HIGH PERFORMANCE PROVIDERS & FREE MARKET MEDICAL ASSOCIATION

GEEK SPEAK

A USEFUL GUIDE TO THE JARGON AND ACRONYMS MOST COMMONLY USED AMONGST HEALTH BENEFIT PROFESSIONALS AND PROVIDERS

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INTRODUCTION

We often find ourselves in need of translation as some of us speak "provider-ese" while others speak "benefit-ese." Within these pages, you will find the most commonly used words, abbreviations, and jargon used amongst health benefit professionals.

Please keep in mind that these definitions are not textbook. They include some opinions based on our 20+ years of experience in the industry. We hope you find this educational, useful, and perhaps even a little entertaining.

Feel we missed something? Please feel free to reach out to us via our Contact Page at HighPerformanceProviders.com we would love to hear from you.

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TRANSLATIONS

Accreditation Association for Ambulatory Health Care (AAAHC): Advocates for high-quality health care through nationally recognized standards and peer-based onsite reviews. Every Ambulatory Surgical Center (ASC) should have this basic accreditation and more.

Administrative Costs: The general administrative costs associated with a health insurance policy – The amount of money it takes to "keep the lights on," process claims, and print member ID cards.

Administrative Fee: A euphemism often used to hide the fact that an amount paid to sell a product is really a "commission." This is most common with GPOs and their group purchasing of medical equipment. For example: A medical supplier allows a facility to charge an administrative fee on top of the discounted price instead of calling the additional fee a commission.

Administrative Services Only (ASO): A carrier (such as Blue Cross, United, Cigna, Aetna & Humana) acting as a Third Party Administrator of a self-funded Plan. Many health insurance carriers offer both fully insured and third party administrative services, which are often called administrative services only (ASO). Health insurance carriers and their subsidiaries provide most of the administrative services for enrollment covered under TPA agreements for health benefits offering their owned PPO Network which allows for misaligned incentives to persist within the self-funded marketplace.

Advisor: In a world of brokers and agents who want to "quote your business" for the highest sales commission, Advisors do what's best for their clients. Advisors seek to educate clients on what is going on in our current healthcare system and address the common frustrations with regard to the ever-increasing costs of healthcare while benefits are proportionately reduced.

Affordable Care Act (ACA) aka Patient Protection and Affordable Care (PPACA); Healthcare Reform; and Obamacare: On March 23, 2010, President Obama signed the hotly contested health reform bill into law which made significant changes to the way employers and employees purchased health benefits, along with significant changes to the healthcare delivery system. The goals of the ACA were to increase the quality and affordability of health insurance, lower the uninsured rate by expanding public and private insurance coverage, and reduce the costs of healthcare for individuals and the government. Since its passage, the law has been challenged in court numerous times by states, private industry, and others for a number of its provisions which defendants have claimed to be unconstitutional.

Aggregate (AGG): Insurance for a self-funded health plan that protects the group plan for claims that exceed a fixed level and appropriate for that size employee group. When properly utilized, this makes a self-funded plan less risky than a fully insured plan.

Allowed Charges: Maximum amount a plan will pay for a covered health care service. May also be called "eligible expense," "payment allowance," or "negotiated rate."

Ambulatory Surgical Center (ASC): A stand-alone facility, oftentimes independent/physician owned, wherein surgeries are done in an outpatient setting. This is the first line of defense when tackling costly "facility fees" which oftentimes make up 85% of surgical costs. Ambulatory Surgical Centers are known to deliver better health outcomes with lower complication and infection rates while providing far superior patient satisfaction levels.

Attachment Point: The maximum dollars of claims that a group/company will have to pay for in any given plan year.

Balance Bills: When a provider bills a patient for the difference between the provider's charge and the allowed amount paid by the insurance carrier. THIS CAN COME AS QUITE A SURPRISE as no one discloses actual costs prior to medical treatment being received.

Billed Charges: An overly inflated amount tied to the chargemaster that a provider bills a health plan for services rendered. Then the health plan pays either a PPO discount, reference-based reimbursement, or custom and ordinary charges.

