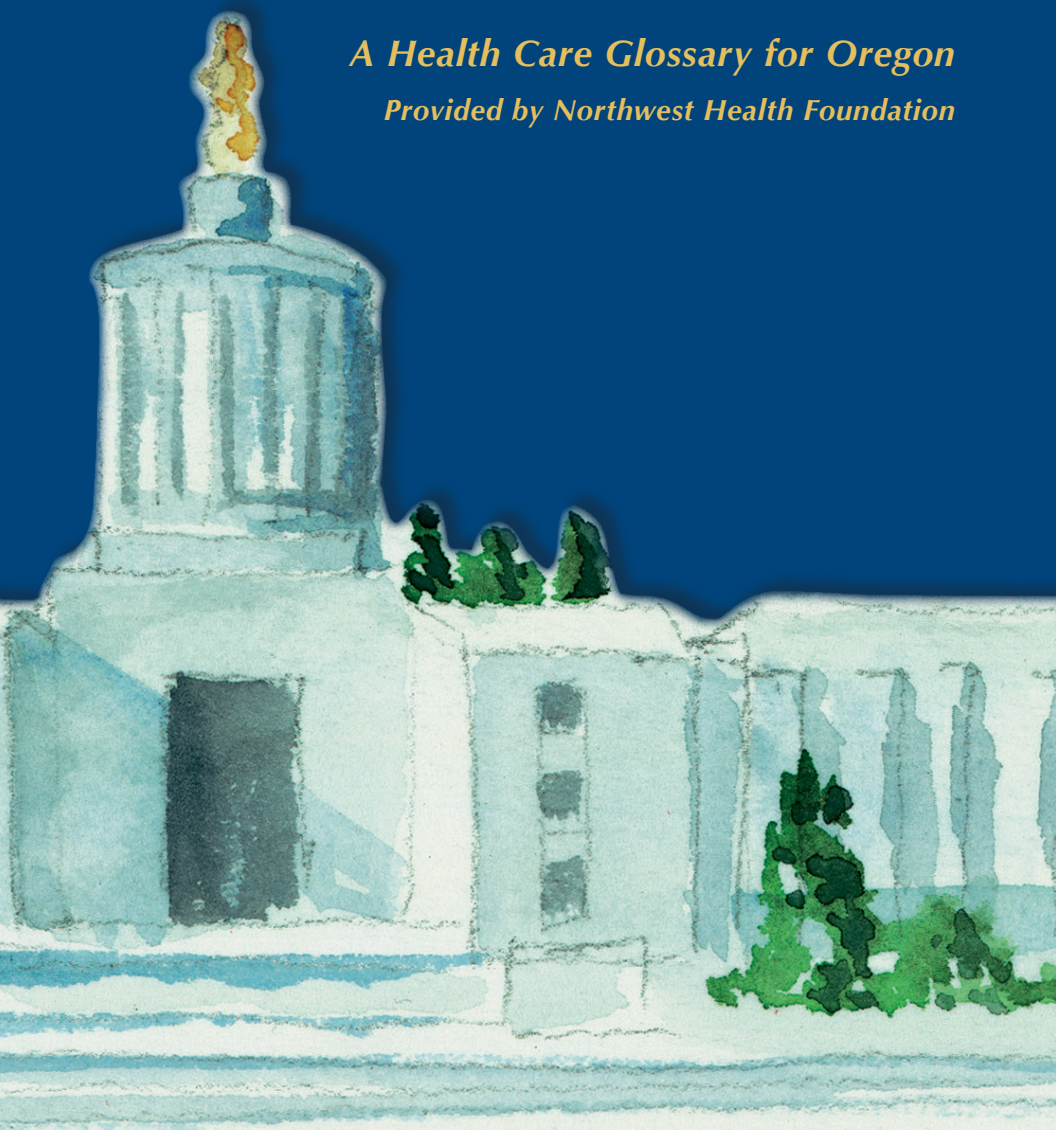


THE ABC'S OF HEALTH CARE REFORM

A Health Care Glossary for Oregon

Provided by Northwest Health Foundation



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This glossary is provided to you by Northwest Health Foundation, whose mission is to advance, support and promote the health of the people in Oregon and southwest Washington. The Foundation focuses its work in three areas: health care reform, health workforce, and public health, and seeks to ensure that the voices of all people are represented in policy discussions.

