

Glossary of Health Benefit Terminology

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Health Benefit Plans

Ambulatory Care – Health care services that do not require a patient to be hospitalized. A patient can receive ambulatory care at a physician’s office, clinic, or outpatient facility.

Ancillary Services – Supplemental services such as laboratory, radiology, therapy services that are provided in conjunction with medical or hospital care.

Alternative Care – Wellness therapies that offer ways to relieve pain such as acupuncture or massage therapy. Many health insurance companies will offer members a discounted program for these services. The information is generally found on the insurance company web site.

Behavioral Health – A term which includes mental health and substance abuse services.

Cafeteria Benefits – An arrangement under which employees may choose their own benefit structure to meet their special needs.

Carrier – A private organization, usually an insurance company, that finances health care.

Carve Out – The separation of a medical service (or a group of services) from the basic set of benefits in some way. Carve out may also refer to a method of coordinating dual coverage for an individual.

Catastrophic Health Insurance – Health insurance that provides protection against the high cost of treatment for severe illnesses or injuries. Generally such policies cover all or a specific percentage of medical expenses above an amount that is the responsibility of another insurance policy up to a maximum limit of liability.

Certificate of Creditable Coverage – A written certificate issued by a group health plan or health insurer that shows prior health coverage (creditable coverage) and is used to satisfy waiting periods for plans with pre-existing conditions.

Coinsurance – A cost sharing requirement under a health insurance policy where the insured pays a percentage of the costs of covered services.

Coordination of Benefits – Procedures to avoid duplicate payments for losses insured under more than one insurance policy.

Durable Medical Equipment (DME) – Medical equipment (ventilator, wheelchair, hospital bed, etc.) that may be prescribed for a patient’s use for an extended period of time.

Exclusive Provider Organization (EPO) – Similar to a PPO, but covers in-network services only. Sometimes has a smaller network of providers.

Fee For Service – Method of billing for health services where the provider of care bills separately for each patient service. This system contrasts with salary, per capita or other prepayment system where the payment is not charged to the physician with the number of services used.

Gatekeeper – The primary care physician in a managed-care organization who determines whether the presenting patient needs to see a specialist or requires other non-routine care. The goal is to guide the patient to appropriate services and avoid unnecessary and costly referrals to specialists.

Group Health Plan – An employee benefit plan established or maintained by an employer or by an employee organization such as a union, or both, that provides medical care to employees and their dependents directly or through insurance, reimbursement or otherwise.

High Deductible Health Plan (HDHP) – A health plan with a large deductible and low premium. A qualified high deductible plan with a minimum deductible of \$1,100 individual and \$2,200 for family coverage for 2007 and that has an out-of-pocket maximum that is no more than \$5,500 for individual only coverage and \$11,000 for family coverage.

Health Savings Accounts (HSA) – A tax exempt trust or custodial account owned by the employee to pay for qualified medical expenses of account holder and dependents. Must be paired with a qualified high deductible health plan and the enrollee cannot be covered by any other health plan that is not a high deductible health plan. Both employers and employees can contribute to the plan. For 2007, the maximum contribution which can be made for individual only coverage is \$ 2,850 and for family coverage is \$5,650.

Health Reimbursement Accounts (HRA) – An employer funded tax exempt account that reimburses employees for qualified medical expenses. Amounts remaining at the end of the year may be carried forward to reimburse medical expenses. Also known as a 105(h).

Indemnity – Also called “traditional fee for services” plans for hospital, medical surgical and extended benefits. Often participating providers accept plan allowances as full payment.

Medically Necessary – A treatment which is appropriate and consistent with a patient’s diagnosis and locally accepted standards of care.

Medigap – A private policy offered to Medicare beneficiaries to cover expenses not paid by Medicare. Medigap plans are standardized and regulated by federal rules. They are also known as Medicare supplemental insurance.

Network – The group of physicians, hospitals, and other health care professionals that a health plan has contracted with to deliver medical services to its members.

Open Enrollment – A period when group members can change their health insurance options without a qualifying event (marriage, divorce, birth, etc).

Out-of-Pocket Maximum – A cap placed on out-of-pocket cost that a member would pay typically in a calendar year for covered health benefits services.

In-Network – Services generally coordinated by a primary care physician. Out-of-network care can be covered, but at a higher out-of-pocket cost.

