



Health Benefit and Medical Quality Glossary

Terms & Definitions

Access: 1. an individual's ability to obtain medical care. 2. the availability of insurance coverage for specific types of care or products.

Accountable health plans (AHPs): a joint venture between practitioners and institutions (insurance companies, HMO's, or hospitals) that assumes responsibility for delivering medical care.

Accreditation: a professional status given to a health care provider by an organization in exchange for meeting a specific set of standards.²

Actual charge: the amount a physician or other provider actually bills a patient for a particular medical service, procedure, or supply in a specific instance. The actual charge may differ from the usual customary, prevailing, and/or reasonable charge.

Actuarial assumptions: factors considered in projecting future costs and activities of a health plan, including basic information about the group, such as number, gender, family, and individual status of plan membership, retired and active status, projected cost increases, projected utilization changes, time period for plan operation, and past plan performance.⁶

Actuarial balance: the difference between the income rate and the expense rate of a health plan as projected by the actuary for a specific time period, usually a plan year.⁶

Actuary: a financial specialist trained to evaluate costs and the financial methods and operation of an organization, including the computing of premiums, losses, reserves, cash flow, and lags.⁶

Acute care: medical care usually requiring active intervention by a medical practitioner for a person with a single episode of short-term illness or with an exacerbation of a chronic condition.

Acute Myocardial Infarction (AMI): the medical term for a heart attack.

Adjudication: the processing of a claim through a series of edits to determine proper payment.²

Adjudication fee: a charge for processing a claim through a series of edits.

Administrative data: information that is collected, processed, and stored in automated information systems. Administrative data includes enrollment or eligibility information, claims information, and managed care encounters. The claims and encounters may be for hospital and other facility services, professional services, prescription drug services, laboratory services, and so on.¹

Administrative costs: the costs assumed for administrative services, such as claims processing, billing, and overhead costs.²

Administrative services only (ASO): an arrangement in which a health plan hires a third party to deliver administrative services, such as claims processing and billing, to the plan; the plan sponsor bears the risk for claims.⁴

Adverse selection: when either healthy, low-risk individuals or unhealthy, high-risk individuals migrate out or in, respectively, of a particular health plan, thereby creating a plan with a disproportionate number of unhealthy, high-risk individuals.

Agency for Healthcare Research and Quality (AHRQ): the health services research arm of the U.S. Department of Health and Human Services that works with public and private sectors to build a knowledge base for what works and does not work in health and health care. The agency also conducts research on many quality indicators, and translating that knowledge into everyday practice and policy making.

Aligned incentives: the assurance that all principal providers working for or with a managed care organization or other corporate health delivery structure have matched financial motives to behave in a way that is beneficial to the organization as a whole.

American Hospital Association (AHA): a national advocacy organization that represents and serves hospitals and health care networks in national health policy development, legislative and regulatory debates, and judicial matters, as well as providing education and issue and trend information for health care leaders.

Annual maximum: see “maximum (annual).”

Association plan: a health plan that is a pool of smaller employers or organizations that wish to combine forces to purchase insurance or to pool risk to self-insure in order to reduce cost and improve services to members.⁶

Average wholesale price (AWP): a published, suggested wholesale drug price obtained from the manufacturer/labeler or a price survey of wholesalers.

Behavior modification: attempts to change an individual’s behaviors, such as diet, exercise, smoking, etc., especially through organized health education programs. This is also called lifestyle change or health promotion.

Behavioral care services: assessment and therapeutic services used in the treatment of mental health and substance abuse problems.

Benchmarking: measuring products and services for comparison against industry leaders—in health care, the method of identifying best practices that relates a specific type of treatment to a specific outcome; part of quality improvement (QI) initiatives.

Beneficiary (also, Eligible; Enrollee, Member): the individual designated by an insuring organization as eligible to receive insurance benefits.

Benefit: service allowed for coverage/financial reimbursement provided under an insurance policy or prepayment plan.

Bona fide wellness program: a program governed by the IRS (prop. reg. § 54.9802-1(f)) that allows companies to institute health insurance cost differentials (savings) for individuals who participate in wellness programs that promote health or prevent disease. Differentials can be up to 20% of the full cost of individual health benefits.

Business associate: entities such as consultants, attorneys, accountants, actuaries, or third party administrators (TPA), to whom a covered entity discloses Protected Health Information (PHI) in order to assist with the performance of payment, treatment, or health care operations.

Business coalition on health: a group of employers, usually from a defined geographic concentration, who join to study and/or purchase health care for their own employees. By creating a larger pool, these employers can often dilute risk and create a more effective purchasing block.

Buying group: an organization representing multiple independent buying sources.

