How to Be a Resilient Caregiver

Ideas, Information and Resources for Healthy Caregiving

REVISED 2014

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Note: How to Be a Resilient Caregiver is a reference guide, and is intended for use throughout the caregiving experience. Please do not be intimidated by the scope of content provided in the manual. The information is designed to be relevant and applicable to the changing needs of the caregiver and the person receiving care over an extended period of time. Use the Table of Contents as a guide to the information that is pertinent for specific issues and situations.

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Section 8

Medicare, Long-Term Care, Social Security and Veterans

What is Medicare?

Medicare is health insurance for:

- People 65 or older
- People under 65 with certain disabilities
- People of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant)

What are the different parts of Medicare?

Medicare Part A (Hospital Insurance) helps cover:

- Inpatient care in hospitals
- Skilled nursing facility care
- Hospice care
- Home health care

You usually don't pay a monthly premium for Part A coverage if you or your spouse paid Medicare taxes while working. This is sometimes called premium-free Part A. If you aren't eligible for premium-free Part A, you may be able to buy Part A, and pay a premium.

Medicare Part B (Medical Insurance) helps cover:

- Services from doctors and other health care providers
- Outpatient care
- Home health care
- Durable medical equipment
- Some preventive services

Most people pay the standard monthly Part B premium.

Note: You may want to get coverage that fills gaps in Original Medicare coverage. You can choose to buy a Medicare Supplement Insurance (Medigap) policy from a private company.

Medicare Part C (Medicare Advantage):

- Run by Medicare-approved private insurance companies
- Includes all benefits and services covered under Part A and Part B
- Usually includes Medicare prescription drug coverage (Part D) as part of the plan
- Usually includes extra benefits and services, in some cases for an extra cost

Medicare Part D (Medicare prescription drug coverage):

- Run by Medicare-approved private insurance companies
- Helps cover the cost of prescription drugs
- May help lower your prescription drug costs and help protect against higher costs in the future

Note: If you have limited income and resources, you may qualify for help to pay for some health care and prescription drug costs. For more information, contact your State Medical Assistance (Medicaid) office, visit socialsecurity.gov, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. If you have questions about Medicare, visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Contact Pima Council on Aging for a no-cost health insurance benefits counseling service for Medicare beneficiaries, caregivers and their families in Pima County that provides easy-to-understand information about Medicare coverage and financial assistance programs. Medicare counselors are trained in Medicare eligibility, benefits and options, health insurance counseling and related insurance products. The program is not connected to any insurance company so you can be sure you are getting accurate and objective information to help you make decisions about Medicare coverage. Call the Medicare line at (520) 546-2011 or email ship@pcoa.org.

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Frequently Used Medicare Acronyms

ABN - Beneficiary Notice - a written notice given to a Medicare beneficiary by a physician, provider or supplier before an item or service is rendered, when the item or service is expected to be denied by Medicare.

AEP - Annual Enrollment Period - the time frame when Medicare beneficiaries can change their health care coverage. The AEP is from October 15th through December 7th each year.

AHCCCS - Arizona Health Care Cost Containment System - Arizona's Medicaid Agency that offers health care programs to serve Arizona residents who meet income and other requirements.

CMS - Centers for Medicare and Medicaid Services - the federal agency that oversees the Medicare and Medicaid programs.

DME - Durable Medicare Equipment - reusable medical equipment such as walkers, wheelchairs and hospital beds. Coverage is provided by Part B, when medically necessary.

HMO - Health Maintenance Organization - a type of Medicare Advantage Plan that usually requires the use of network providers.

IEP - Initial Enrollment Period - the 7-month period when people can apply for Medicare…includes 3 months before age 65, month of 65th birthday and 3 months after 65th birthday. If a person has Medicare due to disability, the same time frame applies, beginning with 3 months before their Medicare begins.

LIS - Low Income Subsidy - extra help with prescription drug costs, for people with limited income and resources.

MA-PDP - Medicare Advantage Prescription Drug Plan - a Medicare Advantage Plan (like a HMO or PPO) that includes prescription drug coverage.

MSN - Medicare Summary Notice - an explanation of benefits provided by Medicare, after a claim has been processed.

MSP - Medicare Savings Programs - programs that help low-income individuals with Medicare costs (premiums, co-pays and medications). The 3 programs are QMB, SLMB and QI.

PFFS - Private Fee-For-Service - a type of Medicare Advantage Plan that allows a person to see any provider that agrees to treat them and accept the plan's payment. Some areas require the use of network providers.

PPO - Preferred Provider Organization - a type of Medicare Advantage Plan that has a provider network. This type of plan allows you to use out of network providers, but at higher out of pocket costs.

QI - Qualified Individual - an AHCCCS program that pays the Medicare Part B premium and lowers Part D costs for those with low incomes.

