

Frequently Used Terms

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Health Care Agencies and Organizations

Agency for Healthcare Research & Quality (AHRQ) A federal agency within the Department of Health and Human Services dedicated to improving the quality, safety, efficiency, and effectiveness of health care.

Aligning Forces for Quality (AF4Q) A Robert Wood Johnson Foundation project to improve the quality of health care provided, reduce racial and ethnic disparities, and provide models for national health care reform in 16 distinct communities across the United States.

Center for Medicare and Medicaid Innovation (CMMI) This organization was established pursuant to the Patient Protection and Affordable Care Act. Its purpose is to test out new payment and delivery models of care to reduce expenditures, while improving the quality of care within the Medicare, Medicaid and, CHIP programs.

Centers for Medicare & Medicaid Services (CMS) The federal agency within the Department of Health and Human Services that administers the Medicare, Medicaid and Children’s Health Insurance Programs.

Community Health Center (CHC) A type of community clinic that provides a range of health care services and charges on a sliding-scale fee basis.

Critical Access Hospital (CAH) A rural community hospital that receives cost-based reimbursement, and meets certain conditions as set forth in the Medicare Conditions of Participation that are different for those for acute care hospitals.

Department of Health and Human Services (HHS) A federal agency that administers federal health programs and welfare activities.

Essential Community Providers (ECPs) Health care providers who treat high-risk special needs, and underserved individuals.

Federally Qualified Health Center (FQHC) A community health center that receives funding under Section 440 of the Public Health Service Act, or a center that has been certified as meeting the same criteria.

Indian Health Service (IHS) A federal health program to provide health care to Native Americans and Alaska natives.

Institute of Medicine (IOM) An independent, non-profit organization that works outside of the government to provide unbiased and authoritative advice to policy makers and the public about health and health care related issues.

Institutional Review Board (IRB) A group comprised of individuals of various backgrounds who have been formally designated to review and monitor research involving human subjects, in order to assure the protection of rights and welfare of the human subjects.

National Committee for Quality Assurance (NCQA) A private, non-profit organization dedicated to improving health care quality. The organization accredits health plans issued in every state, the District of Columbia and Puerto Rico.

National Quality Forum (NQF) A non-profit, non-partisan, public service organization committed to health care transformation through the endorsement and recommendation of health care performance measurements.

Office for Civil Rights (OCR) The federal agency within the Department of Health and Human Services that enforces the Department's civil rights and health privacy rights. OCR investigates complaints, enforces rights, issues regulations, develops policy, and promotes public education to ensure understanding and compliance with non-discrimination and health privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA).

Office of the National Coordinator for Health Information Technology (ONC) The main federal agency charged with coordination and implementation of health information technology and electronic exchange of health information. ONC is an agency within the Office of the Secretary for the Department of Health and Human Services.

Patient Centered Outcomes Research Institute (PCORI) An organization established by the Patient Protection and Affordable Care Act to conduct research on ways to improve consumer decision-making, improve health care outcomes, based on evidence-based information.

Quality Improvement Organization (QIO) A private, usually non-profit organization, staffed by health care professionals trained to review medical care and help Medicare beneficiaries with quality of care complaints and implement quality improvement strategies. CMS contracts with a QIO in each state, the District of Columbia, Puerto Rico and the U.S. Virgin Islands.

Rural Health Clinic (RHC) Established under the Rural Health Clinic Services Act, RHCs address the lack of supply of physicians in rural areas primarily serving Medicare patients, and promote the use of non-physician practitioners in rural areas.

Insurance and Reimbursement

Actuarial value A mathematical calculation used to determine the monetary value of benefits.

Adjusted Community Rating Refers to rate setting allowing health insurance organizations to vary premiums based on specific demographic characteristics (e.g. age, gender, location) but cannot vary premiums based on health status or claims history.

