A thru Z
GLOSSARY
OF MEDICAL
INSURANCE
AND
MANAGED CARE
TERMS
AAHP  See American Association of Health Plans

Access  A patient’s ability to obtain medical care determined by factors such as the availability of medical services, their acceptability to the patient, the location of health care facilities, transportation, hours of operation, and cost of care.

Accidental Death and Dismemberment Insurance (AD&D)  A form of health and accident insurance that provides payment to an insured’s beneficiary or the insured in the event of death or specific bodily losses resulting from an accident.

Accreditation  Accreditation programs give an official authorization or approval to an organization against a set of industry-derived standards.

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

Accrual  Money set aside to cover expected expenses. The accrual is an estimate of medical expenses based on data from the authorization and claims systems and history.

Actively at Work  A requirement of many insurance 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, and eating. Inability to perform ADLs is the basis of Long Term Care Insurance (see definition).

Actual Acquisition Cost  The pharmacist’s net payment made to purchase a drug product, after taking into account such items as purchasing allowances, discounts, and rebates.

Actual Use Effectiveness  The effectiveness of a product in real-life situations. Actual use effectiveness considers compliance rates, physical condition of the patient, and the side effects associated with the product’s use.
**Actuarial Analysis**  A forecast developed by specialized actuarial methods, giving the probability of future events for a given population, such as life expectancy, frequency of hospitalization, or probability of loss from fire. A common use of such forecast is the calculation of insurance premiums and, for the insurer, the necessary reserves. An Actuarial Analysis provides the district with information on future anticipated costs of benefits by reviewing historical data and current statistics. The District uses this information when creating budgets.

**Actuarial Cost of Coverage**  The expected dollar value of a health plan's benefits. The method of determining this value may be based entirely on a plan's provisions, or may adjust for the geographic location and demographic characteristics of enrollees, the actual health care utilization level by plan participants, or the type of plan under which the benefits are provided. The Actuarial Analysis above is used to determine an Actuarial Cost of Coverage. This cost is used when actual rates are pending.

**Actuary**  A person in the insurance field who decides insurance policy rates and reserves dividends as well as conducts various other statistical studies.

**Acute Care**  Treatment for a short-term or episodic illness or health problem.

**AD&D**  See **Accidental Death and Dismemberment Insurance**

**Additional Drug Benefit List (see also Drug Maintenance List)**  The additional drug benefit list is a catalogue of pharmaceuticals approved by a managed health care plan for dispensing drugs when other than those listed under the benefit package are prescribed.

**Adjudication**  Processing a claim through a series of edits to determine proper payment.

**Adjusted Average per Capita Cost**  The estimated average cost of Medicare benefits for an individual in a particular county. It is based on the following population factors: age, sex, institutional status, Medicaid status, and disability status. The Health Care Financing Administration uses this formula to make monthly payments to risk and cost contractors.

**Adjusted Community Rating**  Also called prospective rating, adjusted community rating is set by group demographics and prior experience in the region. See also **Community Rating**.

**ADLs**  See **Activities of Daily Living**
**Administrative Costs** Costs related to activities such as utilization review, marketing, medical underwriting, commissions, premium collection, claims processing, insurer profit, quality assurance, and risk management for purposes of insurance. Administrative Costs are the charges included in rating for services provided. The rate is made up of anticipated claims costs and the costs that the carrier deems as necessary to provide service to the client.

**Administrative Services Only (ASO)** An arrangement with a third party that provides administrative services, primarily claim adjudication, to an employer-sponsored health plan. This type of arrangement usually requires the employer to be at risk for the cost of health care services provided.

**Admissions** The number of patients placed (admitted) in a hospital or inpatient facility for an overnight stay per given time period.

**Adult Day Care** A range of services, such as health, medical, psychological, social, nutritional, and educational services, provided during the day on a regular basis that allows an adult to live at home rather than in an institution.

**Advanced Practice Nurse (APN)** An umbrella term that describes a registered nurse who has met advanced educational and clinical practice requirements beyond the two to four years of basic nursing education required of all registered nurses.

**Adverse Selection** The tendency of individuals with a higher probability of incurring expenses (high risk) to select the maximum amount of insurance protection while those with lower probability elect lower levels, or decline coverage. A particular health plan, whether indemnity or managed care, is selected against by the high risk enrollee, either due to lower cost or higher service levels, and thus an inequitable proportion of enrollees requiring more medical services are found in that plan. Example: Low enrollee out-of-pocket costs might lure those individuals requiring more health services into an HMO rather than into an indemnity plan because the former does not have a deductible. Therefore, the HMO would have a greater proportion of less healthy enrollees, thereby driving up costs and increasing financial risk.

**Aftercare** Services administered after hospitalization or rehabilitation that are individualized for each patient’s needs.

**Agency for Health Care Policy and Research (AHCPR)** Created by Congress in 1989 to conduct federal research into technology assessment and outcomes management, and to develop practice guidelines for public dissemination. The
AHCPPR is perhaps best known for funding the patient outcomes-based research trials (PORTs) that form the basis for its practice guideline efforts.

**Allied Health Personnel** Trained and licensed health workers other than physicians, dentists, optometrists, chiropractors, podiatrists, and nurses. The term is sometimes used synonymously with paramedical personnel, all health workers who perform tasks that must otherwise be performed by a physician, or health workers who do not usually engage in independent practice.

**Allowable Charge** The maximum fee that a third party will reimburse a provider for a given service.

**Allowable Costs** Items or elements of an institution’s costs that are reimbursable under a payment formula. Allowable costs may exclude, for example, uncovered services, luxury accommodations, costs that are not reasonable, and expenditures that are unnecessary.

**All-Payer Contract** An arrangement allowing for payment of health services delivered by a contract provider regardless of product type (e.g., HMO, PPO, indemnity) or revenue source (e.g., premium or self-funded).

**All-Payer System** A plan that would impose uniform prices on medical services for all payers.

**Alternate Care** Medical care received in lieu of inpatient hospitalization. Examples include outpatient surgery, home health care, and skilled nursing facility care. It also may refer to nontraditional care delivered by providers.

**Alternative Delivery Systems** An expression formerly used to describe all forms of health care delivery systems other than traditional fee-for-service indemnity health care.

**Alternative Funding Devices** Non-traditional funding of insurance programs designed to enhance the cash flow of monies allocated for benefit programs. These include: self-funding, minimum premium programs, retrospective premium arrangements, and 60-90 day premium delays.

**Alternative Medicine** Outside the realm of traditional medical practice, alternative medicine can include such therapies as: acupuncture, holistic medicine, homeopathy, massage therapy, herbal therapy, hypnosis, naturopathy, etc. Increasingly, alternative care providers are being contracted by managed care plans.
**Ambulatory Care**  Health services delivered on an outpatient basis. If the patient makes a trip to the doctor’s office or surgical center without an overnight stay, it is considered ambulatory care.

**Ambulatory Setting**  A type of health care setting where health services are provided on an outpatient basis. Ambulatory settings usually include physicians’ offices, clinics, and surgery centers.

**American Association of Health Plans (AAHP)**  The entity created in 1995 by the merger of the Group Health Association of America and the American Managed Care and Review Association.

**American Society of Health-Systems Pharmacists (ASHP)**  Trade group for pharmacists in hospitals and managed care systems.

**Ancillary Care**  Additional health care services performed, such as lab work and x-rays.

**APN**  See **Advanced Practice Nurse**

**ASHP**  See **American Society of Health-Systems Pharmacists**

**ASO**  See **Administrative Services Only**

**At Risk**  A term used in a number of circumstances in health care to indicate that the risk of a loss is on a particular person or institution. For example, if a managed care organization or insurer is paid a set amount for a particular period of time for health care coverage, the organization or insurer is at risk for health care costs that exceed the amount paid. Capitation contracts put the individual or institution accepting the contract at risk, and the individual institution must absorb any costs or treatment that are more than the value of the contract. See also **Capitation**.

**Average Cost (or Benefit)**  The total cost (or benefit) divided by the total units of output.

**Average Wholesale Price (AWP)**  The average cost of pharmaceuticals charged to a pharmacy provider by a large group of pharmaceutical wholesale suppliers.

**Authorization**  As it applies to managed care, authorization is the approval of care, such as hospitalization. Preauthorization may be required before admission takes place or care is given by non-HMO providers.

---

Keenan & Associates License No. 0451271  05/28/08
Confidential – Client Use Only
Balanced Budget Act of 1997  Included far-reaching changes to the Medicare program, including expanded Medicare managed care options. The Balanced Budget Act created the Medicare+Choice program, changed the way in which health plans are paid for Medicare enrollees, added certain preventive care benefits, finalized and made permanent the Medicare Secondary Payer rules, alters greatly what types of home health services the Medicare program will pay for and how they will be reimbursed, transfers most home health care benefits to Medicare Part B and provides funding to states for the State Children’s Health Insurance Program (known nationally as SCHIP, and in California as Healthy Families.)

Bed Days  A measurement used by managed care plans to indicate the total number of days of hospital care provided to a health plan member.

Behavioral Health Care  Treatment of mental health and/or substance abuse disorders.

Beneficiary  The person(s) designated to receive life and/or accidental death benefits upon the death of an insured.

Benefit Bank  A flexible spending arrangement under which a reimbursement account is established. Reimbursements are made from the account, and the employee is entitled to any remaining amounts at the end of the year.

Benefit Levels  The extent or degree of service a person is entitled to receive based on his or her contract with a health plan or insurer.

Benefit Package  Services an insurer, government agency, health plan, or employer offers under the terms of a contract.

Board Certified  A physician who has passed an examination given by a medical specialty board.
**Board Eligible**  A physician who has graduated from an approved medical school and is eligible to take a specialty board examination.

**Business Associate**  HIPAA Privacy Standards also apply to Business Associates (a person who, on behalf of a Covered Entity, performs or helps with an activity involving the use or disclosure of individually identifiable health information) of Covered Entities, by virtue of a Business Associate Agreement, which is required by the Privacy Standards to be in place between those two parties.

**Business Coalition**  A group of employers who use their pooled resources and leverage to study health benefits and, in some cases, purchase health benefit packages.

---

**Cafeteria Plan**  A benefit plan under which employees are permitted to choose among two or more options that consist of cash and certain tax-qualified benefits. Cafeteria plans are also called flexible benefit plans or flex plans.

**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.

**Capacity**  An organized system’s ability to meet both the demands of routine, scheduled, and after-hours care.

**Capitation**  A per-member, monthly payment to a provider that covers contracted services and is paid in advance of its delivery. In essence, a provider agrees to provide specified services to plan members for this fixed, predetermined payment for a specified length of time (usually a year), regardless of how many times the member uses the service. The rate can be fixed for all members or it can be adjusted for the age and sex of the member, based on actuarial projections of medical utilization. This is a provider term. Certain providers such as family practitioners are given a capitated contract which means no matter how many services the provider performs under the capitated contract the provider will be paid the same set rate. When the provider has a capitated contract, it helps keep plan costs down because the provider will perform
services more efficiently.

**Carrier** A term used to identify the party (insurer) to the group contract that agrees to underwrite (carry the risk) and provide certain types of coverage and service.

**Carve Out** To separately purchase services that are typically part of a managed care package. For example, an HMO may “carve out” the vision care benefit and select a specialized vendor to supply these services on a stand-alone basis.

