

SHIBA



Senior

Health

Insurance

Benefits

Assistance

Glossary *and* Acronyms

*SHIBA Volunteer Training Program
2009*

SHIBA Glossary and Acronyms

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Glossary of Terms

AAA (Area Agencies on Aging) - Local or regional nonprofit organizations that collaborate with state and federal government to administer services and programs to Americans age 60 and older under guidelines from the federal Older Americans Act.

ABN (Advanced Beneficiary Notices) - A written notice from Medicare given to a beneficiary before receiving certain items or services, notifying them that Medicare may deny payment for a specific procedure or treatment and that they will be personally responsible for full payment if Medicare denies payment. Gives the opportunity to accept or refuse the items or services and protects from unexpected financial liability in cases where Medicare denies payment and offers the right to appeal.

Abuse - Occurs when unintentional incidents or practices of providers are inconsistent with accepted, sound medical business or fiscal practices.

Actual Charge - This is the amount a physician or supplier actually bills a patient for a particular medical service or supply. This may differ from the allowable amount under Medicare.

Acute Care - Short-term medical care provide to a patient with an immediate need for care.

ADL (Activities of Daily Living) - Daily activities such as getting out of bed, walking, going to the toilet, bathing, dressing, eating, and taking medication.

Adult Day Care - A program of community-based social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or disabled adults who can benefit from care in a group setting outside the home.

Adult Foster Home - A regular family home of a person or persons who are providing personal care, room and board to between one and five adults who are not related by blood or marriage to the person(s) providing the service.

Advanced Directive - A written document in which people clearly specify how medical decisions affecting them are to be made if they are unable to make them, or to authorize a specific person to make such decisions for them.

Advocacy - An individual or group's active support of an idea or cause, especially the act of pleading or arguing for something.

AEP (Annual Enrollment Period) - A period of time from November 15 to December 31, in which Medicare beneficiaries may join or disenroll from Part D prescription drug coverage or Medicare Advantage plan. Changes usually become effective January 1. *Also known as Fall Open Enrollment.*

ALF (Assisted Living Facility) - Provides home and community services in a more homelike and comfortable environment than the typical nursing home setting. Services are designed around the resident's needs. Provides a combination of social interaction and privacy. Medical staff provides medical services.

ALJ (Administrative Law Judge) - The entity that reviews the third level of appeal.

AOR (Appointment of Representative) - A signed document that allows a representative to act on behalf of another individual

Appeal - A resort to a higher authority or greater power, as for sanction, corroboration, or a decision.

Assignment - A method of payment under Medicare Part B. The doctor agrees to accept the amount of the Medicare approved charge as full payment.

Attained Age - Insurance policies whose premiums increase based on the age of the insured.

Beneficiary - Under Medicare, the person who is receiving payments for medical service.

Benefit Period - The period for which benefits are payable. In Original Medicare Part A, for example, the benefit period begins on the first day of hospitalization and ends when the beneficiary has been out of the hospital or associated SNF for 60 consecutive days.

Benefits - The items that are covered under an insurance plan. Also referred to as coverage.

Carrier - A private company that has a contract with Medicare to pay a physician and most other Part B bills.

Catastrophic Coverage - The highest amount of money paid out-of-pocket before a health plan pays the majority of or all co-payment amounts.

Chronic - Being long lasting and recurrent or characterized by long suffering. A chronically ill person is not expected to recover or get much better.

Chronic Care - Care that is necessary to support an existing level of health and is intended to preserve that level from further failure or decline. *Also known as maintenance care.*

Claim - A request for payment of medical services under the terms of an insurance policy. Usually made by either a provider or an insured person.

Clinical Trial - The process of testing a new drug, treatment, or medical device on humans in a controlled manner.

CMS (Centers for Medicare and Medicaid Services) - The division of the Department of Health and Human Services that administers the Medicare and Medicaid programs.

COB (Coordination of Benefits) - If a service is covered under more than one policy, the insurance companies determine which policy pays.

COBRA (Consolidated Omnibus Budget Reconciliation Act) - Rules that permit former employees to buy insurance at group rates from their former employers' insurance companies for a set period of time after they leave their jobs or retire.

