

UNIVERSAL HEALTHCARE COUNCIL 2013 GLOSSARY OF TERMS

access - The patient's ability to obtain medical care. The ease of access is determined by such components as the availability of medical services and their acceptability to the patient, the location of health care facilities, transportation, hours of operation and cost of care. Barriers to access can be financial (insufficient monetary resources), geographic (distance to providers), organizational (lack of available providers) and sociological (e.g., discrimination, language barriers).

actuarial value - Statistical calculations used to determine the managed care company's rates and premiums charged their customers based on projections of utilization and cost for a defined population.

acute care - A pattern of health care in which a patient is treated for an acute (immediate and severe) episode of illness, for the subsequent treatment of injuries related to an accident or other trauma, or during recovery from surgery.

adverse selection - A tendency for utilization of health services in a population group to be higher than average or the tendency for a person who is in poor health to be enrolled in a health plan where he or she is below the average risk of the group. From an insurance perspective, adverse selection occurs when persons with poorer-than-average health status apply for, or continue, insurance coverage to a greater extent than do persons with average or better health expectations.

Affordable Care Act (ACA, PPACA, Obamacare, Health Reform) – A set of federal laws passed in March of 2010, aimed at reducing health care costs and increasing access to care.

ancillary services - Auxiliary or supplemental services, such as diagnostic services, home health services, physical therapy, and occupational therapy, used to support diagnosis and treatment of a patient's condition.

ambulatory care - Health services provided without the patient being admitted. Also called outpatient care. The services of ambulatory care centers, hospital outpatient departments, physicians' offices and home health care services fall under this heading provided that the patient remains at the facility less than 24 hours.

benefit design - The process an organization uses to determine which benefits or the level of benefits that will be offered to its members, the degree to which members will be expected to share the costs of such benefits, and how a member can access medical care through the health plan.

benefit package - Aggregate services specifically defined by an insurance policy or HMO that can be provided to patients. The services a payer offers to a group or individual. The package will specify include cost, limitation on the amounts of services, and annual or lifetime spending limits.

bronze plan – A health insurance plan available through the bronze tier of the state Health Insurance Exchange. Bronze plans have an actuarial value of 60%, meaning that the plan covers 60% of the beneficiary's health costs.

benefit tiers – Plans on the state Health Insurance Exchanges are made available in four tiers, based on the plan's actuarial value (AV). The tiers are: bronze (60% AV), silver (70% AV), gold (80% AV), and platinum (90% AV).

capitation - A method of paying for healthcare services on the basis of the number of patients who are covered for specific services over a specified period of time rather than the cost or number of services that are actually provided.

case management - A process of identifying plan members with special healthcare needs, developing a health-care strategy that meets those needs, and coordinating and monitoring the care, with the ultimate goal of achieving the optimum healthcare outcome in an efficient and cost-effective manner.

catastrophic coverage– A high deductible plan, meaning low premiums but high out-of-pocket costs, available through Covered California. Only people under 30 years old may purchase such plans.

co-insurance – A cost-sharing arrangement in which a plan beneficiary is responsible for a certain percentage of health care costs. In an 80/20 plan, the insurer pays 80% of costs and the beneficiary pays 20%. It is possible for a plan to have both co-insurance and co-payments.

co-payment - A cost-sharing arrangement in which an enrollee pays a specified flat amount for a specific service (such as \$10 for an office visit or \$5 for each prescription drug). The amount paid must be nominal to avoid becoming a barrier to care. It does not vary with the cost of the service and is usually a flat sum amount

such as \$10 for every prescription or doctor visit, unlike co-insurance that is based on a percentage of the cost.

cost sharing - Payment method where a person is required to pay some health costs in order to receive medical care. The general set of financing arrangements whereby the consumer must pay out-of-pocket to receive care, either at the time of initiating care, or during the provision of health care services, or both. This includes deductibles, co-insurance and copayments, but not the share of the premium paid by the person enrolled.

cost sharing subsidies – Federal assistance for out-of-pocket health care costs, available to those earning between 133-250% of FPL and purchasing plans on the state Health Insurance Exchange. Eligible persons may qualify for both cost sharing subsidies and premium tax credits.

coverage – Health insurance

Covered California – The name of California's state health insurance exchange, which will be operative January 1, 2014.

deductible - A flat amount a plan enrollee must pay before the insurer will make any benefit payments. Deductibles may also be met through cost sharing arrangements.

defined contribution coverage - A payment process for procurement of health benefit plans whereby employers contribute a specific dollar amount toward the costs of insurance coverage for their employees. Sometimes this includes an undefined expectation of guarantee of the specific benefits to be covered.

defined contribution health plan - Health Plans that involve employer funding of a fixed (as opposed to variable) dollar amount for health benefits, which employees may then use to purchase benefits from an employer arranged funding mechanism. The benefits could either be group benefits packaged and arranged by the employer, or purchased individually by the employees. See also Variable Contribution Health Plan.

emergency - Sudden unexpected onset of illness or injury which requires the immediate care and attention of a qualified physician, and which, if not treated immediately, would jeopardize or impair the health of the Member, as determined

by the payer's Medical Staff. Significant in that Emergency may be the only acceptable reason for admission without pre-certification.

