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INSURANCE TERMINOLOGY

It is important to know who is responsible for administering and paying for a patient's health benefits. Understanding the terminology is the first step in ensuring that your patients receive the coverage to which they are entitled, and that you receive fair compensation for your services.

INSURANCE COVERAGE

The vast majority of patients with health insurance are covered under group policies. For benefits purposes, a group is any set of individuals who are treated as a single entity. In most cases, groups consist of the employees of a single company or members of an organization and their dependents. Some self-employed or unemployed individuals purchase heath insurance directly under individual policies. However, this type of coverage is not as common.

WAYS OF INSURING

Employers who provide group health benefits for their employees may purchase these benefits in two ways. The most common way, historically, has been for an employer to pay a premium to a managed care plan or insurance company. The insurance company or managed care plan employs underwriters who are responsible for reviewing groups to assess the health risk each group presents and determine appropriate premium levels. The premium payments cover the insurance company's administrative costs, claims costs, and profit.

Larger employers often elect to provide insurance the second way, they self-insure. Under this arrangement, the employer funds health benefits through its own resources without purchasing insurance. The employer can administer the benefits program and process claims itself, or it can hire another organization to provide this function. The term *third-party administrator*, or *TPA*, is used to designate this independent entity that administers group benefits and claims for a self-insured group, TPAs are sometimes referred to just as administrators.

The arrangement between the employer and a TPA to provide these administrative services is called an administrative-services only, or ASO, arrangement. Under an ASO agreement, a third party is contracted to deliver administrative services, such as maintaining a network of providers and processing claims, while the group is at risk for the actual cost of the healthcare services provided. When a TPA receives a claim, it processes the claim and then requests a check from the group to pay the claim amount.

WHO PAYS THE BILLS?

The payer is the entity that is financially responsible for claims payment. In the case of a self-insured company, the company is the payer. In the case of an insurance company or managed care organization (MCO) that underwrites risk and charges premiums, that organization is the payer. If the health benefits have been underwritten by an outside entity, the underwriter may be referred to as a third-party payer. Organizations such as Medicare, Medicaid, Blue Cross and Blue Shield, and commercial insurance companies are considered third-party payers.

In comparison, the term *carrier* refers to an entity that may underwrite or administer a range of health benefit plans. It may refer to an insurance company or MCO, regardless of whether the organization has underwritten the risk or maintains administrative responsibility only. A carrier can be a payer or a TPA.

CARVE-OUT COMPLICATIONS

The distinctions between the involved parties become more complicated when health benefits are *carved out*. In an effort to save money, some payers elect to carve out a portion of the health benefits to allow another entity with expertise in that area to manage it. This is particularly common with psychiatric benefits and pharmacy benefits. In most cases, the carve-out plan acts as a TPA, but it can also be a payer. Depending on the arrangement, the carve-out may provide utilization review services, forward the claims on to a TPA for processing, and have the claims paid by the employer. In other cases, the carve-out will act as a TPA and request claims funds directly from the employer.

PHARMACY BENEFIT MANAGEMENT

Currently most insurers have their pharmacy benefits administered by entities known as PBMs (pharmacy benefit managers, or pharmacy benefit management companies). These companies work with insurers to formulate and administer beneficiaries' prescription drug benefits, and in recent years have become major distributors of prescription drugs. Generally a formulary is established and copays for medications are set based on the medication's status in the formulary. However, copays are also determined by how the drugs are obtained by the patient, either directly from the PBM at a lower copay, or from the neighborhood pharmacy at a higher rate. Pharmacy benefit management is a very complex and constantly evolving issue as insurers employ new methods to attempt to control the cost of providing prescription drugs. For more information on PBMs, call the APA's Managed Care Help Line at 800-343-4671.