

HJR 20: Health Care Price Transparency ***Topic Terminology for Feb. 16, 2018***

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Unless otherwise noted, the definitions in this paper were adapted from HealthCare.gov, the federal health insurance marketplace website.

- **Accessibility of Services.** A person's ability to get medical care and services when they are needed. (cms.gov)
- **Allowed Amount.** The maximum amount a health plan will pay for a covered health care service. This may also be called an "eligible expense," "payment allowance," or negotiated rate." If a provider charges more than the plan's allowed amount, the covered individual may have to pay the difference.
- **Ambulatory Care.** All types of health services that do not require an overnight hospital stay. (cms.gov) These services are sometimes referred to as outpatient services.
- **Coinsurance.** The percentage of costs of a covered health care service that an insured individual must pay after payment of the person's deductible. Generally speaking, plans with low monthly premiums have higher coinsurance, and plans with higher monthly premiums have lower coinsurance.
- **Copayment.** A fixed amount that an insured person pays for a covered health care service after payment of the health plan's deductible. Copayments can vary for different services within the same plan, such as drugs, lab tests, and visits to specialists. Generally, plans with lower monthly premiums have higher copayments. Plans with higher monthly premiums usually have lower copayments.
- **Cost Sharing.** The share of costs covered by a health plan that the insured person must pay out of his or her own pocket. This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost sharing in Medicaid and the Children's Health Insurance Program (CHIP) also includes premiums.
- **Deductible.** The amount an insured individual pays for covered health care services before the health plan starts to pay. With a \$2,000 deductible, for example, the person would pay the first \$2,000 of covered services. Some health plans pay for certain services before a deductible is met. Generally, plans with lower monthly premiums have higher deductibles. Plans with higher monthly premiums usually have lower deductibles. Some plans have very high deductibles. These plans are sometimes called "catastrophic plans" because they only cover hospitalization for major illnesses or injuries.

- **Diagnostic and Procedure Codes.** Medical coding is the process of translating information from patient records –treatments, tests, procedures, and diagnoses – into the standardized codes used to bill patients and third-party payers such as insurance companies, Medicaid, and Medicare. The rating scale is from 1 to 5 with 5 indicating a significant and complex treatment. Reimbursement for service increases according to the code level from 1 to 5.

Diagnosis codes track diseases and other health conditions, inclusive of chronic diseases such as diabetes and heart disease, and infectious diseases such as norovirus and the flu. Procedure codes track interventions performed. These diagnosis and procedure codes are used by health care providers, government health programs, private health insurance companies, workers' compensation carriers, software developers, and others for a variety of applications in medicine, public health and medical statistics, including:

- statistical analysis of diseases and therapeutic actions;
 - reimbursement (e.g., to process claims in medical billing based on diagnosis-related groups);
 - knowledge-based and decision support systems; and
 - direct surveillance of epidemic or pandemic outbreaks. (Wikipedia.org)
- **Explanation of Benefits.** An overview of the total charges for a patient visit and how much the patient and the health plan will have to pay. An EOB is not a bill. You may get a bill separately from the provider.
 - **Health Care Eligibility and Benefits Inquiry.** Health Care Eligibility and Benefits Inquiry is an app that health providers can use to determine if a health service is covered by the patient's insurance. Prior to actually performing the service and billing a patient, the care provider may use software to check the eligibility of the patient for the intended services with the patient's insurance company. This process uses the same standards and technologies as an electronic claims transmission with small changes to the transmission format. This format is known specifically as X12-270 Health Care Eligibility & Benefit Inquiry transaction. (www.HealthIT.gov)
 - **Health Insurance Claims Adjuster.** A health insurance claims processor, or adjuster, decides whether a person's insurance policy covers a particular medical procedure. Most claims adjusters work at insurance companies or doctor's offices processing medical claims from doctors and hospitals. In reviewing a claim, a claims adjuster looks at each policy's benefits to make sure a claim is valid. (<http://work.chron.com/medical-insurance-claims-processor-do-10546.html>)
 - **Health Insurance Marketplace:** A service that helps people shop for and enroll in affordable health insurance. The federal government operates the Marketplace, available at HealthCare.gov, for most states. Some states run their own marketplaces. The Health Insurance Marketplace (also known as the "Marketplace" or "Exchange") provides health plan shopping and enrollment services through websites, call centers, and in-person help. When people apply for individual and family coverage through the marketplace, they provide income and household information to find out if they qualify for premium tax credits and other savings that make insurance more affordable or if they qualify for coverage through Medicaid or CHIP in the states in which they reside.

- **Health Plan.** The definition of health plan can vary. Following are examples from state and federal law:
 - A policy contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. (33-1-801, Montana Code Annotated)
 - Any individual or group plan, policy, certificate, subscriber contract, contract of insurance provided by a managed care plan, preferred provider agreement, or health maintenance organization subscriber contract that is issued, delivered, issued for delivery, or renewed in this state by a health carrier that pays for, purchases, or furnishes health care services to covered persons who receive health care services in this state. (33-22-1902, Montana Code Annotated)
 - A plan that provides or pays for the cost of medical care for an individual or a group of people. A health plan could be issued by a health insurance company or provided in many other ways, including through a health maintenance organization, a multiple employee welfare arrangement, a government-funded plan, or plan funded by an employer. (summary of 160.103, Title 45, Code of Federal Regulation.)

- **High-Deductible Health Plan.** A health plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but the insured person pays more health care costs before the insurance company starts to pay its share. A high-deductible health plan can be combined with a health savings account, allowing the person to pay for certain medical expenses with money free from federal taxes. For 2018, the IRS defines a high-deductible health plan as any plan with a deductible of at least \$1,350 for an individual or \$2,700 for a family. The plan's total yearly out-of-pocket costs (including deductibles, copayments, and coinsurance) can't be more than \$6,650 for an individual and \$13,300 for a family. The limit doesn't apply to out-of-network services.

- **Out-of-Pocket Costs.** Health care expenses that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.

- **Patient Satisfaction Surveys.** The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey is the first national, standardized, publicly reported survey of patients' perspectives of hospital care. HCAHPS (pronounced "H-caps"), also known as the CAHPS Hospital Survey, is a survey instrument and data collection methodology for measuring patients' perceptions of their hospital experience. While many hospitals have collected information on patient satisfaction for their own internal use, until HCAHPS there was no national standard for collecting and publicly reporting information about patient experience of care that allowed valid comparisons to be made across hospitals locally, regionally and nationally.

Three broad goals have shaped HCAHPS. First, the survey is designed to produce data about patients' perspectives of care that allow objective and meaningful comparisons of hospitals on topics that are important to consumers. Second, public reporting of the survey results creates new incentives for hospitals to improve quality of care. Third, public reporting serves

to enhance accountability in health care by increasing transparency of the quality of hospital care provided in return for the public investment. With these goals in mind, the Centers for Medicare and Medicaid Services (CMS) and the HCAHPS Project Team have taken substantial steps to ensure that the survey is credible, useful, and practical. (cms.gov)

- **Surprise Medical Bills.** A term commonly used to describe charges arising when an insured individual inadvertently receives care from an out-of-network provider or when a patient receives planned care from an in-network provider but other providers brought in to participate in the patient's care are not in the same network. For insured patients, the surprise medical bill reflects the difference in patient cost-sharing between in-network and out-of-network providers and the cost of balance billing by out-of-network providers. (Surprise Medical Issues Brief, Kaiser Family Foundation)