

ACRONYMS AND GLOSSARY

ADLs	Activities of Daily Living
AHEC	Area Health Education Center
BCBSNC	Blue Cross Blue Shield of North Carolina
CAP/AIDS	Community Alternatives Program for People with AIDS or Children who are HIV-positive
CAP/C	Community Alternatives Program for Children
CAP/DA	Community Alternatives Program for Disabled Adults
CAP-MR/DD	Community Alternative Placement Program for Children and Adults with Mental Retardation or Developmental Disabilities
CSC	Child Service Coordination
C/MHC	Community or Migrant Health Center
CMS	Centers for Medicare and Medicaid Services
DEC	Developmental Evaluation Centers
DOI	Department of Insurance
DME	Durable Medical Equipment
DRG	Diagnostic Related Grouping
EMTALA	Emergency Medical Treatment and Labor Act
EOC	Evidence of Coverage
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
ERISA	Employee Retirement Income Security Act
EOB	Explanation of Benefits
FDA	Food and Drug Administration
FFS	Fee-for-Service
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HEDIS	Health Plan Employer Data and Information Set
IDEA	Individuals with Disabilities Education Act
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LOS	Length of Stay
LTC	Long-term Care
MCO	Managed Care Organization
MEWA	Multiple Employer Welfare Arrangement
NAIC	National Association of Insurance Commissioners
NC DHHS	North Carolina Department of Health and Human Services
NCQA	National Committee for Quality Assurance
NP	Nurse Practitioner
OB-GYN	Obstetrician-Gynecologist
OTC	Over the Counter medications
PA	Physician Assistant
PCP	Primary Care Provider
POS	Point-of-Service plan
PPO	Preferred Provider Organization
PCCM	Primary Care Case Management
PSA	Prostrate Specific Antigen
UCR	Usual, Customary and Reasonable Charges
UR	Utilization Review
URO	Utilization Review Organization
US DHHS	US Department of Health and Human Services

ACRONYMS AND GLOSSARY

- Access:** The ease and ability of a patient to obtain needed care in a timely manner. In managed care, access to certain providers may be limited because the provider does not contract with the health plan or is not in the plan's approved network. Access may also be limited by a health plan's requirement that services be approved in advance by a PCP or the plan.
- Access Standards:** The process by which a plan determines if there are sufficient numbers and types of providers available to care for members. Access standards often compare the number of providers contracting with a plan with the number of members enrolled in a plan in a particular geographic area (provider:patient ratios), the distance or travel time needed to obtain care from certain providers, and how long members have to wait from the day they make an appointment until the day of the appointment.
- Accreditation:** A quality review process by an outside agency that looks at how well an organization provides services and the system it uses to continuously improve those services. The National Committee for Quality Assurance (NCQA) conducts most of the HMO reviews. Hospitals and other health care facilities must go through a separate review process to become accredited. These reviews are often conducted by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Accreditation should be distinguished from state licensure, as accreditation is a voluntary process. Further, the accrediting bodies (NCQA and JCAHO) do not have enforcement mechanisms to ensure plans provide the required quality of, and access to, care.
- Activities of Daily Living (ADLs):** Refers to basic functions individuals living independently can perform. These are part of the criteria used to evaluate if an individual needs home health services or needs to be in an assisted-living, residential or nursing home facility. The following seven activities comprise the main ADLs: eating, bathing, dressing, getting to the toilet, moving from place to place, getting outside and walking.
- Adjusted Community Rating:** A system which sets health insurance premiums based on the average cost of providing health care for everyone in the plan (or "community"), with some adjustments based on demographic and claims experience factors. In North Carolina, insurers and plans that sell policies to small employer groups may charge higher rates based on age, gender, family size and geographic area. In addition, small group carriers can vary the premiums charged to small employers with similar age, gender, family size and location by no more than 20%. This additional charge is permitted to adjust for the use of health services by small-employer groups. [N.C.G.S. § 58-50-130(b)].

Administrative Costs:	The amount of money spent on administering a health plan. Administrative costs typically include those costs the health plan incurs in paying claims, enrollment, marketing, or the utilization review process.
Ambulatory Review:	Review of the appropriateness, necessity, efficacy or efficiency of health care services performed or provided in an outpatient setting. [N.C.G.S. § 58-50-61(a)(17)(a)].
Annual Limits:	The maximum amount of money that the insurer or plan will pay for a member's health care services in a given year. The insurer can have an annual limit for all health care services, or may have separate annual limits for specific services (for example, prescription drugs or durable medical equipment). Some insurers also have a lifetime limit, which is the maximum amount of money the insurer or plan will pay during the lifetime of a particular member.
Any Willing Provider Laws:	Any willing provider laws require plans to include in their provider network any provider who agrees to accept the plan's compensation and abide by the plan's internal quality assurance, utilization review and other administrative rules.
Appeal:	A request by a member to their health plan to review a noncertification decision—that is, a decision to deny or limit care recommended by the member's physician or provider.
Authorization:	Approval for the provision of health services and referrals to specialists to obtain care outside of the network, or for coverage of a hospitalization. A primary care provider (PCP) can often authorize the provision of health services and referrals to specialists. However, sometimes the health plan requires member to obtain prior authorization from the health plan for non-emergency hospital admissions or certain high-cost or high-technology procedures.
Balance Billing:	Billing the patient directly for the provider's charges that remain after the health plan pays the portion it is willing or obligated to pay. For example, Dr. Jones charges \$115 for a certain procedure. The insurance company will only pay 80% of the usual, customary and reasonable charges (UCR). In this instance, the insurer sets \$100 as the UCR rate, so pays \$80 (80% of \$100). Under balance billing, Dr. Jones would then charge the patient \$35 (the \$20 coinsurance and the remaining \$15 of her bill).
BCBSNC:	Blue Cross Blue Shield of North Carolina.
Board Certified:	Physicians or other health care professionals who have passed a medical specialty board and have been certified to practice in that specialty. Board certification should be distinguished from state licensure, as board certification is a voluntary process.

