Glossary of Terms

401(k) is a method that employees can use to put money aside for their retirement. Generally, taxes on this money are deferred until age 59 ½. Employers can sometimes contribute/match a portion of the employee's contribution.

403(b) is similar to a 401(k), however it is only for nonprofit companies.

A

ACR – See Adjusted Community Rating.

Acute Care is 1) the name of services patients receive in hospitals (inpatient) rather than outpatient (ambulatory) care, or 2) this term is used to describe the American healthcare system because it focuses on inpatient procedures and illness care rather than on primary, preventive or wellness care.

AD&D is an acronym for accidental death and dismemberment insurance.

Adjusted Community Rating (ACR) is the community rating modified by group-specific demographics combined with local experience.

Administrative Services Only (ASO) refers to the management services provided by a third party for an employer group that is at risk for the cost of healthcare services. Management services may include claim payments, medical management services and/or network access – a common arrangement when an employer sponsors a self-funded health benefit program. Also see Third-Party Administrator and Self-Funded/Self-Insured.

Admission is the formal acceptance of a patient into a hospital or other institution for the purposes of providing care.

Adverse Selection is a situation in which the groups of people in one health plan may have a greater than average need for services than the local population. Adverse selection makes one plan have higher costs than plans that don't have these groups. Farming is a dangerous occupation and too many farmers can give a plan the risk of higher costs than plans without many farmers. Age and poverty are other factors that can cause adverse selection. Also see Cherry Picking.

Advocate is a person in the healthcare system who speaks for the patient and who makes certain that the patient receives the necessary services.

Allowed Charges are the costs that an insurance carrier deems as "reasonable and customary" for that particular service. Depending upon the plan, the carrier may pay some or all of the allowed amount. Also see Reasonable and Customary Charges.

ALOS – See Average Length of Stay.

Ambulatory Care refers to healthcare services that do not require overnight or inpatient care. Ambulatory care can refer both to a service and to a facility that provides such a service such as an ambulatory surgery center. Sometimes called Emergency Care or Outpatient Care.

Appeal Process usually refers to a request submitted by a member, which asks the carrier to reconsider a claim or other decision. Sometimes called a Grievance.

ASO – See Administrative Services Only.

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Average Length of Stay (ALOS) is the average number of days in an inpatient facility for each admission. The formula is number of inpatient days divided by number of admissions.

B

Balance Billing is the provider practice of billing the patient for the difference (or balance) between what the service costs are and what insurance pays, even if that cost is above the "reasonable and customary" rate. In some cases, it is incorrect for the provider to balance-bill a member.

Balanced Budget Act of 1997 – See the Tax Equity and Fiscal Responsibility Act of 1982 (TERFA).

Beneficiary is the named person to receive benefits first under a life insurance policy.

Benefits are the specific services members are entitled to use in their insurance plan. Benefits may be flexible benefits from which employees and their families may choose the types of coverage they want, or they can be more standard benefits that employers buy and offer to their employees.

Benefit Summary is an outline (usually only one or two pages long) of the benefits included in a carrier's plan, including a list of the copayments, coinsurance and deductibles involved for each kind of service (hospital services, radiology, etc.). It is provided to the member.

Birthday Rule refers to a rule that applies to dependents who have more than one insurance plan. For instance, if a child has insurance through both parents, and his mother's birthday month (April) appears earlier than his father's (September), the child's primary insurance plan would be under his mother and his secondary insurance plan would be under his father. Also see Primary Coverage and Secondary Coverage.

Blue Cross/Blue Shield is a large health and dental insurance carrier. Formed in the 1930s, they were initially exempt from federal taxes and insured everyone regardless of health status. Their tax status and enrollment policies have evolved over the years. They are separate organizations, and have different benefits, premiums and policies.

Board-Certified means a physician has passed the national examinations in a particular field such as anesthesiology, radiology or internal medicine.

Board-Eligible means a physician has applied for board certification and is awaiting a decision by the certification board.

C

Cafeteria Plan refers to a program in which the employer allots a certain amount of money to employees, who may use it for health insurance or other needs. If the employee exceeds the given amount, the employee usually pays the difference through payroll deductions.

Cap – See Capitation.

Capitation is a fixed fee established to cover the costs of healthcare delivered to a person. The term often refers to a negotiated per capita rate to be pre-paid, usually monthly, to a healthcare provider. It often includes a mechanism that sets an upper limit on the risk assumed by the 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 carrier-provider contract. Sometimes called Cap for short. Also see Contract.

Carrier is another word for insurance company. Also called Insurer or Payor.

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Carryover – See Deductible Carryover.

Case Management is the process of having a patient's healthcare needs coordinated by using an ongoing plan. Case management started with the elderly who have both social and healthcare needs that are usually managed by a social worker or nurse. Case management's role in healthcare is evolving and may mean different things to the AIDS and developmental disability communities than to the aging and long-term care communities. Case management is often confused with discharge planning, which is a one-time-only plan, not a continuous relationship.

Centers for Medicare and Medicaid Services (CMS) is the federal agency that manages Medicare and Medicaid. Until 2001, it was known as Health Care Financing Administration (HCFA).

Certificate of Authority (COA) is a certificate issued by a state government licensing the operation of a health maintenance organization (HMO).

Certificate of Coverage (COC) is a general description of the benefits included in a carrier's plan. It does not include specific information (such as copayment amounts) like a benefit summary does. It is supplied to the member, and it is also called a plan design manual or member certificate.

