



Tufts Health Care Institute

Glossaries

The glossaries provided here contain selected terms to help professionals and consumers better understand the health care system. Terms are organized in two lists.

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Glossary: Delivery System Terms

Accountable care organization	Managed care	Risk
Acute care	Medical error	Risk containment
Adverse event	Misuse	Risk management
Adverse drug event	Near miss	Root cause
Ambulatory care	Outcomes	Root cause analysis
Benign errors	Overuse	Sentinel event
Best practices	Patient-centered care	Skilled nursing care
Chronic disease	Patient-centered medical home (PCMH)	Skilled nursing facility care
Comprehensive Care	Patient-centered outcomes research	Specialty care
Coordination of care	Patient experience	System
Critical incident	Patient safety	Systems approach
Cultural competence	Preventive care	Tertiary care
Diagnosis related group (DRG)	Primary care	Underuse
Disparities (in care)	Primary care provider (PCP)	Utilization
Durable medical equipment (DME)	Provider	Variation
Episodes of care	Provider system	Wellness program
Long-term care	Quality of care	

Accountable care organization (ACO): Generally, ACOs are organizations of health care providers formed with the goal of providing high quality, efficient, coordinated health care to a defined population. The term “ACO” is defined differently based on the certifying entity or organization. The Centers for Medicare & Medicaid Services (CMS) has specific requirements for ACOs that provide care for Medicare patients. However, the ACO model can be used to

provide coordinated care to other populations as well. In Massachusetts, a registered ACO must use alternative payment methodologies, provide medical and behavioral health services across the continuum, and allow for health care price transparency, among other requirements. Registration will be voluntary and will last for two years.

Acute care: Acute care is short-term medical treatment, most often in a hospital, for people who have a severe illness or injury, or are recovering from surgery.

Adverse event: An injury that was caused by a medical intervention or medical management (rather than the underlying disease) and that prolonged the hospitalization, produced a disability at the time of discharge, or both.

Adverse drug event: Any incident in which the use of a medication (drug or biologic) at any dose, a medical device, or a special nutritional product (e.g., dietary supplement, infant formula, medical food) may have resulted in an adverse outcome in a patient.

Ambulatory care: Ambulatory care is medical care provided on an outpatient basis—therefore, not requiring a person to be admitted to the hospital. Ambulatory Care is provided in physicians' offices, clinics, emergency departments, outpatient surgery centers and hospital settings that do not involve a patient staying overnight.

Benign errors: Events which cause no harm or lack an adverse outcome.

Best practices: Best practices are the most up-to-date patient care interventions, which result in the best patient outcomes and minimize patient risk of death or complications.

Chronic disease: A chronic disease is a sickness that is long-lasting or recurrent. Examples include diabetes, asthma, heart disease, kidney disease and chronic lung disease.

Comprehensive Care: A health care program that provides for preventive medical care and rehabilitative services in addition to traditional chronic and acute illness services.

Coordination of care: Coordination of care comprises mechanisms that ensure patients and clinicians have access to, and take into consideration, all required information on a patient's conditions and treatments to ensure that the patient receives appropriate health care services.

Critical incident: A human error or equipment failure that could have lead (if not discovered or corrected in time) or did lead to an undesirable outcome, ranging from increased length of hospital stay to death.

Cultural competence: The ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multi-cultural staff in the policy development, administration and provision of those services. A related term is cultural sensitivity, referring to one's awareness of cultural differences and similarities.

Diagnosis related group (DRG): A method used to pay hospital inpatient cases by classifying different types of admissions into one of approximately 500 codes (DRGs). Providers typically bill insurers based on DRG codes.

Disparities (in care): Disparities in care are differences in the delivery of health care, access to health care services and medical outcomes based on ethnicity, geography, gender and other factors that do not include socioeconomic status or insurance coverage. Understanding and eliminating the causes of health care disparities is an ongoing effort of many groups and organizations.

Durable medical equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Episodes of care: An episode of care is a concept that focuses on a health condition from its inception through evaluation and treatment as a means of measuring both the quality of care received and the efficiency of the care provided.