Cafeteria plan: a corporate benefit plan under which employees are permitted to choose among two or more benefits that consist of cash and certain qualified benefits. Cafeteria plans are also called “flexible benefit plans” or “flex plans.”²

CAHPS (formerly the Consumer Assessment of Health Plans Study): a comprehensive and evolving family of survey instruments and reporting tools used to evaluate consumer and patient experiences with their health care.

Capitation: a payment structure in which an HMO pre-pays a provider a flat amount for each member’s medical care, usually on a monthly basis.²

Capitation, global: a payment structure in which providers are paid a single per-member-per-month rate to cover all care (professional, facilities and technical services) for a population.²

Carve out: to purchase separately services that are typically part of a managed care package. For example, an HMO may “carve out” the pharmacy benefit and select a specialized vendor to supply these services on a stand-alone basis. Carve outs are common among self-funded health plan sponsors.

Case management: the coordination of medical services for patients with extensive, complex or serious medical conditions to ensure planned treatment is both cost effective and of high quality.

Centers for Medicare and Medicaid Services (CMS): a branch of the U.S. Department of Health and Human Services, formerly known as the Health Care Financing Administration, which is responsible for overseeing Medicare, Medicaid, HIPAA and other state and federal programs.

Charge: the total fee requested by a provider in payment for a service, often significantly higher than the actual cost of providing those services, in order to cover general operating expenses and generate profit.

Cherry picking: the practice by private insurance companies of offering medical insurance to individuals whom they believe to be healthy while denying coverage to those whom they believe to be unhealthy. ³

Chronic illness: conditions or disease that is ongoing, often for the lifetime of an individual, and for which medical services, medications, and support services are expected to be needed on a long-term basis. ⁶

Claim: information submitted by a provider or a covered individual to establish that medical services were provided to a covered individual and from which the payment to the provider or covered individual is made.

Clinical care pathway: a systematically developed statement or algorithm that helps providers make informed decisions about appropriate healthcare in specific clinical circumstances; helps improve patient care, reduces inappropriate procedures, eliminates duplication of services, controls costs, and manages risk; also called practice parameters, protocols, care pathways, clinical care pathways, clinical practice guidelines, practice policies, or care maps.

Coinsurance: a cost-shifting technique for a medical insurance plan whereby consumers pay a fixed percentage of the cost of medical care.

Community-acquired infection: an infection contracted outside a hospital.

Community rating: a system for developing the cost of health plan premiums based on the average utilization and cost in a geographic area. Its purpose is to ensure smaller employers of reasonable rates for health plans, although in high-cost area, the employer with better-than-average costs will pay more if plans are community rated. ⁶

Computerized physician order entry (CPOE): an electronic prescribing system that intercept errors at the time medications are ordered—orders are integrated with patient information, including laboratory prescription data.

Concurrent review: the process by which hospital admissions for elective and emergency treatment are certified for appropriateness at the time of service and by which continued stays are verified for medical necessity and level of care. ⁴

Congestive Heart Failure (CHF): heart failure in which the heart is unable to maintain adequate circulation of blood in the tissues of the body.⁷

Consolidated Omnibus Budget Reconciliation Act (COBRA): the federal law that, among other things, requires employers to offer continued health insurance coverage to certain employees and their beneficiaries whose group health insurance coverage has been terminated.

Continuum of care: a range of clinical services provided to an individual or group, which may reflect treatment rendered during a single inpatient hospitalization or care for multiple conditions over a lifetime.

Consumer-directed health care (also called consumer-driven health care or CDHC): a health benefits model in which employees (consumers) are directly involved in the purchase and selection of health care services.

Consumer-purchaser disclosure project: a group of leading employer, consumer, and labor organizations that have united to initiate actions to assure that all individuals in the U.S. have access to publicly reported health care performance information such as nationally standardized measures for clinical quality, consumer experience, equity and efficiency, by 2007.

Continuous quality improvement (CQI): a process which continually monitors program performance, revises approaches as necessary, and monitors the implementation and success of the revised approach.¹

Coordination of benefits (COB): a method by which two or more carriers or plans coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred.

Copayment: the amount paid by the plan member, usually at the time of service, to the medical provider directly, as required by the plan.⁶

Core measures: standardized performance measures that can be applied across accredited health care organizations in each of Joint Commission on Accreditation of Health Care Organization's (JCAHO) accreditation programs.

Coronary Artery Disease (CAD): a condition that reduces the blood flow through the coronary arteries to the heart muscle.⁷

Cost: the total expenses associated with providing a service.

Cost-benefit analysis (CBA): Type of health economic study that determines both costs and outcomes in dollar terms; useful in determining the most beneficial use of limited resources; results are determined by benefit-to-cost ratio, net present value, and return on investment; outcomes can be easily compared from study to study.

Cost containment: control or reduction of inefficiencies in the consumption, allocation, or production of health care services in order to lower health care costs.

Cost-effectiveness analysis (CEA): an economic analysis that examines the degree to which a service meets specified therapeutic goals and is expressed in a C/E ratio.