Coding - Assigning a number that is designated to identify specific diagnoses or procedures that serves as an accounting function for Medicare.

Coinsurance - A fixed percentage paid per service received or prescription filled.

Community Rating - A rating method that assigns a single rate to all ages and classes of individuals in the group, regardless of risk factors such as age or health.

Copayment - A fixed dollar amount paid per service received or prescription filled.

Coverage Gap - The stage in Medicare prescription drug coverage when you have to pay all of your own drug costs. *Also known as the donut hole.*

Creditable Coverage - An insurance policy that is determined to be as good as or better than Medicare coverage.

Critical Access Hospital - A small facility that provides outpatient services, as well as inpatient services on a limited basis, to people in rural areas.

Crossover Claim Participant - A Medigap company that has claims submitted to them electronically, directly from Medicare. This eliminates the need for the beneficiary to submit claims to a secondary payer.

Deductible - A dollar amount determined by an individual's insurance policy (including Medicare) that must be paid by the insured individual for covered services before Medicare or the insurance policy begins paying.

Demonstration Project – A government-sponsored experimental program offered in limited areas. Participants have same rights and protections with a demonstration project as with any other plan.

Denial of Benefits - Official Medicare decision that services will not be approved for Medicare payment. Another insurer can also deny benefits, often because they are excluded or not deemed medically necessary, according to the insurance company.

DHS (Department of Human Services) - The state agency that houses Seniors and Peoples with Disabilities and other assistance programs.

Diagnostic Tests – Tests ordered by a physician to provide information that assists in making a diagnosis when symptoms are present.

Disenrollment - Cancellation of an individual's enrollment in a health plan. May be limited occur during specific time frames, such as Annual and Open Enrollment Periods.

Donut Hole – See Coverage Gap.

DME (Durable Medical Equipment) - Equipment that is medically necessary and prescribed by a doctor for use in the home, such as oxygen equipment, wheelchairs, and other medically necessary equipment.

DRGs (Diagnosis Related Groups) - Categories of illnesses assigned a dollar amount by HHS to determine the actual payment Medicare will make to a hospital for treatment of a specific illness.

Effective Date – The date on which an insurance policy is in effect and its coverage begins.

EFT (Electronic Funds Transfer) – The transfer of funds from one account to another by computer. *Also known as AFT (Automatic Funds Transfer).*

EGHP (Employer Group Health Plan) - A health insurance or benefit plan that is offered through an employer of 20 or more employees.

Election Period - The period during which an eligible person may join or leave Original Medicare or a Medicare Advantage plan.

Enrollee - A person eligible and receiving benefits from an insurance plan or managed care organization. Also called *member* when referring to Medicare Advantage plans.

EOB (Explanation of Benefits) - A form sent to the patient that explains which claims were paid at what level.

ESRD (End-Stage Renal Disease)- a medical condition in which a person's kidneys no longer function, requiring dialysis or a kidney transplant to maintain life.

Excess Charge - The difference between the Medicare approved amount and cannot exceed 15 percent over the provider's actual charge. *Also known as a limiting charge.*

Extra Help - A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance. *Also known as LIS.*

Fall Open Enrollment Period - Another name for Annual Enrollment Period (November 15 - December 31). *See AEP*

Fee-For-Service - A method of reimbursement that presets the fee that will be paid for the service provided.

Fiscal Intermediary - A company that receives bills for Medicare, evaluates their appropriateness, and issues payment on behalf of Medicare.

Foreign Travel Benefits – Medicare coverage for medically necessary emergency care in a foreign country; covers 80 percent of billed charges not covered by Medicare for Medicare-eligible expenses. Subject to time limits, deductibles, and a lifetime maximum.

Formulary – A list of drugs that a health plan will cover. Formulary drugs usually have lower co-payments than non-formulary drugs. A formulary is also known as a Preferred Drug list.

FPL (Federal Poverty Level) – The income level set by the federal government to determine eligibility for many needs-based programs.

Fraud – Occurs when someone intentionally deceives or misrepresents him or herself in a way that could result in unauthorized payments being made.