Bonuses:	A reimbursement system used by some plans to give providers an incentive to be cost-efficient and reduce unnecessary services. Some plans may also pay bonuses based on the results of member satisfaction surveys or other quality of care measures.
Brand Name Drugs:	Medications that are made by the pharmaceutical company that first developed them and have a patent protection on the name and exact formulary of the drug. After the patent ends, other companies can replicate the active ingredients and offer a generic alternative, which is usually significantly cheaper than the brand name drug.
Capitation:	A fixed periodic payment the plan pays to a physician, group practice, hospital or network of providers. The capitation payment is calculated to cover the expected costs of providing certain services to patients over a period of time. The provider gets the same payment each month (or other fixed time period), regardless of the amount or type of services actually rendered. Capitation payment systems can cover just the cost of providing primary care (“primary care capitation”), may cover the costs of primary care and some specialty care (“partial capitation”) or may also include the costs of hospitalization (“full or global capitation”).
Carolina Access:	See PCCM.
Care Coordinator:	A person who acts as a coordinator to ensure that patients receive all needed health care services. Within governmental programs, care coordinators also help patients remove barriers to access, and help link patients to other needed services in the community (such as financial assistance, housing, social services, etc.). Sometimes plans or insurance companies use the term care coordinator for a case manager who is also concerned with controlling health care costs.
Case Management:	A coordinated set of activities to manage the health care services provided to patients with serious, complicated or prolonged health conditions. [N.C.G.S. § 58-50-61(a)(17)(b)]. Case management services may also be offered in governmental programs. See Care Coordinator.
Case Manager:	A person (often a nurse or social worker) who coordinates all of a person’s care. Case managers are often employed by insurance companies or health plans to help coordinate and manage care provided to members with complex or costly medical conditions. In these instances, case managers also help ensure patients receive appropriate care in the least costly setting. Case managers may also be employed by governmental agencies. See Care Coordinator.

Centers for Medicare and Medicaid Services (CMS):	The federal agency responsible for administering the Medicaid and Medicare programs. CMS is part of the U.S. Department of Health and Human Services. (CMS was formerly known as the Health Care Financing Administration, or HCFA.)
Certification:	A determination by an insurer or its designated Utilization Review Organization that an admission, continued stay in a hospital, or other health care services has been reviewed and satisfies the insurer or plan's requirements for coverage. [N.C.G.S. § 58-50-61(a)(17)(c)].
Chemical Dependency:	Physical addiction to a drug or substance, such as alcohol or heroine, that results in biological changes (including withdrawal) if discontinued suddenly.
Child Service Coordination (CSC):	A publicly-funded program that works with families who have children under the age of five with certain medical, developmental, or social/emotional needs. Each family is assigned a care coordinator who works with them to identify their strengths and outstanding needs. Special emphasis is placed on helping families obtain preventive, specialty and support services.
Children Special Health Services:	A publicly-funded program designed to provide health care for children with special health needs. The two main components of this program are: (1) A network of specialty clinics that provides diagnostic evaluations and treatment; and (2) Reimbursement for certain medical services not covered by Medicaid.
Clinical Guidelines:	The criteria used that outlines the process and standard of care to be given for a specific health condition, disease or illness. Clinical guidelines are usually developed by practicing health care providers, and are an attempt to identify the best way to prevent, detect or treat a particular medical condition. Managed care organizations and other health care institutions use clinical guidelines as a way to ensure that practitioners are providing appropriate care, and to standardize care across providers. Clinical guidelines may also be called clinical protocols, practice guidelines, or medical protocols.
Clinical Peer:	“A health care professional who holds an unrestricted license in a state of the United States, in the same or similar specialty, and routinely provides the health care services subject to utilization review.” [N.C.G.S. § 58-50-61(a)(1)]. Plans must use clinical peers in the second-level grievance hearings to determine if requested services should be approved.
Clinical Review Criteria:	The criteria used that outlines the process and standard of care to be given for a specific health condition, disease or illness. May include clinical protocols or practice guidelines used by an insurer to determine the services or treatments that are appropriate and medically necessary for a person with a specific health condition, disease or illness. [N.C.G.S. § 58-50-61(a)(2)].

- Clinical Trials:** Clinical trials are research studies to determine whether new drugs or treatments are safe and effective. Phase I clinical trials are the first evaluation to determine the safety, safe dosage range or side effects of new drugs or treatments. Phase I trials are usually conducted among a small group of people (20-80). Phase II clinical trials test the drugs or treatments among a larger group of people (100-300). Phase III clinical trials examine the drug or treatment among an even larger group of people (1,000-3,000). These trials are used to confirm effectiveness, monitor side effects, and compare the drug or treatment to commonly used treatments. Phase IV studies are conducted after the drug or treatment has been marketed. These studies determine the effect of the drugs or treatments in various populations, and monitor any side effects from long-term use. For more information on clinical trials, check the National Institute of Health: <http://www.clinicaltrials.gov/>.
- Coinsurance:** The percentage of a provider's fee that the patient is expected to pay. For example, some traditional insurance companies pay 80 percent of a doctor's usual, customary and reasonable (UCR) fees. The patient is expected to pay the 20% difference between the doctor's UCR fees and what the insurance company pays. The 20% which the patient pays is called the coinsurance.
- Community Alternatives Program for People with AIDS (CAP/AIDS):** The Medicaid community alternatives program for persons with AIDS as well as children who are HIV-positive. The program helps individuals who would otherwise need nursing facility care, but who can reside safely in a private residence with additional services and supports.
- Community Alternatives Program for Children (CAP/C):** The Medicaid community alternatives program for children was established to provide medically fragile children with a cost-effective home care alternative to institutional care. It provides a package of home care and other support services to enable the children to remain with their families in a private residential setting.
- Community Alternatives Program for Disabled Adults (CAP/DA):** The Medicaid community alternatives program for older adults or people with disabilities who would otherwise need nursing facility care. The program provides services and supports to enable older adults and people with disabilities to be served in the community rather than an institutional setting.