Cost-minimization analysis (CMA): a type of health economic analysis that determines the overall cost (expenditures less savings) for a given medical intervention.

Cost shifting: the practice of causing another entity or person to pay for health care services typically provided by another party.

Cost-utility analysis (CUA): a type of health economic study that is similar to cost-effective analysis (CEA) but takes into account the fact that all outcomes are not equivalent in terms of quality of life or utility; measures costs in dollars and outcomes in qualitative terms; outcomes are often presented as quality-adjusted life years.

Covered entity: any entity, such as a health plan, health care clearinghouse, or provider, who transmits or receives protected health information; an entity regulated by law under HIPAA.

CPT codes: CPT codes (current procedural terminology codes) are published procedure codes used by physicians and hospitals in billing as a uniform description of what medical service was provided. They are linked, by insurance carriers, MCO's, and self-funded plans, with a range of cost based on the geographic area in which they were provided. ⁶

Deductible: an annual out-of-pocket, lump-sum payment for medical services that a consumer must pay before medical insurance provides reimbursement. ³

Defined contribution: defining a set amount of dollars available to pay for benefits when purchasing health insurance on behalf of a population.

Demand management: a catchall phrase used when a plan member initiates service of any kind. It is often delegated to a professional medical firm to provide the demand management services that help with chronic, catastrophic, or urgent health care needs. ⁶

Diagnosis related group (DRG): a prospective hospital claims reimbursement system first implemented by the Medicare program. Reimbursement is based on a predetermined classification of diagnoses, treatments, age, sex and discharge status of patients.⁴ DRG also refers to a classification of patients by diagnosis or surgical procedure into major diagnostic categories for the purpose of determining payment; also called *diagnostic* related group.

Disclosure: the release or divulgence of information by an entity to persons or organizations outside of that entity; also referred to as "transparency."

Discount fee schedule: a published schedule that has been accepted as payment in full for medical services, by providers in a network or by those who have a special contractual relationship with the health plan. ⁶

Disease management: protocols for and interventions by medical professionals with patients and their families for the purpose of assisting with treatment options and services needed to manage a chronic or catastrophic condition or disability. The goal of these services is to improve outcomes, coordinate patient needs, educate and counsel the family, and, in the process, help to reduce costs by making full use of appropriate services.⁶

Disparity: 1. a difference in health care quality based on geography. 2. a difference in health care quality and/or availability based on race, socioeconomic, or some other status.

Dispensing fee: a fee paid to a mail or retail pharmacy for dispensing a drug.

Drug mix: the distribution of drugs in a given therapeutic class that has been influenced by advertising.

Drug utilization review (DUR): a series of third party edits instituted to assure that prescribed drugs are in compliance with plan design, basic safety, eligibility, and efficacy.

Electronic medical record (EMR): also referred to as a computerized medical record or an electronic patient record, this term refers to the capture, storage, and retrieval of a computerized history of a patient's medical and health care records. Sometimes referred to as a longitudinal medical record because it can store information linking a great many encounters across many providers and over a long period of time.

Employee contribution: the amount an employee pays for his or her insurance.

Employee Retirement and Income Security Act (ERISA): landmark federal legislation that requires reporting, disclosure, and strict adherence to standards for fiduciaries of employer-sponsored health plans. ERISA plans include self-funded health plans, labor-management (union) pension and health benefit funds. ⁶

Employer contribution: the amount an employer pays for an employee's insurance.

Evidence based medicine (EBM): medical treatment and interventions based upon scientific medical research, usually expressed in practice guidelines and clinical pathways.

Evidence-based hospital referral (EHR): a Leapfrog Group initiative in which outcome and volume based patient safety information is used to choose hospitals that have safer outcomes for certain high-risk procedures.

Experience rating: premium calculation based on the cost of claims and utilization history. ⁶

Fee-for-service payment: a method of payment for medical care service whereby a medical care provider receives an individual payment for each medical service provided. ³

Financial incentive: a provider payment mechanism used to induce a particular set of behaviors, e.g. cost-effective utilization, low utilization, or increased quality.

First dollar coverage: a health insurance plan that reimburses an individual for all medical care expenses, beginning with the first dollar spent on medical care. ³

Flexible saving account (FSA): an IRC Section 125 plan that gives employees the opportunity to set aside pretax funds for the reimbursement of eligible tax-favored benefits. ⁴

Formulary: a listing of pharmaceutical products, grouped by pricing tiers, that a health plan will cover; also known as a “preferred drug list.”

Fully insured: a group insurance plan in which an insurer pays all claims and assumes all risks for an employer in exchange for payment of a regular premium. ⁴

Gatekeeper: a term used to describe the role of a primary care physician as the authority to approve, arrange, or authorize care in an HMO or other managed care network.²

Generic: a drug that is equal in therapeutic power to brand-name originals because it contains identical active ingredients at the same doses.

