

## Health Care Terms

**ADDITIONAL DRUG BENEFIT LIST** (*see also* **DRUG MAINTENANCE LIST**): The additional drug benefit list is a catalogue of pharmaceuticals approved by a managed health care plan for dispensing drugs when other than those listed under the benefit package are prescribed.

**ADJUSTED COMMUNITY RATING:** Also called prospective rating, adjusted community rating is set by group demographics and prior experience in the region.

**ALLOWABLE CHARGE:** The maximum fee that a third party will reimburse a provider for a given service.

**ALLOWABLE COSTS:** Items or elements of an institutions' costs that are reimbursable under a payment formula. Allowable costs may exclude, for example, uncovered services, luxury accommodations, costs that are not reasonable, and expenditures that are unnecessary.

**AMBULATORY CARE:** Health services delivered on an outpatient basis. If the patient makes a trip to the doctor's office or surgical center without an overnight stay, it is considered ambulatory care.

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

**ANCILLARY CARE:** Additional health care services performed, such as lab work and x-rays.

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

**BEHAVIORAL HEALTH CARE:** Treatment of mental health and/or substance abuse disorders.

**BENEFIT PERIOD:** A consecutive 12 month period during which the terms and provisions of the coverage (e.g. medical, dental, vision) apply.

**BENEFITS:** Those services which the covered individual is entitled to receive under his health program, for which the provider of service will be wholly or partially reimbursed, or, in an insurance plan, for which the covered individual will be wholly or partially reimbursed.

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

**CASE MANAGEMENT:** The process whereby a health care professional supervises the administration of medical or ancillary services to a patient, typically one who has a catastrophic

disorder or who is receiving mental health services. Case managers are thought to reduce the costs associated with the care of such patients, while providing high-quality medical services.

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

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

**CHRONIC CARE:** Care for a patient with a long-term illness.

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

**COINSURANCE:** A percentage of a health care cost – often 20 percent- that you pay after meeting the deductible HR Magazine, August 2008.

**COPAYMENT:** A fixed dollar amount- such as \$15 for each doctor visit-that the you pay for medical services. HR Magazine, August 2008.

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

**COVERED SERVICES:** The services, treatments, or supplies identified as payable in your certificate. Covered services must be medically necessary to be payable, unless stated otherwise.

**DEDUCTIBLE:** The amount of money you are required to pay first before your health insurance plan starts paying (Hope Health Newsletter).

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

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

**DURABLE MEDICAL EQUIPMENT:** Equipment that can be repeatedly used, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use at home. Examples include hospital beds, wheelchairs, and oxygen equipment.

**EFFECTIVE DATE:** The day your insurance coverage begins under your contract.

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

**EMERGENCY CARE:** Medical care given for a serious medical condition resulting from injury, sickness, or mental illness that arises suddenly and requires immediate care.

**EMPLOYEE CONTRIBUTION:** The portion of the insurance premium paid by the employee.

**EPISODE OF CARE:** All treatment rendered in a specified time frame for specific disease.

**EXCLUSIONS:** Specific conditions not covered or services not provided or paid for under a health insurance contract. Typical exclusions may be alcoholism, cosmetic surgery, eyeglasses, drug abuse treatment, and treatment for self-inflicted injuries.

**EXPERIENCE RATING:** (see **COMMUNITY RATING**) The system by which different premium rates are set for different groups of subscribers by the same insurer, based on age, sex, type of work, etc. and the utilization and claims experience of that group. Experience rating tends to limit risk assumptions by the provider. (See "Community Rating").

**FEE FOR SERVICE:** Traditional provider reimbursement in which the physician is paid according to the service performed. This is the reimbursement system used by conventional indemnity insurers.

**FORMULARY:** A list of generic and brand name drugs preferred by the health plan HR Magazine, August 2008.

**GATEKEEPER:** Most HMOs rely on the primary care physician, or "gatekeeper," to screen patients seeking medical care and effectively eliminate costly and sometimes needless referrals to specialists for diagnosis and management. The gatekeeper is responsible for the administration of the patient's treatment and must coordinate and authorize all medical services, laboratory studies, specialty referrals, and hospitalizations. In most HMOs, if an enrollee visits a specialist without prior authorization from his or her designated primary care physician, the medical services delivered by the specialist will have to be paid in full by the patient.