Long-term care: Services that include medical and non-medical care provided to people who are unable to perform basic activities of daily living such as dressing or bathing. Long-term supports and services can be provided at home, in the community, in assisted living or in nursing homes. Individuals may need long-term supports and services at any age. Medicare and most health insurance plans don't pay for long-term care.

Managed care: This term describes many types of health insurance, including HMOs and PPOs. They control the use of health services by their members so that they can contain health care costs and/or improve the quality of care.

Medical error: An adverse event or near miss that is preventable with the current state of medical knowledge. Adverse drug events, hospital-acquired infections and wrong-site surgeries are examples of preventable medical errors.

Misuse: Misuse occurs when an appropriate process of care has been selected, but a preventable complication occurs and the patient does not receive the full potential benefit of the service. Avoidable complications of surgery or medication use are misuse problems. A patient who suffers a rash after receiving penicillin for strep throat, despite having a known allergy to that antibiotic, is an example of misuse. A patient who develops a pneumothorax after an inexperienced operator attempted to insert a subclavian line would represent another example of misuse.

Near miss: A situation in which an event or omission, or a sequence of events or omissions, arising during clinical care fails to develop further—whether or not as the result of compensating action, timely intervention, or by change— thus preventing injury to a patient.

Outcomes: Measures of the effectiveness of particular kinds of medical treatment. This refers to what is quantified to determine if a specific treatment or type of service works. Bad outcome: Failure to achieve a desired outcome of care.

Overuse: Overuse describes a process of care in circumstances where the potential for harm exceeds the potential for benefit. Prescribing an antibiotic for a viral infection like a cold, for which antibiotics are ineffective, constitutes overuse. The potential for harm includes adverse

reactions to the antibiotics and increases in antibiotic resistance among bacteria in the community. Overuse can also apply to diagnostic tests and surgical procedures.

Patient-centered care: Patient-centered care considers patients' cultural traditions, personal preferences and values, family situations and lifestyles. Responsibility for important aspects of self-care and monitoring is put in patients' hands—along with the tools and support they need. Patient-centered care also ensures that transitions between different health care providers and care settings are coordinated and efficient. When care is patient-centered, unneeded and unwanted services can be reduced.

Patient-centered medical home (PCMH): The PCMH model is an approach to providing comprehensive care that relies on a primary care provider to coordinate a patient's care among different providers. It promotes a patient-centered approach and demonstrates a commitment to high quality, safe, accessible care. The National Committee for Quality Assurance (NCQA) has a well-respected national Patient-Centered Medical Home Recognition program.

Patient-centered outcomes research: Research that compares different medical treatments and interventions to provide evidence on which strategies are most effective in different populations and situations.

Patient experience: The patient experience is comprised of research reports and administrative information that reflect quality from the perspective of patients by capturing observations and opinions about what happened during the process of health care delivery. Patient experience encompasses various indicators of patient-centered care, including access (whether patients are obtaining appropriate care in a timely manner), communication skills, customer service, helpfulness of office staff and information resources.

Patient safety: The avoidance, prevention and amelioration of adverse outcomes or injuries stemming from the processes of health care. These events include “errors,” “deviations,” and “accidents.” Safety emerges from the interaction of the components of the system; it does not reside in a person, device, or department. Improving safety depends on learning how safety emerges from the interactions of the components. Patient safety is a subset of healthcare quality.

Preventive care: Preventive care is health care services that prevent disease or its consequences. It includes primary prevention to keep people from getting sick (such as immunizations), secondary prevention to detect early disease (such as Pap smears) and tertiary prevention to keep ill people or those at high risk of disease from getting sicker (such as helping someone with lung disease to quit smoking).

Primary care: Basic or general routine office medical care, usually from an internist, obstetrician-gynecologist, family practitioner, or pediatrician.

Primary care provider (PCP): A primary care provider provides primary health care services and coordinates or helps a patient access a range of health care services. In some insurance products, patients are required to obtain a referral from a PCP in order to obtain care from a specialist or other health care providers. A PCP may be a physician, nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider: A provider is a professional engaged in the delivery of health services, including physicians, dentists, nurses, podiatrists, optometrists, clinical psychologists, etc. Hospitals and long-term care facilities are also providers. The Medicare program uses the term "provider" more narrowly, to mean participating institutions: hospitals, skilled nursing facilities, home health agencies, etc.

