Glossary of Health-Care Terms

The language of health insurance and health care can be confusing and intimidating. But understanding that language can help you know what you are getting when you choose an insurance plan, hospital, or doctor, or treatment option. It can also help you navigate the health system and scope out the changes now underway following the passage of the Affordable Care Act (ACA) in 2010, often referred to as Obamacare.

This glossary is divided into two sections. The first encompasses health insurance, including Medicare, Medicaid, and other public programs. The second deals with what health experts call "the delivery system" —that is, the world of hospitals and doctors and the way care is organized and delivered.

Wikipedia can provide you with further information on most of the terms in this glossary. While Wikipedia's estimated 26,000 health care articles are of varying quality, they provide convenient summaries of primary and secondary sources, supported by citations that can lead you to more authoritative information.

Health Plans vs. Health Policies: Let's make one distinction right away: When is health insurance a "plan" and when is it a "policy?" Today, most insurers talk about and seek to sell you a "plan." That's because almost everybody under age 65 who buys health insurance or gets it through work becomes enrolled in a managed care *plan*, such as an HMO or PPO (see the definitions that follow). The word "policy" is really a throwback to an earlier era (before roughly 1985), when health insurance was organized and sold in a different way.

That said, when you buy health insurance today, you are still buying a "policy" in the sense that it is a legally binding contract that obligates the insurer to pay a portion of your medical bills as long as you keep paying the premiums. In that sense, health insurance operates just like your auto, life, or house insurance (two of which, by the way—auto and house—are essentially mandated if you own a car or buy a house with a mortgage). While we're at it, the term "coverage" (as in "Do you have health coverage?") is synonymous with having health insurance.

Many of the roughly 100 million Americans who get health insurance through Medicare or Medicaid are also enrolled in managed care plans. They don't have health insurance

policies per se, but the government is obligated (via federal and state law) to pay a portion of their medical bills when they enroll.

Health Insurance

Actuarial value. A measure of the percentage of medical services that a health plan will cover and pay for. The actuarial value of a plan is a general measure of the plan's generosity, and it's used to categorize into tiers plans sold to individuals and small businesses. For example, all the new health-care exchanges offer coverage at four levels, or tiers: platinum, gold, silver, and bronze. Platinum plans are the most generous, covering roughly 90 percent of expenses. Bronze plans are the least generous, covering about 60 percent of expenses. Premiums are higher for more generous coverage. For more information, visit *healthcare.gov*.

Annual limits. The maximum amount an insurance plan will provide in benefits in a year. The ACA bars insurers from imposing annual dollar limits, but service limits are still permitted. Some "grandfathered" plans (plans people already had before 2010 and have continued) may still be allowed to have annual limits, and annual limits are still permitted for "nonessential benefits" such as dental care.

Balance billing. The amount an out-of-network provider may bill you, not accepting the insurer's payment as a full reimbursement for services. When you receive services from a doctor or hospital that does not participate in your insurer's network, that provider is not obligated to accept the insurer's payment as full reimbursement and thus may bill you for the balance of the bill. Some states prohibit providers from billing consumers for a balance beyond the insurer's payment under certain circumstances, for example for emergency services.

Benefit design. The features of a health plan, such as patient cost-sharing, scope of coverage, service limits (e.g., number of visits covered), or enrollee incentives to use network providers.

"Cadillac" insurance plans. Expensive plans that offer comprehensive and generous coverage, usually with very low deductibles. The term has received more play in recent years because, beginning in 2018, the ACA imposes an excise tax on employers offering "Cadillac" plans that cost more than $10,200 per year for individual coverage and more than $27,500 for family coverage.

Co-insurance. The consumer's share of the costs of a covered health care service, expressed as a percentage (for example, 20 percent) of the allowed amount for the service.

Co-payment. A flat-dollar amount that an insured person pays when accessing a service—for example, $25 for a routine office visit with a physician.

Cost-sharing. The general term for the costs a patient is responsible for under the terms of a health insurance plan, such as deductibles, co-insurance, and co-payments.

Deductible. The amount that you must pay for medical services each year before the insurer will begin paying a portion of your bills. Deductibles are part of an enrollee's cost-sharing. Certain services, such as preventive care, may be exempt from the deductible.

Children's Health Insurance Program (CHIP). The federal/state program that provides low-cost health coverage to children up to age 19 who are U.S. citizens or eligible immigrants. The program covers around 8 million children. It is usually restricted to low-income children in families with incomes too high to qualify for Medicaid.

