

**OFFICE OF THE HEALTHCARE ADVOCATE
HEALTH CARE GLOSSARY**

ACCESS: The ability to obtain medical care. The ease of access is determined by components such as the availability of medical services and their acceptability to the individual, the locale of health care facilities, transportation, hours of operation and cost of care.

ACUTE: Sudden onset of symptoms that are of short duration.

ACUTE CARE: A level of care that can be rendered only on a hospital.

ADMINISTRATIVE SERVICES ORGANIZATION (ASO): An organization that provides administrative services only to an employer or insurer in the delivery of healthcare services. Typical ASO services include network provision and claims processing. ASO arrangements are non-risk arrangements; the ASO is not responsible for payment of the costs of services.

ADVERSE DETERMINATION: A determination by a utilization review company not to certify an admission, service, procedure or extension of stay because based upon the information provided, the request does not meet the utilization review company's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.

ADJUDICATION: Determination of payment allowance on a claim.

ALLOWABLE CHARGE: The amount of payment an insurance company *allows* for a covered service which may be less than the actual charge by the physician or hospital.

AMBULATORY CARE: An institutional health setting in which organized health services are performed on an outpatient basis, such as a surgery center, clinic or other outpatient facility. Ambulatory care settings also may be mobile units or service, such as mobile mammography.

ANCILLARY SERVICES: Supplemental services, such as laboratory tests and physical therapy services to assist in the diagnosis and treatment of a patient's condition.

APPEAL: The formal review process, initiated by a managed care member, when a service is denied or disapproved.

AUTHORIZATION: The process of obtaining coverage approval for a service (or medication) from the managed care plan before receiving the service (or medication). Managed care plans require such approval for services to a non-participating provider or facility, non-covered medication, continued care for specific services, or exception to a benefit plan.

BALANCE BILLING: The practice by health care providers of charging fees in excess of covered amounts and then billing the patient for that portion of the bill that the payer does not cover.

BEHAVIORAL HEALTH CARE: Mental health and substance use services.

BENEFICIARY: A person who is eligible to receive benefits from an insurance policy.

BENEFITS: List of health and related services guaranteed to be provided in a health plan.

BENEFIT DAYS: Number of days for which the insurance carrier will make payment within a benefit period.

BENEFIT PERIOD: The period of time for which payments for benefits covered by an insurance policy are available.

CAPITATION: A method of reimbursing providers, under which a health plan pays a provider a fixed monthly or yearly amount per person, regardless of how many or few services a consumer uses.

CARE MANAGER: A health professional (e.g. nurse, doctor, social worker) affiliated with a health plan who is responsible for coordinating the medical care of an individual enrolled in a managed care plan.

CARVE OUT: An arrangement whereby the health plan or an employer contracts with outside vendors to administer coverage for a specific category of services (e.g. vision care, mental health and prescription drugs) and contracts with a separate set of providers for those services according to a predetermined fee schedule. The managed care plan remains responsible for the level of medical care.

CASE: A covered instance of sickness or injury.

CASE MANAGEMENT: A process whereby enrollees with specific health needs are identified by the managed care organization and a plan of treatment is set up and monitored to achieve optimum patient outcome in a cost-effective manner.

CERTIFICATE (or EVIDENCE) OF COVERAGE: The description and explanation of benefits covered by your health plan, the health insurance contract.

CLAIM: Information submitted by a provider or enrollee to establish that medical services were provided, from which payment to the provider is made. The term generally refers to the charges submitted to the health plan for services received by enrollees.

CLAIMS REVIEW: Review of claims by insurers, government or other responsible for payment to determine liability and amount of payment. This review may include determination of the eligibility of the claimant; the eligibility of the provider that the benefit is covered; that the benefit is not payable under another policy; and that the benefit was necessary and of reasonable cost and quality.

CLINICAL CRITERIA/GUIDELINES: Guidelines established to aid practitioners or providers in making decisions about a specific clinical course of treatment for a specific clinical case.

CLINICAL TRIALS: Treatment that is considered INVESTIGATIONAL but may be covered by a managed care plan, once a patient qualifies, because of the promising results of the treatment being administered.