QIO - Quality Improvement Organization - an organization that is made up primarily of medical professionals to oversee the quality of care for Medicare beneficiaries. Arizona's QIO is Health Services Advisory Group (HSAG).

QMB - Qualified Medicare Beneficiary - an AHCCCS program that pays the Part B premium, deductibles and coinsurance, and lowers Part D copays for low-income Medicare beneficiaries.

SEP - Special Enrollment Period - time frames that are outside the initial enrollment periods, when people are allowed enroll in certain coverages.

SLMB - Specified Low Income Medicare Beneficiary - an AHCCCS program that pays the Part B premium and lowers Part D costs for low income individuals.

SMP - Senior Medicare Patrol - a federal program that educates seniors as to how to identify and report Medicare fraud, errors and abuse.

SNF - Skilled Nursing Facility - a facility that provides skilled nursing care and rehab services to Medicare beneficiaries after a qualifying hospital stay.

SSA - Social Security Administration - the federal agency that processes applications for Social Security, SSI and Medicare.

SSDI - Social Security Disability Insurance - a federal insurance program managed by the Social Security Administration. It is designed to provide income supplements to people who are unable to work due to disability.

SSI - Supplemental Security Income - a federal income supplement funded by general tax revenues (not Social Security taxes).

State Health Insurance Program

The Arizona State Health Insurance Assistance Program (SHIP) is a no-cost one-on-one personal health benefits counseling program for Medicare beneficiaries and their families or caregivers. Medicare counselors can explain your options, assist you in comparing plans and help you understand how Medicare works with other insurance plans. Trained staff and volunteers provide unbiased information and can help with:

- Medicare eligibility and benefits
- Original Medicare
- Medigap insurance
- Medicare Advantage Plans
- Understanding and enrolling in Medicare Part D
- Long Term Care Insurance
- Medicare and AHCCCS

Welcome to Medicare workshops are offered once a month.

The **SHIP** is an independent program funded by the Administration for Community Living and the Centers for Medicare and Medicaid Services and is not affiliated with the insurance industry.

The **Senior Medicare Patrol (SMP)** is a **SHIP** program that empowers seniors to prevent healthcare fraud. Healthcare fraud, waste, and abuse cost American taxpayers nearly $60 billion each year. This program recruits and trains retired professionals and other older adults who provide presentations about how to:

- Identify potential scams and other fraudulent activity
- Protect personal information including Medicare and Social Security numbers
- Detect errors on Medicare Summary Notices (MSN's) or Explanations of Benefits (EOB's)
- Report suspected fraud or abuse to the proper authorities

For assistance with Medicare, to attend a workshop, to request a presentation, or to learn more about SMP, call the Medicare Line at Pima Council on Aging at **(520) 546-2011.**

Long-Term Care Insurance: What You Should Know

What is Long-term Care?
Long-term care refers to a wide range of medical, personal and social services. You may need this type of care if you have a prolonged illness or disability. This care may include help with daily activities, as well as home health care, adult daycare, nursing home care or care in a group living facility. Long-term care insurance is one way to pay for long-term care. It is designed to cover all or some of the services provided by long-term care.

When will benefits be available?
Long-term care policies have an elimination period, which is the number of days you must need nursing home care or home health care before your policy pays benefits. A shorter elimination period will mean you pay a higher premium. Elimination periods may range from 0 to 180 days. In addition, a long-term care policy does not guarantee coverage unless you satisfy certain requirements. For example, most policies require that you be unable to perform a given number of daily living activities, such as dressing, bathing and eating without assistance. Also, most policies have a benefit trigger for cognitive impairment. For example: as a policyholder you can only qualify for these benefits if you are unable to pass a test assessing your mental functioning.

How much in benefits will the policy pay?
The benefit amount usually is a daily benefit ranging from $50 to $250 per day. You may choose a benefit period that is a specific number of days, months or years. A maximum benefit period may range from one year to the remainder of your lifetime. It is important to ask the person selling the policy if the benefit amounts will increase with inflation and if that coverage increases your premium.

Are there exclusions?
Every policy has an exclusion section. Some states do not allow certain exclusions. Many long-term care policies exclude coverage for the following:

- Mental and nervous disorders or diseases (except organic brain disorders)
- Alcoholism and drug addiction
- Illnesses caused by an act of war
- Treatment already paid for by the government
- Attempted suicide or self-inflicted injury

Considerations before buying long-term care insurance
Whether you should buy long-term care insurance depends on your age and life expectancy, gender, family situation, health status, income and assets.

- Age and Life Expectancy: The longer you live, the more likely it is that you will need long-term care. The younger you are when you buy the insurance, the lower your premiums will be.
- Gender: Women are more likely to need long-term care because they have longer life expectancies and often outlive their husbands.