Community Alternative Placement Program for Children and Adults with Mental Retardation or Developmental Disabilities (CAP-MR/DD):	The Medicaid-financed community alternative placement program for children and adults with mental retardation or developmental disabilities provides support services to enable individuals with developmental disabilities or mental retardation to remain in the community instead of residing in an institutional setting.
Community and Migrant Health Center (C/MHC):	Health care facilities located in medically underserved areas that provide comprehensive primary and preventive care to patients on a sliding fee scale. CHCs receive grant money from the federal government to cover the cost of providing care to uninsured low-income patients as well as for providing other services to help patients access services, such as transportation or translation.
Concurrent Review:	Utilization review conducted during the course of a patient's hospital stay or course of treatment, to determine whether the hospital stay or treatment is still necessary. [N.C.G.S. § 58-50-61(a)(17)(d)].
Congenital Abnormality:	Physical or mental health problem that develops during pregnancy or the birth of a child.
Continuing Care Retirement Community:	A facility which contracts with individuals to provide lodging, nursing services, medical services and other health related services for at least one year. Continuing care retirement communities typically provide a continuum of lodging facilities, from independent living to assisted living facilities and nursing home care.
Copayment (Copay):	A fixed payment that must be paid out-of-pocket by a patient upon receiving health care services. In some HMOs, for instance, you pay a \$20 copayment for a doctor visit, or a \$10 copayment for a prescription.
Cost Sharing:	A generic term used to describe any payment the member must make for covered services. Different cost-sharing methods include deductibles, coinsurance and copayments.
Covered Services:	Services the HMO or insurance company will cover. Not all services listed in the insurance company's or HMO's list of covered services will automatically be covered. Often, the insurance company or HMO will further limit covered services, for example, by limiting services to those deemed "medically necessary." Other services may be limited based on other criteria, such as number of visits or dollar limits.

Credentialing:	The process that health plans use to ensure that health care providers and institutions meet certain minimum competency and malpractice coverage requirements. Typically, plans verify a professional's medical license, board certification (if any), malpractice history, and educational background.
Custodial Care:	Services that relate to daily activity that do not require skilled medical personnel to provide, such as cleaning, dressing, eating and paying bills.
Day Treatment:	Health services provided on an outpatient basis during normal business hours.
Deductible:	The amount an insured person must pay out-of-pocket each year before the insurance plan begins to cover health care costs. A policy with an individual deductible of \$300 and a family deductible of \$900 means that each individual person in the family must pay \$300 of medical expenses before the policy begins paying benefits for that individual. Once the out-of-pocket expenses of the family members reaches \$900, then the insurance company will pay for the covered services provided to all of the insured family members.
Department of Insurance (DOI):	The NC agency charged with regulating and overseeing insurance companies and HMOs.
Developmental Evaluation Centers (DEC):	A publicly funded program with 18 centers located throughout North Carolina whose interdisciplinary staffs provide clinical evaluations, treatment, and case management services for children who have known or suspected developmental disabilities.
Diagnostic Related Groups (DRG):	This classification system was developed in the Medicare program (but used by some private insurers) to pay hospitals based on a patient's primary and secondary diagnosis, surgical procedures, age, sex, and presence of complications.
Discharge Planning:	The process used to determine how a patient's ongoing health care needs will be coordinated and managed after being discharged from a hospital or other health care facility. [N.C.G.S. § 58-50-61(a)(17)(e)].
Disenrollment:	When either an individual or group leaves a particular health plan.
Drug Utilization Review:	A review process used to determine the appropriateness of a physician's medication prescribing patterns. Drug utilization reviews are typically conducted by other providers, and used to provide feedback to practitioners.
Dual Eligible:	A person who is eligible for both Medicare and Medicaid.

Durable Medical Equipment (DME):	Equipment to assist individuals with injury or disease-related problems that can be used repeatedly. Examples of DME include wheelchairs, walkers, and home hospital beds.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT):	A program that provides well-baby and well-child screenings to children receiving Medicaid. Children are entitled to receive all the needed health care services or treatment identified as part of the screening, as long as the federal Medicaid laws permit states to cover that service. In North Carolina, the EPSDT program is known as Health Check.
Efficacy:	Under <i>ideal conditions</i> , how well a treatment, therapy or procedure produces a desired health outcome (cure, alleviation of pain, return of functional abilities).
Effectiveness:	Under <i>real life</i> conditions, how well a treatment, therapy or procedure produces a desired health outcome (cure, alleviation of pain, return of functional abilities).
Employee Retirement Income Security Act (ERISA):	A Federal law that prevents states from enacting laws or regulations that have an impact on employer welfare plans, including employer sponsored health benefits. States can regulate insurance carriers or HMOs. If an employer purchases a regulated insurance or HMO plan, then the enrollees are covered by the state consumer protection laws. However, employers that pay directly for all of health services (self-funded or self-insured plans) are not subject to the same state laws.
Emergency Medical Condition:	North Carolina state law uses a “prudent layperson” definition of emergency medical condition. That is, state law considers certain acute symptoms to be emergency medical conditions if a prudent layperson, possessing an average knowledge of health and medicine, thinks that in the absence of immediate medical attention, the medical condition is likely to place him or her (or in the case of a pregnant woman, her unborn child) in serious jeopardy, or cause serious impairment to bodily functions or bodily organs. [N.C.G.S. § 58-50-61(a)(4)].
Emergency Medical Treatment and Active Labor Act (EMTALA)	Originally part of the Comprehensive Omnibus Reconciliation Act of 1986 (COBRA). It requires all Medicare participating hospitals to screen any individual who comes to the emergency department requesting treatment for a medical condition. If the screening determines that the person does have an emergency, then the hospital must either treat or stabilize the person to transfer the individual to another hospital.
Emergency Services:	“Health care items and services needed to screen for or treat an emergency medical condition until the condition is stabilized, including pre-hospital care and ancillary services routinely available in the emergency department.” [N.C.G.S. § 58-50-61(a)(5)].

