ALTARUM
HEALTHCARE VALUE HUB

Glossary:
Terms in the Healthcare Affordability State Policy Scorecard

The Healthcare Affordability State Policy Scorecard evaluates states' performance on a broad set of actions to make healthcare more affordable for consumers. This glossary contains some of the terms discussed in the Scorecard. More resources can be found at: https://healthcarevaluehub.org/affordability-scorecard.

Term	Acronym	Definition
All-Payer Claims Database	APCD	APCDs are large databases that can include claims data from private insurance companies, state employee health benefit programs, Medicare and Medicaid. APCDs provide a wide range of payment, utilization and disease pattern information that can be used to monitor healthcare spending and identify price variation in healthcare systems, among other activities. When the database does not include data from all provider types, it is referred to as a multi-payer claims database. [Link]
Antibiotic Stewardship		Antibiotic stewardship is the effort to measure and improve how antibiotics are prescribed by clinicians and used by patients. The Centers for Disease Control and Prevention's Core Elements of Antibiotic Stewardship program offers providers and facilities a set of key principles to guide efforts to improve antibiotic use and, therefore, advance patient safety and improve outcomes. [Link]
Basic Health Plan		Section 1331 of the Affordable Care Act (ACA) gives states the option of creating a Basic Health Plan, a health benefits coverage program for low-income residents who would otherwise be eligible to purchase coverage through the Marketplace. This enables states to provide more affordable coverage for these low-income residents and improve continuity of care for people whose income fluctuates above and below Medicaid and CHIP levels. [Link] *Also called basic health program.*
Centers for Medicare and Medicaid Services	CMS	The federal agency within the Department of Health and Human Services, responsible for providing health coverage to residents through Medicare, Medicaid, the Children's Health Insurance Program and the federal Marketplace. [Link]

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Children's Health Insurance Program	CHIP	The Children's Health Insurance Program provides health coverage to children whose family income is above Medicaid eligibility levels. CHIP is a federal-state partnership that is administered by states, according to federal requirements. [Link]
CHIP's "Unborn Child" Option		States have the option to provide CHIP coverage to fetuses as "targeted low-income children," effectively extending coverage to low-income pregnant people, regardless of immigration status. Coverage may be limited to prenatal care or states may provide comprehensive benefits similar in scope to pregnancy-related Medicaid. [Link]
Electronic Health Records	EHR	An electronic version of a patient's medical history that is maintained by the provider over time and may include all of the key administrative clinical data relevant to the patient's care. It can support other care-related activities, including evidence-based decision support, quality management and outcomes reporting. [Link]
Federal Poverty Level	FPL	The federal government's measure of income, used to determine eligibility for certain programs and benefits. [Link]
Fully Funded Insurance Plan		A plan where the health plan bears the risk for covering the claims of the enrolled population. These plans are regulated by the state and typically are purchased by individuals and small employers. [Link] *See also: self-funded insurance plan*
Health Spending Benchmarks		Annual targets for healthcare spending that can be established at a national level, a state level or for other subsets of spending. These targets are used to both measure and constrain aggregate healthcare spending. [Link]
Health Spending Oversight Entity		An agency that keeps track of healthcare spending in a comprehensive and systematic way, provides data and research support to the state and other stakeholders to track healthcare prices and provider quality to determine if state, employer and household resources are used efficiently. [Link]
High Deductible Health Plan	HDHP	A health insurance plan that has a high deductible (as defined by the federal government)—that is, the amount the beneficiary must pay before insurance begins paying for covered services—and lower premiums. [Link]
High-Value Care		Healthcare services that are of proven value and have no significant tradeoffs—that is, the benefits of the services so far outweigh the risks that all patients in a given population should receive them. [Link]