- Family Situation: If you have a spouse or adult children, you may be more likely to receive care at home from family members. If family care is not available and you cannot care for yourself, paid care outside the home may be the only alternative. Different policies may cover different types of long-term care. It is important to buy a policy that will cover the type of care you expect to need and will be available in your area.
- Health Status: If chronic or debilitating health conditions run in your family, you could be at greater risk than another person of the same age and gender.
- Income and Assets: You may choose to buy a long-term care policy to protect assets you have accumulated. On the other hand, a long-term care policy is not a good choice if you have few assets or a limited income. Some experts recommend you spend no more than five percent of your income on a long-term care policy.

Do you qualify for Medicaid?

As an older adult, you may qualify for Medicaid, which pays almost half of the nation's long–term care bills. To qualify for Medicaid, your monthly income must be less than the federal poverty level, and your assets cannot exceed certain limits. Medicaid will cover you only in Medicaid-approved nursing homes that offer the level of care you need. Under certain circumstances, Medicaid will pay for home health care.

Some states have long-term care insurance programs designed to help people with the financial impact of spending down to meet Medicaid eligibility standards. Under these "partnership" programs, when you buy a federally qualified partnership policy, you will receive partial protection against the normal Medicaid requirement to spend down your assets to become eligible. Check with your state insurance department or a counseling program to see if these policies are available in your state.

Key points to remember

- Long-term care insurance policies cover a wide range of medical, personal and social services.
- Understand what must happen for a policy to begin paying benefits.
- Understand the elimination period.
- Understand the daily benefits provided.
- Understand your coverage and exclusions.
- Match your need for long-term care with your need to protect assets and your ability to pay premiums.
- Understand how much your premium will be and how often it must be paid.
- Your premium may increase after your purchase.

The website for the National Clearinghouse for Long-Term Care Information features a number of resources to help individuals start the planning process, including interactive tools such as a savings calculator, contact information for a range of programs and services, and real-life examples of how individuals have planned successfully for long-term care.

The Clearinghouse was authorized by the Deficit Reduction Act of 2005, which mandates that they provide the following: objective information to help consumers decide whether to purchase long-term care insurance or to pursue other private market alternatives that pay for long-term care; information about states with long-term care insurance partnerships under the Medicaid program; and information about the availability and limitations of coverage for long–term care under the Medicaid program. For more information, contact the Centers for Medicare and Medicaid Services: www.cms.gov

Source: National Association of Insurance Commissioners: www.naic.org

Arizona Health Care Cost Containment System (AHCCCS)

The Arizona Health Care Cost Containment System (AHCCCS) is Arizona's version of Medicaid. AHCCCS provides health insurance to low income Arizonans through a health plan. Doctors, hospitals, pharmacies, etc. are included in the health plan to provide all AHCCCS covered services.

In addition to health plans, AHCCCS has several programs for seniors including:

- Medicare Cost Sharing: provides help with Medicare expenses
- SSI Cash/Medical Assistance Only: provides medical coverage for seniors who do not receive monthly cash benefits under the Supplemental Security Income Program (SSI)
- Arizona Long Term Care System (ALTCS) which provides ongoing services at nursing facility level of care either at an individual's home, assisted living facility or in a nursing home.

Medical services

AHCCCS contracts with several health plans to provide covered services. An AHCCCS health plan works like a Health Maintenance Organization (HMO). The health plan works with doctors, hospitals, pharmacies, specialists, etc. to provide care. You will choose a health plan that covers your zip code area. If you are approved, you will choose a primary care doctor that works with that health plan. Your primary doctor will:

- Be the first person you go to for care
- Authorize your non-emergency medical services
- Send you to a specialist when needed

AHCCCS health plans provide the following medical services:

- Doctor's Visits
- Immunizations (shots)
- Prescriptions (Not covered if you have Medicare)
- Lab and X-rays
- Early and Periodic Screening Diagnosis and Treatment (EPSDT) Services for Medicaid eligible children under age 21
- Specialist Care
- Hospital Services
- Transportation to doctor
- Emergency Care
- Pregnancy Care
- Surgery Services
- Physical Exams
- Behavioral Health

- Family Planning Services
- Dialysis
- Glasses (for children under age 21)
- Vision Exams (for children under age 21)
- Dental Screening (for children under age 21)
- Dental Treatment (for children under age 21)
- Hearing Exams (for children under age 21)
- Hearing Aids (for children under age 21)

Coverage for individuals eligible for Arizona Long Term Care (ALTCS)

AHCCCS contracts with several program contractors to provide long term care services. An ALTCS program contractor works like a Health Maintenance Organization (HMO). In addition to the services listed above, people who qualify for long term care can receive services such as:

