HEALTH CARE COST INSTITUTE

Glossary

Acute inpatient: A subservice category of the inpatient facility clams that have excluded skilled nursing facilities (SNF), hospice, and ungroupable claims. This subcategory was previously known as inpatient subset.

Administrative services only (ASO) plan: An arrangement wherein a third party handles the administration of a self-funded benefit program for a fee. See also self-funded benefit program.

Adults: Individuals ages 19 through 64.

Allowed amounts: See prices paid.

Allowed costs: See prices paid.

Ambulatory payment classification (APC): A system of grouping hospital outpatient services with similar clinical characteristics, costs, and procedure codes. These groupings were developed by the Centers for Medicare & Medicaid Services (CMS).[1]

Ambulatory payment classification (APC) weight: Prospectively-determined relative weight assigned to each APC grouping by CMS, published in the Hospital Outpatient Prospective Payment System Final Rule each calendar year.

Babies: See also infants and toddlers.

[1] Centers for Medicare and Medicaid Services. Payment System Fact Sheet Series: Hospital Outpatient Prospective Payment System [Internet]. Baltimore (MD): CMS; 2012 Feb [cited 2012 May 17]. Available from http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//HospitalOutpaysysfctsht.pdf.

Beneficiary: See also insured and member.

Brand prescription: A drug or medical device that is prescribed by a health care provider and marketed under a trade name approved by the U.S. Food and Drug administration (USFDA). See also prescription and generic prescription.

Centers for Medicare & Medicaid (CMS): A federal agency within the U.S. Department of Health and Human services and charged with administering public health care programs, including the Medicare and Medicaid public insurance programs and the U.S. Health Insurance Marketplace.

Census region: Geographic areas determined by the United States Census. In HCCI reporting, census region refers to the division of the 50 United States and the District of Columbia into four geographic areas: Midwest, Northeast, South, and West.[2]

Central nervous system (CNS) agents: A detailed service category of prescriptions that effect the brain and spinal column.

Charges: The dollar amount a provider charged/asked for medical services rendered; such charges can differ from the prices paid to that provider for medical services rendered. See also prices paid.

Children: Individuals ages 0 through 18.

Coinsurance: A portion of covered health care costs borne by an insured. After the insured meets a deductible requirement, insurers often apply coinsurance according to a fixed percentage of the prices paid.

Consumer-driven health plan (CDHP): Health plans that have a high deductible and include either a health reimbursement account (HRA) or a health savings account (HSA).

Copay: A cost-sharing arrangement in which the insured pays a specified charge for a specified service. Typical co-payments are fixed flat amounts for physician office visits, prescriptions, or hospital services.

[2] U.S. Department of Commerce Economics and Statistics Administration, U.S. Census Bureau. Census Regions and Divisions of the United States [Internet]. Available from: http://www.census.gov/geo/maps-data/maps/pdfs/reference/us_regdiv.pdf.

Current procedural terminology (CPT) code: Unique identifiers developed by the American Medical Association (AMA) to classify medical services and procedures furnished by physicians and other health care professionals.[3]

Deductible: The amount that the insured must pay out of pocket to providers before the health plan pays any reimbursement. For example, an insured with a $1,000 deductible would pay the first $1,000 of service costs in the given year. After the deductible is satisfied, the beneficiary and the health plan jointly pay further expenses according to the insurance contract.

Diagnosis-related groups (DRG): A system of classification of inpatient hospital services based on principal diagnosis, secondary diagnosis, surgical procedures, age, gender, and presence of complications.

Diagnosis-related groups (DRG) weights: A metric that captures the average resources used to treat patients within a DRG in a specific fiscal year, assigned by CMS. The metric is often used as a mechanism to reimburse hospitals and selected health care providers for services rendered and is typically based on the average cost of all patients within the group.

Emergency room (ER): A section of the hospital where emergency treatment and diagnosis is provided.

Employer-sponsored insurance (ESI): A health insurance policy provided by an employer to its employees and their families. The employer and employee usually jointly pay premiums. See also fully-insured benefit program and self-funded benefit program.

Facility claim: A request for payment from a facility that provided a medical service, limited to the cost of using a room and associated services within the facility; it does not include any procedures performed by health professionals on the insured. Charges for physician services are rendered separately as "professional procedure claims."

Filled days: The number of days of a prescription as filled by a pharmacy. See also prescription.

[3] CPT codes and descriptions only are copyright of the American Medical Association. All Rights Reserved.

Filled script: One prescription drug claim for a drug or medical device regardless of number of days filled; each refill equals one script. See also prescription.

Fully-insured benefit program: An employee health insurance plan that is purchased by an employer through a health plan. The health plan pays both claims and administrative costs and assumes the insurance risk.

Generic prescription: A drug or medical device that is prescribed by a health care provider, is not marketed under a trade name, but is approved by the U.S. Food and Drug administration (USFDA). Generics have the same quality and chemical composition as a brand prescription and enter the market once exclusions on the brand prescription expire. See also brand prescription.

Healthcare common procedure coding system (HCPCS): A means of classifying medical items or services in claims and patient discharge data.

Hospice: Special care provided by a program or facility for the terminally ill and their families.

Infants and toddlers: Children ages 0 through 3.

Inpatient admission: An admission to a hospital that includes an overnight stay. See also length of stay.

