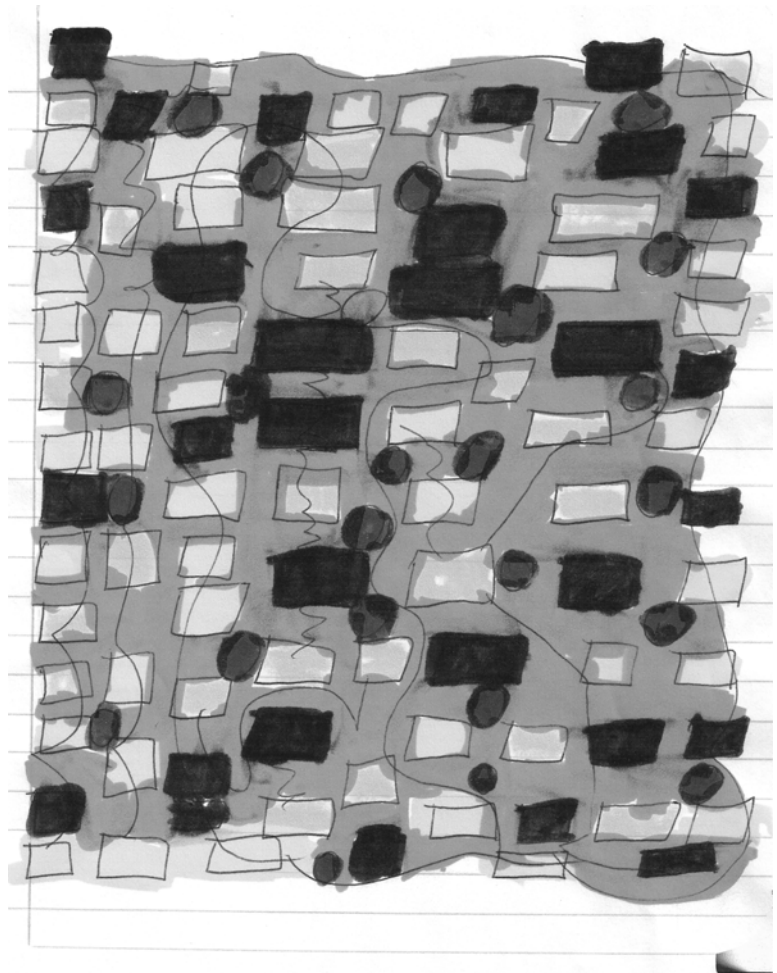


# Appendix



Artist: Maria



# Appendix

This section contains information on:

- Acronyms and Definitions
- Definition of Developmental Disabilities
- Health Insurance Terms and Acronyms



## Acronyms

Following is a list of acronyms that may be used in this document or that you may find in reading other materials.

504	Section 504 of the Rehabilitation Act of 1973
619	Section 619 of the Individuals with Disabilities Education Act (3 through 5 year olds)
AC	Attendant Care
ADA	Americans with Disabilities Act
ADD/ADHD	Attention deficit disorder/attention deficit hyperactivity disorder
AFH	Adult Family Home
APS	Adult Protective Services
A & R	Advocacy and referral
The ARC	Formerly Association for Retarded Citizens
ASW	Autism Society of Washington
BD	Behavior disability or disorder
CA	Community Access
CAP	Community Alternatives Program
CCF	Congregate Care Facility
CD	Communication disordered
CDS	Communication disorder specialist (speech)
CEC	Council for Exceptional Children
CHDD	Center on Human Development & Disability (formerly CDMRC at U of W)

CHMC	Children's Hospital & Medical Center
CP	Cerebral palsy
CPS	Child Protective Services
CRSA	Community Residential Service Association
CSO	Community Services Office (Medicaid)
CSPD	Comprehensive System of Personnel Development
DAC	Disabled Adult Child
DD	Developmentally delayed
DDC	Development Disabilities Council
DDD	Division of Developmental Disabilities
DSHS	Department of Social and Health Services
DVR	Division of Vocational Rehabilitation
EBD	Emotional/behaviorally disabled
EDGAR	Education Department General Administrative Regulations
EEOO	Equal Employment Opportunity Office
EEU	Experimental Education Unit (Birth to 3)
EHA	Education for All Handicapped Children Act
ESD	Education Service District
FAPE	Free appropriate public education
FAS/FAE	Fetal alcohol syndrome/fetal alcohol effect
FEPP	Family/Educator Partnership Project
FHA	Federal Housing Association
FISP	Family Individual Service Plan
FRC	Family Resource Center (0-6)