Generic as a percent of total: the fraction of generic prescriptions as a percent of total prescriptions *regardless of whether generics are available for any particular drug*. Note: this is not the same as the generic substitution rate.

Generic substitution rate: the rate at which generics are substituted *when there is a generic equivalent available*.

Genomics: the study of genetic material in the chromosomes of a particular organism and the material’s activity.

HealthCare 21 Business Coalition (HC21): a non-profit, member driven organization committed to improving the quality and cost of health care in East and Middle Tennessee.

Health Care Finance Administration Maximum Allowable Cost (HCFA MAC): a pricing strategy set by the government for generic drugs regardless of the manufacturer.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): an act of Congress that seeks to 1) ensure the continuity of health care coverage for individuals who change employers, 2) address issues of health information management, 3) simplify the administration of health insurance, and 4) prevent waste and abuse in the health insurance and health care industries.

Health maintenance organization (HMO): a health care delivery system that combines the insurer and provider functions. HMOs are prepaid and in return provide comprehensive services to enrollees. ³

Health Plan Employer Data and Information Set (HEDIS): HEDIS is a set of standardized measures for managed health care plans used to assess plan performance and is designed to allow purchasers and consumers to make informed choices when purchasing health care. HEDIS is a component of the National Committee for Quality Assurance.

Health reimbursement arrangement (HRA): an employer-owned account used to reimburse an employee for medical expenses incurred by the employee. Reimbursements through an HRA are non-taxable and are provided up to a predetermined maximum amount. At the end of a coverage period, an employee can roll over unused portions of the predetermined amount to increase the maximum reimbursement amount of a subsequent coverage period.²

Health risk assessment (HRA): a tool to measure the health risks of those completing a series of lab tests or an information form, or responding to questions about their health history and lifestyle.⁶

Health savings account (HSA): is a tax-sheltered savings account, similar to an IRA, for health related expenses that was created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. HSAs have more flexibility in terms of eligibility requirements and plan design than previous medical savings, spending, or reimbursement accounts. HSAs must be used in conjunction with a High Deductible Health Plan.

Heart Failure (HF): occurs when the heart loses its ability to pump enough blood through the body. Usually the loss in pumping action is a symptom of an underlying heart problem, such as coronary artery disease. Congestive heart failure is a type of heart failure.⁸

High deductible health plan (HDHP): a term applied to health plan designs that have a high deductible and meet specific criteria established by the Internal Revenue Code for use with medical related savings accounts such as Medical Savings Accounts (MSAs) and Health Savings Accounts (HSAs).

High risk: a plan member who for whom a predisposition to one or more diseases or conditions seems likely, by virtue of lifestyle issues such as smoking or obesity, a family history of a condition, personal symptoms, or health history.⁶

Horizontal integration: the melding of like services via contractual relationships, partnerships, or purchases that allows a provider organization to offer a range of a particular type of health care products or services to a defined population.

Hospital-Consumer Assessment of Health Plans Study (HCAHPS): an annual nationwide survey that is used to report information on Medicare beneficiaries' experiences with hospitals.

ICD Codes: International Classification of Diseases codes, a system for coding diagnoses and procedures. Revisions are noted by adding a sequential update number after the code, such as ICD-10 for 10th revision.

Incentives: the use of economic reward by some formularies to promote the use of preferred products.

Indemnity insurance: medical insurance that reimburses the insured a fixed amount for each type of medical service received.³

Independent provider association (IPA): a type of health maintenance organization that contracts with a number of independent medical care providers to deliver medical services at a discounted price or on a capitation basis.³

Institute of Medicine (IOM): a non-governmental entity created to provide unbiased, evidence-based, authoritative information and advice concerning health and science policy to policy-makers, professionals, and leaders in every sector of society, as well as the public at large.

Insurance premium: the cost of medical insurance. In the private market, it equals the sum of expected benefits paid out, administrative costs, taxes, and profits.³

Integrated care: 1. the concept of combining various types of health services in a coordinated manner. 2. integration of multiple services through the use of disease management, case management coordination, and education.⁶

Integrated delivery system (IDS): A health care provider system, typically including different care sites providing different levels of service.

Intensivist: a physician with special training in intensive care.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO): an accrediting body that periodically evaluates and awards accreditation status to facilities such as hospitals, skilled nursing facilities, and health maintenance organizations in recognition of satisfactory performance. Most managed care plans and some state and federal programs require JCAHO certification.⁴

Law of large numbers: an insurance term referring to the concept of spreading risk among a large pool or group of individual risks (persons, organizations, entities) to lessen the impact of loss on all.⁶

Leapfrog Group, The: a national non-profit organization whose objective is to promote large improvements, or “leaps,” in patient safety in a hospital setting.

