

Pocket Guide to Health Care Terms



South Carolina Institute of
Medicine & Public Health

The *Pocket Guide to Health Care Terms* is produced by the South Carolina Institute of Medicine & Public Health as a resource in understanding the numerous terms and acronyms that are part of ongoing health care discussions.

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Access – A patient’s ability to obtain medical care. The ease of access is determined by components such as availability of insurance, the location of health care facilities, transportation, hours of operation, affordability and cost of care.

Accountable Care Organization (ACO) – A group of health care providers who focus on coordinated care and chronic disease management, while working to improve the quality of care patients receive. The organization’s payment is tied to achieving health care quality goals and outcomes that result in cost savings.

Acute Care – Medical services provided to treat an illness or injury, usually over a short period of time (in contrast with chronic care).

Advance Directive – A document that patients complete to direct their medical care when they are unable to communicate their own wishes due to a medical condition.

Aged, Blind, Disabled (ABD) – A Medicaid designation that assists with medical expenses for poor South Carolinians who are aged 65 years or older, blind or disabled (as classified by the Social Security Administration for an adult or child).

Aid to Families with Dependent Children (AFDC) – A federally supported, state-administered program established by the Social Security Act of 1935 that provides financial support for children under the age of 18 (and their caretakers) who have been deprived of parental support or care because of the parent's death, continued absence from the home, unemployment, or physical or mental illness.

BabyNet – South Carolina's interagency system (led by DHEC) of early intervention services for families who have infants and toddlers (up to 3 years of age).

Behavioral Health, Behavioral Health

Care – An umbrella term that includes mental health, psychiatric services, marriage and family counseling, addictions treatment and substance abuse. Services are offered by a variety of providers, including social workers, counselors, psychiatrists, psychologists, neurologists and family practice physicians.

Best Chance Network – Program that provides free screening for breast and cervical cancer to eligible South Carolina residents. Women diagnosed with breast or cervical cancer may be eligible for free health coverage through Medicaid for treatment of their condition.

Capitation – A method of paying for health care services under which providers receive a set payment for each person or “covered life” instead of receiving payment based on the number of services provided or the costs of the services rendered. These payments can be adjusted based on the demographic characteristics, such as age and gender, or the expected costs of the members.

Case Management – A system for assessing, planning treatment for, referring, and following up on patients in order to ensure the provision of comprehensive and continuous service and the coordination of payment and reimbursement for care.

Categorically Needy – Medicaid eligibility based on defined indicators of financial need by families with children and pregnant women, and to persons who are aged, blind, or disabled. Persons not falling into these categories cannot qualify, no matter how low their income. The Medicaid statute defines over 50 distinct population groups as potentially eligible, including those for which coverage is mandatory in all states and those that may be covered at a state's option. The scope of covered services that states must provide to the categorically needy is much broader than the minimum scope of services for other groups receiving Medicaid benefits.

Centers for Disease Control and Prevention (CDC) – A federal agency (based in Atlanta) within the U.S. Department of Health and Human Services that serves as the central point for consolidation of disease control data, health promotion and public health programs.

Centers for Medicare and Medicaid

Services (CMS) – A federal agency within the U.S. Department of Health and Human Services that directs Medicare, Medicaid, and the State Children's Health Insurance Program.

Certificate of Need (CON) – A certificate issued by a governmental body to an individual or organization proposing to construct or modify a health facility, or to offer a new or different health service. The CON program is designed to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which best serve public needs and ensure that high quality health services are provided.

Children's Health Insurance Program

(CHIP) – A state administered program funded partly by the federal government which allows states to expand health coverage to uninsured low income children not previously eligible for Medicaid.

Chronic Diseases – Diseases which have one or more of the following characteristics: permanent, leave residual disability, require special training of the patient for rehabilitation, or may be expected to require a long period of supervision, observation, or care.

Community Health Center (CHC) – An ambulatory health care program usually serving a geographic area which has scarce or nonexistent health services or a population with special health needs. CHCs attempt to coordinate federal, state, and local resources into a single organization capable of delivering both health and related social services to a defined population. While such a center may not directly provide all types of health care, it usually takes responsibility to arrange all medical services needed by its patient population.

