $500, $1,000) that must be incurred by the health plan enrollee and his or her dependents before any health benefits become payable by the health plan. Deductible requirements apply to each individual in a family for a specific time period (usually a year). Some plans specify family deductibles after which no additional individual deductibles are reqiuired; family deductibles are typically equivalent to two or three times the individual deductible.

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 preliminary estimates of poverty thresholds for the continental United States in 1992 were: $7,141 for one person, $9,132 for two persons, $11,187 for three persons, and $14,343 for four persons. Alaska and Hawaii have higher thresholds.

Fee-for-service: In fee-for-semice health care, physicians and other providers bill separately for each patient encounter or service rendered. This system contrasts with salary, per capita, or other prepayment systems, where the payment to the practitioner does not change with the number of services actually rendered.

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. In this report the term includes traditional private indemnity fee-for-service coverage, prepaid health plans such as HMOS, self-funded employment-based health plans, Medicaid, and Medicare.

Health maintenance organizations (HMOS): A health care organization that, in return for prospective per capita (cavitation) payments, acts as both insurer and provider of specified health care services to an enrolled population.

Independent practice association (IPA): A form of HMO in which participating physicians remain in their independent office settings, seeing both enrollees of the IPA and patients covered by other health insurance plans. Participating physicians may be reimbursed by the IPA on a fee-for-service or a cavitation basis.

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: 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 efficiency of health care delivery will improve if independent groups compete with one another for consumers in a government-regulated market.

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, and persons with end-stage renal disease. Medicare consists of two separate but coordinated programs-hospital insurance (Part A) and supplementary medical insurance (Part B).

Nonelderly: Used generally to refer to anyone under age 65. In the Rand Health Insurance Experiment, anyone over age 61 was excluded from participating in the study.

Out-of-pocket expenses or spending: Payments made by an individual for medical services, prescription drugs, and certain medical equipment and supplies. These may include direct payments to providers for uncovered services, or by uninsured people, as well as payments for deductibles and coinsurance for covered services, for provider charges in excess of the plan's limits, and for enrollee premium payments.

Pap smear: A screening test for women for cervical cancer.

Point-of-Service (POS) Plan: A hybrid form of managed care plan based on a mixture of cavitation and fee-for-service (FFS) payment arrangements. POS plans permit health plan enrollees to choose a FFS, PPO, or HMO provider at the time he or she seeks services (rather than at the time they choose to enroll in a health plan).

Preferred provider organization (PPO): Refers to a variety of different insurance arrangements under which plan enrollees who choose to obtain medical care from a specified group of 'preferred' providers receive certain advantages, such as reduced cost-sharing charges. PPO providers typically 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. Premiums paid to health maintenance organizations or similar organizations are often called cavitation payments.

Preventive services: Services intended to prevent the occurrence of a disease or unwanted condition (e.g., pregnancy) or its consequences. Preventive health care includes health care programs aimed at warding off illnesses (e.g., immunizations), early detection of disease (e.g., Pap smears), or inhibiting further deterioration of the body (e.g., exercise or prophylactic surgery). Prevention is also concerned with general preventive measures aimed at improving the healthfulness of the environment and with the promotion of health through altering behavior, especially using health education. Preventive health services are sometimes categorized as primary, secondary, or tertiary. **Primary prevention** is aimed at reducing the incidence of a disease or health problem; **secondary prevention is** aimed at reducing the prevalence of a problem by shortening the duration among those who have the problem; and **tertiary prevention is** aimed at reducing complications.

Provider: See *health care provider,*

Randomized trial: An experiment (e.g., Rand Health Insurance Experiment) designed to test the safety and efficacy of a health technology or the effects of a financing or other intervention in which people are randomly assigned to experimental or control groups, and outcomes are compared.

Single Payer approach: An 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.

Staff-model HMO: In this type of HMO, the majority of health plan enrollees are cared for by physicians who are typically salaried staff of the HMO.

Traditional indemnity plan: A conventional or fee-for-service health plan that typically reimburses the health care provider on a "reasonable and customary' basis or as billed.

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). Measures of utilization of all medical services in any given period are sometimes done in terms of dollar expenditures. Use is also expressed in rates per unit of population at risk for a given time period (e.g., number of admissions to a hospital).

Well-child **care:** Preventive health care for children, including immunizations, health education, parental guidance, physical examinations, and other tests that screen for illness or developmental problems.