Appendix B

LIST OF ABBREVIATIONS and GLOSSARY OF TERMS

List of Abbreviations

ACLI	--American Council on Life Insurance
AIDS	--acquired immunodeficiency syndrome
APS	--attending physician statement
ARC	--AIDS-related complex
BC/BS	--Blue Cross and Blue Shield Associations
CFR	--Code of Federal Regulations
COBRA	--Consolidated Omnibus Budget Reconciliation Act of 1985
ELISA	--enzyme-linked immunosorbent assay
GHAA	--Group Health Association of America
HIAA	--Health Insurance Association of America
HIV	--human immunodeficiency virus
HMO	--health maintenance organization
MIB	--Medical Information Bureau
NAIC	--National Association of Insurance Commissioners
OTA	--Office of Technology Assessment (U.S. Congress)

Glossary of Terms

Adverse selection: The tendency of persons with poorer than average health expectations to apply for, or continue, insurance to a greater extent than do persons with average or better health expectations. Also known as antiselection.

Community-rating: A method of determining premium rates that is based on the allocation of total costs without regard to past claims experience. Community-rating is required of federally qualified HMOS.

Conversion privilege: The right to change insurance without providing evidence of insurability, usually to an individual policy upon termination of coverage under a group contract. Conversion privileges are mandated by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (Public Law 99-272).

Direct pay coverage: See individual health insurance.

Exclusion waiver: An agreement attached to an insurance policy which eliminates a specified preexisting condition from coverage under the policy.

Expe~ience-rating: A method of determining group premium rates based on the actual amount of claims payments made on behalf of the group in a prior period, usually the preceding year.

Federally qualified: An HMO that is certified as meeting the qualification requirements of the Federal Health Maintenance Act of 1973, as amended (42 U.S, C. Sec. 300e et seq.). Federally qualified HMOS must adhere to certain financial, underwriting, and rate-setting standards and provide specified, medically necessary health services.

Individual health insurance: Health insurance that covers an individual and members of his or her family without any association with an employer or membership group of any kind.

Individually underwritten groups: Small employee groups that usually include no more than 50 individuals. Small group underwriting requires that individual group members provide a statement of health and evidence of insurability.

Open enrollment: A health insurance enrollment period during which coverage is offered regardless of health status and without medical screening. Open enrollment periods are characteristic of some BC/BS plans and HMOS.

Preexisting condition: A condition existing before an insurance policy goes into effect and commonly defined as one which would cause an ordinarily prudent person to seek diagnosis, care or treatment.

Rated premium: A premium with an added surcharge that is required by insurers to cover the additional risk associated with certain medical conditions. Rated premiums usually range from 25 to 100 percent of the standard premium.

Risk classification: The evaluation of whether an insurance applicant will be covered on a standard or substandard basis, or not at all.

Self -payers: See individual health insurance.

Standard **risk:** A person who, according to an insurer's underwriting criteria, is entitled to purchase insurance coverage without extra premium or special restriction.

Substandard risk: A person that does not meet the normal health requirements of a standard health insurance policy and whose coverage is provided with a higher premium and/or exclusion waiver.