Free-Look Period - Specified period of time during which an insurance policy may be examined. If the buyer is not satisfied for any reason, the policy may be returned to the insurance company for a full refund. The free-look period begins on the day the policy is received by the client. For long-term-care policies and Medicare supplement policies, the free look period is 30 days.

Full Dual Eligible – A person who qualifies to receive full Medicare and full Medicaid benefits, including long-term care provided in both institutions and in the community as well as prescription drugs. For this group, Medicaid may also pay Medicare premiums and cost sharing.

Generic Drug – A drug sold or dispensed under a name that is not protected by a trademark.

GEP (General Enrollment Period) – An enrollment period for people who did not sign up for Part A or Part B of Medicare during their Initial Enrollment Period. It lasts from January through March and coverage becomes effective July 1.

Grievance – A wrong considered as grounds for complaint, or something believed to cause distress.

Guaranteed Issue Rights – A consumer’s right to purchase insurance policies during certain periods and under certain circumstances in which insurance companies are required by law to offer them.

Guaranteed Renewable - A policy that cannot be canceled by the insurer for any reason as long as the premium is paid and the policyholder did not give false information to obtain coverage.

Health Insurance - Health insurance is a contract between a policyholder and an insurance company where the company assumes the large financial risk of health care expenses in exchange for the individual paying a small amount, the premium, each month. The company spreads the cost of health care losses over a number of people.

HHC (Home Health Care) – Skilled Nursing care and support services for individuals who do not need institutional care. Such services are provided during intermittent home visits and may include nursing care, physical therapy, speech and hearing therapy, occupational therapy, social services, and some support services.

HHS (US Department of Health and Human Services) - The federal agency that administers the Medicare Program through its divisions, the Social Security Administration and Center for Medicare & Medicaid Services (CMS).

High-Deductible Medigap Policies – A Medicare supplement policy in which the beneficiary is responsible for payment of expenses up to a set amount or deductible; once the deductible is met the policy pays 100 percent of covered out-of-pocket expenses.

HIPPA (Health Insurance Portability and Accountability Act) Privacy Rule - Protects personal medical information from being shared to other individuals or entities without expressed consent.

HMO (Health Maintenance Organization) - A type of Medicare Advantage Plan that is available in some areas of the country. Plans must cover all Medicare Part A and Part B expenses. The beneficiary can only go to the doctors, specialists, or hospitals on the plan's list except in an emergency.

Hospice - A public or private agency that provides support services to the terminally ill and their families.

Hospital - A legally operated institution whose primary purpose is to provide acute medical care and treatment for sick or injured persons. Excludes nursing homes, drug and alcohol rehabilitation facilities.

Hospital Utilization Review Committee - A group of professionals from the hospital staff which approves or disapproves a patient's stay or determines the medical necessity of treatment received there.

IEP (Initial Enrollment Period) - A seven-month period of time that surrounds a Medicare beneficiary's 65th birthday (qualifying month); three months before, the month of, and three months after.

Indemnity - A fixed dollar amount paid to an individual for a covered service without regard to the actual cost.

Inpatient Care - Care given an admitted patient in a hospital, nursing home or other medical or post acute institution.

Inpatient Rehabilitation Facility - A hospital, or part of a hospital, that provides an intensive rehabilitation program to inpatients.

Institutional Care - Care provided in a hospital, skilled or intermediate nursing home or other state facility certified or licensed by the state primarily affording diagnostic, preventative, therapeutic, rehabilitative, maintenance or personal care services.

Insurance - A form of risk management allowing an insured person to pay a calculated premium on a regular basis to an insurance company in return for a dollar benefit or services from the insurance company if certain losses occur.

Insured - Any beneficiary or owner of a contract.

Insurer - Insurance companies, fraternal benefit societies, health care service contractors and health maintenance organizations.

Intermediate Care - Nursing and rehabilitative services provided by skilled health personnel on an occasional basis under orders of a physician.

IRE (Independent Review Entity) - The second level of appeal for Medicare Advantage and Part D appeals.

Issue Age - Policies whose premiums are based on your age when purchased. Premiums will not increase due to an increase in age; however, premiums may increase for other reasons.

