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Glossary of Healthcare Terms

TERMS:

Actuarial Analysis: A forecast developed by specialized actuarial methods, giving the probability of future events for a given population, such as life expectancy, frequency of hospitalization, or probability of loss from fire. A common use of such forecast is the calculation of insurance premiums and, for the insurer, the necessary reserves.

Actuarial Cost of Coverage: The expected dollar value of a health plan's benefits. The method of determining this value may be based entirely on a plan's provisions or may adjust for the geographic location and demographic characteristics of enrollees, the actual health care utilization level by plan participants, or the type of plan under which the benefits are provided.

Adjudication: Refers to the process of paying claims submitted or denying them after comparing claims to the benefit or coverage requirements.

Administrative Costs: Costs of an insurance company for services provided to a fully insured plan, including claims processing, billing, utilization review, marketing, medical underwriting, commissions, premium collection, insurer profit, and quality assurance.

Administrative Fees: Fees charged by an administrator for services provided to a self-funded plan, including claims processing, billing, utilization review, premium collection, and quality assurance.

Administrative Services Only (ASO): An arrangement under which an insurance carrier or an independent organization will, for a fee, handle the administration of claims, benefits and other administrative functions for a self-insured group but does not assume any financial risk for the payment of benefits.

Adverse Selection: Among applicants for a given group or individual health insurance program, the tendency for those with an impaired health status, or who are prone to higher-than-average utilization of benefits, to be enrolled in disproportionate numbers in lower deductible plans.

Age/Gender Factor: A measurement used in underwriting which represent the age and gender risk of medical costs of one population relative to another.

Aggregate Stop Loss Insurance: A Policy designed to protect self-funded plans against excessive overall claims during a policy period by reimbursing plans for covered claim costs that exceed the determined maximum claim liability.

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If

the provider charges more than the allowed amount, the member may have to pay the difference. (See Balance Bill).

Appeal: A member request to the health insurer or plan to review a decision or a grievance again.

Attachment Point: The level at which the Aggregate Stop Loss policy will reimburse a self-funded plan for excess aggregate claims. At the beginning of the contract year, the deductible is determined as a projection of expected claim costs plus a corridor.

Average Contract Size: The ratio of total members to the total number of employees covered under the plan. This is the average family size or the average number of members per contract.

Balance Bill: The amount a member could be responsible for (in addition to any co-payments, deductibles, or coinsurance) if a member uses an out-of-network provider and the fee for the particular service exceeds the allowable charge. Refers to the leftover sum that a provider bills to the patient after insurance has only partially paid the charge that was initially billed.

Calendar Year Deductible: The dollar amount for covered services that must be paid during the calendar year (January 1 – December 31) by members before any benefits are paid by the Plan.

Capitation: A per-member, monthly payment to a provider that covers contracted services and are paid in advance of its delivery. In essence, a provider agrees to provide specified services to plan members for this fixed, predetermined payment for a specified length of time (usually a year), regardless of how many times the member uses the service. The rate can be fixed for all members of it can be adjusted for the age and sex of the member, based on actuarial projections of medical utilization.

Centers of Medical Excellence (CME): Health care providers designated as a selected facility for specified medical services. Providers participating in a CME network have an agreement to accept an agreed upon amount as payment in full for covered services.

COBRA Beneficiary: Any former Covered Person of the medical benefit plan continuing participation under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its amendments.

Coinsurance: An arrangement under which the member pays a fixed percentage of the cost of medical care after the deductible has been paid. For example, an insurance plan might pay 80% of the allowable charge, with the member responsible for the remaining 20%, which is then referred to as the coinsurance amount.

Composite Rate or Rating: Grouping covered individuals from separate health insurance plans into a single group for medical underwriting purposes. For example, a composite rate

would be established for those eligible to participate in a multiple option plan regardless of the deliver and financing coverage elected by the plan participants. The number of covered individuals and the projected number and cost of claims under each plan option.

Complete Claims History: All of the following for a minimum of 12 consecutive months immediately preceding the Policy Period:

1. Participant census, and
2. Eligibility information, and
3. Claims Experience, and
4. Large Claim Disclosures, and
5. Details of any condition shown on the trigger diagnosis List in the disclosure statement, if requested during underwriting.

