Glossary of Health Insurance Terms

October 27, 2003

DISCLAIMER: Terms were taken from insurance industry guides, reference books, textbooks, Internet sources, Kentucky Insurance Laws & Regulations, consumer guides, and dictionaries. Some terms are followed by a parenthetical citation listing the source, usually the author of the publication and a page number. A listing of "Works cited" is at the end of this document. We do not intend this glossary to be a final statement on what various terms mean, but hope it will help the average person better understand insurance. The definitions do not constitute official text of the statutes and are intended for informational purposes only. No representation is made as to the accuracy or completeness of these sections. If you have corrections, additions or comments on this glossary, please contact DOI's Office of Communications.

A B C D E F G H I J K L M
N O P Q R S T U V W X Y Z

A

A.M. Best rating: A.M. Best is a rating agency that grades property and liability and life Insurance companies on financial strength from A++ to F, S for "suspended" and E for "under regulatory supervision." "Founded in 1899 by Alfred M. Best, A.M. Best is the world's oldest and most authoritative source of insurance company ratings and information." (A.M. Best online at http://www.ambest.com/)

ABMT: Autologous Bone Marrow Transplant; a treatment for breast cancer.

Actively-at-work: Term used in reference to an employee's start of coverage, whereby the employee must be at work on the day coverage begins.

Activities of daily living (ADLs): A person's basic daily care needs, including bathing, dressing, using the toilet, bladder or bowel control functions, feeding, walking and transferring from a bed to a chair.

Acute care: Medical services provided to treat an illness or medical condition on a short-term or episodic basis.

ADA – Americans with Disabilities Act: A law passed in 1990 that bans discrimination against people with disabilities in the areas of employment and public accommodations.

Administrator: (1) The person or company that oversees the management, accounting and processing for a group insurance contract; (2) For ERISA, the person responsible for managing a plan's assets to decrease the risk of significant losses; acting in the interest of the plan's participants and beneficiaries, providing benefits and paying administrative costs. See *ERISA.*

Admitted assets: Assets that are allowed to be included in an insurer's annual statement to show solvency.

Adult day care: See Day health care centers.

Adverse determination: The health insurer determines a service, treatment, drug or device is not "medically necessary or appropriate" and denies, reduces or terminates coverage of the service, treatment, drug or device. The covered person gets an adverse determination. (DOI publication)

Adverse selection: The tendency of individuals with a poorer risk level to apply for or continue insurance to a greater extent than individuals with average or better-than-average expectations of loss.

Advisory organization: Also known as a *rating bureau*. A cooperative rate-making body. Insurance companies provide these organizations with loss statistics, the raw material used to produce rates.

Examples: the Insurance Service Office (ISO), American Association of Insurance Services and the National Council on Compensation Insurance. There are no rating bureaus in the life insurance field. However, the voluntary Society of Actuaries meets and exchanges information with the goal of improved premium determination. (Vaughn 82, 672)

Affiliated health care provider: Health care providers that contract with a named insurer to supply services to insured patients according to the insurer's standards.

Affiliation Period: The period of time an HMO may require an enrollee to wait before he or she may receive benefits and during which time no premiums may be charged. HMOs that have such a waiting period may not disallow coverage for preexisting conditions.

Agent: Insurance sales agents and brokers help individuals, families, and businesses select insurance policies that provide the best protection for their lives, health, and property. Sales agents may work exclusively for one company or as "independent agents" selling for several companies. Insurance brokers represent several companies and place insurance policies for their clients with the company that offers the best rate and coverage. Agents and brokers must be licensed by the Department of Insurance. (DOI publication) See *Broker.*

AHA: American Hospital Association

AHP: Accountable Health Plan. A type of organized health care delivery system in that it relies on a network of physicians, hospitals and other health care providers to provide care for enrollees in competition with other health care systems in a region.

Alien: An insurer formed under the laws of another country.

Allied health personnel: Health care workers, licensed when required, who handle medical tasks that would otherwise be carried out by physicians and who normally are not found in private practice. Also known as paramedical personnel.

Allowable costs/charges: Costs for health services or supplies that are covered under an insurance policy.

All-payer system: A system of standardizing fee for medical. Used most frequently in reference to how hospitals set their rates.

Alternative care: Care provided in place of that administered on an inpatient basis, including outpatient procedures, home health care and skilled nursing facility care. May also be used in connection with nontraditional health care such as that provided by a midwife.

Alternative delivery system: Cost-efficient health care services including skilled and intermediary nursing facilities, hospice programs, and in-home services.

Alternative medicine: Medical methods that employ nontraditional procedures such as acupuncture, chiropractic treatment and homeopathy; and often rely on natural substances and herbal medicines, as well as a holistic (whole body) approach to healing.

AMA: American Medical Association

Ambulatory care benefits: Reimbursement for outpatient medical services.

Ambulatory care facility: A health care facility that provides services ranging from preventive to emergency treatments that do not require an overnight stay at the facility (outpatient basis).

Ambulatory care: Medical service including diagnosis, treatment, surgery, and rehabilitation provided on an outpatient basis.

Ambulatory setting: See *Ambulatory care facility.*

Ambulatory surgery center: A facility that provides surgery services on an inpatient basis.

Ancillary benefits: Benefits provided for services other than basic health care, such as dental, vision, hearing and prescription drug benefits.

Ancillary charge: (1) Charges for preliminary or secondary care related to a major procedure; (2) Additional cost paid by the insured for prescription drugs that cost more than the plan's maximum allowable cost (MAC).

Ancillary services: Health care services supplied by professionals other than primary care physicians.

Annual policy: A policy that is issued to provide coverage for one year.

Any willing provider (AWP): Term used to describe the state requirement that managed care plans must accept any health care provider who agrees to comply with the plan's terms and conditions.

Appeal: An official request by an insured or provider for an insurer to review a decision in order to resolve a disagreement in a mutually acceptable way.

Arbitration/ADR (Alternative Dispute Resolution): A form of mediation where an impartial person or panel renders an opinion as to who is responsible for or the extent of a loss.

Assigned payment: Term used in reference to Medicare when a patient authorizes a provider to receive payment for services rendered to the patient. The provider agrees to charge no more than Medicare will fully reimburse.

Assignment of benefits: An insured directing a hospital or doctor to collect health insurance benefits directly from the insured's health carrier. If no assignment of benefits occurs, the insured pays for the medical care up front and is then reimbursed by the insurer.

Assisted living benefits: Benefits that cover the cost of residing in an assisted living facility.

Assisted living facilities: Housing for persons who cannot function on their own and need minimal to extensive support and supervision.

Association: An entity, other than an employer-organized association, that has been organized and is maintained in good faith for purposes other than that of obtaining insurance for its members and that has a constitution and bylaws. (Kentucky Insurance Laws and Regulations, Page 238)

Assurance: Original term for "insurance." Some older insurance establishments in Britain still use "assurance" in their company names. (Flexner, 1976. Page 161)

Attained age: A person's age at his or her last birthday.

AUM - alternative underwriting mechanism: An approved set of underwriting guidelines that insurers in Kentucky can use to determine their GAP compensation for insuring persons with specific high-cost conditions. See *GAP.*

Authorized person: A parent, guardian or other person authorized to act on behalf of an insured with respect to health care decisions.

Average length of stay: The average number of days spent on an inpatient basis in a hospital or other health care facility per admission or discharge. This number is determined by dividing the number of admissions for a period of time into the total number of days in the facility for all admissions occurring during that same period. The ALOS varies and is based on patient age, specific diagnoses or sources of payment.

Average wholesale price: The suggested wholesale price of a drug, frequently used by pharmacies to set prices for prescriptions.

Back to the top

B

Bad faith: An accusation by a policyholder that insurers deliberately attempted to keep from paying a claim.

Balance billing: A method of billing patients whereby they are charged for all costs above the physician rate paid by insurers. The practice is prohibited by many managed care plans. See *Hold harmless.*

Behavioral health care: Treatment for mental and substance abuse disorders.

Benefit level: The extent of services an insured may receive according to the plan in which the person is enrolled.

Benefit package: A list of the benefits provided by a health plan.

Benefit period: Time after deductible has been paid by the insured that benefits are paid. Period is typically a year but can be longer. When the period ends, a new deductible must be met before benefits will begin paying again.

Billed claims: The charges for services rendered submitted by a health care provider to the insurance company.

Binder: A temporary agreement between an insured and insurer that offers insurance coverage until the permanent insurance policy can be put in place. Contingent upon payment of premium.

Birthday rule: For purposes of coordination of benefits, this rule stipulates that, if two parents are carrying insurance coverage for the same dependents, primary coverage is determined based on which parent's birthday falls earlier in the calendar year (regardless of their ages). If both parents have the same birthday, the insurance of the parent who has been covered the longest becomes the primary insurer.

Blanket coverage: Term used when the single face amount of a policy applies to all the coverages in the policy.

Blanket health/blanket contract: A policy insuring all members of a particular insured group that doesn't name individuals or give them separate insurance certificates. Such coverage might be used for an athletic team.

Brand name drug: A patented drug that can only be manufactured and marketed by those holding the patent.

Broker: A representative who handles insurance of various kinds for clients. Brokers are similar to agents but unlike agents, they represent the client who is seeking insurance rather than the company that is selling it. Brokers must be licensed by the Department of Insurance. See *Agent.*

Back to the top

C

C of A/COA – Certificate of Authority: State-issued operating license for an HMO.

CAC: Certified Alcoholism Counselor

Cafeteria plan: Also known as flexible benefit plans. A benefit plan (policy) that allows employees to choose from several life, health, disability, dental, and other insurance plans according to their individual needs.

Calendar year deductible: The amount an insured must pay during a calendar year before benefits will be paid by the insurance policy.

Cancel: To discontinue an insurance policy before its normal expiration date, either by the insured or the company.

Cancellation: An insurance policy is discontinued, by an insured or an insurance company, before the policy would normally expire. Cancellation may be flat, short rate or pro-rata. Flat**:** Cancellation occurring at the policy's start date, with all received premiums returned. Pro-rata: cancellation where the amount of premium returned to the insured is a portion based on how much of the policy's term is left. Short rate: cancellation where the amount of premium returned to the insured is not determined pro-rata which results in the amount being less.

Capitation: A set amount paid to a physician or hospital for each person in an insurance plan regardless of the type of service provided or how often the service is rendered.

Captive insurance company: A company owned entirely or largely by non-insurance organization(s) or business(es) in order to provide insurance coverage to those organizations or businesses.

Captive or exclusive agent: An agent who works entirely or largely for non- insurance organization(s) or business(es) providing insurance coverage to those organizations or businesses.

Carrier: The insurance company that issues a policy; or the company that underwrites a particular risk.

Carryover deductible: A feature that allows covered charges incurred during the last three months of the year to be carried over and counted toward the next year's deductible. See *Carryover deductible credit*.