Consumer-directed health plan (also, health savings accounts or high-deductible plan). A health plan that typically features a high deductible and may be accompanied by a tax-advantaged medical savings account. The money in the account can be used for out-of-pocket medical expenses. The accounts encourage consumers to use routine health services judiciously and accumulate heath-account savings. The risk: to save money, people won't go to the doctor or seek care when they need it.

Essential Health Benefits. The package of benefits that health plans are now required to offer under the ACA. They include coverage for hospitalization, outpatient services, maternity care, prescription drugs, emergency care, and preventive services.

Flexible Spending Account (FSA). A benefit offered by some employers, an FSA lets you choose to have money deducted from your paycheck (pretax) and set aside for health and dependent care expenses each calendar year. With an FSA, health and dependent care accounts are separate, not combined. You choose how much to contribute, up to a maximum of $2,500 per year. Money left in the accounts at the end of the year is forfeited.

Formulary. The list of drugs covered fully or in part by a health plan. Formularies often include both brand name and generic drugs, and they are used to manage drug costs. Under the ACA, health plans must include choices within commonly prescribed drug categories.

Grandfathered plan. A plan that was in existence before March 23, 2010 (the date the new health law was signed) and hasn't changed substantially since that time. Grandfathered plans are not required to incorporate the consumer protections mandated by the ACA. For a complete list of consumer protections from which grandfathered plans are exempted, go to: *healthcare.gov/what-if-i-have-a-grandfathered-health-plan/*. As time goes on, fewer and fewer plans will be grandfathered; when a plan is changed in any way, it must then comply with the new consumer protections.

Health insurance marketplace or exchange. Web-based platforms in which people can shop for and buy health insurance in their state of residence. Some exchanges also now

sell to small businesses, and more will over time. You can also apply for Medicaid through the exchanges, and you can find out if you qualify for a government subsidy to pay for private coverage. The ACA required establishment of the exchanges. To learn how they operate or to shop for insurance, go to *healthcare.gov*.

Health maintenance organization (HMO). A type of health plan that provides health care coverage through a network of hospitals, doctors, and other health-care providers. Typically, the HMO pays only for care that is provided by in-network providers.

Health reimbursement arrangement (HRA). A tax advantaged account that may be used to pay premiums or for unreimbursed medical expenses. An HRA must be funded by an employer—it cannot be funded from the employee's salary. An HRA may be offered with other health plans and related benefits, including FSAs.

Health Savings Account (HSA). A savings account, usually attached to a high-deductible health plan, for the purpose of saving for medical expenses. The money can be diverted from taxable income into the account, up to a limit. It grows over time tax-free but must be used only for medical expenses.

In-network. A designation for hospitals and doctors who have contracted with a health plan. When you use in-network providers, you won't face costs over and above the cost-sharing specified by your plan.

Medicaid. The free or low-cost health insurance program for people with low incomes financed jointly by the states and the federal government and administered by the states. In 2014, Medicaid is expected to cover 50 to 60 million people. The ACA includes a significant expansion of Medicaid eligibility, but some states have chosen not to participate in that expansion.

Medical Loss Ratio. A measure of the proportion of premium revenues health insurance companies spend on actual medical care for enrollees. Specific activities to improve the quality and delivery of care are also counted as care itself. The ACA requires insurers to issue rebates to enrollees if the insurer's MLR is not 85 percent or more of total premium dollars for large employers or 80 percent or more for individuals and small businesses.

Medicare. The federally financed and administered insurance program for people 65 and older and people under age 65 with disabilities, as well as people with end-stage renal disease, amyotrophic lateral sclerosis ("Lou Gehrig's Disease"), and, in some cases, multiple sclerosis. Almost all Americans over age 65 have Medicare coverage. For full details on Medicare, go to *Medicare.gov*. If you are nearing Medicare eligibility, we recommend that you download the free book *Medicare and You*, also obtainable at *Medicare.gov*.

Medicare Advantage (Medicare Part C). An alternative to traditional (or original) Medicare. Medicare Advantage lets beneficiaries choose to receive their Medicare benefits through a private insurance company, and more specifically an HMO or PPO.

Insurers contract with the federal government and are required to offer at least the same benefits as traditional Medicare, but they may follow different rules and offer additional benefits, including lower cost-sharing. If you enroll in a Medicare Advantage plan, then you don't have to fuss with separate sign-ups and co-pays for hospital (Medicare part A), doctor (Medicare part B), and prescription drug coverage (part D). Medicare Advantage plans also eliminate the need to buy a "Medigap" policy to cover expenses not paid by traditional Medicare. Unlike traditional Medicare, however, Medicare Advantage enrollees may be restricted to only certain "in-network" providers, or they may be required to pay higher costs if they choose an out-of network provider. About 28 percent of Medicare beneficiaries are now enrolled in a Medicare Advantage plan.

