Glossary - A

Access - A Patient's ability to obtain medical care. The ease of access is determined by components such as the availability to the patient, availability of insurance, the location of health care facilities, transportation, and hours of operation, affordability and cost of care.

Accident - For health insurance purposes, an accident is an unforeseen, unexpected and unintended event resulting in bodily injury.

Accident and Health Plan – An accident and health plan is an arrangement for reimbursement to employees (and their dependents) for expenses caused by personal accidents or sickness. Under one plan, there may be multiple employees, plans, benefits, etc.; such may be insured (including HMO and BCBS) or self-funded.

Accountable Care Organization (ACO) - An Accountable Care Organization is a health provider–led organization designed to manage a patient's full continuum of care, and to be responsible for the overall costs and quality of care for a defined population. Multiple forms of ACOs are possible, including large integrated delivery systems, physician-hospital organizations, multi-specialty practice associations and virtual interdependent networks of physician practices.

Accountable Health Plans (AHP) - Under the Managed Care Act, providers and insurance companies would be encouraged (through tax incentives) to form AHPs, similar to HMOs, PPOs, and other group practices. Accountable health plans would compete on the basis of offering high–quality, low-cost care and would offer insurance and health care as a single product. They would be responsible for looking after the total health of members and reporting medical outcomes in accordance with Federal guidelines.

Accreditation - Approval by an authorizing agency for institutions and programs that meet or exceed a set of pre-determined standards.

Accredited - To meet the standards set by a non-governmental, state or national peer group.

Accrete - The addition of new enrollee to a health plan, usually used in reference to Medicare.

Accumulation Period - The period of time during which an insured person incurs eligible medical expenses toward the satisfaction of a deductible.

Actively-at-work - Most group health insurance policies state that if an employee is not "actively-at-work" on the day the policy goes into effect, the coverage will not begin until the employee returns to work.

Activities of Daily Living (ADL) - This is an index or scale which measures a patient's degree of independence in bathing, dressing, using the toilet, eating and transferring (moving from a bed to a chair, for example). Used to determine need for long-term care and eligibility for payments for care by insurers. (Contrast Instrumental Activities of Daily Living).

Actual Charge - The actual dollar amount charged by a physician or other provider for medical services rendered, as distinguished from the allowable charge.

Actuary - A person professionally trained in the mathematical and statistical aspects of the insurance industry. Actuaries frequently calculate premium rates, reserves and dividends, and assist in estimating the costs and savings of benefit changes.

Actuarial Analysis - The statistical calculations used to determine a managed care company's rates and premiums charged to their customers based on projections of utilization and cost for a defined population.

Actuarial Cost of Coverage - The expected dollar value of a health plan's benefits. The method of determining this value may be based entirely on a plan's provisions, or may adjust for the geographic location and demographic characteristics of enrollees, the actual health care utilization level by plan participants, or the type of plan under which the benefits are provided.

Actuarial Equivalence - Actuarial equivalence computations provide a measure of the economic value of the benefit content of a health care plan. Such computations are often done by Monte Carlo simulations.

Actuarial Justification - This requires a demonstration certified by an actuary that the premiums charged by the issuer (insurer, HMO, MEWA, e.g.) are (a) reasonable to the expected claims, or (b) proportional to the distribution of the expected costs. Such justification is generally required by law or regulation. The ACA mandates that issuers disclose their actuarial justifications to support any unreasonable rate increases.

Actuarial Value (AV) - This is the percentage of Total Average Costs for Covered Benefits that a Health Care Plan will cover. If such percentage is 75%, the Covered Person may be expected to pay 25%.

Actuarial Work Product – An actuarial work-product is a written communication, generally certified by an actuary, consisting of an opinion supported by computations that meets the professional practice standards of the American Academy of Actuaries.

Acupuncture -Typically, acupuncture services include services performed by a licensed acupuncturist.

Acute Care - Medical care administered, frequently in a hospital or by nursing professionals, for the treatment of a serious injury or illness or during recovery from surgery. Medical conditions requiring acute care are typically periodic or temporary in nature rather than chronic.

Acute Care Bed Need Methodology - A formula used to determine hospital bed needs.

Additional Drug Benefit List - See Drug Maintenance List.

Adjusted Average Per Capita Cost (AAPCC) - An estimate of the average cost incurred by Medicare for each beneficiary in the fee-for-service system.

Adjusted Community Rating (ACR) - Community rating impacted by group specific demographics.

Adjusted Payment Rate (APR) - The Medicare capitated payment to risk-contract HMOs. For a given plan, the APR is determined by adjusted county-level AAPCCs to reflect the relative risks of the plan's enrollees.

