# HEALTH CARE GLOSSARY OF TERMS

**Actuarial** — Refers to the statistical calculations used to determine the insured rates and premiums based on projections of utilization and costs for a defined population.

**"Actuarial Difference"**— Under Charter Section A8.428(b)(3), the employers contribute the difference between Active Employee-Only premium and Early Retiree-Only premium. This is the second of three Charter contribution elements applied to the calculation of retiree rates.

**ACA PCORI Fee:** The Affordable Care Act's Patient Centered Outcomes Research Institute fee that was extended beyond its original 2019 expiration to the year 2029 as part of the federal SECURE Act signed into law in December 2019.

**Actuarial Value** — The percentage of benefit costs the health insurer expects to pay toward a health plan. It is based on an average for a population or area and may not necessarily reflect actual cost sharing.

**Adjusted Incurred Claims** — Paid claims net of large claims in excess of the pooling point plus the large claim pooling charge.

**Administration Fees** — The amount included in the premium for the administration of the program not related to claims expense (infrastructure cost such as claims processing, customer service, programing cost, etc.).

**Allowed Amount** — The maximum amount on which payment is based for covered healthcare services. This may be called "eligible expense, "payment allowance," or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference.

**Allowable Charge** — The amount of money the insurance company will pay a non-participating provider based on that provider's geographic region.

**Annual Notice of Change** — A written notification that explains any changes in Medicare plans, that outline the plan's benefit coverage, costs, or service area that will go into effect in January for the upcoming plan year.

**Average Whole Price** (AWP) — The published suggested wholesale price for a drug.

**Base Budget:** The starting point of the budget process is the current years' budget plus cost of living increases and change in fringe benefits (social security, retirement, health etc.) minus any one-time expenditures.

**Brand Name Drugs** — Drugs that are manufactured and marketed under a product name by a pharmaceutical company; typically, the pharmaceutical company holds a patent on the drug's chemical components for a specified period of time.

**CA Department of Insurance** — In California the agency, established in 1868, charged with overseeing insurance regulations, enforcing statutes mandating consumer protections, educating consumers, and fostering the stability of insurance markets in California.

**CA Department of Managed Health Care (DMHC)** — In California, the consumer protection agency, created in 2000, that oversees the operations of managed care organizations. Its mission is to protect consumer healthcare rights and ensure “a stable health care delivery system”.

**Cafeteria Section 125 Plan** — An employee benefits program designed to take advantage of Section 125 of the Internal Revenue Code. It allows employees to pay certain qualified expenses (such as health insurance premiums) on a pre-tax basis, thereby reducing their total taxable income and increasing their spendable/take-home income.

**California Managed Care Organization (MCO) tax** — A per-member tax on the Medi-Cal and non-Medi-Cal enrollment of Managed Care Organizations. It leverages federal funding for Medi-Cal and generates substantial General Fund savings

**Capitation** — A capitation benefit program is one in which a provider contracts with the program’s sponsor or administrator to provide all or most of the services covered under the program to subscribers in return for payment on a per capita basis; this payment is known as a capitation fee, and it is fixed without regard to the actual number or nature of services provided to each person in a set period of time; capitation is the characteristic payment method in HMOs. The services generally including services rendered in a provider’s office and outpatient facility visits that do not result in a hospital admission.

**Center for Medicare and Medicaid Services** (CMS) — Administrators of the Medicare and Medicaid government programs.

**Centers of Excellence** — A network of healthcare facilities selected for specific services based on criteria such as experience, outcomes, efficiency, and effectiveness. For example, an organ transplant managed care program, wherein member's access selected types of benefits through a specific network of medical centers.

**COBRA** — COBRA stands for Consolidated Omnibus Budget Reconciliation Act. It's a federal law that was created in 1985 that gives individuals who experience a job loss or other qualifying event the option to continue their current health insurance coverage for a limited amount of time.

