

A Glossary of Terms

-A-

access - a patient's ability to obtain medical care. The ease of access is determined by components such as the availability of medical services and their acceptability to the patient, the location of health care facilities, transportation, hours of operation and cost of care.

accountable health plans (AHPs) - see organized delivery systems.

accrete - a term used by Medicare to describe the process of adding new enrollees to a health plan.

actively-at-work - a requirement of many insurer's policies stipulating that if a given employee is not actively at work on the day the policy goes into effect, medical coverage will not be provided until that employee returns to work.

activities of daily living (ADLs) - activities performed as part of a person's daily routine of self-care, such as bathing, dressing, toileting, transferring, continence and eating.

actuary - a person trained in the insurance field who determines policy rates and reserves dividends as well as conducts various other statistical studies.

additional drug benefit list - a list of pharmaceutical products approved by the health plan and employer for dispensing in quantities or day supplies other than the standards covered under a benefit package. Also called *drug maintenance list*.

adjusted average per capita cost (AAPCC) - the estimated average cost of Medicare benefits for an individual in a county, based on the following factors: age, sex, institutional status, Medicaid, disability and

end stage renal disease status. HCFA uses the AAPCCs to make monthly payments to risk and cost contractors.

adjusted community rating (ACR) - community rating impacted by group specific demographics and the group's prior experience. Also known as *prospective rating*.

administrative costs - the cost incurred by a carrier, such as an insurance company or HMO, for administrative services such as claims processing, billing and enrollment, and overhead costs. Administrative costs can be expressed as a percentage of premiums or on a per member per month basis.

administrative services only (ASO) - a service requiring a third party to deliver administrative services to an employer group and requiring the employer to be at risk for the cost of health care services provided. This is a common arrangement when an employer sponsors a self-funded health care program.

admissions/1000- the number of hospital admissions per 1,000 health plan members. The formula for this measure is $(\# \text{ of admissions/member months}) \times 1,000 \text{ members} \times \# \text{ of months}$.

admits - the number of admissions to a hospital or inpatient facility.

adverse selection - a term used to describe a situation in which a carrier enrolls a poorer risk than the average risk of the group.

aftercare - services following hospitalization or rehabilitation, individualized for each patient's needs. Aftercare gradually phases the patient out of treatment while providing follow-up attention to prevent relapse.

age/sex factor - a measurement used in underwriting which represents the age and sex risk of medical costs of one population relative to another. A group with an age/sex factor of 1.00 is average. An age/sex factor above 1.00 indicates a higher than average demographic risk of expected medical claims. An age/sex factor below 1.00 indicates a lower than average demographic risk of expected medical claims.

age/sex rates (ASR) - a set of rates for a given group product in which there is a separate rate for each grouping of age and sex categories. One overall table serves a defined group or product. These rates are used to calculate premiums for group billing purposes. This type of premium structure is often preferred over single and family rating in small groups because it automatically adjusts to demographic changes in the group. Also called *table rates*.

alcoholism - a primary, chronic disease with genetic, psychosocial and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial.

allied health personnel - specially trained and licensed (when necessary) health workers other than physicians, dentist, optometrist, chiropractors, podiatrists, and nurses. The term is sometimes used synonymously with paramedical personnel, all health workers who perform tasks which must otherwise be performed by a physician, or health workers

who do not usually engage in independent practice.

allowable costs - charges for services rendered or supplies furnished by a health provider which qualify as covered expenses.

all-payer contract - an arrangement allowing for payment of health services delivered by a contracted provider regardless of product type (e.g., HMO, PPO, indemnity) or revenue source (e.g., premium or self-funded).

all-payer system - a plan which would impose uniform prices on medical services for all payers.

alternative care - medical care received in lieu of inpatient hospitalization. Examples include outpatient surgery, home health care and skilled nursing facility care. Also may refer to nontraditional care delivered by providers such as midwives.

alternative delivery systems (ADS) - a catch all phrase used to cover all forms of health care delivery except traditional fee-for-service, private practice. The term includes HMOs, PPOs, IPAs and other systems of providing health care.

ambulatory care - health care services that do not require hospitalization of a patient, such as those delivered at a physician's office, clinic, medical center, or outpatient facility.

ambulatory setting - an institutional health setting in which organized health services are provided on an outpatient basis, such as a surgery center, clinic or other outpatient facility. Ambulatory care settings also may be mobile units of service, e.g., mobile mammography, MRI.

ancillary - a term used to describe additional services performed related to care, such as lab work, x-ray and anesthesia.

ancillary charge - the fee associated with additional service performed prior to and/or secondary to a significant procedure, such as lab work, x-ray, and anesthesia; or a charge in addition to the copayment and deductible amount which the covered person is required to pay to a participating pharmacy for a prescription which, through the request of the covered person or participating prescriber, has been dispensed in nonconformance with the plan's maximum allowable cost (MAC) list.

appeal - a formal request by a covered person or provider for reconsideration of a decision, such as a utilization review recommendation, a benefit payment or an administrative action, with the goal of finding a mutually acceptable solution.

approved charge - the maximum fee Medicare will pay in a given area for a covered service.

approved health care facility or program - a facility or program that is licensed, certified or otherwise authorized pursuant to the laws of the state to provide health care and which is approved by a health plan to provide the care described in a contract.

assignment of benefits - a method under which a claimant requests that his/her benefits under a claim be paid to some designated person or institution, usually a physician or hospital.

average cost per claim - the average dollar amount of administrative and/or medical services rendered for the unit of measure within each expenditure category (admissions, physician services, outpatient claims). The calculation is: amount/# of units.

average length of stay (ALOS) - the average number of days in a hospital for each admission. The formula for this measure: total patient days incurred divided by the number of admissions and discharges during the period.

average wholesale price (AWP) - the standardized cost of a pharmaceutical, calculated by averaging the cost of an undiscounted pharmaceutical charged to a pharmacy provider by a large group of pharmaceutical wholesale suppliers.

-B-

balance billing - a provider's billing of a covered person for charges above the amount reimbursed by the health plan, (i.e. the difference between billed charges and the amount paid). This may or may not be appropriate, depending upon the contractual arrangements between the parties.

base capitation - a stipulated dollar amount to cover the cost of health care per covered person, less mental health/substance abuse services, pharmacy and administrative charges.

bed days/1000 - the number of inpatient days per 1000 health plan members. The formula is: (# of days/member months) x 1000 members x # of months.

behavioral health care - assessment and treatment of mental and/or psychoactive substance abuse disorders.

beneficiary - a person designated by an insuring organization as eligible to receive insurance benefits.

benefit level - the limit or degree of services a person is entitled to receive based on his/her contract with a health plan or insurer.

benefit package - services an insurer, government agency, or health plan offers to a group or individual under the terms of a contract.

bill review - third-party review of medical bills for excessive or inappropriate charges. Some workers compensation state statutes mandate payers to examine bills.

billed claims - the fees or costs for health care services provided to a covered person, submitted by a health care provider.

biological equivalents - those chemical equivalents which, when administered in the same amounts, will provide the same biological or physiological availability, as measured by blood levels, urine levels, etc.

board certified - a physician who has passed an examination given by a medical specialty board and who has been certified as a specialist in that medical area.

board eligible - a physician who is eligible to take the specialty board examination by virtue of having graduated from an approved medical school, completed a specific type and length of training, and practiced for a specified amount of time.

brand-brand interchange - *see chemical equivalents.*

-C-

calendar year - the period of time from January 1 of any year through December 31 of the same year, inclusive. Most often used in connection with deductible amount provisions of major medical plans providing benefits for expenses incurred within the calendar year. Also found in provisions outlining benefits in basic hospital, surgical, medical plans.

capitation (cap) - in the strictest sense, a stipulated dollar amount established to cover the cost of health care delivered for a person. The term usually refers to a negotiated per capita rate to be paid periodically, usually monthly, to a health care provider. The provider is responsible for delivering or arranging for the delivery of all health services required by the covered person under the conditions of the provider contract.

carrier - an entity which may underwrite or administer a range of health benefit programs. May refer to an insurer or a managed health plan.

carrier replacement (CR) - a situation where a sole carrier replaces one or more other carriers on a specific group client. This allows consolidation of the group's experience and risk.