Length of stay (LOS): refers to the length of time a patient is hospitalized.

Lifestyle drugs: drugs that may improve the user’s quality of life but do little to improve medical outcomes or reduce overall health care costs.

Loading fee: the portion of medical insurance premiums in excess of expected benefits paid out.³

Maintenance medication: a drug usually prescribed for a long period of time or to treat conditions of a long-term or chronic nature.

Managed care organization (MCO): an organization that controls the utilization and cost of medical care by reviewing and monitoring the appropriateness, extensiveness, and costs of medical services.³

Maximum allowable cost (MAC): a ceiling price for selected generic drugs; typically an expansion on the Health Care Finance Administration MAC list.

Maximum (annual): a fixed amount payable for all claims of each plan member during one plan year (often applies only to major medical coverage).⁶

Maximum (lifetime): a fixed amount beyond which the plan will not pay, for all covered claims for each plan member for all types of coverage combined, for the person's lifetime.⁶

Maximum (benefit): a set amount an insurer will pay for specific benefit.⁶

Medicaid: a jointly financed program of the federal and state governments that provides medical insurance to specific segments of the low/limited income population.³

Medical expense ratio: a comparison of insurance premiums (amount paid to the health plan) to the amount a health plan paid out in claims.

Medical expense reimbursement plan (MERP): a reimbursement plan (an employer funded FSA) in which an employee is refunded medical expenses after the employee has returned receipts for the expenses incurred.

Medical savings accounts (MSA): a savings account that can be used to pay for medical expenses not covered by insurance for employees of small businesses or self-employed individuals who are covered under health plans with high deductibles.⁴

Medicare: the national health insurance program for individuals age 65 or older and some under age 65 with disabilities or a specific condition.

Medicare + Choice: part of the Balanced Budget Act of 1997 that significantly increases the number of insurance plans available to Medicare recipients, along with altering the method in which Medicare pays for those plans.³

Medicare provider analysis and review (MedPAR): administrative data on all Medicare beneficiaries discharged from all short stay hospitals.

Medigap insurance policies: private insurance policies purchased by elderly individuals to cover some or all of their medical expenses not paid for by Medicare.³

Minimum premium plan (MPP): under this approach, the employer and the insurance company or the service plan agree that the employer will be responsible for paying all claims up to an agreed-upon aggregate level, with the carrier being responsible for the excess.⁴

Moral hazard: the situation in which individuals (providers or consumers) alter their behavior due to the presence of insurance, for example, requesting more medical services, or ordering more tests.

Morbidity rate: the rate at which a given disease is present in a population.³

Mortality rate: the death rate for a given population measured by the ratio of the number of deaths divided by the average size of the population during a given period.³

Multi-employer welfare arrangement (MEWA): an employee welfare benefit plan governed under ERISA §3(40) which is established or maintained for the purpose of offering or providing any welfare benefit to the employees of two or more employers.

Multipayer system: a system in which health care providers are reimbursed by numerous third-party payers.³

Multisource drug: a drug that is no longer under patent protection and is available from alternative suppliers.³

National Academies: non-governmental organizations that advise on science, engineering, medicine, and research; the Academies consist of four organizations: the National Academy of Science (NAS), the National Academy of Engineering (NAE), the Institute of Medicine (IOM), and the National Research Council (NRC).

National Business Coalition on Health (NBCH): a coalition that represents regional business coalitions on health at a national level.

National CAHPS Benchmarking Database (NCBD): the national repository of CAHPS survey data, designed to facilitate benchmarking and research.

National Committee for Quality Assurance (NCQA): An independent, private sector group that reviews care quality and other procedures of managed care organizations to render an accreditation.⁴

National Drug Code (NDC): a medical code set maintained by the Food and Drug Administration that contains codes for drugs that are FDA-approved. The 11 digit NDC code is divided into three segments which indicate the manufacturer, drug name, and package size.

National Institutes of Health (NIH): an agency of the U.S. Department of Health and Human Services which acts as a steward of medical and behavioral research.

National Quality Forum (NQF): a private, not-for-profit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting.

National Voluntary Consensus Standards for Hospital Care: a set of thirty-nine voluntary consensus standards based on national standardized performance measures endorsed by the NQF to assess the quality of care provided by acute care hospitals.

Network: a group of contracted providers who agree to provide services on some reduced cost basis, subject to acceptance by the network.⁶

Network health maintenance organization: an HMO that provides physician services by contracting with more than one physician group practice.³

Nosocomial infection: infection acquired while in the hospital.

NQF safe practices: a set of thirty healthcare practices that the NQF believes should be universally implemented in applicable clinical settings to reduce medical mistakes.

Open access: arrangements allowing members to see participating providers, usually specialists, without referral from the health plan's gatekeeper.²

Outcome measure: a measure that describes a patient's health status or level of functionality following an episode of healthcare.