**Case Management** The process whereby a health care professional supervises the administration of medical or ancillary services to a patient, typically one who has catastrophic disorder or who is receiving mental health services. Case managers are thought to reduce the costs associated with the care of such patients, while providing high-quality medical services.

**Case Manager** An experienced professional (usually a nurse, physician, or social worker) who handles catastrophic or high-cost cases as a member of a utilization management team. Case managers work with patients, providers, and insurers to coordinate all health care services.

**Case Mix** The number and frequency of hospital admissions or managed care services utilized, reflecting the assorted needs and uses of a hospital’s or MCO’s resources.

**CAT Scanner** See Computerized Axial Tomography

**Catastrophic Health Insurance** Insurance beyond basic and major medical coverage for severe and prolonged illness that poses the threat of financial ruin.

**CDHP** See Consumer Directed Health Plan

**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 members access select types of benefits through a specific network of medical centers.

**Certificate of Authority** A certificate issued by a state government, licensing the operation of an HMO or other health plan.

**Certificate of Coverage** A description of the benefits included in a carrier's plan. The certificate of coverage is required by state law and represents the coverage
provided under the contract issued to the employer.

**Certification**  Certification is the official authorization for use of services.

**Chain Pharmacy**  One of a group of pharmacies under the same management or ownership.

**CHAMPUS (Civilian Health and Medical Program of the Uniformed Services)**  See Tricare

**Channeling**  Use of incentives and plan design to encourage members to utilize network providers.

**Chargeback**  An amount of money returned by a pharmaceutical manufacturer directly or through a wholesaler to a health plan after the purchase of pharmaceuticals. A chargeback is essentially a “discount” for the purchase of the pharmaceuticals. It is usually the difference between the average wholesale price of a drug and the price bid by the pharmaceutical manufacturer.

**Charge-Based Payment System**  A system of paying for a health care service (usually a hospital or other facility) on the basis of what the provider furnishing the service usually charges all patients.

**Chemical Dependency Services**  Services and supplies used in the diagnosis and treatment of alcoholism, chemical dependency, and drug dependencies, as defined and classified by the U.S. Department of Health and Human Services.

**Chemical Equivalents**  Those multiple-source drug products containing essentially identical amounts of the same active ingredients, in equivalent dosage forms, and that meet existing physical/chemical standards.

**“Cherry Picking”**  Refers to an insurance plan practice of enrolling only healthy individuals while not accepting individuals with existing health problems.

**Chiropractor**  A nonmedical doctor, licensed by a state board, who deals with the relationship of the nervous system and spinal column in the restoration and maintenance of health.

**Chronic Care**  Care for a patient with a long-term illness.

**Claim**  Information submitted by a provider or 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.

**Claims Clearinghouse System**  A system that allows electronic claims submission through a single source.

**Claim Lag**  The period of time between the date of health services rendered and the date a claim check is issued to reimburse for the cost of service.

**Claims Review**  The method by which an enrollee’s health care service claims are reviewed before reimbursement is made. The purpose of this monitoring system is to validate the medical appropriateness of the provided services and to be sure the cost of the service is not excessive.

**Clinical Outcome**  The state of a patient’s health after receiving medical care.

**Closed Panel**  Medical services are delivered in the HMO-owned health center or satellite clinic by physicians who belong to a specially formed but legally separate medical group that only serves the HMO. This term usually refers to group and staff HMO models.

**CMS (Centers for Medicare and Medicaid Services)**  The federal agency responsible for administering Medicare and overseeing states’ management of Medicaid. (Formerly known as HCFA, the Health Care Financing Administration.)

**COB**  See **Coordination of Benefits**

**COBRA**  See **Consolidated Omnibus Budget Reconciliation Act**

**Coding Systems:**

- **ICD-9 System**  A listing of diagnoses and identifying codes used by hospitals and physicians for reporting diagnoses of health plan enrollees, for purposes of reimbursement. 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.

- **CPT-4 System**  Used to identify physician services, such as injections and surgeries, for purposes of reimbursement.

- **NDC Coding System**  System used by insurers to pay outpatient pharmaceutical claims.

- **HCPCS System**  A Medicare system for identifying a host of services, including injectable drugs, used in physicians’ offices.
Co-insurance The arrangement by which the insurer and the insured share a percentage of covered losses after the deductible is met.

Collective Bargaining A negotiation between organized labor and employer(s) on matters such as wages, hours, working conditions, and health and welfare programs.

Community Rated A rating methodology where premiums are determined by the aggregate of claims experience and utilization practices of all groups participating in an insurance pool or HMO. See also Adjusted Community Rating.

Community Rating by Class A variation of community rating where the basic premium is determined for all groups, but rates vary from group to group, based on differences between groups in the proportions of enrolled persons in various demographic classes. Classes may be defined in terms of age, sex, family status, marital status, or other factors that may be used to predict expected differences in health risk for persons in the various classes.

Competitive Medical Plan A health care plan that has been approved by the federal government to obtain Medicare-risk contracts.

Compliance Refers to capability of voluntarily following the written instructions for using a drug or other prescribed treatment regimen.

Composite Rate or Rating A group premium rate that does not differentiate between single and family coverage.

Comprehensive Care The provision of a broad spectrum of health services that is required to prevent, diagnose, and treat physical and mental illnesses and to maintain health.

Comprehensive Medical Care Plans Health plans that provide a wide range of care, including physicians’ services in the home, in the office or clinic, and in the hospital.

Computerized Patient Record An electronic system that enables practicing physicians and clinical staff to capture, store, and communicate patient medical information.

Computerized Axial Tomography (CAT) Scanner Uses a computer and highly sensitive X-ray detectors to produce extremely accurate three-dimensional pictures of body and brain tissues.
Concurrent Review  A screening method by which a health care provider reviews a procedure or hospital admission performed by a colleague to assess its necessity.

Consolidated Omnibus Budget Reconciliation Act (COBRA)  A federal law that requires employers to offer continued participation in group health insurance coverage for a specified period to employees who have had their health insurance coverage terminated because of a change in employment status and to dependents who have lost dependent status. COBRA allows for an employee who is no longer active under the plan to continue coverage on a self pay basis. Coverage is limited to 18 months. There are qualifying events that will allow for a longer coverage period, however, no longer than 36 months.

Consumer Directed Health Plan (CDHP) is defined as a health plan where consumers determine how and where to spend their health care dollars, incorporating several health care strategies that heighten consumer awareness of the cost and utilization of healthcare services through plan design incentives. Most plans utilize either an HRA or HSA account, combined with an HDHP.

Consultant Pharmacist  A pharmacist who provides pharmacy and clinical services to a long-term care facility. Often, a consultant pharmacist has a community pharmacy practice and offers his or her services to local nursing homes. The services provided include drug regimen review and pharmaceutical care, among others.

Continuous Quality Improvement (see also Total Quality Management)  A cycle of monitoring, evaluation, action, and more monitoring that has the intended effect of continuously raising the level of quality delivered.

Continuum of Care  A range of clinical services provided during a single inpatient hospitalization or for multiple conditions over a lifetime. It provides a basis for evaluating quality, cost, and utilization over the long term.

Contract  An agreement between two or more parties for doing or not doing certain things. A contract of insurance is embodied in a written document usually called the policy.

Contribution  That part of the insurance premium paid by either the policyholder or the insured or both.

Conversion Privilege  A right given to the insured to change group life and/or medical care coverages to a form of individual insurance without medical examination. The conditions under which conversion can be made are defined in the master policy.

Coordination of Benefits (COB)  A method of integrating benefits payable under
more than one group health insurance plan so that the insured’s benefits from all 
sources do not exceed 100% of allowable medical expenses. It is designed to eliminate 
duplicate payments and provide the sequence in which coverage will apply (primary 
and secondary) when a person is insured under two contracts. The NAIC has created 
uniform COB rules which have been adopted by the insurance regulators of most 
states.

**Co-payment**  The flat dollar amount that an insured has to pay under the terms of 
some health care plans regardless of the actual charges for the care given. Thus, an 
insured may be obligated to pay $10 for each visit to a physician, the health care plan 
being responsible for the difference between the actual cost of the visit and the 
copayment by the patient.

**Cost-Based Reimbursement**  A method of paying hospitals for actual costs incurred 
by the patient. Those costs must conform to explicit principles that are defined by 
third-party payers.

**Cost-Benefit Analysis**  An assessment of both costs and outcomes in dollar terms. It 
helps maximize the return on investment made in alternative pharmaceutical products 
and services that provide a variety of outcomes. In cost-benefit studies, recognition of 
who pays the costs and who receives the benefits is significant.

**Cost Containment**  A strategy that aims to reduce health care costs and encourages 
cost-effective use of services.

**Cost Contract**  An agreement between HCFA and a health plan in which 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.

**Cost Effectiveness**  Usually considered as a ratio, the cost effectiveness of a drug or 
procedure, for example, relates the cost of that drug or procedure to the health 
benefits resulting from it. In health terms, it is often expressed as the cost per year per 
life saved.

**Cost-Effectiveness Analysis**  The premise of cost-effectiveness analysis in health-
related decisions is that, for any given level of resources available, the decision maker 
wishes to maximize the aggregate health benefits conferred to the population of 
concern. Alternatively, a given health benefit goal may be set, the objective being to 
minimize the cost to achieve it.
Cost-Minimization Analysis  This pharmacoeconomic technique finds the lowest cost among pharmaceutical alternatives that provide clinically equivalent outcomes.

Cost Sharing  A cost containment technique embodied in health care plans that require the covered individual to bear some portion of the cost of health care beyond the premium payment. The cost-sharing usually takes the form of coinsurance, copayment, or deductibles. These cost-sharing measures are intended to prevent covered individuals from seeking unneeded care, thus containing costs.

Cost Shifting  Policies designed to shift the relative burden of health care costs borne by one party or market segment to another. COBRA, Medicare reductions, increased employee and dependent premiums, deductibles, and co-insurance are examples.

Cost-Utility Analysis  Measures the costs of therapy in dollars. Economists use the term “utility” to refer to the amount of satisfaction a consumer receives from consuming a particular good. Cost-utility analysis, therefore, measures outcomes in terms of patient preference and quality. In contrast, cost-effectiveness analysis measures the total costs of therapy compared to the number of life-years gained. In cost-utility analysis, patient preference for outcomes is considered in the measurement of quality-adjusted life-years. For example, in the analysis of cancer chemotherapeutic agents, since different agents have varied side effects, the quality of life-years gained may vary, even though the number of years is equivalent. The patient’s preference for a shorter duration of symptom-free survival is considered as an alternative to life prolongation, possibly associated with pain, suffering, and dependence on others.

Counter-detailing  The strategy by which pharmacists or other health care professionals discuss with physicians why they should not be prescribing a particular pharmaceutical therapy. This type of physician education is used to alter drug utilization and drug formulary compliance. (Also see Detailing.)

Coverage  A major classification of benefits provided by a group policy (i.e., term life, short-term disability, major medical), or the amount of insurance or benefits stated in the group policy for which an insured is eligible.

Covered Charges  Charges for medical care or supplies which, if incurred by an insured or other covered person, create a liability for the insurer under the terms of a group policy.