carve out - a decision to purchase separately a service which is typically a part of an indemnity or HMO plan. Example: an HMO may "carve out" the behavioral health benefit and select a specialized vendor to supply these services on a stand-alone basis.

case management - a process whereby covered persons with specific health care needs are identified and a plan which efficiently utilizes health care resources is formulated and implemented to achieve the optimum patient outcome in the most cost-effective manner.

case manager - an experienced professional (e.g. nurse, doctor or social worker) who works with patients, providers and insurers to provide the patient with a plan of medically necessary and appropriate health care.

case mix - the relative frequency and intensity of hospital admissions or services reflecting different needs and uses of hospital resources. Case mix can be measured based on patients' diagnoses or the severity of their illness, the

utilization of services, and the characteristics of a hospital.

centers of excellence - a network of health care facilities selected for specific services based on criteria such as experience, outcomes, efficiency and effectiveness. For example, an organ transplant managed care program wherein employees/dependents access select types of benefits through a specific network of medical centers.

certificate of authority (COA) - a certificate, issued by a state government, licensing the operation of a health maintenance organization.

certificate of coverage (COC) - a description of the benefits included in a carrier's plan. The certificate of coverage is required by state laws and represents the coverage provided under the contract issued to the employer. The certificate is provided to the employee.

certificate of need (CON) - a certificate issued by a government body to an individual or organization proposing to construct or modify a health facility, acquire major new medical equipment, or offer a new or different health service. Such issuance recognizes that a facility or service, when available, will meet the needs of those for whom it is intended.

chemical dependency - see *substance abuse*

chemical equivalents - those multiple-source drug products containing essentially identical amounts of the same active ingredients, in equivalent dosage forms, and meeting existing physical/chemical standards.

claim - information, submitted by a provider or a covered person to establish that medical services were provided to a covered person, from which processing for payment to the provider or covered person is made. The term

generally refers to the liability for health care services received by covered persons.

closed access - a type of health plan in which covered persons are required to select a primary care physician from the plan's participating provider. The patient is required to see the selected primary care physician for care and referrals to other health care providers within the plan. Typically found in a staff, group or network model HMO. Also called *closed panel* or *gatekeep model*.

closed panel - see *closed access*

cognitive impairment - impairment in memory, reasoning or orientation to person, place or time; or an impairment requiring a person to be supervised to protect himself or herself or others from harm.

coinsurance - the portion of covered health care costs for which the covered person has a financial responsibility, usually according to a fixed percentage. Often coinsurance applies after first meeting a deductible requirement.

commission - the portion of premiums or equivalent premium for self-funded groups paid to an insurance agent, sales representative, or broker as compensation for services provided. Commissions are considered part of the selling administrative expenses.

community rating - a method of determining a premium structure that is influenced not by the expected level of benefit utilization by specific groups, but by expected utilization by the population as a whole.

community rating by class (CRC) - the practice of community rating impacted by the group's specific demographics. Also known as *factored rating*.

competitive medical plan (CMP) - a status granted by the federal government to an organization meeting specified criteria, enabling that organization to obtain a Medicare risk contract.

complaint procedure - see *appeal*.

composite rate - a group billing rate which applies to all subscribers within a specified group, regardless of whether they are enrolled for single or family coverage.

concurrent certification - see *admission certification*.

concurrent drug evaluation - an electronic assessment of claims at the point of service to detect potential problems that should be addressed prior to dispensing drugs to patients.

concurrent review - an assessment which determines medical necessity or appropriateness of services as they are being rendered.

confinement - an uninterrupted stay for a defined period of time (as reflected in a benefit contract) in a hospital, skilled nursing facility or other approved health care facility or program, followed by discharge from that same facility or program.

Consolidated Omnibus Budget Reconciliation Act (COBRA) - a federal law that, among other things, requires employers to offer continued health insurance coverage to certain employees and their beneficiaries whose group health insurance coverage has been terminated.

continuation - a situation whereby a covered person who would otherwise lose coverage under health plan due to certain occurrences such as termination of employment or divorce is allowed to "continue" his/her coverage under specified conditions.

continuum of care - a range of clinical services provided to an individual or group, which may reflect treatment rendered during a single inpatient hospitalization, or care for multiple conditions over a lifetime. The continuum provides a basis for analyzing quality, cost and utilization over the long term.

contract year - the period of time from the effective date of the contract to the expiration date of the contract.

contributory program - a method of payment for group coverage in which part of the premium is paid by the employee and part is paid by the employer or union.

conversion - the privilege given to a covered person to change his/her group medical care coverage to a form of individual coverage without evidence of insurability. The conditions under which conversion can be made are defined in the master group contract. Conversion is usually made when a covered person leaves the group.

coordination of benefits (COB) - a provision in a contract that applies when a person is covered under more than one group medical program. It requires that payment of benefits will be coordinated by all programs to eliminate overinsurance or duplication of benefits.

copay - see *copayment*.

copayment - a cost-sharing arrangement in which a covered person pays a specified charge for a specified service, such as \$10 for an office visit. The covered person is usually responsible for payment at the time the health care is rendered. Typical copayments are fixed or variable flat amounts for physician office visits, prescriptions or hospital services. Some copayments are referred to as coinsurance, with the distinguishing characteristics that copayments are flat or variable dollar amounts

and coinsurance is a defined percentage of the charges for services rendered. Also called *copay*.

cosmetic procedures - those procedures which involve physical appearance, but which do not correct or materially improve a physiological function and are not medically necessary.

cost contract - a formal agreement with HCFA to arrange for the provision of health services to plan members based on reasonable cost or prudent buyer concepts. The plan receives an interim capitated amount, derived from an estimated annual budget, which may be periodically adjusted during the course of the contract to reflect actual cost experience. The plan's expenses are audited at the end of the contract to determine the final rate the plan should have been paid. The AAPCC may be a factor in establishing the final payment rate.

cost-effectiveness - the degree to which a service meets a specified goal at an acceptable cost.

cost sharing - a general set of financing arrangements via deductibles, copays and/or coinsurance in which a person covered by the health plan must pay some of the costs to receive care. See also *copayment, coinsurance and deductible*.

covered person - an individual who meets eligibility requirements and for whom premium payments are paid for specified benefits of the contractual agreement.

CPT - see *Physician's Current Procedural Terminology*.

credentialing - a process of review to approve a provider who applies to participate in a health plan. Specific criteria and prerequisites are applied in determining initial and ongoing participation in the health plan.

custodial care - a medical or non-medical services which do not seek to cure, are provided during periods when the medical condition of the patient is not changing, or do not require continued administration by medical personnel. For example, assistance in the activities of daily living.

- D -

date of service - the date on which health care services were provided to the covered person.

days - unit of measurement of the length of a hospital confinement.

days / 100 - see *bed days / 1000*.

deductible - the amount of eligible expense a covered person must pay each year from his/her own pocket before the plan will make payment for eligible benefits.

deductible carry over credit - charges applied to the deductible for services during the last 3 months of a calendar year which may be used to satisfy the following year's deductible. The deductible for the prior calendar year may or may not have been met.

deferred compensation administrator (DCA) - a company that provides services through retirement planning administration, third-party administration, self-insured plans, compensation planning, salary survey administration and workers compensation claims administration.

delete - used by HCFA to describe the process of removing an individual from the plan's Medicare product.

dependent - an individual who relies on an employee for support or obtains health coverage through a spouse, parent or grandparent who is

the covered person. See also *eligible dependent and member*.

designated mental health provider - the organization or entity with which the health plan contracts to evaluate, diagnose, refer and/or provide mental health and substance abuse services.

detoxification - medical management while an individual withdraws from alcohol.

diagnosis - the identification of a disease or condition through analysis and examination.

diagnosis related groups (DRGs) - a system of classification for inpatient hospital services based on principal diagnosis, secondary diagnosis, surgical procedures, age, sex and presence of complications. This system of classification is used as a financing mechanism to reimburse hospital and selected other providers for services rendered.