Medicare Part D. The Medicare prescription drug benefit. If you sign up for traditional Medicare, you have the option of signing up for Part D. Most beneficiaries do so.

Medicare supplemental insurance (Medigap). Optional, private insurance that can be purchased to fill in Medicare's coverage gaps, such as deductibles and co-insurance not covered by traditional Medicare (parts A and B). Some people obtain Medicare supplemental coverage through an employer; others buy Medigap coverage independently. The federal government mandates that all Medigap coverage conform to one of 10 benefit designs. For more information, see Choosing a Medigap Policy, available at: *Medicare.gov/Pubs/pdf/02110.pdf*.

Out-of-network. A term that refers to doctors, pharmacies, hospitals, and other health-care providers not affiliated or contracted with your health plan. The insurance company has not negotiated rates with out-of-network providers, and it may limit coverage of services by those providers if you see them. Using out-of-network providers usually results in higher out-of-pocket costs.

Out-of-pocket limit. The annual limit on all cost-sharing that you can be required to pay out of your own pocket under a health-insurance plan. It includes your deductible. The limit today for most individually purchased plans ranges from $6,000 to $12,000. It does not apply to premiums, balance-billed charges from out-of-network health care providers, or services that are not covered by your plan.

Negotiated rate. A discounted fee for medical providers' services and procedures. The vast majority of doctors negotiate a lower fee with insurers in return for access to a volume of patients who have insurance coverage. Rates may differ from one insurer to the next.

Preauthorization/prior authorization. The approval given by an insurer for a service before it is provided. The need to obtain preauthorization varies from plan to plan, and not all health plans require it.

Preferred provider. A doctor or hospital with a contract with your health-insurance company. Preferred providers are often described as "in-network." Preferred providers

agree to the plan's rules and fee schedules and agree not to charge or "balance bill" patients for amounts beyond the agreed-upon fee.

Preferred provider organization (PPO). The most prevalent type of health-insurance plan. PPOs provide health-care coverage through a network of providers that have contracts with the insurer and agree to certain terms of service and fees. Typically, a PPO requires you to pay higher costs if you seek care from out-of-network providers.

Premiums. The amount you pay to maintain insurance coverage. Typically, if you have coverage through your job, your share of the premium is deducted from your paycheck. If you buy coverage on your own, you usually pay monthly. Failure to pay premiums can result in loss of coverage.

Preventive services. Medical services and screening tests that are intended to prevent disease or to identify disease in the early stages, when it is likely to be more easily treatable. Under the ACA, insurers are required to provide coverage for certain preventive services without deductibles, co-payments, or other cost-sharing. For more information, go to *Healthcare.gov*.

Primary care physician (PCP). Your personal physician and, in many cases, your first contact within the health-care system. Your PCP will usually oversee and direct the course of your treatment and refer you to other doctors or specialists if your care needs go beyond his or her expertise.

Self-insuring. The practice by large employers (and many mid-sized companies, too) of acting as the insurer for their employees. That is, they agree to take on the insurance risk themselves rather than buy coverage through an insurance company. Companies elect to self-insure because a 1970s federal law gives them much more latitude to design their own health benefits that way. The law also exempts companies that insure their employees from state insurance laws. Almost all large companies self-insure. Most, however, hire insurance companies or employee benefit management firms to administer the coverage.

Rate review. The oversight and scrutiny of proposed annual premium rate increases by state health insurance departments or the federal government. Such scrutiny is intended to help moderate premium hikes and keep costs down for individuals, families, and businesses that buy insurance in the buy-your-own marketplace and on the new health insurance exchanges. The ACA requires that any proposed rate increase at or above 10 percent be reviewed to make sure it is justified.

Summary of benefits and coverage. A new, ACA-required standard form that describes the coverage offered by a health plan. All private plans must now use the same form, thus making it easier for consumers to compare insurance plans.

Health-insurance tax credit. Tax credits for the purchase of insurance through the new health insurance exchanges. In general, tax credits lower the amount of income tax you

owe. Only low- and middle-income people qualify for the credits, which are structured so that the direct monthly cost of their coverage is lowered by the amount of the credit they qualify for. For more information, visit *Healthcare.gov*.

Tiered networks. A method of categorizing provider networks (groups of hospitals and/or doctors) using cost or some combination of cost and quality metrics. Typically, you'll pay more to see higher-cost or less-efficient providers and less to see lower-cost, more-efficient providers in a tiered network arrangement. Tiered networks typically use two or three tiers to categorize providers.

