Glossary

Glossary Of Terms Used In This E-Book

Many of the essays presented are technical in nature, and presume a level of experience and understanding of certain terminology frequently used by actuaries practicing in the health care industry.

Following is a list of some terms and their definitions, which the reader may find helpful. Many of these definitions are based on the material in the following textbooks:

Group Insurance, fifth edition, edited by William F. Bluhm.

The Managed Health Care Handbook, fourth edition, edited by Peter R. Kongstvedt.

The Handbook of Employee Benefits, sixth edition, edited by Jerry S. Rosenbloom.

Adverse Selection, Antiselection

When an individual has a choice about an insurance plan, he or she may select the option that best meets his or her estimated future needs. When this selection is unfavorable to the insurer (i.e., to the entity insuring the individual), the selection is referred to as adverse selection or antiselection.

CHIP, SCHIP

The Children's Health Insurance Program (CHIP, formerly the State Children's Health Insurance Program (SCHIP)) was created by the Balanced Budget Act of 1997, enacted Title XXI of the Social Security Act, and allocates funds to help states insure low-income children who are ineligible for Medicaid but cannot afford private insurance. In February 2009, the Children's Health Insurance Program Reauthorization Act of 2009 was approved by Congress and signed by President Obama.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) dictates that medical expense coverage must be made available by employers for terminated employees and certain dependents of terminated and active employees, for specified periods.

Community Rating

A premium rating structure wherein risks are aggregated in a large community, and all risks are charged the same premium rate. This is contrasted with Pooling, where risks are combined into smaller groupings (pools) to produce premium rates that are reflective of the risks in a particular pool, so lower risks pay a lower premium and higher risks pay a higher premium.

Cost Sharing

Any form of coverage in which the insured individual pays some portion of the cost of providing services. Usual forms of cost sharing include deductibles, coinsurance, copayments and payroll deductions toward employer-sponsored coverage.

Evidence-Based Medicine

As defined by a frequently referenced 1996 *BMJ* editorial, Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. It integrates individual clinical expertise with the best available external clinical evidence from systematic research.

Gatekeeper

A model for management of health care, in which a primary care provider must pre-authorize care from other providers in order for it to be covered by the health insurance plan.

Health Savings Account (HSA)

Enacted as part of the Medicare Modernization Act of 2003, health savings accounts are accounts that allow for tax-deductible contributions and tax-favored accumulation, within limits. An HSA must be paired with a qualified high-deductible health plan in order for an individual to realize the account's tax advantages.

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Pooling, or Risk Pooling

A premium rating structure wherein like risks are combined to produce premium rates that are reflective of the risks in a particular pool, so lower risks pay a lower premium and higher risks pay a higher premium. This is contrasted with community rating, where risks are aggregated in a large community, and all risks in the community are charged the same premium rate.

Portability

The ability of an individual to change jobs (and therefore group insurance sponsors) and obtain and/or maintain group health insurance coverage without exclusion of pre-existing health conditions. The Health Insurance Portability and Accountability Act (HIPAA) limits restrictions that a group health plan can place on benefits for pre-existing conditions.

Predictive Modeling

The process of using statistical and other models to predict, as accurately as possible, the future health risk and illness burden of an individual or group. Predictive modeling techniques typically make use of past available health care data such as claims, utilization and diagnoses, and may also make use of other data sources.

Preventive Services

Health care services that are aimed at preventing complications of existing diseases, or preventing the occurrence of a disease. Recommended services may vary by age and gender. Examples of preventive services include physical exams, immunizations and certain cancer screenings.

Risk Adjustment

The process of adjusting payments to health plans or health care providers in order to reflect the health status, or illness burden, of the members. The first step in health risk adjustment is Risk Assessment, and the second step is payment adjustment.

Risk Assessment

The method used to assess the relative risk, in terms of historical or predicted claim dollars, of each individual person in a group.

SCHIP

See CHIP

Stop Loss Insurance

A form of reinsurance that provides protection for annual medical expenses above a certain limit. It can take the form of specific stop loss, where the insurance coverage reimburses all claims above a certain deductible (such as $100,000 per individual); or aggregate stop loss, where the the coverage reimburses a percentage of claims if a group's claims exceed a certain percentage of the expected level (such as 120 percent).