Diagnostic and Statistical Manual-3rd Edition, Revised (DSMIII-R) - American Psychiatric Association's manual of diagnostic criteria and terminology, widely accepted as the common language of mental health clinicians and researchers.

disability - any condition which results in functional limitations that interfere with an individual's ability to perform his/her customary work and which results in substantial limitation in one or more major life activities.

disability management - a prevention and remediation strategy that seeks to prevent disability from occurring, and to promote a safe and appropriate return to work and achievement of optimal functional capabilities following a disabling illness or injury.

disallowance - a denial by the payer for portions of the claimed amount. Examples of possible disallows include coordination of

benefits, not-covered benefits, or amounts over the fee maximum.

discharge planning - the evaluation of patients' medical needs in order to arrange for appropriate care after discharge from inpatient setting.

disease - an interruption, cessation, or disorder of body or mental functions, systems or organs.

disease classification - a systematic arrangement of related diagnoses into a limited number of clinically homogeneous categories, usually to support the analysis for the quality, access, utilization and cost of health care services.

disease episode - the entire time period in which a person has a specific disease.

disease state - a medical condition that presents a specific group of symptoms, clinical signs and laboratory assessment.

disenrollment - the process of terminating individuals or groups from their enrollment with a carrier. See *delete*.

dread disease policy - a type of insurance that provides benefits for treatment of specific diseases named in the insurance policy.

drug formulary - a listing of prescription medications which are preferred for use by the health plan and which will be dispensed through participating pharmacies to covered persons. This list is subject to periodic review and modification by the health plan. A plan that has adopted an "open or voluntary" formulary allows coverage for both formulary and nonformulary medications. A plan that has adopted a "closed, select or mandatory" formulary limits coverage to those drugs in the formulary.

drug maintenance list - see *additional drug benefit list*.

drug price review (DPR) - a weekly updating of drug prices, at average wholesale price (AWP), from the American Druggist Blue Book. Price maximums are subsequently established.

drug use evaluation (DUE) - same as drug utilization review, only qualitative in nature.

drug utilization review (DUR) - a quantitative evaluation of prescription drug use, physician prescribing patterns or patient drug utilization to determine the appropriateness of drug therapy.

dual choice (DC) - a term used to describe a situation in which only two carriers are contracted by a specific group. For example, an employer offers its employees one HMO and one indemnity plan, or two HMOs and no indemnity plan.

dual diagnosis - co-existence of more than one disorder in an individual patient. Commonly refers to a patient who is diagnosed with mental illness in conjunction with substance abuse.

duplicate coverage inquiry (DCI) - a request to an insurance company or group medical plan by another insurance company or medical plan to find out whether other coverage exists for the purpose of coordination of benefits.

duplication of benefits - overlapping or identical coverage of an insured person under two or more health plans, usually the result of contracts with different service organizations, insurance companies or prepayment plans.

duplication of benefits - overlapping or identical coverage of an insured person under two or more health plans, usually the result of contracts with different service organizations, insurance companies or prepayment plans.

durable medical equipment (DME) - equipment which can stand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use at home. Examples of durable medical equipment include hospital beds, wheelchairs and oxygen equipment.

-E-

effective date - the date a contract becomes in force.

electronic data interchange (EDI) - the computer-to-computer exchange of business or other information between two organizations (trading partners). The data may be in either a standardized or proprietary format.

eligibility date - the defined date a covered person becomes eligible for benefits under an existing contract.

eligible dependent - a dependent of a covered employee who meets the requirements specified in the group contract to qualify for coverage and for whom premium payment is made. See also *family dependent*.

eligible employee/person - one who meets the requirements specified in the contract to qualify for coverage. Qualifications might include permanent, full time, 35 or more hours per week employment, or permanent, part time, 40 or more hours per 2-week pay period employment.

eligible expenses - reasonable and customary charges or the agreed upon health services fee for health services and supplies covered under a health plan.

emergency - a serious medical condition resulting from injury, sickness or mental illness which arises suddenly and requires immediate care and treatment, generally within 24 hours of

onset, to avoid jeopardy to the life or health of a person.

emergency-center - see *free-standing emergency medical service center*.

employee assistance program (EAP) - services designed to assist employees, their family members, and employers in finding solutions for workplace and personal problems. Services may include assistance for family/marital concerns, legal or financial problems, elder care, child care, substance abuse, emotional/stress issues, and other daily living concerns. EAPs may address violence in the workplace, sexual harassment, dealing with troubled employees, transition in the workplace, and other events that increase the rate of absenteeism or employee turnover, lower productivity and other issues that impact an employer's financial success or employee relations management. EAPs also can provide the voluntary or mandatory access to behavioral health benefits through an integrated behavioral health program.

employee contribution - the amount an employee must contribute toward the premium costs of the contract.

Employee Retirement Income Security Act of 1974, Public Law 93-406 (ERISA) - this law mandates reporting and disclosure requirements for group life and health plans.

employer contribution - the amount an employer contributes toward the premium costs of the contract. This amount varies widely among employers and is a critical variable in any risk analysis. Employer contribution can be based on dollar amounts, percentages, employment status, length of service, single or family status, or other variables or combinations of the above.

employer coverage mandate - a government requirement that employers provide health care benefits for employees. A mandate may address a single service or a range / package of services, e.g. preventive care coverage.

employer mandate - under the federal HMO act, federally qualified HMOs can mandate or require an employer to offer at least one federally qualified HMO plan of each type (IPS/network or group/staff). Some state laws have similar provisions.

encounter - a face-to-face meeting between a covered person and a health care provider where services are provided.

encounters per member per year - the number of encounters related to each member on a yearly basis. The measurement is calculated as follows: total # of encounters per year/total # of member per year.

enrollee - an individual who is enrolled for coverage under a health plan contract and who is eligible on his/her own behalf (not by virtue of being an eligible dependent) to receive the health services provided under the contract.

enrolling unit - an employer or other entity with which a contract for participation is made.

enrollment - the total number of covered persons in a health plan. Also refers to the process by which a health plan signs up groups and individuals for membership, or the number of enrollee's who sign up in any one group.

episode of care - treatment rendered in a defined time frame for a specific disease. Episodes provide a useful basis for analyzing quality, cost and utilization patterns.

ERISA - see *Employee Retirement Income Security Act*.

evidence of coverage - see *certificate of coverage*.

evident of insurability (EOI) - proof presented through written statements (e.g. an application form) and/or a medical examination that an individual is eligible for a certain type of insurance coverage. This form is required for eligibles who do not enroll during the open enrollment period (generally a 31-day period), or who apply for excess amounts of group life insurance. Also known as *evidence of good health*.

exclusions - specific conditions or circumstances listed in the contract or employee benefit plan for which the policy or plan will not provide benefit payments.

exclusive provider organization (EPO) - a term derived from the phrase preferred provider organization (PPO). However, where a PPO generally extends coverage for non-preferred provider services as well as preferred provider services, and EPO provides coverage only for contracted providers. Technically, many HMOs also can be described as EPOs.

expected claims - the projected claim level of a covered person or group for a defined contract period. This level also becomes known as desired loss ratio or break even point in relationship to projected premium. See also *experience rating*.

experience rating - the process of setting rates based partially or in whole on previous claims experience and projected required revenues for a future policy year for a specific group or pool of groups. See also *expected claims*.

experimental, investigational or unproven procedure - medical, surgical, psychiatric, substance abuse or other health care services, supplies, treatments, procedures, drug therapies or devices that are determined by the health plan

(at the time it makes a determination regarding coverage in a particular case) to be either: not generally accepted by informed health care professionals in the United States as effective in treating the condition, illness or diagnosis for which their use is proposed; or not proven by scientific evidence to be effective in treating the condition, illness or diagnosis for which their use is proposed.

explanation of benefits (EOB) - the statement sent to covered persons by their health plan listing services provided, amount billed, and payment made.

extended care facility - a nursing home or nursing center licensed to operate in accordance with all applicable state and local laws to provide 24-hour nursing care. Such a facility may offer skilled, intermediate or custodial care, or any combination of these levels of care.

extension of benefits - a provision of many insurer's policies which allows medical coverage to continue past the termination date of the policy for employees not actively at work and for dependents hospitalized on that date. Such extended coverage usually applies only to the specific medical condition which has caused the disability and continues only until the employee returns to work or the dependent leaves the hospital. Not as common since the implementation of COBRA regulations.

