



DICTIONARY OF HEALTH INSURANCE AND MANAGED CARE

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Dr. David Edward Marcinko, MBA, CFP®, CMP®, is a health care economist and former board-certified surgical fellow from Temple University in Philadelphia. In the past, he edited four practice-management books, three medical texts in two languages, six financial planning books, and two CD-ROMs for physicians, financial advisors, accountants, attorneys, and business consultants. Internationally recognized for his work, he provides litigation support and expert witness testimony in state and federal court, with clinical publications archived in the Library of Congress and the Library of Medicine at the National Institute of Health. His thought leadership essays have been cited in many scholarly journals (e.g., *Physicians Practice*, *Managed Care Executives*, *Medical Interface*, *Plastic Surgery Products*, *Teaching and Learning in Medicine*, *Orthodontics Today*, *Podiatry Management*, the *Journal of the American Medical Association* [JAMA.ama-assn.org], and *Physician's Money Digest*); by professional organizations (e.g., the Medical Group Management Association [MGMA], American College of Emergency Physicians [ACEP], American College of Medical Practice Executives [ACMPE], and American College of Physician Executives [ACPE]); and by academic institutions (e.g., the Northern University College of Business, UCLA School of Medicine, Medical College of Wisconsin, Southern Illinois College of Medicine, Washington University School of Medicine, University of Pennsylvania Medical and Dental Libraries, University of North Texas Health Science Center, Emory University School of Medicine, and the Goizueta School of Business at Emory University). Dr. Marcinko also has numerous editorial and reviewing roles to his credit. His most recent textbook from Springer Publishing Company is *The Advanced Business of Medical Practice*. A favorite on the lecture circuit and a linguistic docent often quoted in the media, he speaks frequently to medical and financial services societies throughout the country in an entertaining and witty fashion.

Dr. Marcinko received his undergraduate degree from Loyola College (Baltimore), completed his internship and residency training at Atlanta Hospital and Medical Center, earned his business degree from the Keller Graduate School of Management (Chicago), and his financial planning diploma from Oglethorpe University (Atlanta). He is a licensee of the Certified Financial Planner® Board of Standards (Denver) and holds the Certified Medical Planner® designation (CMP®). He obtained Series #7 (general securities), Series #63 (uniform securities state law), and Series #65 (investment advisory) licenses from the National Association of Securities Dealers (NASD) and a life, health, disability, variable annuity, and property-casualty license from the State of Georgia. Dr. Marcinko was also a cofounder of an ambulatory surgery center that was sold to a publicly traded company, a Certified Professional in Health Care Quality (CPHQ), a medical-staff vice president of a general hospital, an assistant residency director, a founder



of a computer-based testing firm for doctors, and a president of a regional physician practice-management corporation in the Midwest.

Currently, Dr. Marcinko is chief executive officer and provost for the Institute of Medical Business Advisors[®], Inc. The firm is headquartered in Atlanta, has offices in five states and Europe, and works with a diverse list of individual and corporate clients. It sponsors the professional Certified Medical Planner[®] charter designation program. As a national educational resource center and referral alliance, the Institute of Medical Business Advisors[®], Inc., and its network of independent professionals provide financial solutions and managerial peace of mind to physicians, emerging health care organizations, and their consulting advisors.



Hope Rachel Hetico RN, MSHA, CPHQ, CMP[®], received her nursing degree from Valpariso University, and master's degree in Health Care Administration from the University of St. Francis, in Joliet, Illinois. She is operations editor of a dozen textbooks and a nationally known expert in managed medical care, medical reimbursement, case management, infection control, health insurance and risk management, utilization

review, National Committee on Quality Assurance (NCQA), Health Plan and Employer Data and Information Set (HEDIS), and Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) rules and regulations. With a well-documented history of identifying innovations in education and accelerating their adoption by the medical, insurance, and financial services industries, she is frequently quoted in the health care business media and brings a decade of entrepreneurship and creative leadership skills to the Medical Business Advisors National Network[®] of independent advisors. Prior to joining the Institute of Medical Business Advisors[®], Inc., as president and chief operating officer, she was a senior hospital executive, financial advisor, licensed insurance agent, Medicare, Medigap and long-term-care specialist, certified professional in health care quality (CPHQ), and distinguished visiting instructor in health care administration for the University of Phoenix, Graduate School of Business and Management, in Atlanta. Ms. Hetico was also regional corporate director for medical quality improvement at Abbey Healthcare, a public company in Costa Mesa, California. Now, she is responsible for leading www.MedicalBusinessAdvisors.com to the top of the exploding business-to-business educational marketplace, while continuing to nurture the company's rapidly expanding list of medical and financial services clients and colleagues.





Preface

“When I use a word,” Humpty Dumpty said, in a rather scornful tone, “It means just what I choose it to mean—neither more nor less.”

“The question is,” Alice said, “whether you can make words mean so many different things.”

“The question is,” said Humpty Dumpty, “which is to be master, that’s all!”

Lewis Carroll,
Through the Looking Glass

Medical insurance and managed care is a component of the protean health care industrial complex. However, it is not contained in a separate space, and its language needs to be codified and documented to avoid confusion over terms of art. Health, Medicare, Medicaid, dental and vision insurance and worker’s compensation, disability, and long-term-care insurance represent financial products that play a critical role in Americans’ personal and professional lives. However, the field is rapidly changing in their cost-constrained economic environment. More products, technology, and terms have reached the marketplace in the past few years than in all previous decades, and the introduction of new words is indeed rapid. Moreover, with its quixotic efforts, the U.S. Department of Health and Human Services, along with the private sector, has created a labyrinth of new programs with confusing terminology, eponyms and jargon, as well as related accounting, Health Insurance Portability and Accountability Act, finance, and economics abbreviations.

And so, the *Dictionary of Health Insurance and Managed Care* was conceived as an essential tool for doctors, nurses, clinics, and hospitals; health care administrators, financial advisors, and business consultants; accountants, actuaries, and benefits managers; health maintenance organizations, preferred provider organizations, and insurance companies; as well as medical, dental, business, and health care administration graduate and doctoral students.

The *Dictionary of Health Insurance and Managed Care* can also be used as a handy quick reference source and supplement to sales literature for insurance agents, brokers, actuaries, underwriters, and managed care product professionals, and to answer prospect questions and inquiries about servicing. Fast, succinct, and technically accurate responses to such questions can sometimes mean the difference between closing and not closing a sale or reducing costs when purchasing a health insurance or managed care product.

And, let us not forget about savvy consumers who will find the *Dictionary of Health Insurance and Managed Care* a wealth of information in readily understood language. It is astonishing that the health insurance purchase decision is often made directly by the layman without sufficient basic knowledge of the various acronyms, definition, and policy provisions!