Covered Entity  Under HIPAA Privacy Standards, a Covered Entity is defined as health plans, health care providers who transmit health information in electronic form and health care clearinghouses. HIPAA regulates how Covered Entities may use and disclose Protected Health Information (PHI – see definition) – including when a use or disclosure
is required or permitted – and the conditions relating to the use or disclosure. Covered 
Entities' use or disclosure of, or requests for, PHI must consist of only the minimum 
amount necessary to accomplish the intended purpose of the use, disclosure, or request. If 
health information does not meet the definition of Protected Health Information, then 
the Privacy Standards do not apply to that information. See also **HIPAA**.

**Covered Person**  An individual who meets a health plan’s eligibility requirements and 
for whom premium payments are paid for specified benefits of the contract between 
the insurance carrier and a contract holder.

**CPT**  See **Current Procedural Terminology**

**CPT-4 System**  See **Coding System**

**Credentialing**  Examination of a physician’s or other health care provider’s 
credentials to determine whether he or she should be entitled to clinical privileges at a 
hospital or to a contract with an MCO.

**Credentialing Verification Organization**  An external organization that contracts 
with a health plan to handle all provider credentialing requirements. These 
organizations may also be subject to accreditation requisites, according to state 
regulations.

**Critical Pathway**  A health care management tool that suggests the best way to treat a 
disease or use a health care procedure. Critical pathways are designed to reduce 
variations in health care treatments.

**Current Procedural Terminology (CPT)**  A five-digit code that accompanies a list 
of medical services performed by physicians and other providers. (Also see **Coding 
Systems**.)

**Customary Charge**  The typical amount charged by a provider for a particular 
service. Payers typically pay the provider a percentage of this amount.
Data Retrieval  The collection of patient care data from medical records.

Death Benefit  The payment made to a beneficiary at the time of death of an insured.

Decision Tree  The fundamental analytic tool for decision analysis, displaying the temporal and logical sequence of a clinical decision problem. It has three structural components: the alternative actions that are available to the decision maker; the probabilistic events that follow from and affect these actions, such as clinical information obtained or the clinical consequences revealed; and the outcomes for the patient that are associated with each possible scenario of actions and consequences.

Deductible  The amount of covered expenses that must be incurred by the insured before benefits become payable by the insurer.

Defensive Medicine  Changes in practice carried out by health care providers for the sole purpose of avoiding malpractice claims.

Deficit Reduction Act of 1984  Several parts of this legislation impact benefits. In particular, the act forbids most taxable benefits from being offered as a part of a flexible benefits plan. It also requires employers to give employee spouses who are age 65 and above the opportunity to enroll in group health benefit plans as an alternative to Medicare.

DEFRA  See Deficit Reduction Act of 1984

Demand  The amount of health care services a population utilizes.

Demand Management  In its most basic form, the appropriate use of decision and self-management support systems that enable health care consumers to make the best use of medical care. Demand management is information-based in that it recognizes that decision making is often influenced by factors other than information, such as personal experience, societal pressures, and cultural norms.

Dependent  An insured’s spouse (wife or husband), not legally separated from the insured, and unmarried children who meet certain eligibility requirements and who are not otherwise insured under the same group policy. The precise definition of a dependent varies by insurer.

Detoxification  Medical supervision while an individual withdraws from alcohol or other addictive substances.
**Detailing**  Prescription Drug Detailing is the process whereby representatives of drug companies make regular presentations to doctors and others in the medical community to educate them about a drug's activity, uses, side effects and proper dosage. Detailing is considered to be a driver of prescription drug cost increases, as some feel that physicians are swayed by such presentations to prescribe newer, high-cost patented drugs instead of older generic drugs which have the same therapeutic value. Also see **Counter-Detailing**.

**Diagnosis**  The identification of a disease or condition through examination.

**Diagnosis-Related Groups (DRG)**  A program in which hospital procedures are rated in terms of cost and intensity of services delivered. A standard rate per procedure is derived from this scale, which is paid by Medicare for their beneficiaries, regardless of the cost to the hospital to provide that service.

**Direct Contracting**  A contractual relationship between a health care provider and an employer, in which services are provided on a predefined price schedule in exchange for the purchase of services in defined volume. Direct contracting creates a direct relationship between the provider and the employer.

**Direct Access**  *see Open Access.*

**Direct Costs**  Costs that are wholly attributable to the service in question. For example, the services of professional and paraprofessional personnel, equipment, and materials.

**Disability**  Any medical condition that results in functional limitations that interfere with an individual’s ability to perform his or her normal work and results in limitations in major life activities.

**Disability Benefit**  A payment that arises because of the total and/or permanent disability of an insured; a provision added to a policy that provides for a waiver of premium in case of total and permanent disability.

**Disability Income Benefits**  Loss-of-Income benefit payable under group life (permanent and total disability income feature), short-term disability income and long-term disability income insurance contract. Sometimes called loss-of-time benefits.

**Disability Income Insurance**  A form of health insurance that provides periodic payments when the insured is unable to work as a result of illness, disease, or injury.

**Disallowance**  A denial by a health care payer for portions of the claimed amount.
Examples could include coordination of benefits, services that are not covered, or amounts over the fee maximum.

**Disease Classification** A list of related diagnoses in a limited number of clinically homogeneous categories, usually to support the analysis of the quality, access, utilization, and cost of health care services.

**Disease Episode** The time period in which a person has a specified disease or disorder *(see also Episode of Care)*.

**Disease Management** A philosophy toward the treatment of the patient with an illness (usually chronic in nature) seeking to prevent recurrence of symptoms, maintain high quality of life, and prevent future need for medical resources by using an integrated, comprehensive approach to health care. Pharmaceutical care, continuous quality improvement, practice guidelines, and case management all play key roles in this effort, which *(in theory)* will result in decreased health care costs as well. Disease Management is where the carrier will manage certain chronic diseases or conditions such as asthma or diabetes to assist in lowering costs while providing the patient with tools to better manage their disease. If the patient can better manage their disease with the tools provided there will be less emergency rooms visits, provider visits, inpatient hospital care, etc.

**Disease State** A medical condition that presents a specific group of symptoms, clinical signs, and laboratory assessments.

**Disenrollment** The procedure of dismissing individuals or groups from their enrollment with a health carrier.

**Dispensing Fee** A charge levied by pharmacists and added to the price of a drug, which covers both their pharmaceutical expertise and the cost involved in the prescription.

**DME** See **Durable Medical Equipment**

**DRG** See **Diagnosis-Related Groups**

**DRR** See **Drug Regimen Review**

**Drug Utilization Review** An evaluation of prescribing patterns or targeted drug use to specifically determine the appropriateness of drug therapy. This analysis of prescribed drugs allows for better patient care and reduces the overall pharmacy costs. By reviewing prescribing patterns it can be determined if patients are being over prescribed or having prescriptions that could interact with each other. For example, if a patient is taking a drug
for acid reflux and shortly thereafter a drug for migraines and then shortly thereafter a drug for nausea. That patient is now taking three medications when what is actually happening is the drug for acid reflux is causing headaches and the drug for the headaches is causing nausea. By changing the drug for acid reflux to eliminate the headaches, the patient is now taking only one drug. By determining if this is the case it is providing better care to the patients while reducing the cost of prescriptions.

**Drug Maintenance List**  Also called an additional drug benefit list, it is a catalog of a limited number of prescription medications, as designated by an MCO, commonly prescribed by health care providers for long-term patient use. This list is usually modified on a regular basis.

**Drug Regimen Review (DRR)**  A frequent evaluation of the medications being taken by a patient in intermediate or long-term care facilities. Typically performed by a pharmacist, DRR is especially useful in avoiding adverse drug reactions and drug interactions in patients taking multiple medications.

**Drug Use Evaluation (DUE)**  An evaluation of prescribing patterns of physicians to specifically determine the appropriateness of drug therapy. There are three forms of DUE: prospective (before or at the time of prescription dispensing), concurrent (during the course of drug therapy), and retrospective (after the therapy has been completed).

**Drug Utilization Review (DUR)**  The process of retrospectively evaluating prescription drug use, physician prescribing patterns, or patient drug utilization to determine the appropriateness of drug therapy.

**DUE** See **Drug Use Evaluation**

**Duplication of Benefits**  Overlapping or identical health coverage of an insured person under two or more plans, usually the result of contracts with different health organizations, insurance companies, or prepayment plans.

**DUR** See **Drug Utilization Review**

**Durable Medical Equipment**  Equipment that can be repeatedly used, 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 include hospital beds, wheelchairs, and oxygen equipment.
EAP See Employee Assistance Plan

**Economic Clinical Trials**  Studies, usually conducted by pharmaceutical manufacturers, that evaluate drugs based on economic endpoints.

**EDI** See **Electronic Data Interchange**

**Effective Date**  The date that insurance coverage goes into effect (may refer to a case, a group contract, a coverage, a benefit, or an insured).

**Electronic Data Interchange (EDI)**  The electronic exchange (through computers) of information between two or more organizations. In the health care setting, EDI has made enormous gains in the transmission of claims information.

**Electronic Patient Record**  *see* **Computerized Patient Record**

**Eligibility**  The provisions of the group policy that state the requirements of the group and/or their dependents must satisfy to become insured.

**Eligibility Date**  The date on which a member of an insured group may apply for insurance.

**Eligibility Period**  The time following the eligibility date during which a member of an insured group may apply for insurance without evidence of insurability (usually 31 days).

**Eligible Dependent**  A dependent of a covered employee who meets the requirements specified in the group contract to qualify for coverage.

**Eligible Employee**  An employee who meets the eligibility requirements specified in the group contract to qualify for coverage.

**Emergency Care**  Medical care given for a serious medical condition resulting from injury, sickness, or mental illness that arises suddenly and requires immediate care.
**Emergicenter** A health care facility, for which the primary purpose is the provision of immediate, short-term medical care for urgent medical conditions.

**Employee Assistance Plan (EAP)** A plan designated 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 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 lower productivity.

**Employee Contribution** The portion of the insurance premium paid by the employee.

**Employer Mandate** An employment-based financing approach that requires employers to provide basic health care coverage to some or all employees and dependents.

**Employee Retirement Income Security Act of 1974 (ERISA)** A federal law that mandates reporting and disclosure requirements for group life and health plans.

**End Stage Renal Disease** Permanent kidney failure requiring dialysis or a kidney transplant.

**Enrollment** The process of explaining the proposed group insurance plan to eligible persons and assisting them in the proper completion of their enrollment cards.

**Episode of Care** All treatment rendered in a specified time frame for a specific disease.

**EPO** See **Exclusive Provider Organization**

**ERISA** See **Employee Retirement Income Security Act of 1974**

**ESRD** see **End Stage Renal Disease**.

**Evidence of Insurability** Proof, presented through written statements on an application form and/or through a medical examination, that an individual is eligible for a certain type of insurance coverage. In group insurance this form is required for eligibles who do not enroll during the open enrollment period (i.e., generally a 31 day period); who apply for reinstatement after having previously withdrawn from the plan; who apply for reinstatement after having received an overall maximum benefit; or who
apply for excess amounts of group life or disability insurance.

**Exclusions** Specified coverages, hazards, services, conditions and alike that are not provided for (covered) under a particular contract.

**Exclusive Provider Organization (EPO)** A form of PPO in which patients must visit a caregiver who is on its panel of providers. If an outside provider is visited, the EPO will offer limited or no coverage for the office or hospital visit.

**Experience-Rated** Premiums for a group plan are determined by all or a portion of actual claims of enrollees within the group. The cost of the group plan is a direct function of the claims incurred by that group.