Tiered formulary. A method of dividing drugs into groups, based primarily on cost but also sometimes on evidence of usefulness and effectiveness. A plan's formulary might have three, four, or even five tiers. Plans negotiate pricing with drug companies. If a plan negotiates a lower price on a particular drug, then it can place it in a lower tier and pass the savings on to its members through lower enrollee cost-sharing requirements.

Underwriting. The process used by insurers to determine a person's insurability using information on health status, health risk, and prior use of medical care. Prior to 2014, the underwriting process was routinely used to set premiums and to decide whether to offer insurance coverage to a person—and which benefits to offer or exclude. Underwriting also applied to the coverage small businesses bought for their workers. (Large companies do not underwrite.) The ACA eliminated medical underwriting for all health plans sold to individuals and small businesses after Jan. 1, 2014.

Utilization management. The process performed by insurers of evaluating the medical necessity, appropriateness, and efficiency of medical services. It includes such practices as precertification, clinical reviews, and appeals by doctors or patients. A utilization review can result in an insurer denying coverage for a procedure or service it deems unnecessary.

Wellness incentives. Measures that promote healthy behavior and lifestyles, typically as "carrots" or "sticks." So-called carrots, or rewards, might reduce premiums by a certain amount for engaging in healthy behaviors, such as quitting smoking or exercising regularly. Sticks, on the other hand, impose an increase in premiums if you don't participate in wellness activities (for example if you won't quit smoking).

Health-Care Delivery

Accountability. A term that refers to measuring the performance of hospitals and individual providers, and the results they achieve for patients. The accountability movement works hand in glove with efforts to pay providers based on their performance, results, and quality of care.

Accountable care organizations (ACOs). Groups of doctors, hospitals, and other health care providers that band together to manage and coordinate care for a group of patients, across the entire spectrum of care. Physicians and providers in the ACO are financially

rewarded if they meet cost and quality thresholds. The goal of coordinated care is to ensure that patients, especially chronically ill people, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. Primary care doctors are put at the hub of coordinating patient care. The ACA provides incentives to providers to create ACOs to serve Medicare beneficiaries.

Accreditation. A process by which an independent third party assesses whether an organization or business is meeting a set of quality standards pertinent to an industry. Accreditation is common for hospitals and insurance plans (such as HMOs and PPOs). It's one important barometer of quality care, but it's not a guarantee. Individual doctors are licensed by states but do not get accredited. Some accrediting groups, however, such as the National Committee for Quality Assurance, (NCQA, *ncqa.org*) have begun to certify physician group practices that submit applications to qualify as "medical homes."

All-payer claims database. A database, typically implemented by a state, that contains data on all the claims (doctor bills) filed with private insurance companies, state employee health benefit programs, and, in some cases, Medicare and Medicaid. The data contains charges and payments, provider information, clinical diagnosis and procedure codes, and patient demographics. Such databases are being mined by public health officials and researchers to examine pricing and treatment trends, fraud, and find areas where care can be improved.

Antitrust law and enforcement. Provisions to assure competition in the marketplace and block mergers that create monopolies not in the best interest of consumers. The Federal Trade Commission oversees antitrust law in health care, but the Department of Justice enforces it. A 1945 law called the McCarran-Ferguson Act exempts the business of insurance from most antitrust laws.

Big data. The wealth of information created by new software programs that gather and analyze trillions of pieces of information on health-care delivery. The data are being used to (a) improve the quality, efficiency, and safety of care and (b) put more actionable information in both providers' and consumers' hands so they can make better health-care choices and decisions.

Bundled payment. An arrangement whereby a hospital, health system, or group practice agrees to be paid a fixed fee for a specific service or episode of care instead of billing separately for every component of that care. For example, a health system that includes hospitals and doctors might agree to a bundled payment of $50,000 for a knee replacement operation. The bundled payment would include all the care a patient getting the operation needs, including preoperative care and counseling, the procedure itself, and postoperative care. Bundled payments remove the incentive for providers to do more than is medically necessary to "pad" medical bills.

Biologics. Complex pharmaceutical or diagnostic products made from living organisms. Biologics are a cutting-edge form of medicine, revolutionizing treatments for certain cancers, arthritis, multiple sclerosis, and other conditions. Although the drugs can sustain and improve the quality of life for many patients, they are usually very expensive—

sometimes costing $100,000 or more annually. The high cost of biologics has stirred controversy and presents problems for insurance coverage determinations.