Out-of-pocket-maximum: the maximum amount of money an individual will pay in addition to premium payments (usually the sum of the deductible and coinsurance payments).⁴

Out-of-pocket price: the price consumers pay for medical care after all third-party payments have been considered.³

Over-the-counter drug (OTC drug): a drug that consumers can purchase without a prescription from a physician.³

Patient dumping: the situation in which a private hospital fails to admit a very sick patient because it fears that the medical bills will exceed a preset limit established by a third-party payer.³

Pay or play: a proposed method of coverage that would require businesses either to pay a payroll tax to a government program to cover their employees or to buy private health insurance for all their full-time employees.

Peer review: an evaluation, provided by medical staff with equivalent training, of the quality of total health care.

Percutaneous Coronary Intervention (PCI): generally refers to techniques used to relieve coronary narrowing, including Percutaneous Transluminal Coronary Angioplasty (PTCA) and other techniques such as atherectomy, implantation of coronary stents, and other catheter devices.⁸

Percutaneous Transluminal Coronary Angioplasty (PTCA): commonly referred to as balloon angioplasty. PTCA is a non-surgical procedure performed in a cardiac catheterization laboratory, where a specially designed catheter with a small balloon tip is guided to the point of narrowing in the artery. Once in place, the balloon is inflated to compress the fatty matter in to the artery wall and stretch the artery open to increase blood flow to the heart. A heart attack patient who received a PTCA treatment quickly has a greatly increased chance of survival.⁸

Performance measure: a specific measure of how well a health plan provides health services to its enrolled population.

Per member per month (PMPM): a common payment method used to charge for health plan premiums, PPO services, nurse call lines, administrative services, and most ancillary services to health plans.⁶

Personal health care expenditures: the total expenditure by individuals on medical care goods and services³

Pharmacoeconomics: a field of study involving the analysis of cost effectiveness/ cost consequences of pharmaceutical therapy and pharmaceutical care.

Pharmacogenomics: a term used to describe drug therapies engineered based upon either the specific genetics of a patient or the genetic information of a pathogen. Pharmacogenomics is also known as a form of “personalized medicine.”

Pharmacy benefit manager (PBM): a company that administers and manages prescription drug benefits for employers, health plans, and other organizations offering prescription drug benefits.²

Pharmacy and therapeutics committee (P&T): a committee of physicians, pharmacists, and healthcare professionals that establishes and maintains a drug list for a given drug management entity.

Physician profiling: the process that selects and monitors the clinical performance of physicians and patient satisfaction.

Plan sponsor: the party that establishes and maintains the plan.

Practice guidelines: systematically developed, evidence-based statements on medical practice that assist a practitioner and a patient in making decisions about appropriate health care for specific medical conditions.

Pre-existing condition: illness or medical condition that exists before a member is covered by a health plan.⁶

Preferred drug list (PDL): See “formulary”

Preferred provider organization (PPO): a third-party payer that offers financial incentives, such as low out-of-pocket prices, to enrollees who acquire care from a preset list of physicians and hospitals.³

Premium: Amount paid to a carrier or health plan for providing insured coverage under a contract.

Prescription drug: a drug that can only be purchased with a physician’s prescription.³

Primary care: refers to 1) medical services that deal with the prevention, early detection, and treatment of disease,³ and 2) basic or general health care as opposed to specialist or sub-specialist care.

Primary care physician (PCP): a physician specializing in family practice, general practice, internal medicine, obstetrics/gynecology, or pediatrics.³

Prior authorization: the process of obtaining prior approval for a service or medication.

Process measure: a measure which focuses on a process that leads to a certain outcome, meaning a scientific basis exists for believing that the process, when executed well, will increase the probability of achieving a desired outcome.⁵ Examples of process measures include prescribing aspirin to patients with coronary heart disease and turning immobile patients in hospital beds on a regular schedule to prevent bed sores.

Prospective review: a pre-approval process implemented *before* medical care is provided; often required in order for insurance to approve payment.

Protected health information (PHI): a term used by HIPAA to describe any health information that is individually identifiable: any individually identifiable health information created or received by a covered entity that relates to 1) a person's past, present or future physical or mental health, 2) provision of health care to that person, or 3) past, present or future payment for that person's health care.

Protocols: guidelines for specific treatment options once a diagnosis is made.

Provider: any of a host of medical professionals that render care to patients.⁶

Public contracting model: a health insurance model in which the government contracts with various health care providers for medical services on behalf of the general population.³

Q-Source: the name of the state of Tennessee's Quality Improvement Organization (QIO).

Quality: the degree to which delivered health services meet established professional standards and judgments of value to the consumer. 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 assessment: a formal, systematic review of part or all of a health delivery program.

Quality Compass: a national database of audited performance indicators (HEDIS & CAHPS) developed and maintained by the NCQA.

