Benefit Strategies

Glossary of Terms

Alternative Medicine: Medical treatments that are used instead of traditional (mainstream) therapies. Also referred to it as “integrative,” or “complementary” medicine. Examples include chiropractic, acupuncture, energy therapies, and herbal medicine.

Benefits Admin Outsourcing: Outsourcing administrative tasks to leverage new technology and allow for more organizational focus on strategy, planning and service to internal business partners.

Centers of Excellence: Program that offers eligible medical plan members access to specially selected hospitals for designated program procedures in an effort to improve the quality of care, increase patient satisfaction, and reduce costs for the member and plan.

Consumer Directed Health Plans (CDHPs): Health plans that are intended to give members more control over health care expenses. CDHPs often involve reduced premium costs in exchange for higher deductibles. Health Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs) are commonly introduced with CDHPs.

Consumer Tools: Educational programs, resources, and initiatives to help plan members make better healthcare purchasing decisions.

Contributions: The amount paid by employees to purchase a healthcare plan, typically taken in the form of payroll deductions.

Copay Assistance: Sometimes referred to as Patient Assistance Programs. These programs provide financial assistance to members to pay for prescriptions drugs. Funded by pharmaceutical manufacturers, these programs usually cover most or all of a member's out of pocket costs.

Claim Audits: Verifying claim controls and payment accuracy.

Deductibles/Coinsurance: A deductible is the specific dollar amount a plan member pays before benefits are provided by a health plan. Coinsurance is the amount or percentage that a plan member pays for most covered health care services after a deductible is met.

Dialysis Carve-out: An arrangement in which dialysis treatment benefits are removed from coverage provided by an insurance plan, but are provided through a contract with a separate set of providers.

Direct Contracting: Entering into a direct agreement between an employer health plan and a provider, specifying the amount to be paid for certain services (e.g. transplants, joint surgeries, etc.).

Disease Management: Designed to improve the health of persons with specific chronic conditions and to reduce health care service use and costs associated with avoidable complications, such as emergency room visits and hospitalizations.

Drug Waste/Abuse Management: More rigorous clinical, design, and process initiatives to reduce inappropriate use of non-specialty drugs and related pricing/cost management efforts.

Eligibility Management: Creating more restrictive eligibility requirements (e.g. working spouse exclusions) and/or enforcing the eligibility rules in place through required documentation and audits.

Group Purchasing: Obtaining services through employer coalitions and broker/consulting firm collectives.

Health Education: Initiatives to help plan members better understand and manage their health status, risks, chronic conditions, and treatment options.

Large Claim Management: Additional review and intervention efforts to mitigate the cost of treating high cost claimants.

Medical Management (Pre-Cert/Prior Auth): The plan’s advance approval process for high cost, non-emergency medical services.

Narrow Networks: Networks with a minority of available providers contracted to provide in-network services. These providers are usually selected based on location, cost and/or demonstrated quality.

Onsite Clinics: Work-site medical clinics that serve local employees and sometimes also their eligible dependents. Many started as occupational health clinics, and then expanded into primary care, wellness and/or chronic condition management services.

Private Exchanges: Transferring administration, design, and vendor management responsibility to brokers/consulting firms that provide exchange options for employees and/or retirees.

Reference-Based Pricing: Bypassing network contracts and/or “blind network” arrangements, plan sponsors pay fixed amounts for the cost of health care services. Reimbursement amounts are often tied to Medicare reimbursement levels. Health plans often provide legal assistance to protect employees from provider attempts to “balance bill” plan members.

Scorecard: A tool that summarizes key financial and non-financial data related to an employer's self-insured medical plan by tracking plan performance and trends on a monthly basis.

Second Opinion Programs: Services that encourage and pay for plan members to receive opinions from other physicians before proceeding with certain scheduled surgeries or complex treatments.

Self-Insurance: A self-insured group health plan (or a 'self-funded' plan as it is also called) is one in which the employer assumes the financial risk for providing health care benefits to its plan members.

Site of Care (Surgical): Steering employees via plan design carrots or sticks to less expensive, appropriate settings for certain simple, routine surgical procedures.

Specialty Drug Management: More rigorous clinical, design and process initiatives to reduce inappropriate use of high cost drugs and sites of care.

Telemedicine: Phone and/or internet access to medical professionals for the purpose of diagnosing and treating common illnesses.

Voluntary Benefits: Benefits offered by employers at a group rate, typically employee-pay-all. Examples may include voluntary life, dental, vision, cancer, critical illness, pet insurance, home and auto insurance, etc.

Wellness: Policies and programs designed to help employees make healthier lifestyle decisions. Common elements include biometric screenings, activity challenges, weight loss challenges, smoking cessation programs, stress management programs, education, etc.