Facets 5.7

EUT.FOV.100: Facets Overview

Job Aid

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| Glossary of Health Care Terms |

**A**

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| Accreditation | An official authorization of approval of a program against a set of industry standards. |
| Accumulation Period | The period during which the covered expenses an insured incurs accumulate toward fulfilling the plan deductible. The accumulation period of a deductible is usually the calendar year (January 1 to December 31). The amount of time allowed for the insured to accumulate the number of days of care needed to satisfy an elimination period. For example, under a long-term care policy, an insured may have to receive long-term care services for 20 days in order to fulfill the elimination period. These 20 days may not have to be consecutive; they may be cumulative. The insured might have an accumulation period of 100 days over which she can accumulate the 20 days. |
| Adverse Selection | In situations where individuals have the option of purchasing health coverage or not (as in contributory or voluntary group plans or in individual insurance), those who are more likely to become ill, either because they are older or because they are less healthy than average, are more likely to choose coverage. This is known as adverse selection. If adverse selection occurs, the covered group is not fully representative of the population at large, but rather has a higher level of claims than average. Consequently, underwriters’ predictions of claims, if they are based on statistical averages, will be lower than actual claims and premiums, and since they are based on those predictions, may be too low to pay for claims. |
| Alternative delivery systems | A catch-all phrase used to cover all forms of health care delivery except traditional fee-for-service, private practice. The term includes **HMOs, PPOs, IPAs**, and other systems of providing health care. |
| Ancillary Services | Services, other than those provided by a physician or hospital, related to a patient’s care. This includes services such as laboratory work, x-rays and anesthesia. |
| Anniversary Date | The beginning of an employer group benefit year. |

**B**

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| Beneficiary | A person who receives the benefits of a policy, program, or financial instrument. The beneficiary of a life insurance policy is the person or party designated by the insured to receive the death benefit of the policy. Medicare beneficiary is someone enrolled in the Medicare program and eligible to receive benefits from it. The beneficiary of a trust is the person who derives financial benefits from the assets of the trust, such as periodic distributions of income or assets. |
| Benefit | An amount of money paid by an insurer to an insured to compensate for a loss the insured has incurred that is covered by the policy. In some cases a benefit may be paid to the insured’s beneficiary (as when the death benefit of a life insurance policy is paid to a survivor) or her assignee (as when the cost of covered health care services is paid directly to the provider of the services). |
| Benefit component | An element of a health plan that defines a specific feature of the plan. For example, the set of administrative information used by the plan is a benefit component in Facets. |
| Benefit component prefix | A code that uniquely identifies different benefit components of the same type. For example, **administrative rules** is a benefit component. If there are several different sets of administrative rules, then they are all benefit components, but they are each uniquely identified by a benefit prefix in Facets. |

