Glossary of Insurance/Managed Care Terms

A B C D E F G H I J L M N O P Q R S T U V W | Jump to a letter above by control-clicking the link

A

Access - A person's ability to obtain affordable medical care on a timely basis. Barriers to access can be financial, geographic, organizational or sociological.

Accreditation - An evaluative process in which a health care organization under goes an examination of its operating procedures to determine whether the procedures meet designated criteria as defined by the accrediting body, and to ensure that the organization meets a specified level of quality.

ACD - See automatic call distributor.

ACF - See ambulatory care facility.

Acquisition - The purchase of one organization by another organization.

ACR - See adjusted community rating.

Actuaries - The insurance professionals who perform the mathematical analysis necessary for setting insurance premium rates.

Ad hoc committees - Committees that are convened to address specific management concerns. Also known as special committees.

Adequacy - The extent to which a network offers the appropriate types and numbers of providers in the appropriate geographic distribution according to the needs of the plan's members.

Adjudication - Processing claims according to contract.

Adjusted community rating (ACR) - A rating method under which a health plan or MCO divides its' members into classes or groups based on demographic factors such as geography, family composition, and age, and then charges all members of a class or group the same premium. The plan cannot consider the experience of a class, group, or tier in developing premium rates. Also known as modified community rating.

Administrative services only (ASO) contract - A contract under which a third party administrator or an insurer agrees to provide administrative services to an employer in exchange for a fixed fee per employee.

Administrative supervision - A situation in which operations are placed under the direction and control of the state commissioner of insurance or a person appointed by the commissioner.

Adverse event - Any harm a patient suffers that is caused by factors other than the patient's underlying condition.

Adverse selection - See anti-selection.

Affiliated provider - A health care provider that is part of a network, usually having a formal arrangement to provide services.

Agent - A person who is authorized by an MCO or an insurer to act on its behalf to negotiate, sell, and service managed care contracts.

Aggregate stop-loss coverage - A type of stop-loss insurance that provides benefits when a group's total claims during a specified period exceed a stated amount.

Ambulatory care facility (ACF) - A medical care center that provides a wide range of healthcare services, including preventive care, acute care, surgery, and outpatient care, in a centralized facility. Also known as a medical clinic or medical center.

Ancillary services - Auxiliary or supplemental services, such as diagnostic services, home health services, physical therapy, and occupational therapy, used to support diagnosis and treatment of a patient's condition.

Annual and lifetime maximum benefit amounts - Maximum dollar amounts set that limit the total amount the plan must pay for all healthcare services provided to a subscriber per year or in his or her lifetime.

Anti-selection - The tendency of people who have a greater-than-average likelihood of loss to seek healthcare coverage to a greater extent than individuals who have an average or less-than-average likelihood of loss. Also known as adverse selection.

Antitrust laws - Legislation designed to protect commerce from unlawful restraint of trade, price discrimination, price fixing, reduced competition, and monopolies. See also Sherman Antitrust Act, Clayton Act, and Federal Trade Commission Act.

Any willing provider law - Laws that require managed care plans to contract with all appropriate health care providers that meet their terms and conditions.

Appeal - A formal request by an insured person or provider for reconsideration of a decision.

Appeals review committee - The committee that reviews member appeals related to medical management or coverage determinations.

Arbitration - A process in which the parties to a dispute submit the dispute to an impartial third party for a final, binding decision.

ASO contract - See administrative services only contract.

Assets - All items of value that a company owns.

At-risk - Term used to describe a provider organization that bears the insurance risk associated with the healthcare it provides.

Authorization - A health plan's system of approving payment of benefits for services that satisfy the plan's requirements for coverage.

Automatic call distributor (ACD) - A device that answers calls with a recorded message and then routes calls to the appropriate department or unit.

Autonomy - An ethical principle which, when applied to managed care, states that managed care organizations and their providers have a duty to respect the right of their members to make decisions regarding the course of their lives.

В

Balance sheet - The financial statement that shows the financial status on a specified date.

Behavioral healthcare - The provision of mental health and chemical dependency (or substance abuse) services.

Benchmarking - A method of planning and implementing quality management programs that consist of identifying the best practices and best outcomes for a specific process and emulating the best practices to equal or surpass the best outcomes.

Beneficence - An ethical principle which, when applied to managed care, states that each member should be treated in a manner that respects his or her own goals and values and that managed care organizations and their providers have a duty to promote the good of the members as a group.

Beneficiary liability - The amount beneficiaries must pay providers for covered services, liabilities can include co-payments, deductibles, and balance billing amounts. CMS (HCFA) has very strict rules about health providers billing patients for their liabilities.

Benefit - Specific areas of a plan's coverage, i.e., outpatient visits, hospitalization and so forth, that make up the range of medical services that a payer covers.

Benefit limitations - Any provision, other than an exclusion, which restricts coverage, regardless of medical necessity.

Benefit design - The process used to determine which benefits or the level of benefits that will be offered to its members, the degree to which members will be expected to share the costs of such benefits, and how a member can access medical care through the health plan.

Best practices - Actual practices in use by qualified providers following the latest treatment modalities, that produce the best measurable results on a given dimension.

Blended rating - For groups with limited recorded claim experience, a method of forecasting a group's cost of benefits based partly on manual rates and partly on the group's experience.

Board of directors - The primary governing body of an organization.

Brand - A name, number, term, sign, symbol, design, or combination of these elements that an organization uses to identify one or more products.

Broker - A salesperson that has obtained a state license to sell and service contracts of multiple health plans or insurers, and who is ordinarily considered to be an agent of the buyer, not the health plan or insurer.

Budgeting - A process that includes creating a financial plan of action that an organization believes will help it to achieve its goals, given the organization's forecast.

Business integration - The unification of one or more separate business (non-clinical) functions into a single function.

C

Call abandonment rate - A measure of how often members hang up before receiving assistance when they make telephone calls to a company and are put on hold.

TOP

Capital - The money that a public company's owners have invested in the company.

Capitation - A method of paying for healthcare services on the basis of the number of patients who are covered for specific services over a specified period of time rather than the cost or number of services that are actually provided.

Capped fee - See fee schedule.

Captive agents - Agents that represent only one health plan or insurer.

Carve-out - The separation of a medical service (or a group of services) from the basic set of benefits in some way.

Case management - A process of identifying plan members with special healthcare needs, developing a health-care strategy that meets those needs, and coordinating and monitoring care.

Case-mix adjustment - See risk-adjustment.

Case rate - Flat fee paid for a client's treatment based on the diagnosis.

Categorically Needy Individuals - Under initial Medicaid eligibility requirements, individuals who received Medicaid benefits because of their welfare status.

CCPs - See coordinated care plans.

CEO - See chief executive officer.

Certificate of Authority (COA) - The license issued by a state to an HMO or insurance company, which allows it to conduct business in that state.

CHAMPUS (the Civilian Health and Medical Program of the United States) - See TRICARE.

Chief executive officer (CEO) - The manager responsible for an organization's overall operation, general administration, and public affairs.

Chief financial officer - See finance director.

Chief information officer (CIO) - The manager responsible for the plan's computer hardware and software systems, its telephone and electronic communication systems, and its electronic commerce capabilities.

Chief marketing officer - See marketing director.

Chief medical officer - See medical director.

Chief operations officer - See director of operations.