FS	Family support
FTE	Full-time Equivalent
GAO	General Assistance Office
GAU	General Assistance Unemployable
GED	General Equivalency Diploma - High School
GEPA	General Education Provisions Act
GH	Group home
HB	House Bill
HHS	Health & Human Services (federal)
HRC	Human Rights Commission (state)
HUD	Housing and Urban Development
ICC	Interagency Coordinating Council
ICFMR	Intermediate Care Facility - Mentally Retarded (institutions and some GH)
IDEA	Individuals with Disabilities Education Act
IE	Individual employment
IEE	Independent Educational Evaluation
IEP	Individualized Education Program
IFSP	Individualized Family Services Plan
IHP	Individual Habitation Plan
IRWE	Impairment related work expenses
ISP	Individual Service Plan
ITEIP	Infant Toddler Early Intervention Program
ITP	Individual Transition Plan

ITS	Intensive Tenant Support (24 hour support)
IWRP	Individual Written Rehabilitation Plan
JRA	Juvenile Rehabilitation Administration
KCPC	King County Parent Coalition
LD/SLD	Learning disability/specific learning disability
LDA	Learning Disabilities Association
LEA	Local education agency
LEP	Limited English Proficient
LRE	Least Restrictive Environment
MAA	Medical Assistance Administration
MBD	Minimal brain dysfunction
MD	Muscular dystrophy
MMR	Mild mental retardation
MPC	Medicaid Personal Care
MR	Mental retardation
NASDSE	National Association of State Directors of Special Education
NECTAS	National Early Childhood Technical Assistance System
NI	Neurologically impaired
OCR	Office for Civil Rights
OSEP	Office of Special Education Programs
OSERS	Office of Special Education and Rehabilitative Services
OSPI	Office of Superintendent of Public Instruction
OT	Occupational therapist
PAC	Parent Advisory Council

PASS	Plan to achieve self-sufficiency (social security)
PAVE	Parents Are Vital in Education
PDD	Pervasive developmental disability
PL	Public Law
PT	Physical therapist
RCW	Revised Code of Washington
RFP	Request for Proposals
RHC	Residential Habilitation Center (institution)
RRC	Regional Resource Center
RSA	Rehabilitation Services Administration
SAFE	Schools are for Everyone
SB	Senate Bill
SBD	Severe Behavior Disorder
SE	Supported Employment
SEA	State Educational Agency
SEAC	Special Education Advisory Council
SEPAC	Special Education Parent/Prof. Advisory Board
SETC	Special Education Technology Center
SI	Specialized Industry
SLD	Specific language/learning disability
SLP	Speech-language pathologist
SOLA	State Operated Living Alternative
SOP	State-operated program
SpED	Special Education

SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
TASH	The Association for Severely Handicapped
TBI	Traumatic brain injury
TDD	Telecommunication device for the deaf
TS	Tenant Support
TTY	Telecommunication device for the deaf
UAP	University Affiliated Program
UCP	United Cerebral Palsy
VRC	Vocational Rehabilitation Counselor
WAC	Washington Administrative Code
WAEYC/NAEYC	Washington/National Association for the Education of Young Children
WAMI	Washington Advocates for the Mentally Ill
WANSAC	Washington Chapter of the National Society for Children and Adults with Autism
WASA	Washington Association of School Administrators
WaSHIF	Washington State Head Injury Foundation
WCCD	Washington Coalition for Citizens with Disabilities
WCLD	Washington Council for Learning Disabilities
WEEdNet	Washington Education Network
WPAS	Washington Protection & Advocacy Services
WSD	Washington State School for the Deaf

WSSB	Washington State School for the Blind
WWW	World Wide Web

*Source: Family Educator Guide  
Date: July 2002*

*FEPP Notebook*

*Joanne O'Neil*



# Definition of Developmental Disabilities

Per Washington Administrative Code, Title 71A

## RCW Title 71A.10.020(3) Definitions.

“Developmental disability” means a disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or another neurological or other condition of an individual found by the secretary to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, which disability originates before the individual attains age eighteen, which has continued or can be expected to continue indefinitely, and which constitutes a substantial handicap to the individual. By January 1, 1989, the department shall promulgate rules which define neurological or other conditions in a way that is not limited to intelligence quotient scores as the sole determinant of these conditions, and notify the legislature of this action.