**Experimental Procedures** Also called investigational or unproved procedures, this covers all health care services, supplies, treatments, or drug therapies that have been determined by the health plan to not be generally accepted by health care professionals as effective in treating the illness for which their use is proposed. Experimental procedures are said to not be proven scientifically to effectively treat the condition for which their use is prescribed.

**Extended Care Facility** A nursing home-type setting that offers skilled, intermediate, or custodial care.

**Extension of Benefits** A component of some insurance policies that allows medical coverage to continue past the termination date of the policy for employees not actively at work.

**Federal Employees Health Benefits Program (FEHBP)** The health benefits program for federal employees that is administered through the U.S. Office of Personnel Management.

**Federally Qualified HMO** An HMO that meets certain standards mandated by the Public Health Service Act. Two of these standards include prepaid care for a fixed amount per month or year and community rating.
**Fee for Service**  Traditional provider reimbursement in which the physician is paid according to the service performed. This is the reimbursement system used by conventional indemnity insurers.

**Fee Schedule**  A comprehensive listing of fees used by either a health care plan or the government to reimburse physicians and/or health care providers on a fee-for-service basis.

**FEHBP**  See **Federal Employees Health Benefits Program**

**First-Dollar Coverage**  A feature of an insurance plan in which there is no deductible, and therefore the plan’s sponsor pays a proportion or all of the covered services provided to a patient as soon as he or she enrolls.

**Flexible Benefit Plan**  A benefit program that offers employees a number of benefit options, allowing them to tailor benefits to their needs.

**Formulary**  A listing of prescription medications that will be covered by a plan or insurance contract that often fosters substitutions of generic or therapeutic equivalents on a cost-effective basis.

**Foundation Model**  A type of integrated health care system whereby the hospital or health care organization creates a new nonprofit organization, which purchases the tangible and intangible assets of physicians, usually in a group practice. The foundation then manages, contracts for, and pays the hospital and physician group. The physician professional corporation has its own governance, management structure, and control over its clinical decision making.

**Freestanding Emergency Medical Service Center**  A health care facility that is physically and financially separate from a hospital, the primary purpose of which is to provide immediate, short-term medical care for urgent medical conditions. Also called an emergicenter or urgicenter.

**Freestanding Outpatient Surgical Center**  A health care facility, which is physically separate from a hospital, that provides prescheduled, outpatient surgical services. Also called a surgicenter.

**Fully Insured**  Fully insured financing is considered the traditional way to finance your group’s health care. Being fully insured means that the carrier processes and pays claims for your covered individual members according to the terms of the benefit options you chose. Each month, you pay a premium amount based on your projected claims experience and operating costs. This means that the carrier takes on the liability of all
claims by charging a fee (rate) to access their provider network for services.

**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 cost, plus stop-loss premium, plus all related fees. A funding level is more common in a self-funded program. In a self-funded program the plan must determine at what level the plan will be funded so that claims and administrative services can be paid without running out of money. When a funding level is set, an actuarial analysis will assist in creating rates. The rates will usually be based upon a single, two-party and family coverage.

---

**G**

**Gag Clause** A statement in an MCO provider contract that prohibits the provider from revealing financial compensation relationships with the health plan and possibly from criticizing the MCO under threat of removal from the provider network. Such clauses have generally been abandoned by MCOs or are now prohibited by state law.

**GASB** Governmental Accounting Standards Board


**GASB 45** - Accounting and Financial Reporting by Employers of Post employment Benefits Other Than Pensions. Establishes uniform standards for the measurement, recognition and display of OPEB expense, expenditures and related liabilities on the employer’s financial statements.

**Gatekeeper** Most HMOs rely on the primary care physician, or “gatekeeper,” to screen patients seeking medical care and effectively eliminate costly and sometimes needless referrals to specialists for diagnosis and management. The gatekeeper is responsible for the administration of the patient’s treatment, and must coordinate and authorize all medical services, laboratory studies, specialty referrals, and hospitalizations. In most HMOs, if an enrollee visits a specialist without prior authorization from his or her designated primary care physician, the medical services delivered by the specialist will have to be paid in full by the patient.
**Generic Drug**  A chemically equivalent copy designed from a brand name drug whose patent has expired. Typically less expensive and sold under the common name for the drug, not the brand name.

**Generic Substitution**  In cases in which the patent on a specific pharmaceutical product expires and drug manufacturers produce generic versions of the original branded product, the generic version of the drug (which is theorized to be the exact same product manufactured by a different firm) is dispensed even though the original product is prescribed. Most MCOs and Medicaid programs mandate generic substitution because of the generally lower cost of generic products.

**Global Budgets**  Prospectively defined caps on spending for some portion of the health care industry, which would ultimately establish binding targets for permissible growth in the U.S. public and private health care system.

**Global Payment**  A method of compensation in which a hospital, for example, receives one negotiated payment for all care rendered to a patient undergoing a particular surgical procedure. Therefore, the hospital is at risk for all expenses incurred beyond the global payment.

**Group** A body of subscribers eligible for group insurance by virtue of some common identifying attribute, such as common employment by an employer, or a membership in a union, association, or other organization.

**Group Contract** The application and addenda, signed by both the health plan and the enrolling unit, which constitute the agreement regarding the benefits, exclusions, and other conditions between the health plan and the enrolling unit.

**Group Practice Without Walls**  Physicians are organized to share common administrative costs in a corporate structure, but they still maintain separate practices and revenue streams. Group practices without walls can be single or multispecialty and are often formed by physicians in an attempt to gain the security that goes along with teaming up with other physicians in a very competitive environment.
HCFA (Health Care Financing Administration) Former name of the federal agency responsible for administering Medicare and overseeing states’ management of Medicaid. It is now called CMS (Centers for Medicare and Medicaid Services.)

HCFA Common Procedural Coding System (HCPCS) A listing of services, procedures, and supplies offered by physicians and other providers. The HCPCS includes CPT (Current Procedural Terminology) codes and national and local alphanumeric codes. The national codes are developed by HCFA in order to supplement CPT codes. They include physician services not included in CPT as well as nonphysician services, such as ambulance, physical therapy, and durable medical equipment. The codes are developed by local Medicare carriers in order to supplement the national codes. These codes have five digits; the first digit is a letter followed by four numbers. The HCPCS codes beginning with A through V are national; those beginning with W through Z are local. Also see Coding Systems.

HCPCS System See Coding Systems

Health Alliances Purchasing pools that are responsible for negotiating health insurance for employers and employees. Alliances use their leverage as large health care purchasers to negotiate contracts.

Health Plan Report Card A report prepared by individual health plans for purchasers (both employers and consumers) to evaluate the quality of health care provided. The quality measures could include performance measures such as admission rates for asthma, cesarean section rates, immunization and prenatal care rates, as well as patient satisfaction measures such as waiting times and access to provider.

HDHP See High Deductible Health Plan

Health Savings Account See HSA

HEDIS (Health Plan Employer Data and Information Set) A set of performance measures designed to help health care purchasers understand the value of health care purchases and measure the performance of multiple health plans. See also National Committee for Quality Assurance (NCQA)

High Deductible Health Plan (HDHP) A health insurance plan with lower premiums and higher deductibles than a traditional health plan. It is sometimes referred to as a catastrophic health insurance plan. Participation in a "qualified"
HDHP is a requirement to be eligible for an HSA. A “qualified” HDHP’s deductibles and out-of-pocket maximums are set by the IRS and adjusted for inflation annually.

**HIPAA (Health Insurance Portability and Accountability Act of 1996)** A federal law that protects workers by improving portability and continuity of employer-sponsored health insurance coverage. Some of the provisions of the Act are:

- Limiting exclusions for pre-existing medical conditions (known as pre-existing conditions)
- Requiring credit against maximum pre-existing condition exclusion periods for prior health coverage, and providing a process for issuing certificates showing periods of prior coverage to a new group health plan or health insurance issuer.
- Providing new rights that allow individuals to enroll for health coverage when they lose other health coverage, get married or add a new dependent
- Prohibiting discrimination in enrollment and in premiums charged to employees and their dependents based on health status-related factors.
- Guaranteeing availability of health insurance coverage for small employers and renewability of health insurance coverage for both small and large employers
- Outlawing the exclusion of people from obtaining health insurance because of pre-existing conditions
- Offering tax deductions to those who are self-employed to help pay for their health benefits.
- Outlining requirements to protect the security and privacy of Protected Health Information (PHI) (See definition)
- Requiring the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. Adopting these standards will improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care.

**HIPAA Privacy Standards** The Privacy Standards are designed to protect each individual's individually identifiable health information ("Protected Health Information" or "PHI") from being used or disclosed by Covered Entities without the individual's express authorization, except as explicitly permitted or required in certain limited circumstances. If health information does not meet the definition of Protected Health Information, then the Privacy Standards do not apply to that information.

Generally, the Privacy Standards restrict how a Covered Entity (essentially, health plans, health care providers who transmit health information in electronic form and health care
clearinghouses) may use and disclose PHI - including when a use or disclosure is required or permitted - and the conditions relating to the use or disclosure. Covered Entities' use or disclosure of, or requests for, PHI must consist of only the minimum amount necessary to accomplish the intended purpose of the use, disclosure, or request.

HMO (Health Maintenance Organization) A form of health coverage in which health plan members prepay a premium for health services, which generally include inpatient and ambulatory care. For the patient, it means reduced out-of-pocket costs (i.e., no deductible), no paperwork (i.e., insurance forms), and only a small copayment for each office visit to cover the paperwork handled by the HMO. The following are some specific forms of the HMO.

- **Staff-Model** The purest form of managed care. All of the physicians are in a centralized site in which all clinical and perhaps inpatient and pharmacy services are offered. The HMO holds the tightest management reins in this setting because none of the physicians traditionally practice on an independent, fee-for-service basis. Physicians are more employees of the HMO in this setting, as they are not in a private or group practice. Kaiser is an example of a staff-model HMO.

- **Individual Practice Association – Model (IPA)** The IPA contracts with independent physicians who work in their own private practices and see fee-for-service patients as well as HMO enrollees. They are paid by capitation for the HMO patients and by conventional means for their fee-for-service patients. Physicians belonging to the IPA guarantee that the care needed by each patient for which they are responsible will fall under a certain amount of money. They guarantee this by allowing the HMO to withhold an amount of their payments (e.g., usually about 20% per year). If, by the end of the year, a physician’s cost for treatment falls under this set amount, then the physician receives his entire “withhold fund.” If the opposite is true, the HMO can then withhold any part of this amount, at its discretion, from the fund. Essentially, the physician is put “at risk” for keeping down the treatment cost. This is a key to the HMO’s financial viability. See also Capitation.

- **Group-Model** In the group-model HMO, the HMO contracts with a physician group, which is paid a fixed amount per patient to provide specific services. Popularized by Kaiser Permanente, one of the pioneers of the HMO movement, the administration of the group practice then decides how the HMO payments are distributed to each member physician. This type of HMO is usually located in a hospital or clinic setting and may include a pharmacy. These physicians usually do not have any fee-for-service patients.
• **Hybrid-Model** A combination of at least two managed care organizational models that is melded into a single health plan. Since its features do not uniformly fit only one type of model, it is called a hybrid.

• **Network-Model** A network of group practices that are under the administration of one HMO. HealthNet is an example of a network-model HMO.

