Common Managed Care Terms & Definitions

**Balance billing:** The practice of billing a patient for the amount remaining after the insurer payment and co-payment has been made. For example, a physician may charge $100 for an office visit and if the insurance company only reimburses the doctor $85, the patient would be billed the additional balance of $15 by the physician. This practice is usually not allowed under most HMOs, but is dependent on the contractual arrangement between the healthcare provider and the health plan.

**Coordination of benefits (COB):** Provision regulating payments when a person is covered by more than one healthcare policy. For example, if an employee is covered under a group plan and also under a spouse's plan, the companies will coordinate payment of benefits so that each company pays the correct portion of the charges and doesn’t reimburse the claimant for more than the cost of the medical care.

**Co-payment:** A cost-sharing arrangement in which a covered person pays a specific charge for a specified service. For example, an HMO may have a $10 office co-payment for physician office visits, so the employee pays $10 at each doctor’s appointment. This amount is paid at the time services are rendered.

**Cost sharing:** A broad term representing the ways in which a covered member shares in the cost of healthcare services with the health plan. Examples of this include deductibles, co-payments, and coinsurance.

**Deductible:** Amount that must be paid prior to receiving medical benefits from a health plan. This is most often associated with PPOs and indemnity companies and can vary from $100 to as high as $2,500 or more. Office visit co-payments are usually paid regardless of whether or not the deductible has been met. Usually, the deductible is based on the calendar year.

**Disallowance:** This occurs when an insurance company or health plan denies payment for certain benefits. For example, if a claim is submitted for teeth whitening, it may be disallowed because of the cosmetic nature of the procedure.

**Drug formulary:** A listing of prescription drugs that are approved by a health plan through participating pharmacies. If the plan is "open formulary" then coverage is provided for drugs that aren’t on the formulary list; if the plan is "closed, select or mandatory" then coverage is only provided for drugs approved by the health plan on the formulary.

**Enrollee:** A person who’s enrolled in a health plan as an employee, not as a dependent.

**Exclusions:** Specific illnesses, injuries or methods of treatment that aren’t covered under an employee benefit plan. An example of this would be a pre-existing condition or a procedure, such as cosmetic surgery, that’s not medically necessary.
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Exclusive provider organization (EPO): A term used to describe a health plan that is similar to an HMO in that it provides benefits only if the insured uses the specified network of providers, but is usually offered as an insured or self-funded product. EPOs usually mandate that coverage be channeled through a primary care physician. Also, EPOs are governed by the state’s Department of Insurance, as are PPOs, whereas most HMOs are governed under the Department of Commerce or the Department of Corporations, depending on specific state structures.

Explanation of benefits (EOB): A statement sent to covered individuals by a health plan explaining the services provided, the amount billed and the level of payment by the health plan.

Formulary: The list of prescription drugs approved for use and covered by an HMO when dispensed through participating pharmacies. Typically, this includes generic drugs that have been found to be safe and effective, and excludes brand-name drugs.

Gatekeeper: Refers to a primary care physician who controls referrals of patients for tests, specialty physician services and hospitalizations.

Gatekeeper model: This is a model for an HMO in which the primary care physician (PCP) serves as the patient’s "gatekeeper," or initial contact for all health care. This is also referred to as "closed access" or a "closed panel." Most HMOs operate under the gatekeeper model, although many are now allowing patients to see some types of specialists, such as an ob/gyn or dermatology physician, without first going through their primary care physician.

Government Plans: Health benefit programs that are governed by the federal government. Examples of Government plans include Medicare, and Medicaid.

Health maintenance organization (HMO): This is a prepaid health plan that provides a range of services in return for monthly premiums and meets the requirements of the federal HMO act. The four basic models of HMOs are the group model, the individual practice association, the network model, and the staff model. HMOs have three distinct characteristics: 1) an organized system for providing health care in a specific geographic area, 2) a specific set of basic and supplemental health maintenance and treatment services and 3) a voluntarily enrolled group of people.