Biosimilar drugs. A drug that has the same general qualities and clinical uses of a biologic drug. It is roughly analogous to a "generic" version of a biologic, but because of the way biologics are manufactured, a biosimilar is not exactly the same as the brand-name drug (unlike generic versions of most chemically made drugs, which are exact duplicates). The ACA has a provision that establishes a pathway for the approval of biosimilars, which are expected, over time, to cost less than the brand-name versions and save both consumers and other payers money.

Capitation. A payment arrangement whereby doctors are paid a set amount per patient per month. It's primarily used by health maintenance organizations (HMOs). The "capitated" fee is based on expected costs, and it takes into account demographic factors (age, race, sex, employment, geographical location) as well as prior medical history of a population of patients. Capitation works better for large group practices that have thousands of patients. The purpose: Give doctors incentives to keep patients healthy, manage costs, and provide only medically necessary care. Capitated fees also allow insurers to shift some of the "insurance risk" to health systems and doctors.

Care coordination. A component of quality care, care coordination can refer to: (1) the process by which a team of care-givers (e.g., doctor, nurse, nutritionist, physical therapist) coordinate to provide a patient with the full range of needed care; (2) coordination of the care of a patient or group of patients among doctors from different disciplines who may not be affiliated with each other or the same hospital; and (3) coordination among medical facilities (e.g., doctor's office, hospital, and nursing home) in the care of a patient or group of patients. Well-coordinated care is one of the hallmarks of high-quality care. In its absence, patients are at higher risk of getting poor quality, duplicate, and unnecessary services.

Clinical guidelines. Standards of care based on the latest evidence and science. Clinical guidelines are developed by expert groups at the behest of (and with funding from) professional medical societies and trade groups. Thousands of guidelines covering most major diseases and conditions now exist. The federal Agency for Healthcare Research and Quality keeps a list at *guideline.gov*. The guidelines aim to help doctors choose the best treatments for patients. They are sometimes criticized as "cookbook medicine," but most doctors appreciate the help. Guidelines are written in medical language for doctors, but many groups also now produce versions for consumers. These are findable on the Web: Search for the name of a condition or disease plus the words "practice guideline" or "treatment guideline."

Comparative effectiveness research (CER). Studies comparing two or more treatments for a condition or disease, for the purpose of showing as clearly as possible which treatment, if any, is superior in terms of the outcome for patients. The ACA created an institute to conduct CER. It's called the Patient-Centered Outcomes Research Institute, or PCORI. (See below for more details.)

Defensive medicine. The practice by doctors of ordering tests, procedures, or visits, or of avoiding high-risk patients or procedures, for the purpose of reducing their own exposure to malpractice liability.

Direct to consumer advertising (DTC advertising). Ads, mostly by drug companies, that present information about prescription medicines to the public through TV, newspapers, and magazines. The ads have become more common in the past 10 years. Only two countries permit them: New Zealand and the U.S. In the U.S., they are controversial, with critics arguing that they promote expensive new brand-name drugs over less-costly generics that are often just as effective.

Electronic health records (EHRs). Computer-based software tools that enable hospitals and doctors to track patients' medical history and treatment in a more organized and coherent way than that paper-based files they are gradually replacing. Doctors are legally required to keep patient records. EHRs also permit patient records to be accessed, shared, and viewed more easily by caregivers. Increasingly, portions of medical records are being shared with patients.

Episode of care. The full range of medical needs associated with an illness, surgical procedure, hospitalization, or medical intervention. The term is usually used in conjunction with a payment arrangement. For example, if you needed surgery to repair a torn knee ligament, your insurer may have negotiated with a health system (doctor plus an outpatient surgery center) to pay a set, "bundled" fee for all your care during the episode, including all pre- and postoperative care.

Evidence-based medicine. An emerging area of research as well as a way of practicing medicine. In the context of research, it refers to the attempt by doctors and scientists to discover which treatments work best for patients with a specific condition or disease. Such results emerge primarily from studies that directly compare treatments and focus on the end result for the patient. In the context of medical practice, EBM refers to doctors' use of the best evidence available to guide their treatment choices. Consumers, too, can access much of the evidence, but most lack the knowledge to interpret it. In some cases, practicing EBM may mean referring to clinical guidelines on the treatment of a specific disease or condition. You may be surprised to learn that doctors don't always base treatment on the latest evidence, but that's what more than a decade of research reveals.

Fee-for-service (FFS). The predominant payment arrangement in health care, a scheme whereby doctors and hospitals bill for each service, test, or procedure they or their staff performs. Fee-for-service payment results in itemized billing. There is a broad effort in the U.S. to find alternatives to FFS because it inherently encourages doctors to deliver as much care as possible, including some that may not be necessary or wise and some that could even be harmful.

