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Access: Right to enter or use health care services.

Acquisition Cost: The cost to an insurer to acquire new business. It includes costs such as underwriting the risk, issuing a new policy, paying commissions and overhead or office expenses.

Activities of Daily Living (ADLs): Everyday activities which are used to measure an individual's ability to function independently. ADLs define the disability in long term care insurance. The loss of some number of ADLs is an insuring or triggering event in all long term care policies. In California, Senate Bill 1943 established seven standard activities of daily living (eating, bathing, dressing, toileting, continence, transferring, ambulating) for any LTC policy that purports to cover home care in its provisions. A loss of 2 to 7 of the ADLs will qualify an insured for benefits. There are LTC programs in California that do not comply with S.B.1943 (California Partnership and CALPERS). These programs have more stringent insuring clauses. ADLs and the loss necessary to trigger benefits may vary from state to state. Additionally, despite standardization, companies choose to define the inability to perform an ADL differently. The NAIC is working to set national standards for ADL definitions.

Actual Charge: The amount a physician or supplier actually bills for a particular medical services or supply.

Actuary: A professional who mathematically analyzes and determines the price of the risk associated with providing insurance coverage. An actuary may also determine the anticipated cost of providing future benefits. Factors considered in the study include the projection of future claims experience, administrative expenses and anticipated investment return.

Acute Care: Care for illness or injury that develops rapidly, has pronounced symptoms and is finite in length. Traditional medical insurance, Medicare and Medicare supplements are designed to provide coverage for acute illness.

Adjusted Average Per Capita Cost (AAPCC): Health Care Financing Administration (HCFA) basis of payment to HMOs and CMPs.

Adjusted Community Rate (ACR): Uniform capitation rate that is charged to all enrollees in a plan based on adjustments for risk factors such as age and sex.

Administrative Services Only (ASO): A type of contract with an insurance company or a third party administrator that provides an employer with administrative services. It does not provide coverage for risk or insurance protection. The usual expenses covered include claims processing, plan design advice and printing benefit booklets. These contracts are usually entered into by large employers who can afford the risk of providing insurance protection with their own money.

Administrator: A person who is designated to be responsible for the proper operation and administration of a plan. When the plan sponsor does not designate a person for this duty, then ERISA considers the plan sponsor to be the plan administrator.

Adult Day Care: Social, recreational and/or rehabilitative services provided for persons who benefit from daytime supervision. An alternative between care in the home or in a institution.

Adverse Selection: A tendency which occurs when a person makes a decision based on his/her diminished health condition or frequency of needed treatment and is, therefore, considered a poorer claims risk than most others in the group.

Aid to Families with Dependent Children (AFDC): Public assistance program that provides payment to families with children 18 years of age and under who have an income below a defined poverty line.

Agent: Licensed by the state, performs the functions for sole proprietors and small businesses that Human Resource Departments do for larger businesses, gathers census data, prepares proposals, makes presentations to businesses, explains benefits to employers, does field underwriting when required, delivers policies and certificates, explains benefits to employees, assists in handling claims, services the business in any other related tasks required by the employer or sole proprietor.

Aggregate Amount (limit): Maximum amount a plan sponsor (employer) is liable for any single loss or series of losses.

Ageism: Prejudice against people because of their age.

Alternate Care Benefit: Payment for a special arrangement of services specifically designed to allow the person to reside in a setting other than a nursing facility (i.e. services to provide assistance, capital improvements such as a ramp, and/or durable medical support).

Alternate Care Facility: (1) A hospice; or (2) a place that provides ongoing care to inpatients in one location and which (a) provides 24-hour care and services sufficient to support needs resulting from inability to perform activities of daily living or cognitive impairment; (b) has a trained and ready-to-respond employee to provide such care; (c) provides three meals a day and accommodates special dietary needs; (d) is appropriately licensed or accredited; (e) has formal arrangements for the services of a physician or nurse to provide emergency medical care; and (f) has appropriate procedures for handling administering drugs.

Alzheimer's Disease: A form of organic dementia resulting in premature mental deterioration, first described in 1906 by German neurologist, Alois Alzheimer. In California, as well as most of the rest of the United States, Alzheimer's Disease is considered a cognitive impairment, thus triggering benefits under long term care insurance policy.

Ambulatory Care: Medical services provided on an outpatient (non-hospitalized) basis. Services may include diagnosis, treatment, surgery, and rehabilitation.

Ancillary Services: Health care services conducted by providers other than physicians and surgeons. These will usually include such services as physical therapy and home health care.

Annual Benefit Cap: Maximum amount paid for specific medical services or total medical services.

Appeals Consideration: Clinical review conducted by appropriate independent clinical peers, when a decision not to certify a requested admission, procedure, or service has been appealed. Sometimes

referred to as “third level review.”

Approved Amount: The amount Medicare determines is reasonable for a service covered under Medicare Part B. It may be less than the actual charge. For many services, including physician services, the approved amount is taken from a fee schedule that assigns a dollar value to all Medicare-covered services that are paid under that fee schedule.

Assessment: A determination of physical and/or medical status by a health professional based on established medical guidelines. The assessment is a central component in home care coverage's and the payment of home care claims. Upon the triggering of benefits, due either to the loss of some number or activities of daily living or a cognitive impairment, an assessment is performed by a multidisciplinary team. This “team” usually spearheaded by the insured's physician, determines the level of functional incapacity and develops a plan of care that will be followed in assisting the insured in the performing the ADLs and IADLs (instrumental activities of daily living).

Assignment: An arrangement whereby a physician or medical supplier agrees to accept the amount approved by Medicare as full payment for services and supplies under Part B. Medicare usually pays 80% of the approved amount directly to the physician or supplier after the beneficiary meets the annual Part B deductible of \$100. The beneficiary pays the other 20 percent.

Assignment of Benefits: Authorization by the insured which allows the insurer or claims payer to pay benefits directly to the medical care provider.

Assisted Living: A non-medical institution providing room, board, laundry, some form of personal care and usually recreational and social services. Licensed by state departments of social services, these facilities exist under several names including domiciliary care facility,, sheltered house, board and care, community based residential care facilities and alternate care facilities.

ASO: A type of contract with an insurance company or a third party administrator that provides an employer with administrative service. It can include coverage for a certain amount of claims risk. The usual administrative expenses include claims processing, plan design advice and printing benefit booklets. Large employers who can afford the risk of providing insurance protection with their own money usually enter into these contracts.

Attachment Point: For aggregate stop-loss insurance, it is the point at which the stop-loss insurance carrier begins to reimburse the employer based upon the cumulative total of claims paid within a policy year.

Attending Physician: The doctor of medicine or doctor of osteopathic medicine with primary responsibility for the care provided to a patient in a hospital or other health care facility.

Authorizations: Consent or endorsement by a primary care physician for patient referral to ancillary services and specialists.

Average Length of Stay: One measure of use of health facilities, reported as an average number of inpatient days spent in a hospital or other health care facility per admission or discharge. It is calculated as follows: total number of days in the facility for all admissions during a particular period divided by the number of admissions during the same period. Average lengths of stay vary and are measured by age, specific diagnosis, or sources of payment.