**Coinsurance** — A cost-sharing requirement under a health insurance policy which provides that the insured will assume a portion or percentage of the costs of covered services; health care cost which the covered person is responsible for paying, according to a fixed percentage or amount.

**Contingency Reserve for Self-Funded Plans:** statistically determined amount which protects against potential for funding estimate shortfalls which could occur when the actual claims incurred over a plan year would exceed projected claims when developing premium equivalents; calculated as of June 30 (last day of fiscal year) annually.

**Contributions** — Dollar amount that enrolled employee/family is required to pay regardless of their benefit use.

**Copayment** — Flat dollar amount paid directly by patient.

**Deductible** — Flat dollar amount deducted from covered charges. Can be annual, Per confinement, or Per service/procedure.

**Disease Management** — A multidisciplinary approach to managing care that proactively identifies patients with or at risk for specific medical conditions, supports the patient-physician relationship, emphasizes the prevention of acute episodes and disease progression, utilizes cost-effective and evidence-based practice guidelines, encourages patient empowerment, and continually evaluates clinical, economic, and humanistic outcomes.

**Dispending Fee** — For third-party insurance prescriptions, pharmacies receive a payment for the negotiated ingredient cost of the drug, plus a dispensing fee. The basis for determination of the ingredient cost and dispensing fee are contractually defined terms in the pharmacy network contract between the pharmacy and the pharmacy benefit manager (PBM).

**Disruption Analysis** — An analysis that looks at the actual provider and facility utilization of the employee population over a certain period of time to determine which providers are in-network today and would be out-of-network under a different network and vice versa. Typically, the analysis looks at the prior 12 months of utilization. Results generally outline the percentage of providers where disruption occurs based on claim count and/or claims dollars, either by moving from in-network to out-of-network or vice versa. An example of the results might be: 95% of in-network provider claims today will be in-network under the new network with 5% moving to out-of-network; 3% of out-of-network provider claims today will be in-network under the new network with 97% remaining as out-of-network.

**Drug Utilization Management** (DUM) — A set of utilization management techniques for determining whether a prescribed drug therapy is the most appropriate form of therapy and which drug is both medically appropriate and financially cost effective for the presenting condition.

**Drug Utilization Review** (DUR) — A review system to monitor usage of prescriptions by enrollees, to identify potential interactions with other medications, or to identify alternative-effective or cost-effective therapies.

**Early Retiree Reinsurance Program** — A temporary early retiree reinsurance program, established in the ACA which reimburses sponsors of employment-based plans for a portion of the cost of providing health coverage to early retirees (as well as their spouses, surviving spouses, and dependents who are eligible under the plan). The purpose of the subsidies is to provide an incentive for employers to maintain retiree health benefits and assist retirees with their costs for health coverage. The program expired in December 2014.

**Employer Group Waiver Plans (EGWP)** — A type of Medicare Advantage plan offered by some employers to employees and retirees of some companies, unions, or government agencies. These plans may offer more benefits than traditional Medicare Advantage plans and are often PPOs.

**Employer Mandate** — Employers with 51 or more employees must offer affordable coverage to its full-time employees or pay a penalty (created by the Affordable Care Act).

**Evidence of Insurability** — A health questionnaire that may be required when enrolling in or making changes to a group life insurance or disability plan that helps the insurance carrier determine qualification for new coverage.

**Exchange** (Health Insurance Exchange) — General term for the online marketplace all states are required to have for individuals and small businesses. They serve as an Expedia or Orbitz for the health insurance market, where private insurers can offer health plans.

**Excise Tax on High-cost Employer Sponsored Health Plans (Cadillac Tax)** — The Affordable Care Act established a 40% excise tax on the employer sponsored health plan coverage that exceeds predetermined threshold amounts. The purpose of the tax is to reduce excess health care spending by employees and employers and help finance the expansion of health coverage under the ACA.

