

## **RPEC – GLOSSARY OF HEALTHCARE TERMS (3/23/25)**

**This Glossary of Healthcare Terms is intended to assist RPEC members to navigate the health care system more effectively and to be a roadmap to direct them to primary sources for each term where they can gain access to more detailed current information. (See links to primary sources at end of this document.)**

### **Accountable Care Organization (ACO)**

Groups of doctors, hospitals, and other health care professionals working together to give you high-quality, coordinated service and health care. (Medicare & You)

### **Appeal**

An action you can take if you disagree with a coverage or payment decision made by Medicare, your Medicare health plan, or your Medicare drug plan. You can appeal if Medicare or your plan denies one of these:

- Your request for a health care service, supply, item, or prescription drug that you think you should be able to get.
- Your request for payment for a health care service, supply, item or prescription drug you already got.
- Your request to change the amount you must pay for a health care service, supply, item or prescription drug.

You can also appeal if Medicare or your plan stops providing or paying for all or part of a health care service, supply, item, or prescription drug you think you still need.

(<https://www.medicare.gov/publications/11525-medicare-appeals.pdf>)

(Also see: How to Appeal a Health Care Insurance Decision—A Guide for Consumers in Washington State [https://www.insurance.wa.gov/sites/default/files/documents/appeals-guide\\_2.pdf](https://www.insurance.wa.gov/sites/default/files/documents/appeals-guide_2.pdf))

### **Assignment**

An agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance. Some doctors do not accept assignment. (Medicare & You)

### **Benefit period**

The way that Original Medicare measures your use of hospital and skilled nursing facility services. A benefit period begins the day you're admitted as an inpatient in a hospital or skilled nursing facility. The benefit period ends when you haven't gotten any inpatient hospital care (or skilled care in a skilled nursing facility) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. (Medicare & You)

### **Centers for Medicare and Medicaid Services (CMS - Medicare)**

The U.S. federal agency that administers federal health financing and related regulatory programs - mainly Medicare, Medicaid, and Peer Review Organization programs. It is also the contracting agency for entities that provide Medicare-managed care plans. (Office of Insurance Commissioner)

**Certificate of Coverage**

The benefits booklets, also called certificate of coverage (COC) or evidence of coverage (EOC), are produced by the health plans to provide detailed information about plan benefits and what is and is not covered. (Health Care Authority)

**Claim**

A request for payment that you submit to Medicare or other health insurance when you get items and services that you think are covered. (Medicare & You)

**Coinsurance**

An amount you may be required to pay as your share of the cost for benefits after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%). (Medicare & You)

**Comprehensive outpatient rehabilitation facility**

A facility that provides a variety of services on an outpatient basis, including physicians' services, physical therapy, social or psychological services, and rehabilitation. (Medicare & You)

**Copayment**

An amount you may be required to pay as your share of the cost for benefits after you pay any deductibles. A copayment is a fixed amount, like \$30. (Medicare & You)

**Creditable prescription drug coverage**

Prescription drug coverage that's expected to pay, on average, at least as much as Medicare drug coverage. This could include drug coverage from a current or former employer or union, TRICARE, Indian Health Service, VA, or individual health insurance coverage. (Medicare & You)

**Critical access hospital**

A small facility located in a rural area more than 35 miles (or 15 miles if mountainous terrain or in areas with only secondary roads) from another hospital or critical access hospital. This facility provides 24/7 emergency care, has 25 or fewer inpatient beds, and maintains an average length of stay of 96 hours or less for acute care patients. (Medicare & You)

**Custodial care**

Non-skilled personal care, like help with activities of daily living like bathing, dressing, eating getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. In most cases, Medicare doesn't pay for custodial care. (Medicare & You)

**Deductible**

The amount you must pay for health care or prescriptions before Original Medicare, your Medicare Advantage Plan, your Medicare drug plan, or your other insurance begins to pay. (Medicare & You)

**Demonstrations**

Special projects, sometimes called “pilot programs” or “research studies,” that test improvements in Medicare coverage, payment, and quality of care. They usually operate only for a limited time, for a specific group of people, and in specific areas. (Medicare & You)