Gag clause. A provision preventing a physician from being open with patients about some terms of the patient's coverage and treatment options. The clause may be incorporated into the doctor's contract with a managed-care organization.

Global budgeting. Expenditure targets for health-care spending. A global budget can be established at a national level, at a state level, or by a health-care business such as a hospital. Global budgets aim to constrain both the level and the rate of increase in health spending from year to year. Many European countries set global budgets every year for all health spending.

Group practice. A business and legal entity wherein two or more doctors practice together for efficiency and collaborative reasons. Small group practices typically have five to 10 doctors; large group practices can have dozens. Most group practices have doctors who are specialists in one area of medicine—for example, internal medicine, pediatrics, neurology, or dermatology.

Health information technology. A broad term referring to the wide range of computer hardware and software tools now being used to improve health-care delivery, quality and efficiency, as well as the ways providers communicate with each other and patients.

Health Information Technology for Economic and Clinical Health Act (HITECH). A law that was part of the economic stimulus legislation enacted in February 2009 in the wake of the 2008 recession, it permits Congress to allocate up to $30 billion over a decade to foster the universal adoption of electronic health records (EHRs). It also funds the federal government's Office of the National Coordinator for Health Information Technology.

Hospital charge master. A compendium of the "list prices" of all services, goods, and procedures a hospital offers. The charge master is used to generate patient bills, but very few patients pay the amount listed. Instead, insurers negotiate substantial discounts from charge master rates.

Hospital Compare. A Medicare website that aggregates vast amounts of data on hospital quality and presents it in a way that helps consumers compare hospitals. The site URL is *medicare.gov/hospitalcompare/search.html.*

Hospital readmissions. A situation in which a patient has been discharged from the hospital after treatment for a specific illness and is then readmitted within 30 days for the same illness. Attention to the phenomenon arose when studies showed that about one in five Medicare patients who had a hospital stay were readmitted within 30 days. That statistic is widely considered to signal a failure—and a costly one—of proper post-hospital care. A nationwide effort is now underway to minimize such readmissions, in part through a payment penalty imposed by Medicare on hospitals that have a higher than predicted number of readmissions.

Independent payment advisory board (IPAB). A new executive-branch entity created by the ACA. The IPAB consists of a 15-member board of medical providers, health-care experts, and consumers. Starting in 2015, IPAB will make "binding recommendations" to

decrease Medicare spending if per-beneficiary growth in spending exceeds certain target growth rates.

Integrated health system. A term that describes organizations of insurers and/or providers that agree to take full responsibility for the health and cost-of-care of enrollees. Typically today, an integrated system is one that takes on the insurance risk and also enters into contracts with hospitals and doctors to provide medical services. Integrated health systems are easier to create in urban and high-density population areas than in sparsely populated rural areas. Kaiser Permanente, which operates in nine states and has 9 million enrollees, is considered an integrated system.

"Less is more." An expression that, in the context of health care, refers to the increasingly popular idea that a high volume of medicine is not always synonymous with high-quality care and good treatment results. Instead, studies indicate that in many medical circumstances the less care provided, the better the result—provided the care is the right care. Excessive care also increases the risk of harming patients. The idea goes hand in hand with the push to apply a higher standard of science and evidentiary proof to treatment decisions and choices. The concept and phrase "less is more" cannot be generalized to all medical care on a population-wide basis, however, because many studies show that populations that have greater access to care (that is, more care) are healthier.

Mandated benefits. A health service (such as pregnancy care) or category of health service provider (such as chiropractors) that insurers are required by the federal government or a state to include in their health plans. The ACA, for example, requires all insurance plans offered in the new exchanges to cover prescription drugs.

Medical loss ratio. An unfortunately obtuse term that refers to an important mechanism in the insurance industry: the proportion that insurance companies spend (of their revenue) on actual medical care instead of on overhead, administration, and profit. It's become important because the ACA, for the first time, requires insurers to spend a minimum amount of premium dollars on medical care: 85 percent in the small business market and 80 percent in the individual market. If they fail to meet these standards, companies are required to provide a proportional rebate to their customers.

Medicare Payment Advisory Commission (MedPAC). An independent Congressional agency established in the 1990s to advise Congress on issues affecting the Medicare program. In addition to advising the Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program, MedPAC is tasked with analyzing access to care, quality of care, and other issues affecting Medicare. It issues regular reports that inform Medicare policy.