Inpatient facility: A medical setting, such as hospitals, hospices, and skilled nursing facilities, where patients are kept overnight for treatment.

Inpatient service category: A classification of inpatient admissions based on the type of service provided during the hospital stay.

Insured: An individual covered by health insurance. See also beneficiary and member.

Insured months: The number of months an insured has health insurance in a given year.

Intensity: A measure of the complexity of a service, including the length of time, the severity of the illness addressed, and the amount of resources required for treatment. It is a component of price per service.[4]

[4] For calculations of intensity, see HCCI's Analytic Methodology (http://www.healthcostinstitute.org/).

Intensity-adjusted price: The amount paid by insurers and beneficiaries to a provider for a health care provision, modified for the resource mix (intensity) of the services provided. It is a component of price per service. The intensity-adjusted price is calculated by dividing the price paid for the service by the intensity of the service. Also called unit price.

Intermediate adults: Adults ages 26 through 44.

Length of stay (LOS): The number of days a patient stays overnight in a hospital or medical facility and usually counted by the presence of the patient in the facility at midnight.

Long-term care: Inpatient or outpatient care received at a skilled nursing facility or hospice.

Major diagnostic category (MDC): A coding scheme composed of 27 diagnosis categories based on major organ systems that are aggregations of Diagnostic-Related Group (DRG) codes.

Member: An individual covered by a specific health insurance plan; could be the primary coverage holder or a dependent. See also beneficiary and insured.

Member months: The number of months for which an individual is covered by a specific health insurance plan. An insured covered for 12 member months in a calendar year would be covered for 1 year of insurance. See also insured months.

Middle age adults: Adults ages 45 through 54.

Neonates/infants: Children younger than 1 year of age.

Observation room: A room in a hospital facility where the status and treatment of a patient is monitored and distinct from a hospital admission.

Out-of-pocket payments: The payments made directly to a health care provider by the insured, including any copayments, coinsurance payments, and deductible payments. Any health care payments made out-of-pocket for which a claim was not filed (such as over-the-counter medicines) are not included in this metric. See also prices paid.

Outpatient facility: A facility or unit in a facility that provides medical services not requiring an overnight stay or hospitalization.

Payer: The party who is financially responsible for the amount of the claim covered by the contract.

Payer expenditures per capita: The dollars paid by the insurer directly to a health care provider on behalf of the insured, excluding any rebates, discounts, incentive payments, or administrative costs not captured by the claims system.

Per capita expenditure: The sum of prices paid divided by the insured population; also calculated by multiplying total utilization and price per service. See also spending per capita.

Place of service (POS) code: A classification scheme to capture the type of health service setting that provided a medical service.

Pre-Medicare adults: Adults ages 55 through 64.

Pre-teens: Children ages 9 through 13.

Prescription: An order from a health care professional and given to a patient to obtain drugs or medical devices that cannot be purchased over the counter.

Price per service: A combination of intensity-adjusted price and intensity; calculated by multiplying the components.

Prices paid: The amount paid to a provider for a medical service or supply after provider discounts. It is also defined as negotiated rates paid by a health plan to a provider for a medical service or supply that qualifies as a covered expense. This amount is the shared responsibility of the health plan and the insured and excludes amounts for non-covered services. It includes the payment by the insurer and the out-of-pocket payments of the insured. Average price is calculated by summing all the dollars spent on a service category, sub-service category, or detailed service category, and dividing by the associated number of service uses.

Primary care provider (PCP): Health professional who offers non-specialist care to patients and usually provides ongoing care for health maintenance. HCCI classified the following types of physicians as PCP providers: family practice, geriatric medicine, internal medicine, pediatrics, and preventive medicine.

Professional procedure claim: A claim filed by a health care professional for medical services rendered. It includes claims for professional procedures as opposed to facility claims, including office visits, lab tests, and immunizations.

Reimbursement: A monetary payment to a provider for any type of claim.

Relative value units (RVU): A classification scheme based on the skill, effort, and time required by a health care professional for a given medical procedure or service in comparison to other medical procedures and services. The scheme is based on the relative level of time and intensity associated with furnishing the service as set by CMS with commercial adjustments.

Revenue code: A code assigned to a medical service or treatment for receiving proper payment, typically in a hospital setting.

Self-funded benefit program: A health insurance plan in which the employer pays the insurance claims. See also administrative services only plan (ASO).

Skilled nursing facility (SNF): A facility that provides skilled nursing and rehabilitation services but with less care and intensity than would be provided in a hospital. Services provided at a skilled nursing facility include both medical and custodial services. Stays that include only custodial care (such as assistance with bathing, feeding, and dressing) are not skilled nursing care.

Specialist: A health care professional who provides care for patients requiring a specific category of medical services and who has intensive training in that category of medicine.

Spending per capita: Per capita health spending is an estimate of total expenditures paid for individuals younger than age 65 and covered by ESI divided by the population of insured individuals.

Teenagers: Children ages 14 through 18.

Therapeutic class: A classification of a drug or a medical device based on function and use.

Unit price: See intensity-adjusted price.

Utilization: The amount of medical service consumed by patients within a given time period; calculated by counting the number of claim lines and calculating an average number of service uses per 1,000 insured.

Young adults (YA): Adults ages 19 through 25.

Younger children: Children ages 4 through 8.