Broker: An authorized individual who works on behalf of specific insurance companies to guide employers through the process of selecting a health insurance policy for themselves and/or their employees. The difference between an Agent and a Broker? An Agent works on behalf of one insurance company while a Broker sells policies from multiple insurance companies.

Broker, Consultant or Advisor?

- **Broker –** If they get paid a commission, they are a broker.
- **Consultant –** If they charge a fee for their advice, they are a consultant. Generally providing what has been predetermined and expected such as solving service issues, providing HR technology, etc.
- **Advisor –** If they charge a fee and act on behalf of the best interests of their clients, they are an Advisor. Advisors are willing to push clients out of their comfort zone. They bring different solutions to deliver different results that benefit clients. This includes pursuing opportunities to share, collaborate and learn how to constantly improve the situation of clients and their employees.

BUCAH: An industry term for the national PPO carriers Blue Cross, United Healthcare, Cigna, Aetna and Humana.

Captive: An independent insurance company that is set up and wholly owned by a non-insurance company to act as a direct insurer or reinsurer for the parent company and its subsidiaries.

Center of Excellence (COE): A designation given to a provider or facility for a specialty line of service. Fortune 500 companies and jumbo employers will often hire a COE Administrator like Edison Health, Carrum Health or Contigo to identify the best performing providers for a particular specialty or sub-specialty. This is most common with high-cost, predictable surgeries such as joint replacement, cancer treatment, cardio, transplants and bariatric surgery. Unfortunately, there are providers and facilities that self-proclaim themselves as a Center of Excellence, when they may not be. There are also hospitals or centers that may be a COE for

one specialty, but not for others. For example, the Cleveland Clinic is globally known for cardiovascular care, but is one of the worst performers in orthopedics. Be wary of those who do not offer proper credentialing and/or published outcomes.

Charge Master: A price list that medical providers, doctors, and hospitals manage and set all their rates from. Unfortunately, in practice, it usually contains highly inflated prices at several times that of actual costs to the hospital. The Charge Master typically serves as the starting point for negotiations with patients and insurance providers. Like MSRP, it is the "Rack Rate." So when a PPO requests a 60% discount, providers and hospitals simply bump up their pricing in order to offer that discount to the insurance company. Negotiating the price of an item that costs $13 and lists for $199.50, even a 60% discount is still no bargain.

Claims: An outline of the medical services provided that a doctor submits to the insurance company so they can get paid.

Co-Advising / Co-broker: A new and growing model that allows for an advisor with an existing employer /client relationship to align with an advisor who understands the Next Gen model of plan design for a self-funded health plan. In essence, it is a collaboration of creative thinkers that have come together to bring a new approach and new way of thinking about the problems ingrained in today's healthcare/insurance and identify and develop resources and share solutions to these problems.

Co-Insurance: The amount of money a patient pays as part of the total payment paid to a medical provider. Coinsurance may apply to any specific benefit, but is generally applied to a claim only after the deductible has been met. Once the deductible has been met, the participant may be responsible for 20% of the remaining amount, while the insurer or plan pays 80%. Unfortunately, sometimes this is higher than the cash or direct contracted rate. For example, a hospital may charge $30k for a hernia repair. A member with a 20% co-insurance would have a member obligation of $6k. Yet if the member went to a direct contracted ASC, they could receive that same hernia repair for $4k.

Co-Payment: A fixed payment for a covered service as defined by a participant's benefit plan. This co-payment is paid by the member each time a medical service is rendered. Though the co-payment is often a small portion of the actual cost of the medical service (i.e. $25 per office visit), it is meant to discourage members from seeking medical care that may not be necessary. Co-payments are often waived in health plans that incorporate direct contracting.

Commercial Carrier: Public and private commercial health insurance policies that are primarily publicly traded and sold for-profit. See BUCA above. Commercial carriers have a financial duty to their Board of Directors and are driven by income/profit lines.

