MANAGED CARE GLOSSARY

Accessibility — Degree to which the healthcare delivery system inhibits or facilitates the ability of an individual to gain entry and to receive services (includes geographic, transportation, social, time, and financial considerations).

Actuary — A person trained in the insurance field, who determines policy rates, reserves, and dividends, and conducts various other statistical studies.

Adjustable Premium — Usually used in connection with guaranteed renewable health policies in which the premium is subject to change based on classes of insured.

Administrative Services Only (ASO) — An arrangement under which an insurance carrier or an independent organization will, for a fee, handle the administration of claims, benefits, and other administrative functions for a self-insured group.

Adverse Selection — When a larger proportion of persons with poorer health status enroll in specific plans or insurance options, while a larger proportion of persons with better health status enroll in other plans or insurance options. Plans with subpopulations with higher-than-average costs are said to be adversely selected. Plans with subpopulations with lower-than-average costs are favorably selected.

Aftercare — The process of providing continuous contact that will support and increase the gains made to date in a health treatment process.

Age/Sex Rating — A method of structuring capitation payments based on health plan enrollee age and sex.

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

Alliances — Purchasing pools responsible for negotiating health insurance arrangements for employers and/or employees. Alliances use their leverage to negotiate contracts that ensure care is delivered in economical and equitable ways (also referred to as health insurance purchasing cooperatives or health plan purchasing cooperative.) (See also **Community Health Purchasing Alliance**.)

Allowable Costs — A Medicare term (sometimes used by third-party payers) that refers to charges for services rendered or supplies furnished by a clinician that qualify as covered expenses.

Alternative Care — Medical care received in lieu of inpatient hospitalization. Examples include outpatient treatment, psychiatric home healthcare, and partial hospitalization.

Alternative Delivery System (ADS) — A structure for providing healthcare benefits that departs from traditional indemnity methods and explicitly integrates the financial and service delivery components. An HMO, for example can be said to be an alternative delivery system.

Ambulatory Setting — Any setting in which organized services are provided on an outpatient basis. Ambulatory care settings also may be mobile units of service.

Ancillary Charge — The fee associated with an additional service performed prior to and/or secondary to a significant procedure. Examples include lab work, x-rays, and pharmacy.

Annual Maximum — The total dollar benefit available during the course of the plan year.

Any Willing Provider Laws — State laws that challenge and establish policy governing managed care organizations. They require the granting of network enrollment to any provider who is willing to join, as long as he or she meets provisions outlined in the plan. The central issue is the fairness of physician deselection by a plan, and conversely, the plan's ability to reduce medical costs by eliminating overusing physicians.

Average Length of Stay (ALOS) — Average number of patient days of service rendered to each inpatient (excluding newborns) during a given period. Varies for patients by diagnosis, age, hospital efficiency, etc. One measure of use of health facilities.

Balance Billing — Billing a patient for charges above the amount reimbursed by the health plan, (i.e., the difference between billed charges and the amount paid). This may or may not be appropriate, depending upon the contractual arrangements between the parties and/or requirements of state and federal law.

Base Capitation — A stipulated dollar amount to cover the cost of healthcare per covered person, less mental health/substance abuse services, pharmacy, and administrative charges.

Basic Health Services — Benefits that all federally qualified HMOs must offer. As far as mental health care is concerned, these include: medically necessary emergency health services; short-term (not to exceed twenty visits) outpatient evaluative and crisis intervention services; and medical treatment and referral services for alcohol and drug abuse and addiction.

Benchmarking — An ongoing measurement and analysis process that compares administrative and clinical practices, processes or methodologies of an organization or an individual with others. The goal is to discover the best practices of others in order to improve one's own. Terms often used are administrative bench-marking and clinical bench-marking.

Beneficiary — The person designated or provided for by the policy terms to receive benefits under the insurance contract.

Benefit Package — A collection of specific services or benefits that are covered by insurance plan.

Benefit Year — A twelve-month period that a group uses to administer its employee fringe benefits program. Most use a January through December benefit year. The benefit year, however, may not match the fiscal year used by a group.

Capitation — A stipulated dollar amount established to cover the cost of healthcare services delivered for a person. The term usually refers to a per capita rate to be paid periodically, usually monthly, for the delivery of all health services required by the covered person under the condition of the contract. The payment to the practitioner is the same regardless of the amount of service needed or rendered. (See also **Base Capitation**.)

Carve-Out — A separate financing and delivery structure established for a particular healthcare benefit package. Example: A mental health benefit may be carved out and separated from other medical benefits covered by an indemnity or HMO plan, and a specialized vendor selected to supply these services on a stand-alone basis. These arrangements are usually provided for a fixed fee per subscriber or per member per month (e.g., capitation). Also sometimes referred to as single service plans (SSPs). (See also **Capitation**.)

Case Management — A process whereby covered persons with specific healthcare needs are identified and a plan is developed and managed whereby all available healthcare resources (and sometimes social services) are utilized to achieve the optimum patient outcome in the most efficient, cost-effective manner. It typically integrates care provided by all the entities involved -- the MCO, the physician or other type of clinician(s), the patient, and the family -- in an effort to find the most appropriate treatment for the patient.

Case Manager — An experienced clinician (e.g., physician, nurse, or social worker) who works with patients, treating clinicians, and insurers to coordinate all services deemed necessary to provide the patient with a plan of medically necessary and appropriated healthcare.

Case Mix — The frequency and intensity of hospital admissions or services reflecting different needs and uses of hospital resources. Case mix can be measured based on patients' diagnoses or the severity of their illness, the utilization of services, and the characteristics of a hospital.

Case Rate – A reimbursement model used by hospitals to establish a flat rate per admission based on an assumed average length of stay per admission. The HMO is charged this rate for each member admitted; unique rates may be set or grouped by diagnosis type or categories of medical/surgical, obstetrical, critical care, etc. Other elements may include sliding scale volume, ALOS by type, volume of ancillary per patient, and contribution margin. Also sometimes used for episodes of post-hospital care.

Cash Indemnity Benefits — Sums that are paid to the insured for covered services and that require submission of a filed claim. The insured may assign such payments directly to clinical providers of services (hospitals, physicians, etc.). Payments may or may not fully reimburse the insured for costs incurred.

Certificate of Need — A certificate required by a governmental authority of an individual or organization proposing to construct or modify a health facility, acquire major new medical equipment, or offer a new or different health service.

Claim — A demand to the insurer for the payment of benefits under the insurance contract.

Claims Completion — A measure used to evaluate the performance of the claims payment function, usually calculated by subtracting the date of receipt of the claim from the date the claim is adjudicated as paid by the payer. A common industry standard is a fourteen-day claims turnaround.

Claims Lag — An analysis, usually performed by an actuary, that allocates the actual dollars paid to the months in which the services are performed. Claims lag analyses are

used to determine completion rates for claims payment performance and are integral in the calculation and projection of claims expenses for a given period.

Claims Procedure — Under ERISA each plan is required to provide a claims procedure, which must be explained to plan beneficiaries. The denial of a claim made under the claims procedure must be in writing, with an explanation of the reasons for the denial. Note, however, that **despite** the essential requirements, there may be considerable variations in these procedures.

Claims-Made Insurance — A type of insurance that covers the policyholder only if the claim is made during the time the policy is held. For example, if you have claims-made insurance coverage in 1998 and a claim is made against you during that year, you are covered. If a claim for malpractice allegedly occurring in 1998 is made in 1999 and you have discontinued paying the insurance premium, you are not covered. (See also **Tail Coverage**.)

Coinsurance — The portion of covered healthcare costs for which the covered person has a financial responsibility, usually according to a fixed percentage. Often coinsurance applies after first meeting a deductible requirement.

Community Health Management Information System (CHMIS) — A system to electronically link clinicians, payers, employers, and consumers in communities to improve healthcare quality and promote community wellness.

Community Health Purchasing Alliance (CHPA) — A purchaser of healthcare benefits on behalf of employer groups

Community Rating — A method of determining a premium structure that is not influenced by the expected level of benefit utilization by specific groups, but by expected utilization by the population as a whole. Everyone in a specified community would pay the same premium for the same package of benefits, regardless of age, sex, medical history, lifestyle, or place of residence. An adjusted community rating is a community rating that is influenced by group-specific demographics.

Concurrent Review — A routine review of the medical necessity for continued treatment, by an internal or external utilization reviewer, during the course of a patient's treatment. This usually occurs for inpatient, residential, and partial hospitalization treatment, though it is becoming more frequent for outpatient treatment as well.