Adverse selection Individuals with a higher than average risk of needing health care are more likely than healthier people to seek health insurance, while health coverage providers try to maintain risk pools of individuals whose health, on average, is the same as that of the general population. Therefore, adverse selection occurs when the less healthy people disproportionately enroll in a risk pool.

Brokers Individuals who act on behalf of consumers to assist them in choosing a health insurance plan. Brokers may be compensated by the consumer or the insurance company.

Capitation A method of payment for health services where a fixed amount is paid for each person served, regardless of the actual number or type of services provided.

Chargemaster A list of prices for all services, goods and procedures in a hospital that have their own charges.

Children's Health Insurance Program (CHIP) A health insurance program targeted to low-income children, established in 1997, and reauthorized in 2009, that is administered by the states and is funded through a combination of federal and state payments.

Churning The process of moving back and forth between federal or state health care programs such as Medicaid and private insurance, as an individual's circumstances change.

Co-insurance A form of beneficiary cost-sharing for covered health insurance benefits and services, which is expressed as a percentage of the approved payment amount for the benefit or the service (e.g. 20% of the payable amount).

Community Rating Requires health insurance providers to offer health insurance policies within a certain geographic area at the same premium price to all persons, regardless of health status.

Co-payment A form of beneficiary cost-sharing for covered health insurance benefits and services expressed as a flat dollar rate (e.g. \$20.00 for a visit to a primary care doctor).

Cost sharing A requirement that insured patients pay a portion of their medical costs, either as coinsurance or a fixed co-payment.

Current Procedural Terminology (CPT) Code A listing of descriptive terms and identifying codes for reporting medical services and procedures in order to provide a uniform language for health care practitioners, patients, and third parties.

Deductible The amount patients must pay out of their own pocket before their health insurance policy begins contributing to the cost of their care.

Diagnostic-related group (DRG) A statistical system for categorizing inpatient stays into groups for payment purposes. The DRG classification system divides diagnoses into 20 major body systems, which are subdivided into 500 groups for Medicare reimbursement. The DRG system is used in states as well as by many health plans.

Fee-for-service A traditional method of paying for medical services under which doctors are paid for each service provided. Bills are paid by the patient, who then submits them to the insurance company for reimbursement.

Geographic Rating Areas One of the factors for health insurance companies to limit premium ratings under the Patient Protection and Affordable Care Act. Geographic rating areas must be based on the geographic divisions of counties, three-digit zip codes, metropolitan statistical areas (MSAs), or non-MSAs.

Group health insurance Health insurance that is offered to a group of people, such as employees of a company. The majority of Americans have group health insurance through their employer or their spouse's employer.

Grandfathered health plan A health benefit plan or health insurance policy in effect as of the date of enactment of the Patient Protection and Affordable Care Act. The term is not defined in the law; the Departments of Health and Human Services, Labor, and Treasury are expected to provide additional clarification regarding the conditions under which grandfathering protections are available as well as what constitutes a "plan" that may be subject to grandfathering limitations.

Guaranteed issue/renewal A rule that bars health insurers from denying or dropping an individual's coverage for any reason other than fraud or nonpayment of health insurance premiums. This prevents insurance companies from denying coverage for any reason or based on an individual's health status.

Health insurance carrier Term used to refer to a licensed health insurance company. It includes both licensed health insurance companies and health maintenance organizations (HMO).

Healthcare Common Procedure Coding System (HCPCS) A 2 level set of standard codes used by Medicare and other health insurance programs, with Level I constituting codes for medical services and procedures, known as CPT codes and Level II being the coding system used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. CPT codes are republished annually by the American Medical Association, while the Level II codes are maintained and distributed by CMS.

Health plan Refers to a health maintenance organization (HMO), a health coverage plan provided by an employer to its employees, or a health coverage plan offered to employers by an insurer or third-party administrator.

Individual health insurance market The insurance market for individuals who are purchasing insurance for themselves and their families and are not part of a group plan. This is also known as the "non-group market."