*Source: Washington Administrative Code*

<http://apps.leg.wa.gov/RCW/default.aspx?cite=71A.10.020>

*Accessed June 2006*

## Health Insurance Terms and Acronyms

Acronym or Term	Definition
<b>Acute Care</b>	Medical care provided in direct response to an illness, injury, or other condition. Acute care contrasts with preventive care, which tries to reduce the chances of acquiring a condition. <sup>1</sup>
<b>Allowable expenses</b>	The necessary, customary, and reasonable expenses that an insurer will cover. <sup>1</sup>
<b>AMBHA</b>	The American Managed Behavioral Healthcare Association, the trade association for managed behavioral health care companies, founded in 1994. AMBHA members are companies that manage benefits, not organizations that are primarily engaged in delivering clinical services. <sup>3</sup>
<b>Ambulatory care</b>	Medical care provide on an out-patient (non-hospital) basis. <sup>1</sup>
<b>Ambulatory care</b>	Health care that does not require a hospital admission for the patient-also called outpatient care. Commonly provided in a doctor's office, clinic, or health center, but can also be provided in a hospital or "surgi-center". <sup>2</sup>
<b>Anniversary date</b>	The date on which a health plan's or insurer's contract with an employer or an individual subscriber is renewed each year. It is the date when premium costs and benefits are most likely to change. It may be preceded by an "open enrollment period," when employees have the option to switch health plans. <sup>2</sup>
<b>Annual maximum limits or caps</b>	The limit an insurance plan sets on a given service. It may be a certain number of visits or a dollar amount. If your child needs more of a given service than is allowed by the limits in your plan, you will need to request an exception. <sup>1</sup>
<b>Average length of stay</b>	Measurer used by hospitals to determine the average number of days patients spend in their facilities. A managed care firm will often assign a length of stay to patients when they enter a hospital and will monitor them to see that they don't exceed it. <sup>1</sup>
<b>Bad faith</b>	The unreasonable refusal to pay a valid claim which can be remedied in a civil suit. <sup>1</sup>
<b>Behavioral health care firm</b>	Specialized (for profit) managed care organizations, focusing on mental health and substance abuse benefits, which they term "behavioral health care." these firms offer employers and public agencies a managed mental health and substance abuse benefit. Almost non existent ten years ago, but they are now a big industry. <sup>3</sup>

<b>Benefits or benefit package</b>	The health care services covered by a health plan or health insurance company, under the terms of its member contract. Terms of the contract also include any cost sharing required through co-payments, deductibles, or coinsurance: limitations on the amount or length of coverage: and conditions such as the requirement to have care authorized in advance and delivered within the HMO network. <sup>2</sup>
<b>Capitation</b>	Method of payment for health services in which the insurer pays providers fixed amount for each person served regardless of the type and number of services used. Some HMOs pay monthly capitation fees to doctors, often referred to as a per member per month amount. <sup>1</sup>
<b>Case management program</b>	Special programs now offered by many insurance companies, particularly for individuals who require high cost care. Under such a program, a case manager is assigned to oversee all of a given child's claims and arrange for alternative benefits, which may not be part of the original contracted insurance plan. These alternative benefits may not be more costly than the stated benefits in the plan. Case management programs have sometimes chosen to pay for home-based care instead of costs of long-term hospitalization. Find out whether such a program is available under your plan, who is eligible, and how it works. <sup>1</sup>
<b>Certificate of insurance</b>	A description of health benefits included in a group health plan, usually given to insured members by the employer or group. <sup>1</sup>
<b>Claim</b>	The documentation of a medical service that was provided to a covered patient by a doctor, hospital, laboratory, diagnostic service, or other medical professional. A claim is filed with the insurer by the provider or the patient to request payment ( or reimbursement ) for the service if the service was not prepaid. <sup>2</sup>
<b>Clinician</b>	A term that is often used to describe all types of medical professional who care for patients -doctors, nurse, physicians' assistants, therapists, etc. <sup>2</sup>
<b>Co-payments ( or coinsurance)</b>	An amount a health insurance policy requires you to pay for medical and hospital service, after payment of a deductible. Indemnity plans typically require a co-payment to be a percent of the charge for the service (e.g. 20%). It may vary based on the type of service when the service was received ( for example within a certain number of days of an emergency) or where the service was received (out-patient versus in-patient). When there is co-payment in managed care plans, it is usually a small fixed amount regardless of the cost of the service. <sup>1</sup>

