Financial and Cost Reporting

Administrative Services Only (ASO)

A contract between a third party administrator or an insurance company and a self-funded plan to provide administrative services only (claims processing, billing, reporting, etc). The self-funded entity assumes all financial responsibility for the employee health insurance.

Adverse Selection

Tendency for utilization of health services in a population to be higher than average. This occurs when persons with worse-than-average health continue insurance and persons with average or better health do not.

Aggregate Stop-Loss Coverage

A type of stop-loss insurance that provides benefits when a group's total claims during a specified period exceed a stated amount.

All-Payer System
A system in which prices for health services and payment methods are the same regardless of who is paying. This prevents health care providers from shifting costs from one payer to another.

Broker
A salesperson who has obtained a state license to sell and service contracts of multiple health plans or insurers, and who is ordinarily considered to be an agent of the buyer, not the health plan or insurer.

Capitation
A negotiated rate which is paid each month to a health care provider. The provider is then responsible for delivering all health care required by the member.

Community Rating
A method of establishing premium rates by using the average cost of actual or anticipated health services for all covered persons within a specific geographic area without regard for variations of health status or claim experience. In New York State all HMOs and small groups (50 employees and less) are pure community-rated which also prohibits rate variation based on age, gender, type of industry, marital status and family size as well as health factors.

Consortium
The establishment of a mechanism which allows individual entities to pool their resources in an effort to provide a health insurance plan which is less costly over time than what could be purchased by each entity individually.

Cost Sharing
Provision of health benefit plans that require the covered person to share a portion of the costs of covered benefits. These usually include deductible, co-insurance and co-pays. Some cost sharing provisions result in a change in behavior resulting in reductions in medical costs and others shift the cost to the patient.

Credibility
A measure of the statistical predictability of a group's experience.

Current Procedural Terminology, Fourth Edition (CTP-4)
A manual which assigns five-digit codes to medical services and procedures to standardized claims processing and data analysis.

Defined Benefit
A funding mechanism where the services to be provided are defined and linked to the years of service and/or an employee's compensation.

Defined Contribution
A funding mechanism which does not define the benefit to be provided but is based on a specific dollar contribution.

Experience Rating
A method of determining premiums based on the historical utilization data and demographics of a specific group. Large groups (over 51 employees) are generally experience-rated.

HCRA/GME Tax
A tax which applies to health plans in New York State as part of the hospital reimbursement formula. It is included in the premium for insured plans, but is paid directly by self-funded plans.

Incurred But Not Reported (IBNR)
Claims or benefits that occurred during a particular time period, but that have not yet been reported or submitted to an insurer so they remain unpaid.

Minimum Premium
A funding arrangement designed to limit the amount of premium tax paid by the group and to limit the claims liability on a monthly basis.

Per Member, Per Month (PMPM)
Method of calculating and comparing costs of providing health care services to plan participants in utilization reports.

Reinsurance
The resale of insurance products to a secondary market thereby spreading the costs associated with underwriting.

Resource-Based Relative Value Scale (RBRVS)
A payment methodology established for Medicare procedures which has a relative value for each procedure, a geographic adjustment factor and a dollar conversion factor. Used by insurance companies as a benchmark when establishing their health care provider payments.

Risk-Adjustment
The statistical adjustment of outcomes measures to account for risk factors that are independent of the quality of care provided and beyond the control of the plan or provider, such as the patient's gender and age, the seriousness of the patient's condition, and any other illnesses the patient might have. Also known as case-mix adjustment.

Self-Funding

The practice of a group assuming financial responsibility for health insurance losses incurred by the membership. Benefits may be administered by the employer or handled through an administrative services only (ASO) agreement with an insurer or a third party administrator.

Specific Stop-Loss Coverage

A type of stop-loss insurance that provides benefits for claims on an individual who exceeds a stated amount in a given period.

Stop Loss

Insuring with a third party against a risk that the plan cannot financially manage. Often purchased by groups which are self-funded.

Third Party Administrators (WA)

Companies who provide certain administrative services to group benefit plans. Most commonly employed by groups which are self-funding.

Underwriting Requirements

Requirements, sometimes relating to group characteristics or financing measures, that health plans at times impose in order to provide health care coverage to a given group and which are designed to balance a health plan's knowledge of a proposed group with the ability of the group to voluntarily select against the plan (anti-selection).