



Cornell University
College of Human Ecology
Cornell Cooperative Extension



Cornell University Resource Education for Medicare Part D

GLOSSARY OF PART D TERMS

Actuarially Equivalent – An insurance term for the determination that the dollar value of drug coverage under one plan is at least equal to the dollar value of coverage under the standard Part D plan.

AIDS Drug Assistance Program (ADAP) – The AIDS Drug Assistance Program provides free medications for the treatment of HIV/AIDS and opportunistic infections to people with partial insurance or a Medicaid spend down requirement.

Annual Coordinated Election Period (ACEP) – The annual period from November 15th to December 31st when a Medicare beneficiary can enroll into a Medicare Part D plan, re-enroll into his existing plan, change plans, or switch into a Medicare Advantage Plan that has a prescription drug plan. The selected plan begins its benefits on January 1st.

Annual Deductible – The amount you must pay for your prescriptions, before your Medicare drug plan coverage begins. The deductible amount cannot exceed the maximum set by Medicare (\$310 for 2010).

Annual Notice of Change – The Centers for Medicare and Medicaid Services requires insurance companies to notify you of any benefit changes that may have occurred in your plan for the following year.

Any Willing Provider – Medicare law states that prescription drug plan sponsors are required to permit any pharmacy willing to accept the plan's terms and conditions to participate in the plan's pharmacy network.

Appeals – See also, "Exceptions Process." If you disagree with any part of a coverage determination, you may request a redetermination by the insurance plan. If you disagree with a redetermination, you may request reconsideration by an Independent Review Entity (IRE) contracted by Medicare. If you disagree with the reconsideration you can appeal the IRE decision to an administrative law judge of the Medicare Appeals Council and federal court.

Auto-Enrollment – The Centers for Medicare and Medicaid Services automatically enrolls full benefit dual eligibles of both Medicare and Medicaid into a prescription drug plan.

Base Beneficiary Premium – The national average premium annually established by the Centers for Medicare and Medicaid Services for all prescription drug plans. This amount may be more or less than the premium of your plan and is used as a benchmark for certain determinations.

Benefit Percentage – The percentage of covered expenses that your plan pays after you meet your deductible.

Brand Name Drug – A patented drug that has a trade name and is produced and sold only by the company holding the patent.

Catastrophic Coverage – The insurance coverage which you will receive until the end of the calendar year after your total drug costs have reached the maximum out-of-pocket amount for the year (\$4550 for 2010). You will still pay a coinsurance (5%) or a co-payment for drugs during this period.

Catastrophic Limit – The maximum amount of out-of-pocket expenses that you will incur in a year before you begin to receive catastrophic coverage for your prescriptions.

Centers for Medicare and Medicaid Services (CMS) – Provides effective, up-to-date health care coverage and promotes quality care for beneficiaries. This federal agency was responsible for carrying out the legislation that put prescription drug plans into existence and oversees administration of the coverage by private insurance companies. CMS also administers Medicare Parts A and B.

<http://www.cms.hhs.gov/>

Certificate of Creditable Coverage – A written certificate issued by a group health plan or health insurance issuer that states the type of coverage and period of time you are covered by your health plan.

Coinsurance – A percentage amount that you pay for a medical service after satisfying any deductibles. In a Medicare prescription drug plan, the coinsurance can vary for drugs in different tiers and coverage zones.

Co-payment – A set dollar amount you pay for a medical service after satisfying any deductibles. For example, this could be \$10 or \$20 for a prescription and may vary based on the formulary status of the drug.

Cornell Cooperative Extension – Cornell Cooperative Extension is a key outreach system of Cornell University with a strong public mission and an extensive local presence that is responsive to needs in New York communities. The Cornell Cooperative Extension educational system enables people to improve their lives and communities through partnerships that put experience and research knowledge to work. <http://www.cce.cornell.edu/>

Cornell University Resource Education for Medicare Part D (CURxED) – CURxED is a Cornell Cooperative Extension project of the Department of Policy Analysis and Management in the College of Human Ecology. CURxED provides Medicare Part D educational materials and programming to the senior citizens of our communities as well as the family members, volunteers, counselors, and human service agencies that assist them.

<http://www.CURxED.human.cornell.edu>

Cost Sharing – The amount you pay for prescriptions which includes copayments, coinsurance, and deductibles.

Coverage Determination – A decision made by the plan that a prescription counts as a benefit under the plan, irrespective of the cost of the medication.