Complication of Pregnancy: Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Condition Care: Helps promote and improve the overall health status and quality of life of members and helps promote and/or prevent disease progression and avoid and/or prevent the complications associate with the conditions.

Consolidated Omnibus Budget Reconciliation Act (COBRA): A Federal law that requires employers to offer continued health insurance coverage to employees who have had their health insurance coverage terminated.

Contract Basis: The Contract Basis is considered in determining what covered expenses will be reimbursed.

Contract Month: A period of one-month that begins on:

1. The effective date of this Policy, or
2. The same day of each following month during the Policy Period.

Coordination of Benefits: This is the process by which a health insurance company determines if it should be the primary or secondary payer of medical claims for a patient who has coverage from more than one health insurance policy.

Co-Payment: A specific charge that a health plan may require a member to pay for a specific medical service or supply after which the insurance company pays the remainder of the charge.

Corridor: The amount by which expected claims are increased to determine the attachment point, usually expressed as a percent of expected claims (e.g., 125%).

Cost Containment Program: A program designed to reduce or control the cost of providing Plan Benefits to participants of the medical benefit plan.

Covered Expenses: Plan Benefits incurred by a Covered Person (or Covered Family):

1. For which benefits are Paid by the Policyholder under the medical benefit plan, and
2. Which are not in excess of the Reasonable and Customary Charge for those services, and
3. Which are Medically Necessary for the treatment of an illness or injury or for any preventative care covered by the medical benefit plan, and
4. Which are reimbursable under this Policy subject to its terms, deductible(s), limitations, and exclusions.

Plan Benefits provided by the medical benefit plan that are specifically excluded by this Policy are not considered Covered Expenses. Covered Expenses shall not include any expenses which are not reimbursable under this Policy, such as:

1. The expenses related to processing a claim payment, or
2. PPO discounts, network or negotiated discounts, rebates and other reductions from billed charges, whether or not they were actually deducted from Plan Benefits, or
3. Salaries paid to any individual, or
4. Claims Administrator's fees, or
5. Litigation expenses, or
6. Premiums paid for coverage under this Policy.

Covered Family: The Covered Person and his or her dependents covered under the medical benefit plan.

Covered Person: An individual covered under the medical benefit plan. This may include:

1. Legally employed covered employees or participants, and
2. Covered dependents, and
3. Participating COBRA Beneficiaries, and
4. Retirees.

Covered Units: A Covered Person, a Covered Family, or such other defined unit as agreed upon by the employer and insurance/stop loss carrier.

Credibility: The weight given to a group's claim experience versus the manual rate in order to determine expected claims.

Deductible: An amount the covered person must pay before payments for covered services begin. The deductible is usually a fixed amount. For example, an insurance plan might require the insured to pay the first $250 of covered expense during a calendar year.

Dependent: Person, (spouse or child), other than the subscriber who is covered under the subscriber's benefit certificate.

Disclosure: The process where the plan provides information on known large claimants to the stop loss carrier. The information will be used to assess and price the stop loss risk.

Disease Management: An effort to improve patient outcomes and lower costs by organizing managed care initiative around patients with a particular disease or condition.

Drug Formulary: A listing or prescribed drugs covered by an insurance plan or used within a hospital. Some insurers will not reimburse for prescribed drugs not listed on the formulary; others may have a limited reimbursement for non-formulary drugs.

Drug Utilization Review: An evaluation of prescribing patterns or targeted drug use to specifically determine the appropriateness of drug therapy.

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include oxygen equipment, wheelchairs, crutches, or blood testing strips for diabetics.

Eligible: Eligible under the medical benefit plan.

Emergency Medical Condition: An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services received in an emergency room.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services: Health care services that the health insurance or plan doesn't pay for or cover.

Expected Claims: The projected claim level for the defined contract period. Underwriting calculates the expected claims based on the group's prior claim experience, trend, differentials (benefit plan design and network efficiency), credibility, and other factors.

Experience Period: The time period for reported claims used by underwriting to project future claims.