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

Continuum of Care — A range of clinical services provided to an individual or group that may reflect treatment rendered during a single patient hospitalization or may include care for multiple conditions during a lifetime. The continuum provides a basis for analyzing quality, cost, and utilization in the long term.

Contract — An agreement executed between a payer and a purchaser to provide healthcare benefits. Also used to designate an enrollee's coverage.

Contract Mix — The distribution of enrollees according to contracts classified by dependency categories. For example, the number or percentage of individuals, couples, or families. Contract mix is used to determine average contact size.

Contracted for Liability — This liability refers to the exposure a clinician may assume by agreeing to an indemnification clause in her/his contract with an MCO.

Coordination of Benefits (COB) — Established procedures to be followed in the event of duplicate coverage, thus assuring that no more than 100 percent of the costs of care are reimbursed to the patient.

Copayment — A cost-sharing arrangement in which a covered patient pays a specific charge for a specified service, such as $10 for an office visit. The covered patient is usually responsible for payment at the time the healthcare is rendered. Typical copayments are fixed or variable flat amounts for physician office visits, prescriptions, or hospital services. Often copayments are referred to as coinsurance, with the distinguishing characteristic that copayments are flat dollar amounts and coinsurance is a defined percentage of the charges for services rendered. Also called copay.

Cost Sharing — A general set of financing arrangements via deductibles, copays, and/or coinsurance in which a person covered by the health plan must pay some of the costs to receive care. See also copayment and coinsurance.

Cost Shifting — The practice by some clinicians of recovering the difference between normal charges and amounts actually received from certain payers by increasing charges made to other payers.

Cost-Effectiveness — The degree to which a service or a medical treatment meets a specified goal at an acceptable cost and level of quality.

Covered Expenses — Hospital, medical, and miscellaneous healthcare expenses incurred by the insured for which she/he is entitled to payment of benefits under a health insurance policy. The term defines, by either description, reasonableness, or necessity the type and amount of expense which will be considered in the calculation of benefits.

Credentialing — A process of review to approve a clinician who applies to participate in a health plan. Specific criteria and prerequisites are applied in determining initial and ongoing participation in the health plan. Decredentialing is the removal of the clinician as a participant in the plan.

Critical Pathways — Charts (often algorithms) showing the key events that typically lead to the successful treatment of patients in a certain homogeneous population. They organize, sequence, and time the major interventions of nursing staff, physicians, and other departments for a particular case type (such as asthma), subset, or condition.

Deductible — Annual expenses a subscriber has to pay before an insurance plan covers healthcare costs. These often apply to a subscriber and his or her family in total.

Dependent — Any member of a subscriber's family who meets the applicable eligibility requirements of the health plan and who has enrolled in the plan in accordance with its enrollment requirements.

Diagnosis Independent Outcome — Outcomes adjusted for severity of illness, based primarily on clinical indicators, independent of the ultimate discharge diagnosis. Thus, there is no direct correlation between the diagnosis and the treatment interventions and outcomes. Examples are MedisGroups and APACHE.

Diagnosis Related Groups: (DRG) — A system of patient classification used by Medicare to reimburse hospitals. Classification under DRGs is based on principal diagnosis, secondary diagnosis, surgical procedures, age, sex, and presence of complications.

Direct Contracting — Individual employers or business coalitions contract directly with clinicians for healthcare services with no third-party intermediary.

Discounted Fee-for-Service — An agreed upon rate for service between the clinician and payer that is less than the clinician's full fee. This may be a fixed amount per service or a percentage discount.

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

Dual Choice — A health benefit offered by an employment group permitting eligibles of the group a voluntary choice of health plan; usually the employer's primary insurer and an HMO.

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

Effective Date — The date on which the insurance under a policy begins.

Electronic Data Interchange (EDI) — The computer-to-computer exchange of information between organizations. The data may be either a standardized or proprietary format.

Eligibility Date — The date on which an individual becomes eligible to apply for insurance.

Eligibility Period — A specified length of time, frequently thirty-one days, following the eligibility date, during which an individual member of a particular group will remain eligible to apply for insurance under a group health or life insurance policy without evidence of insurability.

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

Encounter — Face-to-face meetings between a covered person and a clinician where services are provided or rendered. The number of encounters per member per year is

calculated as the total number of encounters per year, divided by the total number of members per that year.

