

DEFINITIONS OF HEALTH INSURANCE TERMS

In February 2002, the Federal Government's Interdepartmental Committee on Employment-based Health Insurance Surveys approved the following set of definitions for use in Federal surveys collecting employer-based health insurance data. The BLS National Compensation Survey currently uses these definitions in its data collection procedures and publications. These definitions will be periodically reviewed and updated by the Committee.

ASO (Administrative Services Only) – An arrangement in which an employer hires a third party to deliver administrative services to the employer such as claims processing and billing; the employer bears the risk for claims.

- ◆ This is common in self-insured health care plans.

Coinsurance - A form of medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid.

- ◆ Once any deductible amount and coinsurance are paid, the insurer is responsible for the rest of the reimbursement for covered benefits up to allowed charges: the individual could also be responsible for any charges in excess of what the insurer determines to be “usual, customary and reasonable”.
- ◆ Coinsurance rates may differ if services are received from an approved provider (i.e., a provider with whom the insurer has a contract or an agreement specifying payment levels and other contract requirements) or if received by providers not on the approved list.
- ◆ In addition to overall coinsurance rates, rates may also differ for different types of services.

Copayment - A form of medical cost sharing in a health insurance plan that requires an insured person to pay a fixed dollar amount when a medical service is received. The insurer is responsible for the rest of the reimbursement.

- ◆ There may be separate copayments for different services.
- ◆ Some plans require that a deductible first be met for some specific services before a copayment applies.

Deductible - A fixed dollar amount during the benefit period - usually a year - that an insured person pays before the insurer starts to make payments for covered medical services. Plans may have both per individual and family deductibles.

- ◆ Some plans may have separate deductibles for specific services. For example, a plan may have a hospitalization deductible per admission.
- ◆ Deductibles may differ if services are received from an approved provider or if received from providers not on the approved list.

Flexible spending accounts or arrangements (FSA) - Accounts offered and administered by employers that provide a way for employees to set aside, out of their paycheck, pretax dollars to pay for the employee's share of insurance premiums or medical expenses not covered by the employer's health plan. The employer may also make contributions to a FSA. Typically, benefits or cash must be used within the given benefit year or the employee loses the money. Flexible spending accounts can also be provided to cover childcare expenses, but those accounts must be established separately from medical FSAs.

Flexible benefits plan (Cafeteria plan) (IRS 125 Plan) – A benefit program under Section 125 of the Internal Revenue Code that offers employees a choice between permissible taxable benefits, including cash, and nontaxable benefits such as life and health insurance, vacations, retirement plans and child care. Although a common core of benefits may be required, the employee can determine how his or her remaining benefit dollars are to be allocated for each type of benefit from the total amount promised by the employer. Sometimes employee contributions may be made for additional coverage.

Fully insured plan - A plan where the employer contracts with another organization to assume financial responsibility for the enrollees' medical claims and for all incurred administrative costs.

Gatekeeper - Under some health insurance arrangements, a gatekeeper is responsible for the administration of the patient's treatment; the gatekeeper coordinates and authorizes all medical services, laboratory studies, specialty referrals and hospitalizations.

Group purchasing arrangement – Any of a wide array of arrangements in which two or more small employers purchase health insurance collectively, often through a common intermediary who acts on their collective behalf. Such arrangements may go by many different names, including cooperatives, alliances, or business groups on health. They differ from one another along a number of dimensions, including governance, functions and status under federal and State laws. Some are set up or chartered by States while others are entirely private enterprises. Some centralize more of the purchasing functions than others, including functions such as risk pooling, price negotiation, choice of health plans offered to employees, and various administrative tasks. Depending on their functions, they may be subject to different State and/or federal rules. For example, they may be regulated as Multiple Employer Welfare Arrangements (MEWAs).

- ♦ **Association Health Plans** – This term is sometimes used loosely to refer to any health plan sponsored by an association. It also has a precise definition under the Health Insurance Portability and Accountability Act of 1996 that exempts from certain requirements insurers that sell insurance to small employers only through association health plans that meet the definition.