With 5,015 definitions, 3,010 whimsical abbreviations and acronyms, and a collection of 2,015 resources, readings, and nomenclature derivatives, the *Dictionary* is actually a three-in-one reference tool. It contains more than 10,000 entries that cover the language of every health care industry sector: (a) layman, purchaser, and benefits manager; (b) physician, provider, and health care facility; and (c) payer, intermediary, and insurance professional. We highlight new terminology and current definitions and include a list of confusing acronyms and alphabetical abbreviations. The *Dictionary* also contains definitions and offerings of the recent past that are still in colloquial use. These definitions are expanded where appropriate with simple examples and cross-references to research various other definitions or to pursue relevant or related terms.

Of course, by its very nature the *Dictionary of Health Insurance and Managed Care* is ripe for periodic updates by engaged readers working in the fluctuating health insurance and managed health care milieu. It will be periodically updated and edited to reflect the changing lexicon of terms, as older words are retired, and newer ones are continually created. Accordingly, if the reader has any comments or suggestions or would like to contribute substantive unlisted abbreviations, acronyms, eponyms, or definitions to a future edition, please contact us.

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Foreword

Why do we need the *Dictionary of Health Insurance and Managed Care*? And, why do payers, providers, benefits managers, consultants, and consumers need a credible and unbiased source of explanations for their health insurance needs and managed care products?

The answer is clear!

Health care is the most rapidly changing domestic industry. The revolution occurring in health insurance and managed care delivery is particularly fast. Some might even suggest these machinations were malignant, as many industry segments, professionals, and patients suffer because of them. And so, because knowledge is power in times of great flux, codified information protects all people from physical, as well as economic, harm.

For example, federal government forecasts reveal that total expenditures on health services will surpass \$2 trillion in 2007, and account for 17% of the gross domestic product. As a country, Americans spend dramatically more total dollars on health care, and more as a percentage of the economy, than they did two decades ago. Along with these growing expenditures, the government is assuming greater control. Currently, almost 50% of health care costs are under federal or state mandates through Medicare and Medicaid entitlement programs. The recent prescription drug program and implementation of the Health Insurance Portability and Accountability Act add more confusion for medical providers and facilities, insurance agents, health plans, and patients. This tumult occurred so rapidly that Americans can no longer assume operative definitional stability. The resulting chaos is as expected.

Fortunately, the *Dictionary of Health Insurance and Managed Care* provides desperately needed nomenclature stability to health insurance policy issues and managed care procedural concerns. With almost 10,000 definitions, abbreviations, acronyms, and references, the *Dictionary* is the most comprehensive and authoritarian compendium of its kind, to date.

Health care economist Dr. David Edward Marcinko, and his colleagues at the Institute of Medical Business Advisors®, Inc., should be complimented for conceiving and completing this laudable project. The *Dictionary of Health Insurance and Managed Care* lifts the fog of confusion surrounding the most contentious topic in the health care industrial complex today. My suggestion, therefore, is to “read it, refer to it, recommend it, and reap.”

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Acknowledgments

Creating the *Dictionary of Health Insurance and Managed Care* was a significant effort that involved all members of our firm. Major source materials include those publications, journals, and books listed as references, as well as personal communication with experts in the health insurance and managed care industry.

Over the past year, we also interfaced with public resources, such as various state governments, the federal government, the Federal Register (FR), the Centers for Disease Control and Prevention (CDCP), the Centers for Medicare and Medicaid Services (CMS), the Institute of Medicine (IOM), the National Research Council (NRC), the U.S. Department of Health and Human Services (HHS), and the Office of Civil Rights (OCR), as well as numerous private institutions, physicians, nurses, and managed health care experts to discuss its contents. Although impossible to acknowledge every person that played a role in its production, there are several people we wish to thank for their moral support and extraordinary input.

These include: Timothy Alexander, MS, vice president of Library Research, and Robert James Cimasi, ASA, CBA, AVA, FCBI, CMP®, president and founder, Health Capital Consultants, LLC, St. Louis, Missouri; Jerry Belle, president, Aventis Pharmaceuticals North America; Gary A. Cook, MSFS, CFP®, CLU, RHU, CMP®, Content Developer for COOS Development Corporation, Huntersville, North Carolina; Dr. Charles F. Fenton, III, Esquire, health-law attorney, Atlanta, Georgia; Professor Gregory O. Ginn, PhD, CPA, MBA, MEd, Department of Healthcare Administration, University of Las Vegas, Nevada; Timothy R. Hetico, CEO, Hetico Insurance Agency, Springfield, Ohio; Dr. Jay S. Grife, Esquire, founder and CEO, Medical Malpractice Consultants, Inc., Jacksonville, Florida; Dean L. Mondell, MD, president, Rehabilitation Specialists, PC, Las Vegas, Nevada; Paul A. Valle, Jr., MD, Family Care Associates at the Greater Baltimore Medical Center in Maryland; and Sheri W. Sussman, Senior Vice President, Editorial, Springer Publishing, New York, who directed the publishing cycle from conception to release.

Dedication

The *Dictionary of Health Insurance and Managed Care* is dedicated to Mackenzie Hope Marcinko of Atlanta; Rachel Pentin-Maki, board of directors, Finlandia University, Hancock, Michigan; and Ray Hirvonen, Raymond M. Hirvonen Foundation, Marquette, Michigan. They constantly reminded us to present concepts as simply as possible, as we endeavored to create a comprehensive *Dictionary* relevant to the entire health care industrial complex.





INSTRUCTIONS FOR USE

Alphabetization

Entries in the *Dictionary* are alphabetized by letter rather than by word, so that multiple-word terms are treated as a single word.

Cross-References

Contrasting or related terms may be cross-referenced in the *Dictionary* to enhance reader understanding. Once an entry has been fully defined by another term, a reference rather than a definition may be provided (e.g.,: health maintenance organization. *See* MCO. *See* IPA).

Definitions

Because many academic words have distinctly different definitions depending on their context, it is left up to the reader to determine their relevant purpose. However, the various meanings of a term have been listed in the *Dictionary* by bullets or functional subheading for convenience. Older terms still in colloquial use are also noted. *See* Unusual Definitions.

Disclaimer

All definitions, abbreviations, eponyms, acronyms, and information listed in the *Dictionary* are intended for general understanding and do not represent the thoughts, ideas, or opinions of the Institute of Medical Business Advisors®, Inc. Care has been taken to confirm information accuracy, but we offer no warranties, expressed or implied, regarding currency and are not responsible for errors, omissions, or any consequences from the application of this information. Furthermore, terms are not complete because many are written in simplest form. The health insurance and managed care industry is evolving rapidly, and all information should be considered time-sensitive.

Italics

Italic type may be used to highlight the fact that a word has a special meaning to the health care industry. It is also used for the titles of publications, books, journals, articles, and white papers referenced in the *Dictionary*.

Unusual Definitions

Unique trade or industry terms that play an active role in the field of health insurance and managed care are included in the *Dictionary* along with a brief explanation, as needed.