Lapse - A situation in which the policy becomes void or forfeited because the premium was not paid by the policyholder when due or during the grace period.

Late Enrollment Penalty - An amount added to your monthly premium for Medicare Part B or Part D if beneficiaries do not join when they are first eligible. The penalty remains in place as long as the beneficiary has Medicare, with a few exceptions.

Length of Coverage - The maximum number of days or number of dollars that will be allowed by a policy for the insured.

Lifetime Reserve Days - The beneficiary is entitled to 60 additional *reserve days* after Medicare provides 90 days of benefits for hospitalization. These days are not renewable.

Limitations - These are exceptions or reductions to the benefits promised in the policy.

Limiting Charge - See Excess Charge.

LIS (Low or Limited Income Subsidy) - The LIS program is operated by the Social Security Administration and provides Extra Help with prescription drug costs for individuals who meet the income and asset requirements. *See Extra Help.*

Lookback - *See Waiting Period.*

LTC (Long Term Care) - A general term that includes a wide range of services that address the health, medical, personal and social needs of people with chronic or prolonged illnesses, disabilities and cognitive disorders (such as Alzheimer's). The delivery of LTC services can

include skilled nursing care in a nursing home, in-home health and personal care, assisted living, adult day care facilities and other options. Medicare does not cover LTC.

MA (Medicare Advantage) - Any health care organization, including health care providers, insurers, health care services contractors, health maintenance organizations or any combination thereof, that provides directly or by contract basic health care services on a prepaid capitated basis to patients enrolled in the plan and the managed health care system. The plan receives a premium from Medicare, plus additional out-of-pocket co-payments, coinsurance or deductibles, and/or monthly premiums from Medicare beneficiaries. *Also known as Managed Care, Part C or Medicare+Choice.*

MAC (Medicare Appeals Council) - The entity that reviews the second level of appeals for Medicare Part A and Part B.

Major Medical - A type of insurance that provides benefits for most types of medical expenses incurred up to a high limit, subject to a deductible. Usually the insurer pays 80 percent and the insured pays 20 percent.

MAPD (Medicare Advantage with Prescription Drug Coverage) - Medicare Advantage plan that includes a Part D plan.

Medicaid - A federal-state partnership designed to ensure that America's aged, sick and impoverished are cared for. This program is a safety net that provides aid in the form of medical services to poor people who fall below the state-established poverty line. There are strict income and asset guidelines used to qualify people for Medicaid. *Also known as Medicare Savings Program, M.A. (Medical Assistance), or Title 19 (XIX).*

Medical Power of Attorney - A legal document that designates an agent, usually a family member, to make medical decisions if the individual is unable to do so for themselves.

Medically Necessary - Services or supplies that are needed for the diagnosis or treatment of a medical condition and that meet accepted standards of medical practice. *Also known as Reasonable and Necessary.*

Medicare - A federal health insurance program that pays health care costs for the elderly, the permanently disabled, and those with end-stage renal disease.

Medicare-Approved Amount - In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It includes what Medicare pays and any deductible, coinsurance, or co-payment that you pay. It may be less than the actual amount a doctor or supplier charges.

Medicare Part A - Provides coverage for hospital care, skilled nursing facility care, home health care services, and hospice services.

Medicare Part B - Optional coverage covers a portion of the costs for doctors' care and an array of outpatient services.

Medicare Part C - *See Medicare Advantage.*

Medicare Part D - Prescription Drug Benefit as authorized by the Medicare Modernization Act of 2003. It is an optional coverage. *Also known as PDP or stand-alone drug coverage.*

Medigap Plans - Private supplemental health insurance plans sold to Medicare beneficiaries that provide coverage for medical expenses not or only partially covered by Medicare. *Also known as a Medicare Supplement Policy.*

MMA (Medicare Modernization Act) - A federal law that was enacted in 2003 that overhauled the Medicare system.

MSA (Medicare Medical Savings Account) - A high-deductible MA plan combined with a savings account. The plan deposits money from Medicare to an account; the beneficiary can use this money to pay for medical expenses until the deductible is met.