Indemnity: An insurance program in which members are reimbursed for covered medical expenses. This term refers to insurance plans that include little or no managed care components and simply pay a portion of medical bills incurred by the member.

Integrated delivery system: A financial or contractual relationship between physicians and hospitals to offer a range of healthcare services through a separate legal entity. Models of these arrangements include physician-hospital organizations (PHOs), medical foundations, integrated provider organizations (IPOs), and management service organizations (MSOs).
**Marketplace/Exchange/Affordable Care Act:** also referred to as health exchanges, are organizations set up to facilitate the purchase of health insurance in each state in accordance with Patient Protection and Affordable Care Act (ACA) also referred to as "Obamacare". Marketplaces provide a set of government-regulated and standardized health care plans from which individuals may purchase health insurance policies eligible for federal subsidies. Private non-ACA health care exchanges, also referred to as off exchange, also exist. These exchanges were in place prior to the Affordable Care Act and provide insurance plans for employees of small and medium size businesses, and federal subsidies are not available.

**Maximum out-of-pocket costs:** The maximum amount that a member would have to pay in either a calendar or contract year that includes deductibles, co-payments, and coinsurance payments.

**Medicaid:** A federal program that’s administered and operated individually by states that provide healthcare benefits for low-income people under the age of 65. The federal government matches each state’s contribution on a specific minimal level of coverage. Each state can choose or provide additional services or even privatize the program.

**Medicaid Long Term Care or Medicaid LTC:** A federal program that is governed by the state, and may be offered by private companies that contract with the Agency for Health Care Administration (AHCA) to provide healthcare benefits for low-income people who require services such as Hospice, transportation and other home bound services.

**Medicaid Specialty or Medicaid Medical Assistance Specialty SMMA:** A federal program that is governed by the state, and may be offered by private companies that contract with the Agency for Health Care Administration (AHCA) to provide healthcare benefits for low-income people with diagnosis specific benefits and care management.

**Medical necessity:** The evaluation of medical services to determine if they’re: 1) medically necessary and appropriate to meet basic health needs, 2) consistent with the diagnosis, 3) rendered in a cost-effective manner and 4) consistent with national medical practice guidelines.

**Medicare:** A federally administered entitlement program operated by the Center for Medicare Services, or CMS, which covers the costs of hospitalization, medical care, and some related services for eligible persons. The two parts of Medicare are: Part A, which covers hospitalization and is a compulsory benefit, and Part B, which covers outpatient services and is a voluntary program. Medicare also pays for drugs provided in the hospitals, but not for pharmaceuticals prescribed in outpatient settings.

**Medicare Advantage or MA:** A type of Medicare health plan offered by a private company that contract with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans.

**Medicare or Medicaid Medical Assistance MAA:** A federal program that is governed by the state, and may be offered by private companies that contract with the Agency for Health Care Administration (AHCA) to provide healthcare benefits for low-income people. MMA plans include Health Maintenance Organizations and Special Needs Plans with 11 regions in Florida.

**Medicare beneficiary:** A person designated by the Social Security Administration to receive Medicare benefits.

**Medicare supplement policy:** Insurance provided to supplement the reimbursements by Medicare for covered medical services. This guarantees that the deductible, coinsurance, and co-payments covered by Medicare will be paid up to a predetermined benefit level. Also called "Medigap" or "Medicare wrap."
Network: A generic term used to describe all organized groups of healthcare providers. Examples of networks include PPOs, HMOs, and IPAs.

Non-participation provider (non-par): A healthcare provider that doesn’t have a contract with the health plan as a provider of care.

Open access (OA): This arrangement allows HMO members to see participating specialists without having to obtain a referral from their primary care physician. These are most often found in IPA-model HMOs and are also referred to as "open panel."

Open enrollment: A specified time period that occurs, usually annually at the anniversary date, when subscribers are allowed to change healthcare plans or re-enroll in their current plan. This is usually allowed without having to submit evidence of insurability or incur waiting periods.

Open panel: An HMO that contracts with existing physicians and hospitals, rather than a closed panel, which is made up of salaried healthcare providers.