Abbreviations and Acronyms

Abbreviations with multiple meanings are included in the *Dictionary* because the industry does not possess a body of standardized acronyms and abbreviations.

Bibliography

Collated readings from a variety of sources for further research into specific subjects of interest.





TERMINOLOGY: A-Z

A

'A' TIER: The top and usually most expensive level of drugs available from a health insurance policy or managed care plan formulary.

ABSENTEEISM POLICY: Guidance within an organization or business about how to manage the state of chronic absence from work. Absenteeism is usually addressed through progressively stricter disciplinary measures that can result in the termination of the individual's employment. This is generally governed by the organization's absenteeism policy. See Presenteeism.

ABSOLUTE: A complete or final ruling or order on health insurance, without conditions.

ABSTRACT: A collection of information from the medical record by hard copy, charts, or electronic instrument.

ABUSE: Actions that do not involve intentional misrepresentations in health care billing but which may result in improper conduct. Consequences can result in civil liability and administrative sanctions. An example of abuse is the excessive use of medical supplies. See Compliance, FBI, Fraud, and OIG.

ACADEMIC MEDICAL CENTER: A group of related institutions including a teaching hospital or hospitals, a medical school and its affiliated faculty practice plan, and other health professional schools.

ACADEMY OF MANAGED CARE PHARMACY: A trade organization of pharmacists who work for the managed care insurance industry.

ACCELERATED DEPRECIATION: A method in which larger portions of depreciation are taken in the beginning periods of asset life, and smaller portions are taken in later years. See Depreciation.

ACCELERATED PAYMENT: The partial advancement of funds to temporarily pay for delayed healthcare claims.

ACCEPTANCE: The agreement to an offer of a health or managed care insurance contract.

ACCEPT ASSIGNMENT: Physician agreement to accept the fees allowed by an insurance plan, HMO, prospective payment system, or by Medicare.

ACCESS: A patient's ability to obtain medical care. The ease of access is determined by components as the availability of medical services and their acceptability to the patient, the location of health care facilities, transportation, hours of operation, and cost of care. See Applicant and Policyholder.

ACCESS FEE: The managed care or health care insurance plan fee to access its panel of member medical providers.



ACCESSIBILITY OF SERVICES: Ability to get medical care and services when needed.

ACCIDENT: In the context of health insurance, it is an unintended, unforeseen, and unexpected event that generally results in injury or loss. See Illness, Injury, Hazard, Peril, and Loss.

ACCIDENTAL BODILY INJURY: Unforeseen and unintended bodily injury resulting from an accident. Generally considered a more liberal term or definition in accident insurance policies, as distinguished from a technical interpretation of the term “accidental means.” See Accident.

ACCIDENTAL DEATH: Death as the result of accidental bodily injury (i.e., injury that is unintended, unexpected, and unusual). Contrasted with death by accidental means, which means that the cause of the accident itself must be accidental (slipping off a ladder, etc.). Thus, a broken neck as a result of an intended safe dive into a swimming pool is accidental death, but not death by accidental means. See Accident.

ACCIDENTAL DEATH BENEFIT: An extra benefit that generally equals the face value of a health insurance or managed care contract or a principal sum payable in addition to other benefits in the event of death as the result of an accident. See Accident Insurance.

ACCIDENTAL DEATH AND DISMEMBERMENT: A policy or a provision in a disability income, life, or health insurance policy that pays either a specified amount or a multiple of the weekly disability benefit if the insured dies, loses his or her sight, or loses two limbs as the result of an accident. A lesser amount is payable for the loss of one eye, arm, leg, hand, or foot.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT: A policy provision that pays a stated benefit in case of death or the loss of limbs or sight as a result of an accident.

ACCIDENTAL DEATH AND DISMEMBERMENT RIDER: A supplementary benefit rider or endorsement that provides for an amount of money in addition to the basic death benefit of a life or health insurance policy. This additional amount is payable only if the insured dies or loses any two limbs or the sight of both eyes as the result of an accident. Some riders pay one half of the benefit amount if the insured loses one limb or the sight in one eye. See Accident Insurance.

ACCIDENTAL DEATH INSURANCE: A form of life or health insurance that provides payment if the death of the insured results from an accident. It is often combined with Dismemberment Insurance in a form called Accidental Death and Dismemberment. See Accidental Death and Dismemberment.

ACCIDENTAL DISMEMBERMENT: The severance of limbs at or above the wrists or ankle joints or the entire irrevocable loss of sight. Loss of use, in itself, is not usually considered to be dismemberment. See Accidental Means and Accidental Means Death Benefit.

ACCIDENTAL MEANS: An unforeseen, unexpected, unintended cause of an accident. The means that causes the mishap must be accidental for any claim to be payable.

ACCIDENTAL MEANS DEATH BENEFIT: An optionally available health or life benefit providing for the payment of a multiple (usually double) of the face amount of the policy in case of death by accidental means. The benefit usually covers death resulting from bodily injury affected solely through external, violent, and accidental means, independently and exclusively of all other causes, and within 90 days after such injury.

ACCIDENTAL MEANS, DEATH BY: Death resulting from a cause that is accidental, so that both the cause and the result are accidental. See Accidental Means.

ACCIDENT FREQUENCY: The rate of occurrence of accidents. See Accident.

ACCIDENT FREQUENCY RATE: The total number of disabling injuries suffered by employees per 1,000,000 employee-hours of work on an annual basis. See Accident Frequency.

ACCIDENT HEALTH INSURANCE: Insurance under which benefits are payable in case of disease, accidental injury, or accidental death. Also called health insurance, personal health insurance, and sickness and accident insurance.

ACCIDENT INDUSTRIAL: An unforeseen, unintended accident that has occurred as a result of one's employment or occupation.

ACCIDENT INSURANCE: A form of insurance against loss by accidental bodily injury.

ACCIDENT POLICY: Health or life insurance that provides indemnities for loss resulting from accidental bodily injuries. See Accident Health Insurance.

ACCIDENT SEVERITY RATE: The number of days lost from disability injuries or death per 1,000 employee-hours of work, with 6,000 days charged for death.

ACCIDENT SICKNESS INSURANCE: See Accident and Health Insurance.

ACCOUNTABLE: Subject to penalties relative to accepted responsibilities.

ACCOUNTABLE-HEALTH PARTNERSHIP: An organization of doctors and hospitals that provides care for people organized into large groups of purchasers. See Accountable.

ACCOUNTABLE HEALTH PLAN (AHP): A joint venture between medical practitioners and institutions (insurance companies, HMOs, or hospitals) that would assume responsibility for delivering medical care. Physicians and providers work for or contract with these health plans. As independent delivery systems (IDS) form and demonstrate their ability to manage capitated care, they begin to struggle with issues of ownership or alliance partnerships with HMOs, insurance companies, or other financing entities. An accountable health care system describes an IDS plan with a financing

component. When an IDS plan operates one or more health insurance benefit products, or a managed care organization acquires a large-scale medical delivery component, it qualifies as an accountable health system or accountable health plan.