Health Care Plans and Systems

- ♦ **Indemnity plan** - A type of medical plan that reimburses the patient and/or provider as expenses are incurred.
- ♦ **Conventional indemnity plan** - An indemnity that allows the participant the choice of any provider without effect on reimbursement. These plans reimburse the patient and/or provider as expenses are incurred.
- ♦ **Preferred provider organization (PPO) plan** - An indemnity plan where coverage is provided to participants through a network of selected health care providers (such as hospitals and physicians). The enrollees may go outside the network, but would incur larger costs in the form of higher deductibles, higher coinsurance rates, or non-discounted charges from the providers.
- ♦ **Exclusive provider organization (EPO) plan** - A more restrictive type of preferred provider organization plan under which employees must use providers from the specified network of physicians and hospitals to receive coverage; there is no coverage for care received from a non-network provider except in an emergency situation.
- ♦ **Health maintenance organization (HMO)** - A health care system that assumes both the financial risks associated with providing comprehensive medical services (insurance and service risk) and the responsibility for health care delivery in a particular geographic area to HMO members, usually in return for a fixed, prepaid fee. Financial risk may be shared with the providers participating in the HMO.
 - ♦ **Group Model HMO** - An HMO that contracts with a single multi-specialty medical group to provide care to the HMO's membership. The group practice may work exclusively with the HMO, or it may provide services to non-HMO patients as well. The HMO pays the medical group a negotiated, per capita rate, which the group distributes among its physicians, usually on a salaried basis.
 - ♦ **Staff Model HMO** - A type of closed-panel HMO (where patients can receive services only through a limited number of providers) in which physicians are employees of the HMO. The physicians see patients in the HMO's own facilities.
 - ♦ **Network Model HMO** - An HMO model that contracts with multiple physician groups to provide services to HMO members; may involve large single and multi-specialty groups. The physician groups may provide services to both HMO and non-HMO plan participants.
 - ♦ **Individual Practice Association (IPA) HMO** - A type of health care provider organization composed of a group of independent practicing physicians who maintain their own offices and band together for the purpose of contracting their services to HMOs. An IPA may contract with and provide services to both HMO and non-HMO plan participants.
- ♦ **Point-of-service (POS) plan** - A POS plan is an "HMO/PPO" hybrid; sometimes referred to as an "open-ended" HMO when offered by an HMO. POS plans resemble HMOs for in-network services. Services received outside of the network are usually reimbursed in a manner similar to conventional indemnity plans (e.g., provider reimbursement based on a fee schedule or usual, customary and reasonable charges).

- ◆ **Physician-hospital organization (PHO)** - Alliances between physicians and hospitals to help providers attain market share, improve bargaining power and reduce administrative costs. These entities sell their services to managed care organizations or directly to employers.

Managed care plans - Managed care plans generally provide comprehensive health services to their members, and offer financial incentives for patients to use the providers who belong to the plan. Examples of managed care plans include:

- ◆ Health maintenance organizations (HMOs),
- ◆ Preferred provider organizations (PPOs),
- ◆ Exclusive provider organizations (EPOs), and
- ◆ Point of service plans (POSs).

Managed care provisions - Features within health plans that provide insurers with a way to manage the cost, use and quality of health care services received by group members.

Examples of managed care provisions include:

- ◆ **Preadmission certification** - An authorization for hospital admission given by a health care provider to a group member prior to their hospitalization. Failure to obtain a preadmission certification in non-emergency situations reduces or eliminates the health care provider's obligation to pay for services rendered.
- ◆ **Utilization review** - The process of reviewing the appropriateness and quality of care provided to patients. Utilization review may take place before, during, or after the services are rendered.
- ◆ **Preadmission testing** - A requirement designed to encourage patients to obtain necessary diagnostic services on an outpatient basis prior to non-emergency hospital admission. The testing is designed to reduce the length of a hospital stay.
- ◆ **Non-emergency weekend admission restriction** - A requirement that imposes limits on reimbursement to patients for non-emergency weekend hospital admissions.
- ◆ **Second surgical opinion** - A cost-management strategy that encourages or requires patients to obtain the opinion of another doctor after a physician has recommended that a non-emergency or elective surgery be performed. Programs may be voluntary or mandatory in that reimbursement is reduced or denied if the participant does not obtain the second opinion. Plans usually require that such opinions be obtained from board-certified specialists with no personal or financial interest in the outcome.

Maximum plan dollar limit - The maximum amount payable by the insurer for covered expenses for the insured and each covered dependent while covered under the health plan.

- ◆ Plans can have a yearly and/or a lifetime maximum dollar limit.
- ◆ The most typical of maximums is a lifetime amount of \$1 million per individual.

Maximum out-of-pocket expense - The maximum dollar amount a group member is required to pay out of pocket during a year. Until this maximum is met, the plan and group member shares in the cost of covered expenses. After the maximum is reached, the insurance carrier pays all covered expenses, often up to a lifetime maximum. (See previous definition.)

Medical savings accounts (MSA) – Savings accounts designated for out-of-pocket medical expenses. In an MSA, employers and individuals are allowed to contribute to a savings account on a pre-tax basis and carry over the unused funds at the end of the year. One major difference between a Flexible Spending Account (FSA) and a Medical Savings Account (MSA) is the ability under an MSA to carry over the unused funds for use in a future year, instead of losing unused funds at the end of the year. Most MSAs allow unused balances and earnings to accumulate. Unlike FSAs, most MSAs are combined with a high deductible or catastrophic health insurance plan.

Minimum premium plan (MPP) – A plan where the employer and the insurer agree that the employer will be responsible for paying all claims up to an agreed-upon aggregate level, with the insurer responsible for the excess. The insurer usually is also responsible for processing claims and administrative services.

Multiple Employer Welfare Arrangement (MEWA) – MEWA is a technical term under federal law that encompasses essentially any arrangement not maintained pursuant to a collective bargaining agreement (other than a State-licensed insurance company or HMO) that provides health insurance benefits to the employees of two or more private employers.

