

## GLOSSARY OF TERMS

**Absenteeism.** A habitual pattern of absence. For the purpose of this manual, absenteeism refers to absence from the workplace.

**Accountable Care Organization (ACO).** A group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings.<sup>61</sup>

**ACE inhibitor.** Angiotensin-Converting-Enzyme (ACE) inhibitors are a drug prescribed to treat a variety of conditions including high blood pressure, scleroderma and migraines. Examples of common ACE inhibitors are: Benazepril (Lotensin), Captopril, Enalapril (Vasotec), Fosinopril, Lisinopril (Zestril), Moexipril (Univasc), Perindopril (Aceon), Quinapril (Accupril), Ramipril (Altace), Trandolapril (Mavik).<sup>62</sup>

**Affordable Care Act (ACA).** Enacted by the Obama administration, the ACA, along with the Health Care and Education Reconciliation Act (2010) improved accessibility and affordability of preventative care to many Americans.<sup>63</sup>

**American Board of Internal Medicine Foundation (ABIM).** Since 1936, ABIM has worked to establish uniform standards amongst physicians. Certification by the ABIM represents the highest standard in internal medicine and means that certified internists have demonstrated-both professionally and publically-that they have the skills necessary for delivering the highest quality of patient care. ABIM is a non-profit, physician-led group.<sup>64</sup>

**Angiotensin Receptor Blocker (ARB).** ARBs are prescribed to treat conditions such as high blood pressure and heart failure.<sup>65</sup>

**Benefit design.** Benefit design describes the rules by which health care services are covered by a health plan, eligible providers from which members can receive services from and requirements and/or restrictions relating to costs and cost-sharing related to those services.<sup>66</sup>

**Centers for Medicare & Medicaid Services (CMS).** Through Medicare, Medicaid, Children's Health Insurance Plan (CHIP) and the Health Insurance Marketplace, these services aim to broaden the scope of Americans who receive coverage and to improve health by lowering costs and coordinating care to prevent illness.<sup>67</sup>

**Centers of Excellence (COE).** The term COE is commonly used to distinguish health care centers in which providers are specialized in particular services or programs that can produce better health care outcomes for patients.<sup>68</sup>

**Choosing Wisely.** An ABIM Foundation initiative that promotes conversations between patients and providers to discuss care that is appropriate and evidence-based and to question procedures that are not evidence-based and potentially harmful. Connecticut's Choosing Wisely campaign focuses its efforts on

educating providers on non-evidence-based procedures and how to best communicate appropriate services to patients.

**Clinical Nuance.** Recognizes that medical services differ in the benefit provided, and that the clinical benefit derived from a specific service depends on the patients using it, as well as when, where, and by whom the service is provided.

**Compliance.** The consistency and accuracy by which a person follows her/his medical regimen as prescribed by a healthcare provider.<sup>69</sup>

**Connecticut SIM Quality Council's Provisional Measure Set.** A set of measures developed by the Connecticut SIM Quality Council for measuring provider performance.

**Connecticut V-BID Consortium.** An employer-led, multi-disciplinary group convened by Freedman HealthCare. The role of the Consortium was to serve as an advisory body for the V-BID Initiative in Connecticut, advising on strategies for employer and health plan engagement and making recommendations for the development of a V-BID Employer Manual, including benefit design recommendations and justifications and employer guidance for V-BID implementation.

**Copayment.** A type of cost-sharing. Copayments are fixed amounts that a patient is required to pay for a given service. Any outstanding cost not covered by the copayment is covered by a third party payer.<sup>70</sup>

**Cost-sharing.** A term used to describe the amount that a patient is expected to pay out-of-pocket to a provider in return for a service without reimbursement from a third-party payer. Four common approaches include: copayments, co-insurance, deductibles, and balanced billing.<sup>71</sup>

**Deductible.** A type of cost-sharing in which the patient is expected to pay 100% of the cost for all rendered services until their spending satisfies the deductible. Once the deductible is met, other forms of cost-sharing, such as copayments or coinsurance, apply. For preventative services, the deductible requirement may be waived, in which case the patient may be expected to pay other forms of cost-sharing or none at all.<sup>72</sup>

**High Deductible Health Plan (HDHP).** A benefit design plan that features higher deductibles compared to traditional insurance plans. HDHPs can be combined with health savings accounts or health reimbursement arrangements allowing for patients to pay for qualified medical expenses pre-tax.<sup>73</sup>

**Health Enhancement Program (HEP).** Implemented in Connecticut in 2011, HEP is a voluntary program for all State of Connecticut employees, retirees and their dependents enrolled to comply with a schedule of wellness exams and screenings and to participate in disease counseling and education specific to existing health conditions. If a participant is compliant, they become eligible for reduced cost-sharing and other benefits; if participants are not compliant, they are subject to a monetary penalty.

**Health Maintenance Organization (HMO).** A type of insurance plan that limits a patient to only receive coverage for care delivered by a provider who is contracted by the HMO. HMOs provide integrated care with a focus on wellness and prevention.<sup>74</sup>

**Health Reimbursement Account (HRA).** An HRA reimburses employees for employer-approved medical expenses.<sup>75</sup>

**Health Savings Account (HSA).** An HSA is an employee's tax-exempt account for covering medical expenses. Subject to IRS rules, employers can make contributions to an employee's HSA to go towards the cost of health care services.<sup>76</sup>

**Preferred Provider Organization (PPO).** A type of health plan that consist of a network of providers and facilities. There is reduced cost sharing for an enrolled member who uses providers and facilities that belong within the PPO; however members may use out-of-network providers and facilities at a higher cost.<sup>77</sup>

**Premium.** The amount of money a person pays for her/his health insurance or plan. This amount is usually paid monthly, quarterly or annually. <sup>78</sup>

**Presenteeism.** Working while sick, which can cause productivity loss, poor health, exhaustion, and workplace epidemics.

**Primary Care Physician (PCP).** A physician or health care provider that provides, coordinates or helps a patient access and utilize health care services.<sup>79</sup>

**State Innovation Model (SIM) Initiative.** An initiative of the CMS, the SIM initiative provides financial and technical support to developing state-led, multi-payer health care delivery models with the goal of improving health system performance, quality of care while simultaneously reducing costs.<sup>80</sup>

**SWOT analysis.** An analysis of strengths, weaknesses, opportunities, and threats.

**Transparency.** Describes the availability of information on price and quality of health care services, providers and facilities.<sup>81</sup>

**Value-Based Insurance Design (VBID).** Value-based insurance design (V-BID) refers to insurance plans that utilize clinical nuance in realigning consumer incentives with high value health services. The aim of V-BID is to increase healthcare quality and to decrease costs by using differential cost sharing for consumers to promote use of high value services and high performing providers.