

GLOSSARY OF HEALTH CARE AND INSURANCE TERMS

ACCREDITATION Approval by an authorizing agency for institutions and programs that meet or exceed a set of pre-determined standards.

ACTUARY An accredited insurance mathematician who calculates premium rates, dividends, and reserves and prepares statistical studies and reports.

ACUTE CARE Hospital care given to patients who generally require a stay of up to seven days and that focuses on a physical or mental condition requiring immediate intervention and constant medical attention, equipment and personnel.

ADMINISTRATIVE SERVICES ONLY (ASO) AGREEMENT A contract for the provision of certain services to a group employer, eligible group, trustee, and so forth by and insurer or its subsidiary. Such services often include actuarial activities, benefit plan design, claim processing, data recovery and analysis, employee benefits communication, financial advice, medical care conversions, preparation of data for reports to governmental units, and stop-loss coverage.

ADMINISTRATOR The individual or third-party firm responsible for the administration of a group insurance program. Accounting, certificate issuance, and claims settlement may be included activities.

ADVANCED PRACTICE NURSE (APN) A registered nurse who is approved by the Board of Nursing to practice nursing in a specified area of advanced nursing practice. APN is an umbrella term given to a registered nurse who has met advanced educational and clinical practice requirements beyond the two to four years of basic nursing education required for all RNs. There are four types: Certified Registered Nurse Anesthetist (CRNA); Clinical Nurse Specialist (CNS); Certified Nurse Practitioner (CNP); and Certified Nurse Midwife (CNM).

ADVERSE SELECTION The tendency of those who are poorer-than-average health risks applying for or maintaining insurance coverage; also called anti-selection.

AGENT An insurance company representative licensed by the state who solicits, negotiates, or effects contracts of insurance and services the policyholder for the insurer.

AMBULATORY CARE Medical services provided on an outpatient (non-hospitalized) basis. Services may include diagnosis, treatment, surgery, and rehabilitation.

APPROPRIATENESS OF CARE The term used to describe the proper setting – an acute care hospital, an extended care facility, and so forth – for delivery of medical care that best corresponds to a patient's diagnosis.

ASSIGNMENT OF BENEFITS A provision in a health benefits claim form by which the insured directs the insurance company to pay any benefits directly to the provider of care on whose charge the claim is based.

BALANCE BILLING Practice by providers of billing patients for all charges over the physician rate paid by insurers. Many managed care plans prohibit the use of balance billing and may use sanctions against providers who balance bill.

BASE MEDICAL AND MAJOR MEDICAL PLAN A traditional fee for service plan which covers 100% of certain basic health care services such as hospital, surgical and physician services up to established limits. Thereafter, the major medical portion of the plan goes into effect for those items or for benefits not covered under the base plan. Deductibles, co-insurance and co-payments typically apply only to the major medical portion of the plan.

BENEFICIARY The person or persons designated by a policyholder to receive insurance policy proceeds.

BENEFIT The amount payable by the insurer to a claimant, assignee, or beneficiary when the insured suffers a loss covered by the policy.

BENEFIT PERIOD The period of time for which benefits are payable under an insurance contract.

BENEFIT PROVISION The promises made by the insurer, explained in detail in the contract.

BENEFIT WAITING PERIOD The period of time that must elapse before benefits are payable under a group insurance contract.

BLUE CROSS A nonprofit membership corporation providing protection against the costs of hospital care in a limited geographic area.

BLUE SHIELD A nonprofit membership corporation providing protection against the costs of surgery and other items of medical care in a limited geographic area.

BROKER A state-licensed person who places business with several insurers and who represents the insurance buyer rather than the insurance company, even though paid commissions by the insurer.

CAFETERIA PLAN Another term for a flexible benefit plan that allows employees to choose benefits from a number of different options.

CAPITATION A method of payment for health services in which a physician or hospital is paid a fixed amount for each person served regardless of the actual number or nature of services provided to each person.

CARRIER A term sometimes used to identify the party (insurer) to the group contract that agrees to underwrite (carry the risk) and provide certain types of coverage and service.

CARVE-OUT The term used to describe certain services offered by a managed care organization but singled out for individual management, usually with a capitation arrangement. Examples of carve-out service are management of chronic diseases, mental health services, and prescription drugs. Also called a specialty managed care arrangement.

CENTER OF EXCELLENCE A term referring to selected health care facilities that specialize and have demonstrated success in the performance of certain highly complex medical procedures.

CERTIFICATE OF INSURANCE The document delivered to an individual that summarizes the benefits and principal provisions of a group insurance contract. May be distributed in booklet form.

CHRONIC DISEASE A disease which has one or more of the following characteristics: (1) is permanent, leaves residual disability; (2) is caused by nonreversible pathological alternation; (3) requires special training of the patient for rehabilitation, or may be expected to require a long period of supervision, observation, or care.

CLAIM A demand to the insurer by, or on behalf of, the insured person for the payment of benefits under a policy.

CLAIMANT The insured or beneficiary exercising the right to receive benefits.

CLAIM COST CONTROL Efforts made by an insurer both inside and outside its own organization to contain and direct claim payments so that health insurance premium dollars are used as efficiently as possible.

CLAIM RESERVES Funds retained by an insurer to settle incurred but unpaid claims that may also include reserves for potential claim fluctuation.

COINSURANCE The arrangement by which the insurer and the insured share a percentage of covered losses after the deductible is met.

COMMISSION The part of an insurance premium an insurer pays an agent or broker for services in procuring and servicing insurance.

COMORBIDITY A pre-existing condition that will, because of its presence with a specific principal diagnosis, cause an increase in length of hospital stay by at least 1 day in approximately 75 percent of cases.

COMPREHENSIVE MAJOR MEDICAL PLAN A type of traditional medical insurance plan where all health benefits are subject to a deductible, coinsurance and co-payments.

CONCURRENT REVIEW Method of utilization review that takes place on-site when a patient is confined to a hospital.

CONTINUITY OF CARE Continuation of care by a primary care physician or specialist even after the doctor's relationship with a carrier ends. This is important to negotiate for members with an ongoing episode of illness when changing carriers.

CONTRACT A binding agreement between two or more parties. A contract of insurance is a written document called the policy.

CONTRIBUTION The part of the insurance premium or funding level paid by either the policyholder or the insured or both.

CONVERSION PRIVILEGE The right given to an insured person under a group insurance contract to change coverage, without evidence of medical insurability, to an individual policy upon termination of the group coverage.

COORDINATION OF BENEFITS (COB) A method of integrating benefits payable under more than one group health insurance plan so that the insured's benefits from all sources do not exceed 100 percent of allowable medical expenses. The rules of O.R.C. §§ 3902.11 to 3902.14 govern the implementation and interpretation of the COB provisions of the health plans.

CO-PAYMENT A payment made by an individual who has health insurance, usually at the time a service is received, to offset some of the cost of care. Co-payment size may vary depending on the service, generally with low copayments required for visits to low-cost services and higher copayments to higher-cost services. These apply to medical services and products as well as prescription drug products. These typically do not apply to the health plan's out-of-pocket maximum.

COST CONTAINMENT Efforts by medical providers, insurance companies, insureds, or other interested groups to control health care costs.

COVERED CHARGES Charges for medical care or supplies, which, if incurred by an insured or other covered person, create a liability for the insurer under the terms of a group policy.

COVERED PERSON Any person entitled to benefits under a policy (insured or covered dependent).

CREDIBILITY The weight assigned to a group's past claim experience in order to determine future expected claims for premium setting purposes, or to determine future expected claims for premium setting purposes, or to determine claim charges for experience refund purposes for that group. Usually expressed as a percentage between 0 percent and 100 percent.

DEDUCTIBLE The amount of covered expenses that must be incurred and paid by the insured before benefits become payable by the insurer. Most preferred provider organization (PPO) plans have an **EMBEDDED** family deductible, which allows any one person within the family unit to meet their individual deductible before benefits are paid through the coinsurance portion of the plan. Meanwhile, the rest of the family must continue satisfying their deductible until they reach the family-deductible level. Once the family deductible is satisfied, benefits begin for the rest of the family. With a **NON-EMBEDDED** deductible, a family will have to meet the entire deductible before benefits are paid through the coinsurance portion of the plan.

DEPENDENT An insured's spouse (wife or husband), not legally separated from the insured, and unmarried child(ren) who meet certain eligibility requirements and who are not otherwise insured under the same group policy. The precise definition of a dependent varies by insurer.

DIAGNOSIS-RELATED GROUP (DRG) A system of categorizing inpatient medical services and assigning specific reimbursement fees to each category.

DISABILITY A physical or mental condition that makes an insured incapable of performing one or more duties of his or her own occupation or, for total disability, of any occupation.

DISEASE MANAGEMENT Comprehensive, integrated systems approach that targets costly, chronic diseases. Aims to control costs by using the most effective treatments as early as possible.

DISPENSE AS WRITTEN (DAW) Physician's DAW instructions on a prescription specify a brand-name pharmaceutical or medical device.

DRAFT BOOK CLAIM PAYMENT A method of claim settlement whereby the insurer authorizes the policyholder to settle claims and to issue payment on behalf of the insurer.

EFFECTIVE DATE The date that insurance coverage goes into effect.

ELIGIBILITY The provisions of the group policy that state the requirements that members of the group and/or their dependents must satisfy to become insured.

ELIGIBILITY PERIOD The time following the eligibility date (usually 31 days) during which a member of an insured group may apply for insurance without evidence of insurability.

ELIGIBILITY REQUIREMENTS Underwriting requirements that the applicant must satisfy in order to become insured.

ELIGIBLE EMPLOYEES Those employees who have met the eligibility requirement for insurance set forth in the group policy.

EMPLOYEE BENEFITS CONSULTANT A person or firm specializing in the design, sale, and service of employee benefit plans, usually representing the policyholder in placing insurance coverage with an insurer or assisting the employer in the changing or enhancing a benefit program. Compensation is provided either by commissions from the insurer or by the policyholder on a fee-for-service basis.

ERISA (Employee Retirement Income Security Act of 1974) This federal law provides a legal framework for the operation of private non-governmental self-funded health plans while exempting them from state regulation. School district health insurance plans are not subject to ERISA.

EXCLUSIONS (EXCEPTIONS) Specified conditions or circumstances, listed in the policy, for which the policy will not provide benefits.

EXCLUSIVE PROVIDER ORGANIZATION (EPO) Arrangement consisting of a group of providers who have a contract with an insurer, employer, third-party administrator, or other sponsoring group. Criteria for provider participation may be the same as those in PPOs but have a more restrictive provider selection and credentialing process.

EXPECTED CLAIMS The claims forecast for a group; the expected claims level becomes the breakeven point with respect to the expected funding level for a period of coverage. Aggregate stop-loss coverage can be purchased by a health plan sponsor to protect the plan against total annual claims greater than expected; such coverage is usually written to attach at 125 percent of expected annual claims thus providing a 25 percent corridor.

EXPERIENCE RATING The process of determining the premium rate for a group risk based wholly or partially on that risk's experience.

FEE-FOR-SERVICE A method of charging whereby a physical or other practitioner bills for each visit or service rendered.

FORMULARY List of preferred pharmaceutical products to be used by a managed care plan's network physicians. Formularies are based on evaluations of the efficacy, safety, and cost-effectiveness of drugs.

GATEKEEPER Role description of the primary care physician in HMOs who serves to control utilization and referral of enrollees.

GENERALLY ACCEPTED ACCOUNTING PRINCIPLES (GAAP) Principles of accounting and business results reporting developed by the American Institute of Public Accountants.

GENERIC DRUG A drug product that is comparable to brand/reference listed drug product in dosage form, strength, route of administration, quality and performance characteristics, and intended use.

GENERIC DISPENSING RATE The relative percentage of generic drugs that are being utilized within the retail or mail-order portion of a pharmaceutical drug plan.

GENERIC SUBSTITUTION RATE The percentage of generic drugs that were chosen over brand-name drugs when a generic drug was available to the consumer.

GROUP CONTRACT A contract of health insurance made with an employer or other entity that covers a group of persons as a single unit.

GROUP INSURANCE An arrangement for insuring a number of people under a single, master insurance policy.

HEALTH INSURANCE Coverage that provides for the payments of benefits as a result of sickness or injury. Includes insurance for losses from accident, medical expense, disability, or accidental death and dismemberment.

HEALTH MAINTENANCE ORGANIZATION (HMO) An organization that provides for a wide range of comprehensive health care services for a specified group at a fixed periodic prepayment.

HEDIS (Health Plan Employer Data and Information Set) HEDIS is a core set of performance measures developed to attempt to help employers understand what "value" the health care dollar is purchasing and how to hold a health plan accountable for its performance. HEDIS is the result of efforts made by representatives from a variety of health plans and employers.

HOSPICE A mode of care provided to terminally ill patients and their families that emphasizes patient comfort rather than cure and addresses emotional needs, such as coping with pain and death.

INCURRED BUT NOT REPORTED (IBNR) CLAIMS Claims that have not been reported to the insurer as of some specified date.

INCURRED CLAIMS An amount equal to the claims paid during the policy year plus the change of the claim reserves as of the end of the policy year. The change in reserves represents the difference between the end of the year and beginning of the year claim reserves.

INDEMNITY A benefit paid by an insurance policy for an insured loss.

INDIVIDUAL INSURANCE Policies that provide protection to the policyholder and/or his or her family. Sometimes called personal insurance as distinct from group insurance.

INSURABLE RISK The conditions that make a risk insurable are the following: (a) the peril insured against must produce a definite loss not under the control of the insured; (b) there must be a large number of homogeneous exposures subject to the same perils; (c) the loss must be calculable and the cost of insuring it must be economically feasible; (d) the peril must be unlikely to affect all insureds simultaneously; and (e) the loss produced by a risk must be definite and have a potential to be financially serious.

INSURANCE A plan of risk management that, for a price, offers the insured an opportunity to share the costs of possible economic loss through an entity called an insurer.

INSURED The person and dependent(s) who are covered for insurance under a policy and to whom, or on behalf of whom, the insurer agrees to pay benefits.

INSURER The party to the insurance contract that promises to pay losses or benefits. Also, any corporation primarily engaged in the business of furnishing insurance protection to the public.

JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JCAHO) Private, voluntary accrediting organization for all types of health care organizations. Its focus is the outcome, process, and excellence in health care.

LIFETIME MAXIMUM A specified dollar amount or a set number of services that the health plan will provide for each health plan participant on the contract.

LONG-TERM CARE A wide range of health and personal care, ranging from simple assisted living arrangements to intensive nursing home care, for elderly or disabled persons.

LONG-TERM CARE INSURANCE A benefits plan that provides a specific dollar benefit or a percent of expenses charged for nursing home care, home health care, and adult day care if a covered person suffers a loss of functional or cognitive capacity.

LONG-TERM DISABILITY (LTD) INCOME INSURANCE A benefits plan that helps replace earned income lost through inability to work because of disability caused by accident or illness.

MANAGED CARE The term used to describe the coordination of financing and provision of health care to produce high-quality health care on a cost-effective basis.

MANDATED BENEFITS Certain benefits required by state law to be included in health insurance coverage.

MANUAL RATE The premium rate developed for a group's coverage from the insurer's standard rate tables, usually contained in its rate manual or underwriting manual.

MEDICAID Government insurance program for persons of all ages whose income and resources are insufficient to pay for health care. Medicaid is state-administered and financed by both the states and the federal government.

MEDICALLY NECESSARY Term used by insurers to describe medical treatment that is appropriate and rendered in accordance with generally accepted standards of medical practice.

MEDICARE A federally sponsored program that provides hospital benefits, supplemental medical care, and catastrophic coverage to persons aged 65 and older, and to some other eligible members.

MINIMUM PREMIUM PLAN A combination approach to funding an insurance plan aimed primarily at premium tax savings. The employer self-funds a fixed percentage (e.g., 90 percent) of the estimated monthly claims and the insurance company insures the rest.

MORAL HAZARD Risk from any nonphysical, personal characteristic or habit of an applicant or insured that may either increase the possibility or intensify the severity of a loss.

MORBIDITY The frequency and severity of sicknesses and accidents in a well-defined class or classes of persons.

MORTALITY The death rate in a group of people as determined from prior experience.

MULTIPLE EMPLOYER GROUP Employees of two or more employers, such as trade associations of employers in the same industry or union members who work for more than one employer, covered under one master contract.