Competitive Health Insurance Act of 2020 (CHIRA): This Act ends the McCarran-Ferguson Act of 1945 that said that insurance companies are exempt from antitrust lawsuits.

Consolidated Appropriations Act (CAA): Federal law signed at the end of 2020 requiring health insurance agents and brokers to disclose their commissions to clients, in writing, in advance of a sale. After December 27, 2021, if the broker reasonably expects to earn more than

$1,000 in "direct compensation" and/or more than $250 in "indirect compensation" from the health plan or insurance carrier, it must be disclosed to the employer.

Consolidated Omnibus Budget Reconciliation Act (COBRA): Provides individuals with the right to continue health coverage under an employer plan for a limited time after certain events, such as the loss of a job.

Cost Shifting: Essentially, transferring cost from one party to another. In today's medical insurance environment, the shift in cost is from the company or plan sponsor to the employee or medical plan member. Oftentimes when member premiums increase, the employer "cost shifts" the increase to their employees through increased deductibles, out of pocket costs, and copays.

Covered Lives: Or "Members" are all individuals, employees, and dependents for whom the health carrier has an obligation to adjudicate, pay or disburse claim payments. In theory, when a health plan aggregates more additional lives, they can negotiate better discounts with the hospital or health system. This is a fallacy as transparency tools are beginning to prove.

Deductible: The amount of expenses that must be paid out-of-pocket by an individual before an insurer or plan will pay any expenses towards a medical claim. For example, a patient with a $3,000 deductible having surgery will be responsible for the first $3,000 of charges for that surgery before the benefit plan makes any payment to the provider. Nowadays, the High Deductible Health Plans (HDHPs) have deductibles that are often more than the member has in their savings account, further restricting access to health care. Reports show that 90% of employees on these high deductible health plans paid ALL annual healthcare costs (premiums, co-payments, co-insurance, and deductibles) out-of-pocket. In other words, the health plans paid NOTHING for 90% for HDHP members.

Department of Labor (DOL): The department of the United States government responsible for administering ERISA plans. Each health plan has an administrator that is fiduciarily responsible for the plan.

Direct Primary Care (DPC): A membership payment system whereby individuals and families obtain primary medical care from a designated doctor. Normally a monthly service fee provides concierge level service with your doctor, more face time with your doctor, and little or no waiting time in the office. Also see Virtual Primary Care (VPC) - A new variation of direct care delivering 85% of primary care virtually. Primary care should be looked at as routine and preventive maintenance. If you REMOVE it from the insurance equation, costs immediately go down. A comparison would be auto insurance: Does your auto insurance cover the cost of oil changes, tire/brake replacement, and normal wear and tear? Of course not. Insurance is meant to be used for large and catastrophic events.

Drug Rebates: Rebates offered by pharmaceutical companies that are often kept by the PBM (Pharmacy Benefit Management) but are supposed to be passed along to the employer or member. Drug rebates are a back-door way for a pharmaceutical company to "pay commissions" to a PBM for allowing them to be included in their formulary.

Employee Retirement Income Security Act of 1974 (ERISA): A federal law that is supposed to protect the employee. ERISA requires employer health plans to provide plan participants with

plan information, requires an establishment of an appeals process, and gives participants the right to sue for benefits and breaches of fiduciary duty. ERISA also describes and provides guidelines for fiduciary responsibilities for those who manage and control plan assets. HIPAA and COBRA are amendments to ERISA.

Exclusive Provider Organization (EPO): Similar to a PPO, but more restricted. What many call a "narrow network." In theory, this sounds good because it is "exclusive," but it is often a way for commercial carriers to limit the providers a plan member can receive care from. Participants with an EPO network plan receive no reimbursement or benefit if they seek medical care outside of their designated network of doctors and hospitals.

Explanation of Benefits (EOB): A document from an insurance company or TPA giving specific information about the medical procedure, associated costs, and patient responsibility. This document also gives information about the deductible amount met year-to-date.

