

INSURANCE TERMINOLOGY FOR FAMILIES

Insurance has its own unique vocabulary. The following definitions are commonly used in insurance:

Applicant: Person applying for insurance coverage.

Assignment of Benefits: Written authorization by the insured giving the insurance carrier permission to pay benefits directly to the medical care provider.

Benefit Period: A specific period of time (generally 12 months) during which benefits apply.

Birthday Rule: A rule frequently used in determining primary responsibility for claims payment by insurance plans. When a child is covered by both parents under two separate plans and both plans follow the birthday rule, the primary plan will be the plan of the parent whose birth date falls earlier in the year.

Case Management: A method of managing the provision of health care to members with catastrophic or high cost medical conditions. The goal is to coordinate the care to both improve continuity and quality of care as well as lower costs. Case Management is usually performed by the utilization review department.

Certificate of Coverage: A booklet or statement from the insurance carrier that provides specific information about the plan and provides a summary of coverage.

Civilian Health and Medical Program of the United States (CHAMPUS): The federal program providing health care coverage to families of military personnel, military retirees, certain spouses and dependents of such personnel, and certain others.

Claim: A request for reimbursement from the insurance carrier by the insured (or provider).

Comprehensive Health Insurance Plan (CHIP): A public program of health insurance to certain eligible Illinois residents who have been denied major medical coverage by private insurers due to a preexisting health condition or disability.

Consolidated Omnibus Budget Reconciliation Act (COBRA): A section of COBRA requires an employer to offer the opportunity for terminated employees to purchase continuation of health care coverage under the employer's group plan.

Conversion: The right of an individual to convert from group coverage to an individual policy. This may be offered to individuals who lose their group coverage (e.g., through job loss or death of a working spouse) and are ineligible for coverage under another group contract coverage from the same carrier.

Coinsurance or Co-payment: A set amount of money an insured must pay toward covered medical expenses. It may be a percent of the total covered cost or a dollar amount. For example: under a major medical plan, the coinsurance determined amount may be 20% of the covered medical expenses or may be \$10 for each office visit (applies to HMOs), etc. This is known as a co-payment in the HMO plans.

Coordinated Home Care Program: An organized skilled patient care program initiated by a hospital to facilitate early discharge of a patient with home care. Care may be rendered by a hospital's home health department or other licensed home health agency. Patient must be homebound (e.g., unable to leave home without assistance and requiring supportive devices or special transportation) and must require skilled nursing services on an intermittent basis under physician direction.

Coordination of Benefits (COB): When an individual is covered by more than one medical insurance plan, the payment of claims is coordinated so that the plan designated "primary" pays first.

Coverage: The types and amounts of benefits provided under a health plan.

Covered Expense: An expense for which a health plan will provide reimbursement.

Current Procedural Terminology (CPT): Current Procedural Terminology is a listing of descriptive terms and identifying codes, for medical services and procedures performed by physicians and other health care providers, used to facilitate uniform billing nationwide.

Custodial Care Service: Services which do not require the technical skills or professional training of medical and/or nursing personnel in order to be safely and effectively performed. Examples are: assistance with activities of daily living, administration of oral medications, assistance in walking, turning and positioning in bed and acting as a sitter or companion.

Deductible: An amount the insured must pay before the plan benefits (reimbursement for expenses) begin during a benefit period.

Durable Medical Equipment (DME): Medical Equipment which is not disposable (i.e., is reused repeatedly) and is only used to care for a medical condition. Examples are: wheelchairs, braces, hearing aids.

Employment Retirement Income Security Act (ERISA): Federal law developed as protection for employee's overall benefits program. The primary focus of protection is through federal requirement that written summary documents describing the benefit program in detail be maintained by the employer and made available to the employees. ERISA does not mandate employers to provide benefits and does not prohibit discrimination. Self-funded insurance plans are not subject to state regulation or oversight.

Exclusive Provider Organization (EPO): A managed care organization similar to an HMO in that it often uses primary physicians as gatekeepers, often capitates providers, has a limited provider panel, and uses an authorization system.

Exclusion: Specific medical diagnoses, services, supplies and/or equipment not covered by a health plan. These exclusions are listed in the health plan contract.

Explanation of Benefits (EOB): A report provided by the health insurance company summarizing how a claim reimbursement or denial was determined.

Fully Funded or Fully Insured: A health plan in which the risk for medical costs are assumed by the insurance company.

Gatekeeper: An informal, though widely used term, that refers to a primary care case management model health plan. All care from providers other than the primary care physician, except for true emergencies, must be authorized by the primary care physician before care is rendered.

Gender Rule: A rule frequently used in determining primary responsibility for claims payment by insurance plans. When a child is covered by both parents under two separate plans, and both plans go by the gender rule, the plan of the father is considered primary.

Group Insurance: An insurance program protecting a group of associated individuals against financial loss resulting from illness, injury or death.

Group Master Contract: A binding contract between the insurer (insurance company) and the purchaser of a health insurance plan (e.g. employer or union) which specifically details the legal name of the policyholder and location of employees to be insured, classes (job classifications) of employees eligible for coverage, the effective date of the plan, the coverage purchased (both benefits and exclusions), the amount of employee contributions, the policyholder premium payment, and the claims payment method.

