
Postgraduate Certificate in Health Economics and Policy

Healthcare Financing and Insurance

Healthcare Financing and Insurance Key Terms and Vocabulary:

Healthcare financing and insurance play a crucial role in ensuring access to quality healthcare services for individuals and populations. Understanding key terms and concepts in this field is essential for policymakers, healthcare providers, insurers, and patients. In this guide, we will explore important terms related to healthcare financing and insurance in the context of the Postgraduate Certificate in Health Economics and Policy.

1. Health Insurance:

Health insurance is a type of coverage that pays for medical and surgical expenses incurred by the insured. It can be provided by private companies, government programs, or a combination of both. Health insurance aims to protect individuals from high healthcare costs and ensure access to necessary medical services.

Health insurance can come in various forms, including:

- Private health insurance: Purchased by individuals or provided by employers.
- Public health insurance: Provided by government programs such as Medicare and Medicaid.
- Managed care plans: Health insurance plans that involve a network of healthcare providers who agree to provide services to plan members at discounted rates.

2. Health Financing:

Health financing refers to the mechanisms used to raise funds for healthcare services and allocate these funds to providers and patients. It involves collecting revenues, pooling resources, and purchasing services to ensure financial protection and access to healthcare for all individuals.

Key components of health financing include:

- Revenue collection: The process of collecting funds from various sources, such as taxes, insurance premiums, and out-of-pocket payments.
- Risk pooling: The aggregation of funds from multiple individuals or entities to cover the costs of healthcare services for those in need.
- Purchasing of services: The allocation of funds to healthcare providers in exchange for delivering healthcare services to the population.

3. Premium:

A premium is the amount of money that an individual or employer pays to an insurance company to purchase a health insurance policy. It is usually paid on a regular basis, such as monthly or annually, to maintain coverage. The premium amount is determined based on various factors, including the individual's

age, health status, and coverage options.

For example, an individual may pay a monthly premium of \$300 for a health insurance policy that covers medical expenses up to a certain limit. The premium helps the insurance company cover the costs of healthcare services provided to the insured.

4. Deductible:

A deductible is the amount of money that an insured individual must pay out of pocket before their health insurance coverage kicks in. For example, if a health insurance policy has a \$1,000 deductible, the insured must pay the first \$1,000 of medical expenses before the insurance company starts covering costs.

Deductibles can vary depending on the insurance plan and coverage options. Higher deductibles are often associated with lower premiums, while lower deductibles may result in higher premium costs.

5. Copayment:

A copayment, or copay, is a fixed amount that an insured individual must pay for a covered healthcare service, such as a doctor's visit or prescription medication. Copayments are typically due at the time of service and are set by the insurance company as part of the policy terms.

For example, a health insurance plan may require a \$25 copayment for a primary care visit and a \$10 copayment for generic prescription drugs. Copayments help share the cost of healthcare services between the insurer and the insured individual.

6. Coinsurance:

Coinsurance is a cost-sharing arrangement in which the insured individual pays a percentage of the cost of a healthcare service, while the insurance company covers the remaining percentage. For example, if a health insurance policy has a 20% coinsurance rate for hospital stays, the insured must pay 20% of the total cost, and the insurance company pays the remaining 80%.

Coinsurance is often applied after the deductible has been met and can vary depending on the type of service or provider. It helps ensure that individuals have some financial responsibility for their healthcare expenses.

7. Out-of-Pocket Costs:

Out-of-pocket costs refer to the expenses that individuals must pay for healthcare services that are not covered by insurance. These costs can include deductibles, copayments, coinsurance, and services that are not included in the insurance plan's coverage.

Out-of-pocket costs can vary significantly depending on the insurance plan and the individual's healthcare needs. High out-of-pocket costs can be a barrier to accessing necessary medical care for some individuals, especially those with chronic conditions or low incomes.

8. Health Equity:

Health equity refers to the absence of unfair and avoidable differences in health outcomes or access to healthcare services among different populations. It involves addressing social determinants of health, such as income, education, and race, to ensure that all individuals have equal opportunities to achieve good health.

Health equity is a key consideration in healthcare financing and insurance, as disparities in access to care can impact health outcomes and overall well-being. Policymakers and stakeholders must work to promote health equity through policies and programs that address systemic barriers to healthcare access.

9. Risk Pooling:

Risk pooling is a fundamental concept in health insurance that involves combining the financial risks of multiple individuals to create a pool of funds that can be used to pay for healthcare services. By spreading the risk across a larger group, insurance companies can protect individuals from high and unpredictable medical expenses.

Risk pooling allows insurers to offer coverage to a diverse population without charging prohibitively high premiums to individuals with pre-existing conditions or high healthcare needs. It helps ensure that healthcare costs are distributed fairly among all insured individuals.

10. Adverse Selection:

Adverse selection occurs when individuals with higher healthcare risks are more likely to purchase insurance coverage than those with lower risks. This can lead to imbalances in risk pools, higher costs for insurers, and potentially higher premiums for all insured individuals.

For example, if individuals with chronic conditions or high healthcare needs are more inclined to purchase health insurance, insurers may face increased claims costs and financial losses. Adverse selection can undermine the stability of insurance markets and make it challenging to offer affordable coverage to all individuals.

11. Moral Hazard:

Moral hazard refers to the phenomenon where individuals may change their behavior or increase their healthcare utilization once they have insurance coverage. This can lead to higher healthcare costs for insurers and potentially unnecessary or excessive use of healthcare services.