Enrolled Group — Persons with the same employer or with membership in an organization in common, who are enrolled in a health plan. Usually there are stipulations regarding the minimum size of the group and the minimum percentage of the group that must enroll before the coverage is available.

Enrollee — Any person eligible as either a subscriber or a dependent in accordance with an employee benefit plan. (Synonyms: beneficiary, eligible individual, member, participant).

Enrollment — The total number of covered persons in a health plan. The term also refers to the process by which a health plan signs up groups and individuals for membership or the number of enrollees who sign up in any one group.

Episode of Care — Treatment rendered in a defined time frame for a specific disease. Episodes provide a useful basis for analyzing quality, cost, and utilization patterns.

ERISA (Employee Retirement Income Security Act) — A federal law enacted in 1974 that allows self-funded plans to avoid paying premium taxes and exempts them from complying with state-mandated benefits even though insurance companies and managed care plans must do so. Another provision requires that plans and insurance companies provide an explanation of benefits (EOB) statement to a member or covered insured in the event of a denial of a claim explaining why the claim was denied and informing the individual of the rights of appeal.

Exclusions — Charges, services, or supplies that are not covered by a health insurance plan.

Exclusive Provider Organization (EPO) — A managed care organization that provides coverage only if care is provided by contracted clinicians. Technically, many staff-model HMOs also can be described as EPOs.

Experience — The relationship, usually expressed as a percentage or ratio, of premiums collected to claims paid, coverage or benefits, during a slated period of time.

Experience Rating — The process of setting rates based partially or entirely on previous claims experience and projected required revenues for a future policy year for a specific group or pool of groups.

Family Deductible — A deductible that is satisfied by the combined expenses of all covered family members. For example, a program with a $25 deductible may limit its application to a maximum of three deductibles ($75) for the family, regardless of the number of family members. See Deductible.

Fee Maximum — The maximum amount a participating clinician may be paid for a specific healthcare service provided to patients under a specific contract. A comprehensive listing of fee maximums used to reimburse a physicians and/or other clinicians on a fee-for-service basis is called a fee schedule.

Fee Schedule — A listing of fees or allowances for specific medical procedures, which usually represents the maximum amounts the program will pay for specific procedures.

Fee-for-Service — A traditional means of billing for each service performed, referring to payment in specific amounts for specific services rendered (as opposed to capitation, salary, or other contract arrangements).

First-Dollar Coverage — Feature of a healthcare plan in which the plan does not require its participants to pay any deductibles or copayments before benefits are received.

Flat Fee per Case — Flat fee paid for treatment based on the diagnosis and/or presenting problem. For this fee, the psychiatrist or other clinician covers all of the services the patient requires for a specific period of time. (See **Case Rate**)

Functionality — A quality of life indicator that relates to whether a patient has the potential to respond to treatment options and, as a result, be able to function in a normal life.

Gatekeeper — A primary care physician who serves as the patient's initial contact for medical care and who makes referrals to specialists. The gatekeeper function is to coordinate care and control access to other healthcare resources.

Global Budgets — Pre-set limits on the total amount of expenditures in a healthcare system.

Grace Period — A specified period after premium payment is due, in which the policyholder may make such payment, and during which the protection of the policy continues.

Group Insurance — A policy protecting a specified minimum number of persons usually having the same employer or connected to each other through some other entity through which the insurance is purchased.

Group Model HMO — A healthcare model involving contracts with physicians organized as a partnership, professional corporation, or other association. The health plan compensates the medical group for contracted services at a negotiated rate, and that group is responsible for compensating its physicians and contracting with hospitals for care of its patients.

Group Practice Without Walls — A range of physician-created practice arrangements that link doctors through the sharing of central services for contracting purposes, and yet the physicians maintain autonomy by keeping their own offices. Also known as clinics without walls.

Health Alliance — Also called a health purchasing cooperative. A state or regional body that combines consumers' purchasing power in order to negotiate prices with competing health plans.

Health Care Financing Administration (HCFA) — The federal agency responsible for the administration of Medicaid and Medicare programs.