Group Number: A number that identifies to the insurance carrier which particular group an insured is enrolled in.

Health Insurance Portability and Accountability Act of 1996 (HIPA): Federal law guaranteeing access to health insurance to most workers who change or lose jobs. Limits exclusion due to preexisting conditions. Prohibits dropping individuals from insurance plan due to illness.

Health Maintenance Organization (HMO): An organization providing comprehensive health care to an enrolled population for a fixed fee.

Home Health Care: A program which provides skilled nursing care in the home rather than a hospital.

Insurance: Protection against risk, loss, or ruin by a contract in which an insurance company guarantees to pay a sum of money for such an event in return for a premium payment. Examples are: medical, life, auto, property, disability, etc. Insurance may be purchased by a group or an individual.

Insured: An individual (also known as policyholder, subscriber) who is eligible to receive benefits under an insurance policy. Insured may also be used to describe the employer or organization who purchased the policy.

Lifetime Limit: A specific maximum dollar amount an insurance company will pay toward medical expenses over an individual's lifetime.

Maintenance Occupational Therapy/Maintenance Physical Therapy/Maintenance Speech Therapy: Therapy administered to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

Major Medical Insurance: Health insurance to finance the expense of major illness and injuries. Policies usually include a substantial deductible clause, but have large benefit maximums.

Managed Health Care: This is a method of health care delivery that tries to manage the cost of health care, the quality of that health care and access to that care. It is usually paid for on a capitated basis.

Mandated Benefits: Benefits that a health plan are required to provide by state law. Self-funded plans are exempt from mandated benefits under ERISA. Benefits commonly mandated include preventive care, substance abuse treatment, mental illness care and hospice.

Medically Necessary: Services and/or supplies rendered by a medical provider to identify or treat an illness or injury which are consistent with the symptoms or diagnosis of the illness or injury; are commonly accepted standards of medical practice; are not solely for convenience and are the most appropriate supply or level of service which can be safely provided as determined by the health plan.

Medical Services Advisory (also known as Utilization Review/Management Organization): A special unit of health care professionals that help manage health benefits when inpatient treatment and outpatient surgeries are recommended. MSA staff have experience in a full range of medical specialties, can answer questions and work with the providers to ensure getting the best and most appropriate coverage available. They are usually employed by the insurance company.

Open Enrollment Period: The specified period of time (commonly 30 days) an employee has to enroll, add or drop dependents, and/or change insurance plans prior to the policy effective date.

Out of Pocket Maximum: The maximum amount the insured will have to pay for covered expenses under a health plan during a benefit period.

Participating Provider: A physician or other medical care provider who has entered into a contract with an organization, the government, or an insurance company to provide medical care to enrolled persons (insured). The provider is to accept the insurance company's approved fee and only bill the insured for deductibles, co-payments/coinsurance or uncovered services/supplies.

Participating Provider Option: A program of health care benefits designed to provide economic incentives for using designated providers of health care services. This option is common in POS and PPO plans.

Point of Service (POS): An organization which operates as both an HMO and a Major Medical insurance plan. This system allows the choice of using a participating provider or a nonparticipating provider each time medical care is sought.

Precertification: The process of obtaining authorization from a health plan (HMO, PPO, POS) before services are rendered as specified by the plan. Failure to obtain precertification often results in a financial penalty to either the provider or the policyholder.

Preexisting Condition: Any disease, illness, sickness or condition which was diagnosed or treated by a provider before insurance coverage began, or which produced symptoms before insurance coverage began.

Preferred Provider Organization (PPO): An organization arranging contracts with independent providers at a discount for services.

Primary Care Physician (PCP): The physician who is responsible for case managing and authorizing all medical care from providers, except for emergencies.

Private Duty Nursing: Skilled nursing service provided on a one to one basis by a practicing, Licensed Practical Nurse or Registered Nurse who is not employed by a hospital or home health agency.

Self-Funded or Self-Insured: A health plan in which the risk for medical costs are assumed by the employer (association) rather than the insurance company. Many employers with 200+ employees are self-insured.

Skilled Nursing: Services provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) which require the technical skills and professional training of an RN or an LPN and cannot reasonably be taught to an individual who does not have specialized skill and/or professional training.

Third Party Administrator: A person or organization providing certain administrative services to group benefits plans, including record keeping, claims review and payment, claims utilization review and maintenance of employee eligibility records.

Tri-care: The managed care program for the Army, Navy and Air Force.

Usual and Customary Charges: The maximum amount an insurance carrier will consider eligible for reimbursement under the group health plan. Used to control claims costs.

Utilization Review: A cost-control mechanism used by some insurance carriers and employers that evaluates health care on the basis of appropriateness, necessity, and quality. It can include pre-admission certification, concurrent review with discharge planning, and retrospective review.

Write-off: A reduction in the amount charged for medical services after the provider receives the insurance carrier's payment. The reduction is the difference between the fee charged and the fee allowed by insurance.

The following references were used in the development of this brochure:

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Dasco, S.T. and C. C. (1996). Managed Care Answer Book. New York: Panel Publishers

For more information, contact the DSCC office listed below: