***This list is for reference only. It is not all comprehensive but provided to help you understand terms used in Lesson 9. Information from this PDF may be included on quizzes and the certification exam.***

# Understanding the Alphabet-Soup of Health Insurance Terms

**ACA (PPACA or Obamacare)**

The first part of the comprehensive health care reform law enacted on March 23, 2010. The law was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is usually used to refer to the final, amended version of the law. (It's sometimes known as "PPACA," "ACA," or "Obamacare.") This law provides numerous rights and protections that make health coverage fairer and easier to understand, along with subsidies (through "premium tax credits" and "cost-sharing reductions") to make it more affordable. The law also expands the Medicaid program to cover more people with low incomes.

**Accumulation Period**

The period of time during which an insured person incurs eligible medical expenses toward the satisfaction of a deductible.

**Actual Charge**

The actual dollar amount charged by a physician or other provider for medical services rendered, as distinguished from the allowable charge.

**Aging Report**

A financial report which divides outstanding revenue which still needs to be collected according to "age", typically in 30-day increments. A total aging report should be routinely produced and reviewed by the Certified Outpatient Revenue Cycle Manager; but reviewing claims and patient balances separately is just as important. These reports help determine if there are potential major collection problems and allows you to focus on more detailed reports and assign tasks to your workforce.

**Allowable Charge (Allowed Amount)**

Allowable charge is also referred to as the Allowed Amount, Approved Charge or Maximum Allowable. See also, Usual, Customary and Reasonable Charge. This is the dollar amount typically considered payment-in-full by an insurance company and an associated network of healthcare providers. The Allowable Charge is typically a discounted rate rather than the actual charge. It may be helpful to consider an example:

The patient came to your clinic for an earache. The total charge for the visit comes to $250. If the doctor is a member of the patient's health insurance company's network of providers, s/he may be required to accept $80 as payment in full for the visit - this is the Allowable Charge. The health plan will pay all or a portion of the remaining $80, minus any co-payment or deductible that the patient owes. The remaining $20 is considered provider write-off. Your practice cannot bill this amount to the patient, it is considered a contractual write-off. If, however, the doctor is not a network provider, then the patient may be held responsible for everything that the plan will not pay, up to the full charge of $250.

This term may also be used within a Medicare context to refer to the amount that Medicare considers payment in full for a particular, approved medical service or supply.

**Accounts Receivable AR (A/R)**

Accounts receivable (AR) is the revenue that you have billed for but have not yet collected. This is money owed to you. AR consists of any amounts due from patients, insurance companies or other guarantors.

**Accounts Receivable Management**

The primary goal of accounts receivable management in healthcare is to maintain maximum cash flow into the medical (or dental) practice by minimizing the collection period and the costs associated.

**Association Health Plans (AHPs)**

An association health plan (AHP) is a type of group medical insurance for employers that allows smaller companies (as well as freelancers and the self-employed) to access the health insurance savings associated with large group medical coverage. In simpler terms, this means that small employers can get together and act as one large group, which often leads to lower administration expenses and other additional values, such as decreased prices due a larger pool of employees and spreading out risk among them.

**Attending Physician Statement (APS)**

A physician's assessment of a patient's state of health as outlined in office notes and test results compiled by the physician. An APS may be requested by an insurance company in lieu of a medical examination in order to determine the state of a health insurance applicant's health for underwriting purposes.

**Benefit**

A general term referring to any service (such as an office visit, laboratory test, surgical procedure, etc.) or supply (such as prescription drugs, durable medical equipment, etc.) covered by a health insurance plan in the normal course of a patient's healthcare.

**Benefit Level**

The maximum amount a health insurance company agrees to pay for a specific covered benefit.

**Benefit Package**

A description of the healthcare services and supplies that a health insurance company covers for members of a specific health insurance plan.

**Benefit Riders**

This term may be used to describe ancillary products purchased in conjunction with a medical insurance plan.

**Benefit Year**

The annual cycle in which a health insurance plan operates. At the beginning of your benefit year, the health insurance company may alter plan benefits and update rates. Some benefit years follow the calendar year, renewing in January, whereas others may renew in late summer or fall.

**Birthday Rule**

Many dual-income couples have included their children on each of their group health insurance plans to maximize their benefits. However, without some sort of system in place to help the insurance companies coordinate benefits, it's possible that either they or their doctor would be reimbursed for more than 100

percent of the actual cost of the claim.

To prevent this, insurance companies typically designate one parent's health insurance plan as the primary plan and the other as the secondary plan. (That's why the patient questionnaire should always ask for information on primary and secondary coverage.) The primary plan is responsible for paying covered expenses up to the limits of the policy. If any unpaid costs are left over, the secondary coverage kicks in.

The birthday rule is often used to determine which plan is primary and which is secondary. Under this rule, the plan of the parent whose birthday occurs first in the calendar year is designated as primary. The date of birth is the determining factor-not the year-so it doesn't matter which spouse is older. Like most rules, the birthday rule has exceptions:

- If both parents share the same birthday, the parent who has been covered by his or her plan longest provides the primary coverage for the children.

- If one spouse is currently employed and has health insurance through a current employer, and the other spouse has coverage through a former employer (e.g., through COBRA), the plan belonging to the currently employed spouse would be primary.

- In the event of divorce or separation, the plan of the parent with custody generally provides primary coverage. If the custodial parent remarries, the new spouse's coverage becomes secondary.

- The non-custodial parent's plan would provide a third layer of insurance protection. This order of payment can be altered by a court-issued divorce decree or by agreement, but the insurance companies must be notified.

Keep in mind that these practices are common among insurance companies, but *they are not governed by law*. Practices may vary from one insurer to another. Find out how the patient's primary payers handle dual coverage.

**C-Suite**
C-suite, or C-level, is widely-used vernacular describing a cluster of a corporation's most important senior executives. C-suite gets its name from the titles of top senior executives, which tend to start with the letter C, for "chief," as in chief executive officer (CEO), chief financial officer (CFO), chief operating officer (COO), and chief information officer (CIO).

**Capitation**
A method of compensation sometimes employed by health insurance companies, in which payment is made to a healthcare provider on a per-patient rather than a per-service basis. For example, under capitation an HMO doctor may be paid a fixed amount each month to serve as the primary care physician for a specific number of HMO members assigned to his or her care, regardless of how little or how much care each member needs.

**Carrier**

Any insurer, managed care organization, or group hospital plan, as defined by applicable state law.

**Carry-over Provision**
A provision of some health insurance plans allowing medical expenses paid for by the member in the last three months of the year to be carried over and applied toward the next year's deductible.

**Case Management**
When a member requires a great deal of medical care, the health insurance company may assign the member to case management. A case manager will work with the patient's healthcare providers to assist in the management of the patient's long-term needs, with appropriate recommendations for care, monitoring and follow-up. A case manager will also help ensure that the member's health insurance benefits are being properly and fully utilized and that non-covered services are avoided when possible.

**Catastrophic Plan**
Catastrophic health insurance plans have low monthly premiums and very high deductibles. They may be an affordable way for patients to protect themselves from worst-case scenarios, like getting seriously sick or injured, however, patients pay most routine medical expenses themselves.

**Centers for Medicare and Medicaid Services (CMS)**
Formerly known as the Health Care Financing Administration, the Centers for Medicare and Medicaid Services (CMS) is part of the federal government's Department of Health and Human Services, and is responsible for the administration of the Medicare and Medicaid programs. The CMS establishes standards for healthcare providers that must be complied with in order for providers to meet certain certification requirements.

**Certificate of Coverage**
A document given to an insured that describes the benefits, limitations and exclusions of coverage provided by an insurance company.

**COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)**
Federal legislation allowing an employee or an employee's dependents to maintain group health insurance coverage through an employer's health insurance plan, at the individual's expense, for up to 18 months in certain circumstances. COBRA coverage may be extended beyond 18 months in certain circumstances. COBRA rules typically apply when an employee loses coverage through loss of employment (except in cases of gross misconduct) or due to a reduction in work hours. COBRA benefits also extend to spouses or other dependents in case of divorce or the death of the employee. Children who are born to, adopted, or placed for adoption with the covered employee while he or she is on COBRA coverage are also entitled to coverage. All companies that have averaged at least 20 full-time employees over the past calendar year must comply with COBRA regulations.

**Coinsurance**
The amount the patient is required to pay for medical care in a fee-for-service plan after the patient having met the deductible. The coinsurance rate is usually expressed as a percentage. For example, if the insurance company pays 80 percent of the claim, the patient pays 20 percent. Coinsurance is another way of cost sharing.

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

**Co-pay**
The co-pay is a flat rate amount that applies to particular services, such as the Emergency Room (high copay), Per diem Hospital (high copy) or lower copays seen for physician office visits. The deductible of the health plan does not usually have to be met for these charges. The insured can pay the co-pay for doctor office visits and not have to satisfy the deductible of the plan. This co-pay, however, just applies to the doctor office visit charges and usually does not apply to any charges the physician would bill for outside facility charges such as radiology, blood tests, etc.

***For example:*** If the insured goes to the doctor for a case of the flu. The doctor might run blood tests or even do an x-ray of the patient's lungs. The bill would therefore consist mainly of a doctor office charge, a lab test reading, and a radiology charge. The co-pay would usually only apply for the doctor office charge. The radiology and the lab screening would go towards satisfying the deductible and coinsurance levels of the policy.

A co-pay benefit can be a significant portion of the premium that the insured pays each month. Typically, *the lower the co-pay the higher the cost*. Most plans give the insured the ability to remove the co-pay benefit altogether, resulting in an even lower premium.

**Cost-sharing**
Health care provider charges for which a patient is responsible under the terms of a health plan. Common forms of cost-sharing include deductibles, coinsurance, and co-payments. Balance-billed charges from out-of-pocket physicians are not considered cost-sharing. As of 2014, PPACA limits total cost-sharing to $5,950 for an individual and $11,900 for a family. These amounts have been adjusted annually to reflect the growth of premiums.

**Covered Expenses**
Most insurance plans, whether they are fee-for-service, HMOs, or PPOs, do not pay for all services. It is important to verify the type of coverage the patient has. Covered services are those medical procedures the insurer agrees to pay for that are deemed medically necessary.

**Deductible**
The amount the patient owes for covered health care services before the health insurance or plan begins to pay. For example, if the deductible is $1,000, the patient's plan won't pay anything until the $1,000 deductible is met for covered health care services subject to the deductible. The deductible may not apply to all services.

**Exclusions**
Specific conditions, services or treatments for which a health insurance plan will not provide coverage.

**Experimental or Investigational Procedures**
Any healthcare services, supplies, procedures, therapies or devices the effectiveness of which a health insurance company considers unproven. These services are generally excluded from coverage.

**Explanation of Benefits (EOB)**
A statement sent from the health insurance company to a member listing services that were billed by a healthcare provider, how those charges were processed, and the total amount of patient responsibility for the claim.

**Extended Coverage**
A provision of some health insurance plans allowing for coverage of certain healthcare services after the member is no longer covered on the plan. For example, a member's maternity benefits may be extended beyond the expected end of coverage if the woman was already receiving covered maternity services.

**Extension of Benefits**
A provision of some health insurance plans allowing for coverage to be extended beyond a scheduled termination date. The extended coverage is made available only when the member is disabled or hospitalized as of the intended termination date, and continues only until the patient leaves the hospital or returns to work.