Covered Drugs – The drugs that are on the plan's formulary and are available to the beneficiary under the terms and conditions of the plan.

Creditable Coverage – Insurance coverage that is at least equal to, or better than the coverage to which it is being compared, in this case, a Medicare Part D basic plan.

Dual Eligible for Medicaid-Medicare (Duals) – These are people who qualify to receive benefits from both Medicare and Medicaid. Beneficiaries enrolled in Medicaid had their prescription drugs paid for by Medicaid until January 1, 2006. Dual eligibles now receive their prescriptions from a Part D plan and automatically qualify for a subsidy to help pay the premiums, copayments, coinsurance, and deductibles of Medicare. Duals are automatically enrolled into a prescription drug plan.

Exceptions Process – See also “Appeals.” If you are denied coverage for any reason, you may request an exception to the rule. If the plan does not grant the exception and provide access to the drug, you may appeal. Typically, your physician must determine that the preferred drug, formulary drug, or first-tier drug is not effective for you, harmful to you, or is not medically necessary for some other reason.

Elderly Pharmaceutical Insurance Coverage Program (EPIC) – A New York State sponsored prescription plan for senior citizens who need help paying for their prescriptions.

http://www.health.state.ny.us/health_care/epic/

Facilitated Enrollment – The Centers for Medicare and Medicaid Services will automatically enroll all those who are eligible for a low-income subsidy into a prescription drug plan.

Fail-First – A prior authorization mechanism in which a brand name drug is covered only after the plan’s preferred drug has had adverse effects or is therapeutically ineffective.

Formulary – A list of drugs covered by a plan. This list usually also includes any rules for the use of the medications, including the tiers and any restrictions on the use of the drugs.

Federally Qualified Health Center (FQHC) – Medicare provides funding for the FQHC Program which enhances the availability and provision of primary care services in underserved urban and rural communities.

Gap (Donut Hole) – A break in insurance coverage where the patient is responsible for the full cost of the drug. This is also sometimes referred to as a second deductible. Some plans may offer some coverage on some drugs in the gap.

Generic Drug – A prescription drug that has the same active-ingredient formula as a brand-name drug and usually costs less than brand-name drugs. The Food and Drug Administration rates these drugs to be as safe and effective as brand-name drugs.

Health and Human Services (HHS) – The Department of Health and Human Services is the United States government’s principal agency responsible for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.
<http://www.hhs.gov>

Health Insurance Information Counseling and Assistance Program (HIICAP) – This program educates the public about Medicare, Medicaid, managed care, EPIC, and other health insurance options and issues in New York State. <http://hiicap.state.ny.us/>

Initial Coverage Zone – The initial period of insurance coverage after a patient has met any deductible requirement and before expenditures reach the initial limit of the coverage gap.

Initial Enrollment Period (IEP) – For those persons who are just turning 65 or just becoming eligible for Medicare, the Initial Enrollment Period is a seven month period that extends three months before the month when a person reaches 65, plus the month where the person turns 65, plus the three month period after the person turns 65. If you enrolled in the months before turning 65, your Part D policy begins the first day of your birthday month. If you enrolled during or after your birthday month, your Part D plan begins the first day of the next month. Eligible Medicare Part D beneficiaries who did not enroll during their IEP face a lifetime monthly premium penalty.

Independent Review Entity (IRE) – When a beneficiary seeks an appeal, a coverage determination will be issued by the prescription drug plan. The plan enrollee may request a redetermination of an unfavorable coverage determination; the redetermination will be performed by the drug plan. Individuals who remain dissatisfied after the redetermination can request a further review known as reconsideration; the Reconsideration will be performed by the “Independent Review Entity.”

Late Enrollment Penalty – You must pay a late penalty in the form of a 1% per month higher premium if you have a continuous period of 63 days or longer without prescription drug coverage after becoming eligible for Medicare part D.

Low-Income Subsidy (LIS) – Beneficiaries who qualify based on low income and limited assets will receive a subsidy to receive substantial assistance in paying the Part D premium and cost sharing associated with drug coverage.

Mail Order Pharmacies – Mail order pharmacies are used by many plans as a cost-saving and convenient alternative to retail pharmacies. Members typically order their drugs by phone, fax, email or internet and orders are usually received in two to four days.

Medicare Advantage Plan – A Medicare managed care program is insurance under which a private insurance company arranges for all Medicare Part A and B covered services, including physicians, labs and hospitals. Some Medicare Advantage Plans may also offer the Medicare Prescription Drug benefit (MA-PD) to their enrollees in addition to the above covered services.