Provider incentives: Provider incentives serve to induce or motivate the regulation of health care. Examples of incentives include monetary rewards for providers who meet specific benchmark standards for their patient care.

Provider system: A group of physicians and/or hospitals that jointly contract with health insurers.

Quality of care: Degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Risk: The likelihood, high or low, that somebody or something will be harmed by a hazard, multiplied by the severity of the potential harm.

Risk containment: Immediate actions taken to safeguard patients from a repetition of an unwanted occurrence. Actions may involve removing and sequestering drug stocks from pharmacy shelves and checking or replacing oxygen supplies or specific medical devices.

Risk management: (1) Clinical and administrative activities undertaken to identify, evaluate, and reduce the risk of injury to patients, staff, and visitors and the risk of loss to the organization itself. (2) In the context of hospital operations, the term "risk management" usually refers to self-protective activities meant to prevent real or potential threats of financial loss due to accident, injury, or medical malpractice.

Root cause: The most fundamental reason an event has occurred.

Root cause analysis: A process for identifying the basic or causal factor or factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event.

Sentinel event: An adverse event in which death or serious harm to a patient has occurred; usually refers to unexpected or unacceptable events, such as operation on the wrong patient or body part. Sentinel events can trigger an investigation into policies and procedures.

Skilled nursing care: Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Skilled nursing facility care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Specialty care: Specialty care is health care focused on improving the well-being of certain

specialized categories of health, as opposed to general and overall health and well-being. To improve the quality of health care available to consumers and patients, providers must improve the quality and availability of primary and specialty care.

System: Interdependent elements (human and non-human) interacting to achieve a common aim.

Systems approach: An approach with the view that most errors reflect predictable human failings in the context of poorly designed systems (e.g., expected lapses in human vigilance in the face of long work hours or predictable mistakes on the part of relatively inexperienced personnel faced with cognitively complex situations). Rather than focusing corrective efforts on reprimanding individuals or pursuing remedial education, the systems approach seeks to identify situations or factors likely to give rise to human error and implement “systems changes” that will reduce their occurrence or minimize their impact on patients. This “systems focus” includes paying attention to human factors engineering, including the design of protocols, schedules, and other factors that are routinely addressed in other high-risk industries.

Tertiary care: Specialized consultative care, usually on referral from primary or secondary medical care personnel, by specialists working in a center that has personnel and facilities for special investigation and treatment.

Underuse: Underuse refers to the failure to provide a health care service when it would have produced a favorable outcome for a patient. Standard examples include failure to provide appropriate preventive services to eligible patients (e.g., Pap smears, flu shots for elderly patients, screening for hypertension) and proven medications for chronic illnesses (steroid inhalers for asthmatics; aspirin, beta-blockers and lipid-lowering agents for patients who have suffered a recent myocardial infarction).

Utilization: The amount or number of medical services or units of service used by a given population over a period of time.

Variation: Variation is an instance of change or deviation. There is unwarranted variation in the practice of medicine and the use of medical resources in the United States. There is underuse of effective care, such as the use of beta-blockers for people who have heart attacks and screening of diabetics for early signs of retinal disease. There is misuse of preference-sensitive care, such as the choice between mastectomy and lumpectomy for early-stage breast cancer. And there is overuse of supply-sensitive care, such as admitting patients with chronic conditions like diabetes to the hospital, rather than treating them as outpatients.

Wellness Program: A program intended to improve and promote health and fitness that's usually offered through the work place, although insurance plans can offer them directly to their enrollees. The program allows the employer or plan to offer enrollees premium discounts, cash rewards, gym memberships, and other incentives to participate. Some examples of wellness programs include smoking cessation, diabetes management, weight loss, and preventative health screenings.