Free Market Medical Association (FMMA): An organization dedicated to bringing together physicians, patients, and self-funded employers to promote transparency in healthcare. Founded by Dr. Keith Smith, owner of the Surgery Center of Oklahoma and Jay Kempton, owner of Kempton TPA, the FMMA provides resources to promote a successful industry while defending the practice of free market medicine without the intervention of government or other third parties who seek to make healthcare opaque. The FMMA believes that two willing parties (provider and patient) that want to do business together, should be able to do so in a free market manner, offering direct services for flat and transparent pricing.

Fiduciary Duty: Being bound both legally and ethically to act in the best interest of a client (ahead of their own interests) with a duty to preserve good faith and trust. This pertains to the company, not the insurance carrier. The health plan will always be held responsible, rather than a commercial carrier. An example: A large employer in New York was sued by a large health system when the commercial carrier was not paying the provider a fair and reasonable amount. The court then allowed the employer to sue the carrier and was awarded penalties and interest.

Fully Insured: A group health plan, utilizing an HMO or PPO network, purchased and insured by a licensed insurance company. The employer pays a fixed monthly premium to the insurance company, regardless of the plan's claim costs. It is the insurance company that assumes the financial and legal risk of loss if claims exceed projections. If the employer has a good claims year, it is also the insurance company who 'wins' and keeps the excess premiums. With fully insured rates increasing 8-12% annually on average, the insurance company thus ensures profitability year-over-year.

General Advisor (GA) – Co Advising: A person with deeper knowledge in a specific area that serves as a mentor or guide. A GA provides or shares their plan design knowledge to less experienced advisors or brokers and is compensated for doing so. The employer relationship always resides with the incumbent broker.

Group Purchasing Organization (GPO): A group formed for group purchasing and discounts. Functions very much like a PBM in that a GPO can cloak their commissions as a rebate. This commission often appears in the paperwork as an "administrative fee."

Health Care Administrator Association (HCAA): A professional organization of Third-Party Administrators.

Health Insurance: How we pay for the healthcare we get. Health insurance is often confused with "healthcare." Healthcare is the care we get for our health while health insurance is just a financial vehicle to pay for healthcare.

Health Insurance Portability and Accountability Act (HIPAA): As an amendment to ERISA, HIPAA provides important protections for working Americans and their families who have pre-existing medical conditions or might otherwise suffer discrimination in health coverage based on factors that relate to an individual's health. HIPAA has been mostly replaced by language in the Affordable Care Act.

Health Insurance Trend: Based on Wall Street. Health insurers take a true medical trend and compound that with layers of fat incorporated into health insurance premiums to make sure they generate more profit.

Health Maintenance Organization (HMO): A lower cost health plan where providers are paid a capitated rate to manage a population. Plan members are required to get a referral from a primary care physician in order to access specialty care. Oftentimes, the health plan design does not offer an adequate supply of primary care physicians, thus, requiring members to seek care from higher cost centers and emergency rooms.

Healthcare Reform – aka Affordable Care Act (ACA); Patient Protection and Affordable Care Act (PPACA); and Obamacare: See Affordable Care Act (ACA) above.

Health Reimbursement Account (HRA): An IRS-approved health benefit plan that employers may contribute to that reimburses employees for qualified out-of-pocket medical expenses and individual health insurance premiums. Often a tool utilized to steer care to lower cost, higher quality providers and care.

Health Reimbursement Arrangement/Account (HRA): Employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year. Unused amounts may be rolled over to be used in subsequent years. The employer funds and owns the arrangement.

Health Rosetta: An organization that certifies benefit advisors to the new way of health plan design, moving plans ultimately to a self-funded health plan and away from being fully-funded or relying on commercial insurance carriers. A guiding set of principles for healthcare brokers wishing to become true advisors, removing misaligned incentives from health plans. In other words, re-aligning the advisors' compensation to the employer or health plan rather than being paid by a BUCAH.

Health Savings Account (HSA): A savings account that allows employees to set money aside on a pre-tax basis to pay for qualified medical expenses such as deductibles, copayments, and coinsurance to lower overall health care costs. An HSA is often tied to high deductible health plans to help members pay for the extreme out-of-pocket costs.