**Essential health benefits (EHB)**

A set of ten (10) categories of services health care insurance plans must cover under the Affordable Care Act (ACA), including doctors’ services; inpatient and outpatient hospital care; prescription drug coverage; pregnancy & childbirth services; mental health services; and dental coverage for children. (<https://www.healthcare.gov/glossary/essential-health-benefits/>)

**Explanation of benefits (EOB)**

A statement sent to you by your insurance after they process a claim sent to them by a provider. The EOB lists the amount billed, the allowed amount, the amount paid to the provider and any co-payment, deductibles or coinsurance due from you. The EOB may detail the medical benefits activity of an individual or family. (UWMC Consumer Glossary)

**Extra Help**

A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, like premiums, deductibles, and coinsurance. (Medicare & You)

**Grievance**

A complaint about the way your Medicare health plan or Medicare drug plan is giving care. For example, you may file a grievance if you have a problem calling the plan or if you’re unhappy with the way a staff person at the plan has behaved towards you. However, if you have a complaint about the plan’s refusal to cover a service, supply, or prescription, you file an appeal. (Medicare & You)

**Health Care Authority (HCA)**

The HCA functions as the state's largest health care purchaser and its behavioral health authority. Its three largest programs are Apple Health (Medicaid), the Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) programs, and behavioral health and recovery. HCA purchases health care, including behavioral health treatment, for more than 2.7 million Washington residents, including many retirees, and provides behavioral health prevention, crisis, and recovery support to all Washington residents.

**Health care provider**

A person or organization that’s licensed to give health care. Doctors, nurses, and hospitals are examples of health care providers. (Medicare & You)

**Health Maintenance Organization (HMO)**

A type of health carrier that requires subscribers to get all their care from a group of providers (except for some emergency care). The plan may require the subscriber’s primary care doctor to provide them

with a referral before they can see a specialist or go to the hospital. Depending on the type of coverage you have, state and federal rules govern disputes between enrolled individuals and the plan. (How to Appeal a Health Care Insurance Decision—A Guide for Consumers in Washington State)

**Hospice**

A special way of caring for people who are terminally ill. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional, and spiritual needs of the patient. Hospice also provides support to the patient's family or caregiver. (Medicare & Me)

**Income-related monthly adjustment amount (IRMA)**

A surcharge that Medicare beneficiaries with higher incomes pay on top of their Part B and Part D premiums. (<https://secure.ssa.gov/poms.nsf/lnx/0601101020>)

**Inpatient rehabilitation facility**

A hospital, or part of a hospital, that provides an intensive rehabilitation program to inpatients. (Medicare & You)

**Lifetime reserve days**

In Original Medicare, these are additional days that Medicare will pay for when you're in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance. (Medicare & You)

**Long-term care hospital**

Acute care hospital that provides treatment for patients who stay, on average, more than 25 days. Most patients are transferred from an intensive or critical care unit. (Medicare & You)

**Long-term care**

Long-term care refers to a wide range of medical, personal and social services. Some people may need this type of care if they have a prolonged illness or disability. It includes help with daily activities, such as dressing, bathing, eating, toileting, getting in and out of a bed or chair, and walking. It also may include home health care, adult day care, nursing home care or care in a group living facility. (Office of Insurance Commissioner)

**Long-term care insurance**

Long-term care (LTC) insurance is an insurance policy, contract or rider that provides coverage for at least 12 consecutive months to an insured person if they experience a debilitating prolonged illness or disability. LTC insurance typically covers services, such as diagnostic, therapeutic, rehabilitative, etc., if they're provided in a setting other than a hospital's acute care unit. LTC insurance also typically pays benefits when an insured person can no longer independently do two or more activities of daily living, such as bathing, eating, toileting, etc. (Office of Insurance Commissioner)

**Long-term disability (refers to long-term care and disability insurance)**

Typically, a disability is the limitation of normal physical, mental, and social activities that lasts longer than two years. Note: Each individual insurance policy defines the terms "long-term" and "disability." (Office of Insurance Commissioner)

**Long-Term Services and Supports Trust Act (WA Cares Fund)**

A new mandatory long-term care benefit program for workers in Washington state, the WA Cares fund will help pay for eligible long-term care related expenses. Starting July 2023, the program will be funded by a mandatory payroll tax by workers in Washington state. This program is required by state law and is administered by the state of Washington. (Office of Insurance Commissioner)

