HJR 20: Health Care Price Transparency

Topic Terminology for September 12, 2017

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- **Critical access hospitals**
  Critical Access Hospitals (CAHs) are rural hospitals designated by the Centers for Medicare and Medicaid Services (CMS). This designation was created by Congress in the 1997 Balanced Budget Act in response to a string of rural hospital closures in the 1980s and early 1990s. The CAH designation is designed to reduce the financial vulnerability of rural hospitals and improve access to health care by keeping essential services in rural communities. This is accomplished through cost-based Medicare reimbursement. (ruralhealthinfo.org)

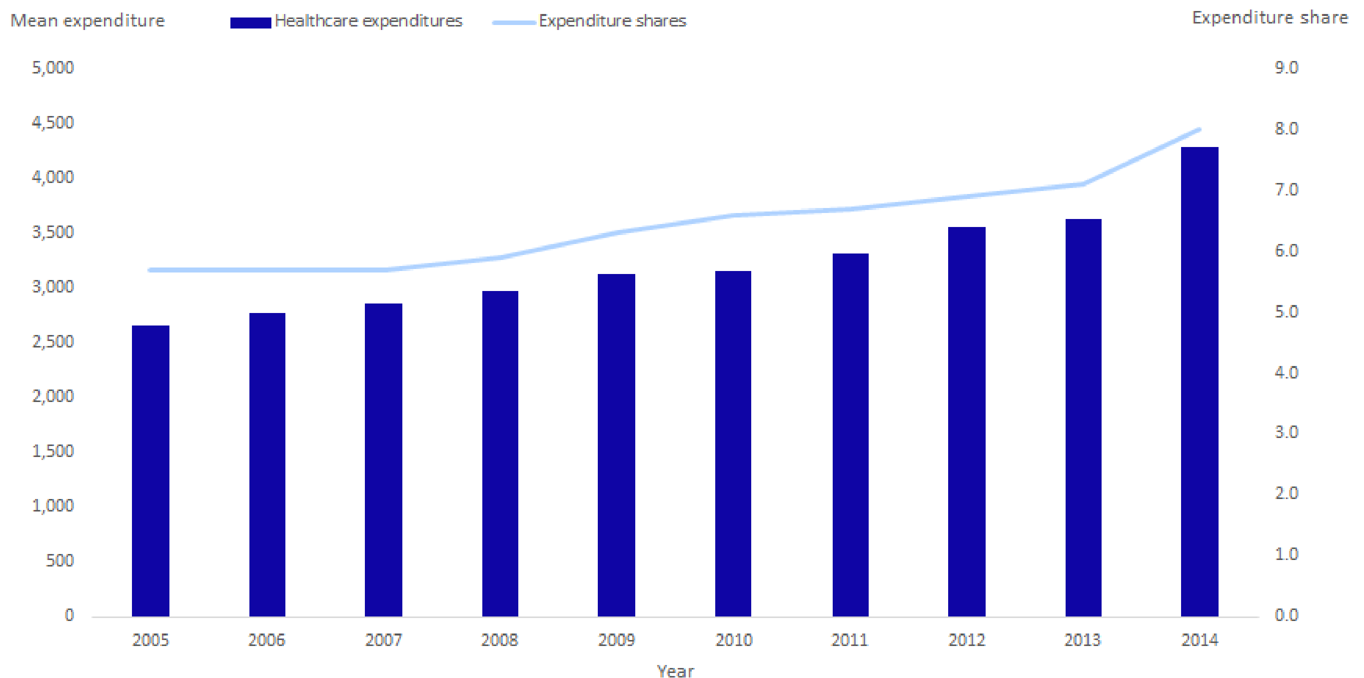
- **Federally Qualified Health Centers**
  Federally qualified health centers (FQHCs) are important providers of primary care in rural areas. Primary care can include a variety of services, including medical and dental care and mental health counseling. In order to qualify for federal support as a health center, an organization must:
    - Offer services to all persons, regardless of the person's ability to pay
    - Establish a sliding fee discount program
    - Be a nonprofit or public organization
    - Be community-based, with the majority of its governing board of directors composed of the organization's patients
    - Serve a medically underserved area or population
    - Provide comprehensive primary care services
    - Have an ongoing quality assurance program

  FQHCs are outpatient clinics that qualify for specific reimbursement systems under Medicare and Medicaid. FQHCs include federally supported health centers as well as certain outpatient Indian providers. (ruralhealthinfo.org)

- **For-profit health care**
  For-profit health care usually refers to for-profit hospitals, investor-owned hospitals, or investor-owned chains of hospitals that have been established particularly in the United States during the late twentieth century. In contrast to the traditional and more common non-profit hospitals, they attempt to garner a profit for their shareholders. According to the American Hospital Association (AHA) about 78% of U.S. hospitals were nonprofit in 2014: 58% were private nonprofits while 20% were publicly owned. The remaining 22% of hospitals were for-profit.