Health Maintenance Organization (HMO) — An organization that provides comprehensive medical care for a fixed annual fee. Physicians and other clinicians often are on salary or on contract with the HMO to provide services. Patients are assigned a primary care doctor or nurse as a gatekeeper, who decides what health services are needed and when. There are four basic models of HMOs: group model, individual practice association, network model, and staff model.

Health Plan Employer Data and Information Set (HEDIS) — A core set of performance measures to assist employers and other health purchasers in understanding the value of healthcare purchases and evaluating health plan performance. Used by the National Center for Quality Assurance (NCQA) to accredit HMOs.

Health Status — An overall evaluation of an individual's degree of wellness or illness, with a number of indicators, including quality of life, and functionality (see **SF36**).

Hospital Affiliation — A contractual relationship between a health plan and one or more hospitals whereby the hospital provides the inpatient benefits offered by the health plan.

Indemnity — An insurance program in which the insured person is reimbursed for covered expenses. It is a traditional health insurance plan with little or no benefit management, a fee-for-service reimbursement model, and few, if any, restrictions in selection of clinicians.

Independent Practice Association (IPA) — A healthcare model that contracts with an entity, which in turn contracts with physicians, to provide healthcare services in return for a negotiated fee. Physicians continue in their existing individual or group practices and are compensated on a per capita, fee schedule, or fee-for-service basis.

Individual Mandate — Requirement that all individuals purchase health insurance, much the same as is done in auto insurance. This proposal is usually combined with some strategy for aiding low-income workers and the unemployed with the costs of such coverage.

Integrated Delivery System — A generic term referring to a combination of clinicians, programs, and facilities, delivering healthcare in an integrated way. Some models of integration include the **physician-hospital organization**, **management service organization**, **group practice without walls**, integrated provider organization, and medical foundation.

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

Legal Reserve — The minimum reserve which a company must keep to meet future claims and obligations as they are calculated under the state insurance code. The reserve amount is usually determined by an actuary.

Length of Stay (LOS) — The number of days that covered patients stay in an inpatient facility.

Lifetime Maximum — Under a health insurance plan, the total benefit dollar available to an individual during the course of a lifetime.

Managed Care — A system that manages or controls what it spends on healthcare by closely monitoring how physicians and other clinicians treat patients. Various techniques for keeping costs down include limiting coverage to care provided by specially selected physicians and hospitals, and requiring preauthorization for hospital care and other services.

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

Managed Mental Health Program (MMHP) — An organization that assumes responsibility for managing the mental health benefit for an employer or MCO. The management may range from utilization management services to the actual provision of the services through its own organization or clinician network. Reimbursement may be on a fee-for-service, shared risk, or full-risk basis.

Management Service Organization(MSO) — A legal entity that provides practice management, administrative, and support services to individual physicians or group practices. An MSO may be a direct subsidiary of a hospital or may be owned by investors.

Maximum Benefits — The maximum annual or lifetime benefits to which a covered individual is entitled.

Maximum Limits — The maximum amount payable under a health plan for each cause for each year or for a lifetime.

Medicaid — A nationwide program, adopted in 1965, of health insurance for eligible disabled and low-income persons, administered by the federal government and participating states. The program's costs are shared by the federal and state governments and paid for by general tax revenue.

Medical Necessity — Generally defined as treatment that is appropriate and necessary to the symptoms, diagnoses, or manifestations of a medical disorder; the treatment falls within standards of good practice for the service modality; and the most appropriate level or supply of service is safely provided to the individual.

Medicare — A nationwide, federally administered health insurance program that covers the costs of hospitalization, medical care, and some related services for eligible persons. Medicare has two parts. Part A covers inpatient costs. Medicare pays for pharmaceuticals provided in hospitals, but not for those provided in outpatient settings. Part B covers outpatient costs for Medicare patients.

Medicare Supplement Policy — A policy guaranteeing that a health plan will pay coinsurance, deductible, and copayments and will provide additional health plan or non-Medicare coverage for services up to a predefined benefit limit (the portion of the cost of services not covered by Medicare). Also called Medigap or Medicare wrap.

Morbidity — An actuarial determination of the incidence and severity of sicknesses and accidents in a well-defined class or classes of persons.

Mortality — An actuarial determination of the death rate at each age as determined from proper experience. A mortality study (table) shows the probability of death and survival at each age for a unit of population.