Emergency Medical Treatment and Labor Act (EMTALA) - An act pertaining to emergency medical situations. EMTALA requires hospitals to provide emergency treatment to individuals, regardless of insurance status and ability to pay.

Employee Retirement Income Security Act of 1974 (ERISA) - Also called the Pension Reform Act, this act regulates the majority of private pension and welfare group benefit plans in the U.S. It sets forth requirements governing, among many areas, participation, crediting of service, vesting, communication and disclosure, funding, and fiduciary conduct. ERISA exempts most large self-funded plans from State regulation and, hence, from any reform activities undertaken at state level--which is now the arena for much healthcare reform.

Employer Mandate – Also known as Employer Shared Responsibility, requires businesses with more than 50 full-time equivalent employees to offer health insurance to full-time employees, beginning in 2015. Employers who do not offer or offer unaffordable coverage, face annual penalties if their employees purchase insurance on the state Health Exchange and receive federal subsidies to do so.

Employer Spending Requirement (ESR) – Under San Francisco's Health Care Security Ordinance, effective 2008, certain San Francisco employers must make minimum expenditures to help qualifying employees access health care.

enrollee (also beneficiary; individual; member) - Any person eligible as either a subscriber or a dependent for service in accordance with a contract.

Essential Health Benefits (EHB) – Beginning in 2014, all non-grandfathered small group and individual health plans must provide a benefits package that includes services from ten benefit categories identified by the ACA. EHB categories are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

excepted benefits – Refers to certain types of benefits that are exempt from some market reform provisions of the ACA. Examples include plans that only offer dental or vision coverage, or are retiree-only.

federal poverty level (FPL) – The U.S. Department of Health and Human Services publishes annual poverty guidelines based on household size and income. For 2013 -14, an individual earning \$11,490 per year, or a family of four earning \$23,550, is at 100% of the federal poverty level (FPL). Under the Affordable Care Act, Medi-Cal will expand eligibility to cover everyone below 133% of FPL, and those between 133-400% of FPL will qualify for subsidies on Covered California.

2013-2014 Federal Poverty Guidelines by Household Size and Income						
	Federal Poverty Level (FPL)					
	100%	133%	150%	200%	300%	400%
Household Size	Income (\$)					
	Annual		Monthly			
1	\$11,490	\$15,282	\$17,235	\$22,980	\$34,470	\$45,960
	958	1,274	1,436	1,915	2,873	3,830
2	15,510	20,628	23,265	31,020	46,530	62,040
	1,293	1,719	1,939	2,585	3,878	5,170
3	19,530	25,975	29,295	39,060	58,590	78,120
	1,628	2,165	2,441	3,255	4,883	6,510
4	23,550	31,322	35,325	47,100	70,650	94,200
	1,963	2,610	2,944	3,925	5,888	7,850
5	27,570	36,668	41,355	55,140	82,710	110,280
	2,298	3,056	3,446	4,595	6,893	9,190
6	31,590	42,015	47,385	63,180	94,770	126,360
	2,633	3,501	3,949	5,265	7,898	10,530
7	35,610	47,361	53,415	71,220	106,830	142,440
	2,968	3,947	4,451	5,935	8,903	11,870
8	39,630	52,708	59,445	79,260	118,890	158,520
	3,303	4,392	4,954	6,605	9,908	13,210
For each additional person, add	\$4,020 335	\$5,347 446	\$6,030 503	\$8,040 670	\$12,060 1,005	\$16,080 1,340

Federally Qualified Health Center (FQHC) - A federal payment option that enables qualified providers in medically underserved areas to receive cost-based Medicare

and Medicaid reimbursement and allows for the direct reimbursement of nurse practitioners, physician assistants and certified nurse midwives. Many outpatient clinics and specialty outreach services are qualified under this provision that was enacted in 1989.

fee-for-service (FFS) payment system - A system in which the insurer will either reimburse the group member or pay the provider directly for each covered medical expense after the expense has been incurred.