CMS (Centers for Medicare & Medicaid Services): The Federal agency, of the Department of Health and Human Services that, among other things, is responsible for administering Medicare and Medicaid.

COBRA (Consolidated Omnibus Budget Reconciliation Act): A federal law that, among other things, requires certain employers to offer continued health insurance coverage, for a definitive amount of time, to certain employees and their beneficiaries who have had their group health insurance coverage terminated. The individual (or family) benefiting from this extension is responsible for the health care premium in full, as well as an additional amount allowed by law, unless the family is otherwise eligible under law for a subsidy to assist with its premium payments. Consumers should contact their employers for specific information regarding the availability of COBRA.

COB (Coordination of Benefits): A provision in a contract that applies when a person is covered under more than one medical program. It requires that payment of benefits be coordinated by all programs to eliminate over-insurance or duplication of benefits.

CO-INSURANCE: The portion of covered health care cost for which the covered person has a financial responsibility; usually according to a fixed percentage. Often co-insurance applies after first meeting a deductible requirement.

COMMUNITY RATING: A method of setting premiums based on expected costs of providing medical benefits to the community as a whole, rather than specific segments of the community, like high-risk groups.

COMPLAINTS: Complaints by members may be generally defined as problems that members bring to the attention of the managed care plan. Complaints that are not resolved to the satisfaction of the member may evolve into formal grievances.

CONCURRENT REVIEW: The review of inpatient hospitalization or other service while the service is being rendered to assure it remains the most appropriate setting for the care being going forward.

CONTRACT: A legal agreement between an individual subscriber or a group, and a Plan expressing the benefits and limitations of the coverage to which a subscriber is entitled. The subscriber/member contract consists of the certificate, endorsements, riders and identification card. (Sometimes referred to as a Summary Plan Description or Certificate (or Evidence) of Coverage.

CO-PAYMENT: A cost-sharing arrangement in which a plan member pays a specific charge for a specified service, such as \$20 for an office visit. The member is usually responsible for payment at the time the health care is rendered.

CPT Codes: A reference to Current Procedural Terminology (CPT), which assigns numeric codes to medical procedures. Providers use CPT codes to file claims with health insurers.

CREDENTIALING: A process of review, conducted by a managed care plan, to include and/or maintain a provider's status as a participating provider in the plan's network.

CREDITABLE COVERAGE: Health coverage you have had in the past, such as coverage under a group health plan (including COBRA continuation coverage), an HMO, an individual health insurance policy, Medicare or Medicaid, and this prior coverage was not interrupted by a significant break in coverage. The time period of this prior coverage must be applied toward any pre-existing condition exclusion imposed by a new health plan. Proof of your creditable coverage may be shown by a certificate of creditable coverage or by other documents showing you had health coverage, such as a health insurance ID card.

DATE OF SERVICE: The date on which health care services were provided.

DEDUCTIBLE: The amount of eligible expense a person must pay each year from his/her own pocket before the health plan will make payment for eligible benefits. In managed care plans, deductible usually applies only to out of network services.

DENIAL: The managed care plan's decision to disallow or reject the services based on specifics outlined in the enrollee's contract with the plan.

DIAGNOSIS-RELATED GROUPS (DRGs): System that reimburses health care providers fixed amounts for all care given in connection with standard diagnostic categories.

DRUG FORMULARY: A listing of prescription medications, sometimes referred to as a "preferred" list, which are approved for use and/or coverage by the plan and which will be dispensed through "participating" pharmacies to a covered member. The list is subject to periodic review and modification by the managed care plan.

DUPLICATION OF BENEFITS: Overlapping or identical coverage of the same insured under two or more health plans, usually the result of contracts of different insurance companies, service organization or pre-payment plans; also known as multiple coverage.

DURABLE MEDICAL EQUIPMENT (DME): Equipment which can stand repeated use, is primarily and customarily used to service a medical purpose, and is appropriate for use at home. Examples include hospital beds, wheelchairs and oxygen equipment.

EARLY PERIODIC SCREENING DIAGNOSTIC and TREATMENT (EPSDT): Comprehensive child health care services to recipients under twenty-one (21) years of age, including all medically necessary prevention, screening, diagnosis, and treatment services listed in Medicaid or HUSKY A. See Section 1905(r) of the Social Security Act.