Certificate of Creditable Coverage is a certificate issued by a member's former insurance plan that verifies the length of creditable coverage for purposes of shortening or eliminating an exclusionary period on a new insurance plan.

Cherry Picking is the practice of insurance companies taking only those businesses, companies or individuals that have good health risks, and avoiding business or people that have higher health risks. Also called Skimming.

Chronic Care is the services for people with chronic illnesses and includes services that are often not directly medical or health-related, such as help in cooking, taking medications and bathing. Sometimes called Custodial Care.

Chronic Illness is a condition that will not improve, that last a lifetime, or reoccurs and may result in long-term care needs. Chronic illnesses include Alzheimer's disease, diabetes, epilepsy and some mental illnesses.

Claims are bills for services. Claims are usually sent by physicians, hospitals, labs and other providers to carriers, but can also be sent to the carrier by the member when the member is seeking reimbursement.

CMS – See Centers for Medicare and Medicaid Services.

CMS 1500 is the universal claim form providers use when billing professional fees to health carriers. Formerly called the HCFA 1500.

COA – See Certificate of Authority.

COB – See Coordination of Benefits.

COBRA is a federal law that requires certain employers to offer continued health, dental and vision insurance coverage to certain employees and their dependents whose group insurance coverage has been terminated. Typically, it makes continued coverage available for up to 18 months. COBRA enrollees are required to pay 100% of the premium, plus an additional 2% service fee (the fee is optional for employers). COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA only applies to groups with 20 or more employees. For those groups with fewer employees, some states (including New Jersey) have laws that allow for continuation of coverage.

COC – See Certificate of Coverage.

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Code Creep describes billing for more severe services than were actually provided and for which a higher payment is received. Also called Upcoding.

Coinsurance is the share of insurance premiums that is paid by the employee after meeting his/her deductible. For example, if a plan specifies coinsurance for lab services, the carrier might pay 90% of the allowed amount, while the member might only be responsible for the remaining 10%.

Community Rating calculates the use of healthcare services by all the people in a given community or defined geographic region, and premiums are based on the expected use and costs of services by all people in that area. This practice is no longer used by most health and dental insurance carriers in New Jersey. Instead, insurance rates are based on the specific health status, occupation, age and sex of the employees in a particular company. Also see Rating, and Community Rating by Class.

Community Rating by Class (CRC) is the practice of community rating affected by a group's specific demographics. Also known as factored rating. Also see Community Rating.

Contract can refer to the written agreement between a company and a carrier (see Group Contract), or between a provider and a carrier (also see Capitation).

Coordination of Benefits (COB) is a provision in a contract that applies when a person is covered under more than one insurance plan. It requires that payments of benefits will be coordinated by all plans to eliminate duplication of payments. It also determines which plan pays first (primary coverage) and which pays second (secondary coverage).

Copay – See Copayment.

Copayment is the patient's part of the bill which he/she pays at the time of service. Copayments are usually flat fees for a particular service, such as $10 for a regular doctor visit or $15 for generic prescriptions. Sometimes called Copay for short.

Core Coverage usually refers to a member's medical plan and sometimes his/her prescription plan. Also see Non-Core Coverage.

Coverage means that the person has private insurance through their employer or as an individual, or public insurance with Medicaid, Medicare, or other public programs. Coverage stems from the meaning that the person's healthcare costs will be paid either by insurance or by the government.

CPT Code is a list of services and procedures performed by physicians and other healthcare providers. Each service is identified by its own unique five-digit code. CPT coding has become the healthcare industry's standard for reporting physician's services. CPT stands for Physician's Current Procedural Terminology. Also called simply a Procedure Code.

CRC – See Community Rating by Class.

Credentialing is the review process on healthcare providers to examine their license, certification, evidence of malpractice insurance and history, and includes information given by the provider as well as by other organizations and individuals.

Credible Coverage is previous insurance coverage that may be applied to shorten or eliminate a member's exclusionary period for a pre-existing condition. In terms of health insurance, most types of health insurance, including group health plans, COBRA coverage, HMO, individual health insurance policies, Medicaid and Medicare, are considered creditable coverage.

Custodial Care is a type of long-term care that is often called personal care. Custodial care is basic care for someone with a terminal or chronic illness who cannot take care of his/her personal needs such as

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eating or dressing. It does not include medical care. It refers to care for people who cannot care for themselves because of debilitating illnesses such as Alzheimer's Disease.

D

Date of Hire usually refers to the date on which an employee began full-time employment.

Date of Service is the date on which services were first provided to the member. For instance, if a person got an X-ray on December 1, 2003, the date of service would be December 1, 2003.

Days Per 1,000 (DPT) is the number of inpatient days per 1,000 health plan members. The formula is: number of inpatient days per month, multiplied by members, divided by 1,000, multiplied by number of months.

DCI – See Duplicate Coverage Inquiry.

Deductible is the money an individual or family must pay from their own funds annually before insurance starts to pay. For example, a member may have to spend an annual deductible of $250 before insurance will pay for certain healthcare services. Usually, the higher the deductible, the lower the monthly premiums.

Deductible Carryover refers to charges applied to the deductible for services during the last three 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.

Deductible Credit is a practice that may occur when a new carrier takes over a plan off-anniversary, in which any portion of the deductible already met would be credited on the plan under the new carrier. For example, let's say the old plan's anniversary is January 1, and the new plan begins June 1. The employee has a $1,000 deductible on the old plan and has already met $500 of it. Let's say he has a $1,000 deductible on the new plan as well. In this case, the new carrier would apply a $500 deductible credit.

