

Glossary of Health Policy Terms



Affordable Care Act (ACA) – The health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is used to refer to the final, amended version of the law.

Accountable Care Organization (ACO) – A group of health care providers who provide coordinated care, chronic disease management, and thereby improve the quality of care patients receive. The organization’s payment is tied to achieving health care quality goals and outcomes that result in cost savings.

Advance Directive – A legal document detailing individuals’ health care wishes, including the person to whom they give the legal authority to act on their behalf and what types of treatment they do and do not want to receive in the event they are unable to speak or communicate.

Adverse Selection – People with a higher-than-average risk of needing health care are more likely than healthier people to seek health insurance. Health coverage providers strive to maintain risk pools of people whose health, on average, is the same as that of the general population. Adverse selection results when the less healthy people disproportionately enroll in a risk pool.

Aged, Blind, Disabled (ABD) – A Medicaid designation that assists with medical expenses for poor individuals who are aged 65 years or older, blind or disabled (disability as classified by the Social Security Administration for an adult or child).

Bundled Payments – Use of a single payment for all services related to a treatment or condition, possibly spanning multiple providers in multiple settings. (Also referred to as case rates or episode-based payment).

Capitation – A method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person served without regard to the actual number or nature of services provided to each person in a set period of time.

Case Management – A process where a health plan identifies covered individuals with specific health care needs (usually for individuals who need high-cost or extensive services or who have a specific diagnosis) and devises and carries out a coordinated treatment plan.

Catastrophic Coverage – A coverage option with limited benefits and a high deductible. These plans are usually geared toward young adults in relatively good health. Under health reform, these plans will be required to exempt some preventive care services from the deductible.

Categorically Needy – Medicaid’s eligibility pathway for individuals who can be covered. There are more than 25 eligibility categories organized into five broad groups: children, pregnant women, adults with dependent children, individuals with disabilities and the elderly. Persons not falling into one of these groups (notably childless adults) cannot qualify for Medicaid no matter how low their income. The ACA simplifies Medicaid eligibility, expanding coverage to all adults up to 138% of FPL (133% + 5% income disregard). This will extend eligibility to an estimated 560,000 Ohioans.

Centers for Medicare and Medicaid Services (CMS) – The federal agency within the Department of Health and Human Services that directs the Medicare and Medicaid programs (Titles XVIII and XIX of the Social Security Act). Formerly the Health Care Financing Administration (HCFA). www.cms.gov

Certificate of Need (CON) – A certificate issued by a governmental body to an individual or organization proposing to construct or modify a health facility, acquire major new medical equipment, modify a health facility or offer a new or different health service. CON is intended to control expansion of facilities, services and costs by preventing excessive or duplicative development of facilities and services.

Children's Health Insurance Program (CHIP)

– Enacted in 1997, CHIP is a federal-state program that provides health care coverage for uninsured low-income children who are not eligible for Medicaid. States have the option of administering CHIP through their Medicaid programs or through a separate program (or a combination of both). The federal government matches state spending for CHIP but federal CHIP funds are capped. Formerly known as **SCHIP**, or State Children's Health Insurance Program, the name was changed when the program was reauthorized in 2009.

CLASS Act – The ACA creates the Community Living Assistance Services and Support (CLASS) Act, which is a national, voluntary long-term care insurance program that will be available after October 2012 to help pay for services and supports to help maintain independence in the community. People over age 18 who are working will have the opportunity to enroll. Enrollees (after contributing to the program for five years) who the program determines have functional limitations expected to last at least 90 days and who meet other eligibility requirements will get a cash benefit to help pay for supports to stay independent. These limitations include needing help with many basic daily living activities such as eating and getting in and out of bed. The minimum average daily benefit will be \$50 a day.

Co-Insurance – A method of cost-sharing in health insurance plans in which the plan member is required to pay a defined percentage of their medical costs after the deductible has been met.

Consolidated Omnibus Budget Reconciliation Act (COBRA) – A 1986 act containing certain health benefit provisions that amend ERISA, the IRS code and the Public Health Service Act to enable qualified individuals who lose their job to maintain the group coverage in which they were enrolled for an additional 18 months after leaving employment. Individuals are required to pay the standard premium of their previously provided plan. Applies to firms with more than 20 employees.