Quality improvement organization (QIO): any of a number of not-for-profit organizations directed by CMS and dedicated to the review and improvement of health care quality.

Quaternary-level care: regionally based, highly specialized care often associated with major academic medical centers.

Report Card on Healthcare: an emerging tool that can be used by policy makers and healthcare purchasers to compare and understand the actual performance of health plans.

Retroactive review: an after-the-fact review of hospital records to verify that appropriate care was given at the time of service and continued stays were verified for medical necessity and level of care.

Return on investment (ROI): a method of performing a cost-benefit analysis that compares the net benefit derived from a particular investment to the overall costs associated with that investment.

Risk adjustment (insurance): the process of setting the capitation rate for an insurance policy based on the health status and expected medical costs of an individual or group purchasing the plan.³

Risk adjustment (medical): a general term for statistical methods that account for patient risk factors and are used to adjust a physician's or hospital's performance results to take into account the illness of their patients.

Risk assessment: the process of modeling and estimating the expected medical costs of a person or group of people.³

Risk aversion: the quality of preferring less risk to more, all things being equal.³

Risk selection: when a greater share of individuals with either higher or lower than expected medical costs enroll in or select a particular medical insurance plan.³

Secondary care: medical care that consists of more sophisticated treatments than primary care services.³

Section 125 plan: refers to flexible benefit plans; derived from the section of the IRS code which defines such plans and stipulates that employee contributions to such plans may be made with pretax dollars.

Selective contracting: when a third-party contracts exclusively with a pre-selected set of medical care providers.³

Self-funding: use of a fund to pay health claims and costs, with moneys deposited to the fund by the plan sponsor.⁶

Self-insurance: establishment and maintenance of a fund and program to provide a health plan with the plan sponsor's assumption of the risk for losses.⁶

Set-up fees: service fees charged by providers and MCO's to establish or modify a health plan or to initiate new services.⁶

Single employer trust: a type of welfare benefit trust established for the use of a single company wherein contributions to the trust are tax-deductible.

Single payer: a situation in which only one third-party payer is responsible for paying health care providers for medical services.³

Single-source drug: a drug covered by patent protection.³

Staff-model health maintenance organization: an HMO that directly employs physicians on a salary basis.³

Statement of work (SOW): annual directives given to the QIO from the CMS which guide quality improvement education programs.

Stop-loss contract 12/12: a contract basis that provides stop loss coverage for claims which are incurred and paid in the 12 month stop-loss contract period.

Stop-loss contract 15/12 (and 24/12): contract basis that provides stop-loss coverage for claims which are incurred three months prior to the beginning of the contract year through the end of contract year which are paid within the 12 month stop loss contract period. Similarly, the 24/12 contract basis provides coverage for claims which are incurred 12 months prior to the beginning of the contract year through the end of the contract year and paid during the contract year.

Stop-loss insurance: insurance that accepts a layer of risk from the health plan sponsor in exchange for a premium calculated on the likelihood that the company will have to pay.⁶

Stop-loss insurance, aggregate: standard insurance, approved by each state, provided by an insurance company for a premium to cover health plan losses that rise above an agreed-upon level for the plan year.⁶

Stop-loss insurance, specific: insurance licensed and regulated by each state and provided by an insurance carrier. This insurance covers the health plan for each individual member whose claims exceed a specific amount for the plan year. Often this amount is set at \$75,000 to \$100,000 for the year which is also called an attachment point.⁶

Summary health information: a term used under HIPAA to describe claims history, claims expenses, or types of claims experience in which all personal identifiers are removed.

Tertiary care: highly complex medical care that involves more sophisticated medical treatments than primary or secondary medical care.³

Theory X of health economics: an economic theory stating that health and disease occur randomly and that economic incentives cannot be called upon to provide quality medical care at low cost; instead, government intervention is needed to ensure that individuals have access to quality medical care.³

Theory Y of health economics: an economic theory stating that individuals have significant control over health through lifestyle choices and that the market mechanism can discipline health care providers to provide high-quality medical care at a low cost; therefore, there is little need for government intervention in health care markets.³

Therapeutic class: a group of drugs that treat the same condition using similar mechanisms.

Third party administrator (TPA): a business, such as a health plan, that provides administrative services for a plan sponsor; the plan sponsor bears the risk for claims. See also “administrative services only.”

Third-party payer: an organization that provides medical care insurance to individuals in return for tax or premium payments.³

Total Quality Management (TQM): A management approach stressing quality control as the responsibility of everyone in the organization, not just the staff formally charged with quality assurance.

Transparency: See “Disclosure.”

Underwriting: a method for calculating risk and its cost used by the insurance industry taking into account a wide range of factors to conclude likely losses for particular groups and large entities.⁶

Underwriting cycle: a regular cyclic fluctuation of health premium costs thought to be caused by the lag time between insurers obtaining, analyzing, and then implementing premium price adjustments.