Enrollee, Insured or Member:	The person covered under the health insurance or HMO plan. The member may include the employee (if covered by an employer group health plan) and his or her dependents.
Evidence of Coverage (EOC):	The document given to HMO enrollees that describes the covered benefits and exclusions, utilization review requirements, cost-sharing, and other coverage provisions. The evidence of coverage is similar to a policy contract that other insurers issue.
Explanation of Benefits (EOB):	A statement sent to insured which explains what services were or were not covered, and the amount the insurer or HMO paid for the services.
Experimental Services:	A new treatment developed from research that is different from the commonly provided standard of care for a given disease, illness or condition. Experimental or investigational drugs, treatments or procedures are typically not approved for use by the FDA, and may be the subject of clinical trials to test its toxicity level, efficacy or effectiveness.
Food and Drug Administration (FDA):	Federal agency that regulates food, drugs, devices, and biological products.
Fee-for-Service (FFS):	Payments to providers based on the specific services rendered. Fee-for-service systems are typically distinguished from capitation payments, which involve a fixed periodic payment per individual regardless of what services are provided. Under a fee-for-service system, the provider is paid each time he or she provides a different service.
Fee Schedule:	A provider reimbursement system that pays providers according to a fixed fee-schedule established by an insurer, HMO or government.
Formulary:	List of pharmaceuticals that the managed care organization will cover. A formulary may limit the type and number of medications available for a physician to select from when treating any given disease, illness or condition.
Gatekeeper:	In managed care systems, a primary care provider who is responsible for authorizing treatment by specialists or non-emergency hospitalizations. If you are in a managed care system that uses “gatekeepers,” you must see your “gatekeeper” before visiting a specialist (for example, a cardiologist).
Generic:	Drug produced after the patent on a brand name drug ends. Generics contain the same active ingredients as the brand name drug.

- Grievances:** A written complaint submitted by a member, which challenges the insurer's decisions, policies or actions related to availability, delivery or quality of health care services; claims payment or handling; reimbursement for services; the contractual relationship between the member and the insurer; or the outcome of an appeal of a noncertification decision. [N.C.G.S. § 58-50-61(a)(6)].
- Group Insurance Plan:** Health benefits purchased to cover individuals who are grouped together for purposes other than purchasing health insurance coverage. Employers often sponsor group insurance plans for their employees. Group plans tend to be less expensive than individual non-group plans because the insurer or HMO can spread the administrative costs and health risks over more individuals. Unions and churches may also sponsor group insurance plans.
- Guaranteed Issue:** Law requiring insurers that participate in the small group market to offer health benefit plans to any small group that applies for coverage. In certain limited situations, state law also requires insurers and HMOs to guarantee issue a health benefit plan to individuals seeking non-group coverage. The goal is to increase access to health insurance for small groups/individuals who, without this type of law, may be turned down by health insurers due to health problems or risks.
- Guaranteed Renewability:** Law requiring insurers to renew the current health plan as long as the insurer continues to offer coverage in that market and the purchaser has not failed to pay premiums, engaged in fraudulent activities or moved from the coverage area. These laws prohibit insurers from terminating health benefits due to enrollees' health status or past use of services.
- Health Benefit Plan:** Health insurance coverage provided by an HMO, Blue Cross Blue Shield, a commercial insurance company, or a plan provided by a multiple welfare arrangement (MEWA). The definition of a health benefit plan (or health plan as used in these documents) does not include long term care, accident, credit, disability, dental, vision or specific disease insurance policies. Under state laws, health benefit plans do not include Medicare supplements, workers' compensation, medical payments under auto or homeowners insurance or hospital income policies. These plans are governed by different laws. [N.C.G.S. § 58-3-200(a)(1)].
- Health Check:** A publicly funded Medicaid initiative to improve Medicaid-eligible children's access to preventive health services. Medicaid-eligible children are eligible to receive comprehensive health care check-ups, immunizations, vision, hearing and dental screening services on a regular basis throughout childhood. Any medically necessary diagnostic or treatment services needed to treat the conditions identified during the screenings will also be covered. Health Check is the name for North Carolina's EPSDT program.

Health Insurance Portability and Accountability Act (HIPAA):	Passed by Congress in 1996, it established minimum standards for access, portability and renewability of coverage for all health plans, including self-funded or ERISA plans. Most of the protections apply to large and small group purchasers and certain individuals leaving or changing group coverage. Provisions of the bill include guaranteed issue, guaranteed renewability, limits on pre-existing condition waiting periods, nondiscrimination based on health status, portability and special enrollment periods. HIPAA also contains provisions to protect the confidentiality of medical records.
Health Maintenance Organization (HMO):	A type of health care organization that manages and finances its members' care. Historically, HMOs emphasized preventive care in order to keep their members healthy. HMOs have exclusive provider networks and often use primary care providers as "gatekeepers." Gatekeepers are responsible for arranging the patient's referral to a specialist or admission to a hospital. While most HMOs use gatekeepers, some HMOs have "open access" plans. These plans allow the patient to choose any primary care provider or specialist in the network without a referral. HMOs also may use reimbursement systems such as fixed payments for each member (called "capitation") or performance incentives to encourage providers to be more cost conscious.
Health Plan Employer Data and Information Set (HEDIS)®:	A standardized set of performance measures that consumers and other purchasers can use to compare health plans. HEDIS® collects information to measure effectiveness of care, access/availability of care, satisfaction with care, health plan stability, informed health care choices, and health plan descriptive information.
In-Area:	The geographic area covered by the managed care organization. Typically, this includes areas where the HMO has provider contracts and enrollees. Generally, managed care organizations will not pay for care sought by members outside of this area, unless it is urgent care or an emergency.
Incentive Payments:	Financial payments managed care organizations give to physicians or facilities to encourage certain behavior. Examples of the types of behaviors for which an MCO may provide incentive payments include cost containment and improving the quality of care provided.
Indemnity Insurance:	Traditional major medical insurance that pays a percentage of the provider's charges. Typically, indemnity plans pay providers on a fee-for-service or discounted fee-for-service basis. Many insurers, for example, will pay providers 80 percent of the usual, customary and reasonable charges for a comprehensive array of services. An indemnity plan that includes a network of providers is generally referred to as a Preferred Provider Organization (PPO).