High Deductible Health Plan (HDHP): A health plan with lower premiums and higher deductibles than a traditional health plan. Being covered by a "qualified" HDHP is also a requirement for having a Health Savings Account (HSA) and Federal guidelines apply.

Hospital Out-Patient Department (HOPD): An ambulatory surgery center or procedure room that is within the walls of a hospital. In other words, a facility that is doing procedures that should be done outside of a hospital. Oftentimes, this is an opportunity for a hospital to bill hospital rates while influencing a plan/member to believe it is lower cost because it is performed on an "out-patient" basis.

In Network: Refers to providers or health care facilities that are part of a health plan's network of providers with which it has negotiated a discount. Carriers sell by the "strength" or "depth" of their network which often includes every provider within a system as they are not allowed to eliminate physicians within a system using quality measures. In-network is a phrase often used by commercial carriers to intimidate members to stay within their network.

Institutional Review Board (IRB): An academic based study issued to validate outcomes.

Joint Commission: Formerly JAHCO, an independent, not-for-profit, accreditation and certification organization that measures and assesses medical facilities to improve the patient care experience.

LeapFrog: A non-profit organization primarily funded by large employers that surveys the safeness of hospitals and ASCs. LeapFrog publishes a safety report card that is often utilized by self-funded employers.

Laser: Assigning a higher Specific deductible for an individual with a known condition that is likely to exceed the Specific deductible.

Level-Funded: An introductory self-funded insurance program with level monthly premiums. Carriers have different programs but normally these types of plans only have an aggregate stop-loss feature. There is no limit on an individual's claims, just a maximum liability for total claims paid number for the group. Often used as a baby-step to self-funding. Less risk and a vehicle to capture/see claims data and understand the use of stop-loss coverage.

Marketing/Loyalty Bonus: A euphemism used by commercial insurance carriers for an additional commission paid to a broker for focusing more of their sales with a particular commercial insurance product. In other words, the more the broker sells, the higher the bonus a broker can make from the carrier without the broker needing to disclose the bonus amount.

Maximum Exposure: The maximum amount that the group, company, or plan sponsor must pay in a year for member claims. This is sometimes referred to as the "attachment point."

Maximum Out of Pocket: The maximum amount an individual or family must pay during the plan year. This is the total patient responsibility that a member or their family is responsible to pay for all medical procedures.

Medical Cost-Share Program: A membership program where members help each other pay their medical bills. Normally includes some form of monthly contribution, premium or minimum payment. Medical bills are shared with the group and individual members contribute any amount they choose until the total bill is paid. There is no network and no pre-determined discount off the charge masters.

Medical Expense Reimbursement Program (MERP): A strategy of moving health plans to a high deductible health plan, saving the employer the increased premium. Then having a specialized MERP TPA manage all claims, paying the claims for members out of the savings found in the premium reduction. This allows the TPA to gather actual claims information to evaluate moving a health plan to fully self-insured, all while saving the health plan money.

Medical Loss Ratio (MLR): A key provision found within the Affordable Care Act. Effectively the way insurance companies, under the law, are required to spend your money. Measured by medical claims + plus adjusted expenses / divided by the total earned premium. This measures the fraction of the total insurance premiums that health plans use on clinical services as opposed to administration and profit. The Affordable Care Act (ACA) limits a carrier to making 15 or 20% of gross spend. In other words, the more a carrier spends, the more profit they can make. This is the single largest flaw of the ACA as it incentivizes a perverse relationship between the commercial carriers and the health care systems to increase spend.

Medical Management: A group that manages medical episodes of patients and pre-certifies or pre-authorizes high-cost procedures. Medical management strategies are designed to modify consumer and provider behavior to improve the quality and outcome of healthcare delivery.