• **Point-of-Service Model (POS)** Sometimes referred to an “open-ended” HMO, the POS model is one in which the patient can receive care from physicians who do or do not contract with the HMO. Physicians not contracting with the HMO but who see an HMO patient are paid according to the services performed. The patient is incentivized to utilize contracted network providers through the comprehensive coverage offerings.

**HMO Act of 1973** A federal law that required employers with more than 24 employees to offer an alternative to conventional indemnity health insurance in the form of a federally qualified HMO. The main intention of the Act was to encourage HMO development.

**Home Care** The term “home care” refers broadly to personal as well as skilled health services provided in the home, such as the broad range of services provided by a Visiting Nurse Service. This includes the range of services provided respite care givers, homemakers, companions, home health aides, nursing and therapy personnel, and medical social workers. In contrast, the term “home health care” generally refers only to services usually performed under the general supervision of a physician that go directly to medical care of the patient in the home. This usage excludes personal services from the definition but includes home health aides, nursing and therapy personnel, and medical social workers.

**Homeopath** A practitioner who follows the philosophy that “like cures like.” Homeopaths try to match a person’s personality, habits, and symptoms with a remedy. The remedy is usually a highly diluted substance that is believed to create the same symptoms that an illness has created in the consumer. Some homeopaths are physicians or other health practitioners who are licensed to practice their profession; others might be unlicensed “laypeople.”

**Hospice** A facility for terminally-ill individuals that, under a physician’s general supervision, provides (1) nursing care; (2) physical or occupational therapy; (3) medical social services; and (4) counseling.
**Hospital Alliance**  A group of hospitals that have joined together to improve competitive positions and reduce costs by sharing common services and developing group purchasing programs.

**HRA (Health Reimbursement Account)**  Health reimbursement accounts consist of funds set aside by employers to reimburse employees for qualified medical expenses, just as an insurance plan will reimburse covered individuals for the cost of services incurred. Employers qualify for preferential tax treatment of funds placed in a health reimbursement account in the same way that they qualify for tax advantages by funding an insurance plan. (Employers can deduct the cost of an insurance plan -- and now a health reimbursement account -- as a business expense under Internal Revenue Code section 162.) A health reimbursement account provides "first-dollar" medical coverage until funds are exhausted. For example, if an employee has a $500 qualifying medical expense, then the full amount will be covered by the health reimbursement arrangement if the funds are available in the account. Under a health reimbursement account, the employer provides funds, not the employee. All unused funds are rolled over at the end of the year. Former employees, including retirees, can have continued access to unused reimbursement amounts. Health reimbursement accounts remain with the originating employer and do not follow an employee to new employment.

**HSA (Health Savings Account)**  A tax-advantaged medical savings account available to individuals who are enrolled in a “qualified” **High Deductible Health Plan (HDHP)**. The funds contributed to the account are not subject to federal income tax at the time of deposit. Funds may be used to pay for qualified medical expenses at any time without federal tax liability. Withdrawals for non-medical expenses are treated very similarly to those in an IRA account in that they may provide tax advantages if taken after retirement age, and they incur penalties if taken earlier. These accounts are a component of consumer driven health care. In addition, HSAs are owned by the individual account holder and therefore portable.

**IBNR (Incurred but not Reported) Expenses**  Expenses that are the financial responsibility of the health plan, but which have not yet been paid as a result of not yet being entered into the claim tracking system, invoiced or otherwise recorded. Sometimes referred to as IBNP (Incurred but not Paid.)
ICD-9-CM (International Classification of Diseases, 9th Edition (Clinical Modification))  A listing of diagnoses and identifying codes used by hospitals and physicians for reporting diagnoses of health plan enrollees, for purposes of reimbursement. 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. (Also see Coding Systems.)

ICD-9 System  See Coding Systems

Indemnity Insurance  Traditional fee-for-service coverage in which providers are paid according to the service performed.

Indirect Costs  Usually termed overhead costs, as they are the costs that are shared by many services concurrently, such as maintenance, administration, equipment, electricity, or water.

Individual Practice Association  see HMO.

Inpatient  A patient admitted to a hospital who is receiving services under the direction of a physician for at least 24 hours.

Insurance  A plan of risk management that, for a price, offers the insured an opportunity to share the cost of possible economic loss through an entity called an insurer.

Insured  The person (employee, dependent, or group member) who is covered for insurance under the group policy and to whom, or behalf of whom, the insurer agrees to pay benefits.

Insurer  The party to the insurance contract that promises to pay losses or benefits. Also, any corporation primarily engaged in the business of furnishing insurance protection to the public.

Integrated Health Care Systems  Health care financing and delivery organizations created to provide a “continuum of care,” ensuring that patients get the right care at the right time from the right provider. This continuum of care from primary care provider to specialist and ancillary provider under one corporate roof guarantees that patients get the appropriate care, thus saving money and increasing quality of care.

Integrated Health Network  see Integrated Health Care Systems.

Internet  The name given to a way of connecting separate computer networks,
forming a “network of networks.” It relies upon an agreement among operators of the network routing computers and switches to carry each other’s traffic and follow a standard set of protocols for addressing, receiving, forwarding, and transmitting messages. Physically, it consists of a small number of interconnected high-speed primary networks called backbones, each with thousands of smaller networks attached to them. There is no owner or manager of the Internet.

**Intranet** A small Internet-type network, usually set up within one organization, that allows a restricted group of people to have access to specific information.

**IPA** See Individual Practice Association

---

**Jackson Hole Group** A nonprofit advocacy organization of health care analysts led by Drs. Paul Ellwood and Alain Enthoven that studies and lobbies for health care reform issues.

**Joint Powers Authority (JPA)** California Government Code Section 6500, et. seq. provides that two or more public agencies may, by agreement, exercise any power common to the contracting parties.

A joint powers authority (JPA) is a risk-sharing partnership of public entities, whose formation and operations are subject to the provisions of the California Government Code, including the Ralph M. Brown Act. The goals of a JPA include:

- Reduced costs by pooling together to take advantage of the economies of large group underwriting
- Long term stability
- Greater flexibility in funding, rate setting and plan design
- Better control over claim costs
- Increased leverage on the insurance industry
- Meet the needs of its members for lines of coverage chosen
Joint Commission on Accreditation of Healthcare Organizations (JCAHO)  A private, nonprofit organization that evaluates and accredits health care organizations that provide inpatient mental health care, ambulatory care, home care, and long-term care services.

JPA See Joint Powers Authority

Late Applicant or Late Entrant  An eligible person who applies for insurance after the normal 31 day open enrollment period.

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 consecutive days a patient is hospitalized.

Licensed Practical Nurse (LPN)  A nurse licensed by the state to carry out specified nursing duties under the direction of a Registered Nurse.

Long-Term Care (LTC) Insurance  Insurance coverage that provides reimbursement or payment for care for people who have an inability to perform Activities of Daily Living (see definition) and need care other than medical care. LTC covers a range of services from home care to adult day care to nursing home care, and from family support to personal assistance with ADLs.

Long-Term Disability (LTD) Insurance  Insurance coverage that helps replace earned income lost through inability to work because of disability caused by accident, injury or illness.

LOS See Length of Stay

Loss Ratio  The ratio of the total incurred claims made against an insurance policy divided by the total premiums. Also called Premium to Claims Ratio. The lower the loss ratio the lower the renewal, the higher the loss ratio the higher the renewal.

LPN See Licensed Practical Nurse
LTC See Long-Term Care Insurance

LTD See Long-Term Disability Insurance

Mail Order Pharmacy  A method of dispensing medication directly to the patient through the mail. Mail order drug distributors can purchase drugs in larger volumes than retail or wholesale outlets.

Managed Care  In its broadest sense, a health care system in which a third party intervenes in the doctor-patient relationship to prevent overutilization of medical resources by monitoring access to, and the quality and frequency of, medical care. Its purpose primarily is to contain medical costs.

Managed Competition  One type of health care reform that would correct the inequalities of the health delivery system through increased competition. Health plans would compete on the basis of cost and other factors; health care purchasers would have information at their disposal that would allow them to compare competing health plans across several dimensions of performance.

Managed Fee-for-Service  A plan in which the cost of covered services is paid by the insurer after services have been used. Various managed care tools, such as precertification, second surgical opinion, and utilization review are used to control inappropriate utilization.

Management Services Organization (MSO)  A type of integrated health care plan in which the hospital provides administrative services to a physician group and the physician group provides patients to the hospital.

Mandated Benefits  Health benefits that health care plans are required by state or federal law to provide to members.

Manual Rates  Rates developed based upon the health plan’s average claims data and then adjusted for group specific demographics, industry factors, or benefit variations. Carriers have a certain employee level, usually under 1000 where they apply a manual rate. When creating a manual rate the carrier does not take into consideration actual client utilization data. The carrier reviews the demographics of the client, the benefit plan and a
review of total claims dollars spent in the previous year. An experience rate is the preferred method, however, there are groups that will not be given experience data, such as those covered by CalPERS.

**Margin** A component of the insurance premium which offsets the risk due to an unexpected upward fluctuation in claim costs.

**Maximum Allowable Cost List** A list of prescription medications, established by the health plan and distributed to pharmacies, that will be covered at a generic product level.

**Maximum Benefit** The highest amount any one individual may receive under an insurance contract.

**Medicaid** An entitlement program run by both the state and federal government for the provision of health care insurance to patients younger than 65 years of age who cannot afford to pay private health insurance. The federal government matches the states’ contribution on a certain minimal level of available coverage. The states may institute additional services, but at their own expense.

**Medicaid Prudent Pharmaceutical Purchasing Act (MPPPA)** Enacted as part of the Omnibus Budget Reconciliation Act of 1990, MPPPA provides that Medicaid must receive the best discounted price of any institutional purchaser of pharmaceuticals. In doing so, drug companies provide rebates to Medicaid that are the difference between the discounted price and the price at which the drug was sold. This bill, which was introduced by Senator David Pryor of Arkansas, has resulted in cost shifting throughout the health industry. For example, HMOs, which were previously able to negotiate some of the best discounts with manufacturers and wholesalers, are now given lower discounts by the vendors to compensate for the Medicaid share of discounted revenue.

**Medical Case Management** A system of patient or client assessment, planning, treatment, referral and follow-up to insure provision of coordinated medical services. Also includes coordination of payment and reimbursement.

**Medical Consumerism** see Demand Management.

**Medical Loss Ratio** A financial term that defines the percentage of every dollar of revenue that goes either toward directly paying for health benefits or paying for administrative services, overhead, promotion, etc. For instance, a health plan with a medical loss ratio of 89% pays $0.89 of every dollar it receives directly for health care services.
Medical Protocols  Medical protocols are the guidelines that physicians in the future may be required to follow in order to have an acceptable clinical outcome. The protocol would provide the caregiver with specific treatment options or steps when faced with a particular set of clinical symptoms, signs, or laboratory data. Medical protocols would be designed through an accumulated database of clinical outcomes.

Medical Savings Accounts (MSA)  A method of paying for health insurance, made available through a pilot program mandated by the Health Insurance Portability and Accountability Act of 1996. The MSA allows a person to place money in an interest-bearing account that can be used to purchase health insurance policies and to pay copays, deductibles, etc. Anything remaining in the account at the end of the year is carried over to the next year, allowing the account to grow. This pilot program has expired, and no new MSAs may be created.