Chronic case - A patient with one or more medical conditions that persist for long periods of time or for the patient's lifetime.

CIO - See chief information officer.

Claim - An itemized statement of healthcare services and their costs provided by a hospital, physician's office, or other provider facility. Claims are submitted to the insurer or managed care plan by either the plan member or the provider for payment of the costs incurred.

Claim form - An application for payment of benefits under a health plan.

Claimant - The person or entity submitting a claim.

Claims administration - The process of receiving, reviewing, adjudicating, and processing claims.

Claims analysts - See claims examiners.

Claims examiners - Employees in the claims administration department who consider all the information pertinent to a claim and make decisions about the payment of the claim. Also known as claims analysts.

Claims investigation - The process of obtaining all the information necessary to determine the appropriate amount to pay on a given claim.

Claims supervisors - Employees in the claims administration department who oversee the work of several claims examiners.

Clayton Act - A federal act that forbids certain actions believed to lead to monopolies, including (1) charging different prices to different purchasers of the same product without justifying the price difference and (2) giving a distributor the right to sell a product only if the distributor agrees not to sell competitors' products. The Clayton Act applies to insurance companies only to the extent that state laws do not regulate such activities. See also antitrust laws.

Clinic model - See consolidated medical group.

Clinic without walls - See group practice without walls.

Clinical integration - A type of operational integration that enables patients to receive a variety of healthcare services from the same organization or entity, which streamlines administrative processes and increases the potential for the delivery of high-quality health-care.

Clinical practice guideline - A utilization and quality management mechanism designed to aid providers in making decisions about the most appropriate course of treatment for a specific clinical case.

Clinical practice management - The development and implementation of parameters for the delivery of health-care services to plan members.

Clinical status - A type of outcomes measure that relates to biological health outcomes.

Closed access - A provision, which specifies that plan members must obtain medical services only from network providers through a primary care physician to receive benefits.

Closed formulary - The provision that only those drugs on a preferred list will be covered by a PBM or MCO.

Closed PHO - A type of physician-hospital organization that typically limits the number of participating specialists by type of specialty.

Closed plans - According to the National Association of Insurance Commissioners' Quality Assessment and Improvement Model Act, managed care plans that require covered persons to use participating providers.

Closed-panel HMO - An HMO whose physicians are either HMO employees or belong to a group of physicians that contract with the HMO.

TOP

CMP - See competitive medical plan.

COA - See certificate of authority.

COBRA - See Consolidated Omnibus Budget Reconciliation Act.

Coding errors - Documentation errors in which a treatment is miscoded or the codes used to describe procedures do not match those used to identify the diagnosis.

Coinsurance - A method of cost sharing in a health insurance policy that requires a group member to pay a stated percentage of all remaining eligible medical expenses after the deductible amount has been paid.

Community rating - A rating method that sets premiums for financing medical care according to the health plan's expected costs of providing medical benefits to the community as a whole rather than to any sub-group within the community. Both low-risk and high-risk classes are factored into community rating, which spreads the expected medical care costs across the entire community.

Community rating by class (CRC) - The process of determining premium rates in which a managed care organization categorizes its members into classes or groups based on demographic factors, industry characteristics, or experience and charges the same premium to all members of the same class or group.

Competitive advantage - A factor, such as the ability to demonstrate quality, that helps organizations to compete successfully with other firms for business.

Competitive medical plan (CMP) - A federal designation that allows MCOs to enter into Medicare risk contracts without having to obtain federal qualification as an HMO.

Complaint - A health plan member's expressions that his expectations regarding the product or the services associated with the program have not been met.

Computer/telephone integration (CTI) - A technology that unites a computer system with a telephone system so that the two technologies function seamlessly.

Computer-based patient record - See electronic medical record.

Concurrent review - A type of utilization review that occurs while treatment is in progress and typically applies to services that continue over a period of time.

Consolidated medical group - A large single medical practice that operates in one or a few facilities rather than in many independent offices. The single-specialty or multi-specialty practice group may be formed from previously independent practices and is often owned by a parent company or a hospital. Also known as a medical group practice or clinic model.

Consolidated Omnibus Budget Reconciliation Act (COBRA) - A federal act which requires each group health plan to allow employees and certain dependents to continue their group coverage for a stated period of time following a qualifying event that causes the loss of group health coverage. Qualifying events include reduced work hours, death or divorce of a covered employee, and termination of employment.

Consolidation - A type of merger that occurs when previously separate providers combine to form a new organization with all the original companies being dissolved.

Contract management system - An information system that incorporates membership data and provider reimbursement arrangements and analyzes transactions according to contract rules. TOP

Coordinated care plans (CCPs) - The Medicare+Choice delivery option that includes HMOs (with or without a point-of-service component), preferred provider organizations (PPOs), and provider-sponsored organizations (PSOs).

Co-payment - A specified dollar amount that a member must pay out-of-pocket for a specified service at the time the service is rendered.

Corporate compliance committee - The committee that monitors and guides all compliance activities, including appointment of a corporate compliance officer, approval of compliance program policies and procedures, review of the organization's annual compliance plan, evaluation of internal and external audits to identify potential risks, and implementation of corrective and preventive actions.

Corporate compliance director - An executive level health plan manager who is responsible for overseeing the plan's compliance with state and federal laws.

Corporation - An organization that is recognized by the authority of a governmental unit as a legal entity separate from its owners.

Cost shifting - The practice of charging more for services provided to paying patients or third-party payers to compensate for lost revenue resulting from services provided free or at a significantly reduced cost to other patients.

CRC - See community rating by class.

Credentialing - The review and verification process used to determine the current clinical competence of a provider and whether the provider meets the pre-established criteria for participation in the network.

Credentialing committee -The committee that establishes and updates credentialing processes and criteria and reviews provider credentials during the credentialing and re-credentialing processes.

Credibility - A measure of the statistical predictability of a group's experience.

Cure provision - A provider contract clause, which specifies a time period (usually 60-90 days) for a party that breaches the contract to remedy the problem and avoid termination of the contract.

Customary, prevailing and reasonable (CPR) - Method of paying physicians under Medicare. Payment is limited to the lowest of the physicians billed charge or the physicians customary charge or the prevailing charge for that service in the community. Similar to the UCR system used by private insurers.

D

Data warehouse - A specific database (or set of databases) containing data from many sources that are linked by a common subject (e.g., a plan member).

Database marketing - A method of marketing that involves creating a database of customer information-including demographic, consumer preference, and sales history information-which is used to narrow the focus of an organization's direct marketing efforts.

Decision support system (DSS) - A form of information technology that uses databases and decision models to enhance the decision-making process for executives, managers, clinical staff, and providers.

Deductible - A flat amount a group member must pay before the insurer will make any benefit payments.

Dental health maintenance organization (DHMO) - An organization that provides dental services through a network of providers to its members in exchange for some form of prepayment. TOP

Dental point of service (dental POS) option - A dental service plan that allows a member to use either a DHMO network dentist or to seek care from a dentist not in the network. Members choose in-network care or out-of network care at the time they make their dental appointment and usually incur higher out'-of-pocket costs for out-of-network care.

Dental FOS option - See dental point of service option.

Dental PPO - See dental preferred provider organization.

Dental preferred provider organization (dental PPO) - An organization that provides dental care to its members through a network of dentists who offer discounted fees to the plan members.

DHMO - See dental health maintenance organization.

Diagnostic and treatment code - Special codes that consist of a brief, specific description of each diagnosis or treatment and a number used to identify each diagnosis and treatment.

Diagnosis related groups - An inpatient classification used to pay the hospital or other provider for their services and to categorize illness by diagnosis and treatment.

Direct mail - An advertising medium, usually in print form, that uses a mail service to distribute an organization's sales offers or advertising messages.

Direct marketing - A method of marketing that uses one or more media to elicit an immediate and measurable action such as an inquiry or a purchase-from a customer or prospect. Also known as direct response marketing.

Direct response marketing - See direct marketing.

Director of operations - The manager who oversees the programs and services that supports the organization as a whole, such as enrollment, claims, member services, office management, human resources, and other "back room" functions.

Discharge planning - A process used to help determine what activities must occur before the patient is ready for discharge and the most efficient way to conduct those activities.

Disease management - A coordinated system of preventive, diagnostic, and therapeutic measures intended to provide cost-effective, quality healthcare for a patient population who have or are at risk for a specific chronic illness or medical condition. Also known as disease state management.

Distribution - The activities and systems designed to make products or services available so that consumers can buy them.

Drive time - The length of time that members must drive to reach a primary care provider, which is typically set at a maximum of 15 minutes for urban areas and up to 30 minutes for rural areas.

Drug cards - See pharmaceutical cards.

Drug utilization review (DUR) - A review program that evaluates whether drugs are being used safely, effectively, and appropriately.

DSS - See decision support system.

"Dual choice" provisions - Provisions in the HMO Act of 1973 that required employers that offered healthcare coverage to more than 25 employees to offer a choice of traditional indemnity coverage or managed healthcare coverage under either a closed-panel HMO or an open-panel HMO.

Dual eligible - Elderly and disabled Medicaid recipients who also qualify for Medicare coverage.

Due process clause - A provider contract provision that gives providers that are terminated with cause the right to appeal the termination.

DUR - See drug utilization review.

F

Early and periodic screening, diagnostic, and treatment (EPSDT) services - A Medicaid program for recipients younger than 21 that provides screening, vision, hearing, and dental services at intervals that meet recognized standards of medical and dental practices and at other intervals as necessary to determine the existence of physical or mental illnesses or conditions.

E-commerce - See electronic commerce.

EDI - See electronic data interchange.

Edits - Criteria that, if unmet, will cause an automated claims processing system to "kick out" a claim for further investigation.

Electronic commerce (e-commerce) - The use of computer networks to perform business transactions and to facilitate the delivery of healthcare and non-clinical services to members.

Electronic data interchange (EDI) - The computer-to-computer transfer of data between organizations using a data format agreed upon by the sending and receiving parties.

Electronic medical record (EMR) - A computerized record of a patient's clinical, demographic, and administrative data. Also known as a computer-based patient record or electronic health record (EHR).

Eligible medical expense - Charges allowed up to the company reimbursement schedules for covered services.

Employee benefits consultant - A specialist in employee benefits and insurance who is hired by a group buyer to provide advice on a health plan purchase.

Employee Retirement Income Security Act (ERISA) - A broad-reaching law that establishes the rights of pension plan participants, standards for the investment of pension plan assets, and requirements for the disclosure of plan provisions and funding.

Employer purchasing coalitions - See purchasing alliances.

Employment-model IDS - An integrated delivery system that generally owns or is affiliated with a hospital and establishes or purchases physician practices and retains the physicians as employees.

EMR - See electronic medical record.

Encounter - A healthcare visit of any type by an enrollee to a provider of care or services.

Encounter report - A report that supplies management information about services provided each time a patient visits a provider.

Enterprise scheduling system - An information system that permits physician groups, hospitals, and other facilities within an enterprise to function as a single organization in arranging access to facilities and resources.

EPO - See exclusive provider organization.

EPSDT - See early and periodic screening, diagnostic, and treatment services.

ERISA - See Employee Retirement Income Security Act.

Error rate - A measure of the accuracy of information given and transactions processed.

Ethics - The principles and values that guide the actions of an individual or population when faced with questions of right and wrong.

Ethics in Patient Referrals Act - A federal act which, along with its amendments, prohibits a physician from referring patients to laboratories, radiology services, diagnostic services, physical therapy services, home health services, pharmacies, occupational therapy services, and suppliers of durable medical equipment in which the physician has a financial interest. Also known as the Stark Laws.

Exchange - The act of one party giving something of value to another party and receiving something of value in return.

Exclusive provider organization (EPO) - A healthcare benefit arrangement that is similar to a preferred provider organization in administration, structure, and operation, but which does not cover out-of-network care.

Exclusive remedy doctrine - A rule, which states that employees who are injured on the job are entitled to workers' compensation, benefits, but they cannot sue their employers for additional amounts.

Executive committee - The committee responsible for handling issues related to overall organizational policy, including lines of business and employment policies.

Executive quality improvement committee - The committee that oversees the organization's quality management committee, accreditation efforts, and other quality functions.

Expansion populations - Medicaid recipients who do not meet categorically needy or medically needy criteria and therefore fall outside the traditional Medicaid population.

Expenses - The amounts spent or committed by an organization to pay for covered benefits and their administration.

Experience - The actual cost of providing healthcare to a group during a given period of coverage.

Experience rating - A rating method under which an organization analyzes a group's recorded healthcare costs by type and calculates the group's premium partly or completely according to the group's experience.

Experience-based criteria - A utilization review resource that recognizes generally accepted community standards of practice and the overall experience and expert opinion of medical directors and other healthcare providers.

Expert system - A knowledge-based computer system whose purpose is to provide expert consultation to information users for solving specialized and complex problems.

External standards - Performance standards that are based on outside information such as published industry-wide averages or best practices.

Extranet - A private computer network that incorporates Web-based technologies and links selected resources of a firm to external entities or individuals.

F

Fax-on-demand - A communication system that enables a member to request specified documents or forms by entering information on the telephone keypad and to receive the requested information by fax.

Federal Employee Health Benefits Program (FEHBP) - A voluntary health insurance program for federal employees, retirees, and their dependents and survivors.

Federal Trade Commission Act - A federal act, which established the Federal Trade Commission (FTC) and gave the FTC power to work with the Department of Justice to enforce the Clayton Act. The primary function of the FTC is to regulate unfair competition and deceptive business practices, which are presented broadly in the Act. As a result, the FTC also pursues violators of the Sherman Antitrust Act. See also antitrust laws.

Fee allowance - See fee schedule.

Fee maximum - See fee schedule.

Fee schedule - The fee determined to be acceptable for a procedure or service, which the physician agrees to accept as payment in full. Also Known as a fee allowance, fee maximum, or capped fee.

Fee-for-service (FFS) payment system - A benefit payment system in which an insurer reimburses the group member or pays the provider directly for each covered medical expense after the expense has been incurred.

FEHBP - See Federal Employee Health Benefits Program.

FFS - See fee-for-service payment system.

Finance committee - The committee that sets the organization's broad investment policies and is responsible for reviewing and approving financial and accounting activities.

Finance director - The manager who is responsible for accounting activities such as budget planning, accounting, and internal audits, and financial operations such as membership billing and underwriting.

Financial management - The process of managing financial resources, including management decisions concerning accounting and financial reporting, forecasting, and budgeting.

First contact resolution rate - The percentage of questions that are answered, requests that are fulfilled, and transactions that are processed and completed at the initial point of contact.

Focus group interview - An unstructured, informal session in which six to ten people are led by a moderator who asks questions to guide the group into an in-depth discussion of a given topic.

Forecasting - A process that involves predicting incoming and outgoing cash flows-primarily revenues and expenses and predicting the values of its assets, liabilities, and capital or capital and surplus.

Formulary - A listing of drugs, classified by therapeutic category or disease class, that are considered preferred therapy for a given managed population and that are to be used by providers in prescribing medications.

Fully funded plan - A health plan under which an insurer or MCO bears the financial responsibility of guaranteeing claim payments and paying for all incurred covered benefits and administration costs.

Functional status - A patient's ability to perform the activities of daily living.

Funding vehicle - In a self-funded plan, the account into which the money that an employer and employees would have paid in premiums to an insurer or MCO is deposited until the money is paid out.

G

Gag clause - A provision of a contract between the managed care organization and the provider of services that restricts the amount of information a provider may share with an enrollee or that limits the circumstances under which a provider may recommend a specific treatment plan.

Gatekeeper - The primary care physician who must authorize or allow most medical services.

Generic substitution - The dispensing of a drug that is the generic equivalent of a drug listed on a pharmacy benefit management plan's formulary. In most cases, generic substitution can be performed without physician approval.

Geographic availability - The number of providers within a given radius of a particular target.

GPWW - See group practice without walls.

Group market - A market segment that includes groups of two or more people that enter into a group contract under which the insuring entity provides healthcare coverage to the members of the group.

Group model HMO – An HMO that contracts with a multi-specialty group of physicians who are employees of the group practice. Also known as a group practice model HMO.

Group practice model HMO - See group model HMO.

Group practice without walls (GPWW) - A legal entity that combines multiple independent physician practices under one umbrella organization and performs certain business operations for the member practices or arranges for these operations to be performed. The GPWW may maintain its own facility for business operations or it may hire another company to provide this function. Also known as a clinic without walls.

Н

Haphazard change - Change that is unplanned and uncontrolled and produces unpredictable results. Also known as random change.

HCQIA - See Health Care Quality Improvement Act.

HCQIP - See Health Care Quality Improvement Program.

Health Care Quality Improvement Act (HCQIA) - A federal act which exempts hospitals, group practices, and HMOs from certain antitrust provisions as they apply to credentialing and peer review 50 long as these entities adhere to due process standards that are outlined in the Act.

Health Care Quality Improvement Program (HCQIP) - A program initiated by the Health Care Financing Administration, now CMS, to improve the quality of care delivered to Medicare enrollees in managed care plans.

Health information network (HIN) - A computer network that provides access to a database of medical information. Also known as a health data network.

Health Insurance Portability and Accountability Act (HIPAA) - A federal law that outlines the requirements that employer-sponsored group insurance plans, insurance companies, and managed care organizations must satisfy in order to provide health insurance coverage in the individual and group healthcare markets.

Health insurance purchasing co-ops - See purchasing alliances.

Health insuring organization (HIO) - An organization that contracts with a state Medicaid agency as a fiscal intermediary.

Health maintenance organization (HMO) - A healthcare system that assumes or shares both the financial risks and the delivery risks associated with providing comprehensive medical services to a voluntarily enrolled population in a particular geographic area, usually in return for a fixed, prepaid fee.

Health of Seniors Survey - A Health Care Financing Administration survey that measures Medicare patients' functional status.

Health Plan Management System (HPMS) - A database of information on Medicare Part A and Part B recipients who are enrolled in coordinated care plans.

Health promotion programs - Preventive care programs designed to educate and motivate members to prevent illness and injury and to promote good health through lifestyle choices, such as smoking cessation and dietary changes. Also known as wellness programs.

Health risk appraisal - See health risk assessment.

Health risk assessment (HRA) - A process by which an organization uses information about a plan member's health status, personal and family health history, and health-related behaviors to predict the member's likelihood of experiencing specific illnesses or injuries. Also known as health risk appraisal.

Healthcare quality - According to the Institute of Medicine, "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

High-cost case - A patient whose condition requires large financial expenditures or significant human and technological resources.

High-risk case - A patient who has a complex or catastrophic illness or injury or who requires extensive medical interventions or treatment plans.

HIN - See health information network.

HIPAA - See Health Insurance Portability and Accountability Act.

HMO - See health maintenance organization.

Hold harmless provision - A contract clause that forbids providers from seeking compensation from patients if the health plan fails to compensate the providers because of insolvency or for any other reason.

TOP

Holding company - A company whose sole business is the ownership of other companies, which are its subsidiaries.

Horizontal division of markets - An illegal business practice that occurs when two or more organizations agree not to compete by dividing geographic marketing areas, product offerings, or customers.

Horizontal group boycott - An illegal business practice that occurs when two competitors agree not to do business with another competitor or purchaser.

Hospice care - A set of specialized healthcare services that provide support to terminally ill patients and their families.

Hospitalists - Physicians who spend a substantial amount of their time in a hospital setting where they accept admissions to their inpatient services from local primary care providers.

HPMS - See Health Plan Management System.

HRA - See health risk assessment.

ı

IBNR - See incurred but not reported claims.

IDS - See integrated delivery system.

Immunization programs - Preventive care programs designed to monitor and promote the administration of vaccines to guard against childhood illnesses, such as chicken pox, mumps, and measles, and adult illnesses, such as pneumonia and influenza.

Income statement - The financial statement that summarizes revenue and expense activity during a specified period.

Incorporation by reference - The method of making a document a part of a contract by referring to it in the body of the contract.

Incurred but not reported (IBNR) claims - Claims or benefits that occurred during a particular time period, but that have not yet been reported or submitted to an insurer or MCO, so they remain unpaid.

Indemnity wraparound policy - An out-of-plan product that an HMO offers through an agreement with an insurance company.

Independent agents - Agents that represent several health plans or insurers.

Independent external review - An appeals review that is conducted by a third party that is not affiliated with the health plan or a providers' association and has no conflict of interest or stake in the outcome of the review.

Independent practice association (IPA) - An organization comprised of individual physicians or a physician in small group practices that contract with entities on behalf of its member physicians to provide healthcare services.

Individual market - A market segment composed of customers not eligible for Medicare or Medicaid who are covered under an individual contract for health coverage.

Individual stop-loss coverage - A type of stop-loss insurance that provides benefits for claims on an individual that exceeds a stated amount in a given period. Also known as specific stop-loss coverage.

Information management - The combination of systems, processes, and technology that is used to provide the company's information users with the information they need to carry out their job responsibilities.

Information system - An interactive combination of people, computer hardware, and software, communications devices, and procedures designed to provide a continuous flow of information to the people who need information to make decisions or perform activities.

Information technology - The wide range of electronic devices and tools used to acquire, record, store, transfer, or transform data or information.

Inside directors - Members of a company's board of directors who hold positions with the company in addition to their positions on the board.

Insolvency - A situation that occurs when an organization's assets or resources are not adequate to cover its debts and obligations.

Integrated delivery system (IDS) - A provider organization that is fully integrated operationally and clinically to provide a full range of health care services, including physician services, hospital services, and ancillary services.

Integration - For provider organizations, the unification of two or more previously separate providers under common ownership or control, or the combination of the business operations of two or more providers that were previously carried out separately and independently.

Interactive voice response (IVR) system - An automated system that answers calls with recorded or synthesized speech and prompts the caller to respond to a menu of options by entering information through a touchtone keypad or by speaking into the phone.

Internal standards - Performance standards that are developed and are based on the organization's historic performance levels.

Internet - A public, international collection of interconnected computer networks.

Intranet - An internal (private) computer network, built on Web-based technologies and standards, which is only available to members of the computer network.

IPA - See independent practice association.

IPA model HMO - A health maintenance organization that contracts with one or more associations of physicians in independent practice who agree to provide medical services to HMO members.

IVR - See interactive voice response system.

J

Joint venture - A type of partial structural integration in which one or more separate organizations combine resources to achieve a stated objective. The independent practices associating companies share ownership of the venture and responsibility for its operations, but usually maintain separate ownership and control over their operations outside of the joint venture.

Justice/equity - An ethical principle, which, when applied to managed care, states that managed care organizations and their providers allocate resources in a way that fairly distributes benefits and burdens among the members.

L

Large group - A large pool of individuals for which health coverage is provided by the group sponsor. A large group may be defined as more than 250, 500, 1,000, or some other number of members, depending on the insurer or MCO.

Large local groups - Accounts that contract on a local basis for group employee health benefits. Contrast with national accounts.

Length of stay (LOS) - The number of days, counted from the day of admission to the day of discharge, that a plan member is confined to a hospital or other facility for each admission.

Length-of-stay guidelines - A utilization review resource that establishes an average inpatient length of stay based on a patient's diagnosis, the severity of the patient's condition, and the type of services and procedures prescribed for the patient's care.

Liabilities - All debts and obligations of a company.

LOS - See length of stay.

Loss rate - The number and timing of losses that will occur in a given group of insureds while the coverage is in force.

M

Mail-order pharmacy programs - Programs that offer drugs ordered and delivered through the mail to plan members at a reduced cost.

Managed behavioral health organization (MBHO) – An organization that provides behavioral health services by implementing managed care techniques.

Managed care - The integration of both the financing and delivery of health-care within a system that seeks to manage the accessibility, cost, and quality of that care.

Managed care organization (MCO) - Any entity that utilizes certain concepts or techniques to manage the accessibility, cost, and quality of health-care.

Managed dental care - Any dental plan offered by an organization that provides a benefit plan that differs from a traditional fee-for-service plan.

Managed indemnity plans - Health insurance plans that are administered like traditional indemnity plans but which include managed care "overlays" such as pre-certification and other utilization review techniques.

Management Services Organization (MSO) - An organization, owned by a hospital or a group of investors, that provides management and administrative support services to individual physicians or small group practices in order to relieve physicians of non-medical business functions so that they can concentrate on the clinical aspects of their practice.

Manual rating - A rating method under which a health plan uses the plan's average experience with all groups and sometimes the experience of other health plans-rather than a particular group's experience to calculate the group's premium. A company often lists manual rates in an underwriting or rating manual.

Market segmentation - The process of dividing the total market for a product or service into smaller, more manageable subsets or groups of customers.

Marketing - The process of planning and executing the conception, pricing, promotion, and distribution of ideas, goods, services to create exchanges that satisfy individual and organizational objectives.

Marketing director - The manager who oversees an organization's marketing and sales activities, including advertising, client relations, and enrollment and sales forecasting.

Marketing mix - The four major marketing elements-product, price, promotion, and distribution (place) that roster the exchange process. MBHO. See managed behavioral health organization.

McCarran-Ferguson Act - A federal act that placed the primary responsibility for regulating health insurance companies and HMOs that service private sector (commercial) plan members at the state level.

MCO - See managed care organization.

Medicaid - A joint federal and state program that provides hospital expense and medical expense coverage to the low-income population and certain aged and disabled individuals.

Medical advisory committee - The committee that evaluates proposed policies and action plans related to clinical practice management, including changes in provider contracts, compensation, and changes in authorization procedures, reviews data regarding new medical technology, and examines proposed medical policies.

Medical center - See ambulatory care facility.

Medical clinic - See ambulatory care facility.

Medical director - The health plan physician executive who is responsible for the quality and cost-effectiveness of the medical care delivered by the plan's providers.

Medical error - A mistake that occurs when a planned treatment or procedure is delivered incorrectly or when a wrong treatment or procedure is delivered.

Medical foundation - A not-for-profit entity, usually created by a hospital or health system that purchases and manages physician practices.

Medical group practice - See consolidated medical group.

Medical underwriting - The evaluation of health questionnaires submitted by all proposed plan members to determine the insurability of the group.

Medically appropriate services - Diagnostic or treatment measures for which the expected health benefits exceed the expected risks by a margin wide enough to justify the measures.

Medically necessary services - Services or supplies as provided by a physician or other healthcare provider to identify and treat a member's illness or injury, which, as determined by the payer, are consistent with the symptoms, diagnosis, and treatment of the member's condition; in accordance with the standards of good medical practice; not solely for the convenience of the member, member's family, physician, or other healthcare provider; and furnished in the least intensive type of medical care setting required by the member's condition.

Medically needy individuals - Individuals who meet the financial resource requirements of categorically needy individuals, but whose monthly income exceeds specified maximums.

Medical-necessity review - See prior authorization.

Medicare - A federal government program established under Title XVIII of the Social Security Act of 1965 to provide hospital expense and medical expense insurance to elderly and disabled persons .

Medicare medical savings account (MSA) plans - The Medicare+Choice delivery option that consists of a high-deductible catastrophic insurance policy and a tax-preferred medical savings account established for individual Medicare beneficiaries.

Medicare Part A - The Medicare component that provides basic hospital insurance to cover the costs of inpatient hospital services, confinement in nursing facilities or other extended care facilities after hospitalization, home care services following hospitalization, and hospice care.

Medicare Part B - The Medicare component that provides benefits to cover the costs of physicians' professional services, whether the services are provided in a hospital, a physician's office, an extended-care facility, a nursing home, or an insured's home.

Medicare SELECT - A Medicare supplement that uses a preferred provider organization to supplement Medicare Part B coverage.

Medicare supplement - A private medical expense insurance policy that provides reimbursement for out-of-pocket expenses, such as deductibles and coinsurance payments, or benefits for some medical expenses specifically excluded from Medicare coverage.

Medicare+Choice - The Medicare component that addresses how covered services are delivered to enrollees and increases the numbers and types of healthcare organizations allowed to participate in Medicare.

Medigap policies - Individual medical expense insurance policies sold by state-licensed private insurance companies.

Member services - The broad range of activities that an organization and its employees undertake to support the delivery of the promised benefits to members and to keep members satisfied with the company.

Mental Health Parity Act (MHPA) - A law that prohibits group health plans from applying more restrictive annual and lifetime limits on coverage for mental illness than for physical illness.

Merger - A type of structural integration that occurs when two or more separate providers are legally joined.

Messenger model - A type of independent practice association (IPA) that negotiates contract terms with entities on behalf of member physicians, who then contract directly with those entities using the terms negotiated by the IPA. This type of IPA is most often used with fee-for-service or discounted fee-for-service compensation arrangements.

MHPA - See Mental Health Parity Act.

MHS - See Military Health System.

Military Health System (MHS) - A worldwide healthcare system operated by the U.S. Department of Defense that focuses its efforts on population health improvement by integrating the delivery of healthcare services for active-duty personnel, retirees, and the families of active-duty personnel and retirees.