**Fiduciary** — Relating to, or founded upon, a trust or confidence. A legal term—a fiduciary relationship exists where an individual or organization has an explicit or implicit obligation to act on behalf of another person's or organization's interests in matters which affect the other person or organization. This fiduciary is also obligated to act in the other person's best interest with total disregard for any interests of the fiduciary.

**First Dollar Coverage** — Medical expenses covered by a benefit plan with no deductibles.

**Flex-Funded Plan** — An arrangement with a health plan whereby there is a fully insured capitated component for professional service provided in physician offices and a self-insured component for the Hospital and pharmacy services.

**Flexible Benefit Plan** — A type of benefit plan that includes employee choice, before-tax dollars, credits, and flexible spending accounts. Also called Cafeteria Plans, Section 125 Plan, and Flexible Compensation.

**Flexible Spending Accounts** (FSA) — FSAs give employees the opportunity to set aside pre-tax funds for the reimbursement of eligible tax-favored welfare benefits. FSAs can be funded through salary reduction, employer contribution, or a combination of both. Monies can be used to pay health insurance deductibles and copayments or pay for childcare benefits.

**Formulary —** A formulary is a comprehensive list of preferred brand name drug products that are covered under a given Medical Plan option. Preferred drug products are selected based on safety, effectiveness, and cost. Drugs that do not appear on this list are considered non-formulary. HMOs may offer an open formulary, a closed formulary, or an incentive formulary. Open formulary means that preferred and non-preferred drugs are eligible for the same level of coverage. Closed formulary means that only preferred drugs are eligible for coverage. Drugs not on the formulary are generally not covered. Incentive formulary means that preferred drugs and non-preferred drugs are eligible for coverage; preferred drugs will cost you less because they have a lower copayment than non-preferred drugs.

**Formulary Brand Drugs —** An approved list of prescription drugs. A list of selected pharmaceuticals and their appropriate dosages felt to be the most useful and cost effective for patient care. Organizations often develop a formulary under the aegis of a pharmacy and therapeutics committee. In HMOs, physicians are often required to prescribe from the formulary.

**Fully Insured Plan** — The method of funding a group benefit plan whereby the employer pays an insurance company to take on claims risk.

**Generic Drugs** — Drugs that have the same chemical components as brand name drugs (and are certified by the U.S. Food & Drug Administration) but are marketed without a brand, using the chemical name only. Federal law requires both brand name and generic drugs to meet the same standards of strength, dosage, safety, and effectiveness. Generic drugs typically cost much less than brand name drugs and are generally considered to be equally effective.

**Generic Equivalent Drugs** — A drug not protected by a trademark; also, the scientific name as opposed to the proprietary, brand name. Equal in therapeutic power to the brand name originals because they contain identical active ingredients at the same doses.

**Generic Requirement** — Requires physicians to prescribe generic drugs when available or the cost to the patient may increase.

**Genomics** — The study of an individual's DNA for medical conditions and risks.

**Geo-Axis Analysis** — The analysis looks at the overall accessibility of a network based on the Zip codes in which the employees live. Access is typically defined as the percentage of employees within a Zip code that meet an access criterion which is expressed as "X number of in-network providers within Y miles of the employees' home Zip codes". The criteria generally vary by provider type (e.g., primary care physician, pediatric physician, hospital) and if the Zip code is considered urban, suburban, or rural. An example of the results might be: 99% of employees in the Zip code 94103 (an urban Zip code) can access at least 2 in-network primary care providers within 5 miles. Another example of results might be: 95% of employees in the Zip code 95321 (Hetch Hetchy, a rural Zip code) can access at least 1 in-network primary care providers within 15 miles.

**Group Health Plan** — Health insurance offered by a group, typically an employer or an association.

**Health Care Spending Account** — Flexible benefits plan feature that permits employees to use pre-tax (tax-free) dollars from their paychecks to pay the cost of out-of-pocket health care expenses up to a certain legislated limit and within very specific guidelines.