Medical Underwriting  A process used by insurance companies to rate the risk of insuring a person or a group applying for health insurance. The degree of risk is used to fix the premium or to deny coverage altogether and is based on such factors as preexisting condition of health, prior use of medical services, age, sex, physical condition, and personal habits.

Medically Necessary  Describes services required to prevent harm to the patient or an adverse affect 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  Administered by the Centers for Medicare and Medicaid Services (CMS), Medicare is the U.S. federal government plan for paying certain hospital and medical expenses for those who qualify. Eligible beneficiaries are people over age 65, people under age 65 with certain disabilities, and any age with ESRD (End Stage Renal Disease.) Benefits are provided regardless of income level. The program is government subsidized and government operated. “Original” Medicare, created in 1965, consists of Part A and Part B. Part A, Hospital Insurance (HI), provides for inpatient hospital services and post-hospital care. Part A also helps cover skilled nursing facility, hospice, and home health care under certain conditions. Part B, Supplementary Medical Insurance (SMI), pays for medically necessary doctors’ services, outpatient hospital services and a number of other medical services and supplies not covered by Part A. Part B also helps cover some preventive services. Enrollment in Part B is voluntary and available for a small premium. See also Medicare Advantage and Medicare Part D.

Medicare Advantage (Also known as Medicare Part C and Medicare+Choice)  The program originally created by the Balanced Budget Act of 1997 that offers
Medicare recipients a variety of health plan options that bundle “Original” Medicare Parts A & B with additional benefits offered through private insurance carriers, including Medicare-Risk HMOs, preferred provider organizations and provider-sponsored organizations. Plans can charge different co-payments, coinsurance or deductibles for these services.

**Medicare Part D** Created by the Medicare Modernization Act of 2003, and effective in 2006, Medicare Part D contracts with private Prescription Drug Providers to offer prescription drug coverage that helps lower out-of-pocket costs. Participation is voluntary, but the individual must be enrolled in Medicare Parts A and B, and an additional monthly premium penalty may be assessed if enrollment is after the first three months of initial eligibility.

**Medicare Risk HMOs** Created by Congress in 1982 under TEFRA, the Medicare managed care program became operational in 1985. A Medicare Risk HMO assumes responsibility for the risk of caring for Medicare recipients completely, replacing Medicare Parts A and B. The plan is reimbursed on a capitated basis by Medicare for all services within the scope of Medicare Parts A and B.

**Medicare Secondary Payer Program** Since 1991, Federal law requires that Medicare is the secondary payer for three categories of beneficiaries, if these beneficiaries are also covered by their employer’s group health plan. The three categories are (1) individuals with end stage renal disease (ESRD) up to the first 30 months; (2) those over age 65 and currently employed (including the spouse of an employed individual); and (3) those who are disabled but “currently employed” (including disabled dependents of active individuals.) Medicare Secondary Payer rules were finalized and made permanent by the Balanced Budget Act of 1997.

**Medicare Supplement Policy** see Medigap.

**Medigap** Insurance provided by private insurance carriers to supplement the reimbursement paid by Medicare for medical services. Since Medicare pays physicians for services according to their own fee schedule, regardless of what the physician charges, the individual may be required to pay the difference between Medicare’s reimbursable charge and the physician’s fee. Medigap insurance is meant to fill this gap in reimbursement, so that the Medicare beneficiary is not at risk for the difference.

**Member** A participant in a health plan who makes up part of the plan’s enrollment population.

**Mental Health Parity Act (MHPA)** A federal act which prohibits group health plans that offer mental health benefits from applying more restrictive limits on
coverage for mental illness than for physical illness.

**Minnesota Care**  Minnesota’s health care program, passed in April 1992. This program is intended to provide health care to all of Minnesota’s citizens while cutting health care costs; it includes cost-containment provisions for setting overall health care spending targets, monitoring providers, reviewing the distribution of new technologies, and evaluating methods for collecting health care data.

**Morbidity**  The incidence and severity of sickness in a defined population.

**Mortality**  The death rate at each age, calculated from prior experience.

**MSA**  See **Medical Savings Accounts**

**MSO**  See **Management Services Organization**

**Multioption Plan**  A health plan design that offers employees the option to choose from one of several coverage types, including an HMO, a PPO, and a major indemnity plan.

**National Association of Insurance Commissioners (NAIC)**  - An organization of state officials that protects the interests of policyholders by promoting the uniformity of legislation and regulations affecting insurance.  NAIC is based in Kansas City, Mo.

**National Committee for Quality Assurance (NCQA)**  NCQA is a private, nonprofit organization dedicated to improving health care quality. NCQA accredits and certifies a wide range of health care organizations and recognizes physicians in key clinical areas. NCQA’s Healthcare Effectiveness Data and Information Set (HEDIS®) is the most widely used performance measurement tool in health care.

**National Drug Code (NDC)**  A national listing of drugs.

**NCQA**  See **National Committee for Quality Assurance**

**Negotiated Discount**  A method of reimbursement for managed care providers that
stipulates specific percentages by which charges may be reduced if included in the provider’s contract or agreement.

**Negotiated Fee Schedule**  The most controversial form of reimbursement. The basis of the PPO network; doctors and hospitals agree to treat PPO patients at a lower rate than non-PPO patients.

**Net Loss Ratio**  The result of total claims liability and all expenses divided by premiums. This represents the carrier’s loss ratio after accounting for all expenses.

**Network**  A defined group of providers, typically linked through contractual arrangements, which supply a full range of primary and acute health care services. A “closed” network is one in which beneficiaries are not allowed to access nonnetwork providers whereas an “open” network allows access to other providers at some cost to the beneficiary.

**Newborns and Mothers Health Protection Act (NMHPA)**  A federal law which mandates that coverage for hospital stays for childbirth cannot generally be less than 48 hours for normal deliveries or 96 hours for cesarean births.

**NDC Coding System**  See Coding System

**NMHPA**  See Newborns and Mothers Health Protection Act

**Nonparticipating Provider**  A health care provider who has not contracted with the carrier or health plan to be a participating provider of health care.

**Nonprofit Plan**  A term applied to a prepaid health plan under which no part of the net earnings may lawfully accrue to the benefit of any private shareholder or individual. Synonymous with “not-for-profit” plan.

**Nurse Practitioner**  A registered nurse who has advanced skills in the assessment of physical and psychosocial health status of individuals, families, and groups in a variety of settings through medical history taking and physical examination.

**Nurse Caring Institution (also Nursing Homes)**  A facility for the provision of long-term care to patients with chronic and disabling conditions. Most nursing home patients are elderly and have limited potential for rehabilitation.
On-Line Adjudication  An electronic assessment of claims at the point of service meant to detect potential problems that should be addressed before drugs are dispensed to patients.

OPEB  Other than Pension Employee Benefits.  Refers to costs associated with providing health benefits to retired employees.  See also GASB.

Open Access  Open-access arrangements allow members to see participating providers, usually specialists, without referral from the health plan’s gatekeeper.  These types of arrangements are most often found in IPA-model HMOs.

Open Enrollment Period  A time during which uninsured employees and/or their dependents may obtain coverage under an existing group plan without presenting evidence of insurability.

OTC  See Over-the-Counter Drug

Out of Area  Refers to places in which the plan will not pay for services.  Out of area can be both geographic as well as a reference to services outside a specific group of providers.

Out-of-Area Coverage  Benefits for health care provided outside the normal service area of the health plan to which a person seeking medical attention belongs.  Such benefits are usually paid for by the plan in emergency circumstances when the health plan participant is away from his or her normal place of residence.

Out-of-Pocket Expenses  Those costs of health care that an individual must pay for directly.  Included are such things as deductibles, coinsurance, copayments, and items and services not included in the health care coverage or which exceed the limits of the coverage.

Out-of-Pocket Limit  An amount specified in a health care plan that is the maximum amount of out-of-pocket expenses for which the covered individual is responsible.  After the maximum is reached, the insurer pays for the covered charges in full, up to the coverage maximum, if any.  Such health plan provisions are, in effect, limits on
cost-sharing.

**Outcomes Management** A clinical outcome is the result of medical and surgical intervention or nonintervention. Improved clinical outcomes may increase patient and payer satisfaction while holding down costs. It is thought that through a database of outcomes experience, caregivers will know better which treatment modalities result in consistently better outcomes for patients. Outcomes management will, as a natural consequence, lead to medical protocols.

**Outcomes Research** Studies that evaluate the effect of a given product, procedure, or medical technology on health or costs.

**Outlier** One who does not fall within the norm; typically used in utilization. A provider who uses either too many services or too few services (for example, anyone whose utilization differs two standard deviations from the mean on a bell curve is termed an outlier).

**Out-of-Pocket Costs** The share of health service payments made by the enrollee.

**Outpatient** A patient 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 to obtain it.

**Partial Hospital Services** A mental health or substance abuse program operated by a hospital which provides clinical services as an alternative or follow-up to inpatient care.

**Patients’ Bill of Rights** Referring to federal or state proposals (or signed legislation) that typically mandates that health plans offer expanded external appeals policies, faster appeals decisions than offered in the past, greater access to specialists than was previously available in many managed care plans, and other specific consumer protections.
PBM See Pharmacy Benefit Management Company

PCP See Primary Care Physician

Peer Review Organization  A group founded by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) to review quality of care and appropriateness of admissions for Medicare and Medicaid beneficiaries. Peer review organizations are accountable for maintaining admission rates and reducing lengths of hospital stays while protecting against inadequate treatment.

Pending Claims  A claim that has been reported but on which final action has not been taken.

Per Diem Cost  Literally, cost per day. Refers in general to hospital or other inpatient institutional cost per day or for a day of care. Per diem costs are averages and do not reflect true costs for each patient.

Per Member per Month (PMPM)  A unit of measurement related to each enrollee for each month.

Pharmaceutical Care  A concept in providing health care; it is a strategy that attempts to utilize drug therapy more efficiently to achieve definite outcomes that improve a patient’s quality of life. A pharmaceutical care system requires a reorientation of physicians, pharmacists, and nurses toward effective drug therapy outcomes. It is a set of relationships and decisions through which pharmacists, physicians, nurses, and patients work together to design, implement, and monitor a therapeutic plan that will produce specific therapeutic outcomes.

Pharmacoeconomics  The field involving the assessment of the cost effectiveness of drug therapy in terms of long-term benefits to the patient.

Pharmacy and Therapeutics (P&T) Committee  A group of physicians, pharmacists, and other health care providers from different specialties, who advise a managed care plan regarding safe and effective use of medications. The P&T Committee manages the formulary and acts as the organizational line of communication between the medical and pharmacy components of the health plan.

Pharmacy Benefit Management Company (PBM)  An organization dedicated to providing prescription benefits to enrollees of managed care plans that utilizes existing community pharmacies. The PBM contracts as a provider group with the managed care organization, so that the individual pharmacies receive negotiating representation in numbers and the prepaid health plan does not have to provide the capital necessary to start, own, and operate their own pharmacy department.
PHO  See Physician-Hospital Organization

Physiatrist A physician who specializes in physical medicine and rehabilitation, and who evaluates the physical functioning of an individual and oversees the individual’s rehabilitation program.

Physician Assistant A health care professional certified to perform certain duties such as history taking, diagnosis, drawing blood samples, urinalysis, and injections under the supervision of a physician.