Medicare Prescription Plan Finder Tool – Accessed at www.medicare.gov, the Plan Finder Tool allows you to search for the Medicare prescription insurance plan in your region that provides the most optimal coverage for your medications.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA 2003) – The law signed into action for Medicare to provide the benefit of prescription drug insurance utilizing tax breaks and subsidies so that private insurance companies may offer this coverage. This legislation is also known as Medicare Part D.

Medication Therapy Management (MTM) – Medication Therapy Management is a service usually provided by a Pharmacist that optimizes therapeutic outcomes for individual patients. Services may include performing assessments of the patient's health status, formulating a medication treatment plan, selecting or administering medication therapy, and monitoring and evaluating the patient's response to therapy.

Negotiated Discount Prices – Prices for covered drugs that the prescription drug plan and pharmacy must make available at preferred pharmacies. These prices are currently negotiated by a third party, the Pharmacy Benefits Manager, for the insurance plan and to help lower costs for the beneficiary.

Network – The doctors, hospitals, and pharmacies having contracts with an insurance plan to provide care to the plan's members. Using your Part D prescription drug plan's network of pharmacies may save you money on your drugs.

Network Retail Pharmacy – A network retail pharmacy is a pharmacy that is part of a group of pharmacies chosen by a prescription drug plan to provide pharmacy care to its members, usually at a lower cost.

Non-Formulary Drug – A drug that is not on a plan-approved drug list. Unless an appeal is granted, a non-formulary drug will not be covered under the plan and costs for that drug will not count towards out-of-pocket expenses.

Non-Preferred Brand-Name Drugs – A non-preferred brand-name drug is a prescription medication that is covered by a prescription drug plan, but will cost a member more than a preferred brand-named drug. A non-preferred brand-name drug is in a higher cost formulary tier than a preferred brand-name drug.

Non-preferred Pharmacy – A pharmacy that offers covered drugs to plan members at higher out-of-pocket costs than what the member would pay at a preferred network pharmacy.

Open Enrollment Period (OEP) – See “Annual Coordinated Election Period”

Office for the Aging (OFA) – This agency offers help to older citizens to be as independent as possible through the advocacy, development, and delivery of cost effective policies, programs, and services which support and empower the elderly and their families, in partnership with the network of public and private organizations which serve them.

<http://www.aging.state.ny.us/>

Out-of-Pocket Costs – The payments made by the beneficiary that count toward the total cost of covered prescriptions, including the deductible, coinsurances, co-payments and the cost of prescriptions during the “donut hole.”

Original Medicare Plan – The federal government sponsored fee-for-service health plan that lets beneficiaries go to any doctor, hospital, or other health care supplier who accepts Medicare and is accepting new Medicare patients. The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). Original Medicare is available to those over 65 years of age and others with certain disabilities.

Over The Counter (OTC) – Medications that do not require a written prescription.

Part A – Medicare Health Insurance which pays for inpatient hospital stays and stays in skilled nursing homes under certain criteria.

Part B – Medicare Supplementary Medical Insurance that pays for some services and products not covered under Part A, generally on an outpatient basis and usually covers doctor office visits.

Part D Eligible Individual – An individual who is entitled to Medicare Part A and entitled to, or enrolled in, Medicare Part B will be eligible for enrolling into a Part D plan.

Part D Plan – Part D is the portion of the Medicare program providing prescription drug coverage. A Medicare prescription drug plan may be either a prescription drug plan added to traditional Medicare or a Medicare Advantage plan that includes Medicare prescription drug coverage.

Pharmacy Assistance Program (PAP) – Pharmacy Industry sponsored programs that provide assistance to individuals to help make prescription drugs more affordable.

Pharmacy Benefits Manager – A company under contract with insurance companies, managed care organizations, self-insured companies, and government programs, to administer pharmacy network management, drug utilization review, outcomes management, and disease management. A pharmacy benefit manager may negotiate prices and fill drug prescriptions by mail order as part of a corporate health insurance plan.

Plan Name – The name of the insurance plan offered by the company that contracts with Medicare. For Medicare Part D, each insurance company may offer up to three different plans in each region.

Preferred Drug – A particular drug which is deemed by the insurance company to be the drug of first choice given a certain condition. This determination is made based on cost, safety and efficacy issues.

Preferred Pharmacy – A network pharmacy that offers covered drugs to plan members at lower out-of-pocket costs than what the member would pay at a non-preferred network pharmacy.

