
Funding

Introduction

Medical care costs money, so do medications, special equipment, supplies and other services your child may require. Insurance may cover some or all of these costs, but choosing insurance that will best suit the needs of you and your child may not be an easy task. There are public insurance options that may be available, but you need to know what is offered and how to apply for these benefits. This section includes information that can help you in obtaining financial support for the expenses that you encounter in pursuing services for your child.

You may wish to personalize the section by including pages of information about your own private insurance, with such details as the policy number and the extent of coverage. If you are involved with any other public funding resources (such as the Illinois Department of Public Aid, Division of Specialized Care for Children or the Office of Rehabilitation Services) you may record information in this section, such as the name and phone number of your contact person at the agency, the agency address, and any information about the services they provide. Pamphlets from these agencies can be placed in the pocket of the section divider.

Like the other sections of the resource book, this section can be removed if you find it useful to take just this section with you to an appointment. It can then be readily replaced.

Tips

Learn what funding resources may be available to help meet your child's particular needs and how to contact those resources. Some private or benevolent organizations offer services for children with specific health care needs. Check the Resource Section (pages V-14/V-19) near the back of this workbook.

Consider applying for Supplemental Security Income (SSI) for your child. If your child is found ineligible at the time of the first application, learn the reason (perhaps appropriate medical reports were not available to make your child's medical diagnosis clear). Be willing to appeal a denial or reapply.

Community fund raising events on your child's behalf may affect financial eligibility for some public services for which your child would otherwise be eligible. You may wish to consult an attorney regarding how to manage funds raised in such a manner to be sure that the fund raising benefit is most useful to your child. You may also check with your child's case manager at the Division of Specialized Care for Children to obtain advice.

Working with government programs can be very frustrating. Hang in there. All public agencies have formal appeal processes that can be initiated whenever services are denied to an applicant. Learn about these appeal processes and your rights. (See the information on appeals in the Rights Section of the Coordinated Care Record, pages IV-8/IV-9.)

Ask other parents about helpful tips they may have.

Income Tax (These tips came from Internal Revenue Service Booklets)

Check with the Internal Revenue Service (IRS) for booklets that may help you identify your deductions. Tax laws change frequently so it is important to stay currently informed.

If you are claiming a large amount of deductions because of the disability, send a letter along with your income tax return to explain your child's disability.

Ask your child's physician(s) to also write a letter explaining the nature of your child's disability and identifying treatment services and therapies that are part of your child's medical care plan. Enclose this with your tax return.

Record every expense related to your child's disability. Include both prescription and nonprescription medication costs. Keep all receipts.

Keep track of transportation expenses related to your child's medical care.

Save receipts and deduction-related records for seven years in case you need them for a tax audit.

A deduction is allowed for the expense of child care that is necessary to permit employment.

Expenses related to removal of architectural barriers or other modifications to your house necessitated by your child's disability may be deductible.

Expenses for medical care that exceed 7.5% of family adjusted gross income may be deductible if you are itemizing deductions and these expenses were not reimbursed by insurance or a government program. Included among these deductions are: health insurance premiums, doctor and hospital fees, x-ray and laboratory charges, the costs of long-distance phone calls related to medical care, equipment costs, lodging and meal expenses necessitated when taking a child for medical care, costs of eyeglasses and hearing aids and the expenses related to attending special workshops or subscribing to publications that relate to your child's disability.

Financial Planning

Financial planning is important for the future of all your children. It is especially important for a child with special health care needs.

It is wise to write a will in order to protect your child. Consider how and where he or she will be cared for and how this would be paid for. Involve an estate planner, financial advisor or attorney to help determine the effects of inheritance on your child's eligibility for government programs and benefits.

Suggest that your attorney review an article on estate planning for the disabled in the July 1987 issue of the Illinois Bar Journal.

Consider designating a portion of your estate as a gift to another relative to be used for the disabled child. However, discuss with your lawyer possible problems that can develop with this approach to estate planning.

Money received from insurance and direct gifts from others can jeopardize a child's eligibility for government benefits. Designating a child as a beneficiary of pension funds or an individual retirement account can also cause similar problems.