<b>COBRA (Consolidated Omnibus Budget Reconciliation Act )</b>	A federal law that includes important benefits for individuals who lose their employee health insurance because of a loss of job or a death. This law provides the opportunity for individuals to continue the same insurance coverage for 18-36 months. The individual is responsible for paying the full insurance premium. There may also be language in your policy on provisions for continuing the same coverage. The Insurance Commissioner in your state or your employer may offer information on your rights for continuation. <sup>1</sup>
<b>Coinsurance</b>	A cost-sharing arrangement typical to traditional health insurance, in which patients pay a portion of the cost of certain covered medical procedures, usually on a fixed percentage basis. For instance, patients might be required to pay 20 to 30 percent of the cost of their doctor's office fees or hospital charges for services they received. Usually coinsurance payments begin after an annual deductible is met. <sup>2</sup>
<b>Community rating</b>	An insurance practice of pooling people within a geographic area and charging everyone a set premium for a set benefit package without considering their individual health status. <sup>1</sup>
<b>Concurrent review</b>	A managed care technique in which a representative of a managed care firm continuously reviews the charts of hospitalized patients to determine if they are staying too long and if the course of treatment is appropriate. <sup>1</sup>
<b>Coordination of benefits</b>	The process for how benefits will be applied if you have more than one private health coverage plan. Regulations on coordination of benefits may exist within your state or your insurance plan may describe how such coordination should happen. Usually one the plan is designated to pay all claims first and the residual bills are the responsibility of the secondary carrier. These provisions are to prevent individuals from collecting more than once for the same medical charge. <sup>1</sup>
<b>Cost shifting</b>	A phenomenon occurring in the U.S. health care system in which providers are inadequately reimbursed for their costs and subsequently raise their prices to other payers in an effort to recoup costs. Low reimbursement rates from government health care programs often cause providers to raise prices for medical care to private insurance carriers. <sup>1</sup>
<b>Cost containment</b>	An attempt to reduce the higher-than-necessary costs surrounding the allocation and consumption of health care. These costs may arise from inappropriately used services and from care that can be provided in less costly settings without harming the patient. <sup>1</sup>

<b>Current procedural technology (CPT)</b>	A set of codes developed by the American Medical Association that describe medical procedures for billing. Each item submitted by your provider to an insurance company for payment must be listed by code on the bill. <sup>1</sup>
<b>Deductibles</b>	The amount that you must pay out-of-pocket for covered medical care before the benefits of the coverage begins. Check what this amount is per family member. There may also be a total family limit. Deductible amounts vary a great deal from policy to policy. Deductibles are usually set as an annual amount. <sup>1</sup>
<b>Diagnosis-related groups (DRGs)</b>	Method of reimbursing providers based on the medical diagnosis for each patient. Hospitals receive a set amount determined in advance based on length of time patients with a given diagnosis are likely to stay in the hospital. Also called prospective payment system. <sup>1</sup>
<b>Documenting</b>	Keeping written records relating to your family's medical care and insurance. You may need detailed records to support your case if you disagree with your insurer. <sup>1</sup>
<b>Effective date</b>	The date on which coverage under a health plan or insurance contract begins. <sup>2</sup>
<b>Employee Retirement Income Security Act (ERISA)</b>	Federal law that establishes uniform standards for employer-sponsored benefit plans. Because of court decisions, the law effectively prohibits states from experimenting with alternative health-financing arrangements without waivers from Congress. <sup>1</sup>
<b>Employer contribution</b>	The amount of money an employer pays toward the health benefit plans of its employees. The employer may pay the same fixed number of dollars toward every plan it offers to its employees (an 'equal-dollar' contribution); it may pay a fixed percentage of the premium for every plan offered ('equal-percentage' contribution); or it may adjust its contribution in other ways. The employee's portion of the health plan premium is typically paid through a payroll deduction. <sup>2</sup>
<b>Enrollment Area</b>	The geographical area within which a health plan member must reside in order to be eligible for coverage. Most HMOs place a limit on the length of time members (except students) can live outside the enrollment area each year and still be covered. <sup>2</sup>
<b>Estimate of benefits (EOB)</b>	The statement from your insurance plan that itemizes the actions taken on claims that have been submitted. <sup>1</sup>
<b>Exclusion</b>	A treatment or service that is not covered by a policy. <sup>1</sup>
<b>Exclusive provider organization</b>	A health care payment and delivery arrangement in which members must obtain all their care from doctors and hospitals within an established network. If members go outside, no benefits are payable. <sup>1</sup>