**C**

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| Cafeteria Plan | A predominantly historical term referring to Group Arrangements under which employees may choose from a menu of benefit options, and if properly qualified according to IRS provisions, may offer tax-advantaged options. Typically the plans involve an employer funded Defined Contribution with employees funding the excess cost of benefits selected. Cafeteria plans often include benefits outside the scope of health care. (See **Flexible Benefit Plan**) |
| Calendar Year | The period beginning January 1 of any year through December 31 of the same year. |
| Capitation | In the strictest sense, a stipulated dollar amount established to cover the cost of health care services delivered for a person. The term usually refers to a negotiated per capita rate to be paid periodically, usually expressed in units of **PMPM** (per member per month) to a health care provider. The provider is responsible for delivering or arranging for the delivery of all health services required by the covered person under the condition of the provider contract. |
| Capitation allocation | The process of moving capitation amounts into a fund used to pay service providers. This amount is determined by the number of eligible members multiplied by a specific fund rate. The allocated amount may be paid each month to the capitated provider organization or used as an accrual and distributed on a periodic basis. |
| Capitation period | The estimated period of time during which provider payment is made on behalf of the eligible members. Normally this period is defined as the first of the month through the end of the month. |
| Case Management | A process whereby a covered person with specific health care needs is identified and a plan which efficiently utilizes health care resources is designed and implemented to achieve the optimum patient outcome in the most cost-effective manner. |
| CDHC | Consumer-driven health care. A health plan design that combines financial incentives with information about cost and quality to help consumers make better informed decisions about their health care. One common design for consumer choice plans involves a high deductible health insurance policy, a tax-exempt health spending account that can be used to pay for qualified health care expenses (see **health reimbursement arrangement** and **health savings account**), and a gap between the deductible and the maximum allowable annual contribution to the account. (That is, after the member spent everything in the account, he has to pay expenses out of pocket until he has satisfied the deductible.) |
| Certificate of Coverage | A document given to an insured that describes the benefits, limitations and exclusions of coverage provided by an insurance company. |
| Claim | Information submitted by a **provider** or **covered person** to establish that medical services were provided to a covered person, from which processing for payment to the provider or covered person is made. The term generally refers to the liability for health care services received by covered persons. |
| COB | See **Coordination of Benefits**. |
| COBRA | Consolidated Omnibus Budget Reconciliation Act. A portion of this act requires employers to offer the opportunity for terminated employees to purchase continuation of health care coverage under the group’s medical plan. Also see **conversion**. Another portion eases a Medicare recipient’s ability to unenroll from an HMO or CMP (Care Management Plan) with a Medicare risk contract. |
| Coinsurance | The portion of covered health care costs for which the covered person has a financial responsibility, usually a fixed percentage. Coinsurance usually applies after the insured meets his/her deductible. |
| Commissions | The portion of **premiums** or equivalent premium for **self-funded** groups paid to an insurance agent, sales representative, or broker as compensation for services provided. Commissions are considered part of administrative expenses. |

**D**

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| Deductible | The amount of eligible expenses a covered person must pay each year from his/her own pocket before the plan makes payment for eligible **benefits**. |
| Deductible Carry Over Credit | Charges applied to the **deductible** for services during the last 3 months of a calendar year that may be used to satisfy the following year’s **deductible**. |
| Dependent | A covered person who relies on another person for support or obtains health coverage through a spouse, parent or grandparent who is the covered person under a plan. The covered member is referred to as the **subscriber** in Facets. All covered subscribers and their dependents are referred to as **members** in Facets. |
| Disease Management | Approach to health care that proactively identifies populations suffering from, or at risk for, certain medical conditions and works to prevent and control those conditions by means of on-going management of care. Disease management programs typically provide patient assessment, education, counseling, and compliance monitoring. They are designed to improve clinical outcomes and health-related quality of life while optimizing the use of medical resources. |

**E**

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| Effective Date | The date insurance coverage begins. |
| Eligible Dependent | A dependent of a covered person (spouse, child, or other dependent) who meets all requirements specified in the contract to qualify for coverage and for whom premium payment is made. |
| Eligible Expenses | The lower of the reasonable and customary charges or the agreed upon health services fee for health services and supplies covered under a health plan. |
| Eligibility date | The defined date a **covered person**becomes eligible for benefits under an existing **contract***.* |
| Emergency | The sudden, and unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s health in serious jeopardy. |
| Employer Funded | Employee benefits that are paid for by the employer, in the form of insurance premium payments, saving or spending account funds, or other applicable items. |
| Entity | A person or organization that has a relationship with a person or organization that contracts with a managed care organization. For example, a claims payor is an entity for an employer group if the claims payor processes claims for the group. A malpractice insurance carrier is an entity (or carrier) for a practitioner and/or a facility. An insurance carrier for a member who has other insurance coverage is also an entity. |
| EOB | See **Explanation of Benefits**. |
| Explanation of Benefits (EOB) | The statement sent to a **member** by a health insurance company listing services provided, amount billed, eligible expenses and payment made by the health insurance company. |
| Exclusions | Specific conditions or instances for which the health plan does not pay for and provide a covered benefit. |
| Experience rating | The method of setting premium rates based on the actual health care costs of a group or groups. |
| Extension of benefits | A provision of many insurers’ policies which allows medical coverage to continue past the termination date of the policy for employees not actively at work and for dependents hospitalized on that date. Such extended coverage usually applies only to the specific medical condition which has caused the disability and continues only until the employee returns to work or the dependent leaves the hospital. Not as common since the implementation of **COBRA** regulations. |

