

# Glossary of Terms

### **Administrative Service Fee**

Fee paid to an insurer or other third party for processing claims, managing regulatory requirements and other tasks related to group health coverage.

### **Benefit Parity**

When the types and costs of services covered by different health plans are equivalent.

### **Blended Rate**

A combined insurance premium that is a composite of two or more rates. An insurer may bring two classes of members into a single risk pool, in order to offer a more equitable premium.

### **Capitated Rate**

Fixed per-person payment, made by insurer to the healthcare provider.

### **Case Management**

Coordination of medical services, to ensure more effective and integrated care.

### **CMS**

Centers for Medicare & Medicaid Services - the US federal agency that administers Medicare, Medicaid, and the Children's Health Insurance Program.

### **Disease Management**

A system of coordinated health care interventions and communications, designed to enhance a patient's compliance with treatment and medication orders.

### **ERRP**

The Early Retiree Reimbursement Program provides reimbursement to participating employment-based plans for a portion of the costs of health benefits for early retirees and

early retirees' spouses, surviving spouses, and dependents. The program was authorized in the federal Affordable Care Act.

### **Flat Renewal**

When an insurer provides the same benefits with no increase in premium rates year over year.

### **Fully Insured Plan**

When an employer contracts with another organization to assume all financial risk for the enrollees' utilization of services and incurred administrative costs

### **Grandfathered Status**

A term used in federal health reform legislation, generally interpreted as an existing health plan that does not make significant changes to benefits, co-pays or premiums.

### **HMO**

A Health Maintenance Organization that assumes the financial risks and responsibilities of providing comprehensive health care in a particular geographic area to HMO members, in return for a fixed, prepaid fee. Financial risk is sometimes shared with physicians' groups and other medical service providers.

### **Indemnity Plan**

A type of medical plan that reimburses the patient and/or provider as expenses are incurred.

### **IPA**

An Individual Practice Association or 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.

### **Large Claim Pooling**

A system designed to help stabilize premium fluctuations in smaller insured groups. Expensive claims (those over a stated amount) are charged to a larger number of plan participants, so the costs are spread in aggregate across a greater number of plan participants.

### **Limited Network**

When, to contain costs, an insurance plan offers medical service only through specific contracted doctors and hospitals.

### **Medical Group**

*See IPA.*

### **Medicare**

A health insurance program administered by the federal government, providing coverage to people who are aged 65 and over, or who meet other special criteria. Traditional or "fee-for-service" Medicare has a standard benefit package that covers medically necessary care that members can receive from nearly any hospital or doctor in the country. Medicare Part A is hospital insurance. Medicare Part B is medical insurance. Medicare Part D covers prescription drugs.

### **Medicare Advantage**

With this type of health plan, the enrollee assigns Medicare benefits to a health plan while he or she is enrolled. The federal government then pays the insurer a capitated rate, or set amount, every month for each participant. Plan enrollees receive service only from within the network contracted by the Medicare Advantage plan.

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### Migration

Movement of enrollees between different health plans.

### Non-Medicare Rates

Health insurance premiums for a group of enrollees who are not eligible to participate in Medicare.

### Network Model HMO

An HMO that contracts with multiple physician groups and/or hospitals to provide services to enrollees. (*See HMO.*)

### Open Network

A health plan that allows enrollees to obtain service from any doctor or hospital.

### Per Capita

Average per person.

### Performance Guarantees

Standards for quality of service provided by the insurer, as established by the contract with the employer. Financial penalties may be levied if the insurer fails to meet specific, required measures.

### Premium

Agreed upon fees paid for health benefits coverage during a defined benefit period. Premiums can be paid by employers, unions, or employees. Premium costs are often shared among these entities.

### PMPM

Per member per month.

### PPO

A Preferred Provider Organization plan, where coverage is given to participants through a network of selected hospitals and physicians. Enrollees may go outside the network, but then incur higher deductibles, higher coinsurance rates, or non-discounted provider charges.

### Rate Guarantee

When an insurer contractually agrees to lock in premium costs for a certain period of time.

### Renewal

Continuing insurance coverage with an existing insurance plan by contractual agreement.

### Re-rating

While negotiating premium rates, an insurer calculates the probability of how much utilization is likely to occur by a particular group. If a significant factor changes, such as the number of expected enrollees, the insurer may re-calculate rates.

### Risk

In general risk is the probability that a return on investment will be lower than expected. With regard to health insurance, risk is based on the amount of money assigned to meet the care needs of a pool of covered individuals, and which party agrees to assume responsibility for any financial shortfall.

### RFP

A Request for Proposal, with clearly defined criteria for comparison, that allows providers of a product or service to bid on the right to supply that product or service.

### Self-Insured Plan

A type of health plan in which the employer and plan participants directly assume the costs of health care and administrative services for individuals in the plan.

### Senior Advantage

*See Medicare Advantage.*

### SSSG

Similarly Situated Subscriber Group - enrollee groups that have very similar characteristics, such as equivalent demographics and utilization.

### Staff Model HMO

A type of HMO where patients receive service in the HMO's own facilities, from health care professionals who are employees of the HMO. (*See also HMO.*)

### Trend

Future projections based on factors, such as enrollment, utilization, service and administrative fees, which impact health plan risk and premium costs.

### Utilization

The extent to which an insured group uses a particular health care service in a specified period. Typically expressed as the number of services used per year per 100 or per 1000 persons.