-F-

factored rating - see *community rating by class*.

family dependent - a person enrolled for coverage under a health plan contract who is: the enrollee's spouse; or an unmarried dependent child (including a stepchild or legally adopted child) of either the enrollee or the enrollee's spouse, and whose principal place of residence is with the enrollee unless other

arrangements have been made with the health plan. The definition also may be subject to certain conditions and limitations spelled out in the contract.

federal qualification - a designation made by HCFA after conducting an extensive evaluation process of an HMO's entire method of doing business: documents, contracts, systems, facilities, etc. An organization must be federally qualified or a designated competitive medical plan to be eligible to participate in certain Medicare cost and risk contracts.

fee-for-service equivalency - a quantitative measure of the difference between the amount a physician and/or other provider receives from an alternative reimbursement system, e.g. capitation, compared to fee-for-service reimbursement.

fee-for-service reimbursement - the traditional health care payment system, under which physicians and other providers receive a payment that does not exceed their billed charge for each unit of service provided.

fee maximum - the maximum amount a participating provider may be paid for a specific health care service provided to a covered person under a specific contract. Sometimes called *fee max*.

fee schedule - a listing of codes and related services with pre-established payment amounts which could be percentages of billed charges, flat rates or maximum allowable amounts.

field underwriting - the process whereby health plan sales personnel screen prospective buyers of the plan's products in order to ensure profitable contracting. Field underwriting also may include authority to quote premium rates of specific products for defined types and sizes of groups.

flexible benefit plan - a type of benefit program offered by some employers in which employees are presented annually with a number of benefit options, allowing employees to tailor benefits to their specific needs.

formulary - see *drug formulary*.

free-standing emergency medical service center - a health care facility that is physically, organizationally and financially separate from a hospital and whose primary purpose is the provision of immediate, short-term medical care for minor but urgent medical conditions. Also called *emergency-center* or *urgency-center*.

free-standing outpatient surgical center - a health care facility, physically separate from a hospital, that provides pre-scheduled, outpatient surgical services. Also called *surge-center*.

frequency - the number of times a service was provided.

funding level - the amount of revenue required to finance a medical care program. Under an insured program, this is usually premium rate. Under a self-funded program, this amount is usually assessed per expected claim costs, plus stop loss premium, plus all related fees.

funding method - the means by which an employer pays for the employee health benefit plan. There are several funding methods which shift risk from the employer to a carrier, or an employer may self-fund the employee health benefit plan. The most common methods are: prospective and/or retrospective premium payments, refunding products, self-funding, and shared risk arrangements.

-G-

gatekeeper model - a situation in which a primary care physician, the "gatekeeper," services as the patient's initial contact for

medical care and referrals. Also called *closed access or closed panel*.

generic drug - a chemically equivalent copy designed from a brand-name drug whose patent has expired. A generic is typically less expensive and sold under a common or "generic" name for that drug (e.g., the brand name for one tranquilizer is Valium, but it is also available under the generic name diazepam). Also called *generic equivalent*.

generic equivalent - see *generic drug*.

generic substitution - dispensing a generic drug in place of a brand-name medication. Substitution guidelines are defined by state regulation.

grace period - a set number of days past the due date of a premium payment during which medical coverage may not be cancelled and the premium payment may be made. This period varies by health plan contract, generally 30, 60, 90 or 120 days.

group - a collection of individuals treated as a single entity; usually, an employer purchasing medical coverage on behalf of its full-time employees.

group contract - the application and addenda, signed by both the health plan and the enrolling unit, which constitutes the agreement regarding the benefits, exclusions and other conditions between the health plan and the enrolling unit. Also, the agreement with persons who obtain coverage for themselves or for themselves and their children, whether under a group or individual program.

group model HMO - a health care model involving contracts with physicians organized as a partnership, professional corporation, or other association. The health plan compensates the medical group for contracted services at a

negotiated rate, and that group is responsible for compensating its physicians and contracting with hospitals for care of their patients.

group practice without walls - typically a network of physicians who have formed a single legal entity but maintain their individual practices. The assets of individual practices may be acquired by the larger entity, but some autonomy is retained at each site. The central management provides administrative support. See *integrated deliver system*.

- H -

HCFA 1500 - a universal form, developed by the government agency known as Health Care Financing Administration (HCFA), for providers of services to bill professional fees to health carriers.

HCFA Common Procedural Coding System (HCPCS) - a listing of services, procedures and supplies offered by physicians and other providers. HCPCS includes CPT (Current Procedural Terminology) codes, national alpha-numeric codes and local alpha-numeric codes. The national codes are developed by HCFA in order to supplement CPT codes. They include physician services such as ambulance, physical therapy and durable medical equipment. The local codes are developed by local Medicare carriers in order to supplement the national codes. HCPCS codes are 5-digit codes, the first digit a letter followed by four numbers. HCPCS codes beginning with A through V are national; those beginning with W through Z are local.

health alliances or regional health alliances - purchasing pools which would be responsible for negotiating health insurance arrangements for employers and/or employees. Alliances would use their leverage to negotiate contracts that would ensure care is delivered in economic and equitable ways. (Also referred to as *health*

insurance purchasing cooperatives or health plan purchasing cooperatives.)

health benefits package - the services and products (coverage) a health plan offers a group or individual.

Health Care Financing Administration (HCFA) - the federal agency responsible for administering Medicare and overseeing state's administration of Medicaid.

health care prepayment plan (HCPP) - a cost contract with the Health Care Financing Administration that prepays a health plan a flat amount per month to provide Medicare-eligible Part B medical services to enrolled members. Members pay premiums to cover the Medicare coinsurance, deductibles and copayments, plus any additional non-Medicare covered services that the plan provides. The HCPP does not arrange for Part A services.

health coverage - protection that provides payment of benefits for covered sickness or injury. This may include short and long term disability, dental, medical and vision care, and sometimes accidental death coverage as well as other benefits.

health history - a form used by underwriting personnel for evaluating the medical history of individuals to determine acceptable risk. See also *evidence of insurability*.

health insurance purchasing cooperatives (HIPC) - see *health alliances*.

health maintenance organization (HMO) - an entity that provides, offers or arranges for coverage of designated health services needed by plan members for a fixed, prepaid premium. There are four basic models of HMOs: group model, individual practice association, network model and staff model.

Under the Federal HMO Act, an entity must have three characteristics to call itself an HMO:

1. an organized system for providing health care or otherwise assuring health care delivery in a geographic area,
2. an agreed upon set of basic and supplemental health maintenance and treatment services, and
3. a voluntarily enrolled group of people. See also *group model, individual practice association, network model and staff model*.

health plan - health maintenance organization, preferred provider organization, insured plan, self-funded plan other entity that covers health care services.

Health Plan Employer Data and Information Set (HEDIS) - a core set of performance measures to assist employers and other health purchasers in understanding the value of health care purchases and evaluating health plan performance.

health service agreement (HSA) - the detailed procedure and benefit description given to each enrolled employer. This agreement is the basis for discussion and/or explanation between the employer and the health plan on enrollment, eligibility limitations, benefit descriptions, etc.

home health agency (HHA) - a facility or program licensed, certified or otherwise authorized pursuant to state and federal laws to provide health care services in the home.

hospice - a facility or program engaged in providing palliative and supportive care of the terminally ill, and licensed, certified or otherwise authorized pursuant to the law of jurisdiction in which services are received.

hospital affiliation - a contractual relationship between a health plan and one or more hospitals whereby the hospital provides the inpatient benefits offered by the health plan.

hospital alliance - a group of voluntary hospitals that have joined together to reduce costs by sharing common services and developing group purchasing programs. Hospital alliances are formed to improve competitive positions over other voluntary institutions and chains.

human risk management - a service designed to reduce the demand for treatment by identifying, assessing, and managing individuals' medical or behavioral health risks before treatment becomes imperative. Human risk management is designed to respond proactively to employee risk areas and to address problems/issues before they become psychological, medical, or financial crises.