Consolidated Omnibus Budget Reconciliation Act (COBRA) – A federal law that requires employers to offer continued health insurance coverage to employees who have had their health insurance coverage terminated. Employees often must pay for the full cost of the coverage.

Co-Payment, Co-Pay – A cost-sharing arrangement in which the health plan enrollee pays a specified flat amount for a specific service (such as \$10 for an office visit or \$5 for each prescription drug). When first implemented, it was thought that the amount paid must be nominal to avoid becoming a barrier to care. However, the amounts of co-pays can vary widely from plan to plan, and many now could be viewed as possible barriers to care.

Cost-Shifting – Charging one group of patients more in order to make up for lack of payment or underpayment by others. Most commonly, charging privately insured patients more in order to make up for losses due to uncompensated or indigent care or lower payments from other payers.

Crowd-Out – A phenomenon whereby a new public program (or an expanded program) designed to extend health insurance coverage to the uninsured actually results in individuals with existing insurance dropping their coverage in order to take advantage of the public subsidy.

Data Warehouse – A specific database (or set of databases) containing information from many sources that are linked by a common subject (e.g., a health plan member).

Deductible – A feature of health plans in which consumers are responsible for health care costs up to a specified dollar amount. After the deductible has been paid, the health insurance plan begins to pay for health care services.

Department of Health and Human

Services (DHHS) – DHHS is the U.S. government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. Many DHHS-funded services, including Medicaid, are provided at the local level by state or county agencies or through private-sector grantees. The department's programs are administered by 11 operating divisions, including eight agencies in the U.S. Public Health Service and three human services agencies.

Disease Management – An effort to improve patient outcomes and lower costs by organizing managed care initiatives around patients with a particular disease or condition.

Disenrollment – The process or end result of a termination of insurance coverage. Voluntary termination would include a policy holder quitting because he or she no longer wants coverage. Involuntary termination would include leaving the plan because of changing jobs. A rare and serious form of involuntary disenrollment is when the plan terminates a policy holder's coverage against their will. This is usually only allowed (under state and federal laws) for gross offenses such as fraud, abuse, nonpayment of premium or copayments, or a demonstrated inability to comply with recommended treatment plans.

Disproportionate Share Hospital Program (DSH) – A federal program that works to increase health care access for the poor. Hospitals that treat a “disproportionate” number of Medicaid and other indigent patients qualify for higher Medicaid payments based on the hospital's estimated uncompensated cost of services to the uninsured.

Doughnut Hole – A common term for the gap in Medicare Part D prescription drug coverage that occurs when a Medicare beneficiary surpasses the prescription drug coverage limit and is financially responsible for the entire cost of prescription drugs until the expense reaches the catastrophic coverage threshold.

Dual Eligible – When someone is eligible for two health insurance plans, usually a person enrolled in Medicare and Medicaid.

Electronic Medical Record (EMR) – A computerized system providing real-time patient data access and evaluation in a medical care setting. Such information is also known as computerized patient record or computerized medical record.

Emergency Medical Services (EMS) – A system of health care professionals, facilities and equipment providing emergency care.

Emergency Medical Treatment and Labor Act (EMTALA) – A federal act passed in 1986 pertaining to emergency medical situations. EMTALA requires hospitals to provide emergency treatment to individuals, regardless of insurance status and ability to pay.

Employee Assistance Programs (EAP) – Workplace programs designed to help identify, educate, rehabilitate, and return the physically or emotionally impaired individual to the job. These programs may include helping employees gain access to health, legal and social services or to control specific conditions (e.g., chemical dependency, gambling, hypertension, stress).

Employee Retirement Income Security Act (ERISA) – A federal law that exempts self-insured health plans from state laws governing health insurance, including contribution to risk pools, prohibitions against disease discrimination, and other state health reforms.

Employer Mandate – The requirement that all employers above a minimum size provide a standard level of health insurance benefits to their employees.

Evidence-Based Medicine (EBM) – An approach to medical therapy that employs the current, best clinical data in making decisions about the care of individual patients.

Federal Medical Assistance Percentage (FMAP) – The statutory term for the federal Medicaid matching rate (i.e., the share of the costs of Medicaid services or administration that the federal government bears). In the case of covered services, FMAP varies from 50 to 76 percent depending upon a state's per capita income; on average, across all states, the federal government pays 57 percent of the costs of Medicaid.