Medical Trend: Independent studies of medical inflation; the actual increase in cost. The medical trend in the United States by and large, has increased somewhere between 5-7% within the last decade. It is important to note that The Center for Medicare and Medicaid Services (CMS) don't inflate prices year-after-year. Which begs the question – Why do the BUCAH's pass of this "medical trend" of 7-10% price increases to their clients year after year? This is largely caused by managed care "network" contracts (PPOs) between the BUCAH's and hospitals who have contractual escalator clauses guaranteed to increase year-after-year. In some cases, as much as 4x annually.

Nurse Navigators: Oftentimes associated with medical management, assisting a patient through the treatment process by connecting them to resources and information to make informed decisions from initial diagnosis to end-of-life treatment (if necessary). The navigator is often involved in cost containment strategies, assisting in redirection to higher performing providers.

Out of Network (OON): Another term used by commercial carriers as a way to intimidate members to stay within their network of providers. When a provider will not accept a ridiculously low reimbursement rate offered by a commercial carrier, or if a commercial carrier wants to narrow their network based on cost only (not quality), they will often not allow a provider in-network.

Out of Pocket (OOP) & Maximum Out of Pocket (MOOP): The most a member will pay during the year. On a written benefit summary provided by the carrier or benefits administrator,

this listed maximum out-of-pocket amount may or may not include the deductible depending on how it is written. There can be a lower plan maximum out-of-pocket, in addition to the new ACA Federal maximum out-of-pocket. If the plan's maximum out-of-pocket is lower than the mandated federal amount, the member will continue to pay co-pays until the Federal amount is reached. A member can have both an in-network and out-of-network maximum out-of-pocket for their plan that accrue separately significantly increasing the member's financial obligation under a traditional health plan.

Override Payment: A euphemism used by commercial insurance carriers for an additional commission paid to a broker outside of their standard commission. This allows a broker to hide bonus commissions paid that are outside of their normal commissions. It is not uncommon for "overrides" to be higher than the standard commission.

PEPM - Per Employee, Per Month: The cost an employer budgets to manage the benefits expense of each employee. Also known as PMPM – Per Member, Per Month.

PEPY - Per Employee, Per Year: Applicable rate paid by employer annually for each employee who is eligible for health insurance coverage.

Performance Guarantee: The presence of a performance guarantee can help companies identify carriers who follow through on the commitments they make and the services provided to employees. They achieve this goal because the guarantees and risk of noncompliance penalties motivate carriers to process claims promptly and facilitate employees' return to work.

Partially-Self-Funded: Another term for a self-funded medical plan. Often used to help define a medical plan that includes a level of insurance to protect the plan and sponsor from catastrophic claims.

Pharmacy Benefit Manager (PBM): A third-party administrator of prescription drug programs for commercial health plans, self-insured employer plans, Medicare Part D plans, the Federal Employees Health Benefits Program, and state government employee plans. PBM's increase a patient's access to medications by contracting with drug manufacturers and wholesalers, negotiating discounts and rebates with drug manufacturers, and process and pay prescription drug claims. Many times, the PBM is owned by the commercial carrier, providing them a vehicle to keep rebates paid by pharmaceuticals to participate in formularies. This is a polite way of calling it commissions.

Plan Members: The insured person offered insurance coverage by the policy holder (generally employer) and/or any of their covered family members.

Pools or Pooling: An effective way for insurance companies to balance the scales and manage their losses. A fundamental structure by which a group of people would pool their resources collectively to be used when needed by someone when they fell ill. It was the first official employer sponsored plan and Blue Cross was born.

Pooling Point: A mathematical calculation of the amount of claims that need to be insured before effectively the rest of those funds that are set aside to pay claims cease, and instead, that claim is then paid out of the pool.

Preferred Provider Organization (PPO): A network of medical doctors, hospitals, and other health care providers who have agreed with an insurer or third party to provide health care at reduced rates or a percentage off billed charges to the insurer's or administrator's clients. A PPO is VERY misleading as it is sold to a health plan, not based on a true cost, but rather a perceived savings. Commercial carriers compete by offering a larger discount. The question that arises is "Discount on what?" If the true cost is not known, a discount carries no value. It also allows the hospital and carrier to collude on increased rates wherein both financially benefit.