<b>Experience rating</b>	An insurance practice of setting premiums based on previous use of health services and health status. An employer whose employees are unhealthy will pay higher rates. This practice generally discriminates against persons with disabilities or chronic illness. <sup>1</sup>
<b>Experimental treatment</b>	Medical treatment not covered by insurance companies or public programs because its efficacy is considered unproven. Insurance companies or public programs may reject claims when they decide that the treatment is experimental. Insurers may rely on an internal medical review, consultation with outside experts, or a combination of these and other means. Articles in the current medical literature may influence decisions. Individuals have won claims by proving that other insurance companies have paid for the treatment in question, or that the treatment has been beneficial in other instances. <sup>1</sup>
<b>Federally qualified</b>	An HMO that has met certain federal standards regarding financial soundness, quality assurance, member services, marketing, and provider contracts can be federally qualified. HMOs that are not federally qualified are still subject to federal and state regulations and requirements intended to protect consumers and providers and ensure quality of care. <sup>2</sup>
<b>Fee for service</b>	A form of payment where a provider is paid for each service, supply, or equipment. Traditional indemnity plans are fee for service plans. <sup>1</sup>
<b>First dollar coverage</b>	A health insurance policy with no required deductible. <sup>1</sup>
<b>Formulary</b>	A list of prescription drugs and their recommended doses, which have been selected by a health plan, insurer, or group of doctors as the best choices, in terms of effectiveness and value, among the many possible options for a given condition. Formulary drugs may be only recommended or they may be required as a condition of HMO prescription drug coverage (unless individual circumstances make a different drug more appropriate choice for the patient). Formularies are used to manage both the cost and the quality of prescription drugs. <sup>2</sup>
<b>Gatekeeper</b>	A term given to a primary care physician in a managed care network who controls the patient access to medical specialists. <sup>1</sup>
<b>Gatekeeper PPO</b>	A health care payment and delivery system consisting of networks of doctors and hospitals. Members must choose a primary care physician, use doctors in the network, or face higher out-of-pocket costs. <sup>1</sup>
<b>Grace period</b>	A period of time after a premium is due but before payment is received during which your health coverage is still in effect. States may have laws requiring health insurance policies to allow a set number of days of "grace". <sup>1</sup>

<b>Guaranteed renewable</b>	An insurance contract that an insurer cannot terminate, providing the insured pays the required premiums in a timely manner. With these contracts, insurers have the right to raise premiums but only for an entire class of policyholders. <sup>1</sup>
<b>Health screening</b>	A method used by some insurers and health plans to determine whether applicants are likely to create a high medical costs, either because they are already sick or because they are likely to have a costly illness in the future. Health screening is used to detect preexisting medical conditions and to determine whether the applicant is at risk for illness because of factors like excessive weight or a past history of drug abuse. <sup>2</sup>
<b>Health Insurance Purchasing Cooperative (HIPC)</b>	A large group of employers and individuals functioning as an insurance broker to purchase health coverage, certify health plans, manage premiums and enrollment, and provide consumer with buying information. Also called health insurance purchasing group, health, plan purchasing cooperative, and health insurance purchasing corporation. <sup>1</sup>
<b>Indemnity health insurance</b>	A plan that reimburses physicians and other providers for health services furnished to enrollees. <sup>3</sup>
<b>Inpatient</b>	Medical care that requires the patient to occupy a bed in a hospital. Not all hospital care is inpatient care; a patient can also receive "outpatient" care in a hospital's emergency room or ambulatory care center. <sup>2</sup>
<b>Lifetime maximum</b>	the total amount that an insurance policy will pay out for medical care during the lifetime of the insured person. Check into other options you have for enrolling in another group plan during an open enrollment period well before your child is approaching a lifetime maximum. <sup>1</sup>
<b>Limitations</b>	A factor (such as a pre-existing condition) which allows an insurer to avoid paying for a service that normally would be covered. <sup>1</sup>
<b>Lock-in</b>	Refers to the requirement that members of an HMO or other managed network health plan must have all of their covered services provided, arranged, or authorized by the plan or its doctors, except in life-threatening emergencies or when members are temporarily 'out of area'. This contrasts with a 'point-of-service' plan, which allows patients to receive covered services without prior authorization but at a high cost, outside the plan's network. <sup>2</sup>
<b>Long-term care</b>	A continuum of maintenance, custodial, and health services for people with chronic illness, disability, or mental retardation. <sup>1</sup>