Support trusts can protect the assets of minor children, but you should be aware that payments made from a trust to a child may be considered income and may jeopardize eligibility for government benefits. A trust set up for medical care expenses may have to be used before government benefits can be used.

Ask your attorney about a "discretionary spendthrift trust." If it is constructed properly, it can supplement available government benefits without having to be utilized prior to use of government benefits.

NOTE: Be sure to discuss options with your attorney. You may wish to contact such organizations as the Illinois Bar Association, Association for Retarded Citizens, Equip for Equality (1-800-537-2632), or other advocacy organizations to ask for help in locating an attorney skilled in estate planning.

Private Insurance

Private insurance is purchased from a private insurance company as a group plan or an individual plan. Most of the insurance people receive through their jobs is group insurance. Very few insurance plans pay for all medical care. Be sure to learn what your policy covers.

The Illinois Insurance Code states that every medical policy must cover the care of a baby born with a congenital defect for as long as the policy is in effect.

If you have any problems with payment of your insurance claim, you may write to:

Assistant Deputy Director
Illinois Department of Insurance
Life, Accident and Health Compliance
Section
320 West Washington
Springfield, IL 62767
Telephone Number: (217) 782-4254
Chicago Tele. Number: (217) 917-2427

If you have problems with "self-insured" or "self-funded" plans, you may contact the Pension Welfare Benefits Administration of the U.S. Department of Labor at 1-800-998-7542 and/or express your concerns to your legislator.

Remember, most insurance companies have a mechanism in place by which you can appeal unfavorable decisions. Find out how this works in your insurance company and use it when necessary.

Types of Insurance Organizations

A. Health Maintenance Organization

A Health Maintenance Organization (HMO) is an organized health care system that is responsible for both the financing and the delivery of health services. It provides comprehensive health care to an enrolled population at a predetermined price.

Members pay fixed, periodic fees and in return receive health care services as the HMO

primary care physician deems necessary and appropriate. HMO enrollment requires the individual to choose a primary care physician from a list of the HMO's contracted physicians. The individual must seek health care service or preapproved physician referrals through the primary care physician.

HMOs operate under a payment structure in which services are paid in advance for an enrolled person prior to knowing the services the person may require. This is different than the traditional fee-for-service payment structure in which a service is provided, the fee is billed and the provider is paid for the service. Under the traditional fee-for-service structure, the member will usually be responsible for a portion of the cost of each service. Members may pay deductibles or might be responsible for charges over the usual and customary rate allowable. With an HMO the member will usually only have a small cost responsibility through co-payments, e.g., the physician might charge \$5.00 per office visit in addition to what he receives from the HMO. HMO providers CANNOT bill members for charges or costs over the prearranged fee reimbursement for covered services.

B. Preferred Provider Organization

A Preferred Provider Organization (PPO) is an organization that arranges contracts between a select group of health care providers (hospitals, physicians) and purchasers of health care (employers, unions), but in itself is neither a provider nor a purchaser. Provider fees are negotiated in advance and providers offer discounts in return for rapid reimbursement and potential increase in patient load. Payment is on a fee-for-service rather than a capitated basis as with an HMO. Strict utilization controls are combined with flexible benefits and freedom of choice with respect to health care providers.

PPOs exist within the traditional plan structure unlike an HMO which is an alternative to a traditional health plan. PPOs typically reimburse services by non-preferred providers at a lower rate than participating providers, but cover, to some extent, all medically necessary services. An HMO requires services be rendered by participating providers in order to be covered. PPOs are usually not regulated, and HMOs are strictly regulated by federal and state law. A PPO facilitates the delivery of cost effective health care and is more of a manager or broker while an HMO delivers health care.

C. Point of Service Organization

A point of Service (POS) is a hybrid of the traditional HMO and PPO plan. The POS offers a member the choice of using network or out-of-network providers for health care. Under the network option, a member chooses a primary care physician (PCP) and seeks all care or referrals for care through the PCP. The out-of-network option allows the member to seek care from any provider. To encourage members to use the network option, services are reimbursed at a higher payment level (e.g., 100% compared to 60%).

POS plans operate under a payment structure similar to HMOs in which the PCP is paid a fixed payment per member per month. In addition, network providers have negotiated fees in advance and offer discounted fees in return for rapid reimbursement and potential increase in patient load. A POS facilitates the delivery of cost-effective health care as a manager which is similar to a PPO.