□ -I-

impairment - any loss or abnormality of psychological, physiological or anatomical structure or function (e.g., hearing loss).

in-area services - health care received within the authorized service area from a participating provider of the health plan.

incurred but not reported (IBNR) - costs associated with a medical service that has been provided, but for which a claim has not yet been received by the carrier. IBNR reserves are recorded by the carrier to account for estimated liability based on studies of prior lags in claim submissions.

incurred claims - the actual carrier liability for a specified period, including all claims with dates of service within a specified period (usually called the experience period.) Due to the time lag between dates of service and the dates claims payments are actually processed, adjustments must be made to any paid claims data to determine incurred claims.

incurred claims loss ration - the result of incurred claims divided by premiums. A defined time period is usually specified.

indemnity - an insurance program in which the insured person is reimbursed for covered expenses.

independent medical evaluation (IME) - an examination carried out by an impartial health care provider, generally board certified, for the purpose of resolving a dispute related to the nature and extent of an illness or injury.

individual practice association (IPA) model HMO - a health care model that contracts with an entity, which in turn contracts with physicians, to provide health care services in return for a negotiated fee. Physicians continue in their existing individual or group practices and are compensated on a per capita, fee schedule, or fee-for-service basis.

initial eligibility period - the period of time specified in the contract during which eligible persons may enroll themselves and dependents under the health plan, usually without providing evidence of good health.

injury - physiological damage other than sickness, including all related conditions and recurrent symptoms.

inpatient - an individual who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a physician for at least 24 hours.

integrated behavioral health - a carve-out benefit plan that combines independent managed care services into a seamless delivery system for behavioral health concerns. Components could include employee assistance services, a telephone counseling triage, utilization management, behavioral health treatment networks, claims payment, and data management.

integrated delivery system - a generic term referring to a joint effort of physician/hospital integration for a variety of purposes. Some models of integration include physician-hospital organization, management service organization, group practice without wall, integrated provider organization and medical foundation.

integrated provider organization - a corporate umbrella for the management of a diversified health care delivery system. The system may include one or more hospitals, a large group practice and other health care operations. Physicians practice as employees of the organization or in a closely affiliated physician group. See *integrated delivery system*.

integrated service network (ISN) - see *organized delivery systems*.

intermediate care facility (ICF) - a facility providing a level of care that is less than the degree of care and treatment that a hospital or skilled nursing facility (SNF) is designed to provide, but greater than the level of room and board.

International Classification of Diseases, 9th Edition (Clinical Modification) (ICD-9-CM)- a listing of diagnoses and identifying codes used by physicians for reporting diagnoses of health plan enrollees. The coding and terminology provide a uniform language that can accurately designate primary and secondary diagnoses and provide for reliable, consistent communication on claim forms.

-J-

Joint Commission on Accreditation of Healthcare Organization (JCAHO) - a private, not-for-profit organization that evaluates and accredits hospitals and other health care organizations providing home care,

mental health care, ambulatory care, and long term care services.

-K-

-L-

large claim pooling - a practice in experience rating which isolates claim amounts per individual over a defined level (e.g., \$30,000). These isolated or pooled amounts are charged to a pool funded by the pool charges of all groups who share this same pooling level. (Pooling large claim amounts helps stabilize significant premium fluctuations more prominent with smaller group sizes. Smaller groups generally will have lower pooling points and larger groups will have larger pooling points.)

legend drug - a drug that, by law, can be obtained only by prescription and bears the label, "Caution: federal law prohibits dispensing without a prescription."

length of stay (LOS) - the number of days that a covered person stayed in an inpatient facility.

long term care - assistance and care for persons with chronic disabilities. Long term care's goal is to help people with disabilities be as independent as possible; thus it is focused more on caring than on curing. Long term care is needed by a person who requires help with the activities of daily living (ADLs) or who suffers from cognitive impairment.

long term care insurance - coverage designed to help pay some or all long term care costs, reducing the risk that the policy-holder would need to deplete his or her assets to pay for long term care. Long term care insurance can help a person avoid relying on family or friends for assistance with activities of daily living and can reduce or eliminate the need to rely on Medicaid.

loss ration - the result of paid claims and incurred claims plus expenses divided by the paid premiums. See also *incurred claims loss ration, net loss ratio, paid claims loss ratio and medical loss ratio*.

-M-

Maintenance list - see *additional drug benefit list*.

major diagnostic category (MDC) - a clinically coherent grouping of ICD-9-CM diagnoses by major organ system or etiology that is used as the first step in assignment of most diagnosis related groups (DRGs). MDCs are commonly used for aggregated DRG reporting.

managed care - a system of health care delivery that influences utilization and cost of services and measures performance. The goal is a system that delivers value by giving people access to quality, cost-effective health care.

managed competition - a proposed policy approach whereby health plans would compete on the basis of cost and other factors. Purchasers would join cooperatives and be given the ability to compare plans across several dimensions of performance. The principle behind this approach is improvement of the health economy through increased health plan competition.

managed health care plan - one or more products which integrate financing and management with the delivery of health care services to an enrolled population; employ or contract with an organized provider network which delivers services and which (as a network or individual provider) either shares financial risk or has some incentive to deliver quality, cost-effective services; and use an information system capable of monitoring and evaluating patterns of covered persons' use of medical services and the cost of those services.

management service organization (MSO) - a legal entity that provides practice management, administrative and support services to individual physicians or group practices. An MSO may be a direct subsidiary of a hospital or may be owned by investors. See *integrated delivery system*.

managing general underwriter - a firm that specializes in guaranteeing risks on behalf of an insurance company. Usually a formal management agreement delineates duties, allowable risk type and limits of authority (e.g. \$1 million per person). Its services usually are used for a specific niche market, such as HMO reinsurers.

mandated benefits - those benefits which health plans are required by state or federal law to provide to policy holders and eligible dependents.

mandated providers - providers of medical care, such as psychologist, optometrists, podiatrists and chiropractors, whose licensed services must, under state or federal law, be included in coverage offered by a health plan.

manual rates - rates developed based upon the health plan's average claims data and adjusted for group specific demographic, industry factor or benefit variations.

master group contract - a legal document between the enrolling unit and the carrier, setting forth in detail the rights and obligations of the enrolling unit, covered person and carrier, and terms and conditions of the coverage provided by the contract.

maximum allowable cost (MAC) list - specified multi-source prescription medications that will be covered at a generic product cost level established by the plan. This list, distributed to participating pharmacies, is

subject to periodic review and modification by the plan. The MAC list may require covered persons to pay a cost differential for a brand name products.

maximum allowable fee schedule - a health care payment system which reimburses up to a specified dollar amount for services rendered.

maximum out-of-pocket costs - the limit on total member copayments, deductibles and coinsurance under a benefit contract.

Medicaid - a federal program administered and operated individually by participating state and territorial governments which provides medical benefits to eligible low income persons needing health care. The program's costs are shared by the federal and state governments.

medical expense trend - the rate at which medical costs are increasing or decreasing, influenced by, for example, utilization, new technology and billed charges.

medical foundation - a not-for-profit entity associated with a physician group that provides medical services under a professional services contract. The foundation acquires the business and clinical assets of the group practice, holds the provider number, and manages the business for both parties. See *integrated delivery system*.

medical loss ratio- the cost of ratio of health benefits used, compared to revenue received. Calculated as follows; total medical expenses/premium revenue.

medical necessity - the evaluation of health care services to determine if they are: medically appropriate and necessary to meet basic health needs; consistent with the diagnosis or condition and rendered in a cost-effective manner; and consistent with national medical practice guidelines regarding type, frequency and duration of treatment.

medical supplies - items which, due to their therapeutic or diagnostic characteristics, are essential in carrying out the care which the physician has ordered for the treatment of the patient's illness or injury (e.g., catheters, needles, syringes, surgical dressings and materials used for dressings, irrigating solutions and intravenous fluids).

Medicare - a nationwide, federally-administered health insurance program which covers the costs of hospitalization, medical care, and some related services for eligible persons. Medicare has two parts:

Part A covers inpatient costs. Medicare pays for pharmaceuticals provided in hospitals, but not for those provided in outpatient settings. Also called *Supplementary Medical Insurance Program*.

Part B covers outpatient costs for Medicare patients.

Medicare beneficiary - a person designated by the Social Security Administration as entitled to receive Medicare benefits.

