MEDICARE CURRENT BENEFICIARY SURVEY

NATIONAL STUDY - COMMUNITY COMPONENT

STATEMENT TERMS GLOSSARY

Approved amount -- The amount allowed by Medicare for a particular *covered service*, which is often less than the *provider* charges or bills. Medicare calculates approved amounts in a variety of ways; the system for calculations for physician's services is in the process of being revised considerably over the next few years.

Assignment -- "Accepting assignment" means accepting the Medicare approved amount as full payment for a service.

Beneficiary -- In MCBS, someone covered by Medicare.

Benefit period -- A period of time over which medical costs are aggregated to determine whether deductibles have been met. The benefit period for many Medicare services is the calendar year.

Claim -- A bill submitted to Medicare or to another health insurance plan.

Coinsurance -- OR, **copayments.** The *beneficiary's* share of the *approved amount* for medical services, after any *deductibles* have been met. In Medicare Part B, the coinsurance rate is 20 percent. This rate is sometimes referred to as "80-20." In Part A, the coinsurance rate varies by type of service and how much of the service (e.g., how many days in the hospital) is used. "Copayment" is also the term used to refer to the beneficiary's payment amount for a service provided by a managed care or HMO plan.

Covered services -- Medical services for which Medicare will pay all or part of *approved* charges.

Deductible -- The amount of approved medical expense that must be incurred before Medicare begins to pay. There are separate deductibles for Part A and Part B Medicare-covered services and these can change from year to year.

Doc-in-a-box -- This is also a term that may vary across regions. This is a form of walk-in or clinic care, usually found in or near a mall or strip shopping area. It generally provides primary care, including some emergency care, and attracts individuals who do not rely on a single physician or other source of care.

Dread disease plan -- A kind of insurance that covers the cost of medical care only for certain diseases, such as cancer or stroke.

Extra billing -- The amount a provider bills a beneficiary beyond the Medicare approved amount for a service (see **Assignment**).

Extra cash plan -- Also called a "hospital indemnity plan," a kind of insurance that pays a covered person a fixed amount (say, $100) for each day spent in a hospital.

Group coverage -- Health insurance provided through an employer, union, or other group, that offers the same plan to a number of people associated with the group at the same cost per person.

Health insurance plan -- A package of benefits for paying for medical care; the "plan" is defined by what services are covered, the conditions for paying and amounts of payment for covered services, and the cost of premium covered persons must pay. The details of a particular plan are usually described formally in a "policy."

Health Maintenance Organization (HMO) -- There are several names for Health Maintenance Organizations. These include: Coordinated care plans, managed care plans and prepaid plans. In addition, competitive medical plans (CMPs), and Health Care Prepayment Plans (HCPPs) are included as prepaid health care. These names may vary by region of the country, some include a Preferred Provider Organization (PPO).

Long-term Care Facility -- A long term care facility is a facility with 3 or more beds; providing either personal care or continuous supervision of residents; is a place or unit certified as a Skilled Nursing Facility (SNF) by Medicare or Medicaid; or is a place or unit certified as a Nursing Facility (NF) by Medicaid.

Long-term Care Insurance -- A form of private health insurance that covers stays in a nursing home, and may cover other health care such as skilled nursing care received at home.

Medicare payment -- The amount Medicare pays on a claim.

Noncovered services -- Medical services for which Medicare will not pay any amount. Dental care is a noncovered service and most prescribed medicines are not covered by Medicare.

Out-of-pocket expenditures -- Out-of-pocket expenditures are a part of the charge(s) that a beneficiary or his/her family have paid/will pay for medical care. This should not include any amount that the SP expects to receive reimbursement for or any amounts that the beneficiary has already received reimbursements for or money from Medicare or a private health insurance plan.

Part A -- The hospital insurance portion of Medicare that covers inpatient care, some nursing home care, and some home health care.

Part B -- The medical insurance portion of Medicare that covers physician services, diagnostic laboratory tests, some medical equipment and supplies, and so on.

Premium -- The amount the beneficiary (or someone else) pays for Medicare coverage. Most other insurance plans have premiums as well, which may be paid in full or in part by the *main insured person*.

Private health insurance -- Health insurance provided by a commercial insurance company such as Blue Cross/Blue Shield.

Provider -- The person or other entity providing a medical service or equipment, e.g., the doctor, therapist, or hospital.

Public health insurance -- A Federal, state, or local government program that pays for all or part of a person's health care. Medicaid is an example of a public health insurance plan.

Reference Date -- A date "bounding" the time a question covers. For the MCBS, the Reference Date is usually the date of the previous interview.

Reference Periods -- A period of time covered by a question. The MCBS *Current Round Reference Period* is generally from the date of the previous interview up to the date of the current interview. The MCBS *Survey Reference Period* generally includes the period of time from the interview 3 rounds back from the current interview to the date of the current interview (e.g., the Round 10 survey reference period begins on the Round 7 interview date and ends on the Round 10 interview date).

Source of payment -- An inclusive term that includes all parties, including insurance and public plans (Medicare) and private payments (family or self out-of-pocket expenses) that pay for medical care. This term includes all sources of payment regardless of the time frame of the payments (e.g., many Medigap plans do not pay until after Medicare has paid the bill). These private payments can take up to a year to be paid.