Pre-Certification – A utilization management technique that requires a plan member or the physician in charge of the member's care to notify the plan, in advance, of plans for a patient to undergo a course of care such as a hospital admission or complex diagnostic test. Also known as prior authorization.

Preferred Provider Organizations (PPO) – Covers in- and out-of-network services, but pays more for in-network services.

Primary Care Provider (PCP) – A generalist (family practice, internist, and pediatrician) and sometimes obstetrics/gynecologist that provides primary care services.

SPD (Summary Plan Description) – An important document that the plan administrator must automatically provide to participants which explains what coverage the plan offers, how the plan operates and the rights and responsibilities of participants and beneficiaries.

Waiting Period – Period of employment that may be required before an employee is eligible to participate in a health insurance plan.

Prescription Drug

Average Wholesale Price (AWP) – Composite wholesale price for a drug that is designated by the manufacturer. This does not necessarily represent what pharmacies pay for a drug, but it does serve as an accepted pricing benchmark. Most health plan plans pay AWP less a certain percentage discount for prescription drugs.

Brand-Name Drug – Medication that is available only from its original manufacturer or licensee under a recognized brand name. A brand-name drug may have a generic equivalent after the original patent expires.

Direct To Consumer Advertising – The advertising of prescription drugs directly to consumers through the media (TV, radio, etc.). Often cited as a reason for increased health care expenditures.

Dispensing Fee (Professional Fee) – The charge levied by pharmacists for both their pharmaceutical expertise and for the costs involved in filling the prescriptions.

Drug Formulary – A list of all the medicines that are covered by a health benefit plan. Formularies are usually developed by a pharmacy and therapeutic committee and added on the basis of safety, effectiveness and cost. A tiered formulary financially rewards patients for using generic and formulary drugs by requiring them to pay progressively higher co-payments for brand-name and non-formulary drugs. For example, in a three tiered benefit structure, co-payments may be \$10 for generic, \$25 for a formulary brand product or \$40 for a non-formulary brand product.

Drug Utilization Review (DUR) – An analysis of drug usage prescribing intended to ensure clinically appropriate drug therapy and quality of patient care. Can be conducted concurrently (between the time the prescription is written and therapy begins), retrospectively (after medication is dispensed) and prospectively (before drugs are prescribed to influence future drug utilization patterns).

Generic Drug – Equivalent version of a brand-name drug produced when the patent on the brand-name drug has expired.

Generic Substitution – The dispensing of a drug product in place of a brand-name drug which: 1) contains the same active ingredients; 2) is identical in dose, form and administrative method; 3) has the same indications, cautions and instructions; and 4) is produced under the same FDA Good Manufacturing Practices.

NDC (National Drug Code) – A standardized classification of all prescription drugs.

Maintenance Medication – Also referred to as "chronic medications." Medications used over a long term to treat or control chronic conditions, i.e. the medication taken daily by high-blood pressure sufferers or diabetics. Many plans encourage participants to purchase these medications through mail-order programs which often results in saving to the participant as well as the health plan.

Maximum Allowable Cost (MAC) – Maximum cost for which a pharmacy can be reimbursed for selected products as defined in the formulary. Some plans require the member to pay the difference between the MAC and the cost of the brand-name prescription drug.

Multi-Source Drug – Drugs for which generic equivalents are available.

Over The Counter (OTC) – Medications which by law do not require a prescription. Some health benefit plans may include OTC medication on their formulary or offer other incentives such as a free sample program to encourage their use. An example would be Prilosec OTC.

Pharmacy and Therapeutics Committee (P & T) – A committee comprised of practicing doctors and clinical pharmacists who review, select, and approve preferred brand-name medicines for their safety, quality and effectiveness.

Pharmacy Benefit Manager (PBM) – An organization that manages the prescription drug benefit for insurance companies and self-funded plans. Some of the services include drug utilization review (DUR), claims processing, retail pharmacy networks, formulary programs, mail service, physician profiling and education. The three largest are Caremark, Express Scripts and MEDCO.

Physician Profiling – A means of comparing prescribing behaviors (or other medical orders) among doctors in order to benchmark and/or improve quality of care. Physician information is often sorted by specialty or diagnosis, and profiling can be used in a managed-care setting as an incentive for quality improvement.

