Medicare Glossary of Terms

COUNCIL FOR AFFORDABLE HEALTH COVERAGE

Area Agencies on Aging (AAAs):
A program established under the Older Americans Act in 1973 to respond to the needs of Americans age 60 and over in every local community. AAAs provide a range of options that allow older adults to choose the home and community-based services and living arrangements that suit them best.

Annual Open Enrollment Period:
A roughly two-month period each fall (October 15-December 7) when eligible beneficiaries can enroll in Medicare for the first time, change their existing coverage or add Medicare Advantage or a prescription drug plan to their coverage.

Beneficiary:
A Medicare enrollee. To qualify for Medicare, people must be 65 or older or have received Social Security disability benefits for two years or more.

Carrier:
A private insurance company that pays Medicare for benefits.

Centers for Medicare & Medicaid Services (CMS):
The federal agency within the Department of Health and Human Services that administers Medicare, Medicaid and several other health-related programs.

Coinsurance:
A percentage of the cost of healthcare services or prescription drugs for which the beneficiary is responsible for paying out of pocket. This is a form of cost sharing.

Copayment:
A dollar amount paid by beneficiaries out of pocket for medical visits, prescription drugs and other procedures. This is a form of cost sharing.

Cost Sharing:
The amount beneficiaries pay out of pocket for healthcare. Coinsurance, copayments and deductibles are common forms of cost sharing.

Coverage Gap (donut hole):
For Medicare Part D recipients, this is a gap in prescription drug coverage after the initial coverage limit has been reached, before the *catastrophic coverage kicks in, where beneficiaries are responsible for lower cost sharing. Recent changes made by Congress in the 2018 Bipartisan Budget Bill will affect cost sharing responsibilities of Part D plans during the coverage gap beginning in 2019. Specifically, these changes severely diminish the cost sharing responsibilities of plans during this stage.

Deductible:
The amount a beneficiary must pay for healthcare or prescriptions out of pocket before an insurance plan kicks in. This is a form of cost sharing.

Dual Eligible:
A beneficiary who is eligible for medical benefits under both the Medicare and Medicaid programs.

* Catastrophic coverage refers to the point when a beneficiary has spent $5,000 out-of-pocket in 2018, and is now out of the coverage gap. Once out of the coverage gap (Medicare prescription drug coverage), the beneficiary automatically gets “catastrophic coverage.” It assures they only pay a small coinsurance amount or copayment for covered drugs for the rest of the year.

[1] https://www.careplushealthplans.com/medicare-information/glossary
[2] https://www.careplushealthplans.com/medicare-information/glossary
[3] https://www.careplushealthplans.com/medicare-information/glossary and https://www.ehealthmedicare.com/about-medicare/glossary/A/?redirectFromHTTP
[4] http://www.cvs.com/healthinsurance/medicare/glossary-of-terms.html
[5] https://www.careplushealthplans.com/medicare-information/glossary
[6] https://www.ehealthmedicare.com/about-medicare/glossary/A/?redirectFromHTTP

Evidence of Coverage (EOC):
A document issued to new members of a health plan or renewing members of a health plan annually that certifies enrollment in a plan and describes that plan's benefits. It is good to keep this documentation in a safe place.

Formulary:
The list of prescription drugs covered by a Medicare Part D or Medicare Advantage prescription drug plan. This list does not remain constant and is subject to change each year, although mid-year changes are limited and a beneficiary will be notified.

Health Maintenance Organization (HMO):
A type of insurance plan offered to Medicare Advantage beneficiaries that offers coverage of the services provided within the HMO network. Beneficiaries typically see a primary care physician who refers patients to specialists when needed. HMOs typically restrict enrollees' choices of hospitals and physicians to a greater extent than Preferred Provider Organizations (PPOs).

Initial Enrollment Period:
This is when a beneficiary is first eligible to enroll in Medicare –three months before and after a beneficiary's 65th birthday month. If the beneficiary doesn't enroll in Medicare during this period and is not covered by an employer's or spouse's insurance, the individual faces an added penalty if he or she enrolls in Medicare at a later date.

Late Enrollment Penalty:
A fee added to beneficiaries' premiums if they did not enroll in Medicare during their Initial Enrollment Period, or if they allowed their insurance coverage to lapse.

Low-Income Subsidy or Extra Help:
This program provides financial assistance to beneficiaries with modest income and resources by reducing or eliminating their premiums and out-of-pocket prescription drug costs. Visit the following link to learn if you qualify for assistance: https://www.medicare.gov/your-medicare-costs/help-paying-costs/save-on-drug-costs/save-on-drug-costs.html.

Medicaid:
A partnership between the federal government and states that provides healthcare to people with low incomes (who may also be covered by Medicare) and those with disabilities.

Medicare Modernization Act of 2003 (MMA):
A law passed in 2003 that added outpatient prescription drug benefits (Part D) to Medicare.

Medicare Part A:
Covers inpatient hospital care, skilled nursing facilities, hospice and other home health visits.

Medicare Part B:
Covers physician visits, preventive services, tests like x-rays, other outpatient care and medicines, such as chemotherapy, that must be administered under physician supervision at a doctor's office, clinic or hospital outpatient department.

Medicare Part C (Medicare Advantage):
Offers benefits covered by Parts A, B, and typically D, as well as supplementary dental and vision benefits, through federally subsidized private insurance plans.

