**ACCOUNTABLE CARE ORGANIZATION (ACO)**
A network of health care providers that band together to provide the full continuum of health care services for patients. The network would receive a payment for all care provided to a patient, and would be held accountable for the quality and cost of care. Proposed pilot programs in Medicare and Medicaid would provide financial incentives for these organizations to improve quality and reduce costs by allowing them to share in any savings achieved as a result of these efforts.

**ALLOWABLE CHARGE, also referred to as the allowed amount, approved charge or maximum allowable.**
This is the dollar amount typically considered payment-in-full by an insurance company and an associated network of healthcare providers. The Allowable Charge is typically a discounted rate rather than the actual charge. It may be helpful to consider an example: You have just visited your doctor for an earache. The total charge for the visit comes to $100. If the doctor is a member of your health insurance company’s network of providers, he or she may be required to accept $80 as payment in full for the visit - this is the Allowable Charge. Your health insurance company will pay all or a portion of the remaining $80, minus any co-payment or deductible that you may owe. The remaining $20 is considered provider write-off. You cannot be billed for this provider write-off. If, however, the doctor you visit is not a network provider then you may be held responsible for everything that your health insurance company will not pay, up to the full charge of $100.

**BENEFIT PACKAGE**
The set of services, such as physician visits, hospitalizations, prescription drugs that are covered by an insurance policy or health plan. The benefit package will specify any cost-sharing requirements for services, limits on particular services, and annual or lifetime spending limits.

**CAPITATION**
A method of compensation sometimes employed by health insurance companies, in which payment is made to a healthcare provider on a per-patient rather than a per-service basis. For example, under capitation an HMO doctor may be paid a fixed amount each month to serve as the primary care physician for a specific number of HMO members assigned to his or her care, regardless of how little or how much care each member needs.

**CENTERS FOR MEDICARE AND MEDICAID SERVICES:**
Formerly known as the Health Care Financing Administration, the Centers for Medicare and Medicaid Services (CMS) is part of the federal government’s Department of Health and Human Services, and is responsible for the administration of the Medicare and Medicaid programs. The CMS establishes standards for healthcare providers that must be complied with in order for providers to meet certain certification requirements.

**CLAIM:**
A bill for medical services rendered, typically submitted to the insurance company by a healthcare provider.

**CO-INSURANCE**
A method of cost-sharing in health insurance plans in which the plan member is required to pay a defined percentage of their medical costs after the deductible has been met.
Co-payment
A fixed dollar amount paid by an individual at the time of receiving a covered health care service from a participating provider. The required fee varies by the service provided and by the health plan.

Cost sharing
Health care provider charges for which a patient is responsible under the terms of a health plan. Common forms of cost-sharing include deductibles, coinsurance, and co-payments. Beginning in 2014, the PPACA limits total cost-sharing to $5,950 for an individual and $11,900 for a family. These amounts will be adjusted annually to reflect the growth of premiums.

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.

Dual Eligibles
A term used to describe an individual who is eligible for Medicare and for some level of Medicaid benefits. Most dual eligibles qualify for full Medicaid benefits including nursing home services, and Medicaid pays their Medicare premiums and cost sharing. For other duals Medicaid provides the “Medicare Savings Programs” through which enrollees receive assistance with Medicare premiums, deductibles, and other cost sharing requirements.

Employer Health Care Tax Credit
An incentive mechanism designed to encourage employers, usually small employers, to offer health insurance to their employees. The tax credit enables employers to deduct an amount, usually a percentage of the contribution they make toward their employees’ premiums, from the federal taxes they owe. These tax credits are typically refundable so they are available to non-profit organizations that do not pay federal taxes.

Essential Health Benefits
A package of benefits set by the Secretary of Health and Human Services that insurers will be required to offer under the exchanges as part of the PPACA.

Fee-for-Service
A traditional method of paying for medical services under which doctors and hospitals are paid for each service they provide. Bills are either paid by the patient, who then submits them to the insurance company, or are submitted by the provider to the patient’s insurance carrier for reimbursement.

Medicaid
Enacted in 1965 under Title XIX of the Social Security Act, Medicaid is a federal entitlement program that provides health and long-term care coverage to certain categories of low-income Americans. States design their own Medicaid programs within broad federal guidelines. Medicaid plays a key role in the U.S. health care system, filling large gaps in the health insurance system, financing long-term care coverage, and helping to sustain the safety-net providers that serve the uninsured.

Medical Home
A health care setting where patients receive comprehensive primary care services; have an ongoing relationship with a primary care provider who directs and coordinates their care; have enhanced access to non-emergent primary, secondary, and tertiary care; and have access to linguistically and culturally appropriate care.

**Medicare**
Enacted in 1965 under Title XVII of the Social Security Act, Medicare is a federal entitlement program that provides health insurance coverage to 45 million people, including people age 65 and older, and younger people with permanent disabilities, end-state renal disease, and Lou Gehrig’s disease.

**Out-of-Pocket Costs**
Health care costs, such as deductibles, co-payments, and co-insurance that are not covered by insurance. Out-of-pocket costs do not include premium costs.

**Out-of-Pocket Maximum**
A yearly cap on the amount of money individuals are required to pay out-of-pocket for health care costs, excluding the premium cost.

**Patient Protection and Affordable Care Act, also known as ACA or Obamacare**
Health reform legislation signed into law in 2010 that includes provisions to expand coverage, control health care costs, and improve health care delivery systems.

**Pay for Performance**
A health care payment system in which providers receive incentives for meeting or exceeding quality, and sometimes cost, benchmarks. Some systems also penalize providers who do not meet established benchmarks. The goal of pay for performance programs is to improve the quality of care over time.

**Payment Bundling**
A mechanism of provider payment where providers or hospitals receive a single payment for all of the care provided for an episode of illness, rather than per service. Total care provided for an episode of illness may include both acute and post-acute care.

**Premium**
The amount paid, often on a monthly basis, for health insurance. The cost of the premium may be shared between employers or government purchasers and individuals.

**Provider Payment Rates**
The total payment a provider, hospital, or community health center receives when they provide medical services to a patient. Providers are compensated for patient care using a set of defined rates based on illness category and the type of service administered.

**UCR (Usual, Customary and Reasonable)**
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.