Family Medical Leave Act (FMLA) – A federal law passed in 1993 requiring that private employers with 50 or more employees (and public employers of any size) allow employees to take leave to care for ill family members and to return to substantially similar employment conditions following the leave.

Federal Medicaid Managed Care Waiver Program – The process used by states to receive permission from the federal government to implement managed care programs for their Medicaid or other eligible beneficiaries.

Federal Poverty Level (FPL) – The amount of income determined by the federal Department of Health and Human Services to provide a bare minimum for food, clothing, transportation, shelter, and other necessities. The level varies according to family size. In 2010, the FPL for a family of four was \$22,050.

Federally Qualified Health Center (FQHC)

– A health center in a medically underserved area that is eligible to receive cost-based Medicare and Medicaid reimbursement and allows for the direct reimbursement of nurse practitioners, physician assistants and certified nurse midwives. Many outpatient clinics and specialty outreach services are qualified under this provision that was enacted in 1989.

Health Impact Assessment (HIA) – A combination of procedures, methods and tools that systematically judges the potential, sometimes unintended, effects of a policy, plan, program or project on the health of a population, including the distribution of those effects within the population, and identifies appropriate actions to manage those effects.

Health Information Technology

(HIT) – Systems and technologies that enable health care organizations and providers to gather, store, and share information electronically.

Health Insurance Exchange – A mechanism that creates a single marketplace for the buying and selling of private health insurance. Similar to a stock exchange or a farmers market where buyers and sellers are brought together, the system is intended for individuals, small businesses, and their employees, while maintaining existing employer-based access to health insurance.

Health Insurance Portability and

Accountability Act (HIPAA) – A

1996 federal law that provides some protection for employed persons and their families against discrimination in health coverage based on past or present health. Generally, the law guarantees the right to renew health coverage, but does not restrict the premiums that insurers may charge. HIPAA does not replace the states' role as primary regulators of insurance. HIPAA also requires the collection of certain health care information by providers and sets rules designed to protect the privacy of that information.

Health Maintenance Organization

(HMO) – A managed care plan that integrates financing and delivery of a comprehensive set of health care services to an enrolled population. HMOs may contract with, directly employ, or own participating health care providers. Enrollees are usually required to choose from among these providers and in return have limited co-payments. Providers may be paid through capitation, salary, per diem, or pre-negotiated fee-for-service rates.

Health Professional Shortage Area

(HPSA) – A geographic area, population group, or medical facility that the Department of Health and Human Services determines to be served by too few health professionals of particular specialties. Physicians who provide services in HPSAs qualify for the Medicare bonus payments, repayment of medical school loans and/or other incentives.

High Deductible Health Plan (HDHP)

– An inexpensive health insurance plan that generally does not pay for the first several thousand dollars of health expenses (i.e., the “deductible”) but will generally cover medical care after the amount is met.

High-Risk Pool – A subsidized health insurance pool organized federally or by individual states as a source of coverage for individuals who have been denied health insurance because of a medical condition or whose premiums are significantly higher than the average due to health status or claims experience.

Home and Community-Based Services (HCBS)

– Services and support covered by most state Medicaid programs and provided in your home or community giving help with such daily tasks as bathing or dressing. This care is covered when provided by care workers or, if your state permits it, by family members.

Home Health Agency – An organization that provides medical, therapeutic or other health services in patients' homes.

Hospice or Hospice Care – Facility or program providing care for the terminally ill. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional and spiritual needs of the patient. Hospice also provides support to the patient's family or caregiver.

Indigent Medical Care – Care given by health care providers to patients who are unable to pay for it.

Long-Term Care (LTC) – Ongoing health and social services provided for individuals who need assistance on a continuing basis because of physical or mental disability. Services can be provided in an institution, the home, or the community, and include informal services provided by family or friends as well as formal services provided by professionals or agencies.

Low-Income Medicaid (LIM) – Medicaid category for those with the lowest individual and family incomes.

Medicaid – A health insurance program, funded jointly by federal and state governments and managed by the states, that provides medical coverage to qualified low-income individuals in need of health and medical care. The program is subject to broad federal guidelines, with states determining the benefits covered and methods of administration.