Administrative Costs - Costs related to activities such as utilization review, marketing, medical underwriting, commissions, premium collection, claims processing, insurer profit, quality assurance, and risk management for purposes of insurance.

Administrative Cost Savings - Reductions in expenditures related to changes in the administrative costs associated with the provision of health care coverage and services.

Administrative Loading -The amount added to the prospective actuarial cost of the health care services (pure premium) for administrative, marketing expenses and profit.

Administrative Reform - Reducing paperwork though simplified universal forms or electronic filing and processing of claims.

Administrative Services Only (ASO) – A business contract under which an insurance company agrees to perform specific administrative duties for the maintenance of a self-funded health insurance plan.

Administration on Aging (AoA) - The AoA is the principal Federal agency responsible for programs authorized under the Older Americans Act of 1965. The AoA serves as an advocate for older persons at the national level, advises Congress and Federal agencies on the characteristics and needs of older people, and develops programs designed to promote the health and well-being of the older population. AoA provides advice, funding, and assistance to achieve community-based systems of comprehensive social services for older people.

Admissions/1000 (APT) - A statistic used by health insurance companies describing the number of hospital admissions for each 1000 persons covered under a health insurance plan within a given time period.

Admits - Hospital admissions; a term used to describe the number of persons admitted to a hospital within a given period.

Adult Day Care - A program of social and health-related services provided during the day in a community group setting. The purpose of the program is to support frail or impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

Adult Foster Care (AFC) - An elderly person's placement with another family when independent living is no longer possible, but nursing care is not necessary. Also see family rest residential.

Adult Protective Services (APS) – Social service interventions for impaired adults at risk of abuse, neglect or exploitation.

Advance Directive/Advance Medical Directive - A document that patients complete to direct their medical care when they are unable to communicate their own wishes due to a medical condition.

Advanced Practice Registered Nurse (APRN) - A registered nurse who is approved by the Board of Nursing to practice nursing in a specified area of advanced nursing practice. APN is an umbrella term given to a registered nurse who has met advanced education and clinical practice requirements beyond the two to four years of basic nursing education required for all RNs. There are four

types: 1. Certified Registered, Nurse Anesthetist (CRNA; 2 Clinical Nurse Specialist (CNS), 3. Certified Nurse Practitioner (CNP); and 4. Certified Nurse Midwife (CNM).

Advance Tax Credit - An Advance Tax Credit is a subsidy to help pay for health insurance that is available when the insurance premium is due without having to wait until a year-end tax return is filed. Also, see Tax Credit.

Adverse Selection - The tendency of those who experience greater health risk to apply for and continue their coverage under any given health insurance plan. When adverse selection increases, health insurance companies experience greater expenses and may raise rates.

Affordable Care Act (ACA) (PL 111-148) - This is the commonly-used and abbreviated name of the Patient Protection and Affordable Care Act of 2010. This law was enacted in March 2010, phasing in major expansions in insurance coverage, changes in insurance rules and delivery system changes over the next several years.

Aftercare - Services following hospitalization or rehabilitation individualized for each patient's needs. Aftercare gradually phases the patient out of treatment while providing follow-up attention to prevent relapse.

Age Change - For insurance purposes, this is the date on which a person's age changes. Note that this may not correspond with the individual's actual birthday, but may fall midway between birthdays. An age change may result in an increase in rates.

Age Discrimination – Drawing the line for mandatory retirement at age 50 for police and at age 60 for airline pilots does not constitute age discrimination. Congress intended plans to discriminate by age so long as such discrimination was at parity with underlying costs. Where discrimination is by years of service only, but which constitutes *de facto* age discrimination as a result thereof, such will be deemed an ADEA violation. It is sufficient to show that age discrimination was not a subterfuge; the cost-parity tests are used for regulatory purposes. It is age discrimination to give a retiree under Medicare plan coverage that is inferior to the plan coverage of a retiree who is not under Medicare. In one decided case, the retirees who were Medicare eligible were given a special HMO Medicare Plus package. Congress intended plans to discriminate by age so long as such discrimination was at parity with underlying costs. Where discrimination is by years of service only, but which constitutes age discrimination as a result.

Age Limits - Ages below and above which an insurance company will not accept applications or renew policies.

Age/Sex Factor - A factor employed by insurance companies in the underwriting process, used to determine a group's risk of incurring medical costs based on the ages and genders of the persons in that group.

Age/Sex Rates (ASR) - Set of rates for a grouping based on age and sex categories used to calculate premiums. This type of premium structure is often preferred over single and family rating in small groups because it automatically adjusts to demographic changes in the group. Also called table rates.