Individuals with Disabilities Education Act (IDEA):	The publicly funded early intervention program is actually two separate programs for young children with special needs. The Infant-Toddler program covers children from birth through age two, and the Pre-school program covers children from three to five (or until the child enters kindergarten).
Insured:	The person covered under the health insurance plan. The insured person may include the employee (if covered by a employer group health plan) and his or her dependents. Insured typically refers to a person covered through an insurance company, whereas member or enrollee typically refers to a person covered by an HMO.
Insurer:	An entity that writes a health benefit plan and that is an insurance company. Sometimes also used generically to include health maintenance organizations and multiple employer welfare arrangements.
Investigational Services:	See Experimental Services.
Joint Commission on Accreditation of Healthcare Organizations (JCAHO or Joint Commission):	An organization that accredits hospitals, home care, other medical facilities, and most recently, health networks.
Late Enrollee:	Generally refers to individuals or their dependents who do not choose to be covered by employer-sponsored coverage when initially offered at the start of employment, during the annual open-enrollment period, or within 30 days of birth in the case of a newborn dependent, or within 30 days of adoption, but do enroll at a later point in time.
Length of Stay (LOS):	The term which refers to the length of stay in hospitals. Often, performance measures examine the average length of stay.
Lifetime Limits:	The maximum amount of money that the insurer or HMO will pay for care over the member's lifetime. The insurer can have a lifetime limit for all health care services, or may have separate lifetime limits for specific services. Some insurers also have annual limits, which is the maximum amount of money the insurer or HMO will pay for the member during a particular year.
Long-Term Care (LTC):	Health services provided in non-hospital facilities for chronically ill or disabled individuals. May include custodial care, maintenance or rehabilitation care for chronic, debilitating conditions. Long-term care can be provided on an inpatient basis (for example, in nursing homes or group homes), or may be provided on an outpatient basis (such as a dult day health care), or in the person's home.

Major Medical Insurance:	A medical insurance plan that provides broad coverage for hospitalizations and outpatient expenses. These policies often have deductibles, coinsurance, and other limitations, but generally provide comprehensive coverage of health care services.
Managed Behavioral Health Plan:	A separate managed care company that typically subcontracts with either an insurance company or another HMO to manage the mental health and substance abuse services provided to the enrollees. In North Carolina, Magellan Behavioral Health, Cigna and Value Behavioral Health are some of the larger managed behavioral health providers.
Managed Care Plan:	A health benefit plan that creates a financial incentive to use providers that are in the health plan's network. Some managed care plans limit coverage to care obtained from network providers. Others pay more if the member obtains care from within the network, but will pay something for covered services obtained from non-network providers (PPOs or POS). Managed care systems often use utilization review mechanisms to oversee the amount and type of health care services being used. Some HMOs also use provider reimbursement methods that discourage unnecessary care.
Managed Care Organization (MCO):	A generic term applied to managed care companies such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) or Point of Service (POS) plans.
Mandated Benefits:	Certain health services that insurers and HMOs must cover because of either state or federal laws. North Carolina law, for example, mandates that insurers and HMOs cover emergency services, pap smears, mammograms and PSAs.
Medicaid:	A governmental health insurance program that provides assistance with medical costs for certain low- and moderate-income individuals and families. The federal government sets the broad guidelines for the program. A state is then given considerable latitude to establish eligibility criteria and to determine what services will be covered for the state's Medicaid population.
Medical Loss Ratio:	The percentage of the health plan's health care related revenues (i.e. premiums) that is used to pay for health care services in contrast to profit or administrative overhead.
Medical Necessity:	See Medically Necessary Services or Supplies.

Medically Necessary Services or Supplies:

State law defines medically necessary services or supplies as “Covered services or supplies that are:

- ◆ Provided for the diagnosis, treatment, cure or relief of a health condition, illness, injury or disease;
- ◆ Not for experimental, investigational, or cosmetic purposes, unless authorized under N.C.G.S. § 58-3-255;
- ◆ Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms;
- ◆ Within generally accepted standards of medical care in the community;
- ◆ Not solely for the convenience of the insured, the insured’s family or the provider.”

[N.C.G.S. § 58-3-200(b)]. HMOs and insurers can compare the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

Medicare:

The national health insurance program provided primarily to older adults (65 or older) and some disabled people who are eligible for Social Security, Railroad Retirement, or Disability benefits. Medicare has two parts: Part A, which is hospital insurance, and Part B, which covers the costs of physicians and other providers. In addition, Medicare offers Part C (Medicare Plus Choice), which expands the availability of managed care arrangements to Medicare recipients.

Multiple Employer Welfare Arrangement (MEWA):

Employee benefit plans created by groups of employers that band together to provide health insurance or other employee benefits to their employees. MEWAs are most often found among small employer groups belonging to a common trade association.

National Association of Insurance Commissioners (NAIC):

Professional or trade association for state Departments of Insurance.