Public Insurance

“Public” insurance means programs that are funded by state and/or federal tax money to provide support for medical care of eligible persons. These programs are: Medicaid, the University of Illinois Division of Specialized Care for Children (DSCC), Comprehensive Health Insurance Plan (CHIP), Supplemental Security Income (SSI), and the Office of Rehabilitation Services (ORS). These programs will be discussed in the following pages.

Medicaid

The Illinois Department of Public Aid administers the federal Medicaid program, which is designed to assure low-income family's adequate medical care. Application for Medicaid is made at the local Public Aid office.

Medicaid covers the following medical services: inpatient and outpatient hospital care, clinic visits, physical rehabilitation, physician's services, eye care, dental care, chiropractic services, laboratory studies, prescription medications, prosthetic and orthotic devices, and some transportation related to medical care. Other services may also be available depending on the specific situation. Medicaid does not pay for care provided by other available insurance or for items or services that are not considered medically necessary.

Often a family applying to Public Aid for assistance will be eligible for more than one service. Public Aid may be able to provide a monthly check, medical assistance, food stamps, assistance with utility expenses, or even job training. In some cases, individuals in the family may be eligible for only the medical card. When this is the case, the Public Aid client is said to be receiving “MANG,” which stands for “Medical Assistance-No Grant.” A child who receives Supplemental Security Income (SSI) may be eligible for MANG and, if eligible, would receive his or her own medical card in addition to the monthly SSI check.

Sometimes a person who applies for MANG has income that is above the eligibility level for the medical card. In such a case, the person may be assigned a “spend-down.” This means that the person is responsible for payment of an assigned dollar amount of medical bills before Public Aid will agree to pay the rest, somewhat like a deductible of an insurance policy. Once the person has incurred the spend-down amount of medical bills (even if the bills are not yet paid), he or she is given a medical card from Public Aid. When the person applies for the medical card and is assigned a spend-down, that assigned spend-down is in effect for twelve months, at which time the person would need to make a new application. The spend-down is assigned on a month-by-month basis. For any month in which the spend-down amount is incurred, a medical card can be issued for the remainder of that month.

Every public agency has an appeal process. If you think you have been denied eligibility from Public Aid without justification, ask the caseworker or his or her supervisor to advise you regarding the steps you need to take to appeal the decision that has been made. If you win the appeal and receive Medicaid, the coverage will be backdated to the day you applied.

Medicare

Medicare is another form of “public insurance” that is available to individuals who meet specific requirements. Both Medicare and Medicaid are federal government programs, using federal dollars to pay for medical care. The names of the two programs are similar, but they are administered separately by different agencies. Medicaid is administered by the

state, Medicare by the federal government. Determination of eligibility for these programs is also handled in different ways.

Medicare, in its most commonly known form, is a hospital care program for people receiving Social Security benefits, who are usually over 65 years of age. This hospital insurance coverage is called Medicare Part A and is automatically available to anyone receiving Social Security. It is paid for by Social Security taxes. Medicare Part B covers doctor bills and other expenses not covered by Part A; there is a monthly premium for Part B.

A disabled child, who has a parent already receiving some form of Social Security benefits, would be eligible to receive his or her own Social Security Disability payments upon reaching age 18. After receiving disability payments for two years, this person would then be able to obtain coverage from Medicare Part A and Medicare Part B.

Division of Specialized Care for Children (DSCC)

The Division of Specialized Care for Children (known as "DSCC" or "the Division") is an official agency of the State of Illinois. It is supported by both state and federal funds. The purpose of the Division is to help children with certain chronic medical problems obtain specialized medical care and other services they may require.

In order to receive services from DSCC, children must be determined medically eligible for the program. In order to receive assistance with medical expenses, families must also submit a financial application.

If a child is medically eligible and the family is found to be financially eligible, DSCC will pay for **SPECIALIZED** medical care, equipment and other needs which are preapproved and meet DSCC guidelines. Routine medical and dental care and care not related to the eligible condition are not provided.

Financial eligibility is usually determined for two years; however, an eligibility period may be less than two year's duration in certain instances.