Medical Loss Ratio (MLR) – The fraction of revenue from an insurance plan's premiums that goes to pay for medical services.

Medical Savings Account (MSA) – A health insurance option consisting of a high-deductible insurance policy and a tax-advantaged savings account. Individuals would pay for their own health care up to the annual deductible by withdrawing from the savings account or paying out of pocket. The insurance policy would pay for most or all costs of covered services once the deductible is met.

Medicare – A federal health insurance program for the elderly and disabled regardless of financial status. It consists of two separate but coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B) and a separate drug coverage program administered by the private sector (Part D).

Morbidity – The extent of illness, injury, or disability in a defined population. It is usually expressed in general or specific rates of incidence (new cases) or prevalence (total cases).

Partners for Healthy Children Program

– The South Carolina Medicaid program for low income children under the age of 19.

Patient Protection and Affordable Care Act (PPACA)

– A comprehensive federal law passed in 2010 that includes numerous health-related provisions and health insurance reforms.

Patient Self-Determination Act (PSDA)

– A federal law passed in 1990 that requires health care facilities to determine if new patients have a living will and/or durable power of attorney for health care and take patients' wishes into consideration in developing their treatment plans.

Pharmaceutical Assistance Program – A program to provide pharmaceutical coverage to those who cannot afford or have difficulty obtaining prescription drugs. Several states operate state-funded pharmaceutical assistance programs which primarily provide benefits to low-income elderly or persons with disabilities who do not qualify for Medicaid.

Pharmacy Benefit Manager (PBM) – A company under contract with managed care organizations, self-insured companies, and government programs for pharmacy network management, drug utilization review, outcomes management, and disease management.

Portability – A concept describing that an individual changing jobs would be guaranteed health coverage with the new employer without a waiting period or having to meet additional deductible requirements.

Pre-Existing Condition – A physical or mental condition of an individual which is known to the individual before an insurance policy is issued.

Preferred Drug List (PDL) – A list of prescription drugs which are covered by a health plan or other payer (e.g., Medicaid).

Preferred Provider Organization (PPO)
– A health care delivery system that contracts with hospitals and physicians to provide services at discounted fees to members. Individuals in a PPO may seek care from non-participating providers of medical care but generally are financially penalized for doing so by the loss of the discount and/or subjection to co-payments and deductibles.

Prescription Drug Plan (PDP) – Managed by commercial and private entities, PDPs are a type of managed care. Individuals can use plan member cards at pharmacies to receive discounts on their prescriptions, provided that the drugs are on the approved/covered lists and members are within the limits of their coverage plan. If an individual has limited income and resources, he or she may get extra help to cover prescription drugs for little or no cost.

Prevention – Actions taken to reduce susceptibility or exposure to health problems (primary prevention), detect and treat disease in early stages (secondary prevention), or alleviate the effects of disease and injury (tertiary prevention).

Primary Care – A basic level of health care provided by a physician with whom an individual has an ongoing relationship and who knows the patient’s medical history. Primary care services emphasize a patient’s general health needs such as preventive services, treatment of minor illnesses and injuries, or identification of problems that require referral to specialists. Typically, primary care physicians include family physicians, internists, gynecologists and pediatricians.

Public Health – A broad array of programmatic and policy-related activities that society performs collectively, often in partnership with federal, state and local government entities, to assure the conditions in which people can be healthy. This includes organized community efforts to prevent, identify, preempt, and counter threats to the public’s health.

Right from the Start Medicaid (RSM)

– Medicaid category for pregnant women and children under age one whose family income is at or below 185% of the federal poverty level.

Rural Health Clinic (RHC) – A public or private hospital, clinic or physician practice designated by the federal government and in compliance with the Rural Health Clinics Act. The practice must be located in a medically underserved area or a Health Professions Shortage Area (HPSA) and use physician assistants and/or nurse practitioners to deliver services. A rural health clinic must be licensed by the state and provide preventive services. These providers are usually qualified for special compensations, reimbursements and exemptions.

Rural Health Network – Refers to any variety of organizational arrangements to link rural health care providers in a common purpose.

Safety Net – Providers and institutions that provide low cost or free medical care to medically needy, low income or uninsured populations. They include community and migrant health centers, free medical clinics and public hospitals.