Experience-rated: Premiums for a group plan determined by all or a portion of actual claims of enrollees within the group. The cost of the group plan is a direct function of the claims incurred by that group.

Experimental or Investigative: A drug, device or medical treatment or procedure is Experimental or Investigative:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished, or
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II or III clinical trials or under study to determine its:
    a. Maximum tolerated dose, or
    b. Toxicity, or
    c. Safety, or
    d. Efficacy, or
    e. Efficacy as compared with the standard means of treatment or diagnosis, or
3. If reliable evidence shows that the consensus among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
    a. Maximum tolerated dose, or
    b. Toxicity, or
    c. Safety, or
    d. Efficacy, or
    e. Efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative peer reviewed medical and scientific literature, or
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure, or
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

Explanation of Benefits (EOB): A form sent to the covered person after a claim for payment has been processed by the carrier that explains the action taken on that claim. This explanation might include the amount that will be paid, the benefits available, reasons for denying payment, or the claims appeal process.

Fiduciary: Any person who has discretion over plan assets, benefit levels, accounting and record keeping, investments, or benefit/eligibility decisions. A fiduciary has a duty under

federal law to operate the plan in a prudent manner and in the exclusive interest of the persons covered under the plan.

Fixed Costs: The premiums and fees that are fixed for the contract period and are not subject to variations. Fixed costs are calculated per covered employee and the total will be determined each month based on the varying number of covered employees.

Formulary: A list of prescription drugs covered by the health plan, often structured in tiers that subsidize low- cost generics at a higher percentage than more expensive brand-name or specialty drugs.

Fully Insured: Fully insured financing is considered the traditional way to finance a group's health care. Being fully insured means that the carrier processes and pays claims for covered individual members according to the terms of the benefit options chosen. Each month, a premium amount based on projected claims experience and operating costs.

Funding Level: The amount of revenue required to finance a medical care program. Under an insured program, this is usually premium rate. Under a self-funded program, this amount is usually assessed per expected claim cost, plus stop-loss premium, plus all related fees.

GASB: Governmental Accounting Standards Board

GASB 43 - Financial Reporting for Post-Employment Benefit Plans Other Than Pension Plans. Establishes uniform financial reporting standards for OPEB **plans**.

GASB 45 - **Accounting** and Financial Reporting by Employers of Post-Employment Benefits Other Than Pensions. Establishes uniform standards for the measurement, recognition, and display of OPEB expense, expenditures, and related liabilities on the employer's financial statements.

Gatekeeper: A primary care physician responsible for overseeing and coordinating all aspects of a patient's medical care and pre-authorizing specialty care.

Grievance: A complaint that a member communicates to the health insurer or plan.

Habilitation Services: Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Assessment: More companies are asking workers to fill out such assessments, which give health improvement tips. Companies can give workers financial incentives to do so.

Health Insurance: A contract that requires the health insurer to pay some or all health care costs in exchange for a premium.

Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulation: The Privacy Standards are designed to protect each individual's individually identifiable health information *("Protected Health Information" or "PHI")* from being used or disclosed by Covered Entities without the individual's express authorization, except as explicitly permitted or required in certain limited circumstances. If health information does not meet the definition of Protected Health Information, then the Privacy Standards do not apply to that information.

Generally, the Privacy Standards restrict how a Covered Entity (essentially, health plans, health care providers who transmit health information in electronic form and health care clearinghouses) may use and disclose PHI - including when a use or disclosure is required or permitted - and the conditions relating to the use or disclosure. Covered Entities' use or disclosure of, or requests for, PHI must consist of only the minimum amount necessary to accomplish the intended purpose of the use, disclosure, or request.

The Privacy Standards also apply to Business Associates (a person who, on behalf of a Covered Entity, performs or helps with an activity involving the use or disclosure of individually identifiable health information) of Covered Entities, by virtue of a Business Associate Agreement, which is required by the Privacy Standards to be in place between those two parties.

Home Health Care: Health care services a person receives at home.