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DEFINITIONS

Accountable care organization (ACO)

A group of health care providers that enters into a formal arrangement to assume responsibility for the care of a specific group of patients. They receive financial incentives to improve the quality and efficiency of care. ACOs can be organized by hospitals, medical practices, clinics and other groups of providers.

Benefit package

A set of guaranteed services provided by a health plan to its members. “Essential health benefits” are the minimum level of services that must be offered by qualified health plans in state health insurance exchanges (*see definitions of “health insurance exchanges” and “qualified health plans” on pages 8 and 12.*)

Bundled payment

A single payment for all health care services related to a specific course of treatment or condition during a certain period of time or episode of care. Under a “bundled-payment system,” providers are not reimbursed for every service or interaction. Instead, a single payment is made for each episode of care for a single patient and is divided amongst the providers.

Capitation

Reimbursing providers a fixed amount for each person they treat, regardless of the actual number or nature of services provided (paying a per-member, per-month rate).

Carrier

A risk bearing company, usually an insurer, which contracts with employers or the government to provide administrative functions, such as paying claims. For example, a Medicare carrier is a private organization that contracts with the federal Centers for Medicare and Medicaid Services (CMS) to process claims under Part B, or the outpatient health care coverage, of Medicare.

Charity care

Free or discounted health services provided to people who cannot afford to pay and from whom a hospital has no expectation of payment.

Children's health insurance program (CHIP)

Provides coverage to children under 18 years old who have incomes of up to 185% of the Federal Poverty Level (*see definition on page 7*). CHIP is jointly funded and administered by the states and the federal government.

Coinsurance

The percentage of a health care provider's charges for which the patient is financially responsible. This is usually expressed as a ratio, such as 80/20, where the insurer pays 80 percent and the patient pays the remaining 20 percent.

Community rating

A way of pricing insurance, where every policyholder in a given territory pays the same premium, regardless of health status, age or other factors.

Competencies

The knowledge, skills, abilities, and behaviors critical to successful job performance. Focusing on competencies in health care can assist in workforce planning and organization and help train and manage the current and future workforce to best meet patient needs.

Cost-sharing

Health care provider charges that a patient is responsible for under the terms of a health plan, i.e. deductibles, coinsurance and co-payments.

Cost shift

When health care rates are set higher than actual costs to recover unreimbursed costs from government, uninsured and underinsured individuals, and other payers.

Disease management

An integrated approach that uses patient education to manage illness and chronic disease. This includes screenings, check-ups, monitoring and coordinating treatment.

Electronic health (EHR) or electronic medical record (EMR)

Computerized medical files that contain the history of a patient's medical care and can be viewed and edited by more than one user.

Employee retirement income security act (ERISA)

The 1974 federal law that sets minimum standards for most voluntarily established pension and health plans in private industry.

Evidence-based medicine

The use of the best available scientific research and practices with proven effectiveness.

Federally qualified health center (FQHC)

Federally-funded nonprofit health centers that care for underserved populations and provide a comprehensive range of primary care services. Oregon has twenty-seven FQHCs, located throughout the state.

Federal match

The amount the federal government will match for funds that states contribute to Medicaid and the Children's Health Insurance Program. Matching rates vary by state and program, but states with more low-income residents receive more federal funding. In Oregon, the federal government provides \$2.69 for every dollar the state spends on Medicaid. For the CHIP program, the match is approximately \$2.83 for each state dollar spent.

Federal poverty level (FPL)

Guidelines established by the federal Department of Health and Human Services that determine an individual's or family's eligibility for federal and non-federal programs. The 2009-2010 Federal Poverty Level for a family of four is \$22,050.

Fee-for-service (indemnity) insurance

Health insurance plans that reimburse physicians and hospitals for each individual service they provide, as opposed to a capitation system (*see definition on page 4*).

Formulary

The list of drugs covered fully or in part by a health plan, created to reduce pharmaceutical costs.

Guaranteed issue

A requirement that insurers sell a health insurance policy to anyone who requests coverage, regardless of his or her health status, claims history, age, or employment.

Health disparities

Measurable differences in health and health care due to race, ethnicity, income, language, and place of residence. Disparities can exist in health care delivery, access to health care services and medical outcomes. For example, some ethnic groups have a significantly higher incidence of certain diseases, such as diabetes or colon cancer. Similarly, access to health services can be significantly lower in rural communities than in urban areas.

Health equity

Achieving the highest level of health for all people, including focusing on avoidable inequalities by equalizing the conditions for health for all groups, especially for those who have experienced a socioeconomic or historical disadvantage.