**Direct Primary Care (DPC)**
The direct primary care (DPC) model gives family physicians a meaningful alternative to fee-for-service insurance billing, typically by charging patients a monthly, quarterly, or annual fee. This fee covers all or most primary care services including clinical and laboratory services, consultative services, care coordination, and comprehensive care management. Because some services are not covered by a retainer, DPC practices often suggest that patients acquire a high-deductible wraparound policy to cover emergencies.

**Disability**
Disability Insurance is defined as reimbursement for income lost as a result of a temporary or permanent illness or injury. There are various types of disability plans. Patients may purchase a policy on their own if not offered through an employer. A patient may be covered under Worker's Compensation disability which requires separate notes and filing of claims. There are national programs, such as Social Security Disability Insurance (SSDI).

**ERISA (Employment Retiree Income Security Act of 1974)**
Federal legislation designed to protect the rights of retirees and beneficiaries of benefit plans offered by employers.

**Exclusive Provider Organization (EPO)**
This is a type of managed care plan. Similar to an HMO, with an EPO, patients must use network providers participating in the plan. The only exception is for emergency care. Unlike an HMO, you do not need to select a Primary Care Physician, nor do you need to contact your PCP for referrals to specialists.

**Federal Trade Commission (FTC)**

The Federal Trade Commission (FTC) is the consumer's protection agency and has information on price fixing. The FTC states that price fixing is an agreement (written, verbal, or inferred from conduct) among competitors that raises, lowers, or stabilizes prices or competitive terms. Generally, the antitrust laws require that each company establish prices and other terms on its own, without agreeing with a competitor.

**Fee-for-Service (Traditional FFS or Indemnity)**

This type of plan allows the patient to choose the doctor, healthcare professional, hospital or service provider of choice and gives the patient the greatest amount of flexibility and freedom in a health insurance plan. Indemnity health plans are also known as: traditional indemnity plan and fee-for-service plan. The plan helps provide protection against the costs of medical expenses.

**Financial Class**

A computerized method of assigning an alpha-numeric value to similar insurances you bill most often in order to consolidate data for reporting and analysis purposes.

**Flexible Spending Accounts**

A Flexible Spending Account (FSA) allows participants to use tax-free dollars to reimburse themselves for qualifying health care and dependent care expenses. The result of opening and offering flexible spending accounts is a tremendous tax savings for the participating employee and the sponsoring employer.

Expenses that are eligible for flexible spending accounts tax free treatment include deductibles, co-payments and the patient's contributing portion of the company's group premium. Additional products and services that typically aren't covered by insurance may also qualify for flexible spending accounts (FSA) such as, medically necessary over-the-counter medications, vision and dental and certain chiropractic care.

**Gatekeeper**

A term used to describe the role of the primary care physician in an HMO plan. In an HMO plan, the primary care physician (PCP) serves as the patient's main point of contact for healthcare services and refer patients to specialists for specific needs.

**Health Maintenance Organization (HMO)**

This is generally the least expensive group health option, and also the least flexible. An HMO requires a Primary Care Physician (PCP) as a gatekeeper. In exchange for a monthly premium, the patient is entitled to doctor visits, preventive care, and medical treatment, all for an additional co-pay for each appointment. The patient cannot visit a doctor who's outside the HMO network. Requiring the patient to visit only doctors who are contracted to provide services allows an HMO to keep its costs down. An HMO covers prescription drugs. The employer decides what percentage of each prescription will be covered by the HMO, and what the employee pays out-of-pocket. This can range from a single-digit co-pay of $5 for some drugs, to a co-payment covering almost the entire cost of the drug. The patient's PCP also can refer the patient to a specialist, who is also within the HMOs network. The only time that an HMO will pay for the patient's medical care without a referral is for emergency-room treatment. By law, an HMO cannot require referrals for emergency care. Types of HMOs:

- Staff model: The HMO owns the facility and pays the providers via salary.
- Group model: The HMO contracts with only one provider group. HMO patients must be seen within that closed group. This group of providers may care for non-HMO patients.
- Network model: Similar to the group model, but the HMO contracts with multiple groups.