Network Model HMO — An HMO type in which the HMO contracts with more than one physician group, and may contract with single- and multispecialty groups. The physician works out of his or her own office and may share in utilization savings, but does not necessarily provide care exclusively for HMO beneficiaries.

Occupancy Rate — The ratio of actual patient days to the maximum patient days, as determined by bed capacity, during a given period.

Occurrence Coverage — Coverage that extends beyond the term of the policy and protects the psychiatrist for all malpractice claims related to services during the term of the policy, regardless of when the claims are made. For example, if you purchased occurrence insurance in 1998 you would be covered for all acts in 1998, even if the claim is filed years later. This type of insurance is more expensive than **claims-made insurance**.

Office of Health Maintenance Organizations (OHMO) — A division of the U.S. Department of Health and Human Services, with headquarters in Rockville, Maryland, that is responsible for administering federal law respecting HMOs.

Open Access — A self-referral arrangement allowing patients to see participating clinicians for open panel specialty care without a referral from a doctor.

Outcome Measures — Assessments that gauge the effect or results of treatment for a particular disease or condition. Outcome measures include the patient's perception of restoration of functional status, as well as measures of mortality, morbidity, cost, quality of life, and patient satisfaction.

Outcomes Management — Definitions vary, but this generally involves collection and analysis of results of medical processes and performances according to agreed-on specifications and the use of that information to optimize healthcare provisions through the collaborative efforts of patients, payers, and clinicians.

Outlier — A patient who varies significantly from other patients with the same diagnosis, such as a longer or shorter length of stay, death, or leaving against medical advice.

Out-of-Area Benefits — Benefits that a managed care plan supplies to its subscribers outside of its geographical area.

Paid Claims — The dollar value of all claims paid (i.e., hospital medical, surgical, etc., during the plan year) regardless of the date that the services were performed.

Participating Provider — A clinician, program, or facility who has contracted with the health plan to provide medical services to covered persons.

Payer — Any individual or organization that pays for healthcare services, including insurance companies and various government programs such as Medicare and Medicaid.

Per Diem — An agreed upon dollar rate per inpatient, residential, or partial hospitalization day that is usually all-inclusive.

Per Incident — The maximum amount of money the insurance company will pay per claim.

Percentage of Occupancy — The ratio of actual patient days to the maximum possible patient days as designated by bed capacity during any given period.

Physician-Hospital Organization — A legal entity formed and owned by one or more hospitals and physician groups in order to obtain payer contracts and further mutual interests.

Plan Administrator — Under ERISA the person designated as such by the instrument under which the plan is operated. If the administrator is not so designated, *administrator* means the plan sponsor. If the administrator is not designated and the plan sponsor cannot be identified, the administrator may be such person as is prescribed by regulation of the Secretary of Labor.

Point-of-Service (POS) — A provision that allows patients to seek treatment outside of the network, typically with a higher copayment.

Portability — Insurance benefit plans moveable from one job to another or from one state to another so as to provide continuous coverage for the individual and his or her family.

Practice Guidelines — Systematically developed statements on medical practice that assist physicians in decisions about appropriate healthcare for specific medical conditions. Terms used synonymously include practice parameters, standard treatment protocols, and clinical practice guidelines.

Preexisting Condition (PEC) — Any medical condition that has been diagnosed or treated within a specified period immediately preceding the covered person's effective date of coverage.

Preferred Provider Organization (PPO) — An organized network of healthcare providers, typically reimbursed on a discounted fee-for-service basis. Coverage may or may not be available outside of the network for a higher copayment.

Primary Data — Information obtained from medical records or other primary sources of clinical findings such as diagnostic tests and physical examination results.

Prospective Reimbursement — Any method of paying hospitals, programs, or clinicians for a defined period (usually one year) according to amounts or rates of payment established in advance.

Provider Profiling — Statistical techniques used to identify clinicians who over- or under-utilize services.

Quality — The features of a product or service that bear on its ability to satisfy the stated or implied needs of the user, or patient. Quality assessment should include patients' evaluations of how well a product or service meets their needs and expectations with respect to process, outcomes, and perceived value.

Reinsurance — A type of protection purchased from insurance companies specializing in underwriting specific risks for a stipulated premium. Typical reinsurance risk coverages include (1) individual stop-loss, (2) aggregate stop-loss, (3) out-of-area, and (4) insolvency protection.