Self-Insured Group Health Plan – Plan set up by employers who set aside funds to pay their employees' health claims. Because employers often hire insurance companies to run these plans, they may look just like fully insured plans. Employers must disclose whether an insurer is responsible for funding the plan or only administering the plan. If the insurer is only administering the plan, it is self-insured. Self-insured plans are regulated by the U.S. Department of Labor, not by South Carolina Department of Insurance.

Small Business Health Options Program

(SHOP) – Under PPACA, a health insurance exchange open to individuals and employers with less than 100 employees.

South Carolina Department of Health and Environmental Control (DHEC)

– State agency charged with protecting public health, coastal resources, and the state's land, air and water quality.

South Carolina Department of Health and Human Services (DHHS)

– State agency that manages the Medicaid program.

State Children's Health Insurance Program (SCHIP)

– A program enacted by Congress in 1997 that provides federal matching funds for states to spend on health coverage for uninsured children. The program is designed to reach uninsured children whose families earn too much money to qualify for Medicaid but are too poor to afford private coverage.

Supplemental Security Income

(SSI) – A federal cash assistance program for low-income elderly, blind and disabled individuals who have little or no income for basic needs. States may use SSI income limits to establish Medicaid eligibility.

Tax Credit – The amount that can be deducted from an actual tax owed.

Temporary Assistance for Needy Families

(TANF) – A program that provides cash benefits to low income families with children. When you qualify for TANF, you generally also qualify for Medicaid.

Trauma System – An organized, coordinated effort in a defined geographic area that delivers the full range of emergency care to all injured patients and is integrated with the local public health system.

Triple Aim Model – A framework focused on improving the individual experience of health care; improving the health of populations; and reducing the per capita costs of health care for populations.

Underinsured – People with public or private insurance policies that do not cover all necessary health services, resulting in out-of-pocket expenses that often exceed their ability to pay.

Uninsurables – High-risk persons who do not have health care coverage through private insurance and who fall outside the parameters of risks of standard health underwriting practices.

Uninsured – People who lack public or private health insurance.

Utilization – A commonly examined pattern or rate of use of a single service or type of service (e.g., hospital care, physician visits, and prescription drugs). Utilization is typically expressed in rates per unit of population at risk for a given period (e.g., the number of annual admissions to a hospital per 1,000 persons over age 65).

Acronym Appendix

- ABD:** Aged, Blind, Disabled
- ACA:** Affordable Care Act (shortened from PPACA)
- ACO:** Accountable Care Organization
- BRFSS:** Behavior Risk Factor Surveillance System
- CDC:** Centers for Disease Control and Prevention
- CMS:** Centers for Medicare and Medicaid Services
- CON:** Certificate of Need
- CHC:** Community Health Center
- DSH:** Disproportionate Share Hospital Program
- EMR:** Electronic Medical Record
- EMS:** Emergency Medical Services
- FMAP:** Federal Medical Assistance Percentage
- FMLA:** Family Medical Leave Act
- FPL:** Federal Poverty Level
- FQHC:** Federally Qualified Health Center
- HIA:** Health Impact Assessment
- HIT:** Health Information Technology

- HIPAA:** Health Insurance Portability and Accountability Act
- HMO:** Health Maintenance Organization
- HPSA:** Health Professional Shortage Area
- HRSA:** Health Resources and Services Administration
- HSA:** Health Savings Account
- LTC:** Long-Term Care
- MCH:** Maternal and Child Health
- NIH:** National Institutes of Health
- PBM:** Pharmacy Benefit Manager
- PPACA:** Patient Protection and Affordable Care Act (sometimes referred to as ACA)
- PPO:** Preferred Provider Organization
- PCP:** Primary Care Provider
- QA:** Quality Assurance
- QI:** Quality Improvement
- SCHIP:** State Children's Health Insurance Program
- TANF:** Temporary Assistance for Needy Families
- YRBSS:** Youth Risk Behavior Surveillance System

The South Carolina Institute of Medicine and Public Health (IMPH) is an independent entity serving as a convener around the important health issues in our state. IMPH also serves as a resource for evidence-based information and to inform health policy decisions. For more information on IMPH publications, initiatives and events, please visit www.imph.org.



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