Hospice Services: Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

IBNR: An acronym for "incurred but not reported". This is an accounting estimate used by health plans to accrue for care that was provided or "incurred" in one accounting period, but not paid or "reported" until another accounting period. Often refers to the costs associated with a medical service that has been provided but for which a claim has not yet been received by the carrier.

Immature Claims: Immature claims do not include any lagged claims incurred in prior months. During the first year, self-funded plans have a reduced claim liability due to the lag between when a claim is incurred and when it is paid. Because of this, the initial plan year is based on immature claims as the group will have only 9-10 months of mature claims experience.

Incurred: The date on which medical care or a service or supply is provided to a Covered Person for Plan Benefits under the medical benefit plan for which a charge results.

Incurred Claims: Claims that have dates of service within a specific period of time but are not necessarily paid in that period.

Individual Stop Loss (Specific Deductible): A policy which protects the self-funded plan against large claims accumulated by any one individual. The policy will have a specified deductible that must be satisfied by a member before the policy will reimburse the plan their excess claims.

In-Network: Refers to the use of providers who participate in the carrier's provider network. Many benefit plans encourage covered persons to use participating (in-network) providers to reduce the individual's out of pocket expense.

Joint Powers Authority (JPA): A JPA is when two or more public entities with common powers to consolidate their forces to acquire better buying power.

Lag: The period of time on average from when a claim is incurred until it is paid. Includes claims that have been Incurred But Not Reported (IBNR).

Large Claim Disclosure: The employer, with the assistance of the claims administrator, agrees to disclose to the stop loss carrier any known or potential shock losses……Typically all losses that exceed 50% of the Specific Deductible must be reported to the stop loss carrier.

Lasering: A common stop loss practice in which an individual member, based on prior claims experience or known conditions, is excluded or covered by the stop loss policy at a higher Specific Deductible than the rest of the group.

Leveraged Trend: The effect of first-dollar medical inflation; the quotient of a stop loss claim reimbursed in the current year divided by the value of the claim reimbursed in the prior year

Loss Limit: The maximum amount of Covered Expenses Incurred by each Covered Person (or Covered Family), which can be used to satisfy the Annual Aggregate Deductible. The maximum allowable amount of Covered Expenses by a Covered Person who has been assigned a Separate Individual Specific Deductible will be the specified amount as shown under the Loss Limit, regardless of that Covered Person's Separate Individual Specific Deductible.

Loss Ratio: For fully insured plans, the ratio of the total incurred claims made against an insurance policy. For self-funded plans, the ratio of health benefits used (paid) compared to revenue received (total claims divided by total revenue/premium).

Manual Rates: Rates developed based upon the health plan's average claims data and then adjusted for group specific demographics, industry factors, or benefit variations.

Mature Claims: Mature claims paid in a month include lagged claims that were incurred in prior months. For a new self-funded plan, the claims will become mature after the 3rd or 4th month as the claim lag will then be accounted.

Maximum Claim Liability: The maximum liability for all aggregate claims up to the attachment point if Aggregate Stop Loss is contracted (expected claims plus the corridor). Once the attachment point is met, the Aggregate Stop Loss policy will reimburse excess claims to the self-funded plan for the reminder of the policy period.

Medical Benefit Plan: The medical benefits an employer has agreed to provide under a plan of benefits for Eligible employees and their Eligible dependents, whether or not it is subject to the Employee Retirement Income Security Act of 1974, as is or as may be amended.

Medically Necessary: A procedure, treatment, service, supply, equipment, drug, or medicine that is:

1. Deemed appropriate, essential and is recommended for the diagnosis or treatment of the Covered Person's symptoms by a licensed physician, dentist or other medical practitioner who is practicing within the scope of his or her license and specialty or primary area of practice, and
2. Within the scope, duration and intensity of that level of care which is required to provide safe, adequate and appropriate diagnosis or treatment, and
3. Prescribed in accordance with the generally accepted, current professional medical practice and is not considered Experimental or Investigative.

Medical Tourism: To have medical care outside the United States.

Member Months: Total membership during an experience period. Determined by adding the enrolled monthly membership for each month of the experience period.

Paid Claims: Claims that are paid within the specified period (contract year or policy term) regardless of when they are incurred. Includes claims that are incurred in a prior time period yet were paid during the specified period.