MULTI-SOURCE DRUG A drug that is available from a brand name manufacturer and also from several generic manufacturers. According to 42 USCS § 1396r-8(k)(7)(A)(i), the term "multiple source drug" means, with respect to a rebate period, a covered outpatient drug (not including any drug described in paragraph (5)) for which there [is] at least 1 other drug product which:

(I) is rated as therapeutically equivalent (under the Food and Drug Administration's most recent publication of "Approved Drug Products with Therapeutic Equivalence Evaluations");

(II) except as provided in subparagraph (B), is pharmaceutically equivalent and bioequivalent, as defined in subparagraph (C) and as determined by the Food and Drug Administration; and

(III) is sold or marketed in the State during the period.

NCQA (National Committee for Quality Assurance). A non-profit institution that reviews and accredits managed care organizations. The NCQA works collaboratively with other organizations to develop the HEDIS specifications for care.

OPEN ENROLLMENT A time during which uninsured employees and/or their dependents may obtain coverage under an existing group plan without presenting evidence of insurability. Differs from a resolicitation in that a minimum number of applications are not required.

OUT-OF-POCKET MAXIMUM Dollar amounts set by a health insurance plan that limit the amount a member has to pay out of his/her own pocket for particular healthcare services during a particular time period. After your share of eligible expenses (deductible and coinsurance) reaches a certain limit, the

Plan will pay 100 percent (unless balance billing applies) of most covered medical expenses for a covered plan member for the remainder of the calendar year.

OVERUTILIZATION Term used to describe inappropriate or excessive use of medical services that add to health care costs.

PALLIATIVE CARE Medical relief of pain rather than cure of illness.

PER MEMBER PER MONTH (PMPM) Computational designation for each enrollee in a managed care program. It is commonly abbreviated as PMPM.

PHARMACY AND THERAPEUTICS (P&T) COMMITTEE A committee of a health insurance carrier or health insuring corporation that develops, updates and administers the company's formulary and regularly reviews reports on clinical trials, drug utilization reports, current and proposed therapeutic guidelines and economic data on drugs.

PHARMACY BENEFIT MANAGER (PBM) A type of managed care specialty service organization that seeks to contain the costs of prescription drugs or pharmaceuticals while promoting more efficient and safer drug use. Also known as a prescription benefit management plan.

POINT-OF-SERVICE (POS) PROGRAM Health care delivery method offered as an option of an employer's indemnity program. Under such a program, employees coordinate their health care needs through a primary care physician.

PRACTICE GUIDELINES Specific, professionally agreed upon recommendation for medical practice used within or among health care organizations in an attempt to standardize practice to achieve consistent quality outcomes. Practice guidelines may be instituted when triggered by specific clinical indicators.

PREAUTHORIZATION Previous approval for specialist referral or nonemergency health care services.

PRECERTIFICATION A utilization management program that requires the individual or the provider to notify the insurer prior to a hospitalization or surgical procedure. The notification allows the insurer to authorize payment, as well as to recommend alternative courses of action.

PRE-EXISTING CONDITION A mental or physical problem suffered by an insured prior to the effective date of insurance coverage.

PRE-EXISTING CONDITIONS PROVISION A restriction on payments for those charges directly resulting from an accident or illness for which the insured received care or treatment within a specified period of time (e.g., three months) prior to the date of insurance.

PREFERRED PROVIDER ORGANIZATION (PPO) A managed care arrangement consisting of a group of hospitals, physicians, and other providers who have contracts with an insurer, employer, third-party administrator, or other sponsoring group to provide health care services to covered persons.

PREMIUM The amount paid an insurer for specific insurance protection.

PREMIUM TAX An assessment levied by a federal or state government usually on the net premium income collected in a particular jurisdiction by an insurer.

PRIMARY CARE PHYSICIAN (PCP) The network physician designated by an employee (and each of his or her dependents) to serve as that employee's entry into the health care system. The PCP often is reimbursed through a different mechanism (such as capitation) than are other network providers. This physician sometimes is referred to as the "gatekeeper."

PROFILING Systematic method of collecting, collating, and analyzing patient data to develop provider-specific information about medical practice.

PROPOSAL A quotation, submitted to a prospective group insurance policyholder by an insurance company primarily through an agent, broker, or group representative that outlines the benefits available under a suggested plan and the costs to both employer and employees.