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Immigrant Five-Year Bar		Federal regulations prohibit lawfully residing immigrants from receiving Medicaid and CHIP without waiting five years. [Link]
Low-Value Care		Unnecessary, inefficient healthcare services that provide little or no benefit to the patient. [Link]
Medicaid Buy-In		A state program in which certain individuals with incomes above Medicaid eligibility levels can pay premiums to access Medicaid coverage.
Medicaid Expansion		Under the ACA, states can expand their Medicaid program—coverage for low-income earners—to all adults with incomes below 138% FPL. Prior to the ACA, Medicaid coverage was limited to low-income families, qualified pregnant women and children and individuals receiving Supplemental Security Income (SSI). [Link]
Medicare Reference Pricing		In which health costs—typically, charges from providers or insurer allowed amounts—are evaluated against the Medicare reimbursement rate for the same service. [Link]
No Surprises Act		Federal legislation that protects people covered under group and individual health plans from receiving surprise medical bills when they receive most emergency services, non-emergency services from out-of-network providers at in-network facilities and services from out-of-network air ambulance service providers, effective January 2022. [Link]
Out-of-Pocket Costs	OOP	Costs that consumers are responsible for and are not covered by insurance. Can include co-payment, co-insurance and deductibles.
Patient-Safety Reporting		The detailed disclosure of patient safety events by the health personnel who were associated with the event. The disclosure of performance data can lead to healthcare quality improvement. Regulatory agencies of the government or accreditation and certification bodies impose reporting requirements of patient safety events on providers that may be voluntary or mandatory. Validation of patient safety events can involve checking data for quality and additional in-depth data review to confirm cases. Healthcare-acquired infections are a type of medical harm where a patient gets an infection while receiving treatment in a healthcare facility for another condition. Central line-associated bloodstream infections (CLABSI) and catheter-associated urinary tract infections (CAUTI) are two common forms of hospital-acquired infections. [Link]

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Personal Consumption Expenditure	PCE	Healthcare PCE measures spending growth among households as well as nonprofit, commercial and government hospitals/nursing homes. [Link]
Premium Subsidies		Tax credits (created by the ACA) to lower the cost of health insurance premiums purchased through the insurance Marketplaces for lower- and middle-income people. [Link]
Price Transparency Tool		A website that displays price information on healthcare services, allowing consumers to "shop" for the best price and budget for expected services. [Link]
Public Option		A government-directed form of health insurance that individuals can purchase, meant to be a high-value and affordable alternative coverage option than private, commercial plans. [Link]
Rate Review		The scrutiny of proposed premium rates by state health insurance departments, or occasionally the federal government. This scrutiny is intended to help moderate premium hikes and lower costs for individuals, families and businesses that buy insurance in these markets. [Link]
Reinsurance		A program that provides payments to health insurers to help offset the costs of enrollees with high health spending, resulting in reduced premium costs for consumers. Many states have established reinsurance programs through Section 1332 State Innovation waivers, established through the ACA. [Link]
Self-Funded Insurance Plan		A plan where the employer or union assumes the financial risk for providing healthcare benefits to enrollees. These plans are regulated by the U.S. Department of Labor and are typically associated with large employers. [Link] *Also called self-insured plan. See also: fully funded insurance plan.*
Short-Term, Limited Duration Health Plans	STLD	Health plans that only provide coverage for a limited term, typically less than 365 days, and are not subject to consumer protections under the ACA. They are less expensive, but offer poor coverage and limited consumer protections, and pose financial risks for consumers. [Link]
Standard Plan Design		Standard plan design makes cost-sharing the same across plans within metal tiers, making it easier for consumers to compare plans. They also help regulators and exchanges negotiate or set rates with insurance carriers, which may translate to lower prices for consumers. [Link]

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State Health Access Data Assistance Center	SHADAC	SHADAC is a multidisciplinary health policy research center with a focus on state policy. It is a program of the Robert Wood Johnson Foundation and a part of the Health Policy and Management Division of the School of Public Health at the University of Minnesota. [Link]
State-Based Exchange		Wherein the state establishes and runs its own health insurance Marketplace for the individual market. Under the ACA, states have three Marketplace options: a state-based exchange; a state-based exchange that is hosted on the federal platform, where states are responsible for many of the Marketplace functions, and the federal government is responsible for eligibility and enrollment functions; or a federally-facilitated Marketplace, where the federal government performs all Marketplace responsibilities. [Link] *Also called state-based Marketplace.*
Surprise Medical Bill	SMB	A medical bill for which a health insurer paid less than the patient expected, leaving the patient to pay for the remaining, unexpected balance. Surprise medical bills often come from healthcare services that the patient did not know was out-of-network until the service was billed. [Link] *Also called balance billing.*