International Classification of Disease (ICD, ICD, ICD-9, ICD-10) The standard diagnostic tool for epidemiology, health management and clinical purposes, and is used to monitor the incidence and

prevalence of diseases and other health problems. It is used to classify diseases and other health problems recorded on many types of health and vital records including death certificates and health records.

Lifetime limits or caps A provision included in health insurance contracts that is designed to limit the total amount the policy will pay out in claims and benefits over the lifetime of the policy.

Managed care A health delivery system that seeks to control access to and utilization of health care services to limit health care costs and improve quality of the care provided. Managed care plans usually rely on primary care physicians to act as “gatekeepers” and manage the care their patients receive.

Medicaid A joint state-federal program established in 1965 under the Social Security Act to provide health insurance to low-income families and individuals with certain disabilities. It is administered by the states and funded jointly with the federal government.

Medical loss ratio (MLR) The percentage of the premium an insurance company spends on medical care, as opposed to administrative costs or profits.

Medicare A federal program established in 1965 under the Social Security Act that provides government-sponsored health insurance to individuals aged 65 and older and certain individuals under 65 with disabilities that meet federal requirements.

National Provider Identifier (NPI) A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA.

Out of pocket costs Health care costs, such as deductibles, co-payments or coinsurance, that are not covered by health insurance. It does not include premiums.

Premium The amount a business or individual pays regularly to maintain health insurance coverage.

Prior Authorization Authorization issued by a health plan or a Medicaid plan to a health care provider before a health care service has been provided.

Prospective Payment System (PPS) A method of Medicare reimbursement based on a predetermined, fixed amount. The payment amount is based on the diagnosis-related group for different health care facilities and services (e.g. inpatient hospital services, home health agencies, hospice, skilled nursing facilities).

Reinsurance Refers to the fact that because health insurers underestimate the amounts to be paid out in medical claims each year, they must protect themselves against losses by purchasing “reinsurance” from a separate company.

Risk pool A special program created by state legislatures to provide a safety net for the "medically uninsurable" population. These are people who have been denied health insurance coverage because of a pre-existing health condition, or who can only access private coverage that is restricted or has extremely high rates.

Self-insured plan A plan where the employer assumes direct financial responsibility for the costs of enrollees' medical claims. Employer sponsored self-insured plans typically contract with a third-party administrator or insurer to provide administrative services for the plan.

Small group market health insurance The health insurance market for employers whose size is smaller than a specified amount (e.g. between 2-50 works).

Utilization Review Used by health insurance companies, this term refers to a review of medical services to safeguard against unnecessary or inappropriate medical care.

Health Reform

Accountable care organizations (ACOs) A group of health care providers that is collectively reimbursed for a single patient's care. The goal of an ACO is to provide high quality, low cost, coordinated care. ACO's are used by Medicare participating providers to provide coordinated care to Medicare patients while sharing in the savings created for the Medicare program.

Comparative Effectiveness Research (CER) A type of health services research that compares different approaches to treating medical conditions in order to determine which methods are most likely to produce the best results.

Employer mandate A requirement under the Patient Protection and Affordable Care Act requiring employers to assist in covering workers and their dependants, either through a health plan or toward coverage as a payment of flat dollar charge, a percentage of payroll, a percentage of an annual insurance premium, or some other amount. This requirement has been delayed until 2015.

Essential health benefits A list of core benefits established under the Patient Protection and Affordable Care Act that must be included under any health insurance plan certified or offered in the health insurance marketplaces/exchanges and by all state Medicaid plans in 2014.

Health insurance marketplace/exchange Regulated marketplaces for the sale and purchase of health insurance established under federal law and operated in accordance with federal requirements. Marketplaces may be state-based, federally-facilitated, or a partnership of state and federal authority.

Health insurance subsidies Federal subsidies made available on an income-related basis to individuals purchasing health care through the health insurance marketplaces.

Individual mandate A requirement under the Patient Protection and Affordable Care Act that all individuals must carry health insurance or pay a penalty starting in 2014.