Carve out: Services separately designed and contracted to an exclusive, independent provider by a managed care plan. (Washington DOI)

Case management: A deliberate method of managing services or treatments for an individual with specific health care needs in an effort to keep costs down and encourage timely intervention to best help the patient.

Catastrophic health care: Health coverage for potentially terminal illnesses and conditions for which treatment may be so long-term and/or costly that it could wipe out a family's or individual's income.

Centers for Medicare & Medicaid Services (CMS): Formerly the Health Care Financing Administration (HCFA). CMS is the federal agency responsible for administering Medicare, Medicaid, State Children's Health Insurance, HIPAA (Health Insurance Portability and Accountability Act), CLIA (Clinical Laboratory Improvement Amendments), and several other health-related programs. CMS includes the Center for Medicare Management; the Center for Beneficiary Choices (Medicare, Medicare Select, Medicare+Choice and Medigap options); and the Center for Medicaid and State Operations (Medicaid, the State Children's Health Insurance Program, insurance regulation functions, survey and certification, and the CLIA). (CMS online) See *CHIP, HIPAA, Medicaid, Medicare.*

Certificate of coverage: A statement given to members of a group policy, spelling out the provisions of their coverage.

Certificate of creditable coverage: Documentation given to insureds upon leaving a health plan or upon request to show evidence that they have or had health coverage under a plan.

Certificate of Insurance: A statement given to members of a group policy, spelling out the provisions of their insurance benefits and related provisions.

Certificate of need/CON: Documentation given by the government to an organization or person intending to build, modify or augment a health care facility assuring that the new facilities will address the needs of the people for whom they were proposed. In Kentucky the process is administered by the Certficate of Need Office in the Cabinet for Health Services.

Certification: The process of evaluating or acknowledging by a government or nongovernment agency a person's professional level or expertise in a particular field.

Certified length of stay: The time a patient is permitted to stay in a hospital for inpatient care.

CHAMPUS: The government's health insurance program for members of the seven U.S. uniformed military services similar to a civilian Health Maintenance Organization (HMO) that provides the lowest out-of-pocket cost, in return for requiring enrollees to use only network doctors, hospitals and other health care providers. Also known as TRICARE.

CHIP -- Children's Health Insurance Program: A program established by Congress in 1997 to provide health insurance coverage for low-income uninsured children. CHIP was the largest single expansion of health coverage for children in more than 30 years. In Kentucky KCHIP is administered by the Cabinet for Health Services. See *KCHIP – Kentucky Children's Health Program*.

Church plan: A plan established and maintained for employees or their beneficiaries by a church or by a convention or association of churches that are tax exempt under the federal Internal Revenue Code

Claim form: The document that is completed and submitted to an insurance company to recover a loss or request reimbursement.

Claim: Notice to an insurance company made by an insured or other individual or entity when payments to recover for a loss are due under the policy's terms. (2) In health insurance, information a provider or insured person submits to an insurance company to request reimbursement for medical services provided to the insured.

Claimant: The person making a claim against an insurance company.

Claims administrator: Person employed by the insurance company who processes a claim and/or assures the claim meets policy criteria.

Claims examiners: Professionals who work for life and health insurance carriers and investigate questionable claims or those exceeding a designated amount. (DOI publication)

Clean claim: Properly completed claims from health-care providers. (DOI publication)

Closed access: See *Closed panel*.

Closed panel: A health care plan that requires insureds to choose a primary care physician from a network list of providers and funnel all health care needs through that physician, seeking referrals to specialists or other network providers when appropriate.

COB – coordination of benefits: A health insurance policy provision relevant when an insured is covered under more than one health plan. It stipulates that benefit payments be coordinated among all plans to prevent duplication of benefits.

COBRA – Consolidated Omnibus Budget Reconciliation Act: This federal law ensures that individuals who work for an employer of 20 or more people may, for a limited time, maintain their health insurance coverage through their employers even after their employment ends. See COBRA on the Free Publications page.

Coding: A method of classifying and describing medical services.

Coinsurance: Arrangement allowing the insurer and the insured to share in degrees payment for losses covered by a policy after the insured meets the deductible.

Coinsurance: The amount you are required to pay for medical care in a fee-for-service plan after you have met your deductible. The coinsurance rate is usually expressed as a percentage. For example, if the insurance company pays 80 percent of the claim, you pay 20 percent. (Agency for Health Care Policy and Research)

Commission: The part of an insurance premium paid to an agent by the insurer in exchange for marketing and servicing the insurance.

Community rating: A method of setting up the premium rate for health insurance based on the average of real or projected services used by all policyholders in one geographic area, with no variance for different groups' claims experience, age, sex, occupation or health status. See also *Modified community ating*.

Comorbidity: A pre-existing condition that will most likely extend the stay for a patient admitted to the hospital for another condition.

Complaint: A formal grievance filed against an insurance company, agent or other licensee.

Composite rate: A premium billed to all members of a subscriber group whether they are enrolled for single or family coverage.

Comprehensive medical care: A wide-ranging package of benefits for health care services including prevention, early detection and early treatment.

Concurrent certification: An ongoing evaluation of inpatient care during a patient's hospital stay to confirm the need for continued care.

Concurrent drug evaluation: A review of a patient's list of prescribed medications, made while the patient is still on the medication, to avoid potentially dangerous or ill-advised combinations of drugs and to determine if all prescribed drugs are on the health plan's list of covered drugs.

Concurrent review: The method used to certify the appropriateness of hospital admissions, level of care, and length of stay for elective or emergency treatment.

Conditionally renewable: The insurer has the option of canceling all policies of that type or not renewing in particular areas. (Breuel, Page 193) See *Guaranteed renewable, Noncancelable and guaranteed renewable,* and *Optionally renewable.*

Confinement: Also called house confinement. A health insurance policy condition requiring that an insured be confined to his or her home in order to collect loss of income benefits.

Consumer Price Index (CPI): A measure of the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services. (U.S. Bureau of Labor Statistics online) See *Cost-of-living index.*

Continuation coverage: Health insurance coverage paid for by an insured who has experienced a qualifying event under COBRA.

Continuation: Term used to refer to coverage under a health care plan that carries on after a qualifying event under COBRA. See COBRA.

Continued stay review (CSR): A review by a utilization review committee to determine whether it is appropriate and necessary for a patient to remain in the hospital.

Continuity of care: Method of outlining a patient's care through a planned program so that he or she will receive an ongoing variety of appropriate services.

Continuous coverage: Extension of group health coverage for a limited period, paid for by an insured who has become ineligible for the group plan due to a qualifying event. See *Creditable Coverage* and *Qualifying event*.

Continuous service: The time of service an employee has put in without a break in salary, including periods of absence with pay or for military service.

Contract year: The period that begins on a contract's effective date and runs to the expiration date of the contract.

Contributory program: A benefit or insurance plan under which the employee is required to pay part of the cost either for participating or for increased benefits.

Conversion: In Kentucky, the insured's right to convert his or her policy to an individual policy with substantially similar benefits upon leaving a group health plan. Kentucky law stipulates minimum benefit requirements for conversion policies. Such policies may cost more than the group policy.

Convertible deductible: When the initial premium for a policy is less than the manual premium and the insured must pay the difference between them in order to receive payment after a loss.

Coordination of Benefits: A system to eliminate duplication of benefits when you are covered under more than one group plan. Benefits under the two plans usually are limited to no more than 100 percent of the claim. (AHCPR)

Copayment: Another way of sharing medical costs. You pay a flat fee every time you receive a medical service (for example, $5 for every visit to the doctor). The insurance company pays the rest. (AHCPR)

Core benefits: The principal coverages a health care plan offers; may be supplemented by other benefits such as dental.

Cosmetic procedures: Medical procedures that are not necessary for a patient's physical or mental health.

Cost sharing: System under which plan members share the cost of health services with employers. Co-pays and deductibles are an example of cost sharing systems.

Coverage denial: The insurer contends that a service, treatment, drug or device is not covered by the person's health benefit plan and sends the covered person a notice of coverage denial.

Coverage: The range of protection provided by an insurance policy, or the risks covered by a policy.

Covered employee: An employee who meets eligibility requirements and for whom premium payments are paid for benefits of the employer's group plan.

Covered expenses: Health care costs accrued by insureds for which their insurer will pay benefits under a health insurance policy.

Covered Expenses: Most insurance plans, whether they are fee-for-service, HMOs, or PPOs, do not pay for all services. Some may not pay for prescription drugs. Others may not pay for mental health care. Covered services are those medical procedures the insurer agrees to pay for. They are listed in the policy. (AHCPR)

Covered person: A person covered by a health benefit plan.

Covered service: (1) a benefit provided under a plan; (2) period of employment during which an employee is covered under a plan.

CPT: Current Procedural Terminology used by a physician.

Credentialing: Acquiring and evaluating the professional qualifications of providers.

Creditable coverage: Health insurance coverage from one of the following types of plans: a group health plan; an individual health plan; Medicare; Medicaid; CHAMPUS (health coverage for military personnel, retirees, and dependents); the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps; or a state health insurance high risk pool. See *Continuous coverage* and *Certificate of creditable coverage*.

Critical care: Medical care provided to extremely ill patients undergoing a medical emergency.

Custodial care: Nonskilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in and out of bed or chair, moving around, and using the bathroom. It may also include care that most people do themselves, like using eye drops. (CMS online glossary)

Customary charge: See *Usual, customary and reasonable charge*.

Back to the top

D

Date of service: The day on which a provider service is administered to an insured.

Day health care centers – Centers providing organized health care services during specified daytime hours, that may include continuous supervision to assure that health care needs are being met, supervision of self-administration of medications, and provision of nursing services, personal care services, self-care training, and social and recreational activities for individuals of all ages. A center that provides health care services must be licensed by the state Cabinet for Health Services. (Cabinet for Health Services)

DCI – See *Dual coverage inquiry*.

Declination: Term used to describe the rejection of an application for insurance by an underwriter.

Deductible period: In long-term care insurance, the number of days you must be in a nursing home or the number of home care visits you must receive before the policy benefits begin. Also known as the elimination period.

Deductible: The amount of covered expenses that must be incurred before benefits become payable under an insurance policy.

Demutualization: Process by which a mutual insurance company (owned by policyholders) is converted to a public company owned by shareholders. See *Mutual insurance company*.

Denial letter: Written refusal to provide coverage for a specific procedure or risk.

Dependent: A person, usually a spouse or child, who relies on someone else for financial support.

Designated mental health provider: A person or organization whose function is to provide mental health services to individuals covered by a specific health plan.

DHHS: Department of Health and Human Services

Disability benefit: The payment made on a regular basis, usually monthly, to the beneficiary of a disability income policy.

Disability income insurance: Insurance that provides a regular payment to compensate for income lost due to the insured's inability to work because of illness or injury.

Disability management: A multi faceted approach for minimizing the effects of injury, disease or disability on employees' ability to perform their jobs that pools the efforts of employers, employees, insurance carriers, health care providers and rehabilitation professionals.