A brochure about DSCC is in the front pocket of this section. Specific information about your current financial assistance can be kept at the back of this section.

For additional information about the Division of Specialized Care for Children, call the toll-free number, 1-800-322-3722.

Comprehensive Health Insurance Plan (CHIP)

CHIP is a program that creates a comprehensive health insurance plan for people unable to obtain traditional insurance because they are considered "high-risk" due to a current or past medical condition.

To inquire about CHIP coverage and request an application, you may contact Mutual of Omaha (Illinois CHIP Administrator) at 1-800-456-0224.

If you would like to be placed on the CHIP Informational Mailing List, contact the Illinois Attorney General's Office or write to the Illinois Department of Insurance, 320 West Washington, 4th Floor, Springfield, IL 62767, Attention: Mr. Rick Carlson.

Supplemental Security Income (SSI)

SSI is not a health insurance program, but it does provide additional or supplemental funds for parents to use in the care of their disabled child.

Children who have a severe physical or mental disability may be eligible for Supplemental Security Income (SSI). SSI is a federal program administered by the Social Security Administration. If your child is found to be both medically and financially eligible for the SSI program, you will receive monthly SSI checks for your child.

Contact your nearest Social Security Administration office in order to begin the application process. If you do not know the location of an office, you may find out by calling 1-800-234-5772.

If your child is approved for SSI, he or she may also be eligible for medical coverage from Public Aid (see "Medicaid" earlier in this section). You may wish to inquire about Medicaid eligibility at your nearest Public Aid office. You should also be aware that receipt of an SSI check could affect your eligibility for other programs.

Division of Rehabilitation Services (DRS)

The Division of Rehabilitation Services provides services to persons with disabilities and is supported by state and federal funding. Its primary function relates to educational and vocational training, but it may also be of some assistance with medical services. For older children (over age 16) this could possibly be medical care that is not eligible for coverage by the Division of Specialized Care for Children and is necessary to further the child's vocational potential. For younger children, the DRS Home Services Program may provide services designed to keep the child from being unnecessarily or prematurely institutionalized; a personal care attendant, home health services and assistive equipment are some of the services that may be provided. Some home remodeling (including construction of ramps) may also be provided by DRS.

You may wish to contact your local DRS office to discuss available services. If you are not aware of the location of the DRS office serving your area, contact your DSCC case manager for assistance or phone 1-800-275-3677.

See the Education/Vocation Section for additional information on DRS services.

Other Possible Funding Resources

Clinic and Hospital Care

Shriners Hospitals and Clinics - Inpatient and outpatient treatment of orthopedic problems and orthopedic related problems resulting from birth defects, injury or disease. Immediate or long-term care following a burn, and/or reconstructive plastic surgery related to burns and selected birth defects. Treatment to support the development of independence and self-care of children who otherwise qualify for the services provided by the particular Shriners Hospital.

A cooperative venture between Shriners and state programs servicing children with special health care needs is called the CHOICES Program. This program compliments the aforementioned by:

- A. Providing more options for quality health care.
- B. Improving access and referral to services for both Shriners Hospitals and the child's state program serving children with special health care needs.
- C. Creating a partnership with the patient/parent being a key member of the care team. To be eligible for services from Shriners Hospitals, the child must be less than 18 years of age at time of application and require treatment that, if provided elsewhere, would pose a financial burden to the family. The child must be sponsored by a Shriner, or can telephone the following number to obtain information regarding sponsorship: 800-237-5055 or 312-622-5400.

Equipment/Orthotics/Prosthetics

Elk's Club - Illinois Chapter has special interest in disabled children. May be a resource for obtaining wheelchairs or specialized equipment.

Contact them at:

Elk's Commission
R.R. 1, Box 2A
P.O. Box 222
Chatham, IL 62629-0222

Or you may contact your local Elk's Club.

Lion's Club - Has special interest in eye care and conditions as well as hearing loss. May assist with eye care, purchase of glasses or special eye services under certain conditions, may purchase hearing aids and other assistive devices.

Contact them at:

Lions of Illinois Foundation
1701 South First Avenue, Suite 406
Maywood, Illinois 60153
(708) 681-8800

Or you may contact your local Lion's Club.