Glossary: Insurance and Financing Terms

Affordable Care Act	Fee schedule	Medically necessary	Reimbursement
Allowed amount	Flexible benefits plan	Network	Reinsurance
Alternative payment methodologies	Flexible spending account (FSA)	Non-preferred provider	Risk
Balance billing	Gross domestic product	Out-of-pocket limit	Risk adjustment
Benefits	Group health plan	Open enrollment period	Risk management
Bundled payment	Health insurance marketplace	Payers	Risk-bearing provider organizations
Capitation	Health maintenance organization (HMO)	Pay-for-performance (P4P)	Risk-sharing contract
COBRA	Health plan	Payment method	Self-insured plan
Co-insurance	Health reimbursement account	Payment reform	Single payer system
Co-payment	Health savings account	Point of service (POS)	Subsidy
Commercial insurer	High deductible health plan	Preauthorization	Third party payer
Coordination of benefits	Indemnity insurance	Pre-existing condition	Total health care expenditures
Cost containment	Individual mandate	Preferred provider	Total medical expenses
Cost sharing	Insurer	Preferred provider organization (PPO)	Transparency
Deductible	Medicaid	Premium	Uncompensated care
Dependent coverage	Medicare	Provider incentives	Unit cost
Essential health benefits	Medicare Advantage (Medicare Part C)	Purchasers	Unit price or price
Excluded services	Medicare Part D	Qualified health plan	UCR (Usual, Customary and Reasonable)
Exclusive provider organization (EPO)	Medical loss ratio	Qualifying life event	Value-based purchasing
Fee-for-service	Medical underwriting	Reference pricing	Worker's compensation

Affordable Care Act: The comprehensive 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.

Allowed amount: Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If the provider charges more than the allowed amount, the patient may have to pay the difference. (See Balance Billing.)

Alternative payment methodologies (APMs): APMs are any kind of payment from an insurer to a provider or provider organization that is not solely based on fee-for-service. APMs are

intended to promote higher quality, lower cost care in comparison to fee-for-service payments that promote higher quantities of care. There are many different types of APMs, including bundled payments, global payments, and shared savings, all of which – to some degree – reward patient-centered, coordinated care and positive health outcomes.

Balance billing: When a provider bills the patient for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill the patient for the remaining \$30. A preferred provider may not balance bill the patient for covered services.

Benefits: The health care items or services covered under a health insurance plan. Covered benefits and services not covered are defined in coverage documents for the health insurance plan. In Medicaid or CHIP, covered benefits and services not covered are defined in state program rules.

Bundled payment: A payment structure in which different health care providers who are treating a patient for the same or related conditions are paid an overall sum for taking care of the patient's condition rather than being paid for each individual treatment, test, or procedure. In doing so, providers are rewarded for coordinating care, preventing complications and errors, and reducing unnecessary or duplicative tests and treatments.

Capitation: A fixed prepayment, per patient covered, to a health care provider to deliver medical services to a particular group of patients. The payment is the same no matter how many services or what type of services each patient actually gets. Under capitation, the provider is financially responsible.

COBRA: A Federal law that may allow individuals to temporarily keep health coverage after their employment ends, or they lose coverage as a dependent of the covered employee, or another qualifying event. If one elects COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, they pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

Co-insurance: The patient's share of the costs of a covered health care service, calculated as a percent (for example, 20 percent) of the allowed amount for the service. The patient pays co-insurance plus any deductibles he or she owes. The health insurance plan pays the rest of the allowed amount.

Co-payment: A fixed amount (for example, \$25) that the patient pays for a covered health care service. The amount can vary by the type of covered health care service.

Commercial insurer: A non-government health insurance company.

Coordination of benefits: A way to figure out who pays first when two or more health insurance plans are responsible for paying the same medical claim.

Cost containment: The method of preventing health care costs from increasing beyond a set level by controlling or reducing inefficiency and waste in the health care system.

Cost sharing: An insurance policy requires the insured person to pay a portion of the costs of covered services. Deductibles, co-insurance and co-payments are cost sharing. It does not include premiums, balance-billed amounts for non-network providers, or the cost of services not covered.

Deductible: The amount that the patient owes for covered health care services before the health insurance or plan begins to pay. For example, if the deductible is \$1,000 per year, the health plan won't pay anything until the patient has met the \$1,000 deductible for covered health services subject to the deductible for that year. The deductible may not be applied to some services, such as preventive services.