Disability: A physical or mental impairment that restricts an individual's ability to work or perform major life activities.

Disallowance: The denial by a health insurance plan for payment of part or all of a health insurance claim.

Disappearing deductible: A graduated benefit plan where the deductible amount increases as the amount of loss increases.

Discharge planning: A hospital-based program focused on providing needed continuing or follow-up care for patients upon their discharge from the hospital.

Disclaimer: A declaration that holds the person making the statement unaccountable for the accuracy of information presented.

Disclosure: The obligation to make certain information available; for a benefit plan, the administrator's obligation to give plan participants materials such as financial reports or summary plan descriptions.

Discounted fee-for-service: A method of fee-setting used by managed care plans under which physicians are paid a predetermined percentage of their normal fees.

Disease management: Comprehensive approach to treatment of expensive chronic diseases that relies on integration of methods and early intervention while aiming to control costs.

Disenrollment: The voluntary or involuntary termination of an employee's health care coverage.

Distribution: Payment made to a plan participant or beneficiary based on profits, interest or dividends earned through investments.

DOB: Date of birth.

DOI – Department of Insurance: The state agency that is responsible for overseeing the business of insurance and all its subcategories in Kentucky.

DOL: Department of Labor

Domestic: An insurer formed under the laws of Kentucky.

Downcoding: The act of changing a benefits code to a less complex and/or less expensive procedure than was actually reported to the third party payer by the service provider.

Dread disease policy: A type of health insurance that offers limited coverage for treatment of specific named diseases, such as cancer.

Drug formulary: See *Formulary.*

Drug utilization review (DUR): A procedure for supervising use of prescriptions by insureds in order to avoid potential dangerous interactions with other medications and/ or find other effective or more cost-effective therapies.

Dual coverage inquiry (DCI): A query by one insurance company or plan to another to find out if an insured has other coverage for the purpose of coordination of benefits.

Due care/due diligence: Assurance by the agent that the recommended insurance plan for the client is suitable for that client's specific needs. This assurance is derived from a careful analysis by the agent of the insurance company's financial strength, the accuracy of the policy illustrations, and the treatment of its previous and current policyowners. (Rubin, page 135)

Duplication of benefits: A situation that occurs when an insured has identical or overlapping coverage under two or more health insurance plans.

Durable medical equipment (DME): Permanent medical equipment, such as a wheel chair or hospital-style bed, that is used repeatedly and can only be used for a medical condition.

DX: Diagnosis Code

Back to the top

E

EAP – employee assistance program: A health service support program that helps identify and work out a variety of personal employee problems that might interfere with an employee's job performance, such as substance abuse, marital trouble or family-related tension. The programs may also offer information on wellness and prevention.

ECP: Electronic Claims Processing; electronic processing for medical billing and posting of payments.

Effective date: The date a policy's coverage goes into effect.

Eligibility date: The date when an individual becomes eligible for benefits under a policy.

Eligibility period: A period of time during which a member of a group covered under a policy may enroll in the plan without providing evidence of insurability.

Eligible dependent: A dependent of an insured who is eligible for benefits under a policy.

Eligible employees: A member of an employee group who is eligible to enroll in a group health or life insurance plan.

Eligible expenses: Expenses due to losses that are covered by an insurance policy.

Elimination period: Also known as the deductible period. In long-term care insurance, the number of days you must be in a nursing home or the number of home care visits you must receive before the policy benefits begin.

Emergency medical services: Medical services provided to patients with serious illness or injury arising from an accident or in a sudden manner.

Emergency/emergency medical condition: A serious injury or illness that occurs suddenly and requires immediate medical care to preserve the life or health of the patient.

Employee benefit plan: A plan set-up by an employer or employee organization in order to provide employees with specific benefits such as health insurance, a pension, profit-sharing, or disability insurance.

Employee contributions: The portion that an employee pays into a plan.

Employee Retirement Income Security Act – See *ERISA.*

Employee welfare benefit plan: A benefit plan run by an employer or employee organization for the purpose of providing benefits other than pension-related to employees and their families. May provide health-related benefits, benefits for disability, disease or unemployment, or day care and scholarship benefits, among others.

Employer contribution: The portion that an employer pays into a plan on behalf of the employee and which the employee becomes eligible to receive according to the plan's guidelines once the employee is vested.

Employer coverage mandate: A directive requiring employers to offer employees health insurance or other types of benefits.

Employer's Liability Insurance (EPLI or EPL): Coverage for an employer's liability for bodily injury to employees that occurs within their employment when such liability is not covered by workers' compensation.

Enrollee: An individual who enrolls in an insurance plan.

Enrollment period: The period of time when a member of a group covered by an insurance plan may enroll in the plan. Most employers allow employees to enroll in a health plan when they are first hired as well as allowing other employees to enroll during a particular time of the year.

EOB – explanation of benefits: See *Explanation of benefits*.

EOI – evidence of insurability: See *Evidence of insurability*.

EPO – exclusive provider organization: A more limiting kind of Preferred Provider Organization (PPO) similar to an HMO, that supplies care to insureds through network health care providers only, with some exceptions for emergencies or out-of-area incidents. (Note: In Kentucky, **EPO** also stands for a noninsurance term: emergency protective order.)

ERISA – Employee Retirement Income Security Act of 1974, Public Law 93-406: A federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans. (U.S. Department of Labor online.) Employer self-funded health benefit plans were authorized under ERISA. The law is administered by the Department of Labor. See *Employer self-funded plan*.

Evidence of insurability: A declaration of a person's physical condition and/or other information that would affect his or her ability to obtain insurance.

Excess benefit plan: A nonqualified employee benefit plan implemented by an employer to provide benefits beyond what the employer's qualified plan is able to provide, according to IRS tax law.

Excess contribution: Amount contributed to a plan beyond that amount which is currently tax deductible; may be carried over to another year and deducted at that time, in keeping with deduction limits.

Exclusion: A condition or circumstance for which a policy will not pay.

Exclusions: Specific conditions or circumstances for which the policy will not provide benefits. (AHCPR)

Exclusive agency system: A system wherein agents represent only one insurer or a group of related insurers and do not own the policy records.

Expense constant: A dollar amount added to the premium charged for a class of policies to cover the cost of issuing and servicing them

Experience rating: Method used to determine a group's premium rate, based on the group's risk as established by its experience.

Expiration date: The date an insurance policy terminates, or stops providing coverage for the insured.

Explanation of benefits (EOB): A statement an insurance company sends to insureds which lists the services to be provided, billing amounts for those services, eligible expenses and the corresponding payments that the company will make.

Extended benefits: Comprehensive benefits furnished over and above a basic health care package; (2) coverage extension for a limited period after membership is terminated; (3) Extension of unemployment benefits.

Extended care facility (ECF): A facility providing health care, such as skilled nursing or convalescent services, for patients who no longer need hospitalization.

Extension of benefits: Benefits that are continued beyond the point where the insured has exhausted his benefits.

External review: Review of a health insurance denial by an independent review entity not associated with the insurer. See *IRE/independent review entity*.

Back to the top

F

Family deductible: A deductible reached by combining qualified expenses of all members of a covered family.

Family practice: Practice that focuses on providing general health care services for the whole family without specializing in one area of medicine.

Federally eligible: A status that affords people certain protections when purchasing individual health coverage. Such standing is achieved once an individual has had 18 months of continuous creditable health coverage, has used up any COBRA or state continuation coverage available to him or her; is not eligible for Medicare or Medicaid and has no other health insurance. Federal eligibility must be applied for within 63 days of an individual's losing his or her previous creditable coverage. See *Creditable coverage* and *COBRA*.

Fee maximum: The highest amount a health insurance program will pay for a specific health care service.

Fee schedule: A list of fees for medical services indicating the maximum amount the insurance program will pay

Fee-for-service/FFS: A traditional insurance plan allowing an individual to go to the doctor of his or her choice and then submit the claim. FFS plans are becoming rare. (DOI publication) See *Managed care.*

FFS: See *Fee-for service.*

Fiduciary liability insurance: Coverage for people and entities who serve as a fiduciary under the provisions of the ERISA. See *ERISA.*

File & Use (rating): The practice of allowing an insurer to implement new rates upon filing them with the insurance commissioner, without having to wait for approval.

Flexible compensation: Benefits provided by an employer that may include health and life insurance and vacation benefits, and which are selected by an employee.

Flexible spending accounts (FSA): A program that allows employees to set aside a portion of their salary before taxes are deducted and spend that money on certain tax-sheltered benefits, such as health insurance deductibles or child care.

FMLA (Family Medical Leave Act): The federal law passed in 1993 that requires employers with more than five employees to allow each employee up to 12 weeks of leave during any year for personal illness, birth or adoption of a child, or illness of a spouse, child or parent. The employer does not have to pay the employee's salary during such leave, but must continue to pay health insurance premiums.

Foreign: An insurer formed under the laws of another state.

Formulary: A list of medications for which a health insurance plan will cover the cost without prior approval. See *Drug formulary.*

401(h) account: An account under a pension plan set up to fund medical benefits for retirees and their dependents.

401(h) plan: A pension or annuity plan provision that pays benefits for health-related expenses for retirees and their dependents.

Fraternal benefit society: Any incorporated not-for-profit society, order, or supreme lodge, without capital stock, which provides insurance benefits. (For a more detailed definition, see Kentucky Insurance Code, Subtitle 29: Fraternal Benefit Societies.)

Freestanding ambulatory facility: Facility that provides outpatient surgery and/or dialysis, but has no capacity for providing inpatient care.

Freestanding emergency medical center: Facility providing treatment for emergency or minor injuries that is open on weekends and in the evenings. Usually less expensive than hospital emergency care.

Freestanding outpatient surgical center (surgi-center): Facility that provides outpatient surgery but has no capacity for providing inpatient care.

Fully Insured Group Health Plan: A health insurance plan purchased by an employer from an insurance company. In contrast with Self-Insured Group Health Plans. See *Self-funded, self insurance.*

Back to the top

G

Gag clause: Also called a gag rule. A provision in some contracts between health plans and physicians that prohibits or restricts the physicians from criticizing the health plan, discussing financial arrangements or providing patients with information concerning services or procedures for which the plan does not provide coverage.

GAP - Guaranteed Acceptance Program: A program for Kentucky residents that assures people with high-cost health conditions have access to individual health plans. An individual may qualify for GAP either by having one of the specified medical conditions or by failing to meet the insurer's underwriting guidelines. GAP program was closed to new enrollees on Jan. 1, 2001. See *AUM.*

Gatekeeper: A covered person's primary care provider in a gatekeeper system.

Gatekeeper system: System of administration used by any health benefit plan in which a primary care provider furnishes basic patient care and coordinates diagnostic testing, indicated treatment, and specialty referral.

Generic drugs/generic equivalent drugs: Drugs that are considered identical in terms of therapeutic ability to their brand name counterpart. They contain the exact types and amounts of ingredients.