**Health Savings Account (HSA)**

A tax advantaged savings account to be used in conjunction with certain high-deductible (low premium) health insurance plans to pay for qualifying medical expenses. Contributions may be made to the account on a tax-free basis. Funds remain in the account from year to year and may be invested at the discretion of the individual owning the account. Interest or investment returns accrue tax-free. Penalties may apply when funds are withdrawn to pay for anything other than qualifying medical expenses.

**High Deductible Health Plan (HDHP)**

A type of health insurance plan that, compared to traditional health insurance plans, requires greater out-of-pocket spending, although premiums may be lower.

**Indemnity Plan (Fee for Service or Traditional FFS)**

An Indemnity health insurance plan is a healthcare plan that allows the patient to choose the doctor, healthcare professional, hospital or service provider of choice and gives the patient the greatest amount of flexibility and freedom in a health insurance plan. Indemnity health plans are also known as: traditional FFS or fee-for-service plan. The plan helps provide protection against the costs of medical expenses.

**Individual Practice Association (IPA)**

An organization of physicians who may maintain separate offices but who negotiate contracts with insurance companies and medical facilities as a group. Some health insurance applications will ask you to provide your primary care physician's IPA number. It can usually be found in the health insurance plan's online directory.

**Integrated Delivery System**

A group of doctors, hospitals and other providers who work together to deliver a broad range of healthcare services.

**Lapse**

The termination of insurance coverage due to lack of payment after a specific period of time.

**Lifetime benefit maximum**

Lifetime maximum or lifetime limits refers to the maximum dollar amount that a health insurance company agrees to pay on behalf of a member for covered services during the course of his or her lifetime. For plan or policy years beginning on or after Sept. 23, 2010, plans may not establish any lifetime limit on the dollar amount of benefits for any individual. All plans are required by PPACA to remove the lifetime maximum restrictions.

**Lifetime Limit**

Many health plans place dollar limits upon the claims that the plan will pay over the course of an individual's life. PPACA prohibits lifetime limits on the dollar value of benefits deemed essential by the Department of Health and Human Services, for plan or policy years beginning on Sept. 23, 2010.

**Managed Care**

A health care delivery system organized to manage costs, use, and quality. These include EPOs, HMOs and PPOs, and many fee-for-service plans can also be managed care. Managed health care plans provide a health insurance policy to individual members *of a group or employer*. The group or employer is the plan sponsor of the managed care plan. A managed health care plan will help beneficiaries—members of the plan—by getting them more favorable rates or discounted medical insurance services from their plan's health provider network. More out-of-pocket expense has been shifted to employees due to higher deductibles and copays.

**Maximum Out-of-Pocket**

The most money the patient is required to pay per year for deductibles and coinsurance. It is a stated dollar amount set by the insurance company that is in addition to regular premiums.

**Medical Savings Account (MSA)**

A tax-advantaged personal savings account used in conjunction with a high-deductible health insurance plan. MSAs are currently being phased out and replaced with HSAs.

**Network**

A "Network" plan is a variation on a PPO plan. With a Network plan, the patient needs to get medical care from doctors or hospitals in the insurance company's network to get claims paid at the highest level. Services rendered by out of network providers may not be covered or may be paid at a lower level.

**Non-cancelable Policy**

A policy that guarantees the patient can receive insurance as long as the patient pays the premium. It is also called a guaranteed renewable policy.

**Point-of-service plan (POS)**

POS plans are almost a hybrid of HMO and PPO plans. Like an HMO, the patient designates an in-network physician to be the patient's primary care provider. However, like a PPO, a POS plan lets the patient go out-of-network. But when the patient goes out of network, they have to pay most of the cost, unless the primary care physician refers the patient to an out-of-network doctor. Then, the health plan will generally pick up the tab.