Military treatment facilities (MTFs) - Hospitals, clinics, and treatment centers that the Army, Navy, Air Force, and Coast Guard operate to deliver care to Military Health System beneficiaries.

Modified community rating - See adjusted community rating.

MSA - See Medicare medical savings account plans.

MEO - See Management Services Organization.

MTFs - See Military treatment facilities.

Mutual company - A company that is owned by its members or policy owners.

N

National accounts - Large group accounts that have employees in more than one geographic area that are covered through a single national contract for health coverage. Contrast with large local groups.

National Practitioner Data Bank (NPDB) - A database maintained by the federal government that contains information on physicians and other medical practitioners against whom medical malpractice claims have been settled or other disciplinary actions have been taken.

Net income - The excess of total revenues over total expenses. Also known as profit.

Net loss - If total expenses exceed total revenues, the excess of total expenses over total revenues.

Network - The group of physicians, hospitals, and other medical care professionals that a managed care plan has contracted with to deliver medical services to its members.

Network management director - A health plan manager who is responsible for developing and managing the provider networks including such activities as recruiting, credentialing, contracting, service, and performance management for providers.

Network model HMO - An HMO that contracts with more than one group practice of physicians or specialty groups.

New business underwriting - The risk evaluation an organization performs when it first issues coverage to a group.

Newborns' and Mothers' Health Protection Act (NMHPA) - A law, which specifies that group health, plans or group healthcare insurers cannot mandate that hospital stays following childbirth be shorter than 48 hours for normal deliveries or 96 hours for cesarean births.

NMHPA - See Newborns' and Mothers' Health Protection Act.

No balance billing provision - A provider contract clause which states that the provider agrees to accept the amount the plan pays for medical services as payment in full and not to bill plan members for additional amounts (except for co-payments, coinsurance, and deductibles).

Nominating committee - The committee that recommends nominations for company officers as required in the organization's by-laws.

Non-group market - A market segment that consists of customers who are covered under an individual contract for health coverage or enrolled in a government program.

Non-malfeasance - An ethical principle, which, when applied to managed care, states that managed care organizations and their providers are, obligated not to harm their members.

NPDB - See National Practitioner Data Bank.

0

One and done customer service - See first contact resolution rate.

Open access - A provision that specifies that plan members may self-refer to a specialist, either in-network or out-of-network, at full benefit or at a reduced benefit, without first obtaining a referral from a primary care provider.

Open formulary - The provision that drugs on the preferred list and those not on the preferred list will both be covered by a PBM or MEO.

Open PHO - A type of physician-hospital organization that is available to all of a hospital's eligible medical staff.

Open-panel HMO - An HMO in which any physician who meets the HMO's standards of care may contract with the HMO as a provider. These physicians typically operate out of their own offices and see other patients as well as HMO members.

Operational integration - The consolidation into a single operation of operations that were previously carried out separately by different providers.

Outcomes measures - Healthcare quality indicators that gauge the extent to which healthcare services succeed in improving or maintaining satisfaction and patient health.

Out-of-pocket maximum - Dollar amounts set by companies that limit the amount a member has to payout of his or her own pocket for particular healthcare services during a particular time period.

Outpatient care - Treatment that is provided to a patient who is able to return home after care without an overnight stay in a hospital or other inpatient facility.

Outside directors - Members of a company's board of directors who do not hold other positions with the company.

Outsourcing - The hiring of external vendors to perform specified functions, such as data and information management activities.

P

P&T committee - See pharmacy and therapeutics committee.

PACE - See Programs of All-inclusive Care for the Elderly.

Parent company - A company that owns another company.

Patient perception - A type of outcomes measure related to whether the patient feels completely "better" after treatment or feels improved compared to how he or she felt prior to receiving treatment.

PBM - See pharmacy benefit management plan.

PCCM - See primary care case manager.

PCP - See primary care provider.

Peer review - A system in which the appropriateness of healthcare services delivered by a provider to health plan members is evaluated by a panel of medical professionals.

Peer review committee - The committee that reviews cases of health--care services delivery in which the quality of care is questionable or problematic.

Peer review organization (PRO) - An organization or group of practicing physicians and other healthcare professionals paid by the federal government to evaluate the services provided by other practitioners and to monitor the quality of care given to Medicare patients.

Per diem rates - A form of payment for services in which the provider is paid a daily fee for specific services or outcomes, regardless of the cost of provision.

Pended authorization - An authorization decision that is delayed.

Performance measure - A quantitative measure of the quality of care provided by a health plan or provider that consumer payers, regulators, and others can use to compare the plan or provider to other plans or providers.

Personal care physician - See primary care provider.

PFFS - See private fee-for-service plans.

Pharmaceutical cards - Identification cards issued by a pharmacy benefit management plan to plan members. These cards assist PBMs in processing and tracking pharmaceutical claims. Also known as drug cards or prescription cards.

Pharmacy and therapeutics (P&T) committee - The committee that develops, updates, and administers the formulary and regularly reviews reports on clinical trials, drug utilization reports, current and proposed therapeutic guidelines, and economic data on drugs.

Pharmacy benefit management (PBM) plan - A type of managed care specialty service organization that seeks to contain the costs of prescription drugs or pharmaceuticals while promoting more efficient and safer drug use. Also known as a prescription benefit management plan.

PHD - See physician-hospital organization.

Physician Practice Management (PPM) Company - A company, owned by a group of investors, that purchases physicians' practice assets, provides practice management services, and, in most cases, gives physicians a long term contract to continue working in their practice and sometimes an equity (ownership) position in the company.

Physician-hospital organization (PHD) - A joint venture between a hospital and many or all of its admitting physicians whose primary purpose is contract negotiations with companies and marketing.

Plan funding - The method that an employer or other payor or purchaser uses to pay medical benefit costs and administrative expenses.

Planned change - Change that is deliberate, controlled, collaborative, and proactive.

Point-of-service (POS) product - A healthcare option that allows members to choose at the time medical services are needed whether they will go to a provider within the plan's network or seek medical care outside the network.

Pooling - The practice of underwriting a number of small groups as if they constituted one large group.

POS product - See point-of-service product.

PPA - See preferred provider arrangement.

PPM - See Physician Practice Management Company.

PPO - See preferred provider organization.

Pre-admission testing - A utilization management technique that requires plan members who are scheduled for inpatient care to have preliminary tests, such as X-rays and laboratory tests, performed on an outpatient basis prior to admission.

Pre-certification - A utilization management technique that requires a plan member or the physician in charge of the member's care to notify the plan, in advance, of plans for a patient to undergo a course of care such as a hospital admission or complex diagnostic test. Also known as prior authorization.

Pre-existing condition - In group health insurance, generally a condition for which an individual received medical care during a stated time period prior to the effective date of coverage.

Preferred provider arrangement (PPA) - As defined in state laws, a contract between a healthcare insurer and a healthcare provider or group of providers who agree to provide services to persons covered under the contract. Examples include preferred provider organizations (PPOs) and exclusive provider organizations (EPOs).

Preferred provider organization (PPO) - A healthcare benefit arrangement designed to supply services at a discounted cost by providing incentives for members to use designated healthcare providers (who contract with the PPO at a discount), but which also provides coverage for services rendered by healthcare providers who are not part of the PPO network.