National Committee for Quality Assurance (NCQA):

A private, independent organization that reviews and assesses the quality of services provided by health plans through an accreditation process. In addition, NCQA created a uniform data collection system to compare the quality of services provided by HMOs (see HEDIS).

Network:

A group of providers (physicians, hospitals, pharmacies, and other health care providers) that contract with managed care organizations to provide health care services to its members.

Noncertification:	A determination by an insurer or its designated utilization review organization to deny, reduce or terminate a requested service, treatment or procedure. The denial must be based on a review and a decision that the requested service, treatment or procedure does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness. [N.C.G.S. § 58-50-61(a)(13)].
Non-Group Insurance Plan:	A health insurance plan that is purchased separately, and not part of a group. Non-group plans are sometimes referred to as plans purchased in the individual market. Individuals or families who purchase health insurance directly from the insurer or HMO, and not through an employer, church or association, are usually purchasing non-group insurance plans.
Non-Participating Provider:	Physician/provider who does not contract with the managed care organization. Care by nonparticipating providers is generally not covered by HMOs without prior authorization. However, Point-of-Service and Preferred Provider Organizations allow members to obtain care from nonparticipating providers, but require the member to pay more for the services.
NC Department of Health and Human Services (NC DHHS):	The state agency responsible for administering Medicaid, NC Health Choice, public health agencies, mental health, developmental disabilities and substance abuse programs, aging programs, as well as other human services programs. In addition, NC DHHS also has responsibility to license and inspect certain health care facilities.
NC Health Choice:	A publicly funded program that offers free or reduced cost health insurance for uninsured children birth through age 18. Uninsured children must have a family income that is equal to or less than 200 percent of the federal poverty guidelines, and must not qualify for Medicaid.
Nursing Facility/Nursing Home:	Residential care for individuals requiring access to medical nursing assistance or staff 24 hours a day.
Off-Label Drugs:	Drugs used for health purposes other than their FDA-approved use(s).
Office Visit:	Outpatient health services provided in a physician's office, group practice, hospital outpatient clinic, rural or community health center.
Open-Access Plan:	An HMO that allows enrollees to see any provider within the network without a referral from a primary care provider. Open-access plans are distinguished from "gatekeeper" plans, which usually require a primary care provider to authorize all visits to specialists within the network.

Open Enrollment Period:	Designated time of year during which individuals have the opportunity to join or switch health plans. Usually applies to individuals in group plans who did not enroll when initially offered the opportunity (i.e., at time of hire or birth/adoption of child), or who want to switch benefit plans. Individuals who do not enroll during this period may have to wait until the next open enrollment period to participate in the health plan. Or they may be subject to certain pre-existing waiting periods for “late enrollees.”
Out-of-Area:	Refers to geographic area where a managed care organization does not have contracts with providers or facilities to care for its members. Often if individuals move out of the MCO’s contract area, they can no longer participate in the plan’s benefits. If members are traveling out of the area, usually only emergency and urgent care services are covered, and the coverage for the care may not be as comprehensive as for care sought within the plan’s service area. Some plans do have affiliates or national networks that their members may be able to participate in with prior approval.
Out-of-Area Emergency:	Care sought for an emergency health condition (see emergency care definition) outside of a managed care organization’s geographic service area.
Out-of-Network:	Care provided by health care providers that are not a part of the managed care organization’s network. Some plans allow members to seek care out of the network, but at a higher out-of-pocket cost and/or deductible to the member (POS and PPO plans). HMOs generally do not cover any of the costs for care obtained out of network, unless contracting health care providers are unavailable to meet the health needs of the insured without unreasonable delay.
Out-of-Network Referral:	Referrals to providers or facilities that are not a part of the HMO’s provider network. Out-of-network care usually requires prior authorization by the HMO and may be limited to cases where contracting health care providers are unavailable to meet the health needs of the insured without unreasonable delay.
Out-of-Pocket:	Money spent by members for health/medical care that the health plan either requires them to pay (such as a deductible or co-pay) or does not cover. Does not include health insurance premium payments.

Out-of-Pocket Limit:	Maximum amount established by a health plan that an individual member or his or her family will have to pay toward their medical care in a given year in deductibles, coinsurance and co-payments. Once this limit is met, the plan will pay 100 percent of the costs of future covered health services until the new policy year begins. However, a health plan may specifically exclude certain costs from the out-of-pocket maximum. For example, an individual member may not be able to count the costs of non-covered services that he or she incurs, or any costs incurred by failing to follow the health plan's prior approval process.
Outcome:	Usually refers to the resulting health or well-being of an individual following some treatment, screening, prevention program or other health promotion intervention. Outcomes typically refers to long-term effects, and may include changes in health status, control of chronic illness, decrease in hospitalizations, ability to engage in the activities of daily living, or mortality. Used to help determine effectiveness of a treatment or intervention.
Outpatient:	Health services that are provided during an office visit or other ambulatory facility. Patients who receive outpatient services do not need to stay overnight.
Outpatient Drugs:	Prescribed medications obtained by the patient at a pharmacy to be taken at home. Medications that are provided as a part of inpatient care or administered in a physician's office, during ambulatory surgery or in clinic setting are not usually considered outpatient medications.
Over-the-Counter (OTC):	Drugs or medications that are available without a prescription. Usually these drugs are not covered by health plans and must be paid in full by the patient. The plan may deny payment even if a prescription is written for the medication and it is available over the counter.
Participating Hospital/Facility:	A hospital or health care facility such as a nursing home or long-term care facility that contractually agrees to provide health care services to members in return for a payment from the managed care organization.
Participating Provider:	A provider who contractually agrees to provide health care services to members in return for payments from the managed care organization. [N.C.G.S. § 58-50-61(a)(14)].
Patient Advocate:	Individual who works with the patient to ensure that he or she receives needed and appropriate care in a timely manner. Patient advocates generally are external to the managed care organization or insurer, and can act more independently to advocate on the patient's behalf.