Medicare supplement policy - a policy guaranteeing that a health plan will pay a policyholder's coinsurance, deductible and copayments and will provide additional health plan or non-Medicare coverage for services up to a predefined benefit limit. In essence, the product pays for the portion of the cost of services not covered by Medicare. Also called *Medigap* or *Medicare wrap*.

medigap - see *Medicare supplement policy*.

member assistance program (MAP) - a human risk management program that focuses on lowering behavioral and medical health costs by proactively reducing demand on the treatment system. This employee assistance type program is targeted to covered persons of health plans and insurers.

member category - a group of members classified (usually based on age and in a capitation environment) to determine physician reimbursement levels. At a minimum, the categories are pediatrics, adults and Medicare. Also called *member type*.

member certificate - same as *certificate of coverage*.

member month - a count which records one member for each month the member is effective.

members - participants in a health plan (subscribers/enrollees and eligible dependents), who make up the plan's enrollment. "Member" also is used to describe an individual specified within a subscriber contract who may or may not receive health care services according to the terms of the subscriber policy.

members per year - the number of members effective in the health plan on a yearly basis. Calculation is: member months/12.

mental health provider - a psychiatrist, licensed consulting psychologist, social worker, or hospital or other facility duly licensed and qualified to provide mental health services under the law or jurisdiction in which treatment is received.

minimum premium - medical benefit financing mechanism in which an employer remits only a portion of the conventional premium to the insurer to cover the cost of administering the benefits program and of providing specific and aggregate stop-loss insurance. The employer funds a "bank account" which the insurer draws upon for the payment of claims.

modified community rating (MCR) - a separate rating of medical service usage in a given geographic area (community) using age-sex data, etc.

modified fee-for-service - a system in which providers are paid on a fee-for-service basis, with certain fee maximums for each procedure.

morbidity - an actuarial determination of the incidence and severity of sicknesses and accidents in a well-defined class or classes of persons.

mortality - an actuarial determination of the death rate at each age as determined from prior experience. A mortality study (table) shows the probability of death and survival at each age for a credible unit of population.

multidisciplinary - determination of treatment plans and delivery of care through professionals with a wide range of specialties.

multiple option plan - a health care plan design which offers employees the option of electing to enroll under one of several types of coverage and usually from among an HMO, a PPO and a major medical indemnity plan.

-N-

national drug code (NDC) - a national classification system for identification of drugs. Similar to the Universal Product Code (UPC).

net loss ratio - the result of total claims liability and all expenses divided by premiums. This is the carrier's loss ratio after accounting for all expenses.

network model HMO - an HMO type in which the HMO contracts with more than one physician group, and may contract with single and multi-specialty groups. The physician works out of his/her own office. The physician may share in utilization savings, but does not necessarily provide care exclusively for HMO members.

non-contributory - a term describing a situation in which the plan sponsor pays the entire cost of premiums for coverage. Employees do not contribute toward the cost of the coverage.

non-participating provider (non-par) - a term used to describe a provider that has not contracted with the carrier or health plan to be a participating provider of health care.

non-participating provider indemnity benefits - a type of health care coverage for services rendered by providers who are not under contract with the health plan. The benefits are covered on an indemnity basis, typically carrying high copayment requirements and deductibles.

-O-

office visit - provision of physician services in an office setting.

open access (OA) - a self-referral arrangement allowing members to see participating providers for specialty care without a referral from another doctor. Typically found in an IPA HMO. Also called *open panel*.

open enrollment period - a time during which subscribers in a health benefit program have an opportunity to re-enroll or select an alternate health plan being offered to them, usually without evidence of insurability or waiting periods.

open panel - see *open access*.

organized delivery systems - proposed networks of providers and payers which would provide care and compete with other systems for enrollees in their region. Systems could include hospitals, primary care physicians, specialty care physicians, and other providers and sites that could offer a full range of

preventive and treatment services. Also referred to as accountable health plans (AHP), coordinated care networks (CCN), community care networks (CCN), integrated health systems (IHS), and integrated service networks (ISN).

outcome measures - assessments which gauge the effect or results of treatment for a particular disease or condition. Outcome measures include the patients' perception of restoration of function, quality of life and functional status, as well as objective measures of mortality, morbidity and health status.

outcomes - results achieved through a given health care service, prescription drug use or medical procedure.

outcomes management - systematically improving health care results, typically by modifying practices in response to data gleaned through outcomes measurement, then remeasuring and remodifying - often in a formal program of continuous quality improvement.

outcomes research - studies aimed at measuring the effect of a given product, procedure, or medical technology on health or costs.

outlier - an observation in a distribution that is outside a certain range, often defined as two or three standard deviations from the mean or exceeding a specific percentile. Frequently refers to a case or hospital stay that is unusually long or expensive for its type, or to a physician practice that uses an abnormally high or low volume of resources.

out-of-area (OOA) - coverage for treatment obtained by a covered person outside the network service area.

out-of-pocket costs / expenses (OOPs) - the portion of payments for health services required

to be paid by the enrollee, including copayments, coinsurance and deductibles.

out-of-pocket limit - the total payments toward eligible expenses that a covered person funds for him/herself and/or dependents: i.e., deductibles, copays and coinsurance - as defined per the contract. Once this limit is reached, benefits will increase to 100% for health services received during the rest of that calendar year. Some out-of-pocket costs (e.g., mental health, penalties for non-precertification, etc.) are not eligible for out-of-pocket limits.

outpatient - a person who receives health care services without being admitted to a hospital.

over-the-counter (OTC) drug - a drug product that does not require a prescription under federal or state law.

-P-

paid claims - the amounts paid to providers to satisfy the contractual liability of the carrier or plan sponsor. These amounts do not include any covered person liability for ineligible charges or for deductibles or copayments. If the carrier has preferred payment contracts with providers (e.g., fee schedules or capitation arrangements), lower paid claims liability will usually result.

paid claims loss ratio - the result of paid claims divided by premiums.

partial hospitalization services - a mental health or substance abuse program operated by a hospital which provides clinical services as an alternative or follow-up to inpatient hospital care.

participating provider - a provider who has contracted with the health plan to deliver medical services to covered persons. The provider may be a hospital, pharmacy or other facility or a physician who has contractually

accepted the terms and conditions as set forth by the health plan.

participation - the number of employees enrolled for medical coverage, usually identified as a percentage relative to the total eligible population. A 75% participation requirement means that at least 75% of eligible employees must enroll for coverage. Participation requirements also apply to eligible dependent units.

payer - a public or private organization that pays for or underwrites coverage for health care expenses.

peer review - the evaluation of quality of total health care provided, by medical staff with equivalent training.

peer review organization (PRO) - an entity established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) to review quality of care and appropriateness of admissions, readmissions and discharges for Medicare and Medicaid. These organizations are held responsible for maintaining and lowering admission rates, and reducing lengths of stay while insuring against inadequate treatment. Also known as *professional standards review organization*.

per contract per month (PC/PM) - the dollar amount related to each effective contract holder, subscriber or member for each month. (PS/PM - per subscriber per month). (PM / PM - per member per month).

per member per month (PM/PM) - the unit of measure related to each effective member for each month the member was effective. The calculation is: # of units/member months. (MM).

pharmacy and therapeutics (P&T) committee - an organized panel of physicians from varying practice specialties, who function as an advisory

panel to the plan regarding the safe and effective use of prescription medications. Often comprises the official organizational line of communication between the medical and pharmacy components of the health plan. A major function of such a committee is to develop, manage and administer a drug formulary.

physician - any doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is duly licensed and qualified under the law of jurisdiction in which treatment is received, or as defined in the summary plan description.

physician contingency reserve (PCR) - the "at-risk" portion of a claim that is deducted and withheld by the health plan before payment is made to a participating physician as an incentive for appropriate utilization and quality of care. This amount - for example, 20% of the claim - remains within the plan and is credited to the doctor's account. The PCR can be used in instances where the plan needs additional funds to pay for claims. The withhold may be returned to the physician in varying levels which are determined based on analysis of his/her performance or productivity compared against his/her peers. Also called *withhold*.

physician-hospital organization (PHO) - a legal entity formed and owned by one or more hospitals and physician groups in order to obtain payer contracts and to further mutual interest. Physicians maintain ownership of their practices while agreeing to accept managed care patients under the terms of the PHO agreement. The PHO serves as a negotiating, contracting and marketing unit. See *integrated delivery system*.

Physician Payment Review Commission (PPRC) - a bipartisan congressional advisory group established in 1986 to advise Congress on setting Medicare and Medicaid reimbursement.

In 1990, PPRC's responsibilities were expanded to include other payment policy issues.