Premium - A prepaid payment or series of payments made to a health plan by purchasers, and often plan members, for medical benefits.

Premium taxes - State income taxes levied on an insurer's premium income.

Prepaid care - Healthcare services provided to an HMO member in exchange for a fixed, monthly premium paid in advance of the delivery of medical care.

Prepaid group practice - A healthcare system that offered plan members a wide range of medical services through an exclusive group of providers in return for a monthly premium payment.

Prescription benefit management plan - See pharmacy benefit management plan.

Price fixing - An illegal business practice that occurs when two or more independent competitors agree on the prices or fees that they will charge for services.

Pricing - The process of deciding the premium to charge for a health plan or a given set of benefits.

Primary care - General medical care that is provided directly to a patient without referral from another physician. It is focused on preventive care and the treatment of routine injuries and illnesses.

Primary care case manager (PCCM) - A primary care provider who contracts directly with the state to provide case management services, such as coordination and delivery of services, to Medicaid patients.

Primary care physician - See primary care provider.

Primary care provider (PCP) - A physician or other medical professional who serves as a group member's first contact with a plan's healthcare system. Also known as a primary care physician, personal care physician, or personal care provider.

Primary source verification - A process through which an organization validates credentialing information from the organization that originally conferred or issued the credentialing element to the practitioner.

Prior authorization - In the context of a pharmacy benefit management (PBM) plan, a program that requires physicians to obtain certification of medical necessity prior to drug dispensing. Also known as a medical-necessity review. See also pre-certification.

Private fee-for-service (PFFS) plans - The Medicare+Choice delivery option under which coverage is provided by private insurance carriers rather than through the federal government.

PRO - See peer review organization.

Process measures - Healthcare quality indicators related to the methods and procedures that an organization and its providers use to furnish service and care.

Professionalism - A set of characteristics or behaviors that are worthy of the high standards of an occupation that requires advanced training in a specialized field.

Programs of All-inclusive Care for the Elderly (PACE) - A community-based program, involving both Medicare and Medicaid, that provides integrated healthcare and long-term care to elderly persons who require a nursing-facility level of care.

Promise keeping/truth telling - An ethical principle which, when applied to managed care, states that managed care organizations and their providers have a duty to present information honestly and are obligated to honor commitments.

Promotion - The element of the marketing mix that an organization uses (I) to inform consumers about its products, the prices of its products, and how to obtain its products, (2) to persuade consumers to purchase its products, and (3) to remind consumers about the benefits associated with transacting business with the organization.

Promotion mix - The four tools of promotion-advertising, personal selling, sales promotion, and publicity.

Prospective review - The review and possible authorization of proposed treatment plans for a patient before the treatment is implemented.

Provider Manual - A document that contains information concerning a provider's rights and responsibilities as part of a network.

Provider profiling - The collection and analysis of information about the practice patterns of individual providers.

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, employer purchasing coalitions, or purchasing coalitions.

Purchasing coalitions - See purchasing alliances.

Purchasing pools - See purchasing alliances.

Pure community rating - See standard community rating.

Q

QISMC - See Quality Improvement System for Managed Care.

Quality - In a managed care context, an MCO's success in providing health-care and other services in such a way that plan members' needs and expectations are met.

Quality Improvement System for Managed Care (QISMC) - A CMS program designed to strengthen MCOs' efforts to protect and improve the health and satisfaction of Medicare and Medicaid enrollees.

Quality management (QM) - An organization-wide process of measuring and improving the quality of the healthcare provided.

Quality management committee - The committee that oversees the organization's quality assessment and improvement activities in both clinical and non-clinical areas.

R

Random change - See haphazard change.

Rate spread - The difference between the highest and lowest rates that a health plan charges small groups. The National Association of Insurance Commissioners' Small Group Model Act limits a plan's allowable rate spread to 2 to 1.

Rating - The process of calculating the appropriate premium to charge purchasers, given the degree of risk represented by the individual or group, the expected costs to deliver medical services, and the expected marketability and competitiveness of the plan.

RBRVS - See Resource-Based Relative Value Scale.

Reactive change - Change that is controlled, but rarely planned, and that can lead to positive, negative, or even unintended results.

Rebate - A reduction in the price of a particular pharmaceutical obtained by a PBM from the pharmaceutical manufacturer.

Receivership - A situation in which the state insurance commissioner, acting for a state court, takes control of and administers an organizations assets and liabilities.

TOP

Re-credentialing - A periodic review of the qualifications of a current network provider to verify that the provider still meets the standards for participation in the network.

Relative value of services - See relative value scale.

Relative value scale (RVS) - A method used to determine provider reimbursement that assigns a weighted value to each medical procedure or service. To determine the amount that will be paid to the physician, a money multiplier multiplies the weighted value. Also known a s relative value of services.

Referral - The process of sending a patient from one practitioner to another for health care services.

Renewal underwriting - The process by which an underwriter reviews each year all the selection factors that were considered when the contract was issued, then compares the group's actual utilization rates to those predicted to determine the group's renewal rate.

Reserves - Estimates of money that an insurer needs to pay future business obligations.

Resource-Based Relative Value Scale (RBRVS) - A method used to determine provider reimbursement that attempts to take into account when assigning a weighted value to medical procedures or services, all resources that physicians use in providing care to patients, including physical or procedural, educational, mental (cognitive), and financial resources.

Retrospective review - A type of utilization review that occurs after treatment is completed in order to authorize payment and medical necessity and appropriateness of care.

Revenues - The amounts earned from a company's sales of products and services to its customers.

Risk-adjustment - The statistical adjustment of outcomes measures to account for risk factors that are independent of the quality of care provided and beyond the control of the plan or provider, such as the patient's gender and age, the seriousness of the patient's condition, and any other illnesses the patient might have. Also known as case-mix adjustment.

RVS - See relative value scale.

S

SCHIP - See State Children's Health Insurance Program.

Screening programs - Preventive care programs designed to determine if a health condition is present even if a member has not experienced symptoms of the problem.

Section 1115 waivers - Waivers that gave states the authority to offer more comprehensive services to specified categories of Medicaid recipients through demonstration projects.

Section 1915(b) waivers - Waivers that allowed states to manage Medicaid recipients' access to providers by assigning recipients to a primary care case manager or by enrolling recipients in an HMO.

Segments - Subsets or manageable groups of customers in a total market.

Self-funded plan - A health plan, under which an employer or other group sponsors, rather than an MCO or insurance company, is financially responsible for paying plan expenses, including claims made by group plan members. Also known as a self-insured plan.

Senior market - A market segment that is comprised largely of persons over age 65 who are eligible for Medicare benefits.

Service levels - The performance standards that an MCO sets for its member services activities.

Service quality - A success in meeting the non-clinical customer service needs and expectations of plan members

Sherman Antitrust Act - A federal act which established as national policy the concept of a competitive marketing system by prohibiting companies from attempting to (1) monopolize any part of trade or commerce or (2) engage in contracts, combinations, or conspiracies in restraint of trade. The Act applies to all companies engaged in interstate commerce and to all companies engaged in foreign commerce. See also antitrust laws.

Site appropriateness listings - A resource for the review of surgery and certain non-surgical interventions that indicates the most appropriate settings for common procedures.

Small group - Although each plans size limit may vary, generally a group composed of 2 to 99 members for which the group sponsor provides health coverage.

Special committees - See ad hoc committees.