Dependent – See Eligible Dependent.

Diagnosis Code – See ICD-10 Code.

Diagnosis Related Group (DRG) is a system of classification for inpatient hospital services based on principal diagnosis, secondary diagnosis, surgical procedures, age, gender and presence of complications. This system of classification is used as a financing mechanism to reimburse hospital and other selected providers for services rendered, typically based on the average costs of all patients with the DRG.

Diagnostic Test is an examination or procedure used to determine a person's particular illness, disease or condition, such as a urine test for pregnancy.

Direct Access – See Open Access.

DME – See Durable Medical Equipment.

DPR – See Drug Price Review.

DPT – See Days Per 1,000.

DRG – See Diagnosis Related Group.

Drug Price Review (DPR) is the weekly update of drug prices, at average wholesale price, from the American Druggist Blue Book. Price maximums are subsequently established by the plan.

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Drug Use Evaluation (DUE) is a qualitative evaluation of prescription drug use, physician prescribing patterns or patient drug utilization to determine the appropriateness of drug therapy.

Drug Utilization Review (DUR) is a quantitative evaluation of prescription drug use, physician prescribing patterns or patient drug utilization to determine the appropriateness of drug therapy.

DUE – See Drug Use Evaluation.

Duplicate Coverage Inquiry (DCI) is a request by a carrier to another carrier to determine if other coverage exists for the purpose of coordination of benefits. Also see Coordination of Benefits.

DUR – See Drug Utilization Review.

Durable Medical Equipment (DME) is medical equipment that can withstand repeated use, is not disposable, is used to serve a medical purpose, is generally not useful to a person in the absence of a sickness or injury, and is appropriate for use in the home. Examples include hospital beds, wheelchairs and oxygen equipment. Certain kinds of DME are covered under certain plans.

E

EAP – See Employee Assistance Program.

EDI – See Electronic Data Interchange.

Effective Date – The date on which coverage begins (enrollment effective date) or ends (termination effective date).

Elective is a healthcare procedure that is not an emergency and that the patient and doctor plan in advance, such as knee replacement or prostate surgery.

Electronic Data Interchange (EDI) is the computer-to-computer exchange of business or other information between two organizations or trading partners. The data must be in either a standardized or proprietary format.

Eligibility Date – The date on which a member becomes eligible for benefits.

Eligible Dependent is a dependent of the policyholder, such as a spouse or a child under a certain age, who is eligible to be enrolled in an insurance plan.

Eligible Employee is an employee who has met the required waiting period (if any) and is working the required number of hours per week, according to the requirements of the group's insurance plan.

Emergency Care is defined differently by each carrier. It usually means care that is obtained in time-sensitive or health-threatening situations.

Employee – See Eligible Employee.

Employee Assistance Program (EAP) refers to services designed to assist employees, their family members and employers in finding solutions to workplace and personal problems. The EAP addresses issues that affect employee morale, or an employer's productivity or financial success. 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, or reduce productivity. EAPs also can

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provide the voluntary or mandatory access to behavioral health benefits through an integrated behavioral health program.

Employer Contribution is the money a company pays for its employees' healthcare. How much the company contributes varies widely and can be based on percentage of costs, length of employment, family circumstances or a flat fee.

Enrollee – See Member.

EOB – See Explanation of Benefits.

EOI – See Evidence of Insurability.

EPO – See Exclusive Provider Organization.

ERISA stands for the Employee Retirement Income Security Act of 1974, Public Law 93-406. This law mandates reporting, disclosure of grievance and appeals requirements, and fiduciary standards for group life and health plans. Sponsored by private, but not public employers. Also preempts state benefit mandates and premium tax laws for self-funded group health plans.

Evidence of Insurability (EOI) is proof presented through medical examination and/or through written statements about a person's health. Such information may be used to determine if the person will be subject to any exclusions for a pre-existing medical condition. It is often used to determine the rates for coverage and is usually required for those who apply for excess amounts of group life insurance. Also known as evidence of good health.

Exclusion List is a list of drugs or services that the carrier will not cover. Exclusions often refers to the services required for a patient's pre-existing health condition, such as cancer.

Exclusionary Period is a period of time during which an insurance plan does not cover the cost of care for a pre-existing condition.

Exclusive Provider Organization (EPO) provides coverage for services only from network providers.

Experience Rating is the insurance practice of basing healthcare premiums on the age, sex and health status of employees in a specific company, and the nature of the business of that company. Businesses such as hospitals have higher rates than banks because hospital employees have higher health risks than bank employees. The expected health "experience" of the group determines their anticipated use and therefore the premium levels that are necessary to cover that use.

Experimental Procedures are healthcare services or procedures that: 1) the CMS or the health insurance plans believe are not widely accepted as effective by American healthcare professionals; or 2) have not been scientifically proven to be effective for a particular disease or condition. Experimental procedures are typically not covered by insurance. What constitutes "experimental" varies from carrier to carrier.

Explanation of Benefits (EOB) are forms sent to patients that explain what procedures and services were given, how much they cost, how much is covered by insurance and how much the patient must pay.

F

FAS 106 – See Financial Accounting Standard 106.

Fee-For-Service is based on an insurance company paying hospitals and doctors the fees they set and charge. Fee-for-service equivalency is the basis of most fees set for HMOs, Medicare, Medicaid or PPOs. Fee-for-service rates are the foundation from which other discounted rates are determined.