EFFECTIVE DATE: The date on which the insurance under a policy begins.

ELECTRONIC MEDICAL RECORD: A computerized, online medical record that is available to providers involved in a patient's treatment or care. The record contains a patient's clinical information

EMERGENCY: A true medical emergency is a sudden and unexpected onset of a condition in which delay in treatment would endanger the enrollee's life or health. Examples include: difficulty breathing, excessive bleeding or chest pain.

ENDORSEMENT: A provision added to a subscriber certificate whereby the scope of its coverage is changed.

ENROLLEE: State law defines a "consumer" as a resident of the state who receives services from an MCO. The managed care industry defines each consumer with insurance coverage under a health plan as a "member". Other terms used include "enrollees" and "covered lives".

ENROLLMENT CARD: A document signed by an employee as notice of desire to participate in the benefits of a group insurance plan.

ENROLLMENT PERIOD: Period during which individuals may enroll for insurance benefits and may changes to benefit selections.

ERISA (Employer Retirement Income Security Act): Federal law which regulates benefit plans that are employer sponsored and mandates reporting and disclosure requirements for group health plans.

ESI: Acronym for "employer sponsored insurance."

EXCLUSIONS: Specific conditions or circumstances listed in the policy for which the policy will not provide benefit payments.

EXPERIMENTAL, INVESTIGATIONAL or UNPROVEN PROCEDURES: Medical, surgical or other health care services, supplies, treatments procedures or devices that are determined by the health plan (at the time it makes a determination regarding coverage in a particular case) to be either:

- (1) not generally accepted by informed health care professionals in the U.S. as effective in treating the condition, illness or diagnosis for which their use is proposed, or
- (2) not proven by scientific evidence to be effective in treating the condition, illness or diagnosis for which their use is proposed
- (3) not part of a clinical trial that allows coverage for specific treatment to certain qualified enrollees

EXPLANATION OF MEDICAL BENEFITS (EOMB): the statement sent to members by their health plan listing services provided, amount billed and payment made.

FEE FOR SERVICE: A provider payment method in which an insurer pays a fee for each service performed.

FEE SCHEDULE: A listing of accepted charges or established reimbursements for specified procedures. It represents a physician's or third party's standard or maximum rate of reimbursement for the listed procedures.

FREE STANDING SURGICAL CENTER: A health care facility staffed by licensed physicians which is designed to handle surgical procedures that do not require overnight hospital care.

GROUP INSURANCE: An insurance plan by which a number of employees (and their dependents), members of a similar homogeneous group, are insured under a single policy, issued to their employer or the group with individual certificates or insurance given to each insured individual or family.

GROUP PRACTICE: Physicians or other health professionals providing services with income pooled and redistributed to the members of the group according to some prearranged plan.

GENERIC DRUG: A chemically equivalent copy designed from a brand name (or single source) drug that has an expired patent, or drug substitute. A generic is typically less expensive and sold under a common or "generic" name for that drug, not the brand name.

GRIEVANCES: Are formal complaints unresolved by the plan; managed care plans are required to have a formal internal grievance procedure according to a time sensitive established review system. State law requires managed care plans to resolve internal grievances within 60 days from the date grievance is commenced.

GUARANTEED ISSUE: A policy or rule requiring an insurer to issue an insurance policy to any person, regardless of any health related status or pre-existing condition.

HEALTH MAINTENANCE ORGANIZATION (HMO) - A company that provides, offers or arranges for coverage of health services needed by plan members for a fixed, prepaid premium. In Connecticut, such organizations are licensed as health care centers

HEALTH SAVINGS ACCOUNTS (HSAs) - HSAs are savings accounts that are often paired with high-deductible health plans (see below) and allow for tax-free savings of money to be used for health expenses. HSAs can be carried forward from year to year and owned by an employee, so they are portable from employer to employer.

HEDIS (Health Plan Employer Data and Information Set): A set of measures and data collected by a managed care plan that can be used to assess the quality and level of care received by its enrollees. These measures are reported to the public annually and used by employers, Medicare and Medicaid and consumers to select and evaluate health plan performance.