Generic substitution: The distribution of a generic drug in place of the brand name counterpart. Each state has its own guidelines for drug substitution.

Genetic counseling: A medical service that provides people with information about the likelihood of their children having genetic diseases, defects or conditions.

Genetic information: Information about an individual's family history or genetic test results indicating the risk of developing a health condition. Such information may not be used by insurers to determine a person's access to coverage unless the person has actually been diagnosed with the health condition by a physician. Moreover, individual health plans and fully insured group health plans cannot change rates based on a genetic test for a condition when symptoms do not exist in the person.

GLBA: Gramm-Leach-Bliley Act; a statute that sets out requirements for protecting the privacy of the non-public personal information of consumers, and requires that federal and state agencies named as functional regulators must implement the act's consumer privacy requirements.

Good faith: Integrity in action during a transaction.

Governmental plan: An employee benefit plan maintained or established by the government of the United States, or any of its subdivisions.

Grace period: The period of time after a premium payment is due but wherein the policyholder may still make the payment, and the policy continues in force.

Graduated benefits: An employee benefit plan wherein an employee's contributions are determined by how long he or she has worked for the employer. Employees with more seniority pay less for their benefits than do newer employees.

Grievance: A formal complaint.

Grievance procedure: A prescribed process for resolving complaints.

Group certificate: An insurance coverage summary provided to participants in an employee benefit plan. See *Certificate of insurance*.

Group contract: An insurance contract that covers all members of a specified group.

Group health plan: A health insurance contract that covers all members of a specified group numbering at least 2.

Group model HMO: An HMO that pays a contracted fee to a multispecialty health care group in return for providing services to the HMO's members. The health care group may also serve non-HMO members.

Group plan: An insurance plan that covers all members of a specified group

Group practice: A group of health care professionals who provide service as a coordinated entity, usually sharing facilities, support staff and other resources needed to provide services.

Guaranteed benefit policy: A policy or contract that provides benefits of a guaranteed amount, stipulated in the policy by the insurer.

Guaranteed renewability: A consumer protection requiring insurers to renew all health plans except in cases of non-payment of premiums, fraud or misrepresentation, non-compliance with the plan's provisions, or if the insurer stops doing business in Kentucky. Guaranteed renewability ensures that a policy cannot be canceled due to the insured's becoming ill.

Guaranteed renewable: A term used to describe a policy that allows the insured the right to continue the coverage in force as long as he or she pays the premium. The insurance company may not make any change to the policy's provisions or riders while the insurance is in force. The company cannot decline to renew the policy, and may revise premiums only on a class basis.

Guaranteed renewable: The policyowner has a contractual right to renew the policy, but the insurer may increase the premiums on all like policies as a class. (Breuel, Page 193) See *Noncancelable and guaranteed renewable, Conditionally renewable,* and *Optionally renewable.*

Guaranty association: Also called a guaranty fund or insolvency fund. Guaranty associations are established by states to pay claims made against a bankrupt company. The money comes from contributions by companies operating in the particular state. The Kentucky Life and Health Insurance Guaranty Association covers life and health insurance, annuities, and supplemental contracts with some exceptions. Policies written by HMOs don't have guaranty fund protection but most are covered by a "hold harmless" provision. See *Hold harmless provision.*

Back to the top

H

Hazard: A situation that may instigate or raise the risk of loss.

HBP: High blood pressure; hypertension.

HCFA – Health Care Financing Administration: As of July 1, 2001, the Health Care Financing Administration (HCFA) is the Centers for Medicare & Medicaid Services (CMS). See *Centers for Medicare & Medicaid Services.*

HCFA 1500: Form used by providers for billing professional fees to Medicare.

Health alliances or regional alliances: A cooperative that purchases health insurance from accountable health plans for consumers and provides them with information regarding the quality of care and services provided by, the cost of and consumer satisfaction with various health insurance plans.

Health benefits package: A plan that pays benefits to cover the cost of various health care services outlined in the package.

Health care provider: Professional licensed individual or facility that offers health services. Hospitals, doctors, pharmacist, physical therapists and nurses are all examples of health care providers.

Health insurance or health plan: Coverage that protects the insured from medical expenses arising from sickness or accidental injury, not including insurance that is specifically limited to accident or disability coverage, workers' compensation, liability coverage (including automobile insurance) for medical expenses, coverage for on-site medical clinics or for limited dental or vision benefits when these are provided under a separate policy.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) : Federal law designed to help people buy and keep health insurance, even when they have serious illness or medical conditions. Protections under this law may vary from state to state according to modifications made at that level. Also known as the Kassebaum-Kennedy Act.

Health maintenance organization/HMO: An HMO charges a predetermined monthly premium for health care provided through a network of doctors, hospitals and other medical professionals that the insured must use in order to be covered under the plan.

Health plan year: The period during which health plan coverage is in effect. Health plan years may begin on January 1or in a different month.

Health status: A person's physical and mental medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

HEDIS/health plan employer data and information set: A fundamental set of measurement materials to help employers and other people who purchase health care plans understand how to evaluate health care plans for quality and value.

HHA -- home health agency: A program that is authorized by state and federal guidelines to provide health care services in the home.

HHS: Department of Health and Human Services

HIAA: Health Insurance Association of America

High cost: Label applied to people whose annual claims amounts exceed the norm.

High risk pools: A state-operated program for helping people with extensive current or expected health care needs obtain insurance. See *Kentucky Access.*

High risk: In health care, an adjective applied to people with extensive current or expected health care needs.

HIPAA: See *Health Insurance Portability and Accountability Act of 1996*

HMO (Health Maintenance Organization): Prepaid health plans. You pay a monthly premium and the HMO covers your doctors' visits, hospital stays, emergency care, surgery, checkups, lab tests, x-rays, and therapy. You must use the doctors and hospitals designated by the HMO. (AHCPR)

HMO: See *health maintenance organization.*

Hold harmless clause: Kentucky law requires all managed care contracts to contain a hold harmless clause that prohibits "balance billing" individuals for money owed by the managed care plan. Individuals are responsible for co-payments, coinsurance and deductibles. But they are not liable for claims the health care provider cannot collect from the plan.

Home health care: Care received in a person's home. Such care may include part-time skilled nursing care, speech, physical or occupational therapies, part-time services of a home health aide or part-time help from homemakers or chore-workers.

Home health services: Medical materials and services provided by a home health agency to a patient at home.

Hospice care: Type of care focused on providing pain relief, symptom management and supportive services to terminally ill patients and their families.

Hospice: An agency that provides medical care and support services to terminally ill persons and their families.

Hospital benefit plan: A plan that pays benefits to cover the cost of various hospital services outlined in the package.

Hospital indemnity policy: A form of health insurance that provides compensation on a preset daily, weekly, or monthly basis during a hospital stay. It pays a set amount regardless of the actual cost of the hospital stay.

Human risk management: A health service that focuses on providing pro-active treatment for individuals' medical or behavioral health risks before they reach a crisis stage.

Back to the top

I

ICD-9 Codes: A directory of codes (International Classification of Diseases) used by physicians for reporting their diagnoses to a health care plan.

ICD-9-CM: A directory of codes (International Classification of Diseases) used by physicians for reporting their diagnoses to a health care plan.

ICF – intermediate care facility: A facility that provides care for persons in stable condition who require daily, but not 24-hour nursing supervision. Such care is supervised by registered nurses or licensed practical nurses and ordered by a physician. Intermediate care is less specialized and requires fewer procedures than skilled nursing care. It often involves more personal care and is generally needed for a longer period of time.

Illegal dealing in premiums: A prohibited practice in which a person willfully collects money as a premium or charge for insurance which is not then provided.

Illegal inducements: Returns, profits or other incentives offered or promised to an individual as an inducement to purchase insurance.

IME – independent medical evaluation: An examination conducted by a neutral health care provider to resolve a dispute about the nature or seriousness of an illness or injury.

In-area services: Health care received from a participating provider within a health plan's recognized service area.

Indemnity health plan: A plan that reimburses the insured or health care provider for the service rendered. Indemnity plans usually do not require insureds to choose from a provider network for covered care but may have other requirements, such as prior authorization of hospital care or other expensive services.

Independent agent: An agent who markets and services the products of two or more insurance companies for a commission.

Independent contractor: An individual or entity that agrees to perform specific work for someone but who is not subject to supervision by and is not an employee of the person who contracted for the services.

Individual market: Market for health insurance coverage offered to individuals other than in connection with a group health plan. (Kentucky Insurance Laws and Regulations)

Individual plan: An insurance contract made with an individual (policyholder) rather than a group, that covers the individual and, sometimes, members of his or her family.

Inflation benefits: A feature in some long-term care policies that allows the benefit amount to increase each year to offset increases in health care and nursing home costs. Benefit may vary according to individual policies.

Informed consent: Permission or approval given with full understanding of the potential consequences of such action.

Initial eligibility period: A period of time, typically the first 30 days of employment, during which an employee may opt to participate in an employee benefit plan without having to prove insurability (i.e. get a physical exam).

In-network : Health-care facilities or providers that are under contract with a managed care plan and, therefore, whose services will be covered under the plan.

Inpatient: The kind of care a patient receives when he or she stays overnight at a hospital or treatment center.

Insurance code: The statutes and regulations that govern insurance marketing and implementation in a state. In this state it is Kentucky Revised Statute, Chapter 304.

Insurance contract: An insurance policy providing for an agreement between the insurer and the insured that upon the insured's payment of premiums, the insurer will supply coverage for certain losses.

Insurance: A contract whereby one undertakes to pay or indemnify another as to loss from certain specified contingencies or perils called "risks,' or to pay or grant a specified amount or determinable benefit or annuity in connection with ascertainable risk contingencies, or to act as surety. (Kentucky Insurance Laws & Regulations, 2002 edition.)

Insured: An individual or group that is covered by an insurance policy.

Insurer: Every person engaged as principal and as indemnitor, surety, or contractor in the business of entering into contracts of insurance. "Person" includes an individual, insurer, company, association, organization, Lloyd's insurer, society, reciprocal insurer or inter-insurance exchange, partnership, syndicate, business trust or corporation, and every other related legal entity. (Kentucky Insurance Laws & Regulations, 2002 edition.)

Insuring agreement: The section of an insurance contract that declares the insurer's responsibility to pay covered claims, subject to specified conditions and exclusions.

Integrated behavioral health: An arrangement of health and supporting administrative services designed to provide a continuum of behavioral health care.

Integrated deductible: A type of deductible included in some major medical plans that can be paid by the insured under basic medical expense plans.

Integrated delivery system: A group of hospitals, physicians, other health care providers and insurers that unite to offer coordinated, cost-effective health care to a community.