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Fee Schedule is the list of services and the maximum amount that insurance plans or carriers will be paid for those specific services.

Financial Accounting Standard 106 (FAS 106) is a requirement that employers account for the future expected costs of retiree health coverage as a current liability.

Flexible Spending Account (FSA) is a mechanism by which an employee may pay for eligible dependent care or uninsured healthcare expenses using pre-tax dollars. Through pre-tax payroll deductions, a portion of the employee's salary is set aside and held by the employer for future reimbursement to the employee. Also see Section 125 Plan.

Formulary is the specific list of drugs that an insurance plan will pay for as part of the benefit package. The list, which is different for each carrier, may be frequently reviewed and revised, and may consist of tiers (generic, brand-name, preferred, etc.) which may correspond to copayment amounts. Drugs that are on the exclusion list are not on the formulary. A formulary is sometimes called a Preferred Drug List.

FSA – See Flexible Spending Account.

G

Generic Drugs are drugs that have basically the same chemicals as a brand-name drug and that are often prescribed as a less expensive alternative for patients. Generic drugs must meet FDA standards in order to be on the market.

Grievance usually refers to a complaint submitted by a company or member to a carrier. Sometimes called an Appeal.

Group Contract is the legal description of the specific benefits and services that are covered, by whom, where, under what conditions and other limits to coverage.

Group Insurance is the most common health insurance in the U.S. Over 75% of all health insurance is offered through businesses, union trusts or other groups and associations. To qualify for insurance in these groups, employees usually need to be working full-time. The cost of the insurance is based on the age, sex, health status and occupation of the people in the group, which is why insurance costs vary from one group to another.

Group Plan Administrator – See Plan Administrator.

H

HCFA – See Centers for Medicare and Medicaid Services.

HCFA 1500 – See CMS 1500.

HCPCS stands for the HCFA Common Procedure Coding System. It is a listing of services, procedures and supplies offered by physicians and other providers. HCPCS includes CPT codes, national alphanumeric codes and local alphanumeric codes. The national codes are developed by CMS (formally HCFA) in order to supplement CPT codes. They include physician services not included in CPT, as well as non-physician services such as ambulance, physical therapy and DME. The local codes are developed by local Medicare carriers to supplement the national codes. HCPCS codes are five-digit codes. The first digit is a letter that is followed by four numbers. HCPCS codes beginning with A through V are national; those beginning with W through Z are local.

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HCPP – See Health Care Prepayment Plan.

Health Care Financing Administration – See Centers for Medicare and Medicaid Services.

Health Care Prepayment Plan (HCPP) is a cost contract with the CMS that prepays a health plan a flat monthly fee to provide Medicare-eligible Part B medical services to enrolled members. Members pay premiums to cover the Medicare coinsurance, deductibles and co-payments, plus any additional non-Medicare covered services that the plan provides. The HCPP does not arrange for Medicare Part A services. Eliminated by the Balanced Budget Act effective December 31, 1998, except for plans sponsored by a union or employer.

Health Maintenance Organization (HMO) is an entity that provides, offers or arranges for coverage of designated health services 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 and the National Association of Insurance Commissioners' Model HMO Act, state and federal standards have been established to define and regulate HMO practices. Under the Federal HMO Act, an entity must have three characteristics to call itself an HMO: an organized system for providing healthcare or otherwise assuring healthcare delivery in a geographic area; an agreed upon set of basic and supplemental health maintenance and treatment services; and a voluntarily enrolled group of people.

Health Plan Employer Data and Information Set (HEDIS) is a core set of performance measures managed by the NCQA to assist employers and other purchasers in evaluating health plan performance. Also used by the CMS to monitor quality of care given by managed care organizations.

Health Service Agreement (HSA) is the document, including any related application and addenda, which specifies the benefits, exclusions and other conditions between the health plan and the enrolling group.

HEDIS – See Health Plan Employer Data and Information Set.

HHA – See Home Health Agency.

HIPAA stands for the Health Insurance Portability and Accessibility Act of 1996, a federal law which has a section devoted to protecting the privacy of patients' health information. HIPAA intends to improve the availability and continuity of health insurance coverage that, among other things: places limits on exclusions for pre-existing medical conditions; permits certain individuals to enroll for available group healthcare coverage when they lose other health coverage or have a new dependent; prohibits discrimination in group enrollment based on health status; guarantees the availability of health coverage to small employers and the renewability of health insurance coverage in the small and large group markets; and requires availability of non-group coverage for certain individuals whose group coverage is terminated.

HMO – See Health Maintenance Organization.

Home Health Agency (HHA) is a facility or program licensed, certified or otherwise authorized according to state and federal laws to provide healthcare services in the home.

Home Healthcare is services provided to people in their own homes. Some services are covered by insurance, such as intravenous therapy, but other services may not be covered because they are not medically necessary, such as help dressing, cooking and bathing. Coverage for home healthcare varies from carrier to carrier. Home Health agencies are the organizations that provide these services.

Hospices are facilities or programs for terminally ill people, which include counseling and healthcare services that give the dying patient and the family comfort. Hospice programs are voluntary, and focus on helping the patient and family through the death and dying process rather than prolonging life with additional medical interventions.

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Hospital Alliances are voluntary hospital groups that cut their costs by joining together to purchase services and equipment.

HSA – See Health Service Agreement.