Agency for Health Care Policy and Research (AHCPR) - A Federal agency within the Public Health Service responsible for research on quality, appropriateness, effectiveness and cost of health care.

Agency for Healthcare Research and Quality (AHRQ) - The Agency for Healthcare Research and Quality (formerly known as the Agency for Health Care Policy and Research) is one of 12 agencies within the United States Department of Health and Human Services. AHRQ is one of three organizational focuses for HHS along with the National Institutes of Health and the Centers for Disease Control. AHRQ's mission is to improve the quality, safety, efficiency and effectiveness of healthcare for Americans.

Agent - A state-licensed individual or entity representing one or more insurance companies. An agent solicits and facilitates the sale of insurance contracts or policies and provides services to the policyholder on behalf of the insurer. See also, Broker

Aging in Place - Process allowing seniors to remain in their current residence despite changes in their needs by adjusting the degree and type of services provided. This can occur at home or in a facility offering multiple levels of care.

Aging Network - A highly complex and differentiated system of Federal, State, and local agencies, organizations and institutions which are responsible for serving and/or representing the needs of older persons. The network is involved in service systems development, advocacy, planning, research, coordination, policy development, training and education, administration, and direct service provision. The core structures in the network include the Administration on Aging (AoA), State Units on Aging (SUA), Area Agencies on Aging (AAA), and local service provider agencies.

Aid to Families with Dependent Children (AFDC) - A Federally supported, state-administered program established by the Social Security Act of 1935 that provides financial support for children under the age of 18 (and their caretakers) who have been deprived of parental support or care because of the parent's

death, continued absence from the home, unemployment, or physical or mental illness.

Alien Insurance Company - An insurance company that operates under the laws of another country.

Aligning Forces for Quality (AF4Q) - This is a national program of the Robert Wood Johnson Foundation designed to help communities across the country improve the quality of health care for patients with chronic conditions such as diabetes, asthma, depression and heart disease.

All Patient Diagnosis Related Groups (AP-DRG) - An enhancement of the original Diagnostic Related Groups, designed to apply to a population broader than that of Medicare beneficiaries, who are predominately older individuals. The APDRG set includes groupings for pediatric and maternity cases as well as of services for HIV-related conditions and other special cases.

All Patient Refined Diagnosis Related Groups (APR-DRG) - The APR-DRG structure is similar to the AP-DRG, but also measures severity of illness and risk of mortality in addition to resource utilization.

All-Payer System - A plan to impose uniform prices on medical services, regardless of who is paying.

Allied Health - General term referring to a variety of non-physician and non-nursing clinicians, practitioners, therapists, technologists and technicians working in the health field.

Allied Health Personnel - Also referred to as paramedical personnel, these are health workers (often licensed) who perform duties that would otherwise be performed by physicians, optometrists, dentist, podiatrists, nurses and chiropractors.

Allopathic - One of two schools of medicine that treats disease by inducing effects opposite to those produced by the disease. The other school of medicine is osteopathic.

Allowable Charge - Also referred to as the Allowed Amount, Approved Charge or Maximum Allowable. See also, Usual Custom Charge and Reasonable Charge. This is the dollar amount typically considered payment-in-full by an insurance company and an associated network of healthcare providers. The Allowable Charge is typically a discounted rate rather than the actual charge. It may be helpful to consider an example. You have just visited your doctor for an earache. The total charge for the visit comes to $100. If the doctor is a

member of your health insurance company's network of providers, he or she may be required to accept$80.00 minus any co-payment or deductible that you may owe. The remaining $20 is considered provider write-off. You cannot be billed for this provider write-off if, however, the doctor you visit is not a network provider then you may be held responsible for everything that your health insurance company will not pay, up to the full charge of $100.00. This term may also be used within a Medicare context to refer to the amount that Medicare considers payment in full for a particular approved medical service or supply.

Allowable Costs - Charges for healthcare services and supplies for which benefits are available under your health insurance plan.

Allowed Amount (AA) - This is the maximum amount upon which the plan deductibles and Copayment will be applied. The Submitted amounts less the unallowed amounts are the allowed amounts. These are also referred to as the covered expenses or covered charges.

Alternative Delivery and Financing Systems (ADFS) - See Alternative Delivery System.

Alternative Delivery Sites - Substitute for traditional inpatient sites for care such as ambulatory care centers, surgical centers, home care, hospice care, or alternative delivery and financing systems such as health maintenance organizations (HMOs), or preferred provider arrangements.