Health information exchange

The transmission of healthcare information electronically among organizations within a region, community or hospital system with a shared patient population. The goal is to improve patient care by improving the quality of available medical information.

Health information technology (HIT)

Using technology to manage and exchange health information among health professionals, consumers, health care providers, health care payers, and public health agencies.

Health insurance exchange

State-based insurance marketplaces 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.

Health insurance portability and accountability act (HIPAA) Federal law that regulates health information privacy, portability (*see definition on page 11*), non-discrimination and health insurance simplification. This is an amendment to ERISA (*see definition on page 6*).

High-risk pool

A state or federal health program for individuals who have been denied health insurance because of a preexisting condition or whose premiums are rated significantly higher than the average due to health status or claims experience. The Oregon Medical Insurance Pool (OMIP) is the high-risk health insurance pool for the state.

Hospital readmissions

A situation where a patient is discharged from the hospital and returns for the same or related care in a specified period of time (e.g., 30 days under Medicare). The number of hospital readmissions is sometimes used to measure the quality of hospital care.

Individual mandate

A requirement that everyone maintain health insurance.

Individual market

The market for health insurance coverage offered to individuals who are not in a group health plan.

Medicaid

A joint state and federally funded program that provides health care coverage to eligible low-income individuals, such as children, pregnant women and people with disabilities. Each state administers its own Medicaid program and has significant flexibility to determine who is eligible, what benefits to cover, and how care is delivered. Oregon's Medicaid program is called the Oregon Health Plan.

Medicaid waiver

Authority granted by the Secretary of Health and Human Services to allow a state to receive federal Medicaid matching funds even though it doesn't meet certain requirements of the Medicaid statute. States can use waivers to implement home- and community-based service programs, managed care, and to expand coverage to uncovered populations. Oregon has applied for and received Medicaid waivers to implement innovative programs.

Medical loss ratio

The percentage of health insurance premiums that are spent by an insurance company on health care services. 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%, indicating that the insurer is using the remaining 20 cents for the cost of doing business, like marketing and administration of claims.

Medicare

A federal program that provides health care coverage for all eligible individuals age 65 or older or under age 65 with a disability, regardless of income or assets. Eligible individuals can receive coverage for hospital services (Medicare Part A), medical services (Medicare Part B), and prescription drugs (Medicare Part D). Together, Medicare Part A and B are known as Original Medicare.

Patient-centered primary care/Medical home

A health care setting where patients receive comprehensive primary care services in an ongoing relationship with a primary care provider team that directs and coordinates their care, have enhanced access to non-emergent primary, secondary, and tertiary care, and can have access to linguistically and culturally appropriate care.

Patient protection and affordable care act (PPACA)

Federal health care reform legislation (Public Law 111-148) signed by President Obama on March 23, 2010.

Payers

The party that assumes the risk of paying for medical treatments. Examples include insurance companies, health plans, uninsured patients, or self-insured employers.

Pay-for-performance (P4P)

The idea that there should be a direct link between what health services are paid for and the value of the services provided. Pay-for-performance uses payment methods to encourage health care providers to deliver higher quality and more efficient services.

Payment reform

Efforts to improve current mechanisms for reimbursing health care providers by including rewards for provider quality and health outcomes.

Portability

Allowing health insurance to move with the insured person so that s/he does not lose coverage due to any change in health or personal status, such as employment, marriage, or divorce.

Preferred provider organization (PPO)

A type of managed care organization that provides health care coverage through a network of providers. Typically, the PPO requires the policyholder to pay higher costs when s/he seeks care from an out-of-network provider.

Premium

The periodic payment required to keep an insurance policy current and valid. Premiums can be paid by employers, unions, employees or individuals, or shared among different payers.

Preventive services

Procedures and treatments to prevent and identify diseases and conditions before they become serious. For example, immunizations, screening programs for breast and prostate cancer, and “well-child” checkups are all preventive services.

Primary care

Health services that cover a range of prevention and treatment for common illnesses.

Primary care providers

Health care professionals who specialize in a primary care practice field, such as family medicine, pediatrics, obstetrics and gynecology, and adult medicine. Most health plans recognize primary care providers as doctors, nurses, nurse practitioners, and physician assistants. Dentists and mental health providers also provide primary care services.

Public health intervention

A policy or activity that takes a population approach to preventing disease or promoting health. Community water fluoridation and cigarette taxes are examples of successful public health interventions.