**F**

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| Family Deductible | Aggregate deductible. A deductible that applies to an entire family. The amount of a family deductible is generally set at two, two-and-a-half, or three times the standard deductible, but it can be satisfied by expenses incurred by any member of the family, and once satisfied, it is satisfied for all family members. |
| Fee-for-service equivalency | A quantitative measure of the difference between the amount a physician and/or other provider receives from an alternative reimbursement system, e.g., **capitation** compared with **fee-for-service reimbursement**. |
| Fee-for-service reimbursement | The traditional health care payment system under which physicians and other providers receive a pre-defined payment that does not exceed their billed charge for each unit of service provided. |
| Fee maximum | The maximum amount a **participating provider** may be paid for a specific health care service provided to a plan **member**under a specific **contract*.*** Sometimes called a fee max. |
| Fee schedule | A comprehensive listing of **fee maximums** used to reimburse a physician and/or other provider on a **fee-for-service** basis. |
| FFS | Fee-For-Service. *See* **fee-for-service reimbursement***.* |
| Flexible Benefit Plan | Cafeteria plan. Historically, employers that provided their employees with group insurance chose one policy for each type of insurance (life, medical expense, disability, etc.), and all employees had the same coverage. This has changed with the introduction of flexible benefit plans; arrangements whereby employers can offer their employees a selection of insurance options. The individual employee can choose whether she wants a particular coverage (for example, whether she wants long-term care insurance). The member can also usually choose between different plans of the same type (for example, two or three medical expense plans). Often, the employer provides each employee with a specific number of credits that can be applied to the combination of benefits chosen. If the employee wants more benefits than those covered by the credits, she may pay for the additional benefits by means of a pretax salary deduction. |
| Formulary | A list of drugs developed by an insurer that provides additional coverage or a lower copay. There may be many drugs available for a particular medical condition, and the most expensive drug is not necessarily the most effective.  **Formularies** encourage the utilization of the most effective and cost efficient drugs.   * Some plans have a closed **formulary**, which generally means that payment is limited to the drugs listed unless preauthorized by the insurer. * Other plans have an open **formulary**, which means that even drugs that are not listed are or may be covered. * In some open **formularies**, called incentive **formularies**, unlisted drugs are covered, but the benefit amount is less and/or the copayment is a way to encourage the use of listed drugs. |
| FSA | **Flexible spending arrangement**(flexible spending account). A pre-tax savings account.  FSA accounts are:   * Funded by payroll deductions * Regulated by the Internal Revenue Service * Designed to pay for medical expenses not reimbursed by health insurance and dependent childcare expenses. * Account funds are (generally) held by a third party administrator   To make a withdrawal against the account balance, the employee must submit proof of an eligible expense. |

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| Generic Drug and Brand-Name Drug | * A brand-name drug carries the name given to it by the original manufacturer, who retains the exclusive right to sell the drug for a certain period. * After that period has expired, the formula of the drug must be released and other manufacturers are free to develop a version of it known as a generic drug. * The generic drug has the same active ingredients as the original brand-name drug, but it may use different inactive ingredients (such as fillers) that affect the color or shape of the drug. * In other respects, the generic drug is clinically identical to the brand-name drug. * Every drug developed has an assigned generic name, which consists of the drug’s active ingredient. * A generic drug usually costs 30 to 60 percent less than the corresponding brand-name drug * Generic versions are available for approximately half of all prescription drugs. * Insurers and health plans encourage greater use of generic drugs where available in order to cut costs. * The most common way of encouraging greater use of generic drugs is to provide a greater benefit for generics. * Drug formularies are used to encourage physicians to prescribe generics. |
| Grace period | A set number of days past the due date of a **premium**payment during which medical coverage may not be canceled.   * During the grace period the premium payment may be made without coverage cancellation. * This period varies by contract, generally 30, 60, 90 or 120 days. |
| Group | A collection of individuals grouped together for the purpose of treating them as a single entity. The term usually refers to an employer purchasing medical coverage on behalf of its full-time employees. |