Consumer-Driven Health Care – Most commonly used to describe the combination of a high-deductible health insurance plan with a tax-preferred savings account used to pay for routine health care expenses.

Community Rating – A method for setting premium rates under which all policy holders are charged the same premium for the same coverage. “Modified community rating” generally refers to a rating method under which health insuring organizations are permitted to vary premiums based on specified demographic characteristics (e.g. age, gender, location), but cannot vary premiums based on the health status or claims history of policy holders.

Under health reform, beginning in 2014, health plans will be required to adopt modified community rating. Variations in premiums will only be allowed for differences in geography, family structure, age (limited to a 3 to 1 ratio) and tobacco use (limited to a 1.5 to 1 ratio).

Co-Payment – A fixed dollar amount paid by an individual at the time of receiving a covered health care service from a participating provider. The required fee varies by the service provided and by the health plan.

Cost-Shifting – Recouping the cost of providing uncompensated care by increasing revenues from some payers to offset losses and lower net payments from other payers. For example, hospitals may increase charges for some payers to offset losses due to uncompensated or indigent care or lower payments (e.g., Medicaid or Medicare) from other payers.

Creditable Coverage – Health insurance that must meet minimum standards.

Crowd-Out – A phenomenon whereby new public programs or expansions of existing public programs designed to extend coverage to the uninsured prompt some privately insured persons to drop their private coverage and take advantage of the expanded public subsidy.

Deductible – A set amount of medical expenses a patient must pay before being eligible for benefits under an insurance program.

Department of Health and Human Services (HHS) – HHS is the U.S. government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. Many HHS-funded services, including Medicare, are provided at the local level by state or county agencies or through private sector grantees. The department's programs are administered by 11 operating divisions, including eight agencies in the U.S. Public Health Service and three human services agencies.

Diagnostic Related Group (DRG) – A system used to classify patients (especially Medicare beneficiaries) for the purpose of reimbursing hospitals. Under the system, hospitals are paid a fixed fee for each case in a given category, regardless of the actual costs.

Disease Management – A process of identifying and delivering within selected patient populations (e.g., patients with asthma or diabetes) the most efficient, effective combination of resources, interventions or pharmaceuticals for the treatment or prevention of a disease.

Disproportionate Share Hospital Program (DSH)

– A federal program that works to increase health care access for the poor. Hospitals that treat a “disproportionate” number of Medicaid and other indigent patients qualify for higher Medicaid payments based on the hospital’s estimated uncompensated cost of services to the uninsured.

Doughnut Hole – A gap in prescription drug coverage under Medicare Part D, where beneficiaries enrolled in Part D plans pay 100% of their prescription drug costs after their total drug spending exceeds an initial coverage limit until they qualify for catastrophic coverage. The coverage gap will be gradually phased out under health reform, so that by 2020, beneficiaries will only be responsible for 25% of all prescription drug costs up to the catastrophic level.

Dual Eligible – A person who is eligible for two health insurance plans, often referring to a Medicare beneficiary who also qualifies for Medicaid benefits.

Electronic Medical Record (EMR) – An individual medical record that has been digitized and stored electronically.

Emergency Medical Service (EMS) – Services utilized in responding to the perceived individual need for immediate treatment for medical, physiological, or psychological illness or injury.

Emergency Medical Treatment and Active Labor Act (EMTALA) – A United States Act of Congress passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) requiring hospitals and ambulance services to provide care to anyone needing emergency treatment regardless of citizenship, legal status or ability to pay.

Employee Retirement Income Security Act (ERISA) – A federal act passed in 1974 that established new standards and reporting/disclosure requirements for employer-funded pension and health benefit programs. To date, self-funded health benefit plans operating under ERISA are exempt from state insurance laws.

Essential Benefits – As specified in the ACA, plans in the health insurance exchange are required to offer coverage for “essential benefits” that must include: emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, preventive and wellness services and chronic disease management, and pediatric services (including pediatric oral and vision care).

Federal Medical Assistance Percentage (FMAP) – The statutory term for the federal Medicaid matching rate—i.e., the share of the costs of Medicaid services or administration that the federal government bears. The

American Recovery and Reinvestment Act (ARRA) provided a temporary increase in the FMAP (also known as enhanced FMAP or **eFMAP**) through December 31, 2010, and additional legislation partially extends this funding through June 30, 2011.