Integrated provider organization: An organization that manages a varied healthcare system, often including one or more hospitals, a large group practice, laboratory support services, and other healthcare organizations; also called integrated service network

Intermediate care: Care needed for persons in stable condition who require daily, but not 24-hour nursing supervision. Such care is supervised by registered nurses or licensed practical nurses and ordered by a physician. Intermediate care is less specialized and requires fewer procedures than skilled nursing care. It often involves more personal care and is generally needed for a longer period of time.

Internal appeal: Review of a health insurance denial by the insurance company. (DOI publication - What You Should Know About Health Insurance Appeals) See *External appeal, IRE/independent review entity.*

Internal Revenue Code (IRC): The federal tax statutes, known as U.S. Code Title 26, many of which have an impact on insurance companies and policies, self-insurance, and employee benefit plans.

IRE/ independent review entity: A health insurance appeal term. Under Kentucky law, an IRE uses health-care professionals and insurance coverage specialists to review decisions and determine if a service is covered or is medically necessary and appropriate. (DOI publication) See *External appeal, Internal appeal.*

ISN – integrated service network: An organization that manages a varied healthcare system, often including one or more hospitals, a large group practice, laboratory support services, and other healthcare organizations; also called integrated provider organization.

Back to the top

J

Jacket: The cover of an insurance policy, often containing general provisions of the policy.

JCAHO: Joint Commission on Accreditation of Healthcare Organizations (JCAHO); a nonprofit accrediting agency for hospitals, mental healthcare, ambulatory care, long-term care services, and health plans and networks

Job lock: The reduction in workers' willingness to quit jobs for fear they will lose health insurance coverage.

Juvenile insurance policy: An insurance policy for children under 16 years old.

Back to the top

K

KCHIP/Kentucky Children's Health Insurance Program -- This program provides health coverage at little or no cost to uninsured children who qualify. KCHIP is administered by the state Cabinet for Health Services. Applications are taken at local Department for Community Based Services (DCBS) offices. For more information, call 1-877-KCHIP-18 or go to the KCHIP Web site http://chs.state.ky.us/kchip/ (KCHIP online)

Kentucky Access: A state-authorized health plan that offers coverage to Kentuckians who find it difficult to obtain health insurance in the individual market. The coverage is not free -- premiums are required. (DOI publication) The toll-free number for Kentucky Access information is 1-866-405-6145. Call this number for an application, enrollment materials, claims information or questions about a Kentucky Access ID card. The Kentucky Access Web Page contains information about eligibility, rates, and benefits, and application forms and other documents can be downloaded from this Web site at http://www.kentuckyaccess.com/index.cfm

Back to the top

L

Lag: The period between when a claim is incurred and when the claim is paid.

Large Group Health Plan: A plan that covers more than 50 employees.

Late Enrollment: Joining a health plan at a time other than the regular enrollment or a special enrollment period. Late enrollees may be subject to a longer preexisting condition exclusion period. See *Special Enrollment Period* and *Exclusion period*.

Legend drug: Any medicinal substance required by the Federal Food, Drug and Cosmetic Act (FDA) to feature a label that reads: "Caution: Federal law prohibits dispensing without a prescription."

Length of stay (LOS): Term used to refer to an insured's time spent in a health care facility.

Level premium: A premium that remains at the same rate throughout the life of a policy.

Liabilities: Accounting term that signifies a company's legal obligations. In regard to insurance companies, refers to what the company expects to pay out in losses covered under policies issued.

Lifetime disability benefit: Insurance coverage that provides disability income for the life of the insured as long as he or she is totally disabled.

Lifetime maximum benefit: The total period that benefits are payable. This may be measured in days or dollar amounts.

Limited liability company (LLC): For health insurers, a way to share risk and equity between hospitals and physician groups, by incorporating so that the entity can be taxed as a partnership, thus providing advantages such as liability protection.

Line: A general class of insurance such as life, property, health or workers compensation. (Rubin, Page 267)

Liquidation: The act of dissolving a company by selling its assets for cash

Living will: Also known as a medical directive or advance directive. A written document that states a person's wishes regarding life-support or other medical treatment in certain circumstances, usually when death is imminent. ('Lectric Law Library online)

Long-term care (LTC): A broad range of maintenance and medical services administered to the chronically ill or disabled lasting for several months or years. Services may be delivered in inpatient facilities (rehabilitation facility, nursing home, mental hospital), or on an outpatient or at-home basis.

Long-term care benefit: Insurance coverage providing for coverage of the cost of long-term care.

Long-term care insurance: Insurance designed to cover the cost of maintenance and medical services administered to the chronically ill or disabled lasting for several months or years. See *Long-term care.*

Long-term disability (LTD): Insurance for employers (group) or individuals that provides a replacement for a reasonable portion of an employee's earned income lost through serious and prolonged illness or disability during his or her career.

Look back: The period of time immediately prior to an insured's enrolling in a health plan that the insurer is permitted to investigate for evidence of preexisting conditions.

Loss of benefits: An employee has a right to his accrued benefits from personal contributions to a plan. However, plans may require forfeiture of vested benefits if the employee dies before retirement.

Loss ratio: An insurance company's estimate of how much money it will pay out in claims compared to how much money it will collect from premiums paid by policyholders.

Back to the top

M

Mail order drug program: Plan in which a managed care organization or pharmacy benefit management company (PBM) mails renewable prescriptions to members. Such programs can help control prescription drug costs.

Major medical insurance: Insurance that offers benefits to cover the expense of major illness and injury, featuring high benefit maximums (up to $250,000) or no limit. After an initial deductible, such insurance pays for the major part of all medical-related charges, and the insured pays the remainder, as coinsurer.

Malpractice: Incorrect care or treatment by a physician, hospital, or other provider of health care.

Managed care: Ways to manage costs, use, and quality of the health care system. All HMOs and PPOs and many fee-for-service plans, have managed care. (AHCPR). See *Health maintenance organization*, *Preferred provider organization*, and *Point of service.*

Mandated benefits: Specific coverage or medical services that a health insurance plan must offer all policyholders.

Mandated providers: Categories of healthcare providers who, by state law, must be included in the coverage offered by any health plan. Such categories vary from state to state, but may include podiatrists, psychologists, optometrists, chiropractors.

Manual rate: The premium rate determined for group insurance coverage based on the company's standard rate tables (underwriting manual).

Master contract: The policy issued to a group policyholder describing the provisions of the group insurance plan. Individuals insured under the policy are issued separate certificates of insurance.

Material modification: A fundamental change to the coverage or conditions of a policy.

Maternity benefits: Health care benefits providing coverage for pregnancy-related services.

Maximum age: The oldest age a person can be and still be covered by a policy; often used in regard to dependents' ages.

Maximum allowable fee schedule/ Maximum fee schedule: Guidelines for reimbursement that establish fee caps or maximums for services delivered by providers.

Maximum benefit: The largest amount that a policy will pay the insured for coverages listed.

Maximum Out-of-Pocket/MOOP: The most money you will be required pay a year for deductibles and coinsurance. It is a stated dollar amount set by the insurance company, in addition to regular premiums. (AHCPR)

Maximum plan limits: Under a health plan, the maximum benefits payable to an insured.

MCO: Managed care organization; a company that offers a health plan that includes a network of providers and utilization review.

Mediation: A type of dispute resolution that avoids litigation. Parties present their cases to a mediator in an informal setting, where upon the mediator tries to persuade the parties to negotiate an agreement.

Medicaid (Title XIX): A joint federal and state public assistance program for persons determined to have medical needs and whose income and resources are insufficient to pay for health care.

Medical expense trend: The rate at which medical expenses increase or decrease.

Medical IRA: See Medical Savings Account.

Medical loss ratio: A calculation determined by finding the difference between total premiums received and total medical expenses paid.

Medical necessity: Evaluative term used when health care services are deemed appropriate and essential to meet the health need in question; in keeping with the diagnosis or condition and delivered in an economical way; and compatible with national medical guidelines for such treatment.

Medical payments insurance: A type of coverage under which the insurer reimburses the insured and others for medical or funeral expenses resulting from bodily injury or accidental death, even if the insured is liable.

Medical practice guidelines: Guiding principles set out by a panel of medical professionals regarding how doctors should proceed in treating various medical conditions, illnesses and disease; used by HMOs and other health insurers to control costs and manage patient care.

Medical savings account (MSA): An individual sets aside money in an MSA that can be used for out-of-pocket medical expenses. Money is carried over at the end of the year and continues to earn interest. Contributions are tax deductible. An MSA is set up in conjunction with a major medical health plan (sometimes called "catastrophic" coverage). (DOI publication - Medical Savings Account Fact Sheet **)**

Medically necessary: A term used in some policies to clarify certain medical needs that must exist in order for benefits to be paid. The definition of medical necessity may vary from policy to policy. Some may rely on your physician's opinion while others may require the insurance provider to make the determination.

Medicare + Choice: Medicare changes enacted by law that allow beneficiaries to choose between original Medicare, HMOs, and other options.

Medicare beneficiary: Individual who is designated by the Social Security Administration as being eligible to receive Medicare benefits.

Medicare Secondary Payer Program: Program that ensures other health and accident insurers pay medical costs for covered beneficiaries before Medicare coverage kicks in.

Medicare supplement policy: See *Medigap policy*.

Medicare: A federal health insurance program that includes limited coverage with specific eligibility requirement for long-term care. Benefits for hospice care, home health care and respite care are also provided by Medicare.

Medigap policy: A private insurance product that makes up the difference between the coverage and compensation that Medicare will provide and what an insured's treatment will actually cost.

Medigap: A term used to describe private insurance that supplements Medicare insurance benefits. See *Medsupp.*

Medsupp: Also called Medigap. Medicare Supplement Policy; a policy that covers Medicare coinsurance, deductible and co-payments for Medicare Parts A and B in addition to other supplemental benefits according to the supplement policy selected.

Member certificate: See *Certificate of coverage*.

Member: Individual who is a participant in a health plan.

Mental health parity – Insurers do not have to offer mental health benefits. But if they do, treatment of mental health conditions must be covered under the same terms and conditions as physical health conditions. Laws dealing with the issue include:

- The Mental Health Parity Act of 1996: **"…**a federal law that may prevent your group health plan from placing annual or lifetime dollar limits on mental health benefits that are lower - less favorable - than annual or lifetime dollar limits for medical and surgical benefits offered under the plan. (Centers for Medicare & Medicaid Services online) For more information go to http://www.cms.hhs.gov/hipaa/hipaa1/content/mhpa.asp
- Kentucky Revised Statute (KRS) 304.17A-661: A state law passed a law in 2000 requiring that health plans issued to groups of more than 50 employees offer similar benefits for physical and mental health.

MEWA: See *Multiple Employer Welfare Arrangement.*

Minimum premium: The lowest premium amount for which an insurance company will issue a policy or will include a particular coverage in a policy.

Misrepresentation: A false, incorrect, improper, or incomplete statement of fact made in the application for a policy.

Modified community rating: A modified community rating as means of determining premiums for a group wherein the rates are allowed to vary according to factors such as age, gender, occupation and place of residence. All people with the same factors are rated the same.