Negotiated Rate: The amount participating providers agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Participating Provider Agreements.

Net Paid Claims: The sum of Covered Expenses Paid during the Policy Period by the employer less the sum of all amounts paid by the employer that exceeds the Loss Limit of any Covered Person(s).

Network: The facilities, providers, and suppliers the health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider: A provider who doesn't have a contract with the health insurer or plan to provide services to members. Members pay more to see a non-preferred provider.

Open Enrollment: A time period during which eligible employees can select among the plans offered by their employer as well as make any other dependent changes.

Original Effective Date: The first day of the Policy Period of the initial Stop Loss Policy. If coverage has not been continuous with the stop loss insurer, then the Original Effective Date shall be the first day of the most recent continuous coverage.

Out-Of-Network: The use of health care providers who have not contracted with the carrier to provide services. Members are generally not reimbursed if they go out-of-network except in emergency situations.

Out-Of-Pocket: The most a member would pay for covered medical expenses in a plan year through copays, deductibles and coinsurance before the insurance plan begins to pay 100 percent of the covered medical expense.

Paid Claims: Claims that are paid within the specified period (contract year or policy term) regardless of when they are incurred. Includes claims that are incurred in a prior time period yet are paid during the specified period.

Participating Provider: A physician, hospital, pharmacy, laboratory or other appropriately licensed provider of health care services or supplies, that has entered into an agreement with a managed care entity to provide such services or supplies to a patient enrolled in a health benefit plan.

Patient Care Services: Health care items or services that are furnished to an individual enrolled in a Qualified Clinical Trial, which are consistent with the usual and customary standard of care for someone with the patient's diagnosis, is consistent with the study protocol for the clinical trial and would be covered if the patient did not participate in the Qualified Clinical Trial.

Patient Care Services must be determined to be eligible under the medical benefit plan. Patient Care Services do not include any of the following:

1. An FDA approved drug or device shall be a Patient Care Service only to the extent that the drug or device is not paid for by the manufacturer, the distributor, or the provider of the drug of device, or
2. Non-health care services that a patient may be required to receive as a result of being enrolled in the Qualified Clinical Trial, or
3. Costs associated with managing the research associated with the Qualified Clinical Trial, or
4. Costs that would not be covered for non-investigational treatments, or
5. Any item, service or cost that is reimbursed or otherwise furnished by the sponsor of the Qualified Clinical Trial, or

6. The costs of services, which are not provided as part of the Qualified Clinical Trial's stated protocol or other similarly, intended guidelines.

Pay, Paid, Payment: Charges that, as of the dates shown in the Contract Basis, are:

1. Covered and payable under the medical benefit plan, and
2. Have been adjudicated and approved, and
3. A check or draft for remuneration is issued and deposited in the U.S. Mail, or other similar conveyance or is otherwise delivered to the payee, and
4. Sufficient funds are on deposit the date the check or draft is issued.

Our reimbursements will not be made until all of these conditions are satisfied. Checks or drafts that are returned to the payor unpaid for any reason will not be considered Paid.

Physician Services: Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan Benefits: The medical expense benefits to which Covered Persons become entitled under the medical benefit plan during the Policy Period which are:

1. Incurred after the effective date of this Policy or the first date of the Run-In Period, whichever is earlier, and
2. Incurred while this Policy is in-force, and
3. Paid during the Policy Period or before the end of the Run-Out Period.

Plan Benefits do not include:

1. Deductibles, or
2. Co-insurance amounts, or
3. Interest, or
4. Plan expenses, or
5. The amounts of any PPO discounts, rebates, network or negotiated discounts, or any other reductions to billed charges, whether or not they were actually deducted, and
6. Claims paid under any medical benefit plan's discretionary clause or similar provision that would not otherwise be payable under the terms and conditions of the medical benefit plan, including but not limited to:
   a. Benefits or services paid where eligibility is determined by materials not provided to the insurer during underwriting of the Policy or prior to issuance of the Policy, and
   b. Costs of complications or other related expenses paid in relation to a condition or service not covered by the medical benefit plan, and
7. Any liability assumed by the member, under any contract, agreement or otherwise, that is not provided for under the medical benefit plan, and
8. Claims that are not covered under the terms and conditions of the medical benefit plan or that are reimbursable from any other source.