Federal Poverty Level (FPL) – Annually updated guidelines established by the U.S. Department of Health and Human Services to determine eligibility for various federal and state programs. In 2011, the FPL for a family of four is \$22,350.

Federally-Qualified Health Center (FQHC) – A health center in a medically under-served area or population that is eligible to receive cost-based Medicare and Medicaid reimbursement and provides direct reimbursement to nurse practitioners, physician assistants and certified nurse midwives. FQHCs are sometimes referred to as CHCs (Community Health Centers). A CHC is an ambulatory health care program usually serving a catchment area that has scarce or non-existent health services or a population with special needs.

Fee-for-Service – A traditional method of paying for medical services under which doctors and hospitals are paid for each service they provide. Bills are either paid by the patient, who then submits them to the insurance company, or are submitted by the provider to the patient's insurance carrier for reimbursement.

Flexible Spending Account (or a Section 125 option) – An employer-sponsored benefit plan that enables employees to use pretax (tax free) dollars to pay for medical expenses or the cost of care for children or elderly dependents, up to legislated limits and within specific guidelines.

Formulary – see **Preferred Drug List**

Grandfathered Plan – A health plan that was in place on March 23, 2010, when the health reform law was enacted, is exempt from complying with some parts of the health reform law, so long as the plan does not make significant changes to its policy. Once a health plan makes changes to its policy, the policy becomes subject to all the requirements of health reform.

Guaranteed Issue – Requires insurers to offer and renew coverage, without regard to health status, use of services, or pre-existing conditions. This requirement ensures that no one will be denied coverage for any reason. Beginning in 2014, the health reform law will require guarantee issue and renewability.

Health Information Exchange (HIE) – Health Information Exchange is the transmission of healthcare-related data among facilities, health information organizations and government agencies according to national standards.

Health Information Technology (HIT) – The secure sharing of medical information to assist health care providers in managing patient care. HIT includes the use of electronic medical records (EMRs) instead of paper medical records to maintain people's health information.

Health Insurance Exchange – A way to pool risk, the Health Insurance Exchange is a competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Exchanges offer a choice of health plans that meet certain benefits and cost standards. An example of this arrangement is the Commonwealth Connector, created in Massachusetts in 2006. Under the ACA, states will have the option to either establish their own exchanges or participate in a national exchange starting in 2014.

Health Insurance Exchange Navigators – Exchanges will be required to contract with professional associations and local organizations to provide Exchange Navigator services. These services include providing education and information about qualified health plans that is culturally and linguistically appropriate; distributing fair and impartial information about enrollment; facilitating enrollment in health plans; and providing referrals for any enrollee with a grievance, complaint, or question regarding a health plan.

Health Insurance Exchange Plans – The Health Insurance Exchanges established under the ACA must offer four levels of coverage (bronze, silver, gold, platinum plans) based on the plan's actuarial value.

Health Insurance Portability & Accountability Act (HIPAA) – Passed by Congress in 1996, HIPAA includes various health insurance coverage and patient privacy protections. The privacy rules were established to protect patients' privacy through the strict enforcement of confidentiality of medical records and other health information provided to health plans, doctors, hospitals and other health care providers.

Health Maintenance Organization (HMO) – A health insurance plan that provides a coordinated array of preventive and treatment services for a fixed payment per month. HMOs provide services through a panel of health care providers. Enrollees receive medically necessary services regardless of whether the cost of those services exceeds the premium paid on the enrollees' behalf.

Health Professional Shortage Area (HPSA) – HPSAs may be designated as having a shortage of primary medical care, dental or mental health providers. They may be urban or rural areas, population groups or medical or other public facilities.

Health Reimbursement Account (HRA) – A tax-exempt account that can be used to pay for current or future qualified health expenses. HRAs are established benefit plans funded solely by employer contributions, with no limits on the amount an employer can contribute. HRAs are often paired with a high-deductible health plan, but do not have to be. Also known as a Health Reimbursement Arrangement.

Health Resources and Services Administration (HRSA) – An agency of the U.S. Department of Health and Human Services (HHS), HRSA is the primary federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable.

Health Savings Account (HSA) – An HSA is a tax-exempt savings account for medical expenses. Funds can be withdrawn from an HSA to meet the deductible of the HDHP (see below) and pay for other medical services and supplies.