**Healthcare Sustainability Fund** — As a result of passage of Prop C (2011), the San Francisco Charter Section A8.423 was amended to include the establishment of the "Healthcare Sustainability Fund", to cover all expenses in connection with obtaining and disseminating information to its members with regard to plan benefits and costs, the investment of such fund or funds as may be established, including travel and transportation costs, member wellness programs, actuarial expenses and expenses incurred to reduce health care costs. The charge is incorporated into premiums as a part of "expenses" on a PMPM basis.

**Health Insurance Portability and Accountability Act of 1996** (HIPAA) — The law that sets standards regarding the security and privacy of person health information.

**Health Maintenance Organization** (HMO) — The common name given to a line of business devoted to managing populations of patients through a prepaid premium, and selling this licensed product directly (or retail) to the employer or purchaser The four types of HMO models are the group model, IPA, network, and staff model. Under the federal HMO act, an entity must have three characteristics—an organized system for providing health care or otherwise ensuring health care delivery in a geographic area, an agreed-on set of basic and supplemental health maintenance and treatment services, and a voluntarily enrolled group of patients.

**Health Insurance Tax (HIT tax)** — This tax was established by the Affordable Care Act. It is an annual fee charged to insurance companies providing health policy premiums. The fee applies to non-self-insured employers, Medicaid managed care, Medicare Part D, and Medicare Advantage. The

tax was permanently repealed, effective January 1, 2021, in the Further Consolidated Appropriations Act 2020 ("Act") on December 19, 2019.

**Health Service Board (HSB)** — Under San Francisco Charter Section A8.422, the Health Service Board is responsible for adopting a plan or plans for providing medical care to member of the Health Service System. The composition of the seven-member a seated member of the San Francisco Board of Supervisors (the Board), appointed by the Board President; an individual who regularly consults in the health care field, appointed by the Mayor; a doctor of medicine, appointed by the Mayor; a member nominated by the Controller a d approved by the HSB; and three members of the Health Service System, active or retired, elected from among their members.

**Incentives** — Variations in plan design intended to change behavior. Positive—higher reimbursement. Negative—benefit reduction or flat dollar penalty eligibility.

**Incurred But Not Reported (IBNR) Reserve for Self-funded Plans:** actuarial estimate of the unpaid claims liability for run-out claims where services were incurred on or before a given date, but those claims have not yet been paid as of that date; calculated as of June 30 (last day of fiscal year) annually for SFHSS plans.

**Indemnity** — The insurance protection against injury or loss of health; although this type of traditional system is now being replaced with other forms of insurance that share risk with providers or employers. Indemnity programs still exist to a large extent to provide reimbursement to the enrolled members for benefits under the contract. Indemnity systems reimburse on a fee for service basis for care and services.

**Individual Mandate** — Law that states most individuals will be required to have health insurance or pay a penalty.

**In-Network Provider** (Participating Provider) — Any physician, hospital, pharmacy, laboratory, or other diagnostic center under contract with the health plan to provide services to members at a specified cost.

**IPA–Model HMO** (Individual Practice Association; Independent Physician Association; Independent Provider Association) — Physicians form a separate legal entity, usually a corporation or partnership, which contracts with the payer / HMO to arrange care in private offices through individual contracts with member physicians in return for a negotiated fee. The IPA in turn contracts with physicians who continue in their existing individual or group practices. The individual practice association may compensate the physician on a per capita, fee schedule, or FFS basis. Represents a wholesale health care delivery component (working with a payer / HMO / retailer that markets the plan directly to employers or patients).

**Knox-Keene Health Care Service Plan Act of 1975** — The set of laws or statutes passed by the California State Legislature to regulate health care service plans, including health maintenance organizations (HMOs) within the State.

**Large Claim Pooling** — Insurance protection against catastrophic or unpredictable losses. Claims beyond the large claim pooling amount per individual in a year are transferred to the insurer, in consideration for a large claim pooling fee paid to the insurer.