ACCOUNTING PERSPECTIVES: Perspectives underlying decisions on which categories of goods and services to include as costs or benefits in an analysis.

ACCOUNTS PAYABLE: The amount of money a health care organization or insurance company is obligated to pay vendors. Also known as APs. See Accounts Receivable.

ACCOUNTS RECEIVABLE: The amount of money a health care organization or insurance company is due from insured patients or vendors. Also known as ARs. See Aging Schedule and Accounts Payable.

ACCOUNTS RECEIVABLE INSURANCE: Insurance coverage for uncollected accounts (ARs) and health insurance or managed care premiums, plus the expenses of record reconstruction and various other collection fees, but without the physical, paper, or electronic devices, computer disks, tapes, or memory sticks. See ARs.

ACCREDITATION: The process used to certify and recognize that a predetermined set of standards has been met.

ACCREDITATION CYCLE FOR MEDICARE + CHOICE DEEMING: The duration of CMS's recognition of the validity of an accrediting organization's determination that a Medicare + choice organization (MEDICARE + CHOICE) is fully accredited. See CMS (Centers for Medicare and Medicaid Services).

ACCREDITATION FOR PARTICIPATION: State requirement that plans must be accredited to participate in the Medicaid managed care program.

ACCREDITED HOSPITAL: A hospital or similar entity whose medical quality standards are accepted by the Joint Commission on Accreditation of Healthcare Organizations.

ACCREDITED INVESTOR: Rule 501 of Regulation D of the Securities Act of 1933, requires a natural person whose individual net worth, or joint net worth together with a spouse, exceeds \$1,000,000. Alternatively, under the same rule, an accredited investor is a natural person with an individual income in excess of \$200,000 in each of the two most recent years or joint income with a spouse in excess of \$300,000 in each of those years and has a reasonable expectation of reaching the same income level in the current year. Often used in private placements for health care facility bonds and securities.

ACCRET: Medicare term for adding new enrollees in a health plan.

ACCRUAL: The amount of money that is set aside to cover health insurance expenses. The accrual is the plan's best estimate of what those expenses are and (for medical expenses) is based on a combination of data from the

authorization system, the claims system, lag studies, and the plan's prior history. See Accrual Basis of Accounting.

ACCRUAL BASIS OF ACCOUNTING: A method of accounting that attempts to match health insurance revenues with medical expenses and claims by recognizing revenue when a service is rendered and expense when the liability is incurred irrespective of the receipt or disbursement of cash. See Accrual.

ACCUE: To accumulate, as in debt or revenue. See Accrual and Accrual Basis Accounting.

ACCRUED EXPENSES: Incurred, but not yet paid, expenses. See Expenses.

ACCRUED INTEREST: Interest dollars added to the contract price of a hospital bond from the last interest payment date. It is always computed up to, but not including the settlement date.

ACCUMULATED DEPRECIATION: The total accumulated amount of depreciation recognized as an asset by a health care organization or managed care or insurance company, since purchase. See Depreciation.

ACCUMULATION: Total utilized medical services per dollar limited of covered benefits.

ACCUMULATION PERIOD: Specific time period for incurred health care expenses that are at least equal to the deductible or similar amount, to begin insurance or managed care benefit period.

ACID TEST: A managed care liquidity financial test that measures how much cash and marketable securities are available to pay all current liabilities of the organization. See Acid Test Ratio and Quick Ratio.

ACID TEST RATIO: A managed care liquidity ratio that measures how much cash and marketable securities are available to pay all current liabilities of the organization. (Cash and marketable securities or current liabilities.) See Acid Test and Quick Ratio.

ACQUISITION COST: The cost of soliciting and acquiring health or managed care insurance business premiums and insured members.

ACTIVE: A currently in-effect insurance status.

ACTIVE, FULL-TIME EMPLOYEE: Working for an employer on a regular basis in the usual course of business to be considered eligible for health insurance or disability insurance coverage. Usually, a minimum number of regular work hours are needed. See Full Time Equivalent.

ACTIVELY-AT-WORK: Describes a health insurer's policy requirement indicating that a member is actively and gainfully employed.

ACTIVE RETENTION: Self-pay. Accepting the costs and risks of not possessing health insurance coverage.

ACTIVITIES OF DAILY LIVING (ADL): An index or scale that measures an individual's degree of independence in bathing, dressing, using the toilet, eating, and moving across a small room. See Long-Term Care Insurance.

ACTIVITY-BASED COSTING (ABC): Defines costs in terms of a health or managed care organization's processes or activities and determines costs associated with significant activities or events. ABC relies on the following three-step process: (a) activity mapping, which involves mapping activities in an illustrated sequence; (b) activity analysis, which involves defining and assigning a time value to activities; and (c) bill of activities, which involves generating a cost for each main activity. See Activity-Based Management.

ACTIVITY-BASED MANAGEMENT (ABM): Supports health insurance operations by focusing on the causes of costs and how costs can be reduced. It assesses cost drivers that directly affect the cost of a product or service and uses performance measures to evaluate the financial or nonfinancial benefit an activity provides. By identifying each cost driver and assessing the value the element adds to the health care enterprise, ABM provides a basis for selecting areas that can be changed to reduce costs. See Activity-Based Costing.

ACTIVITY RATIOS: Financial ratios that measures how effectively a health care organization is using its assets to produce revenues. See Liquidity Ratios.

ACT OF GOD: Accident without human intervention, unforeseeable, and a result of natural causes.

ACTUAL ACQUISITION COST: Net payment, after expenses, for provided medical care or services.

ACTUAL CHARGE: The amount of money a medical provider or health care facility submits for payment from a health insurance carrier. It is usually more than received.

ACTUARIAL: Refers to the statistical calculations used to determine the managed care company's rates and premiums charged their customers based on projections of utilization and cost for a defined population. See Actuary.

ACTUARIAL ASSUMPTIONS: In establishing premium rates, scheduling policy provisions, and projecting future cost increases, a MCO, HMO, or insurance company must make certain estimates. The most important assumptions are based on probabilities of illness, accident, or death using large numbers of insureds (so called mortality and illness assumptions) and assumptions about interest and capital gains, as well as sales commissions and other health insurance expenses.

ACTUARIAL BALANCE: The difference between the summarized small market insurance (SMI) income rate and cost rates over a given valuation period.

ACTUARIAL COST: A cost derived through the use of actuarial present values.

ACTUARIAL DEFICIT: A negative actuarial SMI balance. See Small Market Insurance.

ACTUARIALLY SOUND: A health plan is considered to be actuarially sound when the amount of money in the fund and the current level of premiums

are sufficient (on the basis of assumptions on interest, mortality, medical, claims, and employee turnover) to meet the liabilities that have accrued and that are accruing on a current basis. See Actuary.