Alternative Delivery System (ADS) - An alternative to traditional inpatient care such as ambulatory care, home health care and same day surgery.

Alternative Levels of Care - Alternatives to traditional acute inpatient care, such as ambulatory care centers, surgical centers, home care, skilled nursing facilities, and hospices.

Amended - A designation sometimes found before a House or Senate bill number showing that formal changes have been made to an introduced piece of legislation during the legislative process.

Ambulance Restocking - The practice of hospital replenishing certain drugs and supplies used by an ambulance service during transport of a patient to the hospital.

Ambulatory - Able to get from one place to another independently (even if using assistive devices such as manual wheelchairs, canes or walkers).

Ambulatory Care - Medical care rendered on an outpatient basis and which may include diagnosis, certain forms of treatment, surgery and rehabilitation. See also, Ambulatory Setting.

Ambulatory Patient Groups (APG) - A payment system that pays a fixed price for certain types of outpatient procedures.

Ambulatory Setting - Medical facilities such as surgery centers, clinics and offices in which healthcare is provided on an outpatient basis.

Ambulatory Surgical Center (ASC) - Freestanding center that perform surgeries which do not require an overnight stay.

Ambulatory Utilization Management - Review prior to service against established standards to determine the medical necessity and appropriateness of the care to be provided in an ambulatory setting. The selection of treatment plans subject to pre-service review may be based upon criteria such as proposed care that would require frequent visits, expensive therapy, an extended course of therapy, or costly technology. Concurrent review would be applied as appropriate.

Amendments - See Rider.

American Accreditation Healthcare Commission (AAHC/URAC) - Formerly known as the Utilization Review Accreditation Commission, AAHC/URAC is an independent not-for-profit corporation which develops national standards for utilization review and managed care organizations.

American Association of Homes and Services for the Aging (AAHSA) - AAHSA represents not-for-profit organizations dedicated to providing high quality health care, housing and services to the nation's elderly. Its memberships consists of over 5,000 not-for-profit nursing homes, continuing care retirement communities, senior housing facilities, assisted living and community services. AAHSA organizations service more than one million older persons of all income levels, creed and races. It serves these members by representing the concerns of not-for-profit organizations that serve the elderly through interaction with Congress and Federal agencies. It also strives to enhance the professionalism of practitioner's facilities through the Certification Program for Retirement Housing professionals, the Continuing Care Accreditation Commission, conferences and programs offered by the AAHSA Professional Development Institute and publications representing current thinking in the long-term care and retirement housing fields. As of January 25, 2011, AAHSA changed its name to LeadingAge.

American College of Healthcare Executives (ACHE) - An international professional society of nearly 30,000 healthcare executives. ACHE is known for its prestigious credentialing and educational programs. ACHE is also known for its journal and magazines as well as groundbreaking research and career development and public policy programs. ACHE publishing division is a major publisher of books and journals on all aspects of health services management in addition to textbooks for use in college and university courses. Through its efforts, ACHE works toward its goal of improving the health status of society by advancing healthcare management excellence. ACHE headquarters is based in Chicago, IL.

American Health Care Association (AHCA) - A trade association representing nursing homes and long term care facilities in the United States; based in Washington, D.C.

American Hospital Association (AHA) - A national association that represents allopathic and osteopathic hospitals in the United States; based in Washington, D.C. with operational offices in Chicago.

American Medical Association (AMA) - A national association organized into local and regional societies that represent over 700,000 medical doctors in the United States; based in Chicago.

Americans with Disabilities Act (ADA) - A Federal law which prohibits employers of more than 25 employees from discriminating against any individual with a disability who can perform the essential functions, with or without accommodations, of the job that the individual holds or wants.

Amount, Duration and Scope - How a Medicaid benefit is defined and limited in a state's Medicaid plan. Each state defines these parameters, thus state Medicaid plans vary in what is actually covered.

Ancillary Care - A term used to describe additional services performed related to care, such as lab work, X-ray and anesthesia.

Ancillary Charge - Also referred to as hospital "extras" or miscellaneous hospital charges. They are supplementary to a hospital's daily room and board charge. They include such items as charges for drugs, medicines and dressings, laboratory services, x-ray examinations, and use of the operating room.

Ancillary Products - Additional health insurance products (such as vision or dental insurance) that may be added to medical insurance plan for an additional fee.

Ancillary Services - Supplemental healthcare services such as laboratory work, x-rays or physical therapy that is provided in conjunction with medical or hospital care.

Annual Benefit Limit (ABL) - This is the maximum amount that the plan will pay for any one single service or health condition.