**Managed care plan**

A health plan that coordinates covered health care services for a covered person using a primary care provider and a network. Examples include Health Care Maintenance Organizations (HMOs) and some network plans. (How to Appeal a Health Care Insurance Decision—A Guide for Consumers in Washington State (How to Appeal a Health Care Insurance Decision—A Guide for Consumers in Washington State))

**Medicaid**

A joint federal and state program that helps with medical costs for some people with limited income and (in some cases) resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. (Medicare & You)

**Medically necessary**

Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine. (Medicare & You)

**Medicare Plan - Part A**

Covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care. (Medicare & You) (also see Original Medicare definition)

**Medicare Plan – Part B**

Covers certain doctors' services, outpatient care, medical supplies, and preventive services. (Medicare & You) (also see Original Medicare definition)

**Medicare Advantage Plan (Part C)**

An alternative private-insurance option for Original Medicare. Medicare Advantage Plans contract with Medicare. Medicare Advantage Plans provide all of your Part A and Part B benefits, with a few exclusions, for example, certain aspects of clinical trials which are covered by Original Medicare even though you're still in the plan. Medicare Advantage Plans include:

- Health Maintenance Organizations
- Preferred Provider Organizations
- Private Fee-for-Service Plans
- Special Needs Plans
- Medicare Medical Savings Account Plans

If you're enrolled in a Medicare Advantage Plan:

- Most Medicare services are covered through the plan
- Most Medicare services aren't paid for by Original Medicare
- Most Medicare Advantage Plans offer prescription drug coverage

(Medicare & You)

**Medicare-approved amount**

The payment amount that Original Medicare sets for a covered service or item. When your provider accepts assignment, Medicare pays its share and you pay your share of that amount. (Medicare & You)

**Medicare drug coverage**

See “Prescription drugs”.

**Medicare savings program (MSP)**

Administered by states to provide financial assistance with Medicare Part A (hospital) and Part B (outpatient) insurance premiums, as well as Part A and Part B deductibles, coinsurance and copayments. Eligibility varies by state. (Medicare & You)

**Medicare summary notice (MSN)**

A notice you get after the doctor, other health care provider, or supplier files a claim for Part A or Part B services in Original Medicare. It explains what the doctor, other health care provider, or supplier billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay. (Medicare & You)

**Medigap (aka Supplemental Coverage)**

Medicare Supplement Insurance sold by private insurance companies to fill “gaps” in Original Medicare coverage. (Medicare & You)

**Open enrollment (refers to health insurance)**

A period when eligible members may enroll in or transfer between available health care plans. (Office of Insurance Commissioner)

**Original Medicare:**

A fee-for-service plan that pays a portion of hospital (Part A) and medical (Part B) costs. Under Original Medicare, you don’t have coverage through a Medicare Advantage or other type of Medicare health plan. Many people with Original Medicare also purchase separate Medigap and Part D prescription drug plans to pay for the portion of costs that are not covered by Original Medicare. (Medicare & You, AARP)

**Out-of-pocket limit (refers to health insurance)**

The maximum coinsurance a health care plan requires a person to pay, after which the insurer will pay 100% of covered expenses up to the policy limit. (Office of Insurance Commissioner)

**Out-of-area benefits (refers to health insurance)**

Coverage that a managed care plan allows its members for emergency situations, should they be temporarily outside of their health maintenance organization (HMO), or preferred provider organization (PPO) prescribed service area. (Office of Insurance Commissioner)

**Out-of-area services (refers to health insurance)**

Health care services provided to an insurance plan member while they are outside their plan’s established geographic service area. These services are usually not covered or are covered at a lower amount. (Office of Insurance Commissioner)

**Out-of-Network Provider**

A health care provider (such as a hospital or doctor) that is not contracted to be part of an organization's network (such as an HMO or PPO). Depending on the managed care organization's rules, an individual may not be covered at all or may be required to pay a higher portion of the total costs when he/she seeks care from an out-of-network provider. (Office of Insurance Commissioner)

**Outpatient services (refers to health insurance)**

Health care services provided to a patient in or out of a hospital facility when medical or surgical care does not include an overnight hospital stay. (Office of Insurance Commissioner)

**Pharmacy benefit manager (PBM)**

Pharmacy Benefits Managers (PBMs) manage medication benefits for payers and members. Some of their responsibilities include: claims processing, managing formularies, creating and administering pharmacy networks, operating mail order pharmacies, and administering a rebate program. The PBM for the PEBB Uniform Medical plans is Navitus, a 100% pass through (transparent model). For more information, see <https://www.hca.wa.gov/assets/pebb/peb-board-briefing-book-061324.pdf>. (PEBB) PEBB meeting 6/13/24 briefing book tab 5--Rayan Pisotoresi and Jenny Switzer.