**Loss Ratio** — The ratio of paid and incurred claims plus expenses to premium.

**Low Income Premium Subsidy (LIPS)** — Beneficiaries with Medicare who have limited income and assets may qualify for assistance for the Part D monthly premium, annual deductible, coinsurance and copayments. People that are qualified do not have a gap in prescription drug coverage (commonly referred to as the “Medicare donut hole”.

**MACRA -** Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is a bipartisan legislation signed into law on April 16, 2015. MACRA created the Quality Payment Program that: repeals the Sustainable Growth Rate formula, changes the way that Medicare rewards clinicians for value over volume, streamlines multiple quality programs under the new Merit Based Incentive Payments System (MIPS), and gives bonus payments for participation in eligible alternative payment models (APMs)

**Mandated Benefit** — A specific coverage that an insurer or plan sponsor is required to offer by law. Mandated benefits in insurance contracts can vary from state to state according to each state's insurance laws.

**Mail Order Drug Program** — A type of prescription drug plan where employees order maintenance medications via the mail; generally, offers greatly reduced costs for prescriptions, especially for long-term therapy.

**Managed Care** — The concept of controlling utilization and cost of medical care by using a specific pool of providers (doctors and hospitals) to provide care.

**Managed Care Organization** (MCO) — A generic term applied to a managed care plan; also called HMO, PPO, EPO, although the MCO may not conform exactly to any of these formats.

**Mandatory Generic** — A coverage feature where an HMO requires a generic drug equivalent to be dispensed in place of a brand name drug whenever one is available. If a brand name drug is requested in this circumstance, coverage for the brand name drug may be limited, or it may not be covered by the HMO. While most HMOs require members to pay a higher copayment amount for brand name drugs, some may exclude coverage of the brand name drug or members may be required to pay a higher copayment amount for the brand name drug plus the difference in cost between the generic and the brand name.

**MAPD:** Includes Medicare Part D and is available to beneficiaries enrolled in Medicare Part A and Part B. SFHSS offers only MAPD plans in which the Center for Medicare and Medicaid Services (CMS) pays a Managed Care Organization a per member per month premium. SFHSS negotiates additional benefits not covered by MAPD plans alone.

**Maximum Allowable Cost** (MAC) — A list of health plans distributed to their participating pharmacies describing the maximum amount the plan will pay for specific medications.

**Medicare** — The federally financed hospital insurance system (Part A) and supplementary medical insurance (Part B) for the aged created by the 1965 amendment to the Social Security Act.

**Medicare Part D** — Also called the Medicare prescription drug benefit, is an optional United States federal-government program to help Medicare beneficiaries pay for self-administered prescription drugs through prescription drug insurance premiums (the cost of almost all professionally administered prescriptions is covered under optional Part B of United States Medicare).

**Medicare Part D Credible Coverage Reporting** — The federal requirement that entities (whose policies include prescription drug coverage) to notify Medicare eligible policyholders whether their prescription drug coverage is creditable coverage, which means that the coverage is expected to pay on average as much as the standard Medicare prescription drug coverage.

**Medigap** — (also Medicare supplement insurance or Medicare supplemental insurance) — Refers to various private health insurance plans sold to supplement Medicare in the United States. Medigap insurance provides coverage for many of the co-pays and some of the co-insurance related to Medicare-covered hospital, skilled nursing facility, home health care, ambulance, durable medical equipment, and doctor charges. Medigap's name is derived from the notion that it exists to cover the difference or "gap" between the expenses reimbursed to providers by Medicare Parts A and B for the preceding named services and the total amount allowed to be charged for those services by the United States Centers for Medicare and Medicaid Services (CMS).

**Mental Health Parity** — A Federal requirement that generally prevents group health plans and health insurance issuers that provide mental health and substance use disorder benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical coverage.