**Preferred Provider Organization (PPO)**

More flexible and with a slightly higher premium than an HMO, a PPO allows patients to venture out-of-network and does not require a referral from a primary-care physician. However, the co-payment provides the patient with a financial incentive to stay in the network. Straying from the PPO network means that patients pay the cost of treatment in full, and then submit the bill for reimbursement to the insurance company. A PPO generally reimburses 80 percent of out-of-network costs.

**Premium**
The amount the patient or the patient's employer pays in exchange for insurance coverage.

**Primary Care Physician (PCP)**
Usually, the patient's first contact for health care is the PCP. This is often a family physician or internist, but some women use their gynecologist. A primary care doctor monitors the patient's health, diagnoses, treats minor health problems and refers the patient to specialists if another level of care is needed.

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

**Qualifying Event**
An event (such as termination or employment, divorce or the death of the employee) that triggers a group health insurance member's protection under COBRA.

**Repricers (Brokers)**
"Repricers" are those acting as "brokers" - whose sole purpose is finding and applying the lowest discounted rate for its clients, often without authorization from the physician. This is also called a Silent PPO.

**Relative Value Unit (RVU)**
Relative value units (RVUs) are a measure of value used in the United States Medicare reimbursement formula for physician services.[1] RVUs are a part of the resource-based relative value scale (RBRVS).

**Rx Drug Plan**
Prescription insurance, often referred to as a prescription drug plan, is an insurance policy that covers all or part of the cost of prescription medications. Prescription drug plans can be purchased on an individual basis or can be offered as part of a group-sponsored health benefit package. Most health insurance plans have provisions for prescription drugs.

**Silent PPO (aka "Rental Network")**
A silent PPO can be defined as an undisclosed network in which payers or managed care companies assume a preferential rate but do not disclose that rate. It is a complicated repricing scheme that was not intended by the creators of managed care products. It is also known as hijacking discounted rate through a deceptive market practice. The insurance company sees they don't have a contract with your provider for this patient, so they "borrow" a contract rate when adjudicating the claim.

The ultimate losers with silent PPOs is your office and other doctors and hospitals that are paid a lower rate due to these unauthorized discounts. But there are others who are affected as well. If providers discover an unauthorized discount, they may choose to bill the patient directly for the unpaid balance. Employers also may be held responsible for those charges and benefits managers are likely to get an earful from employees and management. In addition, silent PPOs do not reflect well on the preferred provider organization industry, which has continued to grow faster and serve an ever-increasing and far-larger segment of the health care market than any other managed health care delivery system model.

**Subrogation**
The process by which a health insurance company determines whether medical bills should be paid for by the health insurance company itself or by another insurer or third party. For example, claims are frequently subject to subrogation when medical care is rendered as the result of an automobile accident. In most cases the automobile insurer is considered the primary payer. When a health insurance company has determined through the subrogation process that the automobile insurer will no longer pay on medical claims, then the health insurance company will typically become the primary payer.

**Subscriber**
This term may be used in two senses: First, it may refer to the person or organization that pays for health insurance premiums; Secondarily, it may refer to the person whose employment makes him or her eligible for group health insurance benefits.

**Third Party Administrator (TPA)**
A third-party administrator, otherwise known as a TPA, is a business organization that performs administrative services for a health plan such as billing, plan design, claims processing, record keeping, and regulatory compliance activities.

TPAs are sometimes referred to as Administrative Services Only (ASO) entity. An ASO is not materially different than a TPA. Third party administrators can be extremely helpful in the context of association health plans (AHPs). AHPs allow multiple companies to collaborate on the sponsorship of a health plan. However, there can be aspects of health plan operations outside of the association's expertise, particularly when an AHP is self-funded.

**Third-Party Payer**
Any payer for health care services other than the patient. This can be an insurance company, an HMO, a PPO, or the federal government.

**Usual, Customary and Reasonable Charge (UCR)**
This refers to the standard or most common charge for a particular medical service when rendered in a particular geographic area. It is often employed in determining Medicare payment amounts.