Specialty Medical Resource or Parent

Groups

Muscular Dystrophy Foundation, Illinois Spina Bifida Association, etc. (see Resource Section) may offer funding for specific needs related to a certain medical condition. Contact the specific agency for details.

Township Government

Some townships may have funding for special health care and/or related habilitative needs. Contact your local township officer.

Religious Organizations, Churches

May be willing to help with cost of items. Contact your church to discuss this.

Some communities have information and referral services that provide information to area residents about services that are available in the community. Check the yellow pages of your phone book, under "Social Services Organizations," to find the phone number of the local information and referral service.

Insurance Terms Glossary

The following terms are commonly used by insurance companies:

Applicant: Person applying for insurance coverage.

Assignment of Benefits: Written authorization by the insured giving the insurance carrier permission to pay benefits directly to the medical care provider.

Benefit Period: A specific period of time (generally 12 months) during which benefits are payable.

Birthday Rule: When a child is covered by both parents under two plans and both plans follow the birthday rule, the primary plan will be the plan of the parent whose birthdate falls earlier in the year.

Capitative Payment: A method of payment for health care services in which the health care provider is paid a fixed fee in advance for each person to be served. The payment is on a per capita basis and has no relationship to the type of services provided or the number of services each patient receives.

Case Management: A method of managing the provision of health care to members with catastrophic or high cost medical conditions. The goal is to coordinate the care to both improve continuity and quality of care as well as lower costs. Usually performed by the utilization review department.

Champus: Civilian Health and Medical Program of the Uniformed Services. The federal program providing health care coverage to families of military personnel, military retirees, certain spouses and dependents of such personnel, and certain others.

Claim: A request for reimbursement from the insurance carrier by the insured (or provider).

COB: Coordination of benefits. An agreement that uses language developed by the National Association of Insurance commissioners and prevents double payment for services when a subscriber has coverage from two or more sources.

COBRA: Consolidated Omnibus Reconciliation Act. Cobra requires an employer to offer the opportunity for terminated employees to purchase continuation of health care coverage under the employer's group plan.

Comprehensive Health Insurance Plan (CHIP): The Illinois General Assembly created the Comprehensive Health Insurance Plan to offer a program of health insurance to certain

eligible Illinois residents who have been denied major medical coverage by private insurers due to a pre-existing health condition or disability.

Conversion: The right of an individual to convert from group coverage to an individual policy. This is offered to individuals who lose their group coverage (e.g., through job loss, death of a working spouse) and are ineligible for coverage under another group contract coverage.

Co-insurance or Co-payment: A set amount of money an insured must pay toward covered medical expenses during any one benefit period. It may be a percent of the total covered cost or a dollar amount. For example: Under a major medical plan, the co-insurance determined amount may be 20% of the covered medical expenses or may be \$10 for each office visit (applies to HMOs etc). This is known as a copayment in the HMO plans.

Coordinated Home Care Program: An organized skilled patient care program initiated by a hospital to facilitate early discharge of a patient with home care. Care may be rendered by a hospital's home health department or other licensed home health agency. Patient must be homebound (e.g., unable to leave home without assistance and requiring supportive devices or special transportation) and must require skilled nursing services on an intermittent basis under physician direction.

Coverage: The benefits provided under a health plan.

Covered Expense: An expense for which a health plan will provide reimbursement.

CPT-4: Current Procedural Terminology. Current Procedural terminology is a listing of descriptive terms and identifying codes for medical services and procedures performed by physicians to provide uniform billing nationwide.

CSS: Central Support Services

Custodial Care Service: Services which do not require the technical skills or professional training of medical and/or nursing personnel in order to be safely and effectively performed. Examples are: assistance with activities of daily living, administration of oral medications, assistance in walking, turning and positioning in bed and acting as a sitter or companion.

Deductible: An amount the insured must pay before the health plan benefits (reimbursement for expenses) begin.

Down Coding: An insurance carrier's process of assigning the lowest priced code number when a bill is received without a procedure code and/or without using the standard description of the procedure rendered.

DME: Durable medical equipment. Medical equipment which is not disposable (i.e., is used repeatedly) and is only related to care for a medical condition. Examples would include wheelchairs, home hospital beds, and so forth.