ACTUARIAL PRESENT VALUE: The current worth of a health care amount payable or receivable in the future, in which each such amount is discounted at an assumed rate of interest and adjusted for the probability of its payment or receipt.

ACTUARIAL RATES: One half of the expected monthly cost of the Small Market Insurance program for each aged enrollee (for the aged actuarial rate) and one half of the expected monthly cost for each disabled enrollee (for the disabled actuarial rate) for the duration the rate is in effect. See Actuary.

ACTUARIAL SOUNDNESS: The requirement that the development of capitation and insurance rates meet common actuarial principles and rules. See Actuary.

ACTUARY: A person who determines insurance policy rates, reserves, and dividends, as well as conducts various other statistical studies.

ACUITY: A benchmark of illness severity used to establish medical or allied medical staffing needs.

ACUPOINT (acupuncture point): Any of an indefinite number of points on or near the surface of the body that are allegedly susceptible to healthful activation.

ACUTE CARE: A pattern of health care in which a patient is treated for an acute (immediate and severe) episode of illness, for the subsequent treatment of injuries related to an accident or other trauma, or during recovery from surgery. Personnel with complex and sophisticated technical equipment and materials render acute care in a hospital. Unlike chronic care, acute care is often necessary for only a short time. See Acute Care Certificate.

ACUTE CARE CERTIFICATE: Physician attestation indicating why a patient should remain in a hospital. An advisory committee can review the certificate and decide that the doctor's certificate should be revoked. Health funds are only required to pay the equivalent of the benefit that would be payable to nursing home patients, which is less than the acute care rate. See Certificate of Need.

ACUTE DISEASE: Illness characterized by a single episode of disease and constrained to a fairly brief period of time.

ADDITIONAL BENEFITS: Health care services not covered by Medicare and reductions in premiums or cost sharing for Medicare-covered services. Additional benefits are specified and are offered to Medicare beneficiaries at no additional premium. Those benefits must be at least equal in value to the adjusted excess amount calculated in the ACR. An excess amount is created when the average payment rate exceeds the adjusted community rate (as reduced by the actuarial value of coinsurance, copayments, and deductibles

under Parts A and B of Medicare). The excess amount is then adjusted for any contributions to a stabilization fund. The remainder is the adjusted excess, which will be used to pay for services not covered by Medicare or will be used to reduce charges otherwise allowed for Medicare-covered services. See Average Cost Rate, Medicare Parts C and D, and Medicare Advantage.

ADDITIONAL DIAGNOSIS: Any diagnosis other than the primary or admitting diagnosis. See Comorbid Condition.

ADDITIONAL DRUG BENEFIT LIST: Prescription drugs listed as commonly prescribed by physicians for long-term use. Subject to review and change by the health plan involved. Also called a drug maintenance list. See Medicare Part D.

ADDITIONAL MONTHLY BENEFIT: Riders added to disability income insurance policies to provide additional benefits during the 1st year of a claim while the insured is waiting for Social Security benefits to begin.

ADHESION INSURANCE: Life, health, or managed care insurance contracts issued on a take-it-or-leave-it basis. See Contract and Aleatory Contract.

ADJUDICATION: Processing health insurance claims according to contract. See Mediation.

ADJUSTABLE PREMIUM: A premium change, by classes of insured, in a health insurance policy.

ADJUSTED ADMISSIONS: A measure of all patient care activity undertaken in a hospital, both inpatient and outpatient. Adjusted admissions are equivalent to the sum of inpatient admissions and an estimate of the volume of outpatient services. This estimate is calculated by multiplying outpatient visits by the ratio of outpatient charges per visit to inpatient charges per admission.

ADJUSTED AVERAGE PER CAPITA COST (AAPCC): (1) Actuarial projections of per capita Medicare spending for enrollees in fee-for-service Medicare. Separate AAPCCs are calculated, usually at the county level, for Part A services and Part B services for the aged, disabled, and people with end-stage renal disease (ESRD). Medicare pays risk plans by applying adjustment factors to 95% of the Part A and Part B AAPCCs. The adjustment factors reflect differences in Medicare per capita fee-for-service spending related to age, sex, institutional status, Medicaid status, and employment status. (2) A county-level estimate of the average cost incurred by Medicare for each beneficiary in fee for service. Adjustments are made so that the AAPCC represents the level of spending that would occur if each county contained the same mix of beneficiaries. Medicare pays health plans 95% of the AAPCC, adjusted for the characteristics of the enrollees in each plan. See Medicare Risk Contract and U.S. Per Capita Cost.

ADJUSTED AVERAGE CHARGE PER DAY: The average charge billed by hospitals for one day of care, which is adjusted total charges divided by total days of care. See Adjusted Total Charges.

ADJUSTED AVERAGE CHARGE PER DISCHARGE: The average charge billed by hospitals for an inpatient stay (from the day of admission to the day of discharge), which is adjusted total charges divided by number of discharges.

ADJUSTED COMMUNITY RATING: The process of determining a group's premium rate in which an HMO adjusts the standard or pure community rate premium by adding or subtracting an amount that reflects the groups past claims experience. See Rating, Risk, Hazard, and Peril.

ADJUSTED COVERAGE PER CAPITA COST: Estimate of average monthly benefits cost, after certain adjustments. See AAPCC.

ADJUSTED DRUG BENEFIT LIST: A small number of medications often prescribed to long-term patient or required for long-term chronic care. Also called a drug maintenance list, which can be modified from time to time by a health plan, CMS, or third party administrator. See Drug Formulary or Formulary.

ADJUSTED EARNINGS: Net earnings from a health or other insurer's operations, plus the estimated value of additional insurance in force or of the growth in premiums written. See Net Earnings.

ADJUSTED NET GAIN FROM OPERATIONS: Referring to a health or managed care insurer, the net gain from operations, plus the estimated value of increases in the amount of insurance in force or the growth in premiums during the year.

ADJUSTED NET WORTH: The worth of a managed care, health insurance, or other company, consisting of capital and surplus, plus an estimated value for the business on the company's books. See Net Worth.

ADJUSTED PAYMENT RATE (APR): The Medicare capitated payment to risk-contract HMOs. For a given plan, the APR is determined by adjusting county-level AAPCCs to reflect the relative risks of the plan's enrollees. See Adjusted Average Per Capita Cost.

ADJUSTED TOTAL CHARGES: Because OSHPD regulations require that hospitals report charges for the last 365 days of a stay; only total charges for a patient who stays more than 1 year must be adjusted upward (increased) to reflect the entire stay. Thus, for patients staying longer than 1 year, the average daily charge for the last year of the stay is calculated and applied to the entire stay. The formula is: $(\text{Total Charges} \div 365 = \text{Charge per Day}) \times \text{Length of Stay} = \text{Adjusted Total Charges}$. See OSHPD.

ADJUSTMENT: A change made to an insurance claim or medical bill.

ADJUSTMENT REASONS: A schedule of insurance code information to explain medical bill or fee schedule changes.