Closed panel: A type of HMO in which the physicians are employed by the health plan and only see patients who are members of the HMO.

Outpatient: A patient who receives healthcare services without being admitted to a hospital for an overnight stay.

Participating provider: A healthcare provider who is contracted with a health plan to deliver services to covered persons. The provider may be a hospital, physician, pharmacy or other facility that has contractually accepted the terms and conditions set forth by the health plan.

Payer or payor: A private or public organization that underwrites or pays for healthcare expenses. This usually refers to an insurance company or HMO.

Point-of-service plan (POS): An HMO or PPO that includes an option allowing members to receive services outside the health plan's provider network. These services are usually provided at a reduced benefit with much greater out-of-pocket costs and different benefit levels, and were created to offer additional flexibility in managed care plans.

Pre-certification: The process of communicating the need for health care to the health plan prior to receiving care. This is a standard requirement for most managed care plans and is designed to help reduce unnecessary hospital admissions and medical procedures. Many plans have penalties if a member receives care without pre-certification, and some won’t pay benefits if pre-certification isn’t obtained.

Preferred provider organization (PPO): A group of healthcare providers that contract with an employer or other entity to provide certain healthcare services at a discounted rate. Usually, the benefit contract provides much better benefits for services received from these preferred providers. Covered persons are usually allowed benefits for non-participating providers’ services at a reduced level. Providers are usually reimbursed on a discounted fee-for-service basis. The PPO providers benefit from increased market share of patients. Many PPOs lease their networks to a variety of insurance companies in one geographic region and they may be fully insured or offered on a self-funded basis.

Preferred provider: Physicians, hospitals and other healthcare providers who contract to provide healthcare services to persons covered by a particular health plan. See preferred provider organization (PPO).

Primary care: Basic health care provided by pediatricians, family practice physicians and internal medicine doctors that focuses on preventive care and differs from healthcare services provided by specialists.
**Primary care physician:** Often referred to as a "gatekeeper physician," this physician is usually the first healthcare provider a person sees for an illness or injury. PCPs are devoted to internal medicine, gynecology, family practice or pediatrics.

**Prior authorization:** This is the process of obtaining prior approval by a health plan as to the appropriateness of a service or medication. This process doesn’t guarantee coverage or ensure that benefits will be paid.

**Provider:** A physician, hospital, nursing home, pharmacy, or any individual or group that provides healthcare services or supplies.

"Reasonable and customary" (R & C): This term refers to the most commonly charged or prevailing fees for a health plan in a specific geographic area. Most insurers pay a percentage of the "reasonable and customary" fees, while the insured individual is responsible for paying any amount charged over this "reasonable and customary" fee.

**Referral:** Authorization by the health plan to send a member to another provider, including specialists and hospitals. Referral requests are made by participating health providers and approved by the primary care plan’s medical directors.

**Referral provider:** Physicians who provide services to patients who are referred to them by a participating provider in the health plan.

**Second opinion:** An opinion obtained from an additional healthcare professional prior to the performance of a medical procedure or service. This may be a mandatory, formal process, which is used to educate the patient, seek alternative treatments, and determine the medical necessity of the care.

**Standard benefits package:** A specific set of healthcare benefits that would be offered by an integrated delivery system. This could include preventive care, hospital and physician services, prescription drugs, long-term care, and mental health services.

**Subscriber:** The individual who’s responsible for the payment of premiums through the employer or directly to the health plan. Also, the person who’s the primary member forming the basis for eligibility for membership in an HMO or other health plan.

**Third-party administrator (TPA):** An organization that provides administrative services, including claims processing and underwriting for other entities, such as insurance companies and employers. TPAs are used by organizations that actually fund the health benefit costs but find it more cost effective to outsource the administrative functions.

**Workers’ compensation:** The state-governed system that addresses work-related injuries and illnesses. Under this system, employers assume the cost of medical treatment and lost wages due to an employee's job-related injury or illness, regardless of who is at fault.