Peer Review:	Mechanism of ensuring quality of care within the medical community. The quality assurance review is conducted by health care professionals (peers) to ensure that care provided and services used are appropriate. It is also used to identify fraud and other abuses of health care payment systems.
Performance Measure:	A way to compare health plans on different measurements (such as quality of care, health outcomes, consumer satisfaction, etc). HEDIS [®] is one of the most commonly employed set of performance measures used to compare different HMOs.
Point-of-Service (POS) Plan:	A type of HMO plan that gives patients the opportunity to see providers outside of the network. Patients who use the HMO network of providers pay less than patients who see providers outside the network. The HMO may still require the use of a gatekeeper to authorize in-network or out-of-network services.
Policy Contract:	The document given to insured individuals that describes the covered benefits and exclusions, utilization review requirements, cost-sharing, and other coverage provisions. The policy contract is similar to the evidence of coverage that HMOs provide to their members.
Portability:	Allows individuals to change from one group plan to another without being subject to a pre-existing condition exclusionary period. In order to gain the benefit of this protection, insured individuals must change health plans without a gap of more than 63 days, and must have met prior pre-existing condition waiting periods, if any.
Preauthorization:	The health plan's approval that a requested hospital admission, treatment or procedure is a covered service and is medically necessary and appropriate. Managed care organizations often require that a member or insured individual obtain prior authorization from the health plan before a hospital admission or selected health care services, treatment or procedure will be covered. See also prior authorization or prior approval.
Precertification or Pre-Admission Screening:	Authorization that must be obtained from the health plan before inpatient care is provided in order for the plan to pay for the hospitalization. Pre-admission screening reviews the appropriateness of the requested care, while precertification may specify the allowable length of stay in addition to what services/procedures will be covered.
Pre-Existing Condition:	Mental or physical conditions for which an individual sought medical advice, care or treatment within six months prior to the enrollment in the health plan.
Preferred Provider:	A provider who has agreed to accept the health plan's reimbursement and agreed to other contractual requirements that an insurer imposes (such as quality assurance or utilization review protocols).

Preferred Provider Organization (PPO): PPOs manage medical costs by creating a network of providers who are willing to accept lower reimbursement rates. The providers are often required to meet other requirements, including the insurance company's utilization review procedures. Patients may choose any health care provider, but they will have to pay additional money if they use a provider who is not part of the PPO network. PPOs are usually associated with traditional insurance companies, not HMOs.

Prescription Drug: Medication that can only be obtained with a physician's order. Drugs that are available over the counter, even if the physician writes an order for them, may not be covered by a health plan.

Preventive Care: Medical care provided to protect against, minimize the risk of, or help in the early detection of health problems or diseases. Examples of preventive care include immunizations, pap smears and mammograms.

Primary Care: Comprehensive, coordinated and continuous health care provided by a provider who is trained to manage most of a person's health care needs. Primary care practitioners are most often trained in family medicine, general internal medicine, or general pediatrics.

Primary Care Case Management (PCCM): Primary care case management programs only operate within the Medicaid program. In PCCM programs the Medicaid agency pays a primary care provider a monthly management fee to manage the patient's care. However, the doctor is reimbursed for the services he or she provides on a fee-for-service basis. The primary care provider acts as the patient's "gatekeeper" and must authorize all non-emergency visits to the hospital and all referrals to specialists. In North Carolina, the PCCM program is called Carolina Access.

Primary Care Providers (PCP): Generally, most plans allow family physicians, general practitioners, pediatricians or general internists to serve as primary care providers. Often, advance practice nurses (such as nurse practitioners), or physician assistants (PAs) can be the primary care provider. Sometimes, the health plan will allow an OB-GYN to serve as a primary care provider. Primary care is distinguished from specialty care, which is often concerned with a particular health condition or body organ. Examples of specialty care would include oncologists who deal with cancer or cardiologists who specialize in hearts.

Prior Approval/Prior Authorization/Preauthorization: Verification by the health plan that the requested services are appropriate and will be covered. Must be obtained before services are rendered.

Prospective Review: Utilization review conducted before an admission or a course of treatment. Prospective review includes pre-authorization and pre-certification requirements that may be needed before a patient can be admitted to a hospital or obtain certain health care. [N.C.G.S. § 58-50-61(a)(17)(f)].

Provider:	Person or institution providing health care. Providers include doctors, nurses, physician assistants (PAs), therapists, dentists, hospitals, clinics, nursing homes, pharmacies, companies that sell medical equipment, etc.
Prostrate Specific Antigen (PSA):	A mandated benefit under North Carolina law to test men for prostate cancer.
Prudent Layperson:	Term used to describe how an average, reasonable person who is untrained in medicine would interpret and respond to a health problem. Most often used in determining whether or not emergency care services should be covered.
Quality Assurance:	Refers to a health plan's internal processes to verify that the care provided to its members meets the health plan's or government's quality standards.
Quality Improvement:	Refers to a health plan's internal process for developing better ways to improve the quality of care provided to its members.
Readmission Review:	Review by the health plan of patients who are admitted a second time soon after being discharged from inpatient care for the same health condition. Readmission reviews are typically conducted to determine if the initial hospital discharge was too early and whether the second hospitalization is necessary.
Referral:	Physician recommendation to a patient to see another physician for further evaluation or treatment. In HMOs that use gatekeepers, services provided by specialists or other practitioners require a referral by the patient's primary care provider in order for the health plan to cover the cost of the care.
Rehabilitation:	Services designed to assist an individual in adapting to a loss of physical or mental functioning, or to restore normal functioning. Usually provided following an accident or illness, rehabilitation is often a time-limited benefit that is only authorized if improvement is expected within a short period.
Rehabilitation Facility:	Organization that provides rehabilitation services on outpatient and/or inpatient basis.
Residential Facilities:	Facilities that provide custodial care to persons who are not able to live independently. Residential facilities may include nursing homes, assisted living facilities or group homes.
Respite Care:	Temporary supervision and care of individuals with chronic, debilitating conditions who require constant monitoring. Respite care is provided to give families who normally care for these individuals a rest.