Some MEWAs are sponsored by associations that are local, specific to a trade or industry, and exist for business purposes other than providing health insurance. Such MEWAs most often are regulated as employee health benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA), although States generally also retain the right to regulate them, much the way States regulate insurance companies. They can be funded through tax-exempt trusts known as Voluntary Employees Beneficiary Associations (VEBAs) and they can and often do use these trusts to self-insure rather than to purchase insurance policies.

Other MEWAs are sponsored by Chambers of Commerce or similar organizations of relatively unrelated employers. These MEWAs are not considered to be health plans under ERISA. Instead, each participating employer's plan is regulated separately under ERISA. States are free to regulate the MEWAs themselves. These MEWAs tend to serve as vehicles for participating employers to buy insurance policies from State-licensed insurance companies or HMOs. They do not tend to self-insure.

Multi-employer health plan – Generally, an employee health benefit plan maintained pursuant to a collective bargaining agreement that includes employees of two or more employers. These plans are also known as Taft-Hartley plans or jointly-administered plans. They are subject to federal but not State law (although States may regulate any insurance policies that they buy). They often self-insure.

Premium - Agreed upon fees paid for coverage of medical benefits for a defined benefit period. Premiums can be paid by employers, unions, employees, or shared by both the insured individual and the plan sponsor.

Premium equivalent - For self-insured plans, the cost per covered employee, or the amount the firm would expect to reflect the cost of claims paid, administrative costs, and stop-loss premiums.

Primary care physician (PCP) - A physician who serves as a group member's primary contact within the health plan. In a managed care plan, the primary care physician provides basic medical services, coordinates and, if required by the plan, authorizes referrals to specialists and hospitals.

Reinsurance – The acceptance by one or more insurers, *called reinsurers or assuming companies*, of a portion of the risk underwritten by another insurer that has contracted with an employer for the entire coverage.

Self-insured plan – A plan offered by employers who directly assume the major cost of health insurance for their employees. Some self-insured plans bear the entire risk. Other self-insured employers insure against large claims by purchasing stop-loss coverage. Some self-insured employers contract with insurance carriers or third party administrators for claims processing and other administrative services; other self-insured plans are self-administered. Minimum Premium Plans (MPP) are included in the self-insured health plan category. All types of plans (Conventional Indemnity, PPO, EPO, HMO, POS, and PHOs) can be financed on a self-insured basis. Employers may offer both self-insured and fully insured plans to their employees.

Stop-loss coverage – A form of reinsurance for self-insured employers that limits the amount the employers will have to pay for each person's health care (individual limit) or for the total expenses of the employer (group limit).

Third party administrator (TPA) – An individual or firm hired by an employer to handle claims processing, pay providers, and manage other functions related to the operation of health insurance. The TPA is not the policyholder or the insurer.

Types of health care provider arrangements

- ♦ **Exclusive providers** - Enrollees must go to providers associated with the plan for all non-emergency care in order for the costs to be covered.
- ♦ **Any providers** - Enrollees may go to providers of their choice with no cost incentives to use a particular subset of providers.
- ♦ **Mixture of providers** - Enrollees may go to any provider but there is a cost incentive to use a particular subset of providers.

Usual, customary, and reasonable (UCR) charges - Conventional indemnity plans operate based on usual, customary, and reasonable (UCR) charges. UCR charges mean that the charge is the provider's usual fee for a service that does not exceed the customary fee in that geographic area, and is reasonable based on the circumstances. Instead of UCR charges, PPO plans often operate based on a negotiated (fixed) schedule of fees that recognize charges for covered services up to a negotiated fixed dollar amount.

REFERENCE SOURCES

Survey definitions from:

- ♦ The National Compensation Survey definitions (BLS),
- ♦ The Medical Expenditure Panel Survey definitions (AHRQ), and
- ♦ The National Employer Health Insurance Survey definitions (NCHS).

Definitions from other Federal agencies and surveys, such as:

- ♦ The Current Population Survey (BLS/Census)
- ♦ ERISA-related definitions (from PWBA)

Glossaries and informational papers from websites such as:

- ♦ OPM's Federal Employees Health Benefit Plans (glossary and specific plan booklets),
- ♦ Blue Cross / Blue Shield ,
- ♦ The National Center for Policy Analysis, and
- ♦ The Health Insurance Association of America.

Publications such as:

- ♦ Employee Benefit Plans: A Glossary of Terms, Ninth Edition 1997, Judith A. Sankey - editor, International Foundation of Employee Benefit Plans.
- ♦ "Fundamentals of Employee Benefit Programs, Fourth addition"
- ♦ "Managed Care Plans and Managed Care Features: Data from the EBS to the NCS", Cathy A. Baker and Iris S. Díaz, Compensation and Working Conditions, Spring 2001
- ♦ EBRI Notes Vol. 16, no. 7, July 1995
- ♦ HIAA Source Book

Personal communications with staff from some of the data sources cited above.