Prior Authorization – Often required by plan sponsors that specify criteria for coverage applied to prescriptions written for experimental, high-cost or limited-availability medications.

Rebates – The amount paid by pharmaceutical manufacturers to the PBM as incentives for purchasing their product. A portion of these rebates may be shared with the health plan.

Retiree Drug Subsidy (RDS) - The amount which the federal government will refund to employers who provide prescription drug coverage to retirees over age 65 that is equal to or better than the Medicare Part D coverage.

Single-Source Drug – Medication for which there is one source; that is, one for which only the innovator (brand-name) product is available and for which there is no generically-equivalent substitute.

Specialty Prescription Drugs – High-cost biotech medications (primarily injectables) costing at least \$500 for a 30-day supply. Insurers often contract with a specialty pharmacy benefit manager who offers clinical programs to members and establishes a different process for the distribution of these medications to patients.

Step Therapy – In pharmaceuticals, process of treating a patient with the least intrusive medication or therapy initially, then graduating to more complex medications or therapies if required.

Therapeutic Class – Drugs grouped by their purpose, the symptom or disease they are used to treat. Used often in prescription drug reports.

Three-Tier Co-Payment Structure – A pharmacy benefit co-payment system under which a member is required to pay one co-payment amount for a generic drug, a higher co-payment amount for a brand-name drug included on the health plan's formulary, and an even higher co-payment amount for a non-formulary drug.

Usual and Customary Price – The price a pharmacy charges for a pharmaceutical medication to a person who walks into the pharmacy without a prescription drug card plan.

Consumerism and Quality Measures

Benchmarking – A method of planning and implementing quality management programs that consists of identifying the best practices and best outcomes for a specific process and emulating the best practices to equal or surpass the best outcomes.

Board Certified – Status granted to a medical specialist who completes a required course of training and experience and passes an examination in his/her specialty.

Case Management – A process of identifying plan members with special health care needs, developing a health care strategy that meets those needs, and coordinating and monitoring care.

Consumer Assessment of Health Plans (CAHPS) – A consumer survey which is used to assist employees in selecting health plans and services. Funded by the Agency for Healthcare Research and Quality (AHRQ).

Consumerism – A new trend in health benefits to make employees more aware of cost and quality measures. Many of the new consumer-driven health plans (CDHP) and high deductible health plans (HDHP) include more cost shifting to the employee.

Demand Management (Patient Consumerism) – Process designed to educate and empower consumers to make informed decisions about their health and the care they receive. Consumers become active participants in decisions regarding their health, avoiding unnecessary or inappropriate care and achieving better outcomes.

Disease Management (DM) – Continuous process of influencing the behavior and health objectives of people involved with chronic diseases (diabetes, heart disease, asthma) in order to achieve specific outcomes, improve patient productivity and quality of life, and lower a health plan sponsor's medical costs.

Electronic Medical Record (EMR) – A computerized record of a patient's clinical, demographic, and administrative data. Also known as a computer-based patient record.

Evidence-Based Decision Making – The application of best available scientific evidence to policy decisions about specific medical treatments and the delivery of health care with the goal to improve the quality of care.

Health Risk Assessment (HRA) – A process by which a health plan uses information about a member's health status, personal and family health history, and health-related behaviors to

predict the member's likelihood of experiencing specific illnesses or injuries. Also known as a health risk appraisal.

Health Plan Employer Data Information Set (HEDIS) – A set of performance measures for health plans developed by the National Committee for Quality Assurance (NCQA) which provides purchasers with information on the effectiveness of care, plan finances and costs, and other measures of plan performance.

Leapfrog Group - An organization of large health care purchasers such as General Motors and General Electric whose goal is to use their purchasing power to influence provider of care and improve patient safety. Leapfrog principles recognize and reward providers of care for practices that reduce medical errors.

National Committee for Quality Assurance (NCQA) – A national organization representing consumers, purchasers and providers of care which accredits managed-care organizations based on their quality assurance programs and develops and coordinates programs for assessing the quality of care and service in the managed-care industry.

Pay for Performance (P4P) – Supplemental payments or reductions in administrative requirements for certain providers who adhere to evidence-based treatment guidelines and deliver quality care at a lower cost.

Transparency – The current trend to require more disclosure concerning the price of health care services and the quality of health care providers.