- **General types of health care**
  Health care includes a wide variety of services: prevention/wellness; primary care; procedures and surgeries; management of chronic disabilities, diseases, or conditions; acute care (emergency department care, coronary care, etc.); and end-of-life care (palliative care).

- **Health care consumer spending**
  Health care consumer spending refers to what is spent by the consumer on health care in general. Household health care expenditures include health insurance, medical services, drugs, and medical supplies. National health care expenditures can change due to changes in the prices of these commodities or changes in the extent to which these commodities are used. According to the U.S. Bureau of Labor Statistics (Department of Labor) household health care spending has increased significantly over the past decade or so (see below).



- **Health care provider prices**
  Health care provider prices refer to what health care providers charge for particular services and products. In many cases the price for a particular service is not fixed; instead it varies from patient to patient depending on whether the patient is uninsured or insured and what kind of insurance the individual has. The price a patient pays for health care services depends on the insurance for several reasons.

  First, if patients have private or government insurance, their health insurance plan shares health care costs between the insurance company and the insured patients. The specifics of the health plan coverage, including deductible, copayment, and coinsurance, determine how much of the price of health care the patient will pay and how much the health plan will pay.

  Second, health plans have different networks of doctors, hospitals, and other health care professionals. When the patients choose a doctor or hospital, they need to know if the providers are in their health plan's network They also need to know how much out-of-pocket costs there will be if they use an out-of-network provider. When patients receive care from a network doctor or hospital, they typically pay a lower price. If they go out of the network, they usually have to pay a higher price.

  Third, uninsured patients usually are charged the highest prices for health services because they are not sharing cost with an insurer.

- **Health care provider costs**
  Health care provider costs refer to what health care providers spend on inputs in order to provide particular health care services and products to patients.

- **Health care reimbursement**
  Health care reimbursement refers to the various ways that health care services are paid for, including patient payments and private and public health insurance payments. Health insurance payers have a variety of health care reimbursement plans, and carry contracts with individual practices and health systems (contracts that are periodically renegotiated, which is just one source of change within the system). The complexity of the health care reimbursement process is growing as the industry adjusts to value-based payment models as well as fee-for-service medicine. With every new reimbursement scheme and benefits structure comes a new claims-processing challenge for patients and health insurance plans.

- **Major hospitals (tertiary care)**
  Major hospitals or tertiary hospitals are large medical care centers that receive referrals from primary care and smaller community hospitals. Care at a major hospital is provided by specialized medical and nursing staff and often includes the use of highly specialized medical equipment.

- **Nonprofit health care**
  In economic terms, a nonprofit health care organization uses its revenues to achieve its purpose or mission, rather than distributing surplus income to the organization's shareholders (or equivalents) as profit or dividends. Nonprofit hospitals, for example, are hospitals that are organized as a nonprofit corporation; these hospitals receive preferential federal, state, and local taxation treatment in exchange for providing community benefits. These hospitals may also employ tax-exempt bond financing and may receive tax-deductible donations. Nonprofit hospitals are a more common means of delivering medical care in the United States than for-profit hospitals.

- **Private medical practices**
  Private medical practices are organized in a corporate model in which the physicians or other health care practitioners are shareholders, or where one or more physicians own the practice and employ other physicians or providers. Physicians in private practices are usually reimbursed on a fee-for-service basis. Physician practices are organized into corporations for tax benefits as well as to protect the owners from liability judgments.

- **Private physician group clinics**
  A private clinic (or outpatient clinic or ambulatory care clinic) is a health care facility that is owned by a corporation or group of private health care providers that primarily focuses on the care of outpatients. Most commonly, the word *clinic* refers to a general medical practice, run by one or more general practitioners, but it can also mean a specialist clinic. These clinics typically cover the primary health care needs of populations in local communities, in contrast to larger hospitals which offer specialized treatments and admit inpatients for overnight stays.

- **Solo or small group private health care practices**
  A solo or small group practice is a medical practice with one or more health care providers who are not affiliated with other practice organizations. In the United States, this type of practice used to be the most common model, but in recent years it has become less popular. Small practices are usually characterized by a small staff and typically have a limited patient base. This smaller size and the autonomy of being a small private provider group has the advantage for health care providers of being able to design, grow, and develop their practices as they wish. A smaller patient base provides the opportunity for the health care providers to develop close, personal relationships with their patients and staff and provide their own unique style of medical care. On the other hand, the burden of running the practice rests entirely on the health care providers. This includes the medical care (such as the need to manage or arrange for hospital care and weekend coverage for patients) and business aspects of the practice.