Public option

An insurance plan administered and funded by federal or state government that could be offered along with private plans in a health insurance exchange.

Purchasing pool

A group of people brought together to enhance their bargaining power and to pool financial risks across individuals from the sickest to the healthiest. All purchasing pool members usually pay the same premium for a given plan regardless of their health status,

Qualified health plan

A health insurance policy that is sold through a health insurance exchange.

Safety net

Health care providers that deliver health care services to patients regardless of their ability to pay. These providers may be public hospital systems, community health centers, federally qualified health centers (*see definition on page 6*), local health departments, and other providers that serve a disproportionate share of uninsured and low-income patients.

Self-insured

A type of employer self-funded health insurance plan, usually provided by larger companies, where the employer collects premiums from enrollees and has the responsibility of paying employees' and dependents' medical claims. Self-insured 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

A health care system in which a single entity – generally a country – pays for health care services. This entity collects health care fees and pays for all health care costs but is not involved in the delivery of health care.

Small group market

The market for health insurance coverage offered to small businesses – those with between 2 and 50 employees in most states.

Social determinants of health

The structural causes and conditions of daily life that create health inequalities, such as the distribution of power, income, goods and services, access to health care, schools and education, as well as conditions of work, leisure, housing, transportation and the environment.

Triple aim

Oregon's Triple Aim is the basis for all decisions made by the Oregon Health Authority. Its three goals are: to improve the lifelong health of Oregonians; to increase the quality, reliability, and availability of care; and to lower or contain the cost of care so it's affordable to everyone.

Uncompensated care

Health care or services provided by hospitals or health care providers that are not reimbursed. Uncompensated care generally arises when people don't have adequate insurance or can't afford to pay the actual cost of care.

Underinsured

People whose insurance does not cover their necessary health care services, leaving them with out-of-pocket expenses that exceed their ability to pay.

Value-based purchasing (VBP)

Linking payments to improved performance by health care providers. This form of payment attempts to reduce inappropriate care by identifying and rewarding providers who give high quality care while containing costs.

SELECT OREGON ACRONYMS

DCBS: Department of Consumer and Business Services

Oregon's largest regulatory agency, DCBS administers state laws and rules and protects consumers and workers in the areas of workers' compensation, occupational safety and health, financial services, insurance, and building codes.

HIRAC: Health Insurance Reform Advisory Committee

The Health Insurance Reform Advisory Committee makes recommendations to DCBS about the form and level of coverage under the basic health benefits plans made available by small employer carriers and portability health benefits insurance.

HITOC: Health Information Technology Oversight Council

A statutory body of citizens, appointed by the Governor and confirmed by the Senate, that is developing a strategic plan for health information technology for the state, as well as monitoring progress in achieving goals and providing oversight for implementation of the plan.

OHA: Oregon Health Authority

A state agency created in 2009 by HB 2009 to bring most health-related programs into a single agency to maximize state purchasing power.

OHIP: Oregon Health Improvement Plan

A statewide plan created by a committee functioning under the direction of the Oregon Health Policy Board. The committee has identified evidence-based interventions that incorporate policy, systems and environmental approaches to promote health at the state and community levels for the prevention, early detection and management of chronic diseases. The committee has recommended to the OHPB strategies that link population health to the health care delivery system and communities.

OHP: Oregon Health Plan

Oregon's demonstration project for the expansion of eligibility of the Medicaid program.

OHPB: Oregon Health Policy Board

Created by HB 2009, this nine-member citizen board serves as the policymaking and oversight body for the Oregon Health Authority.

OHPR: Office for Oregon Health Policy and Research

Part of the Oregon Health Authority, this office conducts impartial, non-partisan policy analysis, research and evaluation, and provides technical assistance to support health reform planning and implementation in Oregon. The office serves in an advisory capacity to Oregon Health Policy Board, the Oregon Health Authority, the Governor and the Legislature.

SOURCES

Families USA

www.familiesusa.org

Grantmakers in Health

www.gih.org

Healthcare.gov

www.healthcare.gov

(Managed by the US Department of Health & Human Services)

Health Reform GPS

www.healthreformgps.org

(A project of the George Washington University's Hirsh Health Law and Policy Program and the Robert Wood Johnson Foundation)

Kaiser Family Foundation

www.kff.org

National Association of Insurance Commissioners
and The Center for Insurance Policy and Research

www.naic.org

Northwest Health Foundation

www.nwhf.org

Robert Wood Johnson Foundation

www.rwjf.org

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