- Case Management
- Nursing Home Care
- Hospice
- Attendant Care
- Assisted Living Facility
- Adult Day Care Health Services
- Home Health Services, such as nursing services, home health aide, and therapy
- Home Delivered Meals

Source: Compiled from information on the AHCCCS website www.azahcccs.gov

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Simplified Guide to ALTCS

Arizona Long Term Care System

All information is as of January 2014 and SUBJECT TO CHANGE

ALTCS is a part of AHCCCS—Arizona's version of Medicaid

ALTCS provides funding for:

- Care in a person's home
- Care in **contracted** nursing homes
- Care in **contracted** assisted living centers, assisted living homes, and adult foster care homes

General Eligibility Requirements

- Must be U.S. Citizen or have Legal Resident Status for a required period
- Must have a valid Social Security Number
- Must reside in Arizona

Medical Eligibility

Each applicant is assessed for medical eligibility using a tool called the Pre-Admission Screening (PAS). To be eligible, the individual must need a level of care equal to what is provided at an intermediate level nursing facility.

This usually includes a need for assistance with bathing, toileting, and dressing. Applicants are assessed by social workers or nurses who review medical records, conduct face to face interviews, and assess the applicant's ability to perform activities of daily living.

Generally, a family member or responsible party should be present at the interview to provide input. Applicants often try to show the assessor how well they are doing, while what is needed for eligibility is to show how incapacitated they really are. Applicants may not tell a stranger they are incontinent of bowel or bladder even if they are, and incontinence scores high on the PAS. Also, a diagnosis of Alzheimer's or other forms of dementia gives extra consideration for eligibility.

Income Eligibility

Individuals: Gross Income may not exceed **$2,163/month.**

Married Couples: If the income in the applicant's own name is less than $2,163, he or she will be income eligible. Otherwise, the couple's joint income may not exceed **$4,326/month.**

Note: If income is greater than the limits above but less than the "Average Cost of Care" ($6,648.77/month) the applicant may be able to set up a special **"Income Limiting Trust"** and be eligible. The trust must make the State of Arizona the beneficiary upon death and meet specific guidelines. (We recommend you consult with an Elder Law Attorney for this trust.)

The spouse remaining in the community may keep all income in his or her name. If the community spouse's income is less than $1,938.75/month, then he or she may be able to keep a portion of the institutional spouse's income for a total monthly income of $1,938.75.

Share of Cost

If the member is living in a facility, he or she is expected to pay a share of the cost to the facility.

For an individual the share of cost is equal to their income, less $108.15 they can keep as a "Personal Needs Allowance."

For a couple it is the individual's income less the $108.15 less the amount the community spouse is allowed by ALTCS regulation.

To Apply: Call ALTCS at (520) 205-8600

Social Security and Supplemental Security (SSI) Income Overview

To be eligible for Social Security benefits as a worker you must be:

- Age 62 or older, or disabled or blind
- "Insured" by having enough work credits

For applications filed December 1, 1996, or later, you must either be a U.S. citizen or lawfully present alien in order to receive monthly Social Security benefits.

How much work do you need to be "insured"?
We measure work in "work credits." You can earn up to four work credits per year based on your annual earnings. The amount of earnings required for a work credit increases each year as general wage levels rise.

To be eligible for most types of benefits (such as benefits based on blindness or retirement), you must have earned an average of one work credit for each calendar year between age 21 and the year in which you reach age 62 or become disabled or blind, up to a maximum of 40 credits. A minimum of six work credits is required, regardless of age.

To qualify for Social Security benefits based on a disability other than blindness, the number of work credits you need for disability benefits depends on your age when you became disabled. You generally need 20 work credits earned in the last 10 years ending with the year you become disabled. However, younger workers may qualify with fewer credits.

The rules are as follows:
Before age 24 - You may qualify if you have six work credits earned in the three-year period ending when your disability starts.
Age 24 to 31 - You may qualify if you have credit for having worked half the time between age 21 and the time you become disabled. Example: If at age 27 you become disabled, you would need 12 work credits in the past six years (between age 21 and age 27).
Age 31 and older - You must have earned at least 20 of the credits in the 10 years immediately before you become disabled.

Who can receive benefits on your earnings?
You can receive Social Security benefits based on your earnings record if you are age 62 or older, or disabled or blind and have enough work credits.

Family members who qualify for benefits on your work record do not need work credits. However, if they file an application December 1, 1996 or later, they must be a U.S. citizen or lawfully present alien. The following information describes family members who may qualify for benefits on your work record.

If you are receiving retirement or disability benefits, your spouse may qualify if he or she is:

- Age 62 and over; or
- Divorced from you, age 62 or older, and was married to you for at least 10 years prior to your divorce; or
- Under age 62 and caring for a child (under age 16 or disabled prior to age 22) who is entitled to benefits on your work record.
- If you are age 62 or over and have enough work credits to receive Social Security benefits, but have not filed a claim, your divorced spouse may qualify for benefits, if he or she was married to you for at least 10 years prior to the divorce, and has been finally divorced from you for at least two years.