Modified fee-for-service: A health plan system that pays providers on a fee-for-service basis with maximum fees for each procedure.

MOOP: See *Maximum-Out-of-Pocket*.

Morbidity table: Mathematical statistics used by actuaries to show the frequency and duration of disability.

Morbidity: The frequency and severity of sicknesses and accidents among a specified group.

Mortality: (Health insurance) The number of deaths that result from each particular disease or illness.

MSO – management service organization: An organization that supplies administrative and practice management services to a medical group, typically owned by physicians. The MSO owns all the group's business assets, but the clinic assets stay with the medical group.

Multi-employer plan/multiple employer plan: A plan maintained in keeping with a collective bargaining agreement, to which more than one employer contributes. Employees may move from one employer in the group to another without losing benefits, unless they have a break in service which can cancel credits they earned before the break, depending on the plan.

Multiple employer trust (MET): A plan-sponsored trust that unites a number of small, unrelated employers for the purpose of providing group medical insurance.

Multiple employer welfare arrangement (MEWA): A trust arrangement for self-funding a corporate group benefit plan covering medical and dental insurance and pensions. Formerly known as multiple employer trust.

Multiple option plan: A health insurance plan that offers a variety of coverage options, such as an HMO, PPO, and major medical indemnity, from which employees choose one option upon enrollment.

Multiple-line insurance: A policy combining several different lines of insurance coverage.

Mutual insurance company: An insurance company wherein ownership and control is in the hands of the policyholders and some of the company's surplus earnings may return to them as dividends.

Back to the top

N

National Association of Insurance Commissioners/NAIC: Organization created by state insurance commissioners in 1871 to address the need to coordinate regulation of multistate insurers. (NAIC Web site http://www.naic.org/)

National Committee for Quality Assurance/NCQA: An autonomous accrediting body for managed care organizations that attempts to improve their quality and service through review and evaluation of their performance. NCQA is responsible for managing the HEDIS (health plan employer data and information set) project. See *HEDIS.*

National drug code/NDC : Codes assigned to pharmaceuticals by the U.S. Food and Drug Administration upon FDA approval; each drug has a unique code, but there are different codes for different doses and package sizes. The NDC is used by pharmacists and many Medicaid programs for drug reimbursement.

Net premium: The part of the premium sent to the home office by an agent after expenses -- the agent's commission and any applicable taxes – are deducted.

Network model HMO: An HMO that contracts with multiple physician groups, including single or multi-specialty groups, to provide care for members; also known as group model HMO

Newborns' and Mothers' Health Protection Act of 1996: The Newborns' and Mothers' Health Protection Act (NMHPA) of 1996 offers various protections for mothers and newborns, including provisions requiring that any HMO or other group health plan that provides coverage for hospital stays for childbirth must cover the cost for a minimum stay (48 hours, for both mother and child, for vaginal delivery; 96 hours for a cesarean delivery.)

Nonadmitted: An insurance company not licensed to do business in a particular state.

Noncancelable and guaranteed renewable: The policy cannot be canceled by the insurance company and the premium cannot be raised. (Breuel, Page 193) See Conditionally renewable, Guaranteed renewable, and Optionally renewable.

Noncancellable Policy: A policy that guarantees you can receive insurance, as long as you pay the premium. It is also called a guaranteed renewable policy. (AHCPR)

Noncompliance period: Under COBRA, the period of time that starts on the date a violation first occurs. This is used to figure the penalty excise tax placed on employers who violate COBRA rules. See *COBRA.*

Non-contributory: Employee benefit plan wherein the employer assumes the total cost of the benefits for the employees. All employees must be insured under the plan.

Nondiscrimination rule: A requirement prohibiting group health insurers from denying or restricting coverage or charging higher premiums to certain individuals because of their health status. Coverage may be restricted because of other factors unrelated to health, such as part-time employment status.

Non-par: See *Non-participating provider*.

Non-participating provider/non-par: A healthcare provider who has not contracted with the health plan to be a participating provider, but who may still be eligible for reimbursement under a separate arrangement. PPO health plans will not reimburse members for part or total cost of services received from non-pars. See *Preferred provider organization.*

Nonprofit insurers: An insurer that provides medical expense coverage without the aim of gaining a profit and who is, therefore, usually exempt from most insurer taxes.

Non-renewal: Term to describe what happens when an insurer elects not to renew someone's policy.

Nursing care facility: In Kentucky, skilled and intermediate care now go by one name, *nursing facility care*. By law such care must be covered in all long-term care policies.

Nursing home: A licensed facility, typically operated for profit, that provides skilled nursing care and related services but is not a skilled nursing facility, as defined under Medicare guidelines.

Back to the top

O

Occupational disease: A disease or health condition acquired on the job. Most states now cover such conditions under Workers Compensation.

Office visit: Visit made to a health care provider in an office location.

Older Workers Benefit Protection Act: A law passed to ensure that employers provide older workers benefits equal to younger employees, unless the cost of providing the benefits is greater for the older worker.

OOA: See O*ut-of-area.*

OOP: See *Out of pocket costs/expenses.*

Open access/OA: Also called *open panel*. A managed care plan that allows members to see specialists in the plan without a referral from a primary care physician.

Open enrollment period: A period of time when employees may change or sign up for insurance plans offered by their employer.

Open panel : See *open access*.

Open-ended HMO: See *Point-of-service plan.*

Optional rider: A voluntary attachment to a policy that modifies it by adding or excluding various coverage.

Optionally renewable: On the anniversary date of the contract, the insurer has the right to decide whether or not to renew. (Barron's, Page 333) See *Conditionally renewable, Guaranteed renewable,* and *Noncancelable and guaranteed renewable.*

Organized delivery systems: See Integrated Healthcare System.

Orphan drug: A product that treats a rare disease affecting fewer than 200,000 Americans.

OSHA: Occupational Safety and Health Act -- a federal law that sets national standards for health and safety in the workplace.

Out of network: Refers to treatment received from a provider who is not under contract to the health plan (non-par).

Out-of-area (OOA) benefits: Coverage for treatment received outside the service area of the network to which the covered person belongs.

Out-of-pocket (OOP) costs, expenses: What the insured must pay as his or her portion of covered expenses.

Out-of-pocket limit: The most an insured can expect to pay for covered expenses. The insurance plan will pay the rest of the cost for specific covered expenses.

Outpatient services: Medical and other services, such as physical therapy, X-ray and laboratory tests, that are performed by a hospital or other facility, but which do not require an overnight stay in the hospital.

Outpatient: Treatment received at a doctor's office or clinic, or at a hospital without spending the night.

Over-the-counter (OTC) drugs: Drugs that do not require a prescription and are usually not covered by a health plan.

Overinsurance: When an individual covered under one or more plans can recoup total benefits or reimbursement that goes beyond his or her medical expenses.

Back to the top

P

Package policy: An insurance policy that includes two or more types of coverage under a single contract.

Paid claims: The dollar value of all claims paid during the plan year. This figure is used to measure a plan's performance.

Par Provider: Participating provider; a provider who is a member of the insurer's provider network.

Parity (Rule): The stipulation that an employee loses pension rights if she or he has a break in service from employment that exceeds the greater of five years or the length of time worked.

Partial disability: Any condition, resulting from illness or injury, that keeps an insured from performing one or more occupation-related activities.

Partial hospitalization services: Services intended as an alternative to inpatient psychiatric care, which are expected to improve or maintain an individual's condition and ability to function and to avert relapse or hospitalization.

Participating provider: A health care professional or facility that has contracted with the health plan to provide medical services to insured individuals under terms and conditions set forth by the plan.

Participation requirements: Stipulation in most pension and employee benefit plans that requires the member to wait a certain period of time before she or he is eligible to participate in the plan, or "vested."

Payer: The organization or individual, usually the government or an employer, who pays for healthcare; sometimes can refer to the insurer or health plan because they pay claims and reimburse providers.

PBM/Pharmacy Benefit Administrator: Most insurance companies hire a PBM to process prescription drug claims. These PBMs then contract with pharmacies and create networks of providers to serve their members.

PCP: See *Primary care physician*

Peer review: An evaluation of the quality of healthcare performed by medical personnel with training equivalent to the personnel providing the healthcare and being reviewed.

Pension and Welfare Benefits Administration (PWBA): The Pension and Welfare Benefits Administration administers and enforces the fiduciary, reporting and disclosure provisions of the Employee Retirement Income Security Act (ERISA). See *ERISA.*

Per diem rate: A type of lump sum – or bundled fee – reimbursement that pays hospitals a set amount per patient for each day of hospitalization, regardless of diagnosis or the number of services provided. This method is used by Medicaid and many managed care organizations.

Perils: A condition or occurrence that results in a loss covered by a policy.

Period of confinement: The first day benefits are paid for inpatient long-term care to the day benefits end.

Permanent disability: An employee's inability to work at any job, not just the job held at the time the employee was disabled. Such disability is usually covered by insurance for employees who are disabled before they are 60.

Personal care: See *custodial care*.

PHO/physician-hospital organization: An organization formed by a hospital and physicians for the purpose of seeking managed care contracts while offering some autonomy for the physicians in that they preserve ownership of their practices.

Place of service: The facility or location where services were provided.

Plan administrator: The person, usually designated in the plan contract, who controls the contributions to a plan.

Plan delivery rules: A plan's specific procedures that must be followed to obtain maximum benefits for services.

Plan participant: Any employee or member, former or current, of an employer or employee organization, sole proprietor, or partner in a partnership who is currently or may become eligible to receive a benefit of any type from an employee benefit plan, or who has beneficiaries who may be eligible to receive such benefit.

Plan year: The calendar, policy or fiscal year on which a plan operates.

Point-of-service /POS: A POS is similar to an HMO in that the individual selects a primary care physician to manage his or her care and the physician gives referrals to network providers. A POS plan gives the patient the option of seeing a provider outside the network but the plan pays a reduced rate and the individual will have more out-of-pocket expenses. (DOI publication)

Policy limits: The total amount of coverage provided for each area of coverage identified in a policy.

Policy: Written agreement that puts insurance coverage in place. (Rubin, Page 359) Policy derives from the Italian word "polizza," meaning a written contract evidencing a legal obligation. (Vaughn, Page 51) Prior to the use of the word "policy" by English-speaking people, terms for this practice were "bills of surance or assurance." (Raynes, Page 28)

Policyholder: The person who owns an insurance policy, usually the insured person, but it may also be a relative of the insured or a business.

Policyowner: See *policyholder*.

Pool: A group of insurers or reinsurers who share the underwriting of various kinds of risks.

Portability: A consumer protection requiring that a person receives credit for health insurance coverage when changing jobs. If the person was covered for a specified period of time under the previous policy, benefits for a pre-existing condition must continue under the new policy.

