Industry Glossary

Accountable Care Organization (ACO): A type of payment and healthcare delivery model that ties reimbursement of providers to quality metrics to encourage collaboration among participating providers and with the goal to reduce costs and improve the quality of care provided to assigned patients.

Administrative Services Only (ASO) plans: An arrangement where the employer funds the employee benefits of the health plan and a third party handles the administrative tasks like billing and claims processing.

Alternative care: A healing practice that does not fall within traditional medicine, such as acupuncture or massage therapy.

Ambulatory care: Healthcare services provided on an outpatient basis where the patient's procedure and stay in the facility are completed on the same day.

Ancillary coverage: Benefit coverage that complements health plan coverage, such as dental, vision, or life insurance; also referred to as specialty benefits at Blue Shield.

California Public Employees' Retirement System (CalPERS): A system that provides health and retirement benefits for 1.6 million+ public employees, retirees, and their dependents in California.

Coinsurance: A percentage of the cost for covered services that a member pays under the health plan.

Consolidated Omnibus Budget Reconciliation Act (COBRA): A federal law that, among other things, requires an employer to offer continuation coverage to certain employees and their dependents whose eligibility for coverage under the group health plan has terminated.

Consumer-directed health plan (CDHP): The combination of a financial account with a high-deductible health plan, which are sometimes referred to as account-based health plans. The financial accounts, such as health savings accounts (HSAs), health reimbursement accounts (HRAs), and flexible spending accounts (FSAs), are designed to provide consumers with greater control over their health-related expenses.

Copayment (or copay): A fixed dollar amount that a member pays for covered services under the health plan.

Cost-sharing: A financing arrangement through deductibles, coinsurance, or copayments that a member covered by a health plan is responsible for paying when they access covered services.

Covered services: The benefits covered under the health plan, as defined in the *Evidence of Coverage* or policy.

Deductible: The amount that a member pays for most covered services before the health plan pays for covered services.

Effective date: The date that coverage under the health plan takes effect.

Employee Assistance Program (EAP): An employee benefit program offered by an employer that provides individuals with confidential support for help with personal problems that may affect work, health, and well-being.

Evidence of Coverage (EOC): The contract that defines the terms of health plan coverage.

Exchange: An exchange – also known as a health benefit exchange – is authorized under the Accountable Care Act (ACA) and is intended to improve affordability of coverage and to bring organization and transparency to the health coverage marketplace for individuals and small businesses. Exchanges will offer a choice of health plans that meet certain benefits and cost standards. In August 2010, California became the first state to pass legislation to set up an exchange under health reform.

Experience rating: A method of determining health plan pricing based in whole or in part on the specific claims experience of the specific employer group or pool of groups.

Explanation of Benefits (EOB): A statement sent by a health plan to a covered individual explaining what medical treatment and/or services were paid for on their behalf.

First dollar coverage: A health plan feature that provides full coverage for certain health expenses without a deductible paid first.

Flexible Spending Account (FSA): A tax-advantaged account established by an employer that allows employees to set aside a portion of earnings to pay for qualified medical expenses; FSA funds not used by the end of the plan year are lost by the employee.

Fully funded plan: A traditional health plan in which employers and employees pay premiums to an insurer who assumes the financial risk and pays claims according to the policy.

Health Reimbursement Account (HRA): A program funded solely by an employer to reimburse medical expenses paid by participating employees, yielding tax advantages to offset cost for both parties; the employer decides if and how much of the funds are rolled over from year to year.

Health risk assessment: A questionnaire that helps employees assess their health risks and lifestyle habits to guide improvements in health status and quality of life.

Health Savings Account (HSA): A tax-favored savings account that is used in conjunction with an HSA-eligible high-deductible health plan to pay for eligible medical expenses; unlike an FSA, an HSA is owned by the employee and funds can roll over from year to year.

Integrative Care: A holistic approach to health care that combines conventional medicine with alternative healing practices such as acupuncture or massage therapy.

Medical loss ratio (MLR): The percentage of health plan premiums used to pay for members' medical costs and quality of care programs compared with the amount used for administrative expenses or profits. The Affordable Care Act sets minimum medical loss ratios for different markets, as do some state laws.

Out-of-pocket maximum: The total dollar amount that a member can expect to pay for the deductible, copayments, or coinsurance before the health plan provides coverage for certain covered services at 100% for the remainder of the calendar year. Some out-of-pocket costs do not accrue to the out-of-pocket maximum, including amounts above the allowed amount paid to non-participating providers.

Pharmacy Benefit Manager (PBM): A third-party administrator of outpatient prescription drug coverage that typically handles formulary development, claims processing, and pharmacy contracting.

Preferred physician: A physician who is contracted with a carrier to provide medical services to persons covered under the carrier's health plan.

Premium-only plan (POP): A plan that helps reduce an employer and employee's tax liability by allowing for health plan premiums to be paid with pretax money; also known as an IRS Section 125 Cafeteria Plan.

Primary Care Physician: A physician who provides basic or general health care traditionally provided by family practice, pediatrics, and internal medicine. An OB/GYN may also be considered a Primary Care Physician. Under an HMO plan, the Primary Care Physician (also referred to as a Personal Physician by Blue Shield) is the physician that a member selects in an HMO plan to coordinate all covered services under the plan.

Risk adjustment factor (RAF): Under the Small Group Act in California, the percentage adjustment to be applied equally to each standard employee rate for a particular small employer, and which may not be more than 110 percent or less than 90 percent.

Stop-loss insurance: An insurance policy that limits the financial risk of a self-insured plan to a certain amount.

Third-party administrator (TPA): A person or entity licensed or authorized to charge and collect premium, or settle claims in connection with health plan coverage.

Urgent care center: An alternative setting to the physician's office or an emergency room for a health problem that is not life-threatening but needs medical attention right away.

This glossary is provided to help explain some of the most common terms related to health plans and the industry, and is intended for use as a general reference on Employer Connection. This glossary is not intended to replace definitions provided in documents describing Blue Shield plans, including, but not limited to, contracts, agreements, policies, evidences of coverage, and certificates of insurance.