Resource Based Relative Value Scale (RBRVS) — A fee schedule introduced by HCFA to reimburse physicians' Medicare fees based on the amount of time, resources, and expertise expended in selected specific medical procedures.

Retrospective Review — Determination of medical necessity and/or appropriate billing practice for services already rendered.

Risk Analysis — The process of evaluating expected medical care costs for a prospective group — and determining what product, benefit level, and price to offer under a risk arrangement.

Risk Sharing — A method by which premiums and costs of medical protection are shared by plan sponsors and clinicians.

Self-Funded Health Plans — Plans that provide for the reimbursement of medical expenses incurred by an employee and/or his/her dependents where reimbursements are not provided under an accident or health insurance policy; that is, all or some of the risk is borne directly by the plan. It is possible to insure some benefits and self-insure others; to self-insure or self-fund all benefits up to a certain aggregate claim level; or to set certain individual claim limits for self-funding and insure above that level. Reimbursements to highly compensated individuals must be included in their income unless the self-insured plan satisfies certain requirements relating principally to nondiscrimination in plan benefits and eligibility of expenses.

Self-Insurance — An entity itself assumes the risk of coverage and makes appropriate financial arrangements rather than purchasing insurance from a third party and paying a premium for this coverage.

SF36 — Medical Outcomes Study Short Form with thirty-six questions. A psychometrically strong health status questionnaire designed to measure overall functional status and well-being for adult patients, including physical, social, and mental status.

Single-Payer System — A healthcare financing arrangement in which money, usually from a variety of taxes, is funneled to a single entity (usually the government) that is responsible for the financing and administration of the health system. The controlling entity typically imposes various forms of price controls and rate settings. Single-payer systems can be regional, statewide, or nationwide.

Staff Model HMO — A healthcare model that employs physicians to provide healthcare to its patients. All premiums and other revenues accrue to the HMO, which compensates physicians by salary and incentive programs.

Standard Benefit Package — A specified set of minimum medical benefits available to all persons.

Stop-Loss Insurance — Insurance coverage taken out by a health plan or self-funded employer to provide protection from losses resulting from claims greater than a specific dollar amount per covered person per year (see **Reinsurance**).

Tail Coverage — Extension of insurance coverage for acts occurring during the life of the policy for claims filed after the policy expires.

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, and which defined the primary and secondary coverage responsibilities of the Medicare program and the system of payment for psychiatric inpatient care under Medicare.

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

Third-Party Payer — The insurer who pays for the services provided to a patient.

Total Quality Management (TQM) — An organization-wide process of improving the quality of products and services in any organization. It is also often referred as continuous quality improvement (CQI).

Triple Option — Multiple option plans that typically include indemnity, PPO, and HMO plans through one insurer. Triple option plans, in theory, prevent "adverse selection" by placing all employees in a single risk pool.

Unbundling — Separating packaged units that might otherwise be packaged together. For claims processing, this includes clinicians billing separately for healthcare services that might be combined according to industry standards or commonly accepted coding practices.

Underwriter — The term generally used applies either to 1) a company that receives the premiums and accepts responsibility for the fulfillment of the policy contract; 2) the company employee who decides whether or not the company should assume a particular risk; or 3) the agent who sells the policy.

Usual, Customary, and Reasonable Fee — The fee usually charged for a given service by an individual clinician to his or her private patient; that is, the clinician's own usual fee.

Utilization — The extent to which the beneficiaries within a covered group use a program or obtain a particular service, or category of procedures, during a given period of time. Usually expressed as the number of services used per year or per one thousand persons covered.

Utilization Criteria — The guidelines used to establish the medical necessity and appropriateness of a course of treatment.

Utilization Management — The management of patient utilization of healthcare services by a managed healthcare program.

Utilization Review — A formal assessment by an independent third party of the medical necessity, efficiency, and/or appropriateness of healthcare services and treatment plans on a prospective, concurrent, or retrospective basis.

Withhold — A percentage of payment held back from a practitioner until the total cost of his or her referral or hospital services has been determined. Physicians exceeding the amount determined as appropriate lose the amount held back.

Workers Compensation — A state-governed system designed to address work-related injuries. Under the system, employers assume the cost of medical treatment and wage losses arising from an employee’s job related injury or disease, regardless of who is at fault. In return, employees give up the right to sue employers, even if injuries stem from employer negligence.