PPO/Preferred Provider Organization: A combination of traditional fee-for-service and an HMO. When you use the doctors and hospitals that are part of the PPO, you can have a larger part of your medical bills covered. You can use other doctors, but at a higher cost. (AHCPR)

Practice guidelines: Standardized statements about medical practices and procedures used by physicians to help determine what steps are appropriate to take in administering care to a patient. Commonly used by managed care organizations to determine necessity and appropriateness of care.

Pre-admission certification – PAC: An evaluation of a patient's need for hospitalization, done before the patient is admitted to the hospital.

Pre-authorization: An insurance plan requirement that the insured or the primary care physician notify the insurance company prior to certain medical procedures (like outpatient surgery) in order for such procedures to be covered under the plan.

Pre-emption of state law: Phrase meaning that a federal law supersedes state laws, except where state law is necessary to prevent fraud and abuse, to ensure appropriate state regulation of insurance or health plans, addresses controlled substances, or for other purposes.

Preexisting condition: A health problem that existed before the date your insurance became effective. For Group Health Plans: A physical or mental condition, excluding pregnancy, for which an insured individual sought medical treatment within the six months immediately prior to enrolling in a health plan. Genetic information about an insured's probability of developing a disease or condition, unless there is a diagnosis of that disease or condition, cannot be considered a preexisting condition. Newborns, newly adopted children, and children placed for adoption covered within 30 days are not subject to preexisting condition exclusions. See also *Genetic information*.

Preexisting condition exclusion period: The time during which an insurer will not reimburse for covered care provided for treatment of a preexisting condition.

Preferred Provider Organization: See *PPO.*

Preferred providers: Health care providers who contract with an insurer to provide services to those insured under a specific plan.

Premium: The amount you or your employer pay in exchange for insurance coverage. (AHCPR)

Preventive care: Medical treatment that focuses on avoiding illness or identifying a disease at an early stage and slowing its progress.

Primary care network/PCN: An association of primary care physicians united to share the risk of supplying health care to a group.

Primary care physician/PCP: Usually your first contact for health care. This is often a family physician or internist, but some women use their gynecologist as a PCP. A primary care physician monitors your health and diagnoses and treats minor health problems, and refers you to specialists if another level of care is needed. (AHCPR)

Primary care: Fundamental health care, usually provided by general practitioners, family practice or pediatricians.

Primary coverage: When benefits are coordinated, the coverage that pays first, with no regard to what other insurance coverage may be in effect.

Prior authorization: See *Pre-authorization.*

Private insurance: Voluntary insurance available from a private firm or from the government. This includes *stock insurance companies*, *mutual insurance companies, reciprocals or interinsurance exchanges, Lloyd's associations, health expense associations*, and government insurers (*federal private voluntary* and *state private voluntary insurance*). (Vaughn, Pages 67, 684) See separate entries and *Social insurance*.

PRO/ Professional review organization: An association sponsored by physicians for the purpose of evaluating patient care in light of necessity and appropriateness.

Prompt pay law: Measure passed by the Kentucky General Assembly in 2000 that significantly strengthened the standard for health insurance claims by setting a time frame, defining "clean claim" and establishing interest penalties for late payment. (DOI publication) See *Clean claim*.

Pro-Rata Cancellation: See *cancellation.*

Provider panel: See *Preferred provider; Network*

Provider: Any person (doctor, nurse, dentist) or institution (hospital or clinic) that provides medical care. (AHCPR)

Provider network: An affiliated group of varied health care providers that is established to provide a continuum of healthcare services to individuals. (Kentucky Insurance Laws & Regulations)

Pure premium: The portion of a premium that is used to cover claims and expenses.

Back to the top

Q

Qualified (MEDICARE) beneficiary: A Medicare recipient whose income falls below the federal poverty level, thus making the individual eligible for Part B premiums, deductibles, and co-payments through the state Medicaid program.

Qualified Medicare beneficiary – QMB: An individual who is eligible to receive Medicare Part B benefits, including coverage of premiums, deductibles and co-payments. To be eligible, a person's income must be below the federal poverty line.

Qualifying event: An incident, such as death, termination of employment or divorce, that allows a change in existing coverage.

Back to the top

R

Rate: A unit of cost used to determine an insurance premium.

Rating bureaus: See *Advisory organizations*.

Rating: Method used to determine the premium rate for a group or individual based on characteristics such as age, sex, location, type of work, administrative costs, and other factors.

Reasonable and customary charge: A fee for health services that is both usual and expected or is justified due to the complexity of the insured's problem.

Rebate: An amount of money returned by the prescription drug manufacturer to the payer based on the insured's usage rate or the provider's purchases.

Rebating: Process of returning money from a prescription drug manufacturer to a health plan or pharmacy benefit management company (PBM), once the plan has used a certain volume of drugs.

Referral provider: The health care provider who is seeing a referred patient.

Referral: Approval or consent by a primary care physician for the patient to seek health care through ancillary services or specialists.

Reformation: The act of modifying a policy's terms so that it meets the insurer's and insured's initial intent.

Refund annuity: A kind of annuity for which any excess contributions and interest above the total amount of annuities paid are repaid to a designated beneficiary after the annuitant's death.

Reimbursement: Compensation to cover the cost of a claim for loss or of services received or provided.

Reinsurance : Also called *risk control insurance* or *stop-loss insurance.* A kind of insurance purchased by an insuring entity, such as an HMO, to protect itself from losing too much money from one insured's particularly expensive losses.

Release: (1) A document that acknowledges that the person signing it forfeits specific rights or claims in exchange for a payment of compensation; (2) Document used by insurance adjusters to obtain a claimant's forfeiture of any additional rights to recovery after a claim settlement.

Remittance: A payment.

Renewal: Automatic reestablishment of an insurance policy's in-force status, usually achieved through payment of the premium due. (Barron's, Page 400)

Report card on health care: An account of a health plan's performance, including information about quality, customer approval, efficiency and solvency, that helps policymakers and those who purchase health care make informed decisions.

Representations: Statements of fact made by an applicant seeking to obtain insurance.

Rescission: The act of having a contract voided before it takes affect as a result of fraud or material mispresentation. Rescission may also be brought about by mutual consent of the parties by conduct of parties, or by court decree. (Gifis, Page 420)

Reserves: The actual or possible liability carried by an insurer for covering its responsibility to policyholders.

Residual market : The pool of insurance customers to whom most insurers do not want to sell policies.

Respite care: Short-term care provided to relieve primary care givers.

Restoration of benefits: After some benefits are used, full benefits are restored, as if none of the benefits had been used; usually there are some restrictions to this provision.

Retention: (1) The number of patients that remain with a health plan from one year to the next. (2) The part of the cost of a medical benefit that is kept by the carrier to cover internal costs or to generate profit.

Restricted provider network: A health benefit plan that conditions the payment of benefits, in whole or in part, on the use of the providers that have entered into a contractual arrangement with the insurer to provide health care services to covered individuals. (Kentucky Insurance Laws & Regulations)

Retroactive benefits: Benefits established under a plan (usually in an amendment to the plan) that are paid, according to the plan's benefit formula, to employees for service rendered prior to the amendment.

Return of premium: Some long-term care policies will return a percentage of the premiums paid over the life of the policy if little or no benefits have been used.

Review of coverage denial: An appeals process designed to evaluate an insurer's denial of coverage for an insured.

Rider: An amendment to an insurance policy that covers special conditions not listed in the original policy.

Risk: (1) The insured person (health insurance) or the property for which an insurance policy is written; (2) uncertainty about loss.

Risk classification: The method used by an insurance company to decide how premiums are set according to various risk characteristics, such as age, occupation, health, and then applied them to individuals.

Risk factors: Things that influence a person's health in a potentially negative way. These can be environmental, hereditary, or behavioral.

Risk sharing: A feature of the managed care system requiring managed care plans and their contract providers to share financial risk through methods such as capitation, risk pools, and per diem contracts. See *Capitation.*

Back to the top

S

Schedule: A list of coverages or amounts in regard to persons or things insured.

Scheduled benefits: Benefits paid according to a published schedule in the policy. (Breuel, Page 310)

Scheduled coverage (hospitalization insurance): Insurance that specifies in the policy the amounts to be paid for specific hospital-related expenditures, including surgery and room expenses.

Secondary care: Medical services supplied by specialists who normally do not see patients initially, such as oncologists, neurologists, or cardiologists.

Secondary coverage: When benefits are coordinated, the plan that must cover costs not covered by the insured's primary plan.

Secondary payer: In coordination of benefits, the insurer that is second in line for responsibility of payment.

Section 125 plan: A flexible benefit or cafeteria plan.

Self-administered plan: A health plan administered by self-insured employers.

Self-insured plan: A group health insurance plan in which the sponsoring organization assumes the financial risk of paying for covered services provided to its enrollees. (Kentucky Insurance Laws & Regulations)

Self-referral: An option offered by some HMOs that allows members to refer themselves to a specialist without a referral from the patient's primary care physician.

Service area: The territory serviced by a health plan, as determined by the state and as proclaimed in the certification of authority.

Short rate: See *short term*.

Short term: Policies issued for a period of less than 12 months.

Short-rate cancellation: The termination of a policy before the expiration date at the insured's request.

Short-term disability: A disability not lasting longer than six months.

Single-payer system: Government-funded health care using tax dollars. Often referred to as socialized medicine when done on a national level, but is also done on the local or state level.

Skilled care: Care needed for medical conditions that require care by skilled medical personnel such as registered nurses or professional therapists. This care is available 24 hours per day, is ordered by a physician, and usually involves a treatment plan. Some people need skilled care for only a short time after an acute illness, while others require such care for longer periods. A few who receive such care remain at home with help from visiting nurses. This is the only level of care that may be paid by Medicare.

Skilled nursing facility – SNF: An inpatient facility other than a hospital that provides skilled nursing care, physical and occupational rehabilitation, and custodial care. Usually not used to treat mental illness.

Small Group Health Plan: A plan with at least two but not more than 50 employees.

SMI: Supplemental medical insurance

Social insurance: Programs (like Medicare or unemployment compensation insurance) that pool risks by transfer to an organization, usually governmental, that is required by law to provide benefits under certain conditions. This insurance differs from public assistance or welfare because contributions are made by or behalf of the insured and benefits are a statutory right and not based on "need." (Commission on Insurance Terminology definition quoted by Vaughn Page 57, 61) See *Private insurance.*

Solvency: Financial stability; the capacity an organization or entity has to cover its debt.

Special Enrollment Period: A time prompted by particular events during which employees must be allowed to enroll in a group health plan. Employers and group health insurers must initiate such enrollment periods when an employee's family status or health insurance status changes. These periods must last at least 30 days. See also *Late Enrollment*.

Special risk (health insurance): Policy issued on an individual basis that offers higher than normal health coverage for atypical circumstances, in additional to basic health coverage.

Specialist: A physician whose medical expertise is focused in one area, such as internal medicine, dermatology or neurology.