Retrospective review:	Utilization review of services and supplies that have already been provided to a patient to determine whether they were medically necessary or appropriate. [N.C.G.S. § 58-50-61(a)(17)(g)].
Rider:	A health insurance or HMO policy that supplements regular coverage. For example, some insurers exclude prescription drug or mental health coverage. These services are not included in the comprehensive policy but may be purchased separately through a rider.
Risk:	A term used in managed care systems when some of the financial risk of paying for the costs of the health services provided to enrollees is transferred from a HMO or POS to a provider or group of providers. Capitation, withholds and bonuses are all types of systems that transfer some of the financial risk of caring for the patient to the health care provider. PPOs may not transfer financial risk to providers.
Second Opinion:	The term used when an insured person obtains a clinical evaluation by another provider in addition to the one who originally recommended a proposed service. Second opinions are used to assess the medical necessity and appropriateness of the proposed service. Sometimes insurers or HMOs require the insured individual to seek a second opinion before covering certain services. At other times the insurer or health plan may be willing to pay for the second opinion at the request of the insured individual. [N.C.G.S. § 58-50-61(a)(17)(h)].
Self-Insured or Self-Funded Plans:	Health plans in which the employer is actually the insurer and is responsible for paying the medical bills of those insured through the plan. Even though the employer may contract with an HMO, insurer or other third-party administrator to administer the coverage and pay the claims, the employer retains responsibility for paying all the medical claims. These plans are governed by federal ERISA laws rather than state insurance regulations, and are sometimes called ERISA plans.
Skilled Care:	Care that can only be provided by trained medical personnel. May also require specific licensure or credentials.
Skilled Nursing Facility:	Organization that provides care to patients whose conditions require around-the-clock access to licensed nursing services. Typically referred to as nursing homes.
Stabilize:	Provision of medical care that is appropriate to prevent the person's health condition from deteriorating. [N.C.G.S. § 58-50-61(a)(16)].

Standing Referral:	A referral from a primary care provider to a specialist for a specified period of time (often to cover a course of illness). Health plans must have a process to allow patients with chronic, degenerative, disabling or life-threatening illnesses or conditions to obtain extended or “standing” referrals to in-network specialists. The standing referrals can not exceed 12 months, and must be part of a treatment plan coordinated with the primary care physician, specialist and health plan.
Subscriber:	See Enrollee.
Substance Abuse:	Use of alcohol or drugs that impairs an individuals’ ability to function. The impairment can be mental, physical or financial to the individual abusing the substance or others around him or her.
Telephone Triage System:	Process by which medical staff review patient complaints over the phone to determine urgency of care needed. The medical staff follows the pre-established protocols to advise the patient, recommend when and where to seek care and/or contact the physician on call for assistance.
Termination Date:	The last day a health plan will cover services. The last effective date of the health insurance or HMO contract.
Tertiary Care:	Specialty and sub-specialty care that often uses new technologies and therapies to treat rare conditions or unusual cases. Usually available to patients with conditions that are too complicated, too advanced or too unusual to be treated by physicians or general acute care hospitals.
Third-Party Payer:	The organization responsible for paying for the medical costs incurred by enrollees of a health plan. Examples of third-party payers include commercial insurance plans, Blue Cross Blue Shield, Medicaid or Medicare.
Third-Party Administrator:	Company hired to handle only the non-clinical aspects of a health plan’s business, such as billing, collecting premiums and paying physicians.
Urgent Care:	Care for immediate (acute), but not life threatening health problems. An example of a condition that might require urgent care is an urinary tract infection that left untreated over a weekend could progress and damage the kidneys but does not require an emergency room visit.
Urgent Care Center:	Free-standing clinic, usually open during the evening, that sees patients with immediate health needs. Urgent care centers often do not provide regular, ongoing or preventive care.
US Department of Health and Human Services (US DHHS):	The federal agency responsible for administering most of the federal health programs in the country, including Medicare, Medicaid, public health agencies, maternal and child health programs, as well as other human services programs.

Usual, Customary and Reasonable Charges (UCR):	The prevailing amounts that health care providers charge for medical services. Insurance carriers sometimes set their reimbursement rates as a percentage of usual, customary and reasonable (UCR) charges.
Utilization Review (UR):	A system designed to monitor the use of, or evaluate the medical appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Utilization review may include ambulatory review, case management, certification, concurrent review, discharge planning, prospective review, retrospective review or second opinions. [N.C.G.S. § 58-50-61(a)(17)].
Utilization Review Organizations (URO):	Independent organizations that conduct utilization review for a managed care plan. UROs do not include insurers or health plans that conduct their own internal utilization review. [N.C.G.S. § 58-50-61(a)(18)].
Waiting Period:	Length of time a health plan excludes coverage for a new enrollee's pre-existing health condition. Under the Health Insurance Portability and Accountability Act, the maximum pre-existing condition waiting period is 12 months, or 18 months for late enrollees. However, individuals who change health plans and have a gap in coverage of no more than 63 days will not be subject to a new pre-existing condition waiting period if they already met their pre-existing condition exclusionary period in their prior coverage.
Wellness Program:	Educational and clinical services designed to improve patients' health by promoting healthy behaviors, such as eating well or exercising, and assisting them in altering unhealthy behaviors such as smoking.
Withholds:	A payment system in which the HMO withholds a portion of the provider's payment. This may be refunded based on a set of performance criteria. For example, a provider or group of providers may have a withhold fund established to help offset all or part of the costs of specialty care. If funds remain in the specialty fund at the end of the quarter (or year), the funds may be redistributed back to the providers.