For example, someone with health insurance may be more likely to visit the doctor for minor ailments or undergo unnecessary medical tests because they do not bear the full cost of care. Insurers must account for moral hazard when designing insurance plans and pricing premiums to mitigate the impact on overall costs.

12. Value-Based Care:

Value-based care is a healthcare delivery model that focuses on improving patient outcomes while controlling costs. It emphasizes quality of care, patient satisfaction, and efficiency in healthcare delivery, rather than traditional fee-for-service models that reward volume of services provided.

Value-based care initiatives may include:

- Pay-for-performance programs: Incentivizing healthcare providers to achieve specific quality and outcome targets.
- Accountable care organizations (ACOs): Networks of healthcare providers that work together to coordinate care and improve outcomes for patients.
- Bundled payment models: Reimbursing healthcare providers based on the quality and efficiency of care for a specific episode of treatment.

13. Health Technology Assessment (HTA):

Health Technology Assessment (HTA) is a systematic process that evaluates the medical, economic, social, and ethical implications of healthcare technologies, treatments, and interventions. HTA aims to inform decision-making by assessing the value, effectiveness, and feasibility of adopting new technologies in healthcare.

Key components of HTA include:

- Clinical effectiveness: Evaluating the impact of a technology on patient outcomes and health status.
- Cost-effectiveness: Analyzing the economic implications of adopting a technology relative to its benefits.
- Ethical considerations: Addressing ethical dilemmas and social implications associated with the use of new healthcare technologies.

HTA plays a critical role in healthcare policy and decision-making, helping policymakers, providers, and payers make informed choices about the allocation of resources and the adoption of new treatments.

14. Capitation:

Capitation is a payment model in healthcare in which providers receive a fixed amount of money per patient for a defined period, regardless of the services provided. This approach incentivizes providers to deliver cost-effective care and focus on preventive services and population health management.

Under capitation, healthcare providers assume financial risk for the cost of care beyond the fixed payment amount. This can encourage efficiency, coordination of care, and the adoption of value-based practices to improve patient outcomes while controlling costs.

15. Single-Payer System:

A single-payer system is a healthcare financing model in which a single public entity, typically the government, is responsible for collecting funds and paying for healthcare services for all residents. This system aims to achieve universal coverage, simplify administration, and control costs through a centralized financing mechanism.

Countries with single-payer healthcare systems include Canada, the United Kingdom, and Taiwan. While single-payer systems can provide broad coverage and reduce administrative overhead, they also face challenges related to funding, resource allocation, and political considerations.

16. Multi-Payer System:

A multi-payer system is a healthcare financing model in which multiple public and private entities, such as insurance companies, employers, and government programs, contribute funds and administer coverage for healthcare services. This system allows for diverse coverage options, competition among insurers, and choice for consumers.

The United States has a multi-payer healthcare system, with a mix of private insurance, employer-sponsored plans, government programs like Medicare and Medicaid, and state-based exchanges. Multi-payer systems can offer flexibility and choice but may also lead to disparities in coverage and access to care.

17. Fee-for-Service:

Fee-for-service is a reimbursement model in healthcare in which providers are paid based on the volume of services they deliver. Under this model, providers bill for each individual service or procedure performed, and insurers reimburse them at a predetermined rate.

Fee-for-service reimbursement can incentivize overutilization of services, fragmented care delivery, and focus on quantity rather than quality. To address these challenges, payers are increasingly moving towards value-based payment models that reward providers for delivering high-quality, cost-effective care.

18. Value-Based Payment:

Value-based payment models are reimbursement mechanisms in healthcare that link provider payments to the quality, efficiency, and outcomes of care delivered. These models aim to incentivize high-value care, improve patient outcomes, and reduce unnecessary costs associated with fragmented or low-quality care.

Examples of value-based payment models include:

- Pay-for-performance: Providing financial incentives to providers who meet specific quality and outcome targets.
- Bundled payments: Reimbursing providers a fixed amount for an episode of care, encouraging coordination and efficiency.
- Accountable care organizations (ACOs): Rewarding networks of providers for achieving cost savings and quality improvements for a defined patient population.

Value-based payment models are gaining traction as healthcare systems seek to improve care delivery, enhance patient experience, and control rising healthcare costs.

19. Risk Adjustment:

Risk adjustment is a method used in healthcare financing to account for differences in the health status and healthcare needs of individuals when determining payment amounts to providers or insurers. It aims to ensure fair and accurate reimbursement based on the risk profile of the patient population served.

Risk adjustment models consider factors such as age, gender, health conditions, and social determinants of health to predict healthcare costs and adjust payment rates accordingly. By accounting for risk, risk

adjustment helps prevent insurers from avoiding high-risk individuals and promotes equity in healthcare financing.

20. Social Determinants of Health:

Social determinants of health are the conditions in which people are born, grow, live, work, and age that influence their health outcomes and access to healthcare services. These factors include socioeconomic status, education, housing, environment, and access to resources and support systems.

Addressing social determinants of health is essential for promoting health equity and improving population health outcomes. Healthcare financing and insurance policies must consider these factors to ensure that all individuals have equal opportunities to achieve good health and access quality care.

By familiarizing yourself with these key terms and concepts related to healthcare financing and insurance, you can better understand the complexities of health economics and policy and contribute to informed decision-making in the field. Whether you are a healthcare provider, policymaker, insurer, or patient, having a solid grasp of these terms will empower you to navigate the evolving landscape of healthcare systems and drive positive change in the delivery and financing of healthcare services.