DRG: Diagnosis-related groups. A statistical system of classifying any inpatient stay into groups for purposes of payment. This is the form of reimbursement that the HCFA uses to

pay hospitals for Medicare recipients. Also used by some private health plans for contracting purposes.

ERISA: Employment Retirement Income Security Act. ERISA was developed as protection for employee's overall benefits program. The primary focus of protection is through federal requirement that written summary documents describing the benefit program in detail be maintained by the employer and made available to the employees. ERISA does not mandate employers to provide benefits and does not prohibit discrimination.

Exclusion: Specific medical diagnoses, services, supplies and/or equipment not covered by a health plan. These exclusions are listed in the health plan contract.

Explanation of Benefits: A report provided by the health insurance company summarizing how a claim reimbursement or denial was determined.

EPO: Exclusive Provider Organization. An EPO is similar to an HMO in that it often uses primary physicians as gatekeepers, often capitates providers, has a limited provider panel, and uses an authorization system, etc.

Fee for Service: A method of payment where providers are paid for each service provided.

Gatekeeper: An informal, though widely used term that refers to a primary care case management model health plan. All care from providers other than the primary care physician, except for true emergencies, must be authorized by the primary care physician before care is rendered.

Gender Rule: When a child is covered by both parents under two plans and both plans go by the gender rule, the plan of the father is considered primary.

Group Insurance: An insurance program protecting a group of associated individuals against financial loss resulting from illness, injury, or death.

Group Master Contract: A binding contract between the insurer (insurance company) and purchaser of a health insurance plan (e.g., employer or union) which specifically details the legal name of the policyholder and location of employees to be insured, classes (job classifications) of employees eligible for coverage, the effective date of the plan, the coverage purchased (both benefits and exclusions), the amount of employee contributions, the policyholder premium payment, and the claims payment method.

Group Number: A number that identifies to the insurance carrier which particular group an insured is enrolled in.

HCFA - Health Care Financing Administration: The federal agency that oversees all aspects of health financing for Medicare and also oversees the office of Prepaid Health Care Operating and Oversight (OPHCOO).

HCFA - 1500: A claims form used by professionals to bill for services. Required by Medicare and generally used by private insurance companies and managed care plans.

HCPCS - HCFA Common Procedural Coding System: An alpha-numeric coding system which supplements CPT coding, but also has codes not included in CPT coding. Example: durable medical equipment, medical and surgical supplies, orthotic and prosthetic procedures.

Health Maintenance Organization: An organization providing comprehensive health care to an enrolled population at a predetermined price.

HIPA - Health Insurance Portability and Accountability Act: Federal law guaranteeing access to health insurance to most workers who change or lose jobs. Limits exclusion due to pre-existing conditions. Prohibits dropping individuals from insurance plan due to illness.

ICD-9 - International Classification of Diseases, 9th Edition: This coding system is used to transfer verbal and written description of diseases and injuries and medical procedures into a numerical code.

Insurance: Protection against risk, loss, or ruin by a contract in which an insurance company guarantees to pay a sum of money for such an event in return for a premium payment. Examples are: medical, life, auto, property, disability, etc. Insurance may be purchased by a group or an individual.

Insured: An individual who is eligible to receive benefits under an insurance policy. Also known as policyholder, subscriber. Insured may also be used to describe the employer or organization who purchased the policy.

Lifetime Limit: A specific dollar amount an insurance company will pay toward medical expenses over an individual's lifetime.

Maintenance Occupational Therapy/Maintenance Physical Therapy/Maintenance Speech Therapy: Therapy administered to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

Major Medical Insurance: Health insurance to finance the expense of major illnesses and injuries. Major medical insurance policies usually include a substantial deductible clause, but generally have large benefit maximums.

Managed Health Care: This is a form of health care delivery that tries to manage the cost of health care, the quality of that health care and access to that care.

Mandated Benefits: Benefits that a health plan are required to provide by law. Self-funded plans are exempt from mandated benefits under ERISA.

Medically Necessary: Services and/or supplies rendered by a medical provider to identify or treat an illness or injury and are consistent with the symptoms or diagnosis of the illness or injury; are commonly accepted standards of medical practice; are not solely for convenience and are the most appropriate supply or level of service which can be safely provided as determined by the health plan.