A medical benefit plan expense is incurred at the time the serviced is rendered or the supply is provided.

Performance Guarantees: Contractual agreement between a claim administrator and a self-funded entity that documents service-related expectations in such areas as new business implementation, claim payment time and accuracy, telephone customer service satisfaction, customer plus member satisfaction. Failure to meet agreed-upon criteria typically results in a credit to the entity's administration fee.

Per Member Per Month (PMPM): The unit of measurement related to each effective member for each month that the member was effective.

Per Subscriber Per Month (PSPM): The unit of measurement related to each effective enrollee for each month that the subscriber (employee) was effective. A subscriber includes the covered active employee, COBRA participant, and retiree.

Plan Document: The written document evidencing the medical benefit plan including any amendments.

Policy: A policy may include all of the following:

1. The Application, and
2. This Policy and any Endorsements to it, and
3. The Policyholder's Plan Document and other supporting documents (i.e employee handbooks, summary plan documents) provided

Policyholder: Group coverage: Employer or Plan Sponsor; Individual Coverage: Employee or Dependent.

Policy Period: The period beginning on the effective date and ending on the expiration date or the actual period of time during which the Policy is in force if the Policy terminates prior to the expiration date.

Pooling: A fully insured rating practice where the insurer excludes paid claims exceeding a defined limit on any one person during a policy period in their rating formula. A set pooling fee is included in the plan's premium and is based on the pooling level.

Pooling Level: A specified claim level (e.g., $400,000) for any individual where claims in excess of that level for that individual are not included in the group's experience. Applies to fully insured groups.

Pre-Authorization: A procedure used to review and assess the medical necessity and appropriateness of elective hospital admissions and non-emergency outpatient services before the services are provided.

Preferred Provider: A provider who has a contract with the health insurer or plan to provide services to a covered member at a discount. Some policies have a "tiered" network and members must pay extra to see some providers. The plan may have preferred providers who are also "participating" providers. Participating providers also contract with the health insurer or plan, but the discount may not be as great, and a member may have to pay more.

Premium: The amount that must be paid for a health insurance plan by covered employees, by their employer, or shared by both. A covered employee's share of the annual premium is generally paid periodically, such as monthly, and deducted from his or her paycheck.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that by law require a prescription.

Primary Care Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates, or helps a patient access a range of health care services.

Qualified Clinical Trial: A Qualified Clinical Trial is a clinical trial that meets all the following conditions:

1. The clinical trial is intended to treat cancer or another life threatening condition in a patient who has been so diagnosed, and
2. The clinical trial has been peer reviewed and is approved by at least one of the following:
    a. A federally funded or approved trial; or
    b. A clinical trial conducted under an FDA investigation new drug application; or
    c. A drug trial that is exempt from the requirement of an FDA investigational new drug application.
3. The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that expertise, and
4. The patient meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial, and
5. The patient has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards, and
6. The available clinical or pre-clinical data provide a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial, and
7. The clinical trial does not unjustifiably duplicate existing studies, and

8. The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the patient.

Reasonable and Customary: This refers to the standard or most common charge for a particular medical service when rendered in a particular geographic area. Also known as Usual, Customary and Reasonable (UCR).

Reconstructive Surgery: Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accident, injuries or medical conditions.

Rehabilitation Services: Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Reserves: Monies earmarked to cover anticipated claims and operating expenses for a set period of time. Reserves are an obligated amount have three principal components: reserves for known liabilities not yet paid; reserves for losses incurred but unreported; and other reserves for various special purposes, including contingency reserves for unforeseen circumstances.

Retention: Insurance carrier's provision in experience rating for taxes, cost for the assumption of risk, benefit plan administration, maintaining reserves, other expenses and contributions to the return on equity of the insurance company.

Risk: The chance or possibility of loss often employed as a utilization control mechanism within an HMO setting. Risk is also defined in insurance terms as the possibility of loss associated with a given population.