Medicare Part D (Prescription Drug Benefit):
Offers outpatient prescription drug coverage through federally subsidized private insurance plans.

[7] https://www.ehealthmedicare.com/about-medicare/glossary/A/?redirectFromHTTP
[8] https://www.careplushealthplans.com/medicare-information/glossary
[9] https://www.ehealthmedicare.com/about-medicare/glossary/A/?redirectFromHTTP
[10] https://www.ehealthmedicare.com/about-medicare/glossary/A/?redirectFromHTTP
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[13] http://www.cvs.com/healthinsurance/medicare/glossary-of-terms.html
[14] http://www.cvs.com/healthinsurance/medicare/glossary-of-terms.html

Medigap Plans:
Private insurance plans that supplement traditional Medicare (Parts A and B) and other associated costs.

Original Medicare (Traditional Medicare):
This refers to Medicare Parts A and B.

Out-of-Network Provider:
A healthcare provider who is not covered by an insurance plan. Some insurance plans will pay for out-of-network providers, but require beneficiaries to pay a higher share of the cost. Other plans will not pay for out-of-network providers, requiring beneficiaries to pay 100 percent of the cost out of pocket.

Point-of-Service Option (POS):
Under this plan option, beneficiaries of HMOs can use doctors and hospitals outside of the plan's network at an additional cost.

Preferred Provider Organization Plan (PPO):
A type of Medicare Advantage plan that allows beneficiaries to receive care from any in- or out-of-network provider or facility. Out-of-network care generally involves higher out-of-pocket costs.

Premium:
A monthly fee paid by beneficiaries to insurers for coverage. Premiums do not count toward deductibles or out-of-pocket maximums.

Prior Authorization:
Some plans require beneficiaries or, more commonly, their physicians to seek prior approval in order to prescribe a specific treatment. These plans will not pay for services if prior approval is not secured.

Private Fee-for-Service Plan (PFFS):
Offered by a private insurance company, a PFFS plan sets reimbursements and cost-sharing requirements that may differ from Medicare's rates.

Referral:
Some plans, especially HMOs, require beneficiaries to receive a written note from their primary care physician before seeing a specialist.

Special Election/Enrollment Period:
A period in which a beneficiary can change his/her current plan outside of the initial enrollment or annual open enrollment period. These enrollment periods are options when certain events happen in a beneficiary's life, such as moving or losing other insurance coverage. Rules about when a beneficiary can make changes and the type of changes possible are different for each special enrollment period.

Special Needs Plan:
A Medicare Advantage plan that is only open to enrollment for certain types of beneficiaries, such as those with chronic conditions, those who are dually eligible for both Medicare and Medicaid and those who are institutionalized.

State Health Insurance Assistance Program (SHIP):
Beneficiaries can use this program to receive one-on-one counseling about their Medicare benefits and making plan selections each year.

State Pharmacy Assistance Program (SPAP):
Subsidized by states, this program helps to pay for some prescription drug costs.

[15] http://www.cvs.com/healthinsurance/medicare/glossary-of-terms.html
[16] https://www.medicareinteractive.org/get-answers/introduction-to-medicare/explaining-medicare/what-does-medicare-cover-parts-a-b-c-and-d
[17] http://www.aarp.org/health/medicare-insurance/info-11-2009/Medicare_partD_guide_glossery.html
[18] http://www.aarp.org/health/medicare-insurance/info-11-2009/Medicare_partD_guide_glossery.html
[19] http://www.aarp.org/health/medicare-insurance/info-11-2009/Medicare_partD_guide_glossery.html
[20] https://www.washingtonpost.com/national/health-science/if- you-find- medicare-sign- up-rules- confusing-read-this/2014/10/06/e525ccbe-3472- 11e4-8f02- 03c644b2d7d0_story.html?utm_term=.df08c9796989
[21] http://www.cvs.com/healthinsurance/medicare/glossary-of-terms.html
[22] https://www.ehealthmedicare.com/about-medicare/glossary/A/?redirectFromHTTP
[23] https://www.humana.com/individual-and-family/products-and-services/medical-plans/what-is-ppo
[24] https://www.ehealthmedicare.com/about-medicare/glossary/A/?redirectFromHTTP
[25] http://www.cvs.com/healthinsurance/medicare/glossary-of-terms.html

Step Therapy:
A restriction in which a health plan requires the patient to try a less expensive drug or treatment before it will cover the cost of a more expensive one.

Supplementary Security Income (SSI):
Provides support for people with low incomes who are 65 and older or who are disabled. If beneficiaries qualify for SSI, they also qualify for Part D's Extra Help program.

Tiers:
Insurance plans can place different drugs on different formulary tiers, where the tiers represent the varying levels of cost sharing. The lowest tier may require no or a small copay. The highest tier may require higher cost sharing such as coinsurance. Insurers use tiers to steer patients toward lower cost medications.

[26] https://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/private-fee-for-service-plans.html
[27] https://www.ehealthmedicare.com/about-medicare/glossary/A/?redirectFromHTTP
[28] http://www.aarp.org/health/medicare-insurance/info-11-2009/Medicare_partD_guide_glossery.html
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[34] http://www.aarp.org/health/medicare-insurance/info-11-2009/Medicare_partD_guide_glossery.html