

## Glossary of Terms: Tobacco Cessation Coverage and Health Insurance

### **General**

**Affordable Care Act (Patient Protection and Affordable Care Act):** The 2010 law that reformed the healthcare system in the United States, including creating coverage requirements for health plans, Medicaid expansion and prohibited charging sicker people more for health insurance.

**Bundled payments:** A payment model where a provider (or health system) receives a global payment for a care episode. Examples include birth of a child or hip replacement surgery. The payment does not fluctuate if costs increase or decrease.

**CAHPS measures:** A series of patient surveys that measure patient/member experience with healthcare to advance patient-centered care.

**Capitation:** A payment model where providers (or health systems) receive payments in a fee-for-service model, but the reimbursement is less than the normal amount by a fixed percent. If the provider or health system meets certain quality metrics, they can earn the decreased percentage back and potentially additional funds too.

**Community Rating:** A key Affordable Care Act requirement which states that insurance premiums can only be based on age (3:1), geography, family size and tobacco use.

**Counseling requirements:** When a health plan requires a patient to participate in cessation counseling in order to get cessation medication. While data show that counseling and medication used in combination are most effective, barriers to counseling should not be a barrier to a quit attempt.

**Coverage limitations:** Coverage limitations impede quitting smoking because people who smoke may take 30 or more quit attempts on average before successfully quitting. These limitations include duration limits, annual limits and lifetime limits.

- Duration limits restrict the number of days a treatment can be used
- Annual limits place limits on the number of covered quit attempts a person can make in a year
- Lifetime limits place limits on the number of covered quit attempts a person can make during their lifetime

**Centers for Medicare and Medicaid Services (CMS):** The federal agency, housed within the Department of Health and Human Services, responsible for the administration of the Medicare program and responsible for working with states to implement the Medicaid program.

**Center for Consumer Information and Insurance Oversight (CCIIO):** The federal agency housed within the Department of Health and Human Services, responsible for the administration of Healthcare.gov and many other of the policies created by the Affordable Care Act.



**EHR/EMR:** Electronic health records are a digital version of someone’s medical record. Health information is collected and managed by healthcare providers and EHRs allow it to be electronically exchanged between them.

**Essential Health Benefits:** These are 10 sets of benefits required to be covered by most insurance plans as a result of the passage of the Affordable Care Act. These include prescription drugs, preventive services and maternity care. [Learn more...](#)

**Federally Qualified Health Centers (FQHCs):** Community-based healthcare providers that receive federal funds to provide basic healthcare services to an under served community. [Learn more...](#)

**Fee for service:** A payment model where services are unbundled and paid for separately.

**Guarantee Issue:** A key Affordable Care Act requirement that ensures that insurance coverage cannot be denied because of a pre-existing condition.

**HEDIS:** Performance improvement tool that measures the clinical quality performance of health plans. It is conducted through the collection and analysis of reports of providers.

**Health Insurance Portability and Accountability Act (HIPAA):** Federal law that sets standards on how patient information can be shared.

**ICD-10 codes:** Codes used by physicians and other health care providers to classify and code all diagnoses, symptoms and procedures in U.S. healthcare settings on claims for services provided. These codes are used by payers to determine coverage, not the amount that will be paid.

**Insurance Plan:** A plan that covers basic healthcare treatments for consumers that pay premiums. In the United States, many people have employer-sponsored insurance, meaning the employer pays some or all of the premiums. Each plan has specific coverage and barriers to access care.

**Issuer:** A company that offers insurance plans.

**Mental Health Parity and Addiction Equity Act (MHPAEA):** A federal law that requires mental health or Substance Use Disorder (SUD) benefits be comparable to medical/surgical benefits in health insurance plans. This law does not require plans to offer mental health or SUD benefits; however, insurers that choose to cover either or both are subject to the law’s parity requirements. [Learn more...](#)

**Non-tobacco user discount:** Part of a wellness plan, where non-tobacco users can be charged up to 50% less in premiums than non-tobacco users. Employers who utilize these plans must offer tobacco users an alternative to get the discount.



**Payor:** The entity, typically the insurer or Medicaid, responsible for reimbursing the medical provider.

**Patient Centered Medical Home (PCMH):** A care model where a primary care provider coordinates care for a patient.

**Preventive Services:** Any service or treatment given an “A” or “B” by the United States Preventive Services Task Force. It is one of the 10 essential health benefits that are required to be covered without cost-sharing. [Learn more...](#)

**Prior authorization:** Occurs when plans require that either the patient or their clinician contacts the insurance plan to obtain authorization for using a medication, which can delay or prevent access to the medication.

**Quality Measures:** Tools that compare performance among providers, healthcare systems and outcomes to meet goals of effectiveness, safety, efficiency, patient-centeredness, equity and timely care.

**Rating Rules:** Regulations limiting insurance companies (or issuers) on what factors they can use to calculate an individual’s premiums. Federal law currently limits most plans to only use geographic area, family size, age (3:1) and tobacco use (1.5:1) to determine rates. States can put additional rules into place.

**State Insurance Commissioner:** Individual who regulates any fully insured health plan in the state.

**Shared savings:** Money saved when a healthcare provider participates in an alternative payment model that is shared between the healthcare provider and payor.