HIGH DEDUCTIBLE HEALTH PLANS (HDHP) – HDHPs, also called “consumer-directed health plans,” are high-deductible health insurance. HDHP plans charge a high annual deductible — starting at \$1,200 for single employees and \$2,400 for families in 2010 — in exchange for lower monthly premiums. And in many cases, there is also a tax break.

HIPPA (Health Insurance Protection and Portability Act): Public Law 104-191, was signed into law on August 21, 1996 with its primary intent to provide better access to

health insurance, limit fraud and abuse and reduce administrative costs. It requires the U.S. Department of Health and Human Services to develop standards for maintenance and transmission of health insurance information to protect the security and confidentiality of this data, and ensures portability of healthcare coverage.

HOLD HARMLESS: A requirement that prevents providers from charging a patient if her health plan refuses to pay the provider's claim.

HOME CARE: The delivery of medically necessary services at home

HUSKY: Federal program, through Titles XIX and XXI of the Social Security Act, which provides health care coverage to children in Connecticut with low family income. The HUSKY (Healthcare for Uninsured Kids and Youth) Plan is a comprehensive health insurance program to help CT families obtain and afford coverage for their children.

IDENTIFICATION CARD: A card issued by an insurer to an individual member that verifies enrollment in a plan and that a member must present to providers to obtain covered services.

INDEMNITY: An insurance program in which the insured person is reimbursed for covered expenses. The program may include the application of deductibles and co-insurance requirements. Indemnity payments are based on the plan's definition of usual and customary fees in the service area. (See definition of usual and customary fees). In an indemnity (fee-for-service) plan the member can go to any doctor (or hospital) and the bill is then submitted by the member or the doctor to the insurance company. An indemnity plans usually does not include a utilization review process or defined network of doctors and hospitals.

INDIVIDUAL MARKET: Refers to the portion of the insurance market or individuals that purchase insurance on an individual basis, not through an employer or public plan.

IN-NETWORK PROVIDER: A provider who has contracted with a managed care plan and agrees to deliver medical services to enrollees for an agreed upon fee.

INPATIENT: Refers to the status of a member who is in a 24-hour per day care facility and who receives diagnostic and/or treatment services.

INPATIENT FACILITY: Refers to hospitals, residential treatment facilities and other facilities that provide 24-hour/day care.

JCAHO (Joint Commission on Accreditation of Health Care Organizations): An organization that maintains a voluntary accreditation process for managed care plans and provides information to allow purchasers and consumers of managed care to compare plans. JCAHO is widely known for its hospital accreditation program.

LENGTH OF STAY: The length of an inpatient's stay in a hospital or other health facility, it is one measure of use of health facilities, reported as an average number of days spent in a facility per-admission or discharge.

LIFETIME MAXIMUM: Maximum amount that the insurer will pay towards a subscriber's claim in a lifetime. The amount varies depending of the type of coverage.

MANAGED CARE: A system of health care delivery that attempts to manage the access, cost and quality of health care by monitoring how and in what manner services are provided using tools like utilization review and network management.

MANAGED CARE ORGANIZATIONS (MCOs): Health maintenance systems that are responsible for both the financing and the delivery of a broad range of health services

to an enrolled population. They provide health care services through a network of certain doctors, hospitals and other health care providers to give a range of services to plan members. HMOs are type of "MCO".

MEDICAID: Federal program (Title XIX of the Social Security Act) that pays for health services for certain categories of people who are poor, elderly, blind, disabled, or who are enrolled in certain programs including CT Access (Managed Care Plans for CT recipients). Joint Federal/State funds are used to support the Medicaid program. The program includes **HUSKY A**. (See definition of HUSKY.)

MEDICAL LOSS RATIO: The ratio of incurred claims to earned premiums for the prior calendar year for managed care plans issued in the state. Claims shall be limited to medical expenses for services and supplies provided to enrollees and shall not include expenses for stop loss coverage, reinsurance, enrollee educational programs or other cost containment programs or features.

MEDICAL NECESSITY: Legal term used to determine what services will be provided and paid for. Describes services that are consistent with a diagnosis, meet standards of good medical practice, and are not primarily for the convenience of patient or provider. This definition is consistent across fully-funded plans in Connecticut under Conn.Gen.Stat §§ 38a-482a and 38a-513c. The definition varies across self-funded plans. Medical necessity provides the basis for coverage of services, since a plan only pays for services that meet the plan's medical necessity criteria.