<b>Managed competition</b>	A method for controlling health care costs by organizing employers, individuals, and other buyers of health care in large cooperatives that will purchase coverage for their members. Insurance companies and managed care organizations will compete to supply coverage for the lowest cost. <sup>1</sup>
<b>Managed care</b>	Applies to the integration of health care delivery and financing. It includes arrangements with providers to supply health care services to members criteria for the selection of health care providers, significant incentives for members to use providers in the plan, and formal programs to monitor the amount of care and quality of services. <sup>1</sup>
<b>Mandated benefits</b>	Specific benefits that insurers are required to offer by state law. Each state has its own legislation on mandated benefits. <sup>1</sup>
<b>Medically necessary</b>	A determination made by a third party payor or a review organization regarding whether a given medical intervention was, in fact, necessary for a particular patient. <sup>3</sup>
<b>Medically necessary services</b>	A clause in a health insurance policy that states that the policy only covers services needed to maintain a certain level of health. The clause also defines - often in general terms - what those services are. Be sure to find out exactly what your insurer means by this term - what those services are. Be sure to find out exactly what your insurer means by this term. This information will help you to present your request in the most appropriate way. <sup>1</sup>
<b>National Association of Insurance Commissioners (NAIC)</b>	An organization of state insurance commissioners that writes model laws and regulations governing the insurance industry. <sup>1</sup>
<b>Open enrolment period</b>	A period when you may sign up for a health coverage plan without waiting periods or consideration for preexisting conditions. Many employers offer these periods yearly. You may be offered an open enrollment opportunity when you begin a new job. <sup>1</sup>
<b>Opt-out</b>	The option available through some managed care network plans, such as point-of-service HMOs and preferred provider organizations, to choose to receive care from providers outside the plan's network, at a higher cost, and still be covered. <sup>2</sup>
<b>Out of area</b>	Beyond or outside the geographical area served by an HMO or other managed network plan. When HMO members are inside their HMO's service area, they much have their care provided, arranged, or authorized by their HMO or HMO doctor in order to get full coverage; when they are temporarily out of area, different coverage rules apply. <sup>2</sup>

<b>Out-of-plan services</b>	Services furnished to patients by providers who are not members of a patient's managed care network. <sup>3</sup>
<b>Out-of-pocket costs</b>	All the health expenses that you pay yourself, including deductibles, co-payments, and charges not covered by any health plan. <sup>1</sup>
<b>Outcomes measure</b>	A tool to assess the impact of health services in terms of improved quality and/or longevity of life and functioning. <sup>3</sup>
<b>Outpatient benefits or coverage</b>	Treatment or services received in a setting ( such as a clinic or doctor's office ) where no room and board is charged. Check the out-patient benefits in any plan you are considering carefully, since most of your child's care will take place on an out-patient basis. <sup>1</sup>
<b>Participating providers</b>	A physician who signs a contract with a traditional, PPO, or HMO plan and agrees to accept the plan's allowable charges. <sup>1</sup>
<b>Point of service</b>	A term that applies to certain health maintenance organizations and preferred provider organizations. Members in point of service HMO or PPO can go outside the network for care, but their reimbursement will be less than if they had remained inside. <sup>1</sup>
<b>Practice guidelines or protocol</b>	Description of a course of treatment or established practice pattern. Managed care entities develop and distribute these to providers in their network to guide clinical treatment decisions. <sup>3</sup>
<b>Preexisting conditions</b>	A physical or mental condition that has been treated or would normally have been treated before enrollment in a insurance plan. Policies may exclude coverage for such conditions for a specified period of time. In some cases, preexisting conditions exclude a person completely from buying health insurance; or the insurance company may decide to charge higher premiums or offer the insurance but refuse to cover any treatment relating to the specific condition. <sup>1</sup>
<b>Preferred provider organizations (PPO)</b>	A form of managed care plan in which a group of providers contract with an insurer and agree to provide services at pre-negotiated fees. Members must have a primary care physician who is a member of the PPO. Members are given incentives to use providers within the organization, but may use providers outside the plane for greater out-of-pocket costs. <sup>1</sup>
<b>Premium</b>	The charge that you pay to the insurer for the health coverage. This may be paid weekly, monthly, quarterly, or annually. <sup>1</sup>
<b>Prepaid Health Care Act</b>	Federal law passed in 1973 that sets standards for federally qualified health maintenance organizations. Among the standards are minimum benefits and formal grievance. <sup>1</sup>
<b>Prepaid plans</b>	A health insurance plan where you pay a fixed premium to cover much of the care you receive. Prepaid plans include HMOs and PPOs. <sup>1</sup>