gold plan – A health insurance plan available through the bronze tier of the state Health Insurance Exchange. Gold plans have an actuarial value of 80%, meaning that the plan covers 80% of the beneficiary's health costs.

grandfathered plan – A health insurance plan in existence before 2010, which is exempt from meeting some benefits and cost sharing provisions under the ACA. A plan may retain grandfathered status until it makes substantial changes to premiums, benefits, or cost sharing arrangements.

eligibility – Determination of one's qualifications for participation in public insurance programs, federal subsidies, etc.

health - The state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. It is recognized, however, that health has many dimensions (anatomical, physiological, and mental) and is largely culturally defined. The relative importance of various disabilities will differ depending upon the cultural milieu and the role of the affected individual in that culture. Most attempts at measurement have been assessed in terms of morbidity and mortality.

health benefits package - The services and products a health plan offers.

health care, healthcare - Care, services, and supplies related to the health of an individual. Health care includes preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, among other services. Healthcare also includes the sale and dispensing of prescription drugs or devices.

Health Care Security Ordinance (HCSO) – A local law unanimously passed by the Board of Supervisors in 2006, which created Healthy San Francisco and the Employer Spending Requirement.

health insurance - Financial protection against the health care costs of the insured person; may be obtained in a group or individual policy through one's employer or through a health insurance exchange.

health insurance exchange – An online health insurance marketplace set up by the state, where individuals and small businesses may compare and purchase plans. California's Exchange is called Covered California.

health insurance plans – Health insurance plans can be broadly divided into two large categories: (1) indemnity plans (also referred to as "reimbursement" plans), and (2) managed care plans.

indemnity plans

An indemnity plan reimburses you for your medical expenses regardless of who provides the service, although in some cases the reimbursement amount may be limited. The coverage offered by most traditional insurers is in the form of an indemnity plan.

managed care plans

There are three basic types of managed care plans: (1) Health Maintenance Organizations (HMOs), (2) Preferred Provider Organizations (PPOs), and (3) Point of Service (POS) plans. Although there are important differences between the different types of managed care plans, there are similarities as well. All managed care plans involve an arrangement between the insurer and a selected network of health care providers (doctors, hospitals, etc.). All offer policyholders significant financial incentives to use the providers in that network.

Health Insurance Accountability and Portability Act (HIPAA) - Passed in 1996, this federal law regulates how employee health benefit plans are treated upon termination of employment, and sets national privacy standards for medical records and health care transactions.

health plan - An entity that assumes the risk of paying for medical treatments, i.e. uninsured patient, self-insured employer, payer, or HMO.

health reimbursement account (HRA) – A type of tax exempt reimbursement account used for qualified health care expenses. Only employers may contribute to an HRA, and while the funds may roll over from year to year, the funds ultimately belong to the employer. Under the ACA, HRAs are allowed if coupled with a group health plan, if used to reimburse only dental or vision expenses, or if used to cover only retirees.

health savings account (HSA) – A type of tax exempt reimbursement account that must be linked to a high-deductible health plan, and funds may be used toward out-of-pocket health care costs. While employers and employees may both contribute to an HSA, up to an annual limit determined by the IRS, the funds belong to the employee (i.e. they roll over from year to year and do not revert to the employer upon termination of employment).

Individual Mandate – Also known as Individual Shared Responsibility, requires all non-exempt persons to carry health insurance, starting 2014. Those who choose to go without insurance face annual penalties.

inpatient care - Care given a registered bed patient in a hospital, nursing home or other medical or post acute institution.

Medicaid - Medicaid is a health insurance program for people with low income. It was created in 1965 as a joint federal-state program to provide medical assistance to aged, disabled, or blind individuals (or to needy, dependent children) who could not otherwise afford the necessary medical care.

Medicaid Expansion – Refers to ACA reform that allows state Medicaid programs to cover previously ineligible populations. Starting 2014, states may cover anyone earning below 133% of FPL through Medicaid.

Medicare - Medicare is a federal program that provides health insurance to retired individuals, regardless of their medical condition. Medicare coverage consists of two parts--Medicare Part A (hospital insurance) and Medicare Part B (medical insurance). A third part, Medicare Part C (Medicare+Choice) is a program that allows you to choose from several types of health-care plans. A fourth part, Medicare Part D (prescription drug coverage) is a program that entitled anyone on Medicare to drug coverage.

member services - The department responsible for helping members with any problems, handling member grievances and complaints, tracking and reporting patterns of problems encountered, and enhancing the relationship between members of the plan and the plan itself.

