ALTERNATIVE DELIVERY SYSTEM: An organization or arrangement that provides for the delivery and financing of health care services, serves as an alternative to traditional indemnity insurance. Examples include health maintenance organizations (HMO's), preferred provider organizations (PPO's) and competitive medical plans.

ANY WILLING PROVIDER LAW: Legislation which requires health care plans to accept any qualified provider as a members of their networks.

CAPITATION: A method of payment for health services in which an HMO, medical group, or institution is paid a fixed amount for each person enrolled, usually monthly. The amount paid covers services provided, regardless of the actual number, nature, or value of those services. Specific service costs are often expressed as dollars per-member-per month (PMPM) in development of capitation rates and premiums.

CARRIER: (1) The company responsible for the basic insurance underwriting. A carrier can act as both administrator and underwriter for a plan. (2) The term used to denote insurance companies that serve as administrators under Medicare Part B.

CARVE OUT: A managed care system wherein a group of providers in a given field (e.g. eye care or mental health) contracts with an HMO (or other managed care entity) to provide all services within that specialty to the HMO's members. This allows HMOs to "farm out" certain services without having to build their own staffs of providers within those specialties.

CLOSED PANEL: A program that does not allow all eligible providers to participate in the program. The program usually enlist a small, select number of physicians. Panel participation may be dictated by the acceptance of discounted reimbursements levels, by the type of provider, e.g. ophthalmologists only, or by contracting with the physicians in a salaried arrangement, e.g., HMOs. Most group- or staff-model HMOs and other managed care plans have this type of panel.

COINSURANCE: The predetermined portion or percentage of a physician's charge that is paid by the patient (beneficiary).

COMMUNITY RATING: Method of establishing premiums for health insurance. The premium is based on the average cost of actual or anticipated health care used by all enrollees in a geographic area or industry. It does not vary for different groups of enrollees, or take into account such variables as the group's claims experience, age, sex, or health status. Community rating helps spread the cost of illness evenly over all enrollees (the whole community), rather than charging the sick more than the healthy for insurance. Community rating is the principal means of establishing health insurance premiums. Federally qualified HMO's must community rate.

COPAYMENT: Form of cost sharing whereby an insured person pays a specified flat amount per unit of service or unit of time (e.g. $2 per visit or $10 per day), while the insurer pays the remaining cost. The amount paid by the beneficiary does not vary with the cost of the service (unlike coinsurance, which is payment of some percentage of the cost).

CREDENTIALING: A process which determines the eligibility of a given potential provider to participate in a plan. The process determines the level of services the physician can provide to enrollees.
**DISCOUNT PLAN**: A plan that offers a discount to the patient at the point of service, e.g., a physician's office. Covered services may or may not include the examination and may include a limited or specific selection of materials. This type of plan is often given to employees or clients through such groups as banks. A discount plan is also referred to as a "card system" since eligible recipients are provided with a unique identification card. Some plans are offered by groups of doctors with no fees to the client or group. This then becomes an advertising strategy by the doctors on the panel list.

**ELECTRONIC FILING**: Generally the transmission of insurance claims via computer modem. Designed to increase speed of claims processing (resulting in faster payment for providers) and eliminate excessive paper traffic.

**ERISA (Employee Retirement Income Security Act)**: A federal program that allows qualified companies to self-insure for health care and retirement benefits. An ERISA plan preempts state laws governing items such as freedom of choice of providers and mandated benefits. For a more detailed look at ERISA, see AOA's publication, *Demystifying ERISA*.

**EXPERIENCE RATING**: The process of determining the premium rate charged to a risk group based on the real experience of the claims already processed, taking into account such variables as age, sex, or health status. Federally qualified HMOs are not permitted to use experience rating.

**FEDERALLY QUALIFIED HMO**: A prepaid health plan that has met strict federal standards and has been granted qualification status. Employers of 25 or more workers are required to offer a federally qualified HMO if the plan requests to be included in the company's health benefits program. This is known as the dual choice mandate.

**FEE-FOR-SERVICE**: The tradition method of billing for health services, in which a health provider charges separately for each service rendered.

**FIRST-DOLLAR COVERAGE**: Insurance or prepayment coverage under which the third-party payer assumes liability for covered services as soon as the first dollar of expense for such services is incurred without requiring the insured to pay a deductible.

**FREEDOM OF CHOICE**: Certain clauses in state optometry laws containing language guaranteeing a patient a right to receive health care for the type of provider the patient wishes to see.

**GATEKEEPER**: Usually, the provider at the "entry point" of a managed health care system, e.g., a general practitioner in an HMO. Sometimes used in reference to an agency or process that monitors formal and informal health services provided to an individual or a group.