Dependent coverage: Insurance coverage for family members of the policyholder, such as spouses, children, or partners.

Essential health benefits: Benefits that individual and small group health plans must offer under the Affordable Care Act. They include: 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 dental and vision care.

Excluded services: Health care services that the enrollee's health insurance or plan doesn't pay for or cover.

Exclusive provider organization (EPO) Plan: A managed care plan where services are covered only if the enrollee goes to doctors, specialists, or hospitals in the plan's network (except in an emergency).

Fee-for-service: Fee-for-service is an arrangement under which patients or a third party pay physicians, hospitals, or other health care providers for each encounter or service rendered.

Fee schedule: A fee schedule is a complete listing of fees used by health plans to pay doctors or other providers.

Flexible benefits plan: A benefit program that offers employees a choice between various benefits including cash, life insurance, health insurance, vacations, retirement plans, and child care. Although a common core of benefits may be required, employees can choose how to allocate their remaining benefit dollars for each type of benefit from the total amount promised by the employer. Sometimes employees you can contribute more for additional coverage. Also known as a Cafeteria plan or IRS 125 Plan.

Flexible spending account (FSA): A benefit offered to an employee by an employer which allows a fixed amount of pre-tax wages to be set aside for qualified expenses. Qualified expenses may include uncovered medical expenses, such as insurance copayments and deductibles, and qualified prescription drugs, insulin and medical devices. The amount set aside must be determined in advance and employees lose any unused dollars in the account at year-end.

Gross domestic product: The market value of goods and services produced by labor and property in the United States, regardless of nationality.

Group health plan: In general, a health plan offered by an employer or employee organization that provides health coverage to employees and their families.

Health insurance marketplace: A competitive insurance marketplace where individuals and small businesses can buy qualified health insurance plans. Marketplaces offer you a choice of plans that meet certain benefits and cost standards.

Health maintenance organization (HMO): A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require enrollees to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

Health plan: A payer or insurer that provides some form of health care coverage to patients.

Health reimbursement account (HRA): HRAs are employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year. Unused amounts may be rolled over to be used in subsequent years. The employer funds and owns the account. Health Reimbursement Accounts are sometimes called Health Reimbursement Arrangements.

Health savings account (HSA): A medical savings account available to taxpayers who are enrolled in a High Deductible Health Plan. The funds contributed to the account aren't subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses. Unlike a Flexible Spending Account (FSA), funds roll over year to year if not spent.

High deductible health plan (HDHP): A plan that features higher deductibles than traditional insurance plans. High deductible health plans (HDHPs) can be combined with a health savings account or a health reimbursement arrangement to allow enrollees to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

Indemnity insurance: An insurance product that provides benefit coverage to members regardless of whether the servicing provider is contracted with the insurer. The insurer pays for the costs of covered services after care has been given, and usually defines the maximum amounts which will be paid for covered services.

Individual mandate: Under the Affordable Care Act, an individual must be enrolled in a health insurance plan that meets basic minimum standards. If not, he or she may be required to pay a penalty. The penalty may be waived if the enrollee has very low income and coverage is unaffordable, or for other reasons, including religious beliefs.

Insurer: A payer or health plan that contracts with providers to deliver health care coverage to its members. Insurers may also be referred to as “payers” or “health plans.”

Medicaid: An insurance program for people with low incomes who are unable to afford health care. Although funded by the federal government, Medicaid is administered by each state. Following very broad federal guidelines, states determine specific benefits and amounts of payment for providers.

Medicare: A federal program of medical care benefits created in 1965 designed for those over age 65 or permanently disabled. Medicare consists of two separate programs: A and B. Medicare Part A, which is automatic at age 65, covers hospital costs and is financed largely by employer payroll taxes. Medicare Part B covers outpatient care and is financed through taxes and individual payments toward a premium.

Medicare Advantage (Medicare Part C): A type of Medicare health plan offered by a private company that contracts with Medicare to provide enrollees with all Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare Part D: A program that helps pay for prescription drugs for people with Medicare who join a plan that includes Medicare prescription drug coverage. There are two ways to get Medicare prescription drug coverage: through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that includes drug coverage. These plans are offered by insurance companies and other private companies approved by Medicare.