Minimum Essential Coverage (MEC) - As of January 1, 2014, all non-exempt individuals are required to carry health insurance that meets MEC guidelines. Most individual and group plans, including public insurance programs, qualify as MEC, but those covering only vision or dental benefits (excepted benefit plans) do not.

minimum value (MV) – Per the employer shared responsibility provision of the ACA, a plan provides minimum value to beneficiaries if the plan covers at least 60% of beneficiary health costs, excluding out-of-pocket expenses.

open enrollment – The period during which beneficiaries may make changes to their health insurance. Open Enrollment for Covered CA will be from October 2013-March 2014.

out-of-pocket expenses - Costs borne by the plan enrollee that are not covered by the health care plan, including deductibles, co-payments and co-insurance. In the age of managed care, out of pocket expenses can also refer to the payment of services not covered by or approved for reimbursement by the health plan.

outpatient care - Treatment that is provided to a patient who is able to return home after care without an overnight stay in a hospital or other inpatient facility.

pay or play - Proposal to make employers provide health care coverage for employees or pay a special government tax.

per member per month (PMPM) - Applies to a revenue or cost for each enrolled member each month. The number of units of something divided by member months. Often used to describe premiums or capitated payments to providers, but can also refer to the revenue or cost for each enrolled member each month.

platinum plan – A health insurance plan available through the bronze tier of the state Health Insurance Exchange. Gold plans have an actuarial value of 80%, meaning that the plan covers 80% of the beneficiary's health costs.

premium - Amount paid to a carrier for providing coverage under a contract. Money paid out in advance for insurance coverage.

premium tax credits – Tax subsidies to assist with cost of premiums for qualified persons purchasing insurance on the state Health Exchange and earning between 133-400% of FPL. The subsidy is calculated based on the cost of the second lowest cost silver plan available. Qualified persons may be eligible for both, premium tax credits and cost sharing subsidies.

primary care - Basic or general health care usually rendered by general practitioners, family practitioners, internists, obstetricians and pediatricians -- who are often referred to as primary care practitioners or PCPs. Professional and related services administered by an internist, family practitioner, obstetrician-gynecologist

or pediatrician in an ambulatory setting, with referral to secondary care specialists, as necessary.

primary care provider (PCP) - A physician or other medical professional who serves as a group member's first contact with a plan's healthcare system. Also known as a primary care physician, personal care physician, or personal care provider.

quality - Quality is, according to the Institute of Medicine (IOM), the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Quality can be defined as a measure of the degree to which delivered health services meet established professional standards and judgments of value to consumers. Quality may also be seen as the degree to which actions taken or not taken maximize the probability of beneficial health outcomes and minimize risk and other untoward outcomes, given the existing state of medical science and art. Quality is frequently described as having three dimensions: quality of input resources; quality of the process of services delivery (the use of appropriate procedures for a given condition); and quality of outcome of service use (actual improvement in condition or reduction of harmful effects). Quality programs are commonly called QA, TQM, QI, CQI - all referring to the process of monitoring quality in systematic ways.

Qualified health plan (QHP) – A plan that is available on the state Health Insurance Exchange (Covered CA).

silver plan – A health insurance plan available through the silver tier of the state Health Insurance Exchange. Silver plans have an actuarial value of 70%, meaning that the plan covers 70% of the beneficiary's health costs.

uncompensated care - Service provided by physicians and hospitals for which no payment is received from the patient or from third-party payers. Some costs for these services may be covered through cost-shifting. Not all uncompensated care results from charity care. It also includes bad debts from persons who are not classified as charity cases but who are unable or unwilling to pay their bill. See cost shifting.

uninsured - People who lack public or private health insurance.

universal access - The right and ability to receive a comprehensive, uniform, and affordable set of confidential, appropriate, and effective health services. Universal

service is a reality in countries with national medicine programs or socialized healthcare, such as the UK, Canada, France and most countries in the world. Few countries have the private insurance programs as the primary form of healthcare, as in the US. See Universal Coverage.

universal coverage - A type of government sponsored health plan that would provide healthcare coverage to all citizens.

utilization - Use of services and supplies. Utilization is commonly examined in terms of patterns or rates of use of a single service or type of service such as hospital care, physician visits, and prescription drugs. Measurement of utilization of all medical services in combination is usually done in terms of dollar expenditures. Use is expressed in rates per unit of population at risk for a given period such as the number of admissions to the hospital per 1,000 persons over age 65 per year, or the number of visits to a physician per person per year for an annual physical. See also UR, UM.

This glossary was adapted from the 2006 Universal Healthcare Council glossary, with additional information from the following sources:

United States Department of Health and Human Services
United States Internal Revenue Service
Kaiser Family Foundation
Covered California