**Tobacco Surcharge:** A variation in insurance premiums based on a policyholder (or dependent’s) tobacco use and is considered punitive. It has not been proven effective in encouraging smokers to quit and reducing tobacco use.

**United States Preventive Services Task Force (USPSTF):** An independent, volunteer panel of experts in prevention and evidence-based medicine. Their recommendations are written as guidance for clinicians on what preventive services patients should receive. It has given tobacco cessation interventions for adults an ‘A’ grade.



## **Medicaid**

**Carve-out benefits:** These benefits are ones required by the Medicaid program, but are not included in (or “carved out” of) the Medicaid Managed Care Contracts. Benefits that are carved out will still be provided to Medicaid enrollees, typically through the state’s fee-for-service Medicaid program.

**Federal Medical Assistance Percentage (FMAP):** The percentage of a state’s Medicaid expenses that the federal government will cover. The FMAP is determined by the state’s per capita income, with a floor of 50% federal contributions.

**Medicaid:** A healthcare program administered by states according to federal requirements. These plans usually cover people who meet low-income eligibility standards, children, pregnant woman and others who meet eligibility requirements. [Learn more...](#)

**Medicaid Managed Care Organization (MCO)/Managed Care Plan (MCP):** Medicaid managed care provides the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations.

**Medicaid State Plan:** An agreement between the state and federal government describing how the state will administer its Medicaid program.

**State Plan Amendments:** When a state wants to add or remove an operational service or change the way a particular benefit or population is covered, they must submit a state plan amendment to CMS for review and approval. [Learn more...](#)

**Wrap- around Service:** Typically used to refer to Medicaid services that are required by the federal government but are not part of the Managed Care Contracts. These services are typically provided through the fee-for-service program.

## **Medicare**

**Accountable Care Organizations (ACO):** A payment model within the Medicare program. They are groups of hospitals, doctors and other healthcare providers that voluntarily come together to provide coordinated care to patients. These organizations can recoup part of the savings (shared savings) the Medicare program receives.

**Medicare:** A federal health insurance program for people 65 years old and older and younger people who meet certain disability eligibility requirements. [Learn more...](#)



**Merit-based incentive payment system (MIPS):** A reimbursement structure program created through MACRA. It determines Medicare Part B payment adjustments by using a composite performance score to determine if eligible professionals receive a payment bonus, a payment penalty or no payment adjustment.

**Medicare Access and CHIP Reauthorization Act (MACRA):** A new payment framework enacted in 2015 by CMS. This framework rewards healthcare providers for giving better care instead of more services.

### **Payment**

**Cost Sharing:** Money that patients pay towards the cost of their care. Here are some key cost-sharing terms:

- **Co-pay** – A fixed amount of money paid for a service, such as a prescription or a doctor’s appointment that a patient pays.
- **Co-insurance** – A fixed percent of the cost of the service paid by the patient.
- **Deductible** – The amount of money a patient is required to pay before the insurance plan will pay for care. Patients are often required to pay the full cost of services until the deductible is met. Patients may have to continue to pay co-pays and co-insurance after the deductible is met.
- **Maximum out-of-pocket (MOOP)** – This is a cap on the amount of out-of-pocket costs that a person or family will be required to pay in a year. Once this cap is met, the plan will cover all additional costs. The MOOP does not include premiums.
- **Out-of-pocket costs** – Costs that a patient will have to pay for healthcare services. These include co-pays, co-insurance and deductibles.
- **Premiums** – The amount of money a patient or employer pays for their insurance plan.

**Diagnosis-Related Grouping (DRG):** A classification system used to group together hospital services into a single event (ie. Appendectomy). DRGs are used for prospective payment models and other value-based payment models.

**Per diem:** In the health context, this refers to a fixed amount paid to a healthcare provider on a daily basis for care.

### **Private Insurance**

**ERISA (Employee Retirement Income Security Act):** Federal law that sets standards and regulations for voluntary health plans that are self-insured. These plans are regulated by the federal Department of Labor.



**Fully-Insured plan:** With this kind of plan, the employer pays a certain amount each month (the premium) to the health insurance company. In return, the insurance company covers the costs of the employee's healthcare. This kind of plan offers no additional risk to the employer.

**Minimal Essential Coverage (MEC):** Created by the Affordable Care Act, MEC, means that health insurance coverage will pay for at least 60% of medical costs or have Medicaid or Medicare. Individuals with MEC are considered "insured" by the federal government and were not subject to the tax penalty for not having health insurance. These plans do have to cover some services, but do not have to cover the 10 essential health benefits.

**Non-compliant Plans:** Plans that are not compliant with the Affordable Care Act and are thus, not classified as health insurance. As a result, they are not subject to the same regulations and often limit benefits that have been deemed essential under the ACA. Examples of non-compliant plans include farm bureau health plans and healthcare sharing ministries.

**Self-Insured plan:** Type of plan in which the employer takes on most or all of the costs of benefit claims. The insurance company manages the payments, but the employer is the one who pays the claims.

**Third-Party Administrator:** A company that executes the basic activities of a self-insured plan. This includes processing claims and setting up a provider network.

*If you have additional questions about these terms or anything related to cessation coverage, please contact [CessationTA@lung.org](mailto:CessationTA@lung.org).*

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