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| HCFA | Health Care Financing Administration. The federal agency that oversees all aspects of health financing for **Medicare**, oversees state administration of **Medicaid**, and oversees the Office of Prepaid Health Care Operations and Oversight **(OPHCOO)**. |
| Health Care | This term is used broadly by the general population to refer to all services and activities related to improving and maintaining people’s health. In the health care and insurance fields, however, it is usually defined more narrowly to mean the services provided by health care professionals or facilities. |
| Health Care Provider | A licensed individual or organization that provides health care services (such as physicians, dentists, chiropractors, hospitals, outpatient facilities, etc.). |
| Health Insurance | A range of insurance products that provide benefits when an insured suffers an illness or injury.  The list includes:   * Medical expense insurance, which reimburses for health care costs; * Various supplemental coverages, which pay extra health care benefits not provided by medical expense insurance * Disability income insurance, which replaces lost income if an insured is unable to work because of illness or injury * Long-term care insurance, which pays for nursing home care, home health care, and other services needed by those who are unable to care for themselves for a long period. |
| Health plan | A plan or company that provides health services to **subscribers** and their **dependents** covered by a prepaid program through a **network** of health care **providers**. |
| HIPAA | Health Insurance Portability and Accountability Act of 1996 (HIPAA).   * HIPAA was designed to protect workers and their families seeking health care coverage after changing or losing their jobs. * HIPAA reduces the extent to which a plan or issuer of group health insurance coverage can apply a pre-existing condition exclusion. * Evidence of the individual’s creditable health insurance coverage is contained in the certificate of creditable coverage (COC). * HIPAA has regulated patient privacy rights affecting the way providers and health plans do business. |
| HMO | Health Maintenance Organization.   * An HMO provides, offers, or arranges for coverage of designated health services needed by plan **members** for a fixed, pre-paid **premium**. * There are four basic models of HMOs:   + **Group model**   + **Individual practice association**,   + **Network model**   + **Staff model**. * Under the Federal HMO Act, an entity must have three characteristics to call itself an HMO:   1. An organized system for providing health care or otherwise assuring health care delivery in a geographic area;  2. An agreed-upon set of basic and supplemental health maintenance and treatment services  3. A voluntarily enrolled group of people. |
| HRA | Health Reimbursement Account (arrangement). A tax-exempt account funded and owned by an employer that an insured can draw on to pay health care expenses. Typically, the insured is covered by a health insurance policy with a high deductible, and he or she uses money from the HRA to pay medical expenses not covered by the policy. |
| HSA | Health Savings Account. A tax-exempt trust or custodial account created exclusively to pay for the qualified medical expenses of the account holder and her spouse or dependents. Funds in the HSA are owned by the account holder.  In order to establish an HSA and make tax-deductible contributions into it, the account holder must be covered by a qualified high deductible health plan (HDHP). Funds withdrawn to cover qualified medical expenses are not counted as taxable income, but income taxes and penalties apply if HSA funds are used to cover non-qualified expenses. HSAs are intended to address escalating health care costs by encouraging insured’s to better manage their own medical expenses. They were authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. |
| High Deductible Health Plan | HDHP. This term generally refers to a health benefit plan with a large deductible, but it has a specific meaning in the context of health savings accounts (HSAs).  An HSA:   * Is a policy that meets the requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. * Has a specified deductible (in 2005, $1,000 per person or $2,000 per family) * Has a specified out-of-pocket maximum (in 2005, $5,100 per person or $10,200 per family).   High deductible plans can offer first-dollar coverage of preventive care and still remain qualified. |