Universal coverage: when an entire population has medical insurance coverage.³

Usual, customary, and reasonable rate (UCR): a cost control method utilized by third-party payers to control the fees paid to medical care providers for medical goods and services.³

Utilization: the use of services, as measured by industry norms of inpatient stays, outpatient services, and treatment.⁶

Utilization report: a report detailing which services are used and how often, by which plan members, and in what patterns.⁶

Utilization review: an examination of the service provided—taking into account the condition or diagnosis of the patient, health history, treatment pattern, and previous treatment—to determine if the services provided were appropriate, within medical necessity guideline, in keeping with accepted protocols, and helpful to the patient.⁶

Uncompensated care: a service provided by physicians and hospitals for which no payment is received from the patient or from third-party payers.

Value-based purchasing (VBP): a range of activities initiated by public and private purchasers of health care (i.e. employers and public programs) to use comparative performance information to publicly recognize, financially reward, and promote selection of health care providers (particularly health plans, hospitals, and physicians). There are four critical steps to VBP:

1. **Performance measurement** of health care providers
2. **Public reporting** of comparative performance information
3. **Differential payment** based on comparative performance information
4. **Selection** of health care providers based on comparative performance information

Vertical integration: an integrated health system in which physicians, hospitals, and payers provide a continuum of care.

Acronyms

AAHC – American Accreditation Healthcare Commission (formerly URAC)

ADL – Activities of daily living

AHA – American Hospital Association

AHPs – Accountable health plans

AHRQ – Agency for Healthcare Research and Quality

AMA – American Medical Association

ASO – Administrative services only

AWP – Average wholesale price

CAD – Coronary heart disease

CAHPS – Consumer Assessment of Health Plans Study

CBA—Cost-benefit analysis

CDC – Centers for Disease Control and Prevention

CDHC – Consumer-driven health care *or* consumer-directed health care

CEA—Cost-effectiveness analysis

CHF – Congestive heart failure

CMA—Cost-minimization analysis

CMS – Centers for Medicare and Medicaid Services

COB – Coordination of benefits

COBRA – Consolidated Omnibus Budget Reconciliation Act

CPOE – Computerized physician order entry

CPT codes – Current procedural terminology codes

CQI – Continuous quality improvement

CUA – Cost utility analysis

DHHS – Department of Health & Human Services

DME – Durable medical equipment

DRG – Diagnosis related group *or* diagnostic related group

DUR – Drug utilization review

EBM – Evidence-based medicine

EHR – Evidence-based hospital referral

EMR – Electronic medical record

EOB – Explanation of benefits

ERISA – Employee Retirement and Income Security Act

FDA – Food and Drug Administration

FFS – Fee-for-service

FSA – Flexible saving account

HC21 – HealthCare 21 Business Coalition

HCAHPS – Hospital-Consumer Assessment of Health Plans Study

HCFA MAC – Health Care Finance Administration Maximum Allowable Cost

HDHP – High-deductible health plan

HEDIS – Health Plan Employer Data and Information Set

HF – Health failure

HIMSS – Healthcare Information and Management Systems Society

HIPAA – Health Insurance Portability and Accountability Act of 1996

HMO – Health maintenance organization

HRA – Health reimbursement arrangement *or* health risk assessment

HSA – Health savings account

ICD codes – International Classification of Disease codes

IDS – Integrated delivery system

IOM – Institute of Medicine

IPA – Independent provider association

JCAHO – Joint Commission on Accreditation of Healthcare Organizations

LOS – Length of stay

LTC – Long-term care

MAC – Maximum allowable cost

MCO – Managed care organization

MedPAR – Medicare Provider Analysis and Review

MERP – Medical Expense Reimbursement Plan

MEWA – Multi-employer welfare arrangement

MMA – Medicare Prescription Drug, Improvement and Modernization Act of 2003

MPP – Minimum premium plan

MSA – Medical savings account

NBCH – National Business Coalition on Health

NCBD – National CAHPS Benchmark Database

NCQA – National Committee for Quality Assurance

NDC – National Drug Code

NIH – National Institutes of Health

NQF – National Quality Forum

OTC – Over the counter [drugs]

P&T – Pharmacy & therapeutics

PBM – Pharmacy benefit manager

PCP – Primary care physician

PDL – Preferred drug list

PHI – Protected health information

PHO – Physician hospital organization

PMPM – Per member per month

PPO – Preferred provider organization

PPS – Prospective payment system

PRO – Professional (or peer) review organization

QA/QM – Quality assurance/quality management

QIO – Quality improvement organization

QOL – Quality of life

ROI – Return on investment

SOW – Statement of work

TPA – Third party administrator

TQM – Total quality management

UCR – Usual, customary, and reasonable rate

UM – Utilization management

Glossary Bibliography

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