MSN (Medicare Summary Notice) - A document provided by the Medicare intermediary or carrier. The notice includes: the amount of Medicare coverage, the portion of the deductible paid or owed by the beneficiary, and the days and/or visits used in a benefit period, with co-insurance amounts.

MSP (Medicare Savings Program) - A Medicaid program that helps beneficiary's pay for Part B and Part D costs. *See QMB, SLMB, and SMF.*

NAIC (National Association of Insurance Commissioners) - The NAIC is based in Kansas City. The insurance commissioner of each state is a member. The association develops model rules and assists states in monitoring insurance companies.

Non-assigned Claim - A claim in which the provider has not agreed to accept the Medicare charge as the total charge. The provider may charge up to a 15 percent excess charge.

Non-Participating Provider - A provider who is not approved as a Medicare participating provider, and who does not accept assignment.

Notice of Initial Determination - The form in which Medicare and Medicare Advantage plans inform beneficiaries about claim denials. Usually starts the appeals process. *Also known as Notice of Non-coverage.*

OEP (Open Enrollment Period) - A period during which plans must accept all eligible applicants as long as the plan has not met its member capacity.

OHMA (Office of Medicare Hearings and Appeals) - The US Department of Health and Human Services where the Administrative Law Judge works.

OHP (Oregon Health Plan) - A public-private partnership to assure access to health care for all Oregonians. Managed by the DHS Office of Medical Assistance Programs.

OM (Original Medicare) - Parts A and B of Medicare coverage.

OMIP (Oregon Medical Insurance Pool) - A state program that provides access to health insurance for high-risk Oregonians who are denied medical insurance for health reasons.

OOP (Out-Of-Pocket) Cost - The patient's share of any medical care costs not covered by insurance, Medicare or Medicaid. These are the deductibles, coinsurance, and co-payments that beneficiaries are required to pay.

OPPS (Outpatient Prospective Payment System) - A system under which Medicare pays a set amount for some covered outpatient services needed to diagnose or treat an illness or injury.

OTC (Over the Counter) - Drugs and medical devices that may be sold without a written health care provider's order.

Outliers - Outliers are unusual cases that involve longer hospital stays or higher treatment costs than other cases having the same DRG. A hospital may qualify for additional reimbursement from Medicare for an outlier case.

Outline of Coverage - With Medigap policies this outline must clearly show the benefits paid by Medicare, the benefits paid by the policy, and all exclusions and limitations at the time of sale.

Out-Of-Pocket Maximum - A limit, in some plans, on out-of-pocket expenses. Beneficiaries whose out-of-pocket expenses exceed the maximum don't have further financial responsibility for covered expenses.

Outpatient Care - Services provided by physicians, clinics, mobile x-ray, or free-standing dialysis unit, including physical therapy, x-ray, and lab tests. The patient does not require admission to the hospital as an inpatient.

PACE (Program of All-Inclusive Care) - A program that combines medical, social, and long-term care services for frail people.

Partial Dual Eligible - People who are not eligible for full Medicaid benefits but may receive assistance with some or all of their Medicare premiums and cost sharing. *See MSP.*

Participating Doctors and Suppliers - A doctor or supplier who agrees to accept assignment on all Medicare claims.

PCP (Primary Care Physician) - The physician who sees a patient regularly for routine and preventative care.

PDP (Prescription Drug Plan) - A Medicare Part D plan that covers only drugs. *Also known as a stand-alone drug plan.*

PFFS (Private Fee-For-Service) - A type of Medicare Advantage Plan in which the beneficiary may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare Program, decides how much it will pay and what the beneficiary will pay for the services they get.

Policy - The agreement, or contract, that describes all of the terms and conditions of an insurance policy.

Portability Coverage - Individual health benefit coverage offered to a person who is leaving employer-provided group health benefit coverage. Portability plans are offered by the employer's health benefit insurer, or by the Oregon Medical Insurance Pool if the employer does not provide portability.

POS (Point of Services) - An option that is available with some HMO plans that allow the beneficiary to use doctors and hospitals outside the plan for an additional cost.

POS (Point of Sale) - A location where the transaction takes place.