Your surviving spouse (widow or widower) may qualify if he or she is:

- Age 60 or older; or
- Age 50 or older and disabled; or
- Divorced from you, age 60 or older (age 50 if disabled) and
- Was married to you for at least 10 years prior to your divorce;
- Under age 60 and caring for your child (under age16 or disabled prior to age 22) and who is entitled to child's benefits;
- Divorced from you, under age 60 and caring for his or her child (under age 16 or disabled prior to age 22) who is entitled to benefits on your record.
- A dependent parent(s), age 62 or older, of a deceased worker may qualify for benefits based on the worker's record.
- Unmarried children (including stepchildren, adopted children and, in some cases, grandchildren and children born out of wedlock) of disabled, retired, or deceased workers may qualify if they are:
- Under age 18 (or between ages 18 and 19 if a full time high school student); or
- Age18 or older and disabled before age 22.

What is SSI?

SSI stands for Supplemental Security Income. Social Security administers this program. We pay monthly benefits to people with limited income and resources who are disabled, blind, or age 65 or older. Blind or disabled children may also get SSI.

How is SSI different from Social Security benefits?

Many people who are eligible for SSI may also be eligible for Social Security benefits. In fact, the application for SSI is also an application for Social Security benefits. However, SSI and Social Security are different in many ways.

- Social Security benefits may be paid to you and certain members of your family if you are "insured," meaning that you worked long enough and paid Social Security taxes.
- Unlike Social Security benefits, SSI benefits are not based on your prior work or a family member's prior work. SSI is financed by general funds of the U.S. Treasury--personal income taxes, corporate and other taxes.

- Social Security taxes withheld under the Federal Insurance Contributions Act (FICA) or the Self Employment Contributions Act (SECA) do not fund the SSI program.
- In most states, SSI beneficiaries also can get medical assistance (Medicaid) to pay for hospital stays, doctor bills, prescription drugs, and other health costs.
- In most states, SSI beneficiaries also can get medical assistance (Medicaid) to pay for hospital stays, doctor bills, prescription drugs, and other health costs. Most states also provide a supplemental payment to certain SSI beneficiaries.
- SSI beneficiaries may also be eligible for food assistance in every state except California. In some states, an application for SSI benefits also serves as an application for food assistance.
- SSI benefits are paid on the first of the month.
- To get SSI, you must be disabled, blind, or at least 65 years old and have "limited" income and resources.
- In addition, to get SSI, you must:
    - be a resident of the United States, and
    - not be absent from the country for a full calendar month or more or for 30 consecutive days or more; and
    - be either a U.S. citizen or national, or in one of certain categories of qualified non–citizens.

How is SSI like Social Security benefits?

- Both programs pay monthly benefits.
- The medical standards for disability are the same in both programs for individuals age 18 or older. For children from birth to age 18 there is a separate definition of disability under SSI.
- SSA administers both programs.

Source: Social Security Administration. See www.ssa.gov for more information

VA Non-Service Connected Pension with Aid & Attendance (Improved Pension)

This is a benefit for Veterans or Surviving Spouses who meet eligibility requirements regarding (1) military service, (2) net worth limitations and (3) disabilities and level of care. The final eligibility consideration is (4) income. The purpose of this benefit is to provide some financial assistance when a veteran's (or surviving spouse's) health declines and their medical expenses increase. When a person qualifies for this benefit, the VA considers all sources of income and deducts eligible medical expenses to calculate countable income. The VA then supplements income to bring it back up to income levels as set by Congress.

(1) Military Service Requirements:

Veteran with 90 days active duty*, one day beginning or ending during a period of war. A surviving spouse of a War Veteran must have been married to the veteran at the time of veteran's death. Cannot have a dishonorable discharge.

War Time Service:

WWII	12/07/1941 through 12/31/1946
Korean War	06/27/1950 through 01/31/1955
Vietnam War	08/05/1964 through 05/07/1975 **
Gulf War	08/02/1990 through (yet to be determined) *

(2) Household Net Worth/Asset Limitations:

Based on Household Net Worth/Asset Limitations: See Life Expectancy Chart Versus Rate of Spending Down Net Worth/Assets. This benefit is not intended to preserve an inheritance for heirs. **(The primary residence is excluded as well as primary vehicle)**

(3) Disabilities/Level of Care:

Require regular attendance of another person to assist in eating, bathing, dressing/undressing or taking care of the needs of nature. It also includes individuals who are blind or patients in a nursing home because of mental or physical incapacity. Assisted care in an assisted living facility may also qualify.