High Deductible Health Plan (HDHP) – An HDHP is an inexpensive health insurance plan that generally does not pay for the first several thousand dollars of health care expenses (i.e., the “deductible”) but will generally cover medical care after the deductible is met. HDHPs may have first-dollar coverage (no deductible) for preventive care and apply higher out-of-pocket limits (and co-pays and coinsurance) for non-network services.

High-Risk Pool – A subsidized health insurance pool organized by some states as an alternative for individuals who have been denied health insurance because of a medical condition, or whose premiums are rated significantly higher than the average due to health status or claims experience. Under federal health reform, Ohio has established a high-risk pool that is being administered by Medical Mutual of Ohio. <http://www.ohiohighriskpool.com/>

Home and Community-Based Services (HCBS) – Any care or services provided in a patient's place of residence or in a non-institutional setting located in the immediate community.

Hospice – A facility or program designed to care for patients in the terminal phase of an illness.

Individual Mandate – The requirement that all individuals must obtain health care insurance or pay a penalty. The individual mandate will be in place by 2014, although some exceptions do apply (financial hardship, religious reasons). The penalty, in the form of a tax, will be \$95 per individual or up to 1% taxable income in 2014, whichever is lower. It increases to \$325 or up to 2% taxable income in 2015 and \$695 or up to 3% taxable income in 2016.

Katie Beckett Children – Disabled children who qualify for home care coverage under a special provision of Medicaid, named after

a girl who remained institutionalized solely to continue Medicaid coverage before the provision's enactment. Also known as a "Deeming Waiver."

Long-Term Care (LTC) – A set of health care, personal care and social services provided to persons who have lost, or never acquired, some degree of functional capacity (e.g., the chronically ill, aged, disabled, or retarded) in an institution or at home, on a long-term basis.

Managed Care – health care systems that integrate the financing and delivery of appropriate health care services to covered individuals. Managed care systems arrange with selected providers to furnish a comprehensive set of health care services.

Medicaid – A federally-aided, state-administered and jointly-funded health insurance program that provides medical benefits to qualified indigent or low-income persons in need of health and medical care. The program is subject to broad federal guidelines and states determine the benefits covered and methods of administration.

Medical Home – An approach to providing comprehensive primary care that facilitates partnerships between individual patients, and their personal providers, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health

information exchange and other means to assure that patients get the indicated care when and where they need it in a culturally and linguistically appropriate manner.

Medical Loss Ratio (MLR) – The percentage of premium dollars an insurance company spends on medical care, as opposed to administrative costs or profits. The health reform law requires insurers in the large group market to have an MLR of 85% and insurers in the small group and individual markets to have an MLR of 80%.

Medicare – A federally funded health insurance plan that provides hospital, surgical and medical benefits to elderly persons over 65 and certain disabled persons. Medicare Part A provides basic hospital insurance, and Medicare Part B provides benefits for physicians' professional services. Medicare Part C (Medicare Advantage Plan) allows those covered to combine their coverage under Parts A and B but is provided by private insurance companies. Medicare Part D helps pay for medications doctors prescribe for treatment.

Patient Self Determination Act (PSDA) – A federal law passed by the U.S. Congress in 1990, mandates that most hospitals provide patients with information on state laws regarding their right to refuse medical treatment and document their preferences through an advance directive.

Pay-for-Performance – A health care payment system in which providers receive incentives for meeting or exceeding quality and cost benchmarks. Some systems also penalize providers who do not meet established benchmarks. The goal of pay for performance programs is to improve the quality of care over time.

Pharmaceutical Assistance Program – A program to provide pharmaceutical coverage to those who cannot afford or have difficulty obtaining prescription drugs. Several states, including Ohio, operate state-funded pharmaceutical assistance programs which primarily provide benefits to low-income elderly or persons with disabilities who do not qualify for Medicaid. (<http://www.rxforohio.org/>)

Pharmacy Benefit Manager (PBM) – Companies that manage drug benefit coverage for employees and health plan members.

Preferred Drug List (PDL) – A list of prescription drugs which are covered by a health plan or other payer (e.g., Medicaid). Also known as a formulary.

Preferred Provider Organization (PPO) – A health insurance plan in which health care providers agree to provide services to members at a negotiated price. Covered individuals (members) receive all medically necessary services regardless of whether the cost of the services exceeds the premium paid, although members do have cost sharing obligations.

