The State of Delaware

Glossary of Important Health Care Terms

DRAFT

July 25, 2016

Willis Towers Watson

Note: *Italicized* words refer to other terms defined in this glossary.

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Terminology	Acronym	Definition
Account Based Health Plan	ABHP	Combines a high deductible health plan with a health care account (e.g., *health reimbursement account*, *health savings account*) that can be used to offset the cost of the deductible or pay for other medical services after meeting the deductible.
Accountable Care Organization	ACO	Groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their patients.
Actuarial Value	AV	Percentage of total average costs for covered benefits that a plan will cover. Bronze, silver, gold, and platinum are plans according to the Affordable Care Act that cover an increasingly greater share of enrollees' medical expenses.
Administrative Services Only	ASO	When an organization funds its own employee benefit plan, such as a health insurance program, and it hires an outside firm to perform specific administrative services. Also referred to as "self-funded". Currently, the GHIP has ASO contracts with Aetna, Highmark and Express Scripts.
Bundled Payment	n/a	Lump sum payment covering all health care services related to a specific procedure, episode of care, or population. Bundle is usually based on an acute event plus some specified time period following the event. Payments may be risk adjusted based on the severity of illness/injury or complexity of the procedure(s) covered.
Center of Excellence	COE	Provider that has been identified as delivering high quality services and superior outcomes for specific procedures and/or conditions. May incorporate separate contracting arrangements for a predetermined set of services (e.g., see *bundled payment*).
Consumer Driven Health Plan	CDHP	Allows members to use *health savings accounts*, *health reimbursement accounts*, or other similar medical payment products to pay routine health care expenses directly.
Diagnosis Related Group	DRG	A statistical system of classifying any inpatient stay into groups for the purposes of payment. The DRG classification system divides possible diagnoses into more than 20 major body systems and subdivides them into almost 500 groups for the purpose of Medicare reimbursement. Payments may be risk adjusted based on the severity of illness/injury or complexity of the procedure(s) covered.

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Electronic Medical Record	EMR	A digital version of a paper medical chart that contains all of a patient's medical history from one medical practice. An EMR is primarily used by doctors for diagnosis and treatment.
Evidence-Based Medicine	EBM	An approach to medical practice intended to help providers make decisions about the best possible care for individual patients by using the best evidence available from well-designed, scientifically tested research.
Fee-for-service	FFS	A traditional method for reimbursing medical providers for the services they administer to patients, in which a provider is allowed to charge a fee for each service rendered to a patient. Fees for providers who participate in a third-party administrator's network are typically determined as a percentage discount off of the provider's billed charge.
Flexible Spending Account, Full Use	FSA	A tax-advantaged financial account. Allows an employee to set aside a portion of earnings to pay for qualified medical, dental, and vision expenses. The IRS limit is $2,550, but can be set lower if the employer chooses.
Flexible Spending Account, Limited Purpose	FSA	A tax-advantaged financial account. Allows an employee to set aside a portion of earnings to pay for qualified dental and vision expenses only. The IRS limit is $2,550, but can be set lower if the employer chooses. May be used if a member is enrolled in an HSA.
Global Capitation	n/a	Fixed payment amount (per member) to a physician or group of physicians for a defined set of services for a defined set of members. Fixed or "capitated" payment per member provides physician with an incentive for meeting quality and cost efficiency outcomes, since the physician is responsible for any costs incurred above the capitated amount. May be risk adjusted based on the demographics of the member population or changes in the member population. Often used for *bundled payments* or other *value-based payments*.

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Health Reimbursement Account	HRA	Employer-funded account that reimburses employees for out-of-pocket medical expenses. Employees can choose how to use their HRA funds to pay for medical expenses, but the employer can determine what expenses are reimbursable by the HRA (e.g., employers often designate prescription drug expenses as ineligible for reimbursement by an HRA). Funds are owned by the employer and are tax-deductible to the employee.
Health Savings Account	HSA	Tax-advantaged savings account available to tax payers who are enrolled in an IRS-qualified *high deductible health plan* (i.e., an *account based health plan* that meets IRS guidelines for tax-advantaged status). Can be funded by the employer and/or the employee, up to certain annual limits specified by the IRS. An HSA is a "triple tax advantaged" account, meaning that an individual can deposit money into the account on a pre-tax basis (Federal tax free; the following states assess income tax on HSA deposits: AL, CA, NJ). Funds in an HSA grow at a tax-free rate, and distributions from an HSA are tax free if HSA funds are spent on medical expenses defined by the IRS as being "qualified" or eligible for reimbursement using the HSA. Funds used for non-qualified expenses are subject to taxation. Funds roll over from year to year if they are not spent. The HSA is owned by the individual accountholder and is theirs to keep even if they leave their employer or retire.
High Deductible Health Plan	HDHP	An *account based health plan* that meets IRS guidelines for tax-advantaged status and includes an *HSA*.
High Performance Network	HPN	Typically found in heavily concentrated employer locations. Network provider selection is based on a provider's ability to meet certain cost/quality targets. Often requires provider agreement to accept *value based payments* in lieu of traditional *fee-for-service* arrangements.
Metric-Based Pricing	n/a	See *Reference-Based Pricing*

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Minimum Value	MV	The minimum threshold for the *actuarial value* of a health plan under the Affordable Care Act. A plan with MV should cover at least 60% of the cost of all benefits, i.e., for every $1 spent on medical procedures and treatments, at least $0.60 will be covered by the plan.
Narrow Network	n/a	A smaller panel of providers that have agreed to deliver medical services at a reduced unit cost in exchange for a higher volume of patients that have been directed to the network through plan design incentives.
Partial Capitation	n/a	See above *Global Capitation*, for a defined set of services rendered by a physician or facility, rather than all services rendered by that provider.
Patient-Centered Medical Home	PCMH	A primary care physician who coordinates a team of clinicians providing a holistic approach to caring for a patient. Requires coordination across all elements of the health care system, including specialty care, hospitals, home health care, and community services. Often includes some sort of *value-based payment* to encourage favorable cost and quality outcomes. Also requires consistent and continual use of technology and data sharing to promote *evidence-based medicine* and provide an enhanced patient experience.
Pay-for-Performance	P4P	See *Value-Based Payment*
Pay-for-Value	n/a	See *Value-Based Payment*
Personal Health Record	PHR	An electronic portal, usually a website or an app, used by patients to track and manage their health information in a private, secure, and confidential environment.
Reference-Based Pricing	n/a	Plan sponsors pay a fixed amount or "reference" price toward the cost of a specific health care service, and health plan members must pay the difference in price if they select a more costly health care provider or service.
Self-Funded	SF	See *Administrative Services Only*
Self-Insured	SI	See *Administrative Services Only*

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Terminology	Acronym	Definition
Shared Risk, Upside/Downside	n/a	See *Value-Based Payment*
Shared Savings, Upside/Downside	n/a	See *Value-Based Payment*
Value-Based Network	n/a	See *High Performance Network*
Value-Based Payment	n/a	Paying a medical provider for meeting a predetermined set of performance goal, including quality, cost efficiency and/or referral/prescribing patterns of care. The payment structure and performance goals will vary based on the provider's willingness to accept responsibility for meeting the goals (i.e., "upside" risk may include a bonus payment if goals are met, "downside" risk may require the provider to pay a penalty to the third-party administrator if goals are not met).