Physician's Current Procedural Terminology (CPT) - a list of medical services and procedures performed by physicians and other providers. Each service and / or procedure is identified by its own unique 5-digit code. CPT has become the health care industry's standard for reporting of physician procedures and services, thereby providing an effective method of nationwide communication.

place of service - the location where health services are rendered (e.g., office, home, hospital, etc.).

point-of-service (POS) plan - a health plan allowing the covered person to choose to receive a service from a participating or nonparticipating provider, with different benefit levels associated with the use of participating providers. Point-of-service can be provided in several ways:

- an HMO may allow members to obtain limited services from non-participating providers;
- an HMO may provide non-participating benefits through a supplemental major medical policy;
- a PPO may be used to provide both participating and non-participating levels of coverage and access; or
- various combinations of the above may be used.

pool (risk pool) - a defined account (e.g., defined by size, geographic location, claim dollars that exceed "x" level per individual, etc.) to which revenue and expenses are posted. A risk pool attempts to define expected claim

liabilities of a given defined account as well as required funding to support the claim liability.

pooling - the process of combining risk for all groups or a number of groups.

practice guidelines - systematically developed statements on medical practice that assist a practitioner and a patient in making decisions about appropriate health care for specific medical conditions. Managed care organizations frequently use these guidelines to evaluate appropriateness and medical necessity of care. Terms used synonymously include practice parameters, standard treatment protocols and clinical practice guidelines.

pre-admission certification (PAC) - a review of the need for inpatient hospital care, done prior to the actual admission. Established review criteria are used to determine the appropriateness of inpatient care.

pre-certification review - see *utilization review*.

pre-existing condition (PEC) - any medical condition that has been diagnosed or treated within a specified period immediately preceding the covered person's effective date of coverage under the master group contract.

preferred provider organization (PPO) - a program in which contracts are established with providers of medical care. Providers under such contracts are referred to as preferred providers. Usually, the benefit contract provides significantly better benefits (fewer copayments) for services received from preferred providers, thus encouraging covered persons to use these providers. Covered persons are generally allowed benefits for non-participating providers' services, usually on an indemnity basis with significant copayment. A PPO arrangement can be insured or self-funded. Providers may be,

but are not necessarily, paid on a discounted fee-for-service basis.

preferred providers - physicians, hospitals, and other health care providers who contract to provide health services to persons covered by a particular health plan. See also *preferred provider organization*.

premium - the amount paid to a carrier for providing coverage under a contract. Premiums are typically set in coverage classifications such as: individual, two-party and family; employee and dependent unit; employee only, employee and spouse, employee and child, and employee, spouse and child.

prescription medication - a drug which has been approved by the Food and Drug Administration and which can, under federal or state law, be dispensed only pursuant to a prescription order from a duly licensed physician.

preventive care - comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination, immunization and well person care.

primary care - basic or general health care, traditionally provided by family practice, pediatrics and internal medicine. See also *secondary care* and *tertiary care*.

primary care network (PCN) - a group of primary care physicians who have joined together to share the risk of providing care to their patients who are covered by a given health plan.

primary care physician (PCP) - a physician the majority of whose practice is devoted to internal medicine, family/general practice and pediatrics. An obstetrician/gynecologist may be considered a primary care physician.

primary coverage - under coordination of benefit rules, the coverage plan which considers and pays its eligible expenses without consideration of any other coverage.

principal diagnosis - the condition established after study to be mainly responsible for the patient's seeking health care services from a provider. Commonly refers to the condition most responsible for a patient's admission to the hospital.

prior authorization - the process of obtaining prior approval as to the appropriateness of a service or medication. Prior authorization does not guarantee coverage.

professional review organization (PRO) - a physician-sponsored organization charged with reviewing the services provided patients. The purpose of the review is to determine if the services rendered are medically necessary; provided accordance with professional criteria, norms and standards; and provided in the appropriate setting.

Prospective Payment Assessment Commission (ProPac) - a federal commission established under the Social Security Act amendments of 1983 to advise and assist Congress and the Department of Health and Human Services in maintaining and updating the Medicare prospective payment system.

prospective rating - see *adjusted community rating*.

prospective reimbursement - any method of paying hospitals or other health care providers for a defined period (usually one year) according to amounts or rates of payment established in advance.

provider - a physician, hospital, group practice, nursing home, pharmacy or any individual or

group of individuals that provides a health care service.

-Q-

qualified Medicare beneficiary (QMB) - a person whose income falls below 100% of federal poverty guidelines, for whom the state must pay the Medicare Part B premiums, deductibles and copayments.

quality assurance - a formal set of activities to review and affect the quality of services provided. Quality assurance includes quality assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative and support services.

quality improvement - a continuous process that identifies problems in health care delivery, tests solutions to those problems and constantly monitors the solutions for improvement.

-R-

rate - the amount of money per enrollment classification paid to a carrier for medical coverage. Rates are usually charged on a monthly basis.

rating process - the process of evaluating a group or individual to determine a premium rate in regard to the type of risk it presents. Key components of the rating formula are the age/sex factor, location, type of industry, base capitation factor, plan design, average family size and the administration allowance.

RBRVS - see *Resource Based Relative Value Scale*

reasonable and customary (R&C) - a term used to refer to the commonly charged or prevailing fees for health services within a

geographic area. A fee is considered to be reasonable if it falls within the parameters of the average or commonly charged fee for the particular service within that specific community.

rebate - a monetary amount that is returned to a payer from a prescription drug manufacturer based upon utilization by a covered person or purchases by a provider.

recidivism - the frequency of the same patient returning to the hospital for the same presenting problems. Refers to inpatient hospitalization.

referral - the recommendation by a physician and/or health plan for a covered person to receive care from a different physician or facility.

referral provider - a provider that renders a service to a patient who has been sent to him/her by a participating provider in the health plan.

reinsurance - insurance purchased by an HMO, insurance company, or self-funded employer from another insurance company to protect itself against all or part of the losses that may be incurred in the process of honoring the claims of its participating providers, policy holders, or employees and covered dependents. Also called *risk control insurance or stop-loss insurance*.

renewal - continuance of coverage under a policy beyond its original term by the acceptance of a premium for a new policy term.

report card on health care - an emerging tool that can be used by policy makers and health care purchasers, such as employers, government bodies, employer coalitions and consumers, to compare and understand the actual performance of health plans. The tool provides health plan performance data in major areas of accountability, such as health care quality and utilization; consumer satisfaction;

administrative efficiencies and financial stability; and cost control.

reserve - see *physician contingency reserve*.

reserves - funds for incurred but not reported health services or other financial liabilities. Also refers to deposits and/or other financial requirements that must be met by an entity as defined by various state or federal regulatory authorities.

Resource Based Relative Value Scale (RBVS) - a fee schedule introduced by HCFA to reimburse physicians' Medicare fees based on the amount of time and resources expended in treating patients, with adjustments for overhead costs and geographical differences.

retention - that portion of the cost of a medical benefit program which is kept by the insurance company or health plan to cover internal costs or to return a profit. Can also be referred to as *administrative costs*.

retrospective rate derivation (retro) - an addendum to insurance coverage that provides for risk sharing, with the employer being responsible for all part of that risk. The employer can be at risk for a pre-negotiated percentage of the group's health care cost in excess of total premium dollars paid by the employer during the contract year. The carrier may also be required to refund to the employer a pre-negotiated percentage of premium dollars paid if actual health care costs of the group are less than the premium dollars paid during the contract year.

retrospective review - determination of medical necessity and/or appropriate billing practice for services already rendered.

risk analysis - the process of evaluating expected medical care costs for a prospective group and determining what product, benefit

level and price to offer in order to best meet the needs of the group and the carrier.

risk contract - an agreement between the HCFA and an HMO or competitive medical plan requiring the HMO to furnish at a minimum all Medicare covered services to Medicare eligible enrollees for an annually determined, fixed monthly payment rate from the government and a monthly premium paid enrollee. The HMO is then liable for services regardless of their extent, expense or degree.

risk control insurance - See *reinsurance*.

risk pool - See *pool*.

-S-

sanction - a reprimand, for any number of reasons, of a participating provider.

second opinion - an opinion obtained from an additional health care professional prior to the performance of a medical service or a surgical procedure. May relate to a formalized process, either voluntary or mandatory, which is used to help educate a patient regarding treatment alternatives and/or to determine medical necessity.

secondary care - services provided by medical specialists, such as cardiologists, urologists and dermatologist, who generally do not have first contact with patients. See also *primary care* and *tertiary care*.

secondary coverage - the plan that has the responsibility for payment of any eligible charges not covered by the primary coverage. See also *coordination of benefits*.