Primary Care Provider (PCP) – In insurance terms, a physician selected by or assigned to a patient who provides general care and supervises the patient's access to other medical services.

Prior Authorization – Under a system of utilization review, a requirement imposed by a health plan or third party administrator that a provider justify the need for delivering a particular service in order to receive reimbursement. Prior authorization may apply to all services or only to those that are potentially expensive and/or overused.

Rural Health Clinic – A public or private hospital, clinic, or physician practice designated by the federal government as in compliance with the Rural Health Clinics Act (Public Law 95-210). The practice must be located in a medically underserved area or a Health Professional Shortage Area (HPSA) and use physician assistants and/or nurse practitioners to deliver services.

Rural Health Network – Refers to any variety of organizational arrangements to link rural health care providers in a common purpose.

Safety Net – The safety net is made up of providers and institutions that provide low cost or free medical care to medically needy, low income or uninsured populations.

Supplemental Security Income (SSI) – A federally funded cash assistance program for low-income elderly, blind and disabled individuals who have little or no income with basic needs, such as food, clothing and shelter. Once eligible for SSI, these individuals are also eligible for Medicaid.

Trauma System – A trauma system is an organized, coordinated effort in a defined geographic area that delivers the full range of emergency care to all injured patients and is integrated with the local public health system.

Uncompensated Care – Service provided by physicians and hospitals for which no payment is received from the patient or from third-party payers.

Underinsured – People with public or private insurance policies that do not cover all necessary health care services, resulting in out-of-pocket expenses that exceed their ability to pay.

Uninsurables – High-risk persons who do not have health care coverage through private insurance and who fall outside the parameters of risks of standard health underwriting practices.

Uninsured – People who lack public or private health insurance.

Utilization – Commonly examined in terms of patterns or rates of use of a single service or type of service (e.g., hospital care, physician visits, and prescription drugs). Use is also expressed in rate per unit of population at risk for a given period of time.

Utilization Review – The critical examination, usually conducted by an insurer or third party administrator, of the necessity and/or appropriateness of the health care services provided to an individual patient.

Value-Based Purchasing – A payment reform under which hospitals and other providers are provided bonuses based upon their performance against quality measures. The health reform law establishes a value-based purchasing program in Medicare for hospitals and requires the development of similar programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers, and the testing of pilot programs for other providers.

Acronym Appendix

ABD: Aged, Blind or Disabled

ACA: Affordable Care Act (federal health reform law)

ACO: Accountable Care Organization

CDHP: Consumer-Driven Health Plans

CHIP: Children's Health Insurance Program

CMS: Centers for Medicare and Medicaid Services

CON: Certificate of Need

DME: Durable Medical Equipment

DRG: Diagnosis Related Groups

DSH: Disproportionate Share Hospitals

EMR: Electronic Medical Records

FMAP: Federal Medical Assistance Percentage

FQHC: Federally Qualified Health Center

HCBS: Home and Community Based Services

HDHP: High-Deductible Health Plan

HIPAA: Health Insurance Portability & Accountability Act

HIT: Health Information Technology

HPIO: Health Policy Institute of Ohio

HPSA: Health Professional Shortage Area

MCH: Maternal and Child Health

MLR: Medical Loss Ratio

ODDAAS: Ohio Department of Drug and Alcohol Addiction Services

ODH: Ohio Department of Health
ODI: Ohio Department of Insurance
ODJFS: Ohio Department of Job and Family Services
ODMH: Ohio Department of Mental Health
P4P: Pay-for-Performance
PCP: Primary Care Physician
PBM: Pharmacy Benefit Manager
PPO: Preferred Provider Organization
SN: Special Needs
SNF: Skilled Nursing Facility
TANF: Temporary Assistance for Needy Families

Sources



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About HPIO

The Health Policy Institute of Ohio is a 501 (c)3 nonprofit organization that serves as Ohio's nonpartisan, independent source for forecasting health trends, analyzing key health issues, and communicating current research to policymakers, state agencies and other decision-makers.

Since its founding in 2003, HPIO has become the state's trusted source of information and leadership on health policy issues. HPIO's mission is to provide nonpartisan, unbiased research, analysis and communication that enables policymakers to make the most informed decisions possible on matters that affect the health of all Ohioans.

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