National Committee for Quality Assurance (NCQA). An independent accrediting body with a primary focus on health insurance plans. NCQA accredits plans (primarily HMOs and PPOs) based on dozens of quality and customer-service standards. Most major health plans seek NCQA accreditation, and many employers will not contract to insure their workers with a plan that is not accredited. Since 2005, NCQA has also rated and ranked

insurance plans based on voluntarily submitted data and information. CONSUMER REPORTS presents these ratings for consumers each year in its magazine and on its website (*ConsumerReports.org/health/insurance/health-insurance-plans.htm*). More recently, NCQA has begun certifying physician group practices that have adopted procedures and standards to become "medical homes."

Never events. A term of art in the field of patient safety, it refers to serious mistakes in hospitals that should *never* happen because they are 100 percent preventable. A group called the National Quality Forum has designated 29 never events. They include surgery performed on the wrong body part (for example, on the left knee instead of the right knee) and the death of a patient due to contaminated drugs or devices. Most insurers don't pay when a never event happens. And many hospitals now waive fees in the case of a never event.

Nursing home compare. Comparison data based on federally required quality performance reports from nursing homes that care for Medicare and Medicaid beneficiaries (which mean almost all nursing homes). The data from this effort are analyzed and posted on the nursing home compare website, *medicare.gov/nursinghomecompare/search.html,* to help consumers and their families make smart choices among nursing homes. The site also has a search function to help users locate nursing homes in almost all regions of the nation.

Outcomes research. Research with the focused purpose of determining the success or failure of a treatment from the patient's perspective as well as the doctor's, taking into consideration the patient's full experience of care and return to full health and normal functioning (or not) after treatment. Outcomes research is often invoked as a priority in a medical system in which experts have clearly established that many treatments lack sufficient evidence of effectiveness.

Overtreatment. Services or treatments, usually identified in hindsight, that are useless and do not help the patient. In some cases, overtreatment may do more harm than good. It's been estimated that 30 to 40 cents of every dollar spent on health care in the U.S. is for unnecessary or inappropriate care.

Patient-centered medical homes. Primary care practices (internists, general practice doctors, ob-gyns, and pediatricians) that agree to play a larger role in patient care—by coordinating care should a patient, for example, have a chronic illness and need to see multiple specialists; by emphasizing preventive care; by tracking and reporting on the quality of care; by improving care based on performance and patient reviews; by adopting electronic health records and patient portals that permit patient-doctor e-mails and other electronic communications; and by involving patients more in decisions about their care. Typically, medical homes agree to payment arrangements that let them share in the savings they achieve relative to expected costs.

Patient Centered Outcomes Research Institute (PCORI). An organization, created by the ACA and launched in 2011, whose mission is to fund research that directly compares

treatments and disseminates the results to doctors and consumers, including through a consumer-friendly website. In 2013, PCORI funded close to 300 studies for approximately $400 million. In 2014, the institute expects to dispense $500 million and, by the end of the year, report the first fruits of knowledge from grants made in 2012. PCORI is funded through federal taxes, including a new tax on health insurance companies and employers that self-fund their health insurance plans.

Patient engagement. The push to get consumers to become more proactive and involved in their medical care—an involvement encompassing everything from rating doctors and hospitals online to tracking medical records more carefully and creating a living will to guide care at the end of their life. Many experts believe that more active consumers are a critical part of efforts to make the health system more responsive to patient needs.

Pay for performance (P4P). Any payment arrangement in which providers are paid in whole or in part based on the quality of care they deliver and their scores on selected quality measures. P4P is an alternative to payment on a pure fee-for-service basis.

Physician Compare. A website sponsored by the Department of Health and Human Services. It was mandated by the ACA with the intent that, over time, it will present the same kind of comparative data and information on the quality of care delivered by doctors that Hospital Compare and Nursing Home Compare now do on hospitals and nursing homes. The ACA mandates that by end of 2014 the site begin to display information on physician groups. For now, the site contains a massive directory of about 900,000 providers who participate in Medicare (including most of the nation's doctors) and some useful search functions.

Physician quality reporting system. A system using a combination of incentive payments and payment adjustments to promote reporting to the government of performance and quality information by doctors and non-MD providers who serve Medicare beneficiaries. The program is one part of the ACA's push to pay doctors on the basis of the results they achieve instead of on a fee-for-service basis. Beginning in 2015, doctors who don't report quality measures into PQRS will see their reimbursements from Medicare reduced.

Premium support. An alternative way to organize Medicare that would give beneficiaries a voucher (also referred to as a "defined contribution") to purchase private health insurance. Proponents argue that this system will harness the power of the marketplace to help solve Medicare's fiscal problems by giving beneficiaries incentive to choose low-cost plans and giving plans incentive to compete for beneficiaries on price.