Premium – The payment made to cover the cost of the insurance policy. This does not cover any of the costs of the medications and does not count towards one's true out-of-pocket costs.

Prior Authorization – Approval which must be obtained from an insurance provider before prescription costs are covered for certain drugs. In many instances, your doctor or health care provider must first contact the plan and show there is a medically necessary reason for using a particular drug, justifying the need for that drug.

Quantity Limits – For safety and cost reasons, plans may limit the quantity of drugs that are covered over a certain period of time.

Reconsideration – See “Independent Review Entity”

Redetermination – See “Independent Review Entity”

Reinsurance – In the catastrophic zone, 95% of drug costs are covered. CMS provides 80% of that coverage; the beneficiary is responsible for 5% as a co-payment and the insurance plan is responsible for the remaining 15%. The 80% which CMS pays is the reinsurance. This feature serves in limiting the risk that plans face in providing coverage to the highest costing beneficiaries.

Risk Corridor – Plans that have actual costs that exceed expected costs will receive additional government payments to compensate for those losses. Plans that have spending that falls below the estimated costs will be required to give part of the excessive profit back to the government. The risk corridor partially protects plans from dramatic changes in spending.

Risk Adjustment – Factors such as age, sex, disability, and the presence of certain chronic conditions are taken into account to predict your expected spending to help calculate a drug plan’s monthly premium.

Senior Medicare Patrol (SMP) – The mission of this program is to coordinate, implement, monitor, expand, evaluate, and promote efforts to provide consumer information and protection designed to detect, prevent and report error, fraud and abuse in the Medicare and Medicaid programs.

<http://www.aoa.gov/smp/>

Social Security Administration (SSA) – The federal agency administers America’s major support program for the elderly, disabled and their dependents as well as to other government-run programs such as Medicare, Medicaid, Railroad Retirement, and Food Stamp Programs.

<http://www.ssa.gov/>

Special Enrollment Period (SEP) – A period of time when an individual can enroll in or switch plans outside of the annual enrollment period (November 15th—December 31st). SEP’s are provided by the Center for Medicare and Medicaid Services when they are needed in response to special circumstances.

Specialty Tier – Medications with a cost greater than \$600 per month may be placed in a specialty tier. Special coinsurance rules apply and plans are not required to grant pricing exceptions.

Standard Coverage – Also “standard prescription drug coverage” – refers to the standard formula that apportions annual costs of Medicare prescription drug coverage between you, the Medicare prescription drug plan, and the federal Medicare program. Each Medicare prescription drug plan must offer standard coverage to make it easier for potential enrollees to comparison shop between different sponsors’ plans and their supplemental benefits options.

State Health Insurance Program – A national program that offers one-on-one counseling and assistance to people with Medicare. Through federal grants, SHIPs provide free counseling and assistance via telephone and face-to-face interactive sessions, public education presentations, and media activities. The SHIP in New York State is known as Health Insurance Information Counseling and Assistance Program (HIICAP).

<http://www.shiptalk.org>

<http://www.aging.ny.gov/HealthBenefits/HIICAPIndex.cfm>

State Pharmaceutical Assistance Program – SPAP programs exist in 21 states and 1 territory. They provide assistance to residents to purchase prescription drugs. Most programs are aimed at those who have limited income. The SPAP in New York is known as EPIC.

<http://www.medicare.gov/spap.asp>

Step Therapy – In some cases, plans require you to first try one drug before it will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, a plan may require your doctor to prescribe Drug A first and will cover Drug B only if Drug A does not work.

Subsidization – Payments made by the federal government to lower the costs of a program. For example, federal payments are made to insurance companies to keep the cost of prescription drugs low to the beneficiary.

Subsidy Eligible Individual – A Medicare beneficiary enrolled in a Medicare prescription drug benefit plan who qualifies for one of several levels of assistance to help with premiums and out-of-pocket payments for the purchase of prescription drugs. To qualify for one of the subsidies, income and assets must be at or below certain limits, or the beneficiary must be receiving SSI, Medicaid benefits, or Medicare Saving Program benefits.

Tier (Formulary Status) - Drugs on a formulary are often organized into different drug “tiers,” or groups of different drug types. Your cost depends on which drug tier your drug is in.

For example, a plan may form tiers this way:

Tier 1 – Generic drugs.

Tier 2 – Preferred brand-name drugs.

Tier 3 – Non-preferred brand-name drugs.