PPO (Preferred Provider Organization) - A type of Medicare Advantage Plan in which the beneficiaries pay less if they use doctors, hospitals, and providers that belong to the network. If they use doctors, hospitals, and providers outside of the network there will be an additional cost.

PPS (Prospective Payment System) - Medicare pays for most inpatient hospital care under the PPS. Under PPS, hospitals are paid fixed amounts based on the principal diagnosis for each Medicare hospital stay.

Preauthorization - A practice that insurance plans use in order to require that providers receive authorization for certain services or prescriptions from the plan before a claim will be paid.

Pre-Existing Conditions - A medical condition diagnosed, treated, or needing treatment prior to the purchase of an insurance policy.

Preferred Drug List - *See Formulary.*

Premium - The total of all sums charged, received or deposited as consideration for a contract.

Prescription Drug - A drug that must have a health care provider's written order (prescription) in order to be dispensed.

Preventative (or Preventive) Care - Health care that is intended to keep people from becoming ill; i.e. checkups, mammograms, immunizations, screening tests.

Primary Insurer - When a person has more than one health insurance plan, the primary insurer is the one that covers the initial payments after the deductible, usually paying the largest share. The secondary insurer pays next.

Private Contract - A contract between a Medicare beneficiary and a physician or other practitioner who has *opted out* of Medicare for two years for all covered items and services he or she furnishes to Medicare beneficiaries. The Medicare beneficiary agrees to give up Medicare payment for services furnished by the physician or practitioner and to pay the physician or practitioner without regard to any limits that would otherwise apply to what the physician or practitioner could charge.

Provider - The doctor, hospital, home health agency, hospice, nursing facility, or therapist that delivers health services.

Psychiatric Hospital Care - Medicare Part A can help pay for up to 190 days of care in your lifetime in a participating psychiatric hospital.

QIO (Quality Improvement Organization) - The entity that provides expedited review, pre-admission denials, and pre-authorized service terminations in Skilled Nursing Facilities or Home Health Agencies.

QMB (Qualified Medicare Beneficiaries) - Those who are below designated income levels may have Medicare deductibles, co-insurance, Part B premiums, and Part D Extra Help paid through Medicaid.

Reconsideration - The first level of appeal.

Redetermination - The second level of appeal.

Reimbursement - Repayment, by insurance plan, for services provided to the beneficiary, and for which the insured paid before submitting a claim.

Reinstatement - The process whereby a lapsed policy can be placed back in force within a specified period of time after completing the proper forms and paying back premium. Usually the insured must still be in good health to be reinstated.

Referral - A written order from your primary care doctor for you to see a specialist or get certain medical services. In many HMOs the beneficiary needs to get a referral before they can get medical care from anyone except the PCP. If a referral is not obtained, the claim may not pay for the services.

Reserve Days - Sixty extra days provided by Medicare hospital insurance that can be used in case of a long illness where the stay in the hospital is more than 90 days. Reserve days are not renewable - they can only be used once.

Respite Care - Short-term care given to a sick person in home, nursing home, or hospital, intended to give relief to the principal caretakers.

Rider(s) - Agreements attached to a policy by which the conditions of the policy are expanded, additional coverage added, or a coverage or condition is waived.

Rural Health Clinic - A specially qualified, rural outpatient facility, where there is a shortage of health care service or medical professionals.

Screening Tests - Tests used to try to detect a disease when there is little or no evidence of a suspected disease.

Secondary Insurer - When a person has more than one health insurance plan, the secondary insurer pays after the primary insurer, and supplements the primary coverage.

SEP (Special Enrollment Period) - Opportunity to join or leave a plan outside regular enrollment periods.

Service Area - The specified area that an insurance plan has agreed to cover.

SHIBA (Senior Health Insurance Benefits Assistance) - A program that uses a statewide network of trained volunteers who educate, assist and advocate for Medicare beneficiaries about their rights and options regarding health insurance so they can make informed choices.

SHIP (State Health Insurance Assistance Program) - A nationwide state-based program that offers local one-on-one counseling and assistance to people with Medicare and their families. Through CMS funded grants directed to states, SHIPs provide free counseling and assistance via telephone and face-to-face interactive sessions, public education presentations and programs, and media activities. SHIBA is Oregon's SHIP.