**I**

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| Identification card | A card issued by a **carrier***,* **health plan**, or **TPA** to each **covered person**, identifying the person as being eligible to receive coverage for services. |
| Initial eligibility period | The period of time specified in the **contract** during which eligible **subscribers** and their **eligible dependents** may make application for enrollment in the **health plan** without providing evidence of good health satisfactory to the plan as specified in the contract. |
| Insurance | A form of risk management that, for a price, offers the insured an opportunity to share the costs of possible economic loss through an insurer. The essence of insurance is spreading the risk of a hazard. That is, a large number of people facing the same kind of risk share the cost of economic loss. Premiums form a pool of money from which the company draws to pay for the loss incurred by the few members of the group who actually have a loss. Under this arrangement, everyone in the group of insurance purchasers pays for the loss of the few. Since people who actually have loss is a very small fraction of the entire group, the premium that the individual pays is very small compared with the amount he or she would lose as the result of a loss. |
| Insured | A person who has obtained health insurance coverage under a health insurance plan. In Facets, referred to as the subscriber. |
| IPA model HMO | Individual Physicians Association. A health care model that contracts with an Individual Physicians Association entity to provide health care services in return for a negotiated fee. The Individual Physician Association in turn contracts with physicians who continue in their existing individual or group practices. The Individual Physician Association may compensate the physicians on a per capita, fee schedule, or fee-for-service basis. |

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| Lifetime Maximum | A dollar or service limit imposed under a plan of benefits for a specific benefit or for the entire policy that total cumulative payments or covered services by the plan cannot exceed, over the entire time the policy is in force. |

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| Managed care | A health care system under which physicians, hospitals, and other health care professionals are organized into a group or “network” in order to manage Managed care and coordinate the financing and delivery of health care service to produce high-quality care on a cost-effective basis Managed care organizations include Preferred Provider Organizations (PPOs) and Health Maintenance Organizations (HMOs). |
| Market area | The targeted geographic area or areas of an **HMOs** greatest market potential. The market area does not have to be the same as the defined **service area** for the HMO*.* |
| Medicare | A nationwide, federally-administered health insurance program which covers the cost of hospitalization, medical care, and some related services for eligible persons. Medicare has two parts:   * Part A covers inpatient costs (currently reimbursed prospectively using the DRG system). Medicare pays for pharmaceuticals provided in hospitals, but not for those provided in outpatient settings. Also called Supplementary Medical Insurance Program. * **Part B** covers outpatient costs for Medicare patients including doctor’s office visits, etc. (currently reimbursed retrospectively). |
| Medical Management | The active management of health care services for either patients or populations by means of the coordination of systems and processes among providers, caregivers, utilization review staff, case managers, and others. It promotes patient-focused rather than disease-focused care. |
| Modified fee-for-service | A system in which providers are paid on a **fee-for-service** basis, with certain **fee maximums** for each procedure. |

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| Network | Doctors, hospitals, and other medical providers that are contracted to provide services for a particular plan. PPO members have less out-of-pocket expense when they use network providers. |

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| OOA | Out of Area. A term describing the treatment obtained by a **covered person** outside the HMO’s **service area**. Also see **in-area services**. |
| Out-of-Network Care (OON) | Health care services obtained by **managed** **care** **plan** members from providers unaffiliated with the plan’s network |
| Out-of-Pocket Expenses | Health care expenses that an insured must pay themselves. They include medical expenses not covered by the policy as well as cost-sharing payments such as copayments, coinsurance, and deductibles. |
| Out-of-Pocket Maximum | The total payments that must be paid by a covered person (i.e., deductibles and coinsurance) as defined by the contract. Once this limit is reached, covered health services are paid at 100% for health services received during the rest of that calendar year. |
| Outpatient Medical Care | Non-surgical services provided in a provider’s office, the outpatient department of a hospital or other facility, or the member’s home. |
| Open enrollment period | A period during which **subscribers** in a health benefit program have an opportunity to select an alternate health plan being offered to them, usually without **evidence of insurability** or waiting periods. |
| OPM | Office of Personnel Management. The federal agency that administers the **FEHBP**; the agency with which a managed care plan contracts to provide coverage for federal employees. |