Medical home (PCHM) A health care setting where a patient can receive comprehensive primary care and preventative services in a coordinated manner.

Navigators An individual or organization that's trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including completing eligibility and enrollment forms. These individuals and organizations are required to be unbiased. Their services are free to consumers.

Qualified Entity (QE) Established under the Patient Protection and Affordable Care Act, QEs are authorized to receive standardized extracts of Medicare claims data under Parts A, B, and D to evaluate the performance of providers of services and suppliers.

Qualified health plan (QHP) An insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

Health Information Technology

American National Standards Institute (ANSI) ANSI is a private, non-profit organization that oversees the creation, promulgation, and use of standards and guidelines for most business sectors. ANSI accredits many health-related organizations, including entities that certify EHR technology, and develops standards for many health-related activities, such as claims submission.

Attestation Attestation is the process by which eligible professionals and hospitals report to the Centers for Medicare and Medicaid Services (CMS) that they have met the measures required to demonstrate meaningful use and therefore qualify for the incentive payment.

Clinical Decision Support System (CDSS) A CDSS is interactive computer software that provides health professionals with knowledge and person-specific information to aid in decision-making tasks, such as determining diagnosis for a patient or suggesting default values for a prescription. A CDSS usually includes multiple tools to enhance decision-making, including clinical guidelines, condition-specific order sets, patient data reports and summaries, and documentation templates.

Computerized Provider/Physician Order Entry/Management (CPOE) CPOE is an electronic system in which clinicians directly enter instructions for the treatment of patients under the practitioner's care, which then transmits the order directly to the medical staff or departments (such as pharmacy or laboratory) responsible for fulfilling the order.

Data-sharing Agreement A data-sharing agreement is a formal contract that documents what data are being shared and how the data can be used. The elements of an agreement are relative to the particular arrangement, but generally include items such as the intended use of the data, any constraints on the use of data, and data confidentiality and security requirements.

Electronic health record (EHR) An electronic health record is a record in digital format that includes a comprehensive patient history and is designed to contain and share information from all providers involved in a patient's care. EHR data can be created, managed, and consulted by authorized providers and staff from across more than one health care organization.

Electronic Health Record Certification Electronic health record (EHR) certification is a process defined by the Office of the National Coordinator for Health Information Technology (ONC) to ensure that EHR technologies meet the adopted standards and certification criteria to help providers and hospitals achieve Meaningful Use objectives and measures established by the Centers for Medicare and Medicaid Services (CMS). Eligible professionals and hospitals who seek to qualify for incentive payments are required to use certified EHR technology.

Electronic Laboratory Reporting (ELR) ELR is the automated transmission of laboratory-related data from commercial, public health, hospital, and other labs to state and local public health departments.

Electronic medical record (EMR) An electronic medical record is a digital version of a patient's paper chart that contains the standard medical and clinical data gathered in a single provider's office. An EMR is generally used by providers for diagnosis and treatment.

Health information exchange (HIE) Health information exchange can be the act of electronically sharing health-related information among organizations, or can be a Health Information Exchange (HIE), which is an organization that provides services to enable the electronic sharing of health-related information.

Health information organization (HIO) An HIO is an organization that oversees and governs the exchange of health-related information among organizations in accordance with nationally recognized standards.

Interoperability Interoperability is the ability of diverse EHR systems and software applications to communicate and exchange and share data. Systems are interoperable if they can exchange data and subsequently present that data in a way that can be understood by a user.

Meaningful use Meaningful use is the set of standards defined by the Centers for Medicare and Medicaid Services (CMS) Incentive Programs that govern the use of electronic health records (EHRs); in order to achieve meaningful use, eligible providers and hospitals must adopt certified EHR technology and use it to achieve specified objectives. By achieving meaningful use, eligible participants may earn incentive payments.

Personal health record (PHR) A personal health record is a collection of information about an individual's health that the individual maintains online for his/her own access. The individual controls the information that goes into his/her PHR and can access it at any time on the Internet.