Medical loss ratio (MLR): A basic financial measurement used in the Affordable Care Act to encourage health plans to provide value to enrollees. If an insurer uses 80 cents out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care, the company has a medical loss ratio of 80%. A medical loss ratio of 80% indicates that the insurer is using the remaining 20 cents of each premium dollar to pay overhead expenses, such as marketing, profits, salaries, administrative costs, and agent commissions. The Affordable Care Act sets minimum medical loss ratios for different markets, as do some state laws.

Medical underwriting: A process used by insurance companies to try to figure out a person's health status when applying for health insurance coverage to determine whether to offer that person coverage, at what price, and with what exclusions or limits.

Medically necessary: Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network: The facilities, providers and suppliers with whom the health insurer or plan has contracted to provide health care services.

Non-preferred provider: A provider who doesn't have a contract with the health insurer or plan to provide services to enrollees. The enrollee will pay more to see a non-preferred provider.

Out-of-pocket limit: The most an individual will pay during a policy period (usually a year) before their health insurance plan begins to pay 100 percent of the allowed amount. This limit never includes the premium, balance-billed charges or health care services your health insurance plan doesn't cover. Some health insurance plans don't count all co-payments, deductibles, co-

insurance payments, out-of-network payments or other expenses toward this limit.

Open enrollment period: The period of time during which individuals who are eligible to enroll in a Qualified Health Plan can enroll in a plan in the Marketplace.

Payers: Payers comprise the entity that assumes the risk of paying for medical treatments. Examples include uninsured patients, self-insured employers, health plans or HMOs.

Pay-for-performance (P4P): Pay-for-performance (P4P) is a method for paying hospitals and physicians based on their demonstrated achievements in meeting specific health care quality objectives. The idea is to reward providers for the quality—not the quantity—of care they deliver.

Payment method: The structure than an insurer uses to reimburse health care providers. A variety of payment methodologies exists, such as fee-for-service, per-diem, and capitation.

Payment reform: Payment reform seeks to improve current mechanisms for reimbursing providers by including rewards for provider quality in the reimbursement mechanisms.

Point of service (POS): A type of plan where enrollees pay less if they use doctors, hospitals, and other health care providers that belong to the plan’s network. POS plans require patients to get a referral from their primary care doctor in order to see a specialist.

Preauthorization (or Prior Authorization): A decision by the health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. The health insurance or plan may require preauthorization for certain services before the patient receives them, except in an emergency. Preauthorization does not a promise that the health insurance plan will cover the cost.

Pre-existing condition: A health problem that an enrollee had before the date that new health coverage starts.

Preferred provider: A provider who has a contract with the health insurer or plan to provide services to enrollees at a discount. The health insurance or plan may have a “tiered” network and patients must pay extra to see some providers. The health insurance or plan may have preferred providers who are also “participating” providers. Participating providers also contract with the health insurer or plan, but the discount may not be as great, and patients may have to pay more.

Preferred provider organization (PPO): A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. Enrollees pay less if they use providers that belong to the plan’s network; or they can use doctors, hospitals, and providers outside of the network for an additional cost.

Premium: The amount that must be paid for enrolling in a health insurance plan. The enrollee and/or employer usually pay it monthly, quarterly or yearly.

Provider incentives: Provider incentives serve to induce or motivate the regulation of health

care. Examples of incentives include monetary rewards for providers who meet specific benchmark standards for their patient care.

Purchasers: Purchasers comprise the entity that not only pays the premium for health care costs, but also controls the premium dollar before paying it to the provider. Included in the category of purchasers or payers are patients, businesses and managed care organizations. While patients and businesses function as ultimate purchasers, managed care organizations and insurance companies serve a processing or payer function.

Qualified health plan: Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

Qualifying life event: An event defined by the IRS that allows an individual to change their benefit selections. Examples of events may include marriage, birth of a child or death of a dependent.