I

ICD-10 Code is short for International Classification of Diseases (10th Edition), a list of diagnostic codes physicians use to specify primary, secondary or other diagnosis to report on claims. The ICD-10 code reports diagnosis, while the CPT code specifies procedures and is used for billing. ICD-10 is also known as the ICD-9 code or Diagnosis Code.

IME – See Independent Medical Evaluation.

Independent Medical Evaluation (IME) is an examination carried out by an impartial healthcare 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 Model HMO (IPA) is a healthcare model that contracts with an entity, which in turn contracts with physicians, to provide healthcare 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 – See Waiting Period.

In-Network refers to services, providers or facilities that are covered within the carrier's benefit package. Providers who are in-network are known as participating providers.

Inpatient is a person who is admitted into a hospital as a patient, or has a physician overseeing healthcare services for at least 24 hours.

Insurer – See Carrier.

Integrated Provider Organization (IPO) is a corporate umbrella for the management of a diversified healthcare delivery system. The system may include one or more hospitals, a large group practice and/or other healthcare operations. Physicians practice as employees of the organization or in a closely affiliated physician group.

IPA – See Individual Practice Association Model HMO.

IPO – See Integrated Provider Organization.

J

JCAHO – See Joint Commission on Accreditation of Health Care Organizations.

Joint Commission on Accreditation of Health Care Organizations (JCAHO) is an independent, private, nonprofit organization that evaluates, sets standards for and accredits hospitals, health plans and other healthcare organizations that provide home care, mental healthcare, ambulatory care and long term care services.

K

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L

Lapse – See Significant Break in Coverage.

Length-of-Stay (LOS) is the number of days that a covered person stayed in an inpatient facility for a single admission.

Living Will is a legal document people use to instruct how they want to be treated if they cannot speak for themselves or cannot communicate about what they want to happen to them. Living wills are most frequently used so hospitals and providers know that a person wants no heroic measures to save his/her life or does not wish to be connected to life support systems.

Long-Term Care (LTC) is care for people who have a chronic disease and need care that is not necessarily medical. Long-term care services were primarily for the elderly, but now refer to care for those who have chronic diseases and disabilities. LTC covers the whole range of services from home care to nursing home care, from social supports to medical care. Long-term care is usually not covered by traditional health insurance.

LOS – See Length-of-Stay.

Loss Ratio is the difference between the money spent on paid claims, incurred claims and administrative expenses, and the money received from individual premiums. It is one measure of a health plan's financial well-being.

LTC – See Long Term Care.

M

MAC – See Maximum Allowable Cost List.

Maintenance Drug is a medication that is taken regularly to treat a long-term condition (i.e., blood pressure medication).

Major Diagnostic Category (MDC) is a clinically coherent grouping of ICD-10-CM diagnoses by major organ system or etiology that is used as the first step in assignment of most diagnosis related groups. MDCs are commonly are used for aggregated DRG reporting.

Malpractice Insurance is insurance that physicians and many other healthcare providers have to protect themselves from lawsuits in the event they are sued by a patient about quality of care, outcomes or negligence. Malpractice insurance is said to be a major cause of high healthcare costs.

Managed Care is an organized system of healthcare services in contrast to the fee-for-service system , which has few rules for the structural use of healthcare services. HMOs are the best known examples of managed care systems. Managed care is also used to describe utilization review systems that require the doctor to have approval from the carrier prior to admitting a patient to the hospital or having a surgical procedure. This is not done necessarily to manage the coordination of patient care, but rather it's done to control hospitalizations and other expensive use of healthcare services and facilities. Some people see managed care as a way to provide cost-effective and efficient care, while others see it as limited choice and access to certain services.

Mandated Benefits are services specified by state legislation, which all health plans in the state must offer. For example, a state legislature may pass a law requiring all health plans in the state to offer substance abuse benefits. In that case, all plans would have to do so to operate in the state. ERISA companies are not subject to state mandated benefits. Mandated benefits are seen as one reason for cost increases.

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Maximum Allowable Cost List (MAC) is a list of specified multi-source prescription medications that will be covered at a generic product price level established by a health 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 price differential for a brand-name product.

MDC – See Major Diagnostic Category.

Medicaid is a means-tested federal program that is jointly managed by the state and federal government. Created in 1965 with Medicare, Medicaid was designed to provide healthcare services for the poor. It now is also the major source of nursing home care for the elderly. The federal government sets general guidelines for cots and services, and the states must meet those minimum requirements. States can also add benefits and raise funding levels.

Medically Necessary describes services required to prevent harm to the patient or an adverse effect on the patient's quality of life. The term is usually used to determine whether or not a procedure or service is covered by insurance.

Medicare is a national program created in 1965 to pay for healthcare services for the elderly (over 65) and for people who have been on social security disability for more than two years. Medicare is the only entitlement program that is not based on disability, income or asset requirements. Medicare has two parts: A and B. Medicare Part A covers inpatient hospital costs and prescription drugs that patients receive in the hospital. Part A is virtually automatic at age 65, financed in large part by employer payroll taxes. Medicare Part B covers outpatient/ambulatory care, is voluntary, and is paid for by taxes and individual payments toward the Part B premium.

Medicare Entitlement is when a qualified person is enrolled in Medicare and is able to submit claims, as opposed to being simply Medicare-eligible (which usually denotes age 65).