**Midpoint Trend**—Trend factor is the period between experience period and projection period.

**Multi-Tier Networks** — Multi-Tier Networks use variable network copays. The plan may include Tier A (least cost), B (average cost), and C (most cost). Employees may choose a provider at Tier A, B, or C at their point-of-need. Plan allows employees to make the consumer decision regarding perceived value and cost with every health care need.

**Narrow Network** — These plans have a lower premium, but as a trade-off, the choice of providers is limited. Plans must meet certain regulations, like having enough network providers in different specialties and throughout the geographic area. There must be enough providers to deliver the benefits the plan promises its members.

**Network** — The facilities, providers, and suppliers your health insurer or plan has contracted with to provide healthcare services.

**Non-Formulary Brand Drugs**—Brand name drugs that are not on the preferred drug list of the prescription drug administrator or Prescription Benefit Manager (PBM). Non-formulary drugs should be at a higher cost and less effective than equivalent drugs on the formulary list.

**Non-Participating Pharmacy** — A pharmacy that is not part of the retail network and does not offer a discounted rate. When you fill a prescription at one of these pharmacies, you pay for the prescription and then file a claim for reimbursement; the reimbursement amount will vary depending on your prescription drug coverage.

**Open Enrollment** — The period (usually once a year) during which subscribers in a health plan may have an opportunity to select an alternative plan being offered to them; or a period when uninsured employees and their dependents may obtain coverage.

**Out-of-Network-Provider** (Non-Participating Provider) — Any physician, hospital, pharmacy, laboratory, or other diagnostic center not under contract with a plan to provide services to members at a specified cost. In some benefit plans, members may have reduced coverage (or NO coverage if care is received from non-participating providers).

**Out-of-Pocket Costs** — Healthcare costs that are not covered by insurance, such as copayments, coinsurance, and deductibles.

**Out-of-Pocket Maximum** (OOP max or MOOP) — The maximum amount that an insured person will have to pay for covered expenses under the plan, usually within the plan effective dates.

**OPEB (Other Post-employment Benefits)** — Benefits, other than pensions that state and local governments provide their retired employees. These benefits principally involve retiree health care benefits, but they also can include life insurance, legal, disability, and other services.

**OPEB (Other Post-employment Benefits) liabilities** — Governments are required to record the liability equal to the cumulative amount of unpaid annual required contributions.

**Participating Pharmacy** — A pharmacy that is part of the retail network; when you fill a prescription at one of these pharmacies, you will present your identification card and make a copayment for each covered prescription; the copayment amount will vary depending on your prescription drug coverage.

**Patient Protection and Affordable Care Act** (PPACA) — A law with a series of statues that go into effect beginning March 23, 2010 aimed at increasing access to affordable healthcare for most Americans. Health insurers, healthcare facilities, physicians, individuals, small and large businesses, Medicare, and Medicaid are all impacted by the law.

**PEPM (Per Employee Per Month)** — Employee (also known as subscriber) is defined as the employee/retiree and does not include dependents.

**PMPM (Per Member Per Month)** — Member is defined as the employee/retiree along with the dependents.

**Pharmacy Benefit Manager (PBM)** — is a third-party administrator of prescription drug programs for commercial health plans, self-insured employer plans Medicare Part D plans and state government employee plans. PBMs are primarily responsible for developing and maintaining the formulary, contracting with pharmacies, negotiating discounts and rebates with drug manufacturers, and processing and paying prescription drug claims.

**Point-of-Service** (POS) — A form of managed care in which employees can get in-network as well as out-of-network benefits; a PCP generally manages in-network care only.

**Preferred Provider Organization** (PPO) — A form of managed care in which employees choose to use network or non-network providers when care is needed; there is no primary care physician.

**Premium** — The fee paid to a health insurance carrier by an enrolled company or individual, normally on a monthly basis, for the delivery and financing of healthcare services to the employees or the individual, and their dependents enrolled in the plan.