Medical Services Advisory: A special unit of health care professionals, usually registered nurses, that help manage health benefits when inpatient treatment and outpatient surgeries are recommended. MSA staff have experience in a full range of medical specialties, can

answer questions and work with the providers to ensure getting the best and most appropriate coverage available.

Open Enrollment Period: The specified period of time (commonly 30 days) an employee has to enroll, add or drop dependents, and/or change insurance plans prior to the policy effective date.

OPHCOO - Office of Prepaid Health Care Operations and Oversight: The federal agency that oversees federal qualifications and compliance from HMOs. Once part of the Public Health Service, now part of HCFA.

Out of Pocket Maximum: The maximum amount the insured will have to pay for covered expenses under a health plan.

Participating Provider: A physician or other medical care provider who has entered into a contract with an organization, the government, or an insurance company to provide medical care to enrolled persons (insured). The provider is to accept the insurance company's approved fee and only bill the insured for deductibles, copayments/coinsurance or uncovered services/supplies.

Participating Provider Option: A program of health care benefits designed to provide economic incentives for using designated providers of health care services.

POS: Point of service. A plan where members do not have to choose how to receive services until they need them. The most common use of the term applies to a plan that enrolls each member in both an HMO (or HMO-like) system and an indemnity plan. Occasionally referred to as an HMO swing-out plan, an out-of-plan benefits (e.g., 100% coverage rather than 70%) depending on whether the member chooses to use the plan (including its providers and in compliance with the authorization system) or go outside the plan for services. Dual choice refers to an HMO-like plan with an indemnity plan, and triple choice refers to the addition of a PPO to the dual choice. An archaic, but still valid definition applies to a simple PPO, where members receive coverage at a greater level if they use preferred providers (albeit without a gatekeeper system) than if they choose not to do so.

Precertification: The process of obtaining authorization from a health plan (HMO, PPO, POS) before services are rendered as specified by the plan. Failure to obtain precertification often results in a financial penalty to either the provider or the policyholder.

Pre-existing Condition: A condition that existed, or for which a participant was being treated, before the health plan coverage began. Benefits are usually limited or not available and are restricted to a specified time period.

Preferred Provider Organization: An organization which arranges contracts between a select group of health care providers (hospitals, physicians) and purchasers of health care (employers, unions), but is itself is neither a provider nor a purchaser.

Primary Care Physician: The physician (commonly a family practitioner or pediatrician) who is responsible for providing, arranging and coordinating all aspects of the insured or covered dependent's health care when the insurance plan is an HMO.

Private Duty Nursing: Skilled nursing service provided on a one to one basis by a practicing, licensed practical nurse or registered nurse who is not employed by a hospital or home health agency.

RBRVS - Resource Based Relative Value Scale: A system developed by HCFA for determining the level of provider payments based upon the amount of work involved in the treatment, the skill level of the physician, and the medical malpractice risk.

Self-Funded or Self-Insured: A health plan where the risk for medical costs are assumed by the employer (association) rather than the insurance company.

Third Party Administrator: A person or organization providing certain administrative services to group benefits plans, including record keeping, claims review and payment, claims utilization review and maintenance of employee eligibility records.

Tri-Care: The managed care program for the Army, Navy and Air Force.

UB-92: The common claim form used by hospitals to bill for services. Some managed care plans demand greater detail than is available on the UB-92, requiring the hospitals to send additional itemized bills.

Underwriter: The insurance carrier or governmental agency that sets all policy benefits and establishes all procedural rules for determination of the payment of benefits.

Upcoding: The practice of a provider billing for a procedure that pays better than the service actually performed.

Usual and Customary Charge: The maximum amount an insurance carrier will consider eligible for reimbursement under the group health plan. Used to control claims costs.

Utilization Review: A cost-control mechanism used by some insurance carriers and employers that evaluates health care on the basis of appropriateness, necessity, and quality. For hospital review, it can include pre-admission certification, concurrent review with discharge planning, and retrospective review.

Write-off: A reduction in the amount charged for medical services after the provider receives the insurance carrier's payment. The reduction is the difference between the fee charged and the fee allowed by insurance.