Price transparency. The mounting pressure on providers to make the prices they charge for medical services more prominently public—before the services are rendered—so consumers can compare and shop. The issue is complex, however, because insurers and government pay the bulk of medical bills and they negotiate prices and discounts with providers. The end result (the price the provider gets paid) is often kept secret for competitive reasons. Nevertheless, advocates for price transparency argue that consumers

should always be informed of the cost to them of a particular medical service or procedure. And some advocates believe that consumers should know the total price the provider is being paid as well (the insurer's share plus the patient's share) so they can compare and choose lower-cost, high-quality providers.

Quality of care. The success of treatment—not primarily, as some might think, promptness, staff courtesy, or the amount of time a doctor spends with a patient. The latter are legitimate barometers, but in the context of improving the health-care system and health care itself, quality is defined simply by treatment success.

Quality measurement and reporting. Tools used to improve care. Thousands of measures have been developed in the past decade, and they are a critical precursor to change—what doesn't get measured can't be changed. The goal of quality measurement is to quantify health-care processes, outcomes, patient experiences, and organizational systems. Quality measures are perhaps best understood by giving an example of a group of them surrounding one condition: heart attack. Among heart attack measures used widely are: (a) the percentage of people who get treated in less than 90 minutes after the attack; (b) the percentage of patients who die in the hospital; (c) the percentage who are discharged with prescriptions for medicines that will prevent future attacks, such as aspirin, statins, and beta blockers; and (d) the percentage of smokers who quit. Public reporting of the results of quality measurement is increasing nationwide but still in its infancy. The ACA requires public reporting of health care quality in the Medicare program and nurtures it in private-sector health care as well.

Reference pricing. A payment tool that employers, insurers, and the government are beginning to use to restrain the rise in health-care costs. It's best explained through an example: Say experts determine that the average or fair charge for a colonoscopy (all the fees for it—doctor, out-patient surgery center, and so forth) is $4,000. An employer or insurer could then set that as the reference price. If a consumer goes to a provider that charges $4,000 or less, the full cost would be covered. If, however, the consumer goes to a provider that charges $5,000, the consumer would be on the hook for the price difference, $1,000. The power of reference pricing is that, over time, it pressures most providers to lower their price to the reference price or below. The danger of reference pricing is a shift of costs to consumers if the reference price for a procedure is set too low and providers decline to meet it.

Self-referral. The referral by a physician to a health facility—for example, a diagnostic imaging center—in which he or she has a financial interest.

Sunshine Act. A provision in the ACA that requires pharmaceutical and device manufacturers to report all payments or gifts exceeding $10 they make to doctors. The report has to include the amount and name of the doctor. The program began on August 1, 2013. Companies had to submit the payment information to Medicare—covering August 1 to Dec. 31, 2013—by March 31, 2014. Medicare must then post the data on a dedicated website and in a consumer-friendly format by September 30, 2014. The reason for the provision is that drug and device company payments to doctors for consulting,

research, lectures, and other services has been growing rapidly. This is widely seen as a potential conflict of interest.

Sustainable Growth Rate (SGR). The Medicare physician payment formula enacted by Congress in 1997. The SGR determines how much Medicare pays for services that physicians provide. Under the SGR, cumulative Medicare spending on physicians' services is supposed to follow a target path that depends on the rates of growth in physicians' costs, Medicare enrollment, and gross domestic product per person. If spending in a given year exceeds the SGR target for that year, then the amounts paid to physicians for each service they provide are supposed to be reduced in the following year to move total spending back toward the target path. The SGR is flawed because it attempts to limit payments without addressing the volume or complexity of services, and the formula is rarely followed. In every year since 2003, Congress has prevented the full cuts required by the SGR from going into effect.

Triple aim. First conceptualized by Dr. Donald Berwick, the three overarching goals of health system reform are: (1) improving the health of the population; (2) enhancing the patient experience of care; and (3) controlling the rise of the cost of care.

Value-based benefit design. A tool employers and insurers use to drive improvements in health-care quality and to decrease costs by using financial incentives to promote efficient use of health-care services. By lowering the cost of effective, high-value treatments, health plans can encourage efficient patterns of care. Value-based benefit design may include disincentives as well, such as high cost-sharing, for health services that may be performed at a lower cost using a different approach. To decide which procedures are the most effective and cost efficient, insurance companies may use evidence-based data to design their plans.

Value-based purchasing. A strategy used by employers and the federal government to get better value for the dollars spent on health care. It aims to hold providers accountable for both cost and quality of care by measuring expenditures, patient outcomes, and health status—and then paying providers differentially based on those metrics and the providers' performance. VBP also aims to reduce inappropriate care and identify and reward the best-performing providers.

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