Example:

Total monthly income:		$2,700.00	
Total out- of -pocket medical expenses	-	$2,400.00	
Net income (income – medical expenses)		$300.00	***
Maximum pension benefit with aid and attendance		$1,758.91	****
Less total net income	-	$300	***
Total VA benefit per month		$1,458.91	

(4) Household Income Limitations:

Single Veteran	$1,758.91
Surviving Spouse	$1,130.25
Married Veteran	$2,085.16

How long is the application process?

To actually begin receiving payment from the VA takes an average of 6 to 8 months. However, the VA does pay retroactively to the date they receive the application.

How do I apply?

In order for the VA to determine eligibility you must submit the appropriate VA application for pension with the following documents: DD-214 or separation papers, medical evaluation from physician showing current medical issues, net worth and net income along with out of pocket medical expenses (to include expense for assisted living or nursing home care). Surviving spouse must provide death certificate of veteran and proof of marriage.

Free Application Assistance

The Arizona Department of Veteran Services (ADVS) has service officers available to answer questions, complete applications and provide assistance throughout the claims process. For information please call the Tucson ADVS office at (520) 207-4960.

VA Pension website: http://www.vba.va.gov/bln/21/pension/vetpen.htm

NOTES:
*Veterans of Gulf War must serve minimum of 24 months
** Veterans who served in Vietnam as early as 02/2/1961 are also war time veterans.
*** The VA may allow for medical expenses to be deducted from income reducing income to as low as $0.
****Total income minus medical expenses must be less than the maximum award.

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Glossary of Health Insurance Terms

Accountable Care Organizations - An Accountable Care Organization is a network of doctors, hospitals, and other providers that shares responsibility for providing care to patients. In the Affordable Care Act, an Accountable Care Organization would agree to manage all of the health care needs of a minimum of 5,000 Medicare fee-for-service beneficiaries for at least three years.

Advance Coverage Decision - A decision that your Medicare Private Fee-for-Service Plan makes on whether it will pay for a certain service.

Affordable Care Act - *Patient Protection and Affordable Care Act of 2010* signed into law March 23, 2010 and *The Health Care and Education Reconciliation Act of 2010* signed into law March 30, 2010 together form the Affordable Care Act which addresses health care reform.

Appeals Process - The process used if a beneficiary disagrees with any decision about his or her health care services. If Medicare or a Medicare health plan does not pay for an item or service received or if a service was not provided, the initial Medicare decision can be reviewed.

Assignment - An agreement between a person with Original Medicare, a doctor or supplier, and Medicare. The person with Medicare agrees to let the doctor or supplier request direct payment from Medicare for covered Part B services, equipment, and supplies. Doctors or suppliers who agree to (or must by law) accept assignment from Medicare can't try to collect more than the Medicare deductible and coinsurance amounts from the person with Medicare, the person's other insurance (if any), or from anyone else. If you are in the Original Medicare Plan, it can save you money if your doctor, provider, and supplier accept assignment.

Balance Billing - A situation in which Medicare Private Fee-for-Service Plan providers (doctors or hospitals) can charge and bill up to 15% more than the plan's payment amount for services.

Benefit Period - The way Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you haven't received any hospital (or skilled care in a SNF) for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

Beneficiary - The name for a person who has health insurance through the Medicare or Medicaid (AHCCCS) program.

CMS - Centers for Medicare and Medicaid Services (formerly HCFA-Health Care Financing Administration).

Coinsurance - Sometimes called a "copayment," it is the percentage of your covered medical bills that you pay after your annual deductible has been met, and your insurance plan has paid its portion of the bills. For example, on a standard 80/20 coinsurance plan, the insurance company will pay 80 percent of the covered expenses and you, the insured, will pay 20 percent.

Coordination of Benefits - Insurance company's method of coordinating your payment when you have similar coverage with more than one insurance company. This happens when you have two major medical plans (e.g., Medicare and an employer major medical). Only one plan will pay 80% of the charges. You will not receive duplicate coverage for the same services. Unlike a supplemental insurance, your second major medical may not pay the remaining balance after your first major medical insurance has paid.

Creditable Prescription Drug Coverage - Prescription drug coverage (like from an employer or union), that pays out, on average, as much as or more than Medicare's standard prescription drug coverage.

Custodial Care - Care is considered custodial when it is primarily for the purpose of helping you with daily living or meeting personal needs and could be provided safely and reasonably by people without professional skills or training. Much of the care provided in nursing homes to people with chronic, long-term illnesses or disabilities is considered custodial care. For example, custodial care includes help in walking, bathing, eating, and taking medicine. Even if you are in a hospital or skilled nursing facility, insurance usually does not provide coverage for custodial care.

Copayment - A predetermined fee that you pay directly to the doctor or other healthcare provider when you receive services.