**GENERIC DRUG:** A chemically equivalent copy designed from a brand-name drug whose patent has expired. Typically less expensive and sold under the common name for the drug, not the brand name.

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

**HOME CARE:** In contrast with inpatient and ambulatory care, home care is medical care ordinarily administered in a hospital or on an outpatient basis; however, the patient is not sufficiently ambulatory to make frequent office or hospital visits. For these patients, intravenous therapy, for example, is administered at the patient's residence, usually by a health care professional. Home care reduces the need for hospitalization and its associated costs.

**HOSPICE:** A facility that provides supportive care for the terminally ill.

**INCURRED BUT NOT REPORTED (IBNR) EXPENSES:** a financial accounting of all services that have been performed, but as a result of a short period of time, they have not been invoiced or recorded.

**IN-NETWORK:** Doctors, clinics, hospitals and other providers with whom the health plan has an agreement to care for its members. Typically, members have fewer out-of-pocket costs when they use in-network providers. HR Magazine, August 2008.

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

**INPATIENT CARE:** Those services provided to a patient, in a hospital, extended care facility, nursing home, or other such institution.

**LIFE-THREATENING MEDICAL EMERGENCY:** A medical emergency is an illness that is a life-threatening condition which requires immediate attention and treatment. The condition must have severe symptoms that occur suddenly and unexpectedly, and be such that failure to render immediate treatment could result in significant impairment of bodily functions, cause permanent damage to your health, or place your life in jeopardy. Final diagnosis determines if the condition is life-threatening. When provided in an outpatient department of a hospital, the initial examination and treatment of conditions determined to be medical emergencies are paid at the level of coverage provided by your plan.

**LONG-TERM CARE:** Services ordinarily provided in a skilled nursing, intermediate care, personal care, supervisory care, or elder care facility.

**MAIL ORDER PHARMACY:** A method of dispensing medication directly to the patient through the mail. Mail order drug distributors can purchase drugs in larger volumes than retail or wholesale outlets.

**MANAGED CARE:** A broad term that generally refers to a system that manages the quality of health care, the access to care and the cost of that care. For example, a formulary controls the quality of medications dispensed to enrollees and using a hospital that has an agreement with the plan can save money for the patient and the plan.

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

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

**OUT OF NETWORK:** Doctors, hospitals and medical practitioners other than those with whom the health plan has an agreement; the employee pays more to use such providers.

**OUT-OF-POCKET MAXIMUM:** The plan will set a total amount you are required to pay for health care costs in one year, at which point your plan will pay 100% of eligible costs. It is usually \$500, \$1,000, or \$2,000.

**OUT-OF-POCKET COSTS:** The share of health service payments made by the enrollee.

**OUTPATIENT:** A patient who receives health care services without being admitted to a hospital.

**OVER-THE-COUNTER (OTC) DRUG:** A drug product that does not require a prescription under federal or state law to obtain it.

**PARTICIPATING PROVIDER:** A provider who has signed an agreement with the insurance company to accept its payment for covered services as payment in full, less any deductible or copayment that applies. Dental and vision insurance companies may refer to “panel doctors or providers”.

**PATIENTS’ BILL OF RIGHTS:** Referring to federal or state proposals (or signed legislation) that typically mandates that health plans offer expanded external appeals policies, faster appeals decisions than offered in the past, greater access to specialist than was previously available in many managed care plans, and other specific consumer protections.

**PHYSICAL THERAPY:** Treatment for a patient whose muscles do not function due to illness or injury. The treatment is intended to restore or improve the patient’s use of the specific muscles or joints, usually through exercise and therapy. The treatment is designed to improve:

- ◆ Muscle strength
- ◆ Joint motion
- ◆ Coordination
- ◆ General mobility

To be payable, physical therapy must:

- ◆ Be prescribed by the patient’s attending physician.
- ◆ Be given by or under the supervision of a physician or a licensed physical therapist.
- ◆ Be given for a condition which is capable of significant improvement in a reasonable and generally predictable period of time.

**PHYSICIAN:** A person legally qualified and licensed to practice medicine and perform surgery. The following are considered physicians when acting within the scope of their licenses: doctors of medicine (M.D.), osteopathy (D.O.), podiatry (D.P.M.).