Skilled Care - Acute care for an illness or injury, which requires the training and skills of a licensed professional nurse, is prescribed by a physician, and is medically necessary for the condition or illness of the patient.

Skilled Utilization Review Committee - A group of professionals from a nursing facility's staff that determines if the care received at the facility qualifies for Medicare payment.

SLMB (Specified Low Income Medicaid Beneficiary) - Those who are below designated income levels and have Medicare premiums paid through Medicaid. *See also SMB.*

SNF (Skilled Nursing Facility) - A facility at which medically necessary (prescribed) care is provided by licensed health-care professionals.

SNP (Special Needs Plan) - Private insurance plans that provide Medicare benefits, including drug coverage. People eligible for Medicare and Medicaid, those living in certain LTC facilities and those with severe chronic or disabling conditions may qualify to join.

Specialist - The physician who provides expertise and care in a particular area; i.e. surgeon, oncologist, dermatologist, allergist, etc.

Spend Down - A process of becoming eligible for Medicaid by exhausting the savings and assets of an individual.

SSI (Supplemental Security Income) - Monthly amount paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 or older.

SSA (Social Security Administration) - A government agency responsible for the Social Security system.

SSDI (Social Security Disability Insurance) - Determined by Social Security, a monthly benefit for eligible people who are unable to work for a year or more due to a disability.

Stand-Alone Drug Plan - *See PDP.*

Supplement Insurance - Private health insurance designed to fill some of the gaps in Medicare. *Also known as Medigap.*

Tier - Different levels of co-payment amounts depending on the type of drug. The lowest co-payment is for generics, followed by formulary brands, and a non-formulary co-payment is in the highest tier.

Total Drug Costs - The total amount paid for prescription medicines. It includes what the beneficiary pays and also what the drug plan pays.

TROOP (Total Out-Of-Pocket) Costs - Total amount a beneficiary pays out of pocket in a Part D plan.

TRICARE - A health insurance program offered by the Department of Defense to military personnel.

TTY (Teletypewriter) - A communication device used by people who are deaf, hard-of-hearing, or have severe speech impairment. *Also known as TDD.*

Underwriting - The process by which an insurer determines whether or not, and on what basis, it will accept an application for insurance.

UCR (Usual, Customary, or Reasonable Charges) - The fee charged by the majority of doctors in that specialty for a specific procedure in a given geographical area

Utilization Review - A review of health care services to assure they are appropriate.

Waiting Period - The amount of time that must pass before benefits will be paid or before pre-existing conditions or specific illnesses are covered by a health insurance policy.

Waiver of Liability - A request that Medicare review the denial of services or supplies in cases when the beneficiary was unaware that Medicare would not cover them.

Waiver of Premium Benefit - While policy benefits are being received (while the insured is *in claim*) the policyholder is not required to pay insurance premiums that come due. Not all insurance policies contain this benefit.

Waiting Period - The amount of time that must pass before benefits will be paid or before pre-existing conditions or specific illnesses are covered by a health insurance policy.

Acronym Glossary

AAA	Area Agency on Aging
AARP	American Association of Retired Persons
ABN	Advanced Beneficiary Notice
ABN-G	General Advanced Beneficiary Notice
ADL	Activities of Daily Living
AEP	Annual Enrollment Period
AFS	Adult and Family Services
ALF	Assisted Living Facility
ALJ	Administrative Law Judge
ALS	Amyotrophic Lateral Sclerosis
AOR	Appointment of Representation
ASC	Ambulatory Surgical Center
CCF	Client Contact Form
CCNO	Community Connection of Northeast Oregon
CDC	Centers for Disease Control & Prevention
CIGNA	Connecticut General Life Insurance Company
CHAMPUS	Civilian Health and Medical Program of the Uniform Services
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
COCOA	Central Oregon Council on Aging
CORF	Comprehensive Outpatient Rehabilitation Facility