MEDICARE: The federal health insurance program for older Americans and the disabled.

MEDIGAP POLICY: A health insurance policy designed to supplement Medicare coverage.

MEMBER: State law defines a "consumer" as a resident of the state who receives services from an MCO. The managed care industry defines each consumer with insurance coverage under a health plan as a "member". Other terms used include enrollees and covered lives.

MENTAL HEALTH PARITY and ADDICTION EQUITY ACT of 2008

(MHPAEA): Federal law requiring group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA): An organization that maintains a voluntary accreditation process for managed care plans and provides information to allow purchasers and consumers of managed health care to compare plans. NCQA was founded with the specific purpose of providing oversight and setting standards for managed care organizations.

NETWORK: A list of participating providers that participate with a managed care plan.

NON-COVERED SERVICE: A medical service that is excluded from the plan's contracted benefits. Non-covered services are outlined in the Summary Plan Description or Member Contract provided to the new enrollee.

NON-PARTICIPATING PROVIDER: A provider that is not an in-network provider.

OPEN ACCESS: A term describing a member's ability to self-refer for specialty care. Open access arrangements allow a member to see a participating specialty provider without a referral from another doctor.

OPEN ENROLLMENT: The period during which consumers may choose to enroll in a health plan or change health plan coverage. Open enrollment periods are usually held in the fall.

OUT-OF-POCKET MAXIMUM: The limit of out-of-pocket payments under an insurance plan for which a consumer is responsible before the plan pays full coverage.

OUT-OF-POCKET PAYMENTS: The portion of the cost for services borne directly by a consumer/member.

OUT OF PLAN or OUT OF AREA: A term describing the treatment obtained by an enrollee outside the network provider choices and/or outside the network service area.

OUTPATIENT: A consumer who is receiving ambulatory care at a hospital or other health facility without being admitted to the facility.

OVER-THE-COUNTER DRUG (OTC DRUG): A drug that is advertised and sold directly to the public without a prescription (eg. aspirin).

PARTICIPATING PROVIDER: A provider who has contracted with a managed care organization to deliver medical services to enrollees for an agreed upon fee.

PEER REVIEW: The evaluation by physicians or other professionals of the effectiveness and efficiency of services ordered or performed by other members of the profession whose work is being reviewed.

PHARMACY BENEFIT MANAGER (PBM): A specialized managed care organization that manages prescription benefits.

POINT OF SERVICE PLAN: Managed care members covered under this type of health benefit plan may decide whether to use services of a participating or non-participating provider each time they seek covered services. Therefore, the member is allowed to make a coverage choice at the "point of service" (or POS) when medical care is needed. Care receiving from a non-participating provider typically will include deductibles and coinsurance.

PRE-EXISTING CONDITION: any medical condition that has been diagnosed or treated within a specified period immediately preceding the enrollee's effective date of coverage under the group contract.

PREFERRED PROVIDER ORGANIZATION (PPO): A network of health professionals who agree to provide medical services to plan enrollees for discounted rates. Plan enrollees may go out of network to seek medical services from non-affiliated medical professionals. Enrollees pay higher out of pocket charges for services by providers who are not in the PPO.

PRIMARY CARE PHYSICIAN (PCP): A doctor who provides, arranges, authorizes, coordinates and monitors the care of managed care members. Upon joining a managed care plan a member chooses such a doctor from an extensive list of network physicians. In general, family practitioners, internists and pediatricians are usually considered PCPs.

PRE-AUTHORIZATION (or PRE-CERTIFICATION): The process of obtaining coverage approval for a service or medication from the managed care plan before receiving the service. Managed care plans require such approval for services to a non-participating provider or facility, noncovered medication, continued care for specific

services, or exception to a benefit plan. (The term “pre-certification” is often used in connection with hospitalizations/surgeries/residential treatment centers.)

PROVIDER: A physician, hospital, nursing home, pharmacy or any individual or group of individuals that provides a health care service.

REASONABLE AND CUSTOMARY CHARGE: The maximum amount an insurer will reimburse for medical care expenses covered under group health insurance.