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

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

**PREDETERMINATION:** BCBS requires all elective and emergency hospital admissions to be reviewed if the proposed service is appropriate. Other insurance carriers may also require predetermination before authorizing particular services.

**PREFERRED PROVIDERS:** Physicians, hospitals, and other health care providers who contract to provide health services to persons covered by a particular health plan.

**PREFERRED PROVIDER ORGANIZATION (PPO):** PPOs are managed care organizations that offer integrated delivery systems (i.e., networks of providers) that are available through a vast array of health plans and are readily accountable to purchasers for cost, quality, access, and services associated with their networks. They use provider selection standards, utilization management, and quality assessment techniques to complement negotiated fee reductions as an effective strategy for long-term cost savings. Under a PPO benefit plan, covered individuals retain the freedom of choice of providers but are given financial incentives (i.e., lower out-of-pocket costs) to use the preferred provider network. Preferred provider organizations are marketed directly to employees as well as to insurance companies and TPAs, who then market the network to their employer clients.

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

**PREVENTIVE SERVICE:** Those medical and dental activities aimed at the protection against and early detection and minimization of the ill effects of disease and disability.

**PRIMARY CARE:** First contact, first-level professional care. Usually provided by a general practitioner, internist, dentist, pediatrician, but may also be provided by a physician, but may also be provided by a physician assistant, pediatric nurse-practitioner, etc. Not the same as “First Aid.” (See “Secondary Care”, Tertiary Care”)

**PROFESSIONAL PROVIDER:** The following are considered professional medical providers when acting within the scope of their licenses: doctors of medicine (M.D.), osteopathy (D.O.), and podiatry (D.P.M.); chiropractors (D.C.), fully-licensed psychologist.

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

**QUALIFYING STATUS CHANGES:** Incidents, if they occur, that allow you to start, stop, or increase your flexible spending deduction at a time other than open enrollment.

**RADIOLOGY SERVICES AND RADIOLOGICAL THERAPY:** These include x-ray exams, radium, radon, cobalt therapy, ultra-sound testing, radioisotopes, and computerized transaxial tomography (CAT) scans.

**RATING:** The method that is used to determine the cost of premiums for the members of a managed health care or indemnity insurance plan.

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

**REPORT CARD ON HEALTH CARE:** A tool used by employers, the government, employer coalitions, and consumers to compare and understand the actual performance of health plans. Report cards provide health plan performance data, such as health care quality and utilization, consumer satisfaction, administrative efficiencies, financial stability, and cost control.

**RESERVES:** Withholding a certain percentage of premiums to provide a fund for committed but undelivered health care, uncertainties, contingencies, overutilizations of referrals, catastrophes, and other situations.

**RIDER:** A legal document which amends a certificate by adding, limiting, or clarifying benefits.

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

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

**SKILLED NURSING FACILITY (SNF):** Typically an institution for convalescence or a nursing home, the skilled nursing facility provides a high level of specialized care for long-term or acute illness. It is an alternative to extended hospital stays or difficult home care.

**SPECIALISTS:** Providers whose practices are limited to a specific disease (rheumatologist); part of the body (ear, nose, and throat); age group (pediatrician); or procedure (oral surgery). Specialists may be Board-certified, Board-eligible, or otherwise specially trained through post-graduate residencies, etc., or merely self-styled.

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

**SUBSCRIBER:** The person who signed and submitted the application for insurance coverage. All communications from the carrier are addressed to the subscriber.

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

**THIRD-PARTY ADMINISTRATOR (TPA):** An organization that is outside of the insuring organization that handles the administrative duties and sometimes utilization review. Third-party administrators are used by organizations that fund the health benefits but do not find it cost effective to administrate the plan themselves.

**THIRD-PARTY PAYER:** A public or private organization that pays for or underwrites coverage for health care expenses.

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

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

**URGENT CARE CENTER:** A medical facility where ambulatory patients can be treated on a walk-in basis, without an appointment, and receive immediate, non-emergency care. The urgent care center may be open 24 hours a day; patients calling an HMO after-hours with urgent, but not emergent clinical problems are often referred to these facilities.

**USUAL, CUSTOMARY, AND REASONABLE (UCR):** Fee-for-service payment to physicians based on the usual and customary fee for the same service in the area where the practice is located or on some other judgment of reasonableness.

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