Run-In Claims: Claims that were incurred prior to the stop loss policy effective date and paid after the new policy effective date. A contract with a run-in period covers claims incurred in those months prior to the policy effective date and are paid during the 12 month policy period.

Run-Out Claims: Claims that were incurred prior to the date of termination of the stop loss policy and paid after the policy termination date. A contract with a run-out period covers claims incurred during the 12 month policy period and are paid during the months following termination of the policy.

Self-Funding: A self-funded health care plan is funded entirely by the employer. A self-funded plan may be self-administered, or the employer may contract with an outside administrator for an administrative services only arrangement. Self-funded plans obtain stop-loss insurance on an aggregate or individual basis to limit their liability of catastrophic claims.

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Shock claim: A catastrophic claim on any one person that results in a significant medical expense.

Skilled Nursing Facility: An inpatient healthcare facility with the staff and equipment to provide skilled care, rehabilitation and other related health services to patients who need nursing care, but do not require hospitalization.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

State Mandated Benefits: Benefits that are required by state law to be covered, such as specific health care services and treatments, certain types of health care providers, and some categories of dependents.

Stop-loss Insurance: Insurance provided to employers who self-fund their benefit programs to protect the employer from catastrophic claims. Employers assume liability for claims up to a predetermined limit at which point the stop loss insurance assumes liability.

Subscriber: An eligible employee who elects coverage under the benefit plan. Also includes individuals covered under COBRA and retiree plans.

Terminal Liability Protection: A stop loss option that provides additional protection for claims paid beyond the termination date of the stop loss policy for a determined amount of time. Terminal liability allows run-out claims to accumulate towards the stop loss deductible. Terminal liability typically must be purchased in advance of termination (either at new business or renewal) before it can be executed.

Third Party Administrator (TPA): An independent third-party entity that administers group benefits, claims, and administration services for a self-funded entity.

Transparency: The ability for patients to have easy access to understandable information about the cost and quality of their health care options. They should be able to obtain this information from their health plan and medical providers prior to the time of treatment.

Trend: The rate at which medical costs are changing due to factors such as prices charged by medical care providers, changes in the frequency and pattern of utilizing services, cost shifting, and advances in technology.

Trend Factor: An adjustment factor to represent the predicted change in the level of costs for services from one period to another due to inflation and utilization increases.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so sever as to require emergency room care.

Usual, Customary and Reasonable (UCR): A fee controlling system to determine the value of physician reimbursement based on: (1) the physician's usual charge for a given procedure; (2) the amount customarily charged for the service by other physicians in the area; and (3) the reasonable cost of services for a given patient after medical review of the case.

Utilization (review): Evaluation of the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities on a perspective, concurrent, or retrospective basis.

PRODUCTS:

Exclusive Provider Organization (EPO): A type of managed care plan where services are covered only if the member goes to doctors, specialists, or hospitals in the plan's network (except in an emergency); similar to a PPO except there is no benefit for non-network providers and may have benefits that similar to an HMO

Employee Assistance Program (EAP): A program that is designed to assist in the identification and resolution of productivity problems associated with personal concerns of employees. The program provides employees and their dependents with access to confidential, short- term counseling by qualified practitioners, in person or over the phone.

Flexible Spending Account (FSA): Accounts that let workers set aside pre-tax money from their paycheck toward premiums or costs not covered by their health plan, such as co-payments. All the money must be used within the plan year or it is lost.

High Deductible health plan (HDHP): An HDHP features higher annual deductibles than traditional health plans, such as a preferred provider organization (PPO) or health maintenance organization (HMO) plan. Except for preventive care, covered employees must meet the annual deductible before the plan pays benefits. HDHPs, however, may have significantly lower premiums than a PPO, HMO, EPO, or other traditional plan.

HMO (Health Maintenance Organization): A form of health coverage in which health plan members prepay a premium for health services, which generally include inpatient and ambulatory care. For the patient, it means reduced out-of-pocket costs (i.e., no deductible), no paperwork (i.e., insurance forms), and only a small copayment for each office visit to cover paperwork handled by the HMO. The following are some specific forms of the HMO.