Primary Care Physician (PCP): A physician that delivers primary care such as family medicine, internal medicine, OBGYN, etc.

Rate Pass: A term used when there is not an increase in premiums.

Reasonable & Customary (R&C): See also Usual, Customary and Reasonable (UCR). The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The "reasonable" amount sometimes is used to determine the "allowed" amount.

Rebate (Pharma): A euphemism for a commission paid by pharmaceutical manufacturers to insurance carriers by way of their PBM to "include" a particular drug on their formulary. Most do not realize that the majority of PBMs are owned by the commercial carriers. This rebate cloaks the commission. An example would be a drug that is priced at $100 with a $70 "rebate" that the PBM gets paid for formulary inclusion. In other words, a 70% commission.

Redirection: An action taken by medical management or nurse navigators to redirect a patient to a higher quality and/or lower cost provider. This often involves incentivizing a member to make a better choice. An example would be a patient receiving a $4,000 MRI (with personal financial obligations of $800 in co-pay) that would cost $500 from an independent imaging center. The member is often incentivized by waiving deductibles and co-pays.

Reference Based Pricing (RBP): A reimbursement model where a health plan functions without a network and pays providers a percentage of Medicare. This creates noise/friction when plan members are balanced billed.

Reinsurance aka Stop Loss Coverage: See also Stop Loss Coverage. Almost all insurance, even commercial carriers, are backed by some level of reinsurance. In a fully insured plan, it is not seen, but exists. In a self-insured plan it is called Stop Loss.

Relative Value Unit (RVU): A term used by health systems for inbound referrals from primary care. The more a primary care physician refers internally, the higher the RVU payment is to that physician for the referral. The more images prescribed, the higher the RVU payment, etc.

Self-Funded Plan aka Self-Funded Healthcare: A plan in which the employer assumes the financial risk for providing health care benefits to its employees. In practical terms, self-insured employers pay for claims from general assets as they are presented instead of paying a pre-determined premium to an insurance carrier for a fully insured plan. Unless exempted, such plans create rights and obligations under the Employee Retirement Income Security Act of 1973

("ERISA"). Typically, self-funded employers purchase stop loss insurance to guard against catastrophic claims.

Self-Insurance Institute of America (SIIA): A professional association of parties involved in self-funding their insurance. SIIA provides continuing education, networking, and annual conferences where those involved in self-funding gather to share best practices.

Society of Professional Benefit Administrators (SPBA): A national association of Third Party Administration (TPA) firms who provide comprehensive ongoing administrative services to client employee benefit plans.

Spec Deductible: The plan deductible for an individual in a Self-funded medical plan. This is the amount that the plan must pay before the insurance will pay for that individual.

Specific Stop-Loss (SPEC): The insurance coverage that pays for claims on an individual for claims (medical bills) over the spec deductible.

Stark Laws: Also known as the "Physician Self-Referral Law" which prohibits physicians from referring patients to receive services from entities in which they have an immediate financial relationship.

Steerage: Also called "redirection." Practice of directing employees and members on a benefit plan to alternative solutions of either in-network doctors, hospitals, or bundled/transparent providers as a way of reducing high healthcare costs.

Stipend: A Euphemism used by hospitals when paying a hospitalist group for increased utilization.

Stop-Loss Insurance aka Reinsurance: A product designed to protect employers and self-funded health plans from catastrophic losses. There are two types of coverage: 1) Specific - employer protection against a large expenditure by an individual; and 2) Aggregate - employer protection against excessive claim expenditures for the entire group.

Stop-Loss Captives: Allows employers to share a layer of predetermined risk among a larger population. The sharing of the risk layer insulates individual employers from higher claim fluctuations as single claims are absorbed into a larger pooling arrangement.

Taft-Hartley: A Taft-Hartley plan, sometimes called a "Multi-Employer Welfare Arrangement" (MEWA), is an older law that governs collective bargaining agreements for unions. Under Taft-Hartley plans, unions negotiate a health and wellness plan into a bargaining agreement allowing the union to provide benefits to members on behalf of the employer. These plans may be fully insured or self-funded.