Regional health information organization (RHIO) A RHIO is a type of health information exchange organization (HIO) that brings together health care stakeholders within a defined geographic area and governs health information exchange among them for the purpose of improving health and care in the community.

Health Level Seven International (HL7) HL7 is a nonprofit, American National Standards Institute (ANSI)-accredited standards developing organization dedicated to providing a comprehensive framework and related standards for the exchange, integration, and retrieval of electronic health information that supports clinical practice and the management, delivery, and evaluation of health services.

Health Care Privacy (HIPAA)

Business Associate A business associate provides certain services to or performs certain functions or activities on behalf of a covered entity, where those services or functions involve access to or use of protected health information. Business associates must comply with HIPAA rules on privacy and security.

Covered Entity A covered entity is a health plan, health care clearinghouse (an entity that processes nonstandard health information it receives from another entity into a standard format, or vice versa), or a health care provider who transmits health information electronically. Covered entities must comply with the HIPAA Privacy, Security, and related rules governing protected health information.

De-identified data De-identified data is health information that does not identify an individual and does not provide any reasonable basis on which an individual could be identified. HIPAA does not restrict the use or disclosure of de-identified data.

Health care operations Health care operations are certain administrative, financial, legal, and quality improvement activities carried out by a covered entity, which are necessary to support its payment and treatment functions. The activities included in the definition of health care operations are specifically listed in the HIPAA Privacy Rule.

Health care payment Health care payment is the activities of health care providers to obtain payment or be reimbursed for their services and of a health plan to obtain premiums, to fulfill coverage responsibilities and provide benefits under the plan, and to obtain or provide reimbursement for the provision of health care. The HIPAA Privacy Rule gives examples of common payment activities.

Health care treatment Health care treatment is the provision, coordination, or management of health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another.

Limited data set A limited data set is protected health information from which sixteen identifiers have been removed. A limited data set may contain certain information that could potentially be used to identify an individual, such as date of birth or geographic subdivision.

Protected health information (PHI) Protected health information individually identifiable health information, which is information pertaining to: an individual's past, present, or future physical or mental health condition; the provision of health care to an individual; or to the past, present, or future payment for the provision of health care to an individual. Protected health information either directly identifies an individual or provides a reasonable basis to believe that the information could be used to identify the individual.

Topic Areas

Antitrust Antitrust law regulates the conduct and organization of business corporations to promote fair competition that benefits consumers. There are a number of federal and state statutes governing antitrust, which generally prohibit collusion that restrains trade, restrict mergers and acquisitions that could substantially limit competition, and prohibit the creation of monopolies and the abuse of monopoly power. In the healthcare information context, antitrust law impacts whether and how providers and insurance companies share health information or use health information exchanges.

Care Coordination/Care Management Care coordination facilitates the appropriate delivery of health care services by integrating care activities across multiple providers who are dependent upon each other to carry out disparate activities in a single patient's care. Every participant requires adequate knowledge about his/her own and others' roles, as well as about available resources, and must rely on the exchange of information to acquire this knowledge. Care coordination involves entities such as Accountable Care Organizations (ACOs) and Medical/Health Homes; communication and sharing of information between and among providers; treatment, discharge, and transfer planning; and disease management.

Equity and Disparities Health equity refers to equality in health and healthcare, including health outcomes and access to health care, across different racial, ethnic, sexual orientation, gender, and socioeconomic groups. Health disparities exist where health and healthcare is different according to

differences in populations. This topic covers the collection of information on minority health, health service planning on a geographic or demographic basis, language or cultural service requirements for health plans and healthcare providers, and laws that deal with disparities reduction.

Federal and State Program Integrity Program integrity refers to efforts to improve government assistance programs by reducing fraud, waste, and abuse, increasing efficiency, and streamlining administrative practices. This topic includes laws on false claims, self-referrals, kickbacks, and audit procedures.