Physician Contingency Reserve 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 contingency reserve can be used in instances where the plan needs additional funds to pay for claims. The withheld amount may be returned to the physician in varying levels which are determined based on analysis of his or her performance or productivity compared against his or her peers.

Physician Dispensing A physician gives the patient his or her initial doses of a commonly prescribed drug during the office visit. The prescription is usually refilled at the pharmacy, and not the physician’s office. Doctors who dispense medications usually stock 20 to 30 drugs (antibiotics, anti-inflammatories, etc.). Pharmacists see this as a reduction in their marketshare, whereas physicians see this as both an extra service and convenience to their patients.

Physician-Hospital Organization (PHO) A type of integrated health care system that, in its simplest form, is an organization that collectively commits both physicians and the hospital to payer contracts. They sometimes use existing IPA structures or individual physician contracting. In its most effective form, the PHO must commit the entire physician and hospital panel, without an opt-out, to the PHO organization.

PMPM See Per Member per Month

Point of Sale A term usually used to describe information use for on-line technology. For example, a computer terminal at the pharmacist’s counter (i.e., the “point of sale”) connected to an MCO’s information system will be able to inform the pharmacist whether the patient’s prescription is for a formulary product and the requirement copayment before the prescription is dispensed.

Point of Service (POS) see HMO.
Pooling Point  A pre-determined individual claim dollar amount. Amounts in excess of this level are not charged against the insured group’s experience but charged to the insurance company’s catastrophic claims pool.

POS See Point-of-Service Model

PPO  See Preferred Provider Organization.

Practice Guidelines  Also called practice parameters or medical protocols, physicians may be required to follow these in order to obtain the best clinical outcome. The guideline provides the caregiver with specific treatment options or steps when faced with a particular set of clinical symptoms, signs, or laboratory data. The protocols can be very flexible in nature or very rigid. They are designed through an accumulated database of clinical outcomes.

Preadmission Certification  The practice of reviewing claims for hospital admission before the patient actually enters the hospital. This cost-control mechanism is intended to eliminate unnecessary hospital expenses by denying medically unnecessary admissions.

Preexisting Condition  Any medical condition that has been diagnosed or treated within a specified period before the member’s effective date of coverage under the group contract.

Preferred Providers  Physicians, hospitals, and other health care providers who contract to provide health services to persons covered by a particular health plan.

Preferred Provider Health Care Act of 1985  A federal law easing restrictions on PPOs and allowing subscribers to use health care providers outside of the PPO.

Preferred Provider Organization (PPO)  PPOs are managed care organizations that offer integrated delivery systems (i.e., networks of providers) that are available through a vast array of health plans and are readily accountable to purchasers for cost, quality, access, and services associated with their networks. They use provider selection standards, utilization management, and quality assessment techniques to complement negotiated fee reductions as an effective strategy for long-term cost savings. Under a PPO benefit plan, covered individuals retain the freedom of choice of providers but are given financial incentives (i.e., lower out-of-pocket costs) to use the preferred provider network. Preferred provider organizations are marketed directly to employers as well as to insurance companies and TPAs, who then market the network to their employer clients.
**Prepaid Group Practice** A multispecialty association of physicians and other health professionals who contract to provide a wide range of preventive, diagnostic, and treatment services on a continuing basis for enrollees.

**Prepayment** Paying, in advance of service, the cost of predetermined benefits for a population group through regular periodic payments in the form of premiums or contributions, including those contributions that are made to a health and welfare fund by employers on behalf of their employees.

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

**Primary Care Network** A group of primary care physicians who have joined together to share the risk of providing care to their patients, who are members of a given health plan.

**Primary Care Physician (PCP)** Sometimes referred to as a “gatekeeper,” the primary care physician is usually the first doctor a patient sees for an illness. The physician then treats the patient directly, refers the patient to a specialist (secondary care), or admits the patient to a hospital. Often, the primary care physician is a family doctor or internist.

**Professional Review Organization (PRO)** An organization that reviews the activities and records of a health care provider, institution, or group. The reviewer is generally a physician if a physician is the subject of the review; a group of administrators, physicians, and allied health care personnel if a hospital is the subject of the review; etc. The PRO can be state sponsored or independent.

**Profiling** Profiling is an analytical tool that uses epidemiologic methods to compare practice patterns of providers on the dimensions of cost, service use, or quality of care. The provider’s pattern of practice is expressed as a rate, aggregated over time, for a defined population of patients.

**Prospective Payment** A payment that is received before care is actually needed. It gives the provider organization a financial incentive to utilize fewer resources, as they
get to keep the difference between what is prepaid and what is actually used.

**Protected Health Information (PHI)** Under HIPAA, PHI is *individually identifiable* health information that is created or received by a Covered Entity (see definition), or employer, and relates to:

- A person's past, present or future physical or mental health;
- Provision of health care to that person; or
- Past, present or future payment for that person's health care.

*Identifiable* refers not only to data that is explicitly linked to a particular individual (that's *identified* information). It also includes health information with data items which reasonably could be expected to allow individual identification. PHI can be information in any form – electronic, oral or written. If health information does not meet the definition of Protected Health Information, then the HIPAA Privacy Standards do not apply to that information.

**Provider** Any supplier of health care services, i.e., physician, pharmacist, case management firm, etc.

**Pryor Bill** *see* Medicaid Prudent Pharmaceutical Purchasing Act.

**P&T** *See* Pharmacy and Therapeutics Committee

**Purchasing Alliances** Locally based, privately operated organizations that offer affordable group health coverage to businesses with fewer than 100 employees. Also known as purchasing pools, health insurance purchasing co-ops (HPCs), employer purchasing coalitions, or purchasing coalitions.

**Quality-Adjusted Life-Year** This unit of measure is one way to quantify health outcomes resulting from some type of intervention. The number of quality-adjusted life-years is the number of years at full health that would be valued equivalently to the number of years of life experienced in a less-desirable health state. For example, if a year of life confined to bed is considered one half as desirable as a year spent in full health, then 10 years of survival confined to bed would be counted as five quality-adjusted life-years.
Quality Assurance (QA)  Quality assurance or quality assessment is the activity that monitors the level of care being provided by physicians, medical institutions, or any health care vendor in order to ensure that health plan enrollees are receiving the best care possible. The level of care is measured against preestablished standards, some of which are mandated by state and federal law.

Quality Improvement  A continuous process that identifies problems, examines solutions to those problems, and regularly monitors the solutions implemented for improvement.

Quality of Care  A desired state of excellence in the provision of health care. Though quality is a subjective attribute, various characteristics usually associated with the health care delivery process are thought to be determinants of quality.

Quality-of-Life Measures  An assessment of the patient’s perceptions of how they deal with their disease or every-day life when suffering from a particular condition. Although it is subjective, it has been in the health care literature for at least 25 years. It has been tapped in the area of pharmaceuticals most recently in the last seven or eight years. Through statistical means, the indices that have been developed to measure the various quality-of-life aspects have been validated over time, and these measures are reliable and reproducible.

Rate Bands  A statutorily imposed limit on the maximum and minimum premium that can be charged by carriers for health benefits coverage. Rate bands also can impose limits on the demographic factors, such as age, gender, health status and occupation, that can be used in determining rates. Because of the nature of community rating, rate bands generally affect only experience-rated premiums.

Rating  The method that is used to determine the cost of premiums for the members of a managed health care or indemnity insurance plan. Two types of rating methods are:

- Community Rating  Rating method in which actuarial statistics are used with regard to a total population to determine a uniform premium. See also
**Community Rating** and **Adjusted Community Rating**.

- **Experience Rating** Rating method in which actuarial statistics are with regard to a specific group’s medical experience (e.g., age, sex, etc.) to determine the premium. For example, if an employer with 10 workers has three with diabetes, that employer’s health insurance premiums would be higher than an employer with 10 healthy workers.

**RBRVS** See **Resource-Based Relative Value Scale**

**Referral** A recommendation by a physician or managed care plan for a patient to be evaluated or treated by a different physician or specialist.

**Registered Nurse (RN)** A nurse who has graduated from a formal, accredited program of nursing education and who has been granted an RN license by the appropriate state authority after passing a licensing examination.

**Reinsurance** A shared-risk technique in which insurance is purchased by the primary insurer from another insurer to cover part of a risk the primary insurer has assumed. For example, an HMO might purchase reinsurance for certain specified, high-cost items or services it has agreed to provide its enrollees. Another example would be an HMO reinsuring certain risks, perhaps catastrophic cases, that would otherwise be assumed by health care providers under a capitation agreement with the HMO. Such insurance is also known as Risk-Control Insurance and **Stop-Loss Coverage**.

**Relative Value Scale (RVS)** A table of weighted, numerical values assigned to various items and services of medical care that can be used to determine the price of an item or service. To calculate the price of a particular item or service, the RVS is multiplied by a fixed dollar amount. Thus, since the items and services are evaluated in relation to each other, the prices of the various items and services are based on the relative evaluations. Medicare uses such a system, which is called Resource-Based Relative Value System (RBRVS), to fix the payments it will make to physicians. Medicare considers five factors: (1) patient contact time; (2) preservice and postservice time; (3) intensity per unit of time for performing services; (4) practice costs; and (5) opportunity cost of postgraduate training required to become a qualified specialist.

**Report Card on Health Care** A tool used by employers, the government, employer coalitions, and consumers to compare and understand the actual performance of health plans. Report cards provide health plan performance data, such as health care quality and utilization, consumer satisfaction, administrative efficiencies, financial stability, and cost control.
Reserves Created by setting aside a certain percentage of premiums to provide a fund for committed but undelivered health care, uncertainties, contingencies, overutilization of referrals, catastrophes, and other situations.

Resource-Based Relative Value Scale (RBRVS) The RBRVS became effective in January 1992; it is a financing mechanism that reimburses health care providers on a classification system that measures training and skill required to perform a given health care service. This classification system is used to correct Medicare’s inequitable tendency to overcompensate for services, such as surgery and diagnostic tests and to underpay for primary care services. Also see RVS.

Retention The portion of the insurance premium which is allocated for expenses, administration, commissions, risk charges, taxes and profit. Retention is another term used to describe the costs included in a rate for administrative services.

Retrospective Review A manner of judging medical necessity and appropriate billing practices for services that have already been rendered.

Risk The possibility that revenues of the insurer will not be sufficient to cover expenditures incurred in the delivery of contractual services.

Risk Analysis The process of evaluating expected medical costs for a prospective group and determining what product, benefit level, and price best meet the needs of the group and the carrier.

Risk Contract An agreement between 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 by the enrollee. The HMO is then liable for services regardless of their extent, expense, or level.

Risk Pool A defined patient population and geographic location from which revenue and expenses are determined. A risk pool seeks to define expected claim liabilities of a given defined account as well as required funding to support the claim liability.

Risk Retention The financial liability one undertakes when signing, for example, capitated contracts. See also Capitation.

Risk Sharing An arrangement in which the health care system assumes total responsibility for all health care services related to a specific diagnosis-related group or disease process for a fixed dollar amount or in which the system receives capitation for a specific number of members and in turn provides health care services. See also
Capitation

RN See Registered Nurse

RVS See Relative Value Scale

SCHIP – See Balanced Budget Act of 1997

Screening  The method by which MCOs limit access to unnecessary health care. Most HMOs require a phone call to the physician before an office visit can be arranged. Gatekeepers and concurrent review are other methods of screening patients.