Reference pricing: A cost-saving strategy in which purchasers, rather than limiting a provider network, offer enrollees access to a broad network, and the enrollee decides whether to be treated at a lower-price provider with no out-of-pocket expense beyond typical cost sharing or a higher-price facility with additional cost above the reference price. This approach is typically applied to services where there appears to be little variation in quality to avoid the perception and potential reality of steering patients to lower-quality providers. Reference pricing is used for prescription drugs with generic alternatives or therapeutic equivalents, and a variety of medical services including inpatient orthopedic surgery, outpatient arthroscopy and cataract removal surgery, and imaging and laboratory services.

Reimbursement: The amount paid to providers for services they provide to patients.

Reinsurance: A reimbursement system that protects insurers from very high claims. It usually involves a third party paying part of an insurance company's claims once they pass a certain amount. Reinsurance is a way to stabilize an insurance market and make coverage more available and affordable.

Risk: The responsibility for profiting or losing money based on the cost of health care services provided. Traditionally, health insurance companies have carried the risk. Under capitation, health care providers bear risk.

Risk adjustment: A statistical process that takes into account the underlying health status and health spending of the enrollees in an insurance plan when looking at their health care outcomes or health care costs.

Risk management: (1) Clinical and administrative activities undertaken to identify, evaluate, and reduce the risk of injury to patients, staff, and visitors and the risk of loss to the organization itself. (2) In the context of hospital operations, the term "risk management" usually refers to self-protective activities meant to prevent real or potential threats of financial loss due to accident,

injury, or medical malpractice.

Risk-bearing provider organizations: Risk-bearing provider organizations are those that assume financial risk through Alternative Payment Methodology (APM) contracts with insurers. Such financial risk allows provider organizations to share in savings (or losses) associated with reduced total health care spending and higher quality of care.

Risk-sharing contract: A contract between a health insurer and a provider that puts the provider at risk for some or all of the costs of care associated with the provision of medical care for a particular population. There are various types of risk-based contracts, such as capitated or globally paid contracts and withhold arrangements where return of withheld amounts depends on keeping total medical expenses (TME) below a certain level.

Self-insured plan: Type of plan usually present in larger companies where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees' and dependents' medical claims. These employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third party administrator, or they can be self-administered.

Single payer system: A health care reform proposal in which health care costs are paid by taxes rather than by the employer and employee. All people would have coverage paid by the government.

Subsidy: A fixed amount of money or a designated percentage of the premium cost provided to help purchase health insurance through the Individual Marketplace.

Third party payer: An organization other than the patient or health care provider involved in the financing of personal health services.

Total health care expenditures (THCE): THCE is the per capita cost figure adopted in Massachusetts that will be used to determine if the state is meeting the cost growth benchmark. The law defines THCE as the total per capita sum of public and private health care expenditures, including non-claims payments and patient cost sharing amounts, and the net cost of private health insurance.

Total medical expenses (TME): TME measures the total health spending for a defined population on a per member per month basis. TME includes all payments made by insurers to providers, including both claims-based payments and other payments, such as performance bonuses, shared savings, infrastructure payments, and other adjustments. TME also includes payments made by patients to providers for covered services, such as deductibles, cost-sharing, and co-payments. TME is often adjusted for patient health status within each specific payer's data to account for providers that care for sicker populations. TME is only one component of Total Health Care Expenditures (THCE).

Transparency: Transparency is the process of collecting and reporting health care cost, performance and quality data in a format that can be accessed by the public and is intended to improve the delivery of services and ultimately improve the health care system as a whole.

Uncompensated care: Health care or services provided by hospitals or health care providers that don't get reimbursed. Often uncompensated care arises when people don't have insurance and cannot afford to pay the cost of care.

Unit cost: The amount of money that it costs a health care provider to deliver a unit of service. The terms “price,” “unit price,” or “payment” refer to the rate, or amount, that an insurer pays a provider for medical services, and reserve the term “unit cost” for a hospital's own internal cost of delivering medical services.

Unit price or price: The contractually negotiated amount (or reimbursement rate) that an insurer agrees to pay a particular hospital, physician, or other health care provider for a given health care service. This is the “pricetag” that the insurer agrees it will pay each time one of its members incurs a covered expense.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Value-based purchasing: Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.

Worker's compensation: An insurance plan that employers are required to have to cover employees who get sick or injured on the job.