Health Information Technology Health information technology (HIT) allows the comprehensive management of health information and enables its exchange among health professionals, healthcare providers, healthcare payers, and public health agencies. This topic includes laws governing electronic health records, telehealth, electronic information security, health information exchanges, and electronic billing and claims submission.

Health Insurance Exchanges A health insurance exchange (often referred to as a “marketplace” or HIX) is a concept introduced by the Affordable Care Act, and is a set of government-regulated and standardized health care plans from which individuals and small businesses can purchase health insurance. This topic covers a description of state exchanges, as well as requirements for recordkeeping, data collection, reporting, confidentiality, disclosure and access to data.

Medicaid and CHIP Data Requirements Medicaid and CHIP are healthcare programs financially sponsored by the federal government and operated by each state. This topic includes a description of state programs and covers requirements for records maintenance, reporting, recordkeeping, confidentiality, and access, as well as care coordination, quality reporting and the meaningful use program.

Medicare Data Requirements Medicare is a healthcare program financially sponsored and administered by the federal government. This topic covers requirements for records maintenance, reporting, recordkeeping, confidentiality, and access, as well as care coordination, quality reporting and the meaningful use program.

Medical Records Collection, Retention, and Access Medical records are those records kept on individual patients by providers that include health history, diagnostic information, and provider notes, among other pieces of data. Medical records can be kept on paper or electronically. This topic covers records maintenance as a condition of provider licensure, recordkeeping requirements for a variety of facilities, and laws governing record retention and ownership, access to records, data collection, and storage and destruction.

Patient Safety Patient safety is a subset of healthcare quality that is both a healthcare discipline as well as an attribute of health care systems that minimizes the frequency and severity, and maximizes recovery from, adverse healthcare events. This topic covers reporting requirements for adverse and sentinel events, patient abuse and neglect, and malpractice, as well as oversight programs.

Peer Review Peer review in the medical context is a process in which a professional body evaluates a practitioner’s competence and/or professional conduct to determine whether the practitioner has met relevant standards of care in the performance of his/her duties. Peer review may be used to determine a practitioner’s clinical privileges or membership in a professional society. Peer review is primarily concerned with promoting health care quality and patient safety. This topic covers laws about the confidentiality and disclosure of information held by a medical board or obtained through a peer review process.

Privacy and Confidentiality of Health Information Privacy and confidentiality of health information pertains to patient's right to the confidentiality of his or her medical information as well as rules governing when and how a provider may disclose information and to whom.

Private Insurance Data Requirements Private insurance refers to any health insurance plan or carrier that is not a government-sponsored payer. This topic includes laws on reporting requirements, correction, amendment, and deletion of insurance information, privacy and disclosure notification requirements, cost reporting, and confidentiality requirements, as well as laws governing certain subsets of information collected and used by insurance plans, such as preexisting conditions and genetic information.

Provider Resource Use Measurement and Reporting Provider resource use captures indicators of the cost and efficiency of health care. The amount and cost of the resources used to create a specific product, such as a visit, procedure, or a specific health outcome, are reported to help evaluate efficiency and quality of health care services. This topic covers the reporting of cost, utilization, and financial data by providers as well as the collection of that information from a variety of facilities.

Public Health Data Collection and Reporting Public health data is information on health behaviors, diseases, and injuries. This data is collected and analyzed to determine the frequency of or risk factors for deaths, illnesses, and injuries across a particular geographic area. This topic includes reporting requirements for several types of health care facilities and for specific diseases such as cancer, HIV/AIDS, brain tumors, and STDs, laws governing registries that collect information for public health purposes, and screening requirements for reportable diseases.

Quality Measurement and Reporting Quality measurement aims to quantify various healthcare processes, outcomes, patient experiences, and organizational structures. Information obtained through quality measurement enables patients to pursue the best available care and gives feedback to health care providers and facilities to help address quality issues and make improvements. This topic covers quality assurance programs, quality assessment and performance measurement, quality reporting requirements, patient satisfaction, grievance programs, and confidentiality requirements.