**Preauthorization (or prior authorization)**

Preauthorization is when you seek approval from your health plan for coverage of specific services, supplies, or drugs before receiving them. Some services or treatments (except emergencies) may require preauthorization before the plan pays for them. Preauthorization is not a guarantee, however, that your plan will pay for those services, supplies or drugs. (Health Care Authority)

**Preferred Provider Organization (PPO)**

This is a network of health care providers who work with health insurance plans. A health insurance plan often pays more if members get their care from doctors or hospitals that contract with a PPO. The providers and hospitals are called "network" providers. Members pay more if they go to a doctor or hospital not listed in the plan's network. The providers in this PPO have agreed to accept negotiated fees for their services. (How to Appeal a Health Care Insurance Decision—A Guide for Consumers in Washington State)

**Premium**

The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage. (Medicare & You)

**Prescription drugs:****A. Actual Medicare drug coverage (Medicare.gov)**

Actual Medicare drug coverage costs will vary depending on:

- Your prescriptions and whether they're on your plan's list of covered drugs (formulary).
- What "tier" the drug is in.
- Which drug benefit phase you are in (whether you have met your deductible or if you are in the catastrophic coverage phase).

- Which pharmacy you use (whether it offers preferred or standard cost sharing, is out of network and/or is mail order). Your out-of-pocket drug costs may be less at a preferred pharmacy because it has agreed with your plan to charge less.

#### **B. Formulary (Medicare.gov)**

- Most Medicare drug plans (Medicare drug plans and Medicare Advantage Plans with prescription drug coverage) have their own list of what drugs are covered, called a formulary. Plans include both brand-name prescription drugs and generic drug coverage. The formulary includes at least 2 drugs in the most commonly prescribed categories and classes. This helps make sure that people with different medical conditions can get the prescription drugs they need. All Medicare drug plans generally must cover at least 2 drugs per drug category, but plans can choose which drugs covered by Part D they will offer.
- The formulary might not include your specific drug. However, in most cases, a similar drug should be available. If you or your prescriber (your doctor or other health care provider who's legally allowed to write prescriptions) believes none of the drugs on your plan's formulary will work for your condition, you can ask for an exception.
- A Medicare drug plan can make some changes to its drug list during the year if it follows guidelines set by Medicare. Your plan may change its drug list during the year because drug therapies change, new drugs are released, or new medical information becomes available.
- Your plan coinsurance may increase for a particular drug when the manufacturer raises the price. Your copayment or coinsurance may also increase when a plan starts to offer a generic form of a drug, but you continue to take the brand name drug.
- Plans offering Medicare drug coverage under Part D may immediately remove drugs from their formularies after the Food and Drug Administration (FDA) considers them unsafe or if their manufacturer removes them from the market. Plans meeting certain requirements also can immediately remove brand name drugs from their formularies and replace them with new generic drugs, or they can change the cost or coverage rules for brand name drugs when adding new generic drugs. If you're currently taking any of these drugs, you will get information about the specific changes made afterwards.
- For other changes involving a drug you're currently taking that will affect you during the year, your plan must do one of these:
  - Give you written notice at least 30 days before the date the change becomes effective.
  - At the time you request a refill, provide written notice of the change and at least a month's supply under the same plan rules as before the change.
  - You may need to change the drug you use or pay more for it. You can also ask for an exception. Generally, using drugs on your plan's formulary will save you money. If you use a drug that isn't on your plan's drug list, you'll have to pay full price instead of a copayment or coinsurance, unless you qualify for a formulary exception.

#### **C. Tiers (Medicare.gov)**

Medicare drug coverage typically places drugs into different formulary levels, called "tiers". Drugs in each tier have a different cost. For example, a drug in a lower tier will generally cost you less than a drug in a higher tier.