ADMINISTRATION: The cost center that includes the overall management and administration of the health care institution, general patient accounting, communication systems, data processing, patient admissions, public relations, professional liability and non-property-related insurance, licenses

and taxes, medical record activities, and procurement of supplies and equipment.

ADMINISTRATIVE COST CENTERS: Health care organizational support units responsible for their own costs. *See* Administrative Cost Centers.

ADMINISTRATIVE COSTS: Medical costs related to utilization review, insurance marketing, medical underwriting, agents' commissions, premium collection, claims processing, insurer profit, quality assurance programs, and risk management. Includes the costs assumed by a managed care plan for administrative services such as billing and overhead costs. *See* Administration and Expenses.

ADMINISTRATIVE LAW JUDGE: Hearing officer settling a dispute by a health care insurance, managed care, or other administrative agency.

ADMINISTRATIVE PROCEEDING: Adjudication by a health care insurance, managed care, or other administrative agency.

ADMINISTRATIVE PROFIT CENTERS: Health care organizational support units responsible for their own profits.

ADMINISTRATIVE SERVICES ONLY (ASO): A contract between a health insurance company and a self-funded plan in which the insurance company performs administrative services only and the self-funded entity assumes all risk.

ADMINISTRATIVE SIMPLIFICATION COMPLIANCE ACT: Signed into law on December 27, 2001, as Public Law 107-105, this Act provided a 1-year extension to HIPAA "covered entities" (except small health plans, which already had been extended until October 16, 2003) to meet HIPAA electronic and code set transaction requirements. Also, allows the Secretary of HHS to exclude providers from Medicare if they are not compliant with the HIPAA electronic and code set transaction requirements and to prohibit Medicare payment of paper claims received after October 16, 2003, except under certain situations.

ADMISSION: The process of administrative registration for a patient in need of in-patient or outpatient medical care services.

ADMISSION CERTIFICATION: A method of assuring that only those patients who need hospital care are admitted. Certification can be granted before admission (preadmission) or shortly after (concurrent). Length-of-stay for the patient's diagnosed problem is usually assigned upon admission under a certification program. *See* Acute Hospital.

ADMISSION, HOSPITAL: The number of patients formally admitted for a certain type of care in a hospital facility. Includes the discharge from acute and formal admission to nonacute, and vice versa. *See* Acute Care.

ADMISSION (LTC FACILITY): The number of patients formally admitted to the facility or transferred from a residential care unit of the long-term care facility. Does not include patients returning to the facility under a

bed-hold or leave, in which a bed has been held specifically for patient's return. See LTC.

ADMISSION REPORT: The daily hospital or health facility census report, listing patients gained, lost, or changed in their course of care in a particular facility.

ADMISSION SOURCE: The physical site from which the patient was admitted: home, residential care facility, ambulatory surgery facility, skilled nursing/intermediate care facility, acute hospital care, other hospital care, newborn, prison/jail or other; the licensure of the site: this hospital, another hospital; and the route of admission: hospital's emergency room, or another emergency room, etc.

ADMISSIONS PER 1,000: An indicator calculated by taking the total number of inpatient or outpatient admissions from a specific group (e.g., employer group, HMO population at risk) for a specific period of time (usually 1 year), dividing it by the average number of covered members in that group during the same period, and multiplying the result by 1,000. This indicator can be calculated for behavioral health or any disease in the aggregate and by modality of treatment (e.g., inpatient, residential, and partial hospitalization).

ADMISSION TYPE: The four admission types are: scheduled, unscheduled, infant, and unknown.

ADMISSION WIRE: Formal notification of membership admission or treatment to or by a BC/BS facility or provider.

ADMITS: The number of admissions to a hospital (including outpatient and inpatient facilities). See Admissions, Hospital, Source, and Type.

ADMITTED ASSETS: All insurance company assets that are approved by the state insurance department as existing property in the ownership of the company. Such assets include all funds, securities, property, equipment, rights of action, or resources of any kind owned by the company or held in trust for others. See Assets.

ADMITTED, OR AUTHORIZED COMPANY: An insurance company authorized and licensed to do business in a given state. See Foreign Insurer and Domestic Insurer.

ADMITTING PHYSICIAN: A licensed practitioner who has the necessary privileges at a hospital to admit patients for care or treatment. (In a group practice setting there are often hospital-based physicians.) Internal Medicine usually does all admitting and treatment planning. See Gatekeeper and Internist.

ADULT: A legal determination referring to one who has reached maturity; a person who has reached the age of legal capacity and can enter into insurance contracts.

ADULT DAY CARE: A group program for functionally impaired adults, designed to meet health, social, and functional needs in a setting away from the adult's home.

ADULT FOSTER CARE: Those aged older than 18–21 who do not need daily nursing care but still require assistance in a facility with a home-like environment or atmosphere.

AD VALOREM TAX: A direct tax calculated “according to value” of hospital property. Such tax is based on an assigned valuation (market or assessed) of real hospital property and, in certain cases, on a valuation of tangible or intangible personal property.

ADVANCE CHECK: Payment sent to a health care facility or medical provider that precedes the filing of a health insurance claim.

ADVANCE COVERAGE DECISION: A decision that private fee-for-service plans make on whether or not it will pay for a certain service.

ADVANCED BENEFICIARY NOTICE (ABN): Notice from a medical provider, health care facility, or DME vendors that certain products or medical services may not be covered charges by Medicare. Signature may indicate patient payment responsibility.

ADVANCE DIRECTIVE (HEALTH CARE): A directive that is a written document declaring what medical decisions will be made if the ability to make self-decisions is lost. A health care advance directive may include a living will and a durable power of attorney for health care. See Living Will.

ADVANCED REGISTERED NURSE PRACTITIONER: Nurse with advanced training in a medical specialty that is registered with the state board of nursing to practice in an advanced role. Specialty designations include certified clinical nurse specialists, certified nurse midwives, certified nurse practitioners, and certified registered nurse anesthetists. An ARNP may provide care as an independent practitioner or in collaboration or consultation with a physician.

ADVERSE EVENT: Patient harm or injury as a result of medical intervention.

ADVERSE SELECTION: The tendency of people who are less than standard health insurance risks to seek or continue insurance to a greater extent than other individuals. This so-called “selection against the insurer,” or “antiselection,” is a form of stacking the deck and is also found in the tendency of policy owners to take advantage of favorable options in health insurance or managed care contracts. Or, a particular health plan, whether indemnity or managed care, is selected against by the enrollee, and thus an inequitable proportion of enrollees requiring more medical services are found in that plan. Example: Low enrollee out-of-pocket costs might lure those individuals requiring more health services into an HMO rather than an indemnity-plan because the former does not have a deductible. Therefore, the HMO would have a greater proportion of less-healthy enrollees, thereby driving up costs and increasing financial risks. Also occurs with one of the following:

- When a premium doesn’t cover costs. Some populations, perhaps because of age or health status, have a great potential for high utilization.