Financial and Cost Reporting

Administrative Services Only (ASO) – A contract between a third party administrator or an insurance company and a self-funded plan to provide administrative services only (claims processing, billing, reporting, etc). The self-funded entity assumes all financial responsibility for the employee health insurance.

Adverse Selection – Tendency for utilization of health services in a population to be higher than average. This occurs when persons with worse-than-average health continue insurance and persons with average or better health do not.

Aggregate Stop-Loss Coverage – A type of stop-loss insurance that provides benefits when a group's total claims during a specified period exceed a stated amount.

All-Payer System – A system in which prices for health services and payment methods are the same regardless of who is paying. This prevents health care providers from shifting costs from one payer to another.

Broker – A salesperson who has obtained a state license to sell and service contracts of multiple health plans or insurers, and who is ordinarily considered to be an agent of the buyer, not the health plan or insurer.

Capitation – A negotiated rate which is paid each month to a health care provider. The provider is then responsible for delivering all health care required by the member.

Community Rating – A method of establishing premium rates by using the average cost of actual or anticipated health services for all covered persons within a specific geographic area without regard for variations of health status or claim experience. In New York State all HMOs and small groups (50 employees and less) are pure community-rated which also prohibits rate variation based on age, gender, type of industry, marital status and family size as well as health factors.

Consortium – The establishment of a mechanism which allows individual entities to pool their resources in an effort to provide a health insurance plan which is less costly over time than what could be purchased by each entity individually.

Cost Sharing – Provision of health benefit plans that require the covered person to share a portion of the costs of covered benefits. These usually include deductible, co-insurance and co-pays. Some cost sharing provisions result in a change in behavior resulting in reductions in medical costs and others shift the cost to the patient.

Credibility – A measure of the statistical predictability of a group's experience.

Current Procedural Terminology, Fourth Edition (CTP-4) – A manual which assigns five-digit codes to medical services and procedures to standardized claims processing and data analysis.

Defined Benefit – A funding mechanism where the services to be provided are defined and linked to the years of service and/or an employee's compensation.

Defined Contribution – A funding mechanism which does not define the benefit to be provided but is based on a specific dollar contribution.

Experience Rating – A method of determining premiums based on the historical utilization data and demographics of a specific group. Large groups (over 51 employees) are generally experience-rated.

HCRA/GME Tax – A tax which applies to health plans in New York State as part of the hospital reimbursement formula. It is included in the premium for insured plans, but is paid directly by self-funded plans.

Incurred But Not Reported (IBNR) – Claims or benefits that occurred during a particular time period, but that have not yet been reported or submitted to an insurer so they remain unpaid.

Minimum Premium – A funding arrangement designed to limit the amount of premium tax paid by the group and to limit the claims liability on a monthly basis.

Per Member, Per Month (PMPM) – Method of calculating and comparing costs of providing health care services to plan participants in utilization reports.

Reinsurance – The resale of insurance products to a secondary market thereby spreading the costs associated with underwriting.

Resource-Based Relative Value Scale (RBRVS) – A payment methodology established for Medicare procedures which has a relative value for each procedure, a geographic adjustment factor and a dollar conversion factor. Used by insurance companies as a benchmark when establishing their health care provider payments.

Risk-Adjustment – The statistical adjustment of outcomes measures to account for risk factors that are independent of the quality of care provided and beyond the control of the plan or provider, such as the patient's gender and age, the seriousness of the patient's condition, and any other illnesses the patient might have. Also known as case-mix adjustment.

Self-Funding – The practice of a group assuming financial responsibility for health insurance losses incurred by the membership. Benefits may be administered by the employer or handled through an administrative services only (ASO) agreement with an insurer or a third party administrator.

Specific Stop-Loss Coverage – A type of stop-loss insurance that provides benefits for claims on an individual who exceeds a stated amount in a given period.

Stop Loss – Insuring with a third party against a risk that the plan cannot financially manage. Often purchased by groups which are self-funded.

Third Party Administrators (TPA) – Companies who provide certain administrative services to group benefit plans. Most commonly employed by groups which are self-funding.

Underwriting Requirements – Requirements, sometimes relating to group characteristics or financing measures, that health plans at times impose in order to provide health care coverage to a given group and which are designed to balance a health plan's knowledge of a proposed group with the ability of the group to voluntarily select against the plan (anti-selection).