- Tier 1—lowest copayment: most generic prescription drugs
- Tier 2—medium copayment: preferred, brand-name prescription drugs
- Tier 3—higher copayment: non-preferred, brand-name prescription drugs



- Specialty tier—highest copayment: high-cost prescription drugs

#### **D. Generic prescription drugs (Medicare.gov)**

The Food and Drug Administration (FDA) says generic drugs are copies of brand-name drugs and are the same as those brand-name drugs in:

- Dosage form
- Safety
- Strength
- Route of administration
- Quality
- Performance characteristics

Generic drugs use the same active ingredients as brand-name prescription drugs. Generic drug makers must prove to the FDA that their product works the same way as the brand-name prescription drug. In some cases, there may not be a generic drug the same as the brand-name drug you take, but there may be another generic drug that will work as well for you. Talk to your doctor or other prescriber about your generic drug coverage.

#### **E. Step-Therapy**

Step therapy is a type of prior authorization. In most cases, you must first try a certain, less expensive drug (or multiple drugs) on the plan's formulary that's been proven effective for most people with your condition before you can move up a "step" to a more expensive drug. For instance, some plans may require you first try a generic drug (if available), then a less expensive brand-name drug on their drug list before you can get a similar, more expensive, brand-name drug covered.

However, if your prescriber believes that because of your medical condition it's medically necessary for you to be on a more expensive step therapy drug without trying the less expensive drug first, you or your prescriber can contact the plan to request an exception. Your prescriber can also request an exception if he or she believes you'll have adverse health effects if you take the less expensive drug, or if your prescriber believes the less expensive drug would be less effective. Your prescriber must give a statement supporting the request. If the request is approved, the plan will cover the more expensive drug, even if you didn't try the less expensive drug first. (Medicare.gov)

#### **Preventive services**

Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms). (Medicare & You)

#### **Primary care doctor**

The doctor you go to first for most health problems. They may talk with other doctors and health care providers about your care and refer you to them. (Medicare & You)

#### **Reference-based pricing (RBP)**

Reference-based pricing is a cost-containment strategy that looks at costs in a different way by using public data as a pricing benchmark. Rather than relying on the hospital or facility's chargemaster price (which is often over-inflated) to price a claim, RBP uses a more data-driven approach to establish a fair cost of care. To determine this more reasonable cost, most RBP providers use a benchmark like Medicare, usual and customary costs, or the actual cost reported by the facility to determine the reimbursement. With the established benchmark in place, the RBP provider reprices the claim, adding a fair profit on top of the reference price. This becomes the new amount paid to the healthcare provider. (<https://www.imagine360.com/understanding-reference-based-pricing/>)

**Referral**

A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, your plan may not pay for services from a specialist. (Medicare & You)

**Service area**

An area you must live in for the plan to accept you as a member. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. Plans can, and in some cases must, disenroll you if you move outside their service area. (Medicare & You)

**Shared decision making (SDM)**

A collaborative process allowing patients and their providers to make health care decisions together considering the best scientific evidence available and patients' values & preferences by using "patient decision aids" (PDA). In 2007, WA became the first state to pass legislation around shared decision making with the focus on end-of-life care, orthopedics, maternity and cancer-screening. (<https://www.hca.wa.gov/assets/program/sdm-fact-sheet.pdf>)

**SHIBA (refers to health insurance)**

A free, unbiased counseling service, the Statewide Health Insurance Benefits Advisors (SHIBA) program uses trained volunteers to assist health insurance consumers statewide with health insurance options including finding access to health care and prescription-drug programs. SHIBA is a service of the Office of the Insurance Commissioner and is sponsored by local community-based organizations. (Office of Insurance Commissioner)

**Skilled nursing facility (SNF)**

A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services. (Medicare & You)

**Skilled nursing facility (SNF) care**

Skilled nursing care and therapy services provided on a daily basis in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a physical therapist or a registered nurse. (Medicare & You)

**Step-therapy**

See "Prescription Drugs".

**Supplier**

Generally, any company, person, or agency that gives you a medical item or service, except when you're an inpatient in a hospital or skilled nursing facility. (Medicare & You)

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