<b>Preventive care</b>	Medical services that try to reduce the chances of illness, injury, or other condition. This contrasts with acute care, which is given after the condition has occurred. <sup>1</sup>
<b>Primary care case management</b>	When a specific primary care provider acts as gatekeeper by approving and monitoring all covered services, and is paid for this service. <sup>3</sup>
<b>Primary care</b>	Routine medical care, usually provided in a doctor's office. <sup>1</sup>
<b>Prior authorization</b>	Before services are rendered, approval from the insurance plan or a designated primary care physician must be obtained or the service will not be reimbursed. <sup>1</sup>
<b>Prior authorization</b>	The approval a provider must obtain from an insurer or other entity before furnishing certain health services, particularly inpatient hospital care, in order for the service to be covered under the plan. <sup>3</sup>
<b>Professional Review Organization (PRO)</b>	Organization that determines whether care and services provided are medically necessary and meet professional standards under Medicare and Medicaid. <sup>1</sup>
<b>Prolonged illness clause or extended benefits</b>	A possible option in your coverage for 100% reimbursement (instead of partial) for all services relating to your child's condition. This option may also add to your child's lifetime maximum. <sup>1</sup>
<b>Provider</b>	A hospital, skilled nursing facility, outpatient surgical facility, physician, practitioner, or other individual or organization which is licensed to provide medical or surgical services and accommodations. <sup>1</sup>
<b>Quality assurance</b>	Term that describes attempts by managed care organizations to measure and monitor the quality of care delivered. <sup>1</sup>
<b>Rationing</b>	The allocation of medical care by price of availability of services. <sup>1</sup>
<b>Referral</b>	A formal process by which a patient is authorized to receive care from a medical specialist or a hospital. HMOs usually require a referral from the member's primary care doctor or the HMO in order for specialty care to be covered. <sup>2</sup>
<b>Renewal</b>	The clause in your insurance plan that describes how you might renegotiate the contract after the term is finished. Guaranteed renewability of an insurance policy protects you from losing your coverage, although the insurer may still raise the premiums. <sup>1</sup>
<b>Report card</b>	A published report for consumers on the premium costs for a plan and overall quality of a health plan or provider. Report cards generally include measures of the plan's delivery of appropriate services, patient outcomes, patient satisfaction and cost structure. <sup>3</sup>
<b>Rider</b>	A legal document added to an insurance plan that either restricts or adds to coverage. States may have regulations about riders. <sup>1</sup>

<b>Risk</b>	Possibility that revenues of the insurer will not be sufficient to cover expenditures incurred in the delivery of contractual services. A managed care provider is at risk if actual expenses exceed the payment amount. <sup>3</sup>
<b>Risk</b>	An insurance term related to financial responsibility for medical care. A "high-risk" individual is someone who has a high likelihood of having a serious illness, because of past medical history, family history, or health-related behavior, such as smoking or alcohol abuse. "At risk" or "risk-bearing" means being responsible for the cost of care for a group of people. For instance, if an HMO pays a hospital a fixed amount of money per member to provide all of the care he or she needs, the hospital is "at risk" for the member. "Risk adjustment" means paying a health plan an extra amount if its members are, on average, sicker and more expensive to care for. <sup>2</sup>
<b>Risk pools</b>	Arrangements by states to provide health insurance to the unhealthy uninsured who have been rejected for coverage by insurance carriers. <sup>1</sup>
<b>Risk-sharing</b>	A situation in which the managed care entity assumes responsibility for services for a specific group but in which it is protected against unexpectedly high costs by a pre-arranged agreement for higher payment for those individuals who need significantly more costly services. Risk is usually shared by the managed care entity and the state. <sup>3</sup>
<b>Second opinion review</b>	A managed care technique in which a second physician is consulted regarding diagnosis or course of treatment. Thought to be of questionable effectiveness in reducing costs. <sup>1</sup>
<b>Secondary Care</b>	A level of medical care between primary care and tertiary care, usually provided by medical specialists and usually requiring a referral from an HMO member's primary care doctor. <sup>2</sup>
<b>Self-insured</b>	Some places of employment write their own plans to cover health care costs for employees. Benefits and costs are determined by the employer. These plans may be administered by an insurance company, or involve an insurance company.
<b>Self-referral</b>	The ability for an HMO patient to refer himself or herself, under certain circumstances, for specialty medical care, without receiving a formal referral or prior authorization from the patient's HMO or primary care doctor. <sup>2</sup>
<b>Service Area</b>	The geographical area within which an HMO or other managed care network plan provides and arranges medical care for its members. This area is sometimes the same as the plan's enrollment area, but not always. <sup>2</sup>