Medicare Supplement Policy is a policy that an insurer will pay a policyholder's Medicare coinsurance, deductible and co-payments for Medicare Parts A and B and may provide additional supplemental benefits according to the supplement policy selected. Medicare supplement coverage is state-regulated and insurers may only offer ten predetermined benefit plans, referred to as "A through J." Also called Medigap or Medicare wrap.

Medigap – See Medicare Supplement Policy.

Member is the person who is entitled to services under an insurance plan, such as employees and their dependents. Also called Enrollee or Subscriber.

Member Number is the number by which a member is known in the carrier's computer system. The member number appears on the member's insurance ID card. Depending upon the insurance plan, the member number may be the policyholder's social security number, may have prefixes or suffixes, or may be a unique number that the carrier assigns the member.

N

NAIC – See National Association of Insurance Commissioners.

National Association of Insurance Commissioners (NAIC) is the national group of state officials who regulate insurance practices in each of the states.

National Committee for Quality Assurance (NCQA) is a private, nonprofit organization governed by purchasers of healthcare (employers and government), health plans and consumers, that accredits health plans and develops performance measures known as HEDIS.

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National Drug Code (NDC) is a national classification system for the identification of drugs. Similar to the Universal Product Code (UPC).

NCQA – See National Committee for Quality Assurance.

NDC – See National Drug Code.

Non-Core Coverage usually refers to a member's dental and vision plans. Also see Core Coverage.

Non-Par Provider – See Out-of-Network

Non-Participating Provider – See Out-of-Network. Sometimes called a Non-Par Provider for short.

Non-Preferred Drug is a prescription drug that an insurance plan has determined will have a higher copay than generic or preferred drugs. Sometimes called a non-preferred brand name drug.

O

Open Access is a self-referral arrangement allowing members to see participating physicians for specialty care without a referral from a primary care doctor or authorization from the plan. Typically found in an IPA model health plan. Also called Open Panel or Direct Access.

Open Enrollment Period is the period of time (usually annually) in which an employee who waived his/her initial enrollment opportunity may enroll in the insurance plan. Open enrollments are used to control the rate of change by having limited periods of time during which members can make choices and changes.

Open Panel – See Open Access.

OTC – See Over-the-Counter Drugs.

Outcomes are measures of treatments and their effectiveness in patient care. Outcomes are usually measured in terms of cost, mortality, health status, quality of life and patient function. Outcome measures are the specific criteria used to determine or describe the outcome.

Out-of-Area is coverage for treatment obtained by a covered person temporarily outside the network service area.

Out-of-Network is coverage for treatment obtained from a provider that does not participate in a specific insurance plan's network of providers. Typically, it requires payment of a deductible, and higher co-payments and coinsurance than for treatment from a participating provider. Also see Non-Participating Providers.

Out-of-Pocket Cost refers to the portion of payments required to be paid by the member for deductibles, copayments or non-covered expenses during the contract period. Usually, there is an annual out-of-pocket maximum, beyond which the insurance picks up part or all of the tab.

Outpatient is a person who undergoes care that does not require an overnight stay at a hospital or other healthcare facility. Sometimes called Emergency Care or Ambulatory Care.

Over-the-Counter (OTC) Drugs is a drug that does not require a prescription under federal or state law.

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P

P&T Committee – See Pharmacy & Therapeutics Committee.

PAC – See Pre-Admission Certification.

Paid Claim refers to the money that the insurance plan pays the provider for approved services rendered. It does not include the patient's portion of those services, such as a copayment. Paid claims are only those costs for which the plan is responsible according to the contract between the provider and the plan.

Par Provider – See In-Network.

Participating Provider – See In-Network. Sometimes called Par Provider for short.

Payer – See Carrier.

PCN – See Primary Care Network.

PCP – See Primary Care Physician.

PCR – See Physician Contingency Reserve.

Pharmacy & Therapeutics Committee is sometimes called a P&T Committee. It is an organized panel of physicians and pharmacists from varying practice specialties who function as an advisory panel to the plan regarding the safe and effective use of prescription medications. It 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.

PHO – See Physician-Hospital Organization.

Physician Contingency Reserve (PCR) is 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 remains within the plan and is credited to the doctor's account. The withhold can be used in instances when claims costs exceed the health plan's budget for a particular period. The withhold may be returned to the physician in varying levels determined based on analysis of performance or productivity compared with peers.

Physician-Hospital Organization (PHO) is a group of physicians and/or hospitals who organize to coordinate the delivery of a range of healthcare services to a defined population, or by directly contracting with a self-funded employer group or government program. A PHO may be structured in a variety of forms, including a physician-owned venture, a hospital or hospital system that owns physicians' practices or a partnership between physicians and hospitals. PHOs are sometimes called provider service networks (PSNs).

Plan Administrator is usually the employer or another entity defined in the ERISA summary plan description as the responsible party for plan administration and compliance.

Point of Service (POS) is a health benefit plan allowing the covered person to choose to receive a service from a participating or non-participating provider, with different benefit levels associated with the use of participating providers. Point-of-service can be provided in several ways: (1) an HMO may allow members to obtain limited services from non-participating providers; (2) an HMO may provide non-participating benefits through a supplemental major medical policy; (3) a PPO may be used to provide both participating and non-participating levels of coverage and access; or (4) various combinations of the above.

POS – See Point of Service.

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PPO – See Preferred Provider Organization.

Practice Guidelines are general procedures and suggestions about what is an acceptable range of practice for particular diseases or conditions. Also called practice parameters. Practice guidelines are of increasing interest for malpractice liability, cost and quality of care.