- Some population parameter such as age (e.g., a much greater number of 65-year-olds or older to young population) that increases the potential for higher utilization and often increases costs above those covered by a payer's capitation rate. See Risk, Rating, Hazard, and Peril.

ADVISOR: The registered individual or organization that is employed by a hospital or health care entity to give professional advice on its investments and management of its assets or endowment funds. See Agent and Broker.

ADVISORY OPINION: A formal opinion having no legal or presidential force.

ADVOCATE: A person who supports or protects the rights of an insured.

AFFIDAVIT OF CLAIM: A written, signed statement required when a claim is filed with an insurer and containing the facts on which the claim is based.

AFFILIATED CONTRACTOR (Provider): A Medicare carrier, medical professional, or other contractor, such as a durable medical equipment regional carrier (DMERC), which shares some or all of the program safeguard contractor's (PSC's) jurisdiction in which the affiliated contractor performs non-PSC Medicare functions, such as claims processing or education.

AFFILIATED PERSON: Anyone in a position to influence decisions made in a healthcare corporation, including officers, directors, principal stockholders, and members of their immediate families. Their shares are often referred to as "Control Stock."

AFFILIATED PROVIDER: A health care provider or facility that is paid by a health plan to give service to plan members.

AFTERCARE: Services following hospitalization or rehabilitation individualized for each patient's needs, including outpatient facility services and home health care.

AFTERMARKET: A market for a health care security either over the counter or on an exchange after an initial public offering has been made.

AGE: The age in years of an applicant, insured, or beneficiary. Some companies use the age at the last birthday. Other companies use the age at the nearest birthday (last or next).

AGE-ADJUSTED MORTALITY RATE: A mortality rate statistically modified to eliminate the effect of different age distributions in the different populations.

AGE-ATTAINED RATING: A method for establishing health insurance premiums whereby an insurer's premium is based on the current age of the beneficiary. Age-attained-rated premiums increase as the purchaser grows older. See Rating.

AGE BREAK: The grouping of age-related cohorts for medical insurance rating purposes.

AGE CHANGE: The point between natural birthdays at which a client is considered the next age for the purpose of setting insurance premium rates.

AGED ENROLLEE: An individual aged 65 or older, who is enrolled in the small market insurance (SMI) program.

AGE-AT-ISSUANCE RATING: A method for establishing health insurance premiums whereby an insurer's premium is based on the age of individuals when they first purchased health insurance coverage.

AGE AT ISSUE: The age of an insured at the time health insurance coverage goes into effect. Some insurers define issue age as the age at the insured's last birthday. In others, it is defined as the insured's age at the nearest birthday.

AGE LIMITS: Minimum or maximum age limits for the insuring of new applicants or for the renewal of an insurance, HMO, or MCO policy.

AGENCY: The legal relationship empowering one party to act on behalf of another in dealing with third parties. A health or life insurance agent does not generally have the authority to bind the insurance company. See Agent and Broker.

AGENCY AGREEMENT OR CONTRACT: A legal document containing the terms of the contract between the agent and company, signed by both parties.

AGENCY BUILDER: A term used to describe a life or health insurance general agent or agency manager, usually pertaining to some measure of growth in production or gross sales, and usually pertaining to the type of operation in which new agents are recruited and contracted regularly.

AGENCY DEPARTMENT: The home office department of a health insurance company responsible for the appointment and servicing of the agency organization. The agency department is most often responsible for policy sales, conservation of old business, service to policy owners, and various marketing services.

AGENCY DEVELOPMENT: The ongoing building of a life or health insurance agency by a general agent or manager through recruitment of new agents and the continued development of the existing personnel.

AGENCY DIRECTOR: Company director in charge of supervising a territorial division's agencies on a particular type of health insurance sales market.

AGENCY FOR HEALTH CARE POLICY AND RESEARCH (AHCPR): The agency of the Public Health Service responsible for enhancing the quality, appropriateness, and effectiveness of health care services.

AGENCY PLANT: The total force of agents representing a health insurance company. Can also mean the physical facilities of an agency.

AGENCY PROGRAM: Eligible provider of health services other than a facility, practitioner, or supplier. An example is a diabetic rehabilitation education program.

AGENCY SUPERINTENDENT: An officer or other executive of a company in charge of supervising health insurance agencies, either of a territorial division or of the entire company, and usually reporting directly to the agency vice president. Also called superintendent of agencies.

AGENCY SYSTEM: A method of marketing and selling health and life insurance. Entails sales and service by commissioned insurance agents, most often supervised by general agents or agency managers, in contrast to sales by salaried employees or by mail.

AGENT: A person who solicits health insurance or assists in the placing of risks, delivery of policies, or collection of premiums on behalf of an insurer. Typically, a person placing products for a specific insurer is considered the insurer's agent rather than an agent of the policy owner. Or, the role of a broker or dealer firm when it acts as an intermediary, or broker, between its customer (hospital or health care facility, insurance company, HMO, MCO, etc.) and a market maker or contrabroker. For this service, the firm receives a stated commission or fee. See Broker.

AGENT OF RECORD: The agent writing the initial policy application and who is entitled to any and all commissions on the issued insurance contract or the agent assigned by the agency or home office to service a particular policy owner. Also, an agent given written authorization by a present policy owner to seek out and negotiate insurance contracts with companies other than his or her own. Similar to a broker, the agent of record represents the interests of the client in dealings with other insurance companies' agents. The agent of record usually receives a percentage of the commission earned on the new policy. See Agent.

AGENT'S BALANCE: A periodic statement issued by the company of the sums owed to or by a health insurance agent.

AGENT'S COMMISSION: The payment of a percentage of the premium generated from a health or life insurance policy to the agent by a company. See Commission.

AGENT'S LETTER OF RECORD: Written authorization by a policy owner granting the agent authority to act on his or her behalf in negotiating a life or health insurance contract with an insurer other than the agent's own company.

AGENT, SURVEYING: A local agent who submits health insurance business by means of applications but does not actually write policies.

AGE/SEX FACTOR: A measurement used in underwriting. It represents the age and sex risk of medical costs of one population relative to another. A group with an age or sex factor of 1.00 is average. A group with an age or sex factor higher than 1.00 is expected to have higher average medical costs. A group with an age or sex factor less than 1.00 is expected to incur lower than average medical costs.

AGE/SEX RATES (ASR): Also called table rates, they are given group products' set of rates in which each grouping, by age and sex, has its own rates. Rates are used to calculate premiums for group billing and demographic changes are adjusted automatically in the group.

AGE-SPECIFIC MORTALITY RATE: A mortality rate limited to a particular age group. The numerator is the number of deaths in that age group;

the denominator is the number of persons in that age group in the population.

AGGREGATE INDEMNITIES: The sum total that can be collected under all health insurance policies applicable to the covered loss.

AGGREGATE INDEMNITY: Maximum dollar amount collected for a disability or period of disability.