<b>Single-payer system</b>	A health care financing arrangement in which money, usually from a variety of taxes, is funneled to a single government entity which then pays the medical bills for all citizens. <sup>1</sup>
<b>Single-point of entry</b>	An individual can gain access to services only through a primary-care provider who decides what services are needed (see Gatekeeper). <sup>3</sup>
<b>Skimming</b>	A practice by which insurers or health plans try to avoid enrolling people whose medical care may be very expensive, including people who are elderly or have a history of illness. <sup>2</sup>
<b>Socialized medicine</b>	A health care financing and delivery system in which doctors work for the government and receive a salary for their services. <sup>1</sup>
<b>Sole-source option</b>	A term meaning that an employer has chosen a single insurer or health plan to cover all of its employees. If the sole-source option is an HMO, it will usually offer both a standard lock-in plan and a point-of-service plan that allows members to choose to get care outside the HMO network, at a higher cost. <sup>2</sup>
<b>Staff-model HMO</b>	An HMO that directly employs on a salaried basis the doctors and other providers who furnish care. <sup>3</sup>
<b>State insurance regulations</b>	Every state has laws and regulations that govern insurance companies operating within the state. There is also a state process for filing complaints and appeals. Check with your state Commissioner of Insurance for information and assistance. <sup>1</sup>
<b>Stop-loss</b>	A clause that limits your liability to a specified amount on medical expenses covered by the policy. After expenses reach that amount, the insurance company would pay all of your remaining covered medical expenses for the year including deductibles and co-payments. <sup>1</sup>
<b>Targeted case management</b>	Medical term for case management services covered under Title XIX of the Social Security Act (as of November 1995). Federal law defines Targeted Case Management as services that will assist individuals eligible under the state Medicaid plan in gaining access to needed medical, social, educational, and other services. <sup>3</sup>
<b>Tertiary care</b>	The upper level of medical care and services, usually provided in hospitals by highly trained "sub-specialists" using the most advanced medical technology. <sup>2</sup>
<b>Third party administrator</b>	An organization not a party to an insurance contract that maintains records and pays claims of those insured under the contract. <sup>1</sup>
<b>Third party payment</b>	Payment for health care by a party other than the beneficiary. <sup>3</sup>
<b>Uncompensated care</b>	Charity care provided by doctors and hospitals for which no reimbursement or payment is made. <sup>1</sup>

<b>Underwriting</b>	An insurance company practice of assessing risks of illness and costs, and setting premiums based on these assumptions. <sup>1</sup>
<b>Usual, customary, and reasonable (UCR)</b>	A fee controlling system to determine the lowest value of physician reimbursement based on: 1) the physician's usual charge for a given procedure, 2) the amount customarily charged for the service by other physicians in the area, and 3) the reasonable cost of services for a given patient after medical review of the case. <sup>1</sup>
<b>Utilization</b>	The amount of medical services used by a given population, usually over a specific period of time or as an average related to the number of people in the population. For instance, an HMO's utilization rate for doctors' office visits might be five visits per member per year. Hospital utilization is often reported as the number of days in the hospital, on average, for each 1,000 members of the group being measured (days/1,000). In the interest of reducing costs, health plans and insurers try to reduce unnecessary or inappropriate utilization through "utilization management" or "utilization review." <sup>2</sup>
<b>Utilization review</b>	A managed care technique in which the managed care firm or insurance company attempts to reduce the length of hospital stays and the number of unnecessary hospital admissions. <sup>1</sup>
<b>Waiting periods</b>	The period of time required by the insurance company after a person is covered by a policy before specific health services are covered by the plan. This time can vary from a number of months to a number of years. <sup>1</sup>
<b>Wrap-around</b>	A supplementary insurance plan designed to pay for additional health benefits not covered by another plan. A wrap-around policy can provide more comprehensive benefits for a child with extensive needs. <sup>1</sup>
<sup>1</sup> Unknown source <sup>2</sup> Alan Raymond, <i>The HMO Health Care Companion</i> . <sup>3</sup> Health Law, <i>Managing Managed Care</i> . Bazalon center	

Source: [http://www.spokaneparentcoalition.org/health\\_insurance\\_acronyms.htm](http://www.spokaneparentcoalition.org/health_insurance_acronyms.htm)  
Date: 2003