**P**

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| Participating Provider | | A medical **provider** who is contracted to render medical services or supplies to insureds at a pre-negotiated fee. Providers include hospitals, physicians, and other medical facilities. |
| Per diem reimbursement | | Reimbursement of an institution based on a set rate per day rather than on actual charges. Can be varied by service or can be uniform regardless of services rendered. |
| Per member per month | | See **PMPM**. |
| PMPM | | Per Member Per Month. Applies to a revenue or cost for each enrolled member each month. The unit of measure related to each effective member for each month the member was effective. The calculation is: (# of units) (member months). See Capitation. |
| Practitioner | | An individual who contracts with a managed care organization to provide health care services to enrollees of a health plan. A practitioner can be a physician, nurse, or any other individual licensed to practice the health care profession. |
| Pre-existing condition | | Any medical condition that has been diagnosed or treated within a specified period immediately preceding the covered person’s effective date of coverage under the master group contract. |
| Preferred Provider Organization (PPO) | | A managed care organization that contracts with health care providers to deliver services to its members at a discount, in exchange for the volume of patients that the PPO can offer. Members of a PPO have financial incentives to use these contracted providers, but they may receive coverage for care from non-network providers. |
| Premium | | The amount paid (usually monthly) for insurance. |
| Prescription Drugs | | Prescription drugs include:   * Brand name prescription drug: the initial version of a medication developed by a pharmaceutical manufacturer or a version marketed under a pharmaceutical manufacturer’s own registered trade name or trademark. * Legend drug: a medicinal substance, dispensed for outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label, “Caution: Federal law prohibits dispensing without a prescription.” * Formulary: a list of pharmaceutical products developed in consultation with physicians and pharmacists and approved for their quality and cost effectiveness. * Generic prescription drug: drugs determined by the FDA to be bio-equivalent to brand name drugs and that are not manufactured or marketed under a registered trade name or trademark. |
| Preventive Care | | Comprehensive care that emphasizes prevention, early detection and early treatment of conditions through routine physical exams, immunizations and health education. |
| Preventive Health Care | | Health care services intended to prevent a medical condition from occurring, or to detect the onset of a condition early so that it can be more effectively treated. Preventive care includes regular medical check-ups, screening tests, vaccinations, and the encouragement of a healthy lifestyle. Health plans often give members incentivesto make use of preventive care (for instance, they may waive copayments). |
| Primary care | | Basic or general health care traditionally provided by family practice, pediatrics, and internal medicine. *Also see* **secondarycare**, **tertiary care**. |
| Primary coverage | | Under **coordination of benefits** rules, the coverage plan which pays its **eligible expenses**without consideration of any other coverage. |
| Product | | In Facets, a product represents a plan of benefits which is available to and/or selected by a subscriber. |
| Provider | A physician, hospital, group practice, nursing home, pharmacy, or any individual or group of individuals that provides a health care service. | |
| Provider group | A provider group is a set of physicians who usually have individual practices but are joined together under a common contract. One advantage to a physician in joining a provider group is the ability to offer a range of physician services at reduced cost to the contracting organization in exchange for a higher volume of patients than the physician would otherwise treat in a single practice. | |