**Proposition B** (**2008)** — A San Francisco Charter Amendment that defines eligibility for retiree health benefits. Employees hired after January 9, 2009 must have at least five years of credited service with a City employer: City and County of San Francisco, San Francisco Unified School District, San Francisco City College, or San Francisco Superior Court. Other government service is not credited.

**Proposition C (2008)** — A San Francisco Charter Amendment that defines eligibility for retiree health benefits. Employees hired after January 9, 2009 must have at least five years of credited service with a City employer: City and County of San Francisco, San Francisco Unified School District, San Francisco City College, or San Francisco Superior Court. Other government service is not credited.

**Proposition E Contribution (2000):** Under Charter Section A8.428(b)(3)(iii) and A8.428(c), employer contributions toward Retiree Only and Retiree +1 rates = 50% x [Total Rate Cost – 10-County Amount – "Actuarial Difference"]. This is the third of three Charter contribution elements that applied to the calculation of retiree rates.

**Qualifying Event** — An event that enables an individual to make a change to their health plan outside of the enrollment period. Examples include divorce, termination of employment, or birth of a child.

**Rate Stabilization Reserve —** A reserve to spread any underwriting gains or losses into the following year's premium calculation in a consistent manner to reduce volatility from year-over-year changes in premium. The underwriting gains or losses are added or subtracted from the premium amounts to adjust for previous losses or gains. Per HSB policy, each year's loss or gain is spread over the next three years.

**Reasonable and Customary** (R&C) — The prevailing charge made by physicians of similar expertise for a similar procedure in a participating geographic area; sometimes referred to as usual and customary (U&C).

**RFI (Request for Information)** — A request to collect written information about the capabilities of various suppliers. Normally it follows a format that can be used for comparative purposes.

**RFP (Request for Proposal)** — A document that solicits proposal, often made through a bidding process for procurement of a commodity, service, or asset, to potential suppliers to submit business proposals.

**RFQ (Request for Quotes)** — A is a step sometimes used in the formal process of procuring a product or service, by a government agency. It is typically used as a screening step to establish a pool of vendors (businesses or individuals to provide a product or service) that are then qualified, and thus eligible to submit responses to an RFP.

**Risk** — The possibility that costs associated with insuring a particular group will exceed expected levels, thereby resulting in losses for an insurance carrier or self-insurer.

**Risk Corridor** — the percentage of expected claims, beyond those expected claims, which the employer is responsible to fund before the insurer covers the remaining claims that exceed the risk corridor percentage.

**Risk Pool** — A financial arrangement that spreads the risk of utilization and cost among the participants generally the insurer, the hospitals, and the physicians. The pool may insure against

unusually high utilization and costs. The pool may also provide incentives for controlling utilization and costs.

**San Francisco Administrative (Municipal) Code** — Municipal Codes do not require a vote of the electorate to update or modify, they instead require approval by the Board of Supervisors via an Ordinance. Generally, Ordinances require a simple majority of the Board to pass legislation. Some Board actions take the form of Resolutions, which do not have the same legal weight as an Ordinance. Just as an Ordinance cannot modify the Charter, a Resolution may not modify the Municipal Codes.

**San Francisco Charter** — The fundamental law of the City which may only be changed by the voters of San Francisco. Twenty-five years ago, the voters adopted a new charter "the 1996 Charter" which reorganized the prior governing laws, which were largely outgrowths of the prior 1932 Charter, which had grown unwieldly. Many of the reforms of the new charter involved shifting laws and rules into the Municipal Codes (Such as the Administrative, Campaign and Government Conduct, Fire, Health, Police, and Planning Codes for example). Because the Charter is a challenge to modify, it made more sense as a practical matter to place rules related to everyday governance in the Codes, which could be modified by the Board of Supervisors.

**San Francisco Health Service System Adoption and Surrogacy Assistance Plan** — This plan, implemented in 2016, provides a one-time benefit of reimbursement of up to $15,000 to an eligible employee or eligible retiree for qualified expenses incurred in connection with either an eligible adoption or eligible surrogacy.