Deductible - The amount of covered expenses that the insured must pay in each benefit period before the insurer pays for allowable claims. A higher deductible will usually result in a lower premium.

Deemed - Providers are "deemed" when they know, before providing a service, that you are in a Medicare Private Fee-for-Service Plan; they have reasonable access to the plan's terms and conditions of payment; and the service is covered by the plan. Providers that are "deemed" agree to follow your plan's terms and conditions of payment for the services you get.

Diagnosis Related Groups (DRG) - Illness/inpatient admission categories established by Medicare and used by hospitals to determine payment under the Prospective Payment System.

End-Stage-Renal Disease (ESRD) - Permanent kidney failure requiring dialysis or a kidney transplant.

Fee-For-Service - You (or your insurance) are charged for each visit or service provided by a physician or other healthcare professional.

Formulary - A list of certain kinds of prescription drugs that a Medicare drug plan will cover subject to limits and conditions and which will be dispensed through participating pharmacies to covered enrollees.

Grievance - Complaints about the way a Medicare health plan provides care (other than complaints about providing a service or payment for a service), such as cleanliness of the health care facility, problems calling the plan by phone, staff behavior, or operating hours.

Health Care and Education Reconciliation Act of 2010 - Legislation signed into law March 30, 2010 which addresses health care reform along with the *Patient Protection and Affordable Care Act of 2010* signed into law March 23, 2010 - together referred to as the *Affordable Care Act*.

Health Maintenance Organization Plan (HMO) - A type of Medicare Advantage Plan that must cover all Medicare Part A and Part B health care. Some HMO's cover extra benefits, like extra days in the hospital. In most HMO's, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. Your costs *may* be lower than in the Original Medicare Plan.

Home Health Care - Home healthcare services are given at home to aged, disabled, sick or convalescent individuals who do not need institutional care. The most common types of home care are visiting nurse services (e.g. IV therapy, wound care, medication administration), and speech, physical, occupational, and rehabilitation therapy. Home health agencies, hospitals or other community organizations provide these services.

Hospice Care - Hospice care for the terminally ill (e.g. end stage cancer, emphysema, heart disease, or renal disease) and their families, in the home or a non-hospital setting, emphasizing alleviating pain rather than medical cure.

Hospitalist - A doctor who specializes in the care of patients who are in the hospital. A hospitalist might be an internal medicine doctor or a specialist. The best example of a doctor who has a role like a hospitalist is the emergency room (ER) doctor.

Indemnity - An indemnity is a benefit paid by an insurance policy for a specific illness, injury or hospitalization. Often it is used to refer to benefits paid directly to the insured. An example would be a policy that pays you $75 for every day you are confined to a hospital. Accident policies, income policies, and cancer policies are types of indemnity plans. Major medical is another type of indemnity policy.

Insurance Department - Each state has an insurance department that is responsible for implementing state insurance laws and regulations. The Arizona Department of Insurance can be reached at (602) 364-2499 or (800) 325-2548. They also handle complaints about insurance companies.

Limitations - Limitations describe conditions or circumstances under which the insurer will not pay or will limit payments. Detailed information about limitations and exclusions are found in your insurance policy. For example, if you have a pre-existing condition for which you have been diagnosed, received treatment, or incurred expenses for prior to your insurance coverage eligibility, you may not be covered by your insurance for a specific amount of time.

MA-PDP's - Medicare Advantage-Prescription Drug Plans sold in conjunction with the medical health plans under Medicare Advantage. The coverage can be through an HMO (Health Maintenance Organization), PPO (Preferred Provider Organization), or a PFFS (Private Fee-for-Service Plan).

Major Medical - Major medical insurance plans provide broad coverage and substantial protection from large, unpredictable medical care expenses. Members are usually responsible for deductible and coinsurance amounts.

Maximum Out-of-Pocket Liability - The maximum amount of money an insured will pay in a benefit period, in addition to regular premium payments is called the maximum out-of-pocket. It is usually the sum of deductibles and coinsurance payments that the policyholder must pay before the insurance company pays 100% of the covered expenses. Non-covered expenses are the policyholder's responsibility in addition to out-of-pocket amounts.

Medical Underwriting - The process that an insurance company uses to decide whether or not to take your application for insurance, whether or not to add a waiting period for pre-existing conditions, and how much to charge you for that insurance.

Medically Necessary - Services or supplies that meet all of the following:

- Are proper and needed for the diagnosis or treatment of your medical condition.
- Are provided for the diagnosis, direct care, and treatment of your medical condition.
- Meet the standards of good medical practice in the local area.
- Are not mainly for the convenience of you or your doctor.