CPT	Current Procedural Terminology
DAB	Departmental Appeals Board
DAVS	Disability, Aging & Veteran Services
DCBS	Department of Consumer and Business Services
DHS	Department of Human Services
DMAP	DHS Office of Medical Assistance Programs
DMD	Duals with Mental Disabilities
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DMERC	Durable Medical Equipment Regional Carriers
DO	Doctor of Osteopathy
DOJ	Department of Justice
DOS	Date of service
DRG	Diagnosis Related Groups
EGHP	Employer Group Health Plan
EOB	Explanation of Benefits
FEHB	Federal Employees Health Benefits
FHIAP	Family Health Insurance Assistance Program
FI	Fiscal Intermediary
FPL	Federal Poverty Level
GEP	General Enrollment Period
GI	Guaranteed Issue
HAP	Health Assistance Partnership
HHA	Home Health Agency

HHABN	Home Health Advance Beneficiary Notice
HHC	Home Health Care
HHS (DHHS)	US Department of Health and Human Services
HINN	Hospital-Issued Notice of Non-coverage
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
ICD-9	International Classification of Diseases, ninth revision
IEP	Initial Enrollment Period
IP	Inpatient
IRE	Independent Review Entity
IV	Intravenous
LCD	Local Coverage Determination
LIS	Low or Limited Income Subsidy
LPN	Licensed Practical Nurse
LTC	Long-Term Care
MA	Medicare Advantage, Medical Assistant, or Medical Assistance
MAC	Medicare Administrative Contractor or Medicare Appeals Counsel
MAPD	Medicare Advantage with Prescription Drug
MCO	Managed Care Organization
MCOG	Mid-Columbia Council of Governments
MD	Medical Doctor
MIPPA	Medicare Improvements for Patients and Providers Act of 2008

MMA	Medicare Modernization Act of 2003
MMAF	Medicare/Medicaid Assistance Program
MRN	Medicare Redetermination Notice
MSA	Medicare Medical Savings Account
MSN	Medicare Summary Notice
MSP	Medicare as Secondary Payer or Medicare Savings Program
N4A	National Association of Area Agencies on Aging
NAIC	National Association of Insurance Commissioners
NCD	National Coverage Determination
NWSDS	Northwest Senior Disability Services
OBRA	Omnibus Budget Reconciliation Act
OEP	Open Enrollment Period
OHP	Oregon Health Plan
OID	Oregon Insurance Division
OIG	Office of Inspector General
OM	Original Medicare
OMHA	Office of Medicare Hearings and Appeals
OMIP	Oregon Medical Insurance Pool
OP	Outpatient
OPDP	Oregon Prescription Drug Program
OPHP	Office of Private Health Partnerships
OT	Occupational Therapy
OTC	Over the counter
PA	Physicians Assistant

PACE	Program of All-Inclusive Care
PAM	Public and Media form
PCP	Primary Care Physician
PDP	Prescription Drug Plan
PFFS	Private Fee-for-Service plan
PMD	Power mobility devices
POS	Point of Service or Point of Sale
POV	Power operated vehicles
PPO	Preferred Provider Organization
PT	Physical Therapy
QI	Qualified Individual
QIC	Quality Improvement Contractor
QIO	Qualified Improvement Organization
QMB	Qualified Medicare Beneficiary
QMB-DW	Qualified Medicare Beneficiary Disabled and Working Individual
RRB	Railroad Retirement Board
RN	Registered Nurse
RSVP	Retired Senior Volunteer Program
SEP	Special Enrollment Period
SHIBA	Senior Health Insurance Benefits Assistance
SHIP	State Health Insurance Assistance Program
SLMB	Specified Low-Income Medicare Beneficiary
SLMB-B/SMB	Specified Low-Income Medicare Beneficiary - Basic
SMB-F/SMF	Specified Low-Income Medicare Beneficiary - Full

SNF	Skilled Nursing Facility
SNFABN	Skilled Nursing Facility Advance Beneficiary Notice
SPD	Seniors and People with Disabilities
SNP	Special Needs Plan
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
ST	Speech Therapy
TANF	Temporary Assistance to Needy Families
URC	Utilization Review Committee
VA	Veterans Administration