**R**

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| Rate | The amount of money per enrollment classification paid to a **carrier**for medical coverage. Rates are usually charged on monthly basis. |
| Rating process | The process of evaluating a group or individual to determine a premium rate in regard to the type of risk it presents.  Key components of the rating formula are:   * Age gender factor * Location * Type of industry * Base capitation factor * Plan design * Average family size * Demographics * Administration costs |
| Reasonable and Customary | A term used to refer to the commonly charged or prevailing fees for health services within a geographic area. A fee is generally considered to be reasonable if it falls within the parameters of the average or commonly charged fee for the particular service within that specific community.  Note: Charges within a PPO network are not normally limited to reasonable and customary fees. |
| Reciprocity | An agreement among two or more HMOs whereby a member may receive treatment from another prepaid plan for illness or injuries that cannot be postponed until the member returns to his home service area. |
| Re-enrollment | The number of subscribers currently enrolled plus those who elect to join the HMO during open enrollment less those subscribers who leave the HMO; the net number of subscribers who enroll in the HMO. |
| Referral | The recommendations by a physician and/or health plan for a member to receive care from a different physician or facility. |
| Referral provider | A provider that renders a service to a patient who has been sent to him by a participating provider in the health plan. |
| Renewal | Continuance of coverage under a policy beyond its original term by the acceptance of a premium for a new policy term. |
| Reimbursement | In the context of health insurance, a payment by an insurer to an insured to compensate for an expense the insured has incurred that is covered by the policy, or a payment by an insurer to a health care provider to compensate for a service rendered to an insured that is covered by the insured’s policy. |
| Revenue | The premium/dollars received by the health plan from the employer group(s) for health care and administrative services. |

**S**

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| Secondary coverage | The plan that has the responsibility for payment of any **eligible charges** not covered by the **primary coverage**. Also see **coordination of benefits***.* |
| Self-insured Group | Self-funded group. A large company or union, instead of purchasing coverage for its employees or members from an insurer, may establish its own health insurance program and pay claims out of its own funds. This allows the company to cut out the middleman and improve cash flow, and it also has some tax and regulatory advantages. |
| Service area | The geographic area serviced by the **health plan** as approved by the state regulatory agencies and/or detailed in the **certification of authority**. |

**T**

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| TEFRA | Tax Equity and Fiscal Responsibility Act of 1982. The federal law that created the current risk and cost contract provisions under which health plans contract with the **HCFA** and defined the **primary** and **secondary coverage** responsibilities of the **Medicare** program. |
| Termination date | The date that a group **contract** expires; or, the date that a **subscriber** and/or **member** ceases to be eligible. |
| Tertiary care | Those health care services provided by highly-specialized providers such as neurosurgeons, thoracic surgeons, and intensive care units. These services often require highly-sophisticated technologies and facilities. Also see **primary care**, **secondary care**. |
| Third party payor | A public or private organization that pays for or underwrites coverage for health care expenses or another entity, usually an employer (e.g., Blue Cross, Blue Shield, Medicare, Medicaid, commercial insurers). Also known as **Third Party Administrator*.*** |
| TPA | **Third Party Administrator.**  An independent person or corporate entity (third party) who administers group benefits, claims, and administration for a **self-insured** company/group. A **TPA** does not underwrite the risk. |

**U**

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| Underwriting | A review of prospective and renewing cases for appropriate pricing, risk assessment, and administrative feasibility. |
| Usual and Customary Charge | The amount a plan pays for a particular **procedure** usually based on a prevailing average. |
| Utilization Management | The management of the use of resources in a health care delivery system to ensure the medical necessity, appropriateness, and cost-effectiveness of health care services delivered to patients. Utilization management includes utilization review, but goes beyond it to cover a broad range of activities such as early intervention, prevention, and disease management. |

**W**

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| Well-Child Visit | A physician visit that includes the following components:   * An age-appropriate physical exam * History, anticipatory guidance and education; e.g., examining family functioning and dynamics * Injury prevention counseling, discussing dietary issues, reviewing age-appropriate behaviors, etc. * Assessment of growth and development * For older children, a well-child visit also includes safety and health education counseling. |
| Working aged | Medicare members over the age of 65 who are employed. |