REFERRAL: The process by which a managed care patient's primary care doctor recommends or authorizes treatment from a medical specialist or facility. Some types of referrals also require approvals by the managed care plan as well as the doctor.

REPORT CARD: method by which the managed care plans quality and practices are compared to other health plans. These are usually sponsored by accreditation or oversight bodies, such as the State of Connecticut, and published for use by consumers.

RESIDENTIAL TREATMENT FACILITY: A treatment center accredited as a residential treatment facility that provides 24/7, subacute care for patients with mental health, substance use conditions.

RIDER: A legal document which modifies the protection of an insurance policy, either expanding or decreasing its benefits, or adding or excluding certain conditions from the policy's coverage.

SELF-INSURED PLANS: are offered to approximately 50% of the employees in CT by their employers. In a self-insured (or self-funded) plan, the costs of medical care are borne by the employer on a pay-as-you-go basis. There is no true "insurance".. The plan sponsor (usually a large employer like GE or UTC) decides what services are covered. A managed care plan (HMO, etc.) may be contracted with by the employer for the process of paying claims. Rules governing self-funded plans fall under federal ERISA law and are not controlled by state legislation.

SERVICE AREA: The geographic area within which a managed care plan provides health care for its members.

SERVICE LIMITS: Certain number of times you may use a health service and a certain time period when you may use a service.

SKILLED NURSING FACILITY (SNF): An institution providing skilled nursing and related services to residents; a nursing home.

SPEND-DOWN: The process of using up all income and assets on medical care in order to qualify for Medicaid.

SUMMARY PLAN DESCRIPTION (SPD): A description of the entire benefit package available to an employee covered by a plan. Also called a Certificate or Evidence of Coverage or contract.

SUBSCRIBER: An individual and eligible dependent. Also referred to as a member.

SUBSCRIBER AGREEMENT: The contract between the insurer and the subscriber. Also referred to as a Summary Plan Description or a Certificate or Evidence of Coverage.

SUPPLEMENTAL SECURITY INCOME (SSI): Monthly cash assistance for people, including children, who have low incomes and who meet certain age or disability guidelines; includes access to Medicaid.

THIRD PARTY ADMINISTRATOR: An arrangement whereby the health plan or an employer contracts with outside vendors to administer coverage for services.

THIRD PARTY PAYOR: An organization that pays or insures health or medical expenses on behalf beneficiaries or recipients. Such payments are called third-party payments.

TITLE XVIII: The title of the Social Security Act which contains the principal legislative authority for the Medicare program. A common name for the Medicare program.

TITLE XIX: The title of the Social Security Act which contains the principal legislative authority for the Medicaid program. A common name for the Medicare program.

TITLE XXI: The title of the Social Security Act which contains the principal legislative authority for the SCHIP or HUSKY B program. A common name for the HUSKY B program.

URGENT CARE: Occurs when a patient has an illness that is not life-threatening but requires immediate attention.

USUAL, CUSTOMARY AND REASONABLE REIMBURSEMENT: The rate of payment to a doctor based on the commonly charged or prevailing fees for health services within a geographic area. A fee is considered to be reasonable if it falls within the parameters of the average or commonly charged fee for the particular service, (e.g. x-ray) within that specific community, (e.g. New Haven County).

UTILIZATION REVIEW (UR): The assessment process that determines the medical necessity and appropriate level of care provided to members. A review may take place either before the services can be provided or while they are being provided in order to decide whether to pay for those services. Services denied by UR can be appealed.

WAIVER: An agreement attached to a policy which exempts from coverage certain disabilities or injuries which are normally covered by the policy.

WAIVER OF PREMIUM: A provision included in some insurance policies which exempts the policy holder from paying the premiums while an insured is disabled.

ADDITIONAL DEFINITIONAL INFORMATION ON High Deductible Health Plans (HDHP) with Health Savings Accounts (HSA) – See chart on next page

The chart be found on the web at the following url:

<http://www.opm.gov/hsa/chart.asp>

U.S. Office of Personnel Management - Ensuring the Federal Government has an effective civilian workforce

High Deductible Health Plans (HDHP) with Health Savings Accounts (HSA)