Telemedicine: A new way to access primary medical care via a phone call or video chat. About 70% of what is diagnosed in an office visit can be diagnosed through telemedicine.

Third-Party Administrator (TPA): A company that processes claims and helps manage an employer's self-funded medical plan. Responsibilities include maintaining eligibility,

adjudicating and paying claims, client and provider customer service, utilization management, etc. It also provides services such as arranging for stop loss coverage, provider network access, and a pharmacy benefit management company. There are three types of TPAs: 1) independent; 2) ASO (carrier owned); and 3) a hybrid of two (an independent who utilizes carrier networks). The type of TPA an employer hires drastically impacts their interactions with a provider.

Usual, Customary and Reasonable (UCR): See also Reasonable & Customary (R&C). The amount paid for a medical service in a geographic area based on what providers in the area usually charge.

Utilization: A global term for medical claims for a group. This represents how much a group of members uses their medical plan. This could be measured by the number of procedures completed or the total dollars of claims.

Validation Institute (VI): An organization that validates claims made by advisors, TPAs, Providers, etc. Claims are reviewed by a team of data scientists for an un-biased, data-driven approach to improve outcomes, strengthen accountability, and offer cost savings. VI was formed by GE and Intel Corporation as a way to "validate" claims being made by those offering health care and benefits. Today VI offers a $25,000 guarantee on all validations.

Virtual Primary Care (VPC): Similar to Direct Primary Care (DPC), but utilization is done via telemedicine. Becoming a more popular option post COVID pandemic.

PHARMACUTICAL SPECIFIC TERMS

Active Pharmaceutical Ingredients (APIs): Ingredients that go into drugs made for Americans – 90% of which are manufactured in the People's Republic of China.

Formulary (RX): The "approved list" of prescription drugs available to participants managed by the PBM (Pharmacy Benefit Management). Drugs must be on the formulary in order to be covered. Varying drastically between drug plans, formularies differ in the number of drugs covered and costs of co-pays. Most formularies cover at least one drug in each drug class. Generic substitution is always encouraged, and many times mandatory. Many also have step therapy protocol requirements. The formulary is often a tool used to solicit and collect rebates from pharmaceutical companies as a commission or incentive. It is not uncommon for the PBM to change mid-year because a new pharmaceutical drug offers them a larger rebate for doing so. This often takes members by surprise when they see a $200 increase on a drug that was once covered.

Non-Formulary Drug: Drugs that are non-formulary are typically not covered by a health plan.

Non-Preferred Name Brand Drug: Part of a Tiered Formulary, Non-Preferred Name Brand drugs will have a higher co-pay than Preferred Name Brand drugs. All Name Brand drugs have higher co-pays than Generic drugs. High dollar Name Brand drugs often require prior authorization and clinical review to determine medical necessity.

Preferred Name Brand Drug: Part of a Tiered Formulary, Preferred Name Brand drugs will have a lower co-pay than a Non-Preferred Name Brand drugs, but a higher co-pay than Generic drugs.

Specialty Drug: Often referred to as Biotech drugs, Specialty drugs typically require special handling, administration and/or monitoring, and are commonly injectable or infusions. Very rarely can Specialty drugs be obtained without medical review or prior authorization by the insurer or plan. They can cost tens of thousands of dollars and are for serious illnesses.

Step Therapy (RX): Requires a participant to try lower cost medications before "stepping up" to a higher cost medication. If a lower cost medication has not been tried, the higher cost medication will not be covered.

Tiered Formulary Drug Plan: A type of drug plan with financial incentives for patients to select lower-cost drugs. Formularies vary drastically between drug plans and differ in the number of drugs covered and co-pays. Most formularies cover at least one drug in each drug class. Generic substitution is always encouraged, and many times mandatory.

Rx Switch Operators: A mechanism used between pharmaceutical companies and PBMs, allowing the pharmaceutical companies to pay a “fee” to the PBM rather than calling it a commission.

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