Specialist - A healthcare professional whose practice is limited to a certain branch of medicine, specific procedures, certain age categories of patients, specific body systems, or certain types of diseases.

Specialty health maintenance organization (specialty HMO) - An organization that uses an HMO model to provide healthcare services in a subset or single specialty of medical care.

Specialty HMO - See specialty health maintenance organization.

Specialty services - Healthcare services that are generally considered outside standard medical-surgical services because of the specialized knowledge required for service delivery and management.

Specific stop-loss coverage - See individual stop-loss coverage.

Staff model HMO - A closed-panel HMO whose physicians are employees of the HMO.

Staffing ratios - Ratios that relate the number of providers in the network to the number of enrollees in the health plan.

Standard community rating - A type of community rating that considers only community-wide data and establishes the same financial performance goals for all risk classes. Also known as pure community rating.

Standard of care - A diagnostic and treatment process that a clinician should follow for a certain type of patient, illness, or clinical circumstance.

Standards - "Authoritative statements of: (1) minimum levels of acceptable performance of results, (2) excellent levels of performance or results, or (3) the range of acceptable performance or results," according to the Institute of Medicine.

Standing committees - Long-term advisory bodies on ongoing issues such as finance management, compliance, quality management, utilization management, strategic planning, and compensation. TOP

State Children's Health Insurance Program (SCHIP) - A program, established by the Balanced Budget Act, designed to provide health assistance to uninsured, low-income children either through separate programs or through expanded eligibility under state Medicaid programs.

Statutory solvency - An HMO's ability to maintain at least the minimum amount. of capital and surplus specified by state insurance regulators.

Step-down unit - A ward or section of a ward in a hospital that is devoted to delivering sub-acute care to patients following a period of acute care.

Stock company - A company that is owned by the people and organizations that purchase shares of the company's stock.

Stop-loss insurance - A type of insurance coverage that enables provider organizations or self-funded groups to place a dollar limit on their liability for paying claims and requires the insurer issuing the insurance to reimburse the insured organization for claims paid in excess of a specified yearly maximum.

Strategic planning committee - The committee responsible for directing the company's strategic direction and goals.

Structural integration - The unification of previously separate providers under common ownership or control.

Structure measures - Healthcare quality indicators related to the nature, quantity, and quality of the resources that an insurer or MCO has available for member service and patient care.

Subsidiary - A company that is owned by another company, its parent.

Surplus - The amount that remains when an insurer subtracts its liabilities and capital from its assets.

Т

Termination provision - A provider contract clause that describes how and under what circumstances the parties may end the contract.

Termination with cause - A contract provision, included in all standard provider contracts, that allows either the entity or the provider to terminate the contract when the other party does not live up to its contractual obligations.

Termination without cause – A contract provision that allows either the entity or the provider to terminate the contract without providing a reason or offering an appeals process.

Therapeutic substitution - The dispensing of a different chemical entity within the same drug class of a drug listed on a pharmacy benefit management plan's formulary. Therapeutic substitution always requires physician approval.

Third party administrator (TPA) - A company that provides administrative services to companies or self-funded health plans but that does not have the financial responsibility for paying benefits.

Three-tier co-payment structure - A pharmacy benefit or physician co-payment system under which a member is required to pay one co-payment amount for a generic drug, a higher co-payment amount for a brand-name drug included on the health plan's formulary, and an even higher co-payment amount for a non-formulary drug. In the case of physician charges the co-pay may vary between PCPs and SCPs as well as added services.

TPA - See third party administrator.

TRICARE - A Department of Defense regionally managed health-care program for active duty and retired members of the uniformed services and their families that combines military healthcare resources and networks of civilian healthcare professionals.

TRICARE Extra - A reduced fee-for-service (FFS) plan similar to the network portion of a PPO.

TRICARE Prime - An enrollment-based managed care option designed to provide coordinated care managed by a primary care manager, who is similar to a primary care provider in a commercial HMO.

TRICARE Standard - A fee-for-service plan that allows participants to use TRICARE authorized providers or non-network providers.

Turnaround time - The amount of time required to complete a particular member-initiated transaction.

Two-tier co-payment structure - A pharmacy or physician co-payment system under which a member is required to pay one co-payment amount for a generic drug and a higher co-payment amount for a brand-name drug. In the case of physician services the member would pay a co-payment to see their PCP and a higher co-payment to visit with a Specialist.

Tying arrangements - An illegal business practice that occurs when an organization conditions the sale of one product or service on the sale of other products or services.

U

UCR - See usual, customary, and reasonable fee.

Unbundling - A coding inconsistency that involves separating a procedure into parts and charging for each part rather than using a single code for the entire procedure.

Underwriting - The process of identifying and classifying the risk represented by an individual or group.

Underwriting impairments - Factors that tend to increase an individual's risk above that which is normal for his or her age.

Underwriting manual - A document that provides background information about various underwriting impairments and suggests the appropriate action to take if such impairments exist.

Underwriting requirements – Requirements, sometimes relating to group characteristics or financing measures, that carriers at times, impose in order to provide healthcare coverage to a given group and which are designed to balance a health plan's knowledge of a proposed group with the ability of the group to voluntarily select against the plan (anti-selection).

Up-coding - A coding inconsistency that involves using a code for a procedure or diagnosis that is more complex than the actual procedure or diagnosis and that results in higher reimbursement to the provider.

UR - See utilization review.

URO - See utilization review organization.

Usual, customary, and reasonable (UCR) fee - The amount commonly charged for a particular medical service by physicians within a particular geographic region. Traditional health insurance companies use UCR fees as the basis for physician reimbursement.

Utilization guidelines - A utilization review resource that indicates accepted approaches to care for common, uncomplicated healthcare services.

Utilization management (UM) - Managing the use of medical services to ensure that a patient receives necessary, appropriate, high-quality care in a cost-effective manner.

Utilization review (UR) - An evaluation of the medical necessity, appropriateness, and cost-effectiveness of healthcare services and treatment plans for a given patient.

Utilization review organization (URO) - An external organization that conducts reviews to assess the medical appropriateness of suggested courses of treatment for patients, thereby providing the patient and the purchaser increased assurance of the value and quality of healthcare services.



Variances - The differences obtained from subtracting actual results from expected or budgeted results.

W

Wait time - The length of time, on average, that members must stay on the telephone before they receive assistance.

Web site - A specific location on the Web that provides users access to a group of related text, graphics, and, in some cases, multimedia and interactive files.

Wellness programs - See health promotion programs.

WHCRA - See Women's Health and Cancer Rights Act.

Withhold - A percentage of a provider's payment that is "held back" during the plan year to offset or pay for any cost overruns for referral or hospital services. Any part of the withhold not used for these purposes is distributed to providers.

Women's Health and Cancer Rights Act (WHCRA) - A law that requires health plans that offer medical and surgical benefits for mastectomy to provide coverage for reconstructive surgery following mastectomy.

Workers' compensation - A state-mandated insurance program that provides benefits for healthcare costs and lost wages to qualified employees and their dependents if an employee suffers a work-related injury or disease.

Workers' compensation indemnity benefits - Benefits that replace an employee's wages while the employee is unable to work because of a work-related injury or illness.

World Wide Web (WWW) - An Internet service that links independently owned databases containing text, pictures, and multimedia elements. Also known as the Web.

WWW - See World Wide Web.