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HEALTH LAW PRIMER
BASIC HOSPITAL AND MANAGED CARE CONCEPTS FOR TEXAS PRACTITIONERS

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I. OVERVIEW

In keeping with the spirit of the Health Law Primer pioneered by Dick Cheney, this paper presents basic managed care concepts and terms useful to a health care lawyer in Texas. It is derived from my experiences representing managed care entities including an HMO and hospitals forming an integrated delivery system in the Dallas/Fort Worth Metroplex.

Entire seminars cover the topics mentioned here, and you will receive much more detailed information during the course of the Health Law Conference. The general purpose here is to provide a basic framework and vocabulary to make the more in-depth subject treatments during the conference more meaningful. The materials consist of summaries of concepts and definitions rather than interpretations or conclusions. The remaining seminar sessions will provide the deeper and, sometimes, startlingly complex scenarios and analyses you will encounter in your daily practice.

II. RESOURCES

Among the best reference materials you will find are the excellent materials at this and prior Texas Health Law conferences as well as other seminars sponsored by the American Academy of Hospital Attorneys (AAHA) and the National Health Lawyers Association (NHLA). In addition, the sources below can be used to acquire a broader understanding of the managed care industry in general or of a particular issue. It is hard to go wrong with any of them.

Texas Medical Jurisprudence, Fulbright & Jaworski, L.L.P.

Perhaps the best single reference for Texas health law practitioners.

Furrow, Greaney, Johnson, Jost and Schwartz's Health Law, 2d, Vols. 1& 2, 2000 West Publishing Company.

A excellent reference written for lawyers by lawyers and hence is three times the length.

III. GLOSSARY/ALPHABET SOUP

ASO - Administrative Services Only: Services such as claims processing, stop-loss coverage, etc.

ANHC - Approved Non-Profit Health Corporation: A non-profit health corporation certified under Section 5.01(a) Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes).

AWP - Any Willing Provider Legislation: Legislation prohibiting limitations on managed care plan participation for qualified providers.

Capitation: A method of compensation to a physician or provider based on a predetermined payment per enrollee for a specified period of time for certain enrollees in exchange for arranging for or providing a defined set of covered health care services to such enrollees for a specified period of time, regardless of the amount of services actually provided.

CHAMPUS - Civilian Health and Medical Program of the Uniformed Services: Federal program providing health care coverage to military family dependents and retirees.

CMS – Center for Medicare and Medicaid Services: An agency of the U.S. Department of Health and Human Services responsible for Medicare, Medicaid and Child Health Insurance programs. Formerly known as HCFA – the Health Care Financing Administration.

Coinsurance: The portion of the cost of care received for which an individual is financially responsible.

Copayment: An additional charge to an enrollee for a service which is not fully prepaid.

CPT-4 - Current Procedural Terminology 4th Ed. Codes: Five digit codes describing medical services; often used for billing.

Days Per Thousand: A common measure of utilization of medical services.

Deductible: The portion of an individual's health care expenses that the patient must pay before coverage from the insurer begins.

Direct Contracting: The concept of individual employers, business coalitions or government entities contracting directly with providers for healthcare services without an HMO/PPO intermediary.

DRG - Diagnosis-Related Group: A numerical system of classifying inpatient care into groups for purposes of payment.

Emergency Care: As defined in the Insurance Code, Article 20A.02(t). Bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

A. placing the patient's health in serious jeopardy;
B. serious impairment to bodily functions; or
C. serious dysfunction of any bodily organ or part.

ERISA - The Employee Retirement Income Security Act of 1974: Sets federal requirements for private pension plans.

FFS - Fee-for-Service: The patient is charged according to a fee schedule set for each discrete service and/or procedure to be provided.

Gatekeeper: A primary care physician in an HMO who makes referrals. His/her function is to reduce or moderate health care utilization and costs.

HCQIA - Health Care Quality Improvement Act of 1986: Federal legislation creating standards and immunities for peer review actions.

Health Savings Accounts: Tax-deductible accounts (much like an individual retirement account or IRA) coupled with a high deductible insurance policy. The account holder is responsible for all (most) medical expenses until the deductible is met. Existing account balances grow tax free and accounts transfer from employer to employer.

HEDIS - Health Plan Employer Data and Information Set (Versions 2.0, 2.5, 3.0): A standardized approach developed by NCQA to measure health plans in their service quality and cost.

HIPAA - Health Insurance Portability and Accountability Act: The federal government's first effort to regulate health insurance. Affects preexisting conditions, fraud and abuse sanctions and establishes medical savings accounts.

HMO Delivery Network: A health care delivery system in which an HMO arranges for health care services directly or indirectly through contracts and subcontracts with providers, physicians, other HMOs and approved non-profit health care corporations.

HMO - Health Maintenance Organization: An organization of health care personnel and facilities that provides a comprehensive range of health services

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