AGGREGATE LIMIT: Maximum dollar amount of coverage in force under a health insurance policy.

AGGREGATE MARGIN: A margin that compares revenues to expenses for a group of hospitals, rather than a single hospital. Computed by subtracting the sum of expenses for all hospitals in the group from the sum of revenues and dividing by the sum of revenues.

AGGREGATE MORTALITY TABLE: A mortality table based on health and life insurance experience in which the rates of mortality at any age are based on all insurance in force at that age, without reference to the duration of insurance.

AGGREGATE PPS OPERATING MARGIN/AGGREGATE TOTAL MARGIN: A prospective payment system operating margin or total margin that compares revenue to expenses for a group of hospitals, rather than a single hospital. Computed by subtracting the sum of expenses for all hospitals in the group from the sum of revenues and dividing by the sum of revenues.

AGGREGATE STOP LOSS: The form of excess health insurance risk coverage that provides protection for the employer against accumulation of claims exceeding a certain level. This is protection against abnormal frequency of claims in total, rather than abnormal severity of a single claim.

AGING SCHEDULE: Method of classifying accounts receivable (ARs) since the amount of time they were recognized. See Accounts Receivable.

AGREEMENT HOSPITAL: Have a set charge that is agreed to with a health fund for the cost of accommodation and other hospital-related charges. These arrangements will vary between funds but provide a higher level of benefit than nonagreement hospitals.

AGREEMENT OF LIMITED PARTNERSHIP: Contractual agreement between the limited partners and the general partner(s).

AHA: American Hospital Association; a trade association for health care facilities.

A&H, A&S (ACCIDENT AND HEALTH INSURANCE, ACCIDENT AND SICKNESS INSURANCE): Once commonly used as generic designation for the entire field now called health insurance.

AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC) PROGRAM: A program established by the Social Security Act of 1935 and eliminated by welfare reform legislation in 1996. AFDC provided cash payments to needy children (and their caretakers) who lacked support because at least one parent was unavailable. Families had to meet income and resource criteria

specified by the state to be eligible. The AFDC program was replaced by a block grant but its standards are retained for use in Medicaid.

AIDS: Acquired Immune Deficiency Syndrome is a life-threatening illness characterized by “opportunistic” (pneumocystosis, candidiasis, cryptococcosis, mycobacterium, herpes, leukoencephalopathy, and Kaposi’s sarcoma) infections, immunodeficiency, and tumors caused by the human immunodeficiency virus I (HIV-I). Patients are usually members of high-risk groups identified as homosexuals, intravenous drug users, hemophiliacs, bisexuals, and prostitutes. By 2005, the disease claimed more than 25 million deaths worldwide and infected more than 60 million people. The ELISA (enzyme linked immunosorbent assay) test is the initial screening serologic tool used to detect the antibody to HIV-I. It has a sensitivity and specificity from 95% to 99%. The Western blot (immunoblot) test is then used to verify the ELISA test although it too may produce conflicting results. The polymerase chain reaction (PCR) test, for viral test loading, is used in cases of conflicting information (amplicor HIV-1 monitor test). It can detect 200 copies of HIV RNA per millimeter of plasma (200–1,000 T-cell count range). It is the “gold standard” viral culture diagnostic test for the disease. Another viral load test is the DNA test, to produce a chemical reaction with HIV RNA, producing measurable light (range: 10,000–1,600,000 eq/ml.). The test is not as precise as the PCR but is more precise over time. Another amplification test is known as the LCx-R (ligase chain reaction) test. Indirect but suggestive traditional laboratory values that may indicate HIV infection include: anemia (of any type), leukopenia, increased erythrocyte sedimentation rate (ESR), decreased cholesterol, and increased serum albumin.

ALEATORY: That which depends on an uncertain event. See Contract of Adhesion.

ALEATORY CONTRACT: Health insurance contract that may or may not provide more in monetary medical benefits than the aggregate amount of premiums paid. See Adhesion Insurance.

ALIEN CARRIER: An insurer whose domicile is a foreign country. See Domestic Carrier.

ALIEN COMPANY: An insurance company incorporated or organized under the laws of any foreign nation, province, or territory.

ALIGNMENT OF INCENTIVES: The economic arrangement between medical providers in health facilities that allow the sharing of fiscal risks and rewards of patient treatment, care, and intervention.

ALL CLAUSE DEDUCTIBLE: A single deductible to cover patient expenses as the result of the same or similar health insurance causes within a given time period.

ALLERGY TREATMENT: A variety of techniques, such as skin testing, immunotherapy (“allergy shots”), and other medications, used to diagnose, prevent, or relieve symptoms of adverse immune responses (allergies).

ALLIANCES (HEALTH INSURANCE PURCHASING COOPERATIVES):

Organizations consisting of large groups of purchasers of health care. The buying power of alliances is expected to force competitive marketing among providers.

ALLIED HEALTH PERSONNEL: Specially trained and licensed health workers other than physicians, podiatrists, dentists, osteopaths, optometrists, and nurses.

ALL-INCLUSIVE VISIT RATE: Aggregate costs for any one patient visit based upon annual operating costs divided by patient visits per year. This rate incorporates costs for all health services at the visit.

ALL-OR-NONE OFFERING: A “best-efforts” offering of newly issued hospital securities in which the corporation instructs the investment banker to cancel the entire offering (sold and unsold) if all of it cannot be distributed.

ALL-OR-NONE (AON) ORDER: An order to buy or sell more than one round lot of hospital or other securities at one time and at a designated price or better. It must not be executed until both of these conditions can be satisfied simultaneously.

ALLOCATED BENEFITS: Payments for a specific covered medical purpose, up to a set maximum, such as an x-ray, casts, blood test, etc.

ALLOCATION BASE: Statistic used to allocate health care costs based on a casual relationship.

ALLOGENIC BONE MARROW TRANSPLANT: Bone transplant or marrow from a donor other than the recipient.

ALLOPATHY: Traditional branch of medicine that suggests antagonistic conditions are useful interventions for the illness or condition being treated. See Medical Doctor and MD.

ALLOWABLE CHARGE: The maximum fee that a third party will reimburse a provider for a given service. See UCR.

ALLOWABLE COSTS: Items or elements of an institution's costs that are reimbursable under a payment formula. Allowable costs may exclude, for example, uncovered services, luxury accommodations, costs that are not reasonable, and expenditures that are unnecessary.

ALLOWANCE FOR UNCOLLECTABLE ACCOUNTS: Balance sheet entry that lists the total number of accounts that will not be collected. Also known as bad debt expenses.

ALLOWANCE FOR UNCOLLECTIBLES: Balance sheet account that estimates a medical provider or health care organizations total amount of patient accounts receivable that will not be collected. See Bad Debt Expenses.

ALLOWED AMOUNT: Maximum dollar amount assigned for a procedure based on various pricing mechanisms. Also known as a maximum allowable. See UCR.