**San Francisco Health Service System Member Rules** — A document, approved by the Health Service Board, that provides eligibility and enrollment rules,

**San Francisco Health Service Trust Fund** — San Francisco Charter Section A8.428 establishes the Health Service Trust Fund for the purpose of funding benefits for employees, retirees and their families of the City and County of San Francisco, San Francisco Unified School District, San Francisco Community College District, and Superior Court. The Health Service Board has fiduciary responsibilities of this fund.

**San Francisco Retiree Health Care Trust Fund** — Proposition B (2008) established a Trust Fund to be used to pay for the City's contribution to the health care premiums of its retirees and their survivors. The fund is built through a percentage-based formula of the salary contributions from City and County of San Francisco employees. The fund is administered by the Retiree Health Care Trust Fund Board.

**Self-Insurance or Self-Funded** — Plans set up by employers who set aside funds to pay their employees' health claims. Because employers often hire insurers or HMOs to run these plans, they may look just like fully insured plans to members. Employers must disclose in your benefits information whether an insurer is responsible for funding or for only administering the plan; if the insurer is only administering the plan, it is self-insured. The U.S. Department of Labor regulates self-insured plans.

**Single Retiree Offset** — Under Charter Section A8.428(b)(2), the 10-County amount is the first of three Charter contribution elements used to calculate retiree rates. Employers are required to pay lesser of the 10-County amount or actual cost of coverage for each retiree member.

**Stabilization Reserve for Self-Funded Plans** — The annual determination of the financial gain or loss for the self-funded/flex-funded plans calculated annually as of the last day of plan year.

**Stop Loss Insurance** — An insurance product that provides protection against catastrophic or unpredictable losses. It is **purchased** by employers who have decided to self-fund their employee benefit plans, but do not want to assume 100% of the liability for losses arising from the plans.

**Social Determinants of Health (SDOH)** — Social determinants of health are conditions in the environments in which people are born, live, learn, work, play that affect a wide range of health, functioning, and quality-of-life outcomes and risks. By applying SDOH, not only will improve individual and population health but also advance health equity.

**Summary of Benefits** — This is a list of medical services and supplies a health insurance plan covers and the associated costs. These summaries are useful when comparing different plans. The Affordable Care Act requires health plans to provide a summary of benefits written in plain English that includes certain information. It includes covered services, deductible amounts, copays, coinsurance, cost for prescription medicines, coverage exclusions, limits to coverage, and common medical events

**Summary of Benefits Coverage** — A requirement under the Affordable Care Act, that insurance companies and group health plans provide consumers with a standardize and concise document detailing, in plain language, simple and consistent information about health plan benefits and coverage. It summarizes the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions.

**Summary of Material Modifications** — If a group health plan or health insurance issuer makes a modification to their plan's coverage or plan terms, they will need to inform their plan participants.

**Telehealth** — The use of electronic information and telecommunications technologies to support and promote long- distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

**Ten County Survey Amount** — Amount derived from annual survey described in Charter Section A8.423 of contributions provided by 10 most populous counties in CA, not including San Francisco— called the “average contribution”.

**Transitional Reinsurance Fee** — A fee established on all health insurance issuers and third-party administrators on behalf of self-insured group health plans to support payments to individual market issuers that cover high-cost individuals (payment-eligible issuers). The tax was assessed for the 2014, 2015 and 2016 benefit years.

**Trend** — A persistent and pervasive change in direction over a period of time, primarily associated with medical and pharmacy costs year-over-year.

**Voluntary Benefits** — Benefits that are optional and are employee-paid.

**Wellness Plan / Program** — An employer-sponsored program that can be part of the overall health plan or a separate program. Wellness programs aim to improve health and prevent disease

while reducing overall healthcare costs, maintaining / improving employee health, and reducing illness-related absenteeism.

**Wholesale acquisition cost (WAC)** — The manufacturer's list price for [a] drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price.