Section 125 plan - a term used to refer to flexible benefit plans. The reference derives from the section of the IRS code which defines such plans and stipulates that employee

contributions to such plans may be made with pre-tax dollars.

self-funding, self-insurance - a health care program in which employers fund benefit plans from their own resources without purchasing insurance. Self-funded plans may be self-administered, or the employer may contract with an outside administrator for an administrative services only (ASO) arrangement. Employers who self-fund can limit their liability via stop-loss insurance on an aggregate and/or individual basis.

service area - the geographic area serviced by the health plan as approved by state regulatory agencies and/or as detailed in the certification of authority.

sickness - physical illness or disease, or pregnancy (does not include mental illness).

single carrier replacement - the process by which a purchaser of group health care coverage covers all eligibles through one carrier and drops all other carriers.

single-payer system - a health care financing arrangement in which money, usually from a variety of taxes, is funneled to a single entity (usually the government) which then is responsible for the financing and administration of the health system. Single payer systems can be regional, statewide or nationwide.

skilled nursing facility (SNF) - a facility, either freestanding or part of a hospital, that accepts patients in need of rehabilitation and medical care that is of a lesser intensity than that received in a hospital.

small group pooling - combining all or segments of small group businesses into a pool or pools. Expected claims, and therefore premium rates, are determined by pool and not

on a group-specific basis. See also *pool* and *pooling*.

staff model HMO - a health care model that employs physicians to provide health care to its members. All premiums and other revenues accrue to the HMO, which compensates physicians by salary and incentive programs.

standard benefit package - a set of specific health care benefits that would be offered by deliver systems. Benefit packages could include all or some of the following: preventive care; hospital and physician services; prescription drugs; limited mental health and chemical dependency services; and long-term care.

standard class rate (SCR) - a base revenue requirement on a per member or per employee basis, multiplied by group demographic information to calculate monthly premium rates.

standard prescriber identification number (SPIN) - under development by the National Council of Prescription Drug Programs in conjunction with other professional organizations, this standard number could be used to identify prescribers.

stop-loss insurance - insurance coverage taken out by a health plan or self-funded employer to provide protection from losses resulting from claims greater than a specific dollar amount per covered person per year (calendar year or illness-to-illness). Types of stop-loss insurance:

1. Specific or individual - reimbursement is given for claims on any covered individual which exceed a predetermined deductible, such as \$25,000 or \$50,000.00
2. Aggregate - reimbursement is given for claims which in total exceed a predetermined level, such as 125% of the amount expected in an average year. See also *reinsurance*.

subrogation - a procedure under which an insurance company can recover from third parties the full or some proportionate part of benefits paid to an insured. For example, should a claimant who has received benefits under a state's statutory plan covering disability benefits enter into litigation or make claim against a third party, the insurance carrier has a right to place a lien against any benefit the third part action may provide.

subscriber - the person responsible for payment of premiums or whose employment is the basis for eligibility for membership in an HMO or other health plan.

subscriber contract - a written agreement, which also may be called a subscriber certificate or a member certificate, describing the individual's health care policy.

substance abuse - the taking of alcohol or other drugs at dosages that place a person's social, economic, psychological and physical welfare n potential hazard, or endanger public health, morals, safety or welfare, or a combination thereof. Also called *chemical dependency*.

summary plan description - a description of the entire benefits package available to an employee as required to be given to persons covered by self-funded plans.

superbill - a modified claim form that lists specific and/or specialty medical services provided by a physician. A superbill is not acceptable in place of the standard AMA form. See also *claim*.

supplemental services - optional services that a health plan may cover or provide in addition to its basic health services.

surgi-center - see *free-standing outpatient surgical center*.

-T-

table rates - see *age/sex rates*.

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) - the federal law which created the current risk and cost contract provisions under which health plans contract with HCFA and which defined the primary and secondary coverage responsibilities of the Medicare program.

termination date - the date that a group contract expires; or, the date that a subscriber and/or covered person ceases to be eligible.

tertiary care - those health care services provided by highly specialized providers such as neurosurgeons, thoracic surgeons and intensive care units. These services often require highly sophisticated technologies and facilities.

therapeutic alternatives - drug products containing different chemical entities but which should provide similar treatment effects, the same pharmacological action or chemical effect when administered to patients in therapeutically equivalent doses.

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third party administrator (TPA) - an independent person or corporate entity (third party) that administers group benefits, claims and administration for a self-insured company/group. A TPA does not underwrite the risk.

third party payer - a public or private organization that pays for or underwrites

coverage for health care expenses or another entity, usually an employer (examples: Blue Cross, Blue Shield; Medicare; Medicaid; commercial insurers).

treatment facility - a residential or non-residential facility or program licenses, certified or otherwise authorized to provide treatment of substance abuse or mental illness pursuant to the law or jurisdiction in which treatment is received.

trend factor - the rate at which medical costs are changing due to such factors as prices charged by medical care providers, changes in the frequency and pattern of utilizing various medical services, cost shifting and use of expensive medical technology.

trekking - a calculation used to predict future utilization of a group based on past utilization by applying a trend factor.

triage - the classification of sick or injured persons according to severity in order to direct care and ensure the efficient use of medical and nursing staff and facilities.

triple option - a type of health plan in which employees may choose from an HMO, PPO or indemnity plan, depending on how much they are willing to contribute to cost. See also *multiple option plan*.

trust fund - an organization established to control, invest and otherwise administer moneys, securities or other property for the benefit of others. The fund is operated under the guidance of a trust agreement by trustees whose fiduciary responsibility requires a prudent, successful administration of the funds' purpose. Most common to the group health field are those created by unions for the benefit of their members and by trade associations for the benefit of the employees of association members.

turnaround time (TAT) - the measure of a process cycle from the date a transaction is received to the date completed. (For claims processing, the number of calendar days from the date a claim is received to the date paid.)

-U-

unbundling - separately packaging units that might otherwise be packaged together. For claims processing, this includes providers billing separately for health care services that should be combined according to industry standards or commonly accepted coding practices. Also refers to the practice of providing separate prices and administrative support for services such as prescription drug benefit management, mental health/substance abuse services and utilization review.

underwriting - a review of prospective and renewing cases for appropriate pricing, risk assessment and administrative feasibility.

Uniform Billing Code of 1992 (UB-92) - a revised version of the UB-82, a federal directive requiring a hospital to follow specific billing procedures, itemizing all services included and billed for on each invoice, which was implemented October 1, 1993.

upcoding - in claims submission, using a higher level procedure coded than the level of service actually provided.

URAC accreditation - verification that a utilization review organization meets national utilization review standards for prospective and concurrent review services.

URAC Standards - national utilization review guidelines developed by URAC's member organizations and used to evaluate utilization review organizations for accreditation.

urgency-center - see *free-standing emergency medical service center*.

usual, customary and reasonable (UCR) - see *reasonable and customary*.

utilization - the extent to which the members of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time. Usually expressed as the number of services used per year or per 100 or 1,000 persons eligible for the service.

utilization management (UM) - a process of integrating review and case management of services in a cooperative effort with other parties, including patients, employers, providers, and payers.

utilization review (UR) - a formal assessment of the medical necessity, efficiency, and/or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis.

Utilization Review Accreditation

Commission (URAC) - a Washington-based, not-for-profit corporation formed in 1990 and dedicated to improving the quality of utilization review in the health care industry by providing a method of evaluation and accreditation of utilization review programs.

-V-

voluntary formulary - see *drug formulary*.

-W-

withhold - see *physician contingency reserve*.

workers compensation - a state-governed system designed to address work-related injuries. Under the system, employers assume the cost of medical treatment and wage losses arising from a worker's job-related injury or

disease, regardless of who is at fault. In return, employees give up the right to sue employers, even if injuries stem from employer negligence.

wrap-around coverage or combination coverage - see *point of service plan*.

Workgroup for Electronic Data Interchange (WEDI) - a task force formed in 1991 by the Secretary of Health and Human Services to develop recommendations for government and industry relating to the advancement of electronic data in health care. WEDI's steering committee consists of senior executives from more than 25 insurance and health care organizations.

-X-

-Y-

-Z-