Research This topic covers the use of certain types of information for research purposes, including publicly reported data, disease-specific information, and registry data, as well as specific types of research, such as mortality and morbidity studies, studies for epidemiological purposes, and comparative effectiveness research. This topic also includes laws governing research authorization, confidentiality of research data, informed consent, and access to research information.

Security of Health Information Security of health information includes requirements for storage of health information and technical and nontechnical safeguards for health information, as well as laws governing unauthorized access or disclosure of health information and penalties for violating the security of health information.

Key Federal Laws

American Recovery and Reinvestment Act of 2009 (ARRA) ARRA (known as “the Stimulus” or “the Recovery Act”) was designed in response to the global economic decline in 2007 and 2008. Among other things, ARRA made investments in healthcare. ARRA called for the adoption and meaningful use of health information technology as a national policy priority and included the Health Information Technology for Economic and Clinical Health (HITECH) Act.

Family Educational and Privacy Act (FERPA) FERPA protects the privacy of information maintained in student education records, such as student health records and immunization records, and is applicable to all education agencies and institutions that receive federal funding.

The Federal Information Security Management Act of 2002 (FISMA): FISMA requires every federal agency to develop and implement an agency-wide program to protect government information and information systems from unauthorized access, use, disclosure, or destruction.

Freedom of Information Act (FOIA) FOIA gives any person the right to obtain access to information contained in the records of federal agencies, unless the information is specifically protected from disclosure under an exemption.

Genetic Information Nondiscrimination Act of 2008 (GINA) GINA protects individuals' genetic information from being used by health plans and issuers to make eligibility, coverage, underwriting, and premium-setting decisions about covered individuals. GINA also prohibits employers from discriminating against employees or applicants based on genetic information and from using genetic information in employment decisions.

Health Information Technology for Economic and Clinical Health Act (HITECH) HITECH is part of the American Recovery and Reinvestment Act of 2009 (ARRA). HITECH established the Office of the National Coordinator for Health Information Technology (ONC) to oversee the development of a national health information network as well as a strategic health information plan for the nation. HITECH strengthened standards for health information privacy and security and authorized financial incentives for certain health care providers and facilities who demonstrate meaningful use of certified electronic health record technology.

The Health Insurance Portability and Accountability Act (HIPAA) HIPAA regulates health insurers and health benefit plans and provides privacy protection for health information. Among other provisions, HIPAA set forth guidelines for the privacy and security of individually identifiable health information. The HIPAA Privacy, Security, Enforcement, and Breach Notification Rules were established to implement those guidelines.

Patient Protection and Affordable Care Act (ACA) The Patient Protection and Affordable Care Act (commonly referred to as Obamacare or the Affordable Care Act) was enacted in 2010 and represented a significant overhaul of the United States healthcare system. The law primarily focuses on reducing the uninsured population and decreasing health care costs

The Patient Safety and Quality Improvement Act of 2005 (PSQIA) PSQIA created a voluntary program for providers to share information relating to patient safety events with patient safety organizations. PSQIA imposes confidentiality and privilege requirements on such information to encourage providers to share the information without fear of liability.

Social Security Act The Social Security Act established a system of Federal old-age benefits and gives funding to states to provide for the elderly, the blind, dependent children, mothers of dependent children, pregnant women, the physically disabled, for public health purposes and to administer state unemployment compensation laws. The laws establishing the Medicare, Medicaid, and the State Children's Health Insurance Program (S-CHIP, or CHIP) are all contained in the Social Security Act.

42 C.F.R. Part 2 Part 2 is a regulation that restricts the use and disclosure of substance abuse records obtained by federally assisted programs that provide substance abuse treatment, diagnosis, or referral for treatment.

The Privacy Act of 1974 The Privacy Act governs the collection, use, and disclosure of personally identifiable information about individuals maintained in a system of records by federal agencies, where the records are retrievable by a personal identifier (such as an individual's name or social security number).

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