Annual Limit - Many health insurance plans place dollar limits upon the claims the insurer will pay over the course of a plan year. Beginning September 23, 2010, PPACA phases annual dollar limits will be phased out over the next 3 years until 2014 when they will not be permitted for most plans. There is an exception to this phase out for Grandfathered Plans. Except for Grandfathered Plans, beginning September 23, 2012 annual limits can be no lower than $2 million. Except for Grandfathered Plans, beginning January 1, 2014, all annual dollar limits on coverage of essential health benefits will be prohibited.

Anti-Kickback Statute - A Federal law that prohibits the paying or receiving of remuneration in exchange for the referral of patients or businesses paid by a Federal health care program.

Antitrust - A health plan to accept on its provider panels every physician, hospital or other practitioner that wants to participate in the health plan's products.

Any Willing Provider - This is a legal requirement - typically a state law - that a managed care organization must accept any properly licensed provider willing to meet the terms of a plan's contract, whether the organization wants or needs that provider. Often described by managed care groups as anti-managed care legislation.

Appeal - An appeal is a request for review of a denial of coverage of a particular medical service or inadequate payment for services already received. Medicare beneficiaries have the right to appeal in either of these circumstances, whether they are enrolled in traditional Medicare or in a Medicare Advantage plan. Under the ACA, all consumers will have the right to appeal decisions, including coverage denials and rescissions, made by their health plans first through the plan's internal process and then to an outside, independent decision-maker.

Application Fee - The health insurance company may require a one-time application fee. Some insurance companies may refund this fee if the application is not approved. See More Insurance Plan Details section for additional information.

Approved Charge - See Allowable Charge

Approved Health Care Facility or Program - A medical facility of healthcare program (often organized through a hospital or clinic) that has been approved by a health insurance plan to provide specific services for specific conditions.

Area Agency on Aging (AAA) - A Public or private nonprofit organization designated by the state to develop and administer the area plan on aging within a sub-state geographic planning and service area. AAAs advocate on behalf of older people within the area and develop community-based plans for services to meet their needs. AAAs administer Federal, State, local and private funds through contracts with local service providers. In Delaware the State Unit on Aging also services as the state's sole Area Agency on Aging.

Asset - Medicaid term referring to resources such as savings, stocks, bonds, and certain possessions that are considered in determining financial eligibility.

Assignment of Benefits - The payment of health insurance benefits to a healthcare provider rather than directly to the member of a health insurance plan.

Assisted Living Facility (ALF) - Home-like residential option that provides personal care and scheduled nursing care as needed.

Assistive Devices or Technology - Any tools that are designed, fabricated, and/or adapted to assist a person in performing a particular task, e.g., cane, walker, shower chair, computer speech recognition, or communication device.

Associate Degree in Nursing (ADN) - A degree received after completing a two-year nursing education program at a college or university.

At Risk - Having to assume the financial liability for a loss that occurs when premiums paid are less than the cost of services provided.

Attendant - Term used most often by the disability community to refer to an aide who provides personal assistance in the community. Also see personal care.

Attending Physician Statement (APS) - A physician's assessment of a patient's state of health as outlined in office notes and test results compiled by the physician. An APS may be requested by an insurance company in lieu of a medical examination in order to determine the state of a health insurance applicant's health for underwriting purposes.

Attrition Rate - Disenrollment or fall-out rate expressed as a percentage of total

membership. Off-open enrollment terminations are generally due to subscriber's employment or relocation outside of the MCO's service area, and cannot be controlled. Open enrollment terminations are sometimes due to subscriber dissatisfaction and thus may be controllable.

Audiologist - Performs duties directly related to problems and disorders of human communication in the process of speech and hearing

Audit of Provider Treatment - Review of the patient's medical record and charges and claims for services to assure that the services provided were consistent with the patient's diagnosis and that documentation in the medical record supports the submitted charges.

Authorization - As it applies to managed care, authorization is the approval of care, such as hospitalization. Pre-authorization may be required before a patient is admitted or care is given by (or reimbursed to) non-HMO providers.

Auto-Assignment - A term used with Medicaid mandatory managed care enrollment plans. Medicaid recipients who do not specify their choice for a contracted plan within a specified time frame are assigned to a plan by the state. Can also refer to assignment to primary care physicians.

Average Cost (or Average benefit) - The average cost (or benefit) for a unit of output (e.g., one day in a hospital for one patient) is the total cost (or benefit) of the total units of output delivered by the total units of output.

Average Length of Stay (ALOS) - A standard hospital statistic used to determine the average amount of time between admission and discharge for patients in a diagnosis related group (DRG), an age group, a specific hospital or other factors.