Second Surgical Opinion  An attempt to verify the need for surgery by encouraging the insured to seek the advice of another physician or surgeon who will not perform the operation.

Secondary Care  Health care services provided by medical specialists who generally do not have first contact with patients, but are referred to them by primary care and family physicians.

Self-Funding  Also known as self-insurance, self-funding is a health care plan funded entirely by employers who do not purchase insurance. Self-funded plans may be self-administered, or the employer may contract with an outside administrator for an administrative-services-only arrangement. Self-funded plans obtain stop-loss insurance (see definition of stop-loss insurance) to cover catastrophic illnesses.

Single-Payer System  A financing arrangement whereby money is funneled to the government, which assumes responsibility for the financing and administration of the health care system. These systems can be regional, statewide, or nationwide. The most popular example of the single-payer system is Canada.

Skilled Nursing Facility (SNF)  Typically an institution for convalescence or a nursing home, the skilled nursing facility provides a high level of specialized care for long-term or acute illness. It is an alternative to extended hospital stays or difficult home care.
Small Group Pooling  Small businesses combine resources and bargaining clout to obtain better insurance rates. Claims are then determined by a pool and not on a group-specific basis.

Specialist  A health professional, such as a physician, who has special training and perhaps certification in a particular area of medical care of services, such as obstetrics, cardiology, radiology, or surgery, and who restricts his or her medical practice to that area.

Standard Benefit Package  A set of specific health benefits offered by delivery systems.

State Children’s Health Insurance Program – See Balanced Budget Act of 1997

State Mandated Benefits  Each state requires insurance policies sold in that state to include benefits for a variety of medical conditions or providers. These mandated benefits can add to costs greatly.

Step Therapy  A prescription protocol used by HMOs and PPOs to utilize the most cost-effective drug therapy for selective diagnoses. If the patient does not respond satisfactorily, progressively more advanced therapy is prescribed as needed.

Stop-Loss Coverage  Insurance provided to employers who self-fund their benefit programs to protect the employer from catastrophic claims. Employers assume liability for claims up to a predetermined limit at which point the stop loss insurance assumes liability.

- **Specific**  This coverage protects the plan from large losses on any one participant who suffers serious accident or illness during the plan year. It accomplishes this by limiting the plan liability on any individual to a specific dollar amount (deductible). If an individual's claims exceed that dollar amount, the stop loss coverage reimburses the plan for all eligible claims incurred and paid for the remainder of the covered period. Experts in self-funded plans consider Specific Stop Loss to be the primary protection of the plan assets and to be essential to the financial solvency of the plan.

- **Aggregate**  This coverage protects the plan from claims incurred and paid on the entire group over the course of the covered period in excess of the anticipated level. Aggregate Stop Loss is a safety net for the plan as a whole and is helpful for budgeting purposes because it gives a maximum claims cost for the year. Aggregate Stop Loss is priced significantly less than Specific Stop Loss because it is experience rated, usually has a corridor between expected claims
and the maximum aggregate attachment point for the year, and claims above the specific deductible are not considered under the aggregate.

**Supply-Side Management** Health care supply-side management strategies utilized to control health care costs and improve the overall quality of care have traditionally focused on the providers of health care techniques such as **capitation**, case management, claims review, concurrent review, cost sharing, deductibles, drug use evaluation, fee schedule, formularies, profiling, therapeutic substitution, utilization review, and withhold funds.

**Surgicenter** A separate, freestanding medical facility specializing in outpatient or same-day surgical procedures. Surgicenters drastically reduce the costs associated with hospitalizations for routine surgical procedures because extended inpatient care is not required for specific disorders.

**Systems Management** This concept looks at the entire system of care and integrates all services. It considers early intervention, appropriate referral, the analysis of intervention itself, report cards, with special emphasis on the outcomes of interventions and results of clinical support mechanisms. All of these things, bundled together as a concept, is systems management.
Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)  The federal law that created the current risk and cost contract provisions under which health plans contract with HCFA (now CMS) and the Medicare program. It also enacted the Medicare Risk program that allowed Medicare beneficiaries to enroll in HMOs, and provided that Medicare function as a secondary insurer for Medicare beneficiaries who are working full-time and covered by an employer group plan. (See Medicare Secondary Payer.)

Technology Assessment  The term used to describe the evaluation process of new or existing diagnostic and therapeutic devices and procedures. Technology assessment evaluates the effect of a medical procedure, diagnostic tool, medical device, or pharmaceutical product. In the past, technology assessment primarily meant evaluating new equipment and focused on the clinical safety and efficacy of an intervention. In today’s health care world, it includes both a broader view of clinical outcomes, such as the effect on a patient’s quality of life and effect on society, such as cost-benefit analysis.

TEFRA See Tax Equity and Fiscal Responsibility Act of 1982

Telemedicine  The provision of consultant services by off-site physicians to health care professionals on the scene by means of closed-circuit television; the ability of health care providers to examine patients, not in person, but by means of a computer screen.

Terminal Liability (Run Out)  The liability remaining, after plan termination, for claims incurred but not yet paid under an insured program. This liability is funded by reserves set aside from previously paid premiums in fully insured plans. Under a self-funded program, the liability falls to the employer who may or may not have pre-funded this claim cost.

Tertiary Care  Tertiary care is administered at a highly specialized medical center. It is associated with the utilization of high-cost technology resources.

Therapeutic Substitution  A drug that is believed to be therapeutically equivalent (i.e., will achieve the same outcome) to the exact drug prescribed by a physician. The
drug is substituted by the dispensing pharmacist without the need to obtain permission from the physician. Therapeutic substitution is generally mandated by formulary or cost-containment concerns.

**Third-Party Administrator (TPA)** An organization separate from the insuring organization that handles the administrative duties and sometimes utilization review. Third-party administrators are used by organizations that fund the health benefits but do not find it cost effective to administer the plan themselves.

**Third-Party Payer** A public or private organization that pays for or underwrites coverage for health care expenses.

**Total Quality Management** Total quality management is a philosophy of management in which, through a continuous loop of monitoring, evaluating, and correcting, businesses increase and maintain the highest quality output possible. This philosophy played a vital role in transforming the Japanese manufacturing industry from a source of poor-quality goods to a source of state-of-the-art products. Many health organizations are attempting to use this philosophy for the improvement of health care delivery.

**Treatment Facility** A residential or nonresidential facility or licensed program authorized to provide treatment of substance abuse or mental illness.

**Trending** A calculation used to anticipate future utilization of a group based on past utilization by applying a trend factor; the rate at which medical costs are changing because of various issues, including prices charged by health care providers; changes in the pattern of utilization; and the use of expensive medical equipment.

**Triage** A term that originated on the battlefield, triage is the evaluation of patient conditions for urgency and seriousness, and establishment of a priority list for multiple patients. In the setting of managed care, triage is often performed after office hours on the telephone by a nurse or other health professional to screen patients for emergency treatment.

**Tricare** The military’s integrated health care delivery system. The Tricare system includes the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Tricare gives the regional military treatment facilities control of health care delivery costs and purchasing. The Tricare system splits U.S. military bases into 12 designated regions. One major military health care facility within each of the regions is designated as the “lead agent,” which is responsible for organizing and maintaining an integrated delivery network, including civilian providers.
UCR See Usual, Customary, and Reasonable

Unbundling The act of separating a medical procedure or operation into its many components, resulting in payment for each component rather than a lower global price for the entire procedure.

Undertreatment Failure on the part of the provider to recommend or deliver at the proper time one or more doses of services which are necessary and appropriate.

Underwriter Usually refers to a company that receives premiums and accepts responsibility to fulfill the health insurance policy contract. Can also apply to an insurance company employee who decides whether or not the carrier should assume a risk or the agent who sells the policy.

Universal Coverage This term refers to proposals to provide every American with access to health benefits coverage.

Upcoding The intentional or accidental act of changing a procedure code, such as a CPT code digit, to reflect a higher intensity of care and thus a higher payment. See also Coding.

URAC See Utilization Review Accreditation Commission

Urgent Care Center A medical facility where ambulatory patients can be treated on a walk-in basis, without an appointment, and receive immediate, nonemergency care. The urgent care center may be open 24 hours a day; patients calling an HMO afterhours with urgent, but not emergent clinical problems are often referred to these facilities.

Usual, Customary, and Reasonable (UCR) A fee controlling system to determine the value of physician reimbursement based on: (1) the physician’s usual charge for a given procedure; (2) the amount customarily charged for the service by other physicians in the area; and (3) the reasonable cost of services for a given patient after medical review of the case.
Utilization Review  Evaluation of the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities on a prospective (pre-admission), concurrent, or retrospective basis.

Utilization Review Accreditation Commission (URAC)  A Washington-based, nonprofit corporation formed in 1990 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 and PPOs.

Validation Criterion  Determination of whether a patient had the diagnosis or problem ascribed to him or her in the patient medical record.

Value-Added Services  These services, such as handling complicated paperwork and reimbursement forms, are offered by pharmaceutical manufacturers or drug wholesalers to enhance their competitive edge.

Variation  In utilization review, an instance in which information on a patient’s record does not conform to a screen criterion. The information in question may or may not subsequently be justified by audit committee review.

Vertical Integration  A provider strategy, usually accomplished through partnerships, joint ventures, and contractual agreements, whereby providers establish a local or regional health care delivery network serving a geographically-defined population. This system provides a seamless, full range of services and delivery settings for patients.

Volume Performance Standards  Standards for rates of increase for physician services expenditures, enacted as part of the Omnibus Budget Reconciliation Act (OBRA) to control the rate of increase in the volume and intensity of services provided to Medicare beneficiaries. Designed so that physicians order fewer tests of limited value for patients.

Vouchers  A government document issued to eligible populations for the receipt of health benefits coverage. Vouchers are commonly proposed to provide coverage to
low-income populations. Vouchers would be financed through tax revenues.
Wage and Price Controls  A government-imposed cost control mechanism applied to any or all sectors of the national economy to stem the rate of growth in prices. Wages and prices could be frozen at their current rate at a specified point in time. Wage and price controls were applied in the early 1970s under Richard Nixon’s economic stabilization period. While wage and price controls were effective in slowing the rate of growth in the health sector during that period, price controls were generally viewed as unsuccessful due to the steep rise in the price after the controls were lifted.

Waiver  An agreement attached to an insurance policy that exempts certain disabilities or injuries from coverage normally covered by the policy.

WEDI See Workgroup for Electronic Data Interchange

Well Baby Care  Those medical services, physician visits, and immunizations that are recommended by the American Pediatric Association as appropriate and routine care for a normal child from birth to 1 year of age.

Wellness  A health care process that fosters awareness and attitudes toward healthy lifestyles so that individuals can make informed choices to achieve optimum physical and mental health.

Withhold Fund  The portion of the monthly capitation payment to physicians withheld by the MCO until the end of the year or other time period to create an incentive for efficient care. If the physician exceeds utilization norms for other members of his group or geographic region, he or she loses the fund. The principle of the withhold fund may be applied to hospital services, specialty referrals, laboratory and imaging usage, etc. See also Capitation.

Workers’ Compensation  A state-governed system that addresses work-related injuries. Under this system, employers assume the cost of medical treatment and wage losses stemming from a worker’s job-related injury. In return, employees give up the right to sue employers.

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.

**Work-up** The total patient evaluation, which may include assessments, radiologic
series, medical history, and diagnostic procedures.