- ***Staff-Model:*** The purest form of managed care. All of the physicians are in a centralized site in which all clinical and perhaps inpatient and pharmacy services are offered. The HMO holds the tightest management reins in this setting because none of the physicians traditionally practice on an independent, fee–for-service basis. Physicians are more employees of the HMO in this setting, as they are not in a private or group practice. Kaiser is an example of a staff-model HMO

- ***Individual Practice Association – Model (IPA):*** The IPA contracts with independent physicians who work in their own private practices and see fee-for-service patients as well as HMO enrollees. They are paid by capitation for the HMO patients. Physicians belonging to the IPA guarantee that the care needed by each patient for whom they are responsible will fall under a certain amount of money. They guarantee this by allowing the HMO to withhold an amount of their payments (e.g., usually about 20% per year). If, by the end of the year, a physician's cost for treatment falls under this set amount, then the physician receives his entire "withhold funds." If the opposite is true, the HMO can then withhold any part of this amount, at its direction, from the fund. Essentially, the physician is put "at risk" for keeping down the treatment cost. This is key to the HMO's financial viability.

- ***Group-Model:*** In the group-model HMO, the HMO contracts with a physician group, which is paid a fixed amount per patient to provide specific services.

- ***Network-Model:*** A network of group practices or IPA's that are under the administration of one HMO. Blue Cross is an example of a network-model HMO.

Indemnity Health Plan: Similar to a fee-for-service plan in which the insurer pays for all or part of covered services that the patient chooses to purchase from health care providers.

Integrated Delivery System: Collaboration between physicians and hospitals for a variety of purposes. Some models of integration include physician-hospital organization, management-service organization, integrated provider organization and medical foundation.

Medical Expense Reimbursement Plan: A plan arrangement where an organization reimburses employees for out-of-pocket expenses incurred by employees or their dependents.

Medigap: Refers to various private health insurance plans sold to supplement Medicare.

POS (Point of Service): Sometimes referred to an "open-ended" HMO, the POS model is one in which the patient can receive care from physicians who do or do not contract with the HMO. Physicians not contracting with the HMO but who see an HMO patient are paid according to the services performed. The patient is incentivized to utilize contracted network providers through comprehensive coverage offerings.

PPO (Preferred Provider Organization): PPO's are managed care organizations that offer integrated delivery systems (i.e., networks of providers) that are available through a vast array of health plans and are readily accountable to purchasers for cost, quality, access, and services associated with their networks. They use provider selection standards, utilization management, and quality assessment techniques to complement negotiated fee reductions as an effective strategy for long-term cost savings. Under a PPO benefit plan, covered individuals retain the freedom of choice of providers but are given financial incentives (i.e., lower out-of-pocket costs) to use the preferred provider network. Preferred provider organizations are marketed

directly to employers as well as insurance companies and TPAs, who then market the network to their employer clients.

HSA (Health Savings Account): Think of HSA's as "medical" IRAs. They are tax-free accounts that individuals with an HSA-compatible high-deductible insurance policy can fund and use to pay for medical expenses. Because they are tax-advantaged and balances can accumulate over time, HSA's can also be used to accumulate wealth. In addition, HSA's are owned by the individual account holder and therefore portable.

HRA (Health Reimbursement Accounts): Health reimbursement accounts consist of funds set aside by employers to reimburse employees for qualified medical expenses, just as an insurance plan will reimburse covered individuals for the cost of services incurred. Employers qualify for preferential tax treatment of funds placed in a health reimbursement account in the same way that they qualify for tax advantages by funding an insurance plan. (Employers can deduct the cost of an insurance plan -- and a health reimbursement account -- as a business expense under Internal Revenue Code section 162.) A health reimbursement account provides "first-dollar" medical coverage until funds are exhausted. For example, if an employee has a $500 qualifying medical expense, then the full amount will be covered by the health reimbursement arrangement if the funds are available in the account. All unused funds are rolled over at the end of the year. Former employees, including retirees, can have continued access to unused reimbursement amounts. Health reimbursement accounts remain with the originating employer and do not follow an employee to new employment.