Pre-Admission Certification (PAC) is a review of the need for inpatient hospital care done prior to actual admission. Established review criteria are used to determine the appropriateness of inpatient care. Also see Precertification.

Preauthorization – See Precertification.

Precert – See Precertification.

Precertification is sometimes called a Precert for short, or Preauthorization. It's a review by the carrier that happens before a patient has a certain service (for instance, a CAT scan or surgery) or is prescribed a certain medication to make sure that the service/medication is necessary and appropriate according to their plan. Without this certification, the provider often faces a financial penalty, and sometimes balance-bills the member for the service. Also see Pre-Admission Certification.

Pre-Existing Condition is sometimes called a Pre-X for short. It is any medical condition that has been diagnosed or treated within a specified period immediately preceding the covered person's effective date of coverage. Pre-existing conditions may not be covered for some specified amount of time as defined in the certificate of coverage (usually six to 12 months). If a person has a 63-day or greater lapse of coverage, pre-existing conditions could apply. As a result of HIPAA, an individual can be required to satisfy a pre-existing waiting period only once, as long as they maintain continuous group health plan coverage with one or more carriers.

Preferred Drug is a brand-name prescription drug preferred by an insurance plan when a generic drug is not available. Preferred drugs usually have a higher copay than the generic drugs, and a lower copay than non-preferred drugs.

Preferred Drug List – See Formulary.

Preferred Provider Organization (PPO) is a program that establishes contracts with providers of medical care. Providers under such contracts are referred to as preferred providers. Usually, the benefit contract provides significantly better benefits and lower member cost for services received from preferred providers, thus encouraging covered persons to use these providers. Covered persons generally are allowed benefits for non-participating providers' services, usually on an indemnity basis. A PPO arrangement can be insured or self-funded. Providers may be, but are not necessarily, paid on a discounted fee-for-service basis.

Premium is the money a company or person pays for an insurance plan every month. Premiums vary in cost depending on age, sex, health status, number of people in the family, and other factors.

Preventive Care refers to those services that stress annual check-ups, regular testing, screening for diseases (such as mammograms or blood tests), having childhood immunizations, and other health services that detect diseases early or prevent them from occurring.

Pre-X – See Pre-Existing Condition.

Primary Care is the care provided to a member by his/her primary care physician. Also see Secondary Care and Tertiary Care.

Primary Care Network (PCN) is 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.

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Primary Care Physician (PCP) is a person's main physician – the physician they go to first for their care, especially preventive care. It is a physician, the majority of whose practice is devoted to internal medicine, family/general practice or pediatrics. An obstetrician/gynecologist sometimes is considered a primary care physician, depending on the member's coverage. Some plans require that the member chose a PCP, and go there first to obtain care or to obtain referrals to specialists.

Primary Coverage refers to the insurance plan that considers claims first, when a member has more than one insurance plan. After the primary insurance plan considers the claim, the claim should then be submitted to the secondary plan for consideration.

PRO – See Professional Review Organization.

Procedure Code – See CPT Code.

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

Provider describes people and/or institutions that give health, prescription, dental or vision services, including social workers, physicians, dentists, acupuncturists, hospitals, pharmacists, nurses, radiologists, chiropractors, or any other formal caregiver.

Q

QA – See Quality Assurance.

QMB – See Qualified Medicare Beneficiary.

Qualified Medicare Beneficiary (QMB) is a person whose income falls below federal poverty guidelines, for whom the state must pay the Medicare Part B premiums, deductibles and co-payments.

Qualifying Event is a situation that allows a person who previously declined coverage to enroll themselves or their eligible dependents in an insurance plan. Depending upon the plan, these special situations could include involuntary loss of other coverage, marriage, birth or adoption.

Quality Assurance (QA) is a formal set of activities to review and determine 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. Federal and state HMO legislation typically require plans to have formal quality assurance programs.

R

Rating is the process that determines how much a particular package of benefits will cost and what will be charged (premium) to cover those expected costs for a specific group of people. Rates can be based on such factors as age, sex, occupation, region, type of health plan, health status and other factors. Also see Community Rating, Adjusted Community Rating, and Experience Rating.

Reasonable and Customary Charges is 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. Also see Allowed Charges.

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Referral may be an informal suggestion from one provider for the patient to see another provider, or it may be a formal process within managed care plans by the primary care physicians to specialists, hospitals or other services. When used in a formal environment, having a qualified referral has a direct impact on who pays for the services and how much. A formal referral (a formal "script") is usually a piece of paper that a physician provides the member, certifying that the member needs certain services from another physician (i.e, a specialist) or facility (such as an imaging center). Some plans require the member to obtain a referral from their PCP before going to another provider.

Reinsurance is an added level of insurance that employers, health plans or other groups buy to protect themselves from major losses or catastrophic claims. Also called Stop-Loss Insurance.

Retrospective Rate Derivation is an addendum to insurance coverage that provides for risk sharing, with the employer being responsible for all or part of that risk. The employer can be at risk for a pre-negotiated percentage of the group's healthcare cost in excess of total premium dollars paid by the employer during the contract year. The carrier also may be required to refund to the employer a pre-negotiated percentage of premium dollars paid if actual healthcare costs of the group are less than the premium dollars paid during the contract year. A variation of experience-based pricing.

S

Script is usually a piece of paper from a physician, certifying that the member should obtain certain services from another provider. A prescription slip is an example of a script. Also see Referral.

Secondary Care is the care provided to a member by a specialist. Also see Primary Care and Tertiary Care.