**GATEKEEPER MECHANISM**: Means of limiting a patient's freedom of choice, in which a patient is assigned to, or may choose from, a selected group of primary care physicians. The primary care physician assumes responsibility for reviews, and approves all medical care the patient receives, including care from specialists. The gatekeeper could be an optometrist.

**GLOBAL BUDGETING**: A method of cost containment in which predetermined limits would be made on total expenditures for certain services provided within a specified time period. This ceiling would apply to expenditures by insurers or individuals.

**GROUP MODEL HMO**: An HMO that contracts with one medical group to provide services to members. As with the staff model, all services except hospital care are generally provided under one roof. A group model plan is a "closed panel" plan, in which physicians in the group treat HMO patients exclusively or primarily.
HCFA (HEALTH CARE FINANCING ADMINISTRATION): The federal agency responsible for administering Medicare and overseeing states' administration of Medicaid.

HCFA-1500 FORM: A universal form for providers of services under Medicare and most major medical programs to bill health care carriers for professional services. The HCFA-1500 (12/90) is the most current edition of this form.

HCPCS: HCFA Common Procedural Coding System: This is the U.S. Government's coding system for procedural codes not included in CPT-4. The majority of the codes applicable to optometry are called the "V codes" and allow the physician to submit for reimbursement for the supply of materials, e.g. lenses, frames, and contact lenses. Example: Frame (V2020).

HEALTH MAINTENANCE ORGANIZATION (HMO): A prepaid health care plan. A staff model HMO has its own staff physicians, clinics, and hospitals. A group model HMO contracts with one medical group to provide services to members. Health care is generally provided "in-house". Some specialty services may be contracted for with local specialists or IPAs. If a non-HMO physician sees a patient under one of these plans, it is unlikely the physician will qualify for reimbursement from the HMO, or that the patient will be reimbursed for any out-of-pocket expenses.

INDEMNITY INSURANCE: This is a tradition fee-for-service plan. It allows the beneficiary to secure health care services and submit for reimbursement under a predetermined schedule of allowances. If the patient's charges are greater than the schedule of allowances, the patient must pay the physician for the additional expenses at the doctor's usual and customary rate.

INDEPENDANT PRACTICE ASSOCIATION (IPA): A legal entity that provides prepaid health care services to subscribers of a health plan. An arrangement usually exists between a health plan and a group of physicians outlining the provision of services and a jointly established method of provider compensation. The providers are usually reimbursed on a discounted fee-for-service or capitation basis. In an IPA arrangement, providers maintain a greater sense of independence than in a staff model HMO.

INTEGRATED SERVICE NETWORK (ISN): An organization under which a network of providers deliver all needed health care services to a defined population for a fixed payment amount. This organizational structure will create an incentive for ISNs to provide care as efficiently and effectively as possible. An ISN may be formed by providers, HMOs, insurance companies, employers or other organizations.

MAJOR MEDICAL: A patient's medical insurance, which usually covers diagnosed disease-related conditions, physician services, and hospital services. Routine vision care is usually not covered under major medical plans. Health care services defined as "medically necessary" can be submitted for reimbursement under major medical programs. "Medically necessary" services are determined by the diagnosis and, in some instances, by coverage definition.

MANAGED CARE: A term which includes types of health care delivery systems that strictly control utilization, quality, and claims using a variety of cost-containment methods. The primary goal is to deliver cost-effective health care without sacrificing quality or access. HMOs and PPOs are examples of managed care entities.

MANAGED COMPETITION: A health care reform model originated by Alain Enthoven and usually associated with the Jackson Hole Group, a loose-knit group of academics and health industry experts that has met for the last few years in Jackson Hole, Wyoming. Managed competition calls for creation of large groups of employers that would purchase high-quality, low-cost health care services from large provider-insurer-
hospital groups. The government would mandate a standard package of benefits that must be offered by all providers and would ensure universal access by subsidizing costs for the uninsured. The managed competition model, in part, was used to model the Clinton Administration's health care plan in 1993.

**MEDIGAP:** Medicare supplemental policies designed to fill specific gaps in the Medicare benefit structure, a.k.a. coinsurance.

**MOST-FAVORED-NATION CLAUSE:** A provision in a provider contract that does not allow a charge for a given service to be greater than the least that is charged by the provider to any other nongovernmental organization or plan. Most-favored-nation clauses have recently come under scrutiny by antitrust regulators.

**NETWORK MODEL:** A type of HMO that contracts with more than one multispecialty group to provide services to enrollees. The groups are generally unrelated and located in different areas.

**OPEN PANEL:** A program open to participation by all qualified physicians who will sign an agreement to abide by the program's parameters. An open panel program is also referred to as an "any willing provider" program.

**PEER REVIEW:** A mechanism allowing claims review and disputes, ideally by like physicians.