Laws, Regulations and State and Federal Programs

Article 5(G) – An article of the general municipal law which allows municipal consortiums to be formed. A municipal consortium is formed when two or more municipal corporations join together to purchase a service or commodity as a single group. This can involve purchasing insurance, pooling costs, sharing risk and establishing a reserve fund to cover the liabilities.

Article 44 Employee Welfare Funds – A trust fund established or maintained jointly by one or more employers together with one or more labor organizations to provide employee benefits by the purchase of insurance.

Article 47 – The New York State insurance law which regulates self-insured municipal consortium health plans. Contains reserving, reporting and operational requirements.

Centers for Medicare and Medicaid (CMS) – The government agency within the Department of Health and Human Services that directs the Medicare and Medicaid programs (Titles XVIII and XIX of the Social Security Act). Formerly the Health Care Financing Administrations (HCFA).

Child Health Plus/Family Health Plus – Child Health Plus is New York State’s health insurance program for children under age 19 who have no or limited health insurance. Family Health Plus is a public health insurance program for adults who are aged 19 to 64 who do not have health insurance - either on their own or through their employers - but have income or resources too high to qualify for Medicaid.

Government Accounting Standards Board (GASB) – An independent, non-governmental organization that sets accounting standards for state and local governments including school districts and counties.

Empire Plan – The managed PPO plan offered to New York State employees and made available to participating agencies (schools and municipalities).

ERISA (Employee Retirement Income Security Act of 1974) – ERISA is a federal act that regulates employee benefit plans, such as group health plans that private sector employers, employee organizations (such as unions), or both, offer to employees and their families. To date, self-funded health benefit plans operating under ERISA have been held to be exempt from state insurance laws.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – Federal legislation which amended the Employee Retirement Income Security Act (ERISA) to provide new

rights and protections for member of group health plans. Some of these protections include portability of coverage and patient privacy.

Healthy New York – A New York State program for sole proprietors, small employers and working individuals who are not insured or have limited insurance and meet certain criteria.

Mandated Health Insurance Benefits - Minimum health insurance coverage requirements specified by government statute. Self-funded plans are exempt from state-mandated benefits.

Medicaid – The federal medical assistance program for the indigent enacted by Congress in 1965. The program is the responsibility of the state which has the costs with the federal government.

Medicare – A federal government program established under Title XVIII of the Social Security Act of 1965 to provide hospital expense and medical expense insurance to persons 65 years of age or those under 65 who are totally disabled as determined by the Social Security Administration. There are four parts of Medicare:

- Part A - Hospital inpatient services and skilled nursing facilities
- Part B - Outpatient services, medical surgical services
- Part C - Medicare Advantage Plans (HMO or PPO)
- Part D - Prescription Drug

Mental Health Parity Act (MHPA) – A federal law which prohibits group health plans from applying more restrictive annual and lifetime limits on coverage for mental illness than for physical illness.

Multiple Employer Welfare Arrangement (MEWA) – As defined in 1983 Erlenborn ERISA Amendment, as employee welfare benefit plan to any other arrangement providing any of the benefits of employee welfare benefit plan to the employee of two or more employers. MEWAs that do not meet the ERISA definition of employee benefit plan and are not certified by the U.S. Department of Labor may be regulated by states. MEWAs that are fully insured and certified must only meet broad state insurance laws regulating reserves.

Newborns' and Mothers' Health Protection Act (NMHPA) – A federal law which specifies that group health plans or group health care insurers cannot mandate that hospital stays following childbirth be shorter than 48 hours for normal deliveries or 96 hours for cesarean births.

New York State Health Insurance Program (NYSHIP) – The statewide program which is offered to New York State employees and participating agencies and administered by the New York State Department of Civil Service. The Empire Plan is part of NYSHIP.

Timothy's Law – A New York State law which requires parity for mental health services.

TRICARE – A Department of Defense regionally managed health care program for active duty and retired members of the uniformed services and their families that combines military health care resources and networks of civilian health care professionals. Formerly known as CHAMPUS (the Civilian Health and Medical Program of the United States).

Women's Health and Cancer Rights Act (WHCRA) – The WHCRA is a federal law that provides important protections for individuals who have undergone a mastectomy.

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