Specified disease insurance: Insurance that pays benefits only for the treatment of a specific disease, such as cancer, stated in the policy. These policies usually have a waiting period before benefits begin and some do not pay for separate treatment or other conditions or diseases caused by the specified disease. See *Dread disease policy.*

Staff model HMO: A health care system that pays physicians and other providers a salary to supply health care services to its members.

Stand-alone plan: A separate insurance plan that provides coverage for a specified risk or potential expense, such as prescription drugs.

Standard benefit package: A group of basic health coverages offered by an insurance plan, such as hospital and physician care, prescription drugs, substance abuse and preventive health care.

Standardized plan: A qualified model plan created to meet various tax qualification requirements spelled out in IRS guidelines.

State Continuation Coverage: A Kentucky program designed to ensure extended health coverage for people not covered by COBRA. Persons leaving employment with a business that employs only two – 19 people are able to retain coverage through their employer for up to 18 months by paying the premium.

Stock insurance company: Company is owned by stockholders who invest in the company's stock. Profits are shared with the stockholders. (Breuel, Page 310)

Stop loss: Provision in an insurance policy, especially a major medical policy, that limits the amount of expenses an insured must pay. (Breuel, Page 310)

Stop-loss insurance: Insurance designed to cover an insurer or self-insured employer for losses above a predetermined amount. Policies may cover insured for specific or individual losses, or for aggregate losses.

Subscriber : The individual responsible for paying the premiums or whose employment gains him or her membership in the health plan.

Subscriber contract: A written description of an insured's health care policy. Sometimes called a subscriber certificate or member certificate.

Subsidiary (company): A entity whose voting stock is owned in majority by a parent company.

Summary plan description: An explanation of a plan's benefit package required to be given to those insured under self-funded plans.

Supplemental major medical coverage: Services in addition to a major medical plan's basic coverage that an insured may elect to receive, sometimes for additional cost.

Supplemental services: Services in addition to a plan's basic coverage that an insured may elect to receive, sometimes for additional cost.

Surgi-center: A facility that provides surgery services on an inpatient basis.

Back to the top

T

Termination date: The expiration date for a group insurance policy or the date an insured becomes ineligible for coverage.

Tertiary care: Health care services requiring highly complex technology and facilities and which are provided by specialized providers. An intensive care unit is an example of tertiary care.

Therapeutic alternatives: Drugs that are chemically different from their counterparts but that offer similar effects when used in the same dosage.

Therapeutic substitution: Exchanging one therapeutic alternative for another, with the approval of a the attending physician

Third party: A person or entity not a party to a contract but with ties to the business therein.

Third-party administrator/TPA: An entity that administers an insurance contract for a self-insured group but that does not pay the claims. The self-insured group pays its own claims.

Third-party payer: Any payer for health care services other than you. This can be an insurance company, an HMO, a PPO, or the federal government. (AHCPR)

Total disability: A disability that prevents an insured person from performing duties essential to his or her regular job. However, a policy's definition of total disability may change after a specified period of time, usually two years. People are defined as being totally disabled, therefore, only if their disabilities stop them from working at any job for which they are reasonably prepared by education, training, or experience.

TPA: See *Third-party administrator.*

24-hour coverage: An employee plan provision that connects group health insurance and workers' compensation insurance in a single program so that employees are covered regardless of where or when an injury or illness occurs.

Back to the top

U

UB 82: See *Uniform Billing Code of 1992*.

Unbundled services: Services that would usually be grouped together but which are provided as separate units.

Unbundling: Packaging as separate units items that might normally be packaged together; (1) In life insurance, the act of specifying in the insurance policy the mortality, investment, and expense factors used to determine the policy's premium rates and cash values; (2) in health insurance, the act of billing separately for services that would normally be billed as one service, or providing separate pricing and administrative support for additional services such as prescription drug benefits or substance abuse services.

Underwriter: Most underwriters work for insurance companies. They identify and calculate the risk of loss from policyholders, establish appropriate premium rates, and write policies that cover these risks. The term "underwriter" comes from the early days of insurance when an individual willing to assume a risk would actually "underwrite" or sign his name under the proposal. (DOI publication)

Underwriting profit or loss: Money that an insurer earns or loses in its underwriting operations, as opposed to money earned or lost in investments.

Underwriting: The process of reviewing insurance applications or obtaining physician statements and other medical information to determine if the insurance company will issue a policy.

Unearned premium: The amount of premium for coverage for the unexpired part of the policy period, which remains after deducting the earned premium from written premium.

Unfair Claims : The deceptive or otherwise state-prohibited handling of insurance claims by an insurer. Such practices may include knowingly misrepresenting policy provisions, excessively slow processing of a claim or forcing claimants to litigate to receive complete compensation for their losses.

Uniform Billing Code of 1992 (UB-92): A federal edict mandating that all hospitals follow explicit procedures for billing and itemizing invoices. This is the revised version of UB-82.

Upcoding: A dishonest practice whereby a health care provider reports service codes to an insurance provider at their highest value when in fact the services actually rendered cost much less.

UR/Utilization review: A method by which employers and insurers oversee the suitability, necessity, and quality of health-care services for the purposes of controlling costs.

Urgent care center: An ambulatory care center that provides minor emergency medical care – such as for treatment of cuts or bruises – at a cheaper rate than an emergency room

Usual, customary and reasonable (UCR) fees : The dollar amount a health insurance plan will reimburse for the cost of a particular medical procedure, usually determined by what is considered "reasonable" for that procedure in the service area.

Utilization management (UM): A process that combines review and case management of medical services through the cooperative efforts of patients, providers, employers and insurers.

Utilization review (UR): A method by which employers and insurers oversee the suitability, necessity, and quality of health-care services for the purposes of controlling costs.

Utilization: The frequency with which members of an insured group use a particular service or type of procedure over a specified period of time.

Back to the top

V

VEBA: See *Voluntary employees' beneficiary association.*

Vest; vesting: The act of becoming eligible to receive benefits from a plan. Usually there is a time period attached to the eligibility.

Vested benefits: A benefit plan that entitles the participant to receive benefits if the participant leaves the plan, as used in relation to used pension and employee benefits. The participant must remain in the plan a certain number of years before the benefits are “vested.” See *Vest, vesting.*

Voluntary employees' beneficiary association/VEBA: Serves as the foundation for an employer-sponsored employee benefit plan, which pays death, health, accident or other benefits to employee member and their families.

Voucher program: An employer-sponsored program in which employees submit monthly vouchers to the employer for covering all or part of the cost of dependents’ health care expenses.

Back to the top

W

Waiting Period: (1) A prescribed period of time stated in the insurance policy that must pass before some or all coverage begins. (2) In disability income insurance, a period of time beginning with the onset of the disability during which benefits are not payable. Sometimes referred to as the elimination or probationary period. (3) For group insurance, the length of time new members must wait before they are eligible to join the plan. Also referred to as a probationary period. Not all employers or health insurance plans require a waiting period.

Waive: To stipulate in a contract that one party voluntarily abandons a particular right or benefit.

Waiver of premium: A term used when premiums are no longer required to be paid after a specified period of time while benefits are being received.

Waiver: A stipulation in a contract that one party voluntarily abandons a particular right or benefit.

Warranty: A provision in a policy that some declaration in the policy must be true.

Wellness program: A program initiated by an employer or insurer to maintain and/or improve the health of employees/insureds by focusing on healthy habits and preventive measures.

Workers compensation: Government-mandated insurance that pays benefits to employees and their dependents in the case of the employee's job-related injury, disease, or death.

Wrap-around coverage or combination coverage : See *point-of-service plan.*

Written premium: The total amount of premiums written by an insurer during a specified period of time, including both earned and unearned premiums.

Back to the top

Y

Yearly renewable term: Designates a term policy written for one year of coverage that is renewable every year without requiring the policyholder to provide evidence of insurability.

Back to the top

Works cited

AHCPR, Agency for Health Care Policy and Research, *Checkup on Health Insurance Choices*. AHCPR Publication No. 93-0018, December 1992., Rockville, MD. http://www.ahrq.gov/consumer/insuranc.htm Accessed Nov. 6, 2002.

A.M. Best online. Retrieved July 30, 2002. http://www.ambest.com/

American Academy of Osteopathy online. Retrieved on Aug. 13, 2002. http://www.academyofosteopathy.org/

American Pharmaceutical Association online. Retrieved Aug. 21, 2002. http://www.aphanet.org/

Anderson, Dan R., "Insurance," in World Book, 1991 ed.

Breuel, Brian H. *The Complete Idiot's Guide to Buying Insurance and Annuities*, Alpha Books, New York, 1996.

Cabinet for Health Services (CHS).

CMS online. Retrieved Aug. 14, 2002. http://www.cms.hhs.gov/

CMS online glossary. Medicare and Medicaid glossary http://cms.hhs.gov/glossary/ Accessed Nov. 12, 2002 (Centers for Medicare & Medicaid Services)

Cunningham, Robert III and Robert Jr. *The Blues: A History of the Blue Cross and Blue Shield System*, Northern Illinois University Press, Dekalb, Ill., 1997.

Department of Labor online. http://www.dol.gov/ Accessed June 3, 2003.

Flexner, Stuart Berg *I Hear America Talking,* Van Nostrand Reinhold Co., New York, 1976. Flexner, Stuart Berg *Listening to America,* Simon and Schuster, New York, 1982.

Gifis, Steven H. , *Dictionary of Legal Terms*, Third Edition, Barron's Educational Series, Hauppauge, N.Y., 1998.

Hungelmann, Jack *Insurance for Dummies*, IDG Books, Foster City, Calif., 2001.

KCHIP (Kentucky Children's Health Insurance Program) online. Retrieved August 2002.

Kentucky Department of Insurance, Consumer publications.

Kentucky Fair Plan online. Access July 2002. http://www.kyfairplan.com/

Kentucky Insurance Laws & Regulations, 2000 edition.

'Lectric Law Library online. Retrieved Aug. 16, 2002. http://www.lectlaw.com/def/l050.htm

National Flood Insurance Program online. Retrieved July 30, 2002. http://www.fema.gov/fema/csb.shtm

Raynes, Harold E. *A History of British Insurance*, Sir Isaac Pitman & Sons, LTD, 1948.

Rubin, Harvey W, Ph.D., CLU, CPCU, *Dictionary of Insurance Terms*, Third Edition, Barron's Business Guides, Hauppauge, N.Y., 1995.

South Carolina Department of Insurance online.

U.S. Bureau of Labor Statistics online. Retrieved Aug. 12, 2002. http://www.bls.gov/cpi/home.htm - overview

Vaughan, Emmett J. and Therese M. Vaughan, *Fundamentals of Risk and Insurance*, eighth edition, John Wiley & Sons, Inc., New York, 1999.

Washington State Department of Insurance online, *A Consumer's Insurance Glossary: A Compendium of Words and Phrases Insurance People Use (But the Rest of Us Don't Really Understand)* Retrieved July 31, 2002. http://www.insurance.wa.gov/glossary.htm Site no longer available.

Back to the top