Secondary Coverage refers to the second insurance plan that considers claims, when a member has more than one insurance plan. After the primary insurance plan considers the claim, the claim should then be submitted to the secondary plan for consideration.

Section 125 Plan refers to Section 125 of the IRS Code. Contributions that employees make to these plans can be from pre-tax dollars. An example of this sort of plan is a cafeteria plan. Also see Flexible Spending Account.

Self-Funded/Self-Insured refers to businesses that use their own money to pay for their employees' health insurance claims. Companies or trusts that self-insure typical need to have 100 or more employees to have this option be financially possible. Organizations that self-insure can process their own claims or have that work done by other organization, such as third-party administrators (TPAs). These groups also purchase re-insurance or stop-loss insurance to protect themselves from catastrophic claims. Self insured companies are exempt from state insurance regulations and premium taxes. Also see Administrative Services Only (ASO).

Service Area is the physical area in which an insurance plan has a network established. Some insurers are statewide or national, while others have smaller areas in which they operate.

SIC – See Standard Industry Code.

Significant Break in Coverage is a time period of 63 or more consecutive days during which a person does not have creditable coverage through an insurance plan. A waiting period does not count toward determining this significant break. Also called a Lapse.

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

Skimming – See Cherry Picking.

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SPD – See Summary Plan Description.

Specialist is a physician who specializes in a certain area of medicine or dentistry other than family medicine or general medicine (i.e., cardiologist, oral surgeon, urologist, etc.). Some plans require the member to obtain a referral from their PCP for a specialist visit.

Standard Industry Code (SIC) categorizes the type of industry a business is in, such as retail, banking, farming, etc. Industry codes are important because some occupations have higher risks and therefore higher costs than other occupations. Premiums are in part based on these industry codes.

Stop-Loss Insurance – See Reinsurance.

Subscriber – See Member.

Summary Plan Description (SPD) is a description of the entire benefits package available to an employee as required under ERISA given to people covered by self-funded plans. It is usually distributed to the employer.

T

TAMRA is short for the Technical and Miscellaneous Revenue Act of 1988, the legislative provision which allows the IRS to conduct audits and impose excise taxes on employers for COBRA compliance failures.

Tax Equity and Fiscal Responsibility Act of 1982 (TERFA) is the federal law that created the risk and cost contract provisions under which health plans contracted with HCFA (now CMS), and defined the primary and secondary coverage responsibilities of the Medicare program. Superceded by the Balanced Budget Act of 1997.

Tax Reform Act of 1986 is a piece of federal legislation that concerns the continuation of group health coverage for individuals.

TEFRA – See Tax Equity and Fiscal Responsibility Act of 1982.

Tertiary Care is the care provided to a member by a sub-specialist (a specialty within a specialty, such as neurosurgeons or heart transplant surgeons). Also see Primary Care and Secondary Care.

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

TPA – See Third-Party Administrator.

Triage is the way patients are directed to services based on the severity of the patient's injury or illness. Usually used to refer to catastrophic events, such as disasters or war. Triage also may now refer to using a nurse or other healthcare professional to direct patients, often by phone, to the type of services they need or to answer some questions before seeing a physician.

Turnaround Time is the measure of a process cycle from the date a transaction is received to the date completed. For claims processing, it is the number of calendar days from the date a claim is received to the date paid.

U

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UB-92 – See Uniform Billing Code of 1992.

UCR – See Usual, Customary and Reasonable.

Unbundling is a prohibited practice that some providers use to charge more for services. Within a major operation, for example, are many smaller procedures. In unbundling, the physician might charge for the major operation as well as each particular procedure within the operation in order to gain more payment.

Underinsured refers to people who have some type of healthcare insurance, such as catastrophic care, but not enough insurance to cover all their healthcare costs.

Underwriting is the process that analyzes the health status, claims experience (cost), age and general health risks of the individual or group seeking insurance coverage. This review determines the rate of the monthly premium for most groups or individuals, and whether or not pre-existing condition clauses will be included.

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

Uninsured refers to people who do not have health insurance coverage of any type.

Upcoding – See Code Creep.

Usual, Customary and Reasonable (UCR) refers to what the payer considers 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. What is considered reasonable by one party is not always considered reasonable by another.

Utilization Management is a process of integrating clinical review and case management of services in a cooperative effort with other parties, including patients, employers, providers and payers.

Utilization Review is a formal assessment of the medical necessity, efficiency, and/or appropriateness of healthcare services and treatment plans on a prospective, concurrent or retrospective basis.

V

Veterans Administration is an independent division of the federal government that offers healthcare services to veterans who have been injured in action during wars or have been injured while on active duty. It is separate from the Department of Defense and their military treatment facilities. The Veterans Administration (or VA) includes hospitals, as well as outpatient care and nursing home care.

W

Waiting Period is the time a member must wait before he/she can apply for insurance coverage without having to pass a health screen. The waiting period is sometimes three months from the full-time date of hire. Other times, there’s no waiting period at all. It depends on the member’s particular plan. Also called Initial Eligibility Period.

Waiver usually refers to a form completed by employees who are refusing the offer of insurance.

Workers Comp – See Workers Compensation.

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Workers Compensation is a program paid by employers but managed by states. It covers injuries and work-related health problems of employees. Employers pay taxes to the state, and the state assumes the cost of healthcare and lost wages for work-related injuries. Also called Workers Comp for short.

X

Y

Z

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