Medicare Advantage Plan - A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. In most cases, Medicare Advantage Plans also offer Medicare prescription drug coverage. Medicare Advantage (formerly Medicare + Choice or Part C) Plans include:

- Medicare Managed Care Plans (HMO)
- Medicare Managed Care Plans w/POS (Point of Service)
- Medicare Preferred Provider Organization Plans (PPO)
- Medicare Private Fee-for-Service Plans (PFFS)
- Medicare Specialty Plans (Special Needs)
- If you have one of these plans, you don't need a Medigap policy.

Medicare Administrative Contractors (MAC's) - A single point of contact. The MAC's process both Part A and Part B claims which reduces duplication of activities.

Medicare Approved Cost (MAC) - A doctor and supplier fee schedule that lists payments for each Part B service. The fee schedule takes into account geographic variation for practice costs. The MAC is the lower of either the Medicare fee schedule amount, or the doctor's/suppliers actual charge.

Medicare SELECT - A type of Medigap policy that may require you to use hospitals and, in some cases, doctors within its network to be eligible for full benefits.

Medicare Summary Notice (MSN) - After Medicare pays a claim, Medicare sends the patient a MSN notice. This notice is not a bill. It provides information for patient records on the services they received.

Medigap - A Medicare supplemental health insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Minnesota, Massachusetts, and Wisconsin, there are 10 standardized policies labeled Plan A, B, C, D, F, G, K. L, M, and N. Medigap policies only work with the Original Medicare Plan. Plans E, H, I, and J were no longer sold after June 1, 2010—existing policies were grandfathered.)

Medigap High-Deductible Option Plan - Insurance companies may offer a "high deductible option" on Medigap Plans F and J. If you choose this option, you must pay a $2,070 deductible for the year 2012 before the policy pays anything. This amount can go up each year. In addition to the $2,070 deductible (in 2012) that you must pay for the high-deductible option for Plans F and J, you must also pay separate deductibles for

- Foreign travel emergency ($250 per year for Medigap Plans F and J), and
- Prescription drugs ($250 per year for Medigap Plan J only, because Medigap Plan F doesn't cover prescription drugs). This only applies to Medigap policies bought before January 1, 2006. Medigap policies sold after this date can't include prescription drug coverage.

Original Medicare Plan - A fee-for-service health plan that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay any applicable deductible. Medicare then pays its share of the Medicare-approved amount, and you pay your share (coinsurance). The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Outpatient Services - A service you get in one day (24 hours) at a hospital or community health center.

PDP's - Medicare Prescription Drug Plans - A stand-alone drug plan, offered by insurance and other private companies to add prescription drug coverage to the Original Medicare Plan, and Medicare Private Fee-for-Service Plans that don't have prescription drug coverage.

Patient Protection and Affordable Care Act of 2010 - Legislation signed into law March 23, 2010 which addresses health care reform along with *The Health Care and Education Reconciliation Act of 2010* signed into law March 30, 2010 - together referred to as the *Affordable Care Act*.

Point of Service - A POS Plan consists of several different options of insurance coverage that the participant can choose from at the time healthcare services are sought - going out of network for some services (higher costs will apply). The plan provides financial incentives for using network providers.

Preferred Provider Organization Plan (PPO) - A type of Medicare Advantage Plan in which you pay less if you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Private Fee-for-Service Plan (PFFS) - Private fee-for-service is a type of Medicare Advantage Plan in which you 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 pays and what you pay for the services you will get. You may pay more or less for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan doesn't cover.

Prospective Payment System - Hospitals, Skilled Nursing Facilities, Home Health Agencies and Hospice are paid a set rate based on payment categories. In some cases the Medicare payments are more than the actual costs; in other cases, less than the actual costs. Even if Medicare pays less than the cost of care, the beneficiary does not have to make up the difference.

Quality Improvement Organization (QIO) - Groups of practicing doctors and other health care professionals paid by the federal government to monitor care given to Medicare patients. Each state has a QIO with the authority to decide whether care given to Medicare patients is reasonable and necessary, provided in the most appropriate setting and meets standards of quality generally accepted by the medical profession.

Reasonable and/or Customary Charge - Healthcare service charges that are determined by comparing similar services in a specific geographic area.

Special Needs Plan - A special type of plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid (AHCCCS - Arizona Health Care Cost Containment System), those with a chronic health condition, or those who reside in a nursing home.

Supplemental Insurance - See Medigap Insurance.

TRICARE for Life - A joint program between Medicare and the Department of Defense to provide military retirees, qualifying family members and survivors, and certain former spouses, medical and prescription benefits exceeding the limitations of the Medicare Program.

Unassigned Claim - If a physician/supplier doesn't agree to accept the Medicare approved charge, as the total charge, it is called an unassigned claim. In this case, the beneficiary pays the doctor or supplier. Medicare reimburses the beneficiary 80% of the approved amount after subtracting any part of the Part B annual deductible which has not been met.

Source: Pima Council on Aging - Medicare/Health Insurance Assistance Program