PROVIDER DISCOUNTS An element of network-based managed care programs whereby financial arrangements are negotiated with providers to reduce fees for medical services rendered.

REASONABLE AND CUSTOMARY CHARGE A charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographic area.

REIMBURSEMENT An amount paid to an insured for expenses actually incurred as a result of an accident or sickness. Payment will not exceed the amount specified in the policy.

REINSURANCE Acceptance by one insurer (the reinsurer) or all or part of the risk of loss underwritten by another insurer (the ceding insurer).

RENEWAL Continuation of coverage under a policy beyond its original term by the insurer's acceptance of the premium for a new policy term.

RENEWAL UNDERWRITING The review of the financial experience of a group case and the establishment of the renewal premium rates and terms under which the insurance may be continued.

RESERVE A sum set aside by an insurance company as a liability to fulfill future obligations.

RETENTION That portion of the premium kept by the insurer for expenses, contingencies, and contributions to surplus (profit).

RFP (Request for Proposal) a transparent procurement method in which proposals from competing vendors are invited by openly advertising the scope, specifications and terms and conditions of the proposed contract as well as the criteria by which the proposals will be evaluated.

RIDER A document that modifies or amends the insurance contract.

RISK The probable amount of loss foreseen by an insurer in issuing a contract. The term sometimes also applies to the person insured or to the hazard insured against.

RISK ADJUSTMENT Correction of capitation or fee rates based upon factors that can cause an increase in medical costs such as age or sex.

SELF-INSURANCE A program for providing group insurance with benefits financed entirely through the internal means of the policyholder, in place of purchasing coverage from commercial carriers.

SHORT-TERM DISABILITY (STD) INCOME INSURANCE Form of health insurance that provides benefits only for loss resulting from illness or disease and excludes loss resulting from accident or injury.

SINGLE SOURCE DRUG As defined in Section 1927(k)(7)(A)(iv) of the Social Security Act, a single source drug is a covered outpatient drug which is produced or distributed under an original new drug application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors operating under the New Drug Application (NDA). It also includes a covered outpatient drug approved under a Product License Approval (PLA), Establishment License Approval (ELA), or Antibiotic Drug Approval (ADA).

STATUTE An enactment of a legislature (state or federal) declaring, commanding, or prohibiting something.

STOP-LOSS INSURANCE Protection purchased by self-insured and some managed care arrangements against the risk of large losses or severe adverse claim experience. Composed of specific stop-loss for individuals and aggregate stop-loss for a group.

SUBROGATION The substitution of the insurer in place of an insured who claims medical expenses from a third party.

THIRD-PARTY ADMINISTRATION The method by which an outside person or firm, not a party to a contract, maintains all records regarding the persons covered under the group insurance plan and may also pay claims using the draft book system.

THIRD PARTY PAYER Any organization, public or private, that pays or insures health or medical expenses on behalf of beneficiaries or recipients.

UNDERWRITER The term generally applies to (a) a company that receives the premiums and accepts responsibility for the fulfillment of the policy contract; (b) the company employee who decides whether the company should assume a particular risk; or (c) the agent who sells the policy.

UNDERWRITING The process by which an insurer determines whether and on what basis it will accept an application for insurance.

UTILIZATION Patterns of usage for a single medical service or type of service (hospital care, prescription drugs, physician visits). Measurement of utilization of all medical services in combination usually is done in terms of dollar expenditures. Use is expressed in rates per unit of population at risk for a given period, such as number of annual admissions to a hospital per 1,000 persons over age 65.

UTILIZATION REVIEW A program with various approaches designed to reduce unnecessary hospital admissions and to control inpatient lengths of stay through use of preliminary evaluations, concurrent inpatient evaluations, or discharge planning.

WAITING PERIOD The time a person must wait from the date of entry into an eligible class or application for coverage to the date the insurance is effective.

WELLNESS PROGRAMS Employer programs provided to employees to lessen health risks and thus avoid more serious health problems.

WORKERS' COMPENSATION Liability insurance requiring certain employers (a) to pay benefits and furnish medical care to employees for on-the-job injuries and (b) to pay benefits to dependents of employees killed by occupational accidents.