

## **Glossary Of Terms Medicare Prescription Drug Benefit (Part D)**

(All Italicized Words Used In the Definitions Also Have Definitions In This Glossary)

**Actuarial equivalence** – Actuarial equivalence is an insurance term for a determination that the dollar value of drug coverage under one plan is equal to the dollar value of coverage under another plan. Two plans with different *co-payments, deductibles, formularies* and other features are “*actuarially equivalent*” if, at the end of the year, a person would have obtained the same total dollar benefit from either plan.

**Appeals** – If a person disagrees with any part of a *coverage determination* (including an *exception* request), the person may request a redetermination by the Medicare Prescription Drug Benefit Plan (and have the redetermination expedited under certain circumstances). A person who disagrees with a redetermination may request reconsideration by an independent review entity (IRE) contracted by Medicare and may also appeal the IRE decision to an administrative law judge, the Medicare Appeals Council and federal court.

**Assets** – include bank accounts, stock accounts, real estate, homes and cars – but exclude primary residence and one car. In determining whether the beneficiary is a *subsidy-eligible individual*, assets and those of the spouse (if married and live in the same household) will be added together.

**Catastrophic coverage** – catastrophic coverage refers to the much higher level of coverage (95% or more payment by the plan, depending on income) received for all *covered drugs* after the beneficiary has spent more than the *TrOOP* limit for prescriptions in that year. For 2006, the *TrOOP* limit is \$3,600.

**Creditable coverage** – includes a drug benefit through an employer or union plan, TriCare, a Federal Employees Health Benefit Plan, or Veterans benefits that is the *actuarial equivalent* of the **Medicare Prescription Drug Benefit**. People who have creditable coverage do not have to pay the *late enrollment penalty or higher premium* for failing to enroll in Medicare Prescription Drug Benefit as soon as they are eligible.

**Co-insurance** – a fixed percentage of the *negotiated discount price* of a *covered drug* paid by the Medicare Prescription Drug Benefit enrollee. The *coinsurance* may be different for one drug than for another depending on whether it is a generic drug or a *nonpreferred* drug. It may vary throughout the year, from 0 to 100%, depending on whether the enrollee’s total spending that year is still in the *deductible* period, or has reached the “*doughnut hole*”. Even with all of these differences, the total *out-of-pocket* payments for *covered drugs* in the year will not exceed *TrOOP*.

**Co-payment** – a fixed dollar amount to be paid by the Medicare Prescription Drug Benefit enrollee for each prescription dispensed. For example, a *subsidy eligible individual* who has a very low income will pay no more than \$3 to the pharmacy for each brand name prescription filled at the pharmacy, and \$1 for each generic drug, regardless of the cost of the covered drug.

**Coverage determination** – a decision by the **Medicare Prescription Drug Benefit** plan that the prescription counts as a benefit under the plan, no matter how much the plan actually pays for the drug.

**Covered Drugs** – prescription drugs that are on the plan’s *formulary*; the Medicare Prescription Drug Benefit enrollee’s payments for *covered drugs* count toward the *TrOOP* limit.

**Deductible** – an amount the Medicare Prescription Drug Benefit enrollee must pay before benefits are paid by the Plan. In 2006, for *standard coverage*, the enrollee pays a \$250 *deductible* before the plan begins to pay for prescriptions.

**“Doughnut hole”** – The full cost of prescriptions assigned to the enrollee after the annual *initial coverage limit* is reached and before reaching the *TrOOP* limit. This portion of the Medicare Prescription Drug Benefit is sometimes referred to as *“doughnut hole.”*

**Dose restrictions** – a *formulary* restriction that causes a particular drug not to be covered for the number of doses prescribed. A *formulary* with *dose restrictions* limits the number of tablets (or other dosage forms) that may be dispensed by a pharmacy to a beneficiary during a specific amount of time (typically per month).

**Dual-eligible – also “duals”** These are people who qualify to receive benefits from both Medicare and Medicaid (Medical Assistance in Minnesota). Beneficiaries enrolled in Medicaid have had their prescription drugs paid for by Medicaid. Effective January 1, 2006 dual eligibles will receive their prescriptions from a **Medicare Prescription Drug Benefit Plan**, but they automatically qualify for a subsidy to help with their premiums, copayments, coinsurance and deductibles.

**Enhanced alternative coverage** – see also *supplemental benefits*. Includes *standard prescription drug coverage* and *supplemental benefits*.

**Enrollment period** – more commonly, *initial enrollment period*. The initial enrollment period will be the same for the **Medicare Prescription Drug Benefit** as for Medicare Part B. It is the seven-month period that begins three months before the month an individual first meets the eligibility requirements for Medicare and ends three months after that first month of eligibility. The *initial enrollment period* for those individuals who are already eligible for Medicare as of November 15, 2005, is from November 15, 2005, until May 15, 2006.

**EW (elderly waiver):** A Medicaid waiver program that provides home and community-based services as an alternative to nursing home care to individuals age 65 or older at a higher income level than individuals not requiring a nursing home level of care.

**Exceptions process** – also *“exception.”* See also *“appeals.”* See also *“rights of enrollees.”* A beneficiary denied coverage for the following reasons may request an *exception*:

- The prescription is not on the plan *formulary*, or
- Plan denied a request to have a *non-preferred drug* treated as a *preferred drug* under a *tiered formulary*, or
- Plan denied a request to access a drug outside of the plan’s *step therapy* requirements. If the plan does not grant the *exception* and provide access to the drug, the individual may *appeal*. Typically, the beneficiary’s physician must determine that the preferred drug, formulary drug, or first-tier drug is not effective for the beneficiary, harmful to the beneficiary, or both or is medically necessary for some other reason.

**Formulary** – a list of *covered drugs* available through the Medicare Prescription Drug Benefit Plan. The plan is also using a *formulary* if they limit the number or size of dose a beneficiary may receive (*dose restriction*) or require a beneficiary to try another drug (*step therapy*) before allowing access to the one selected by the physician. Money spent “on formulary” prescriptions count towards *TrOOP*; money spent on “non-formulary” prescriptions do not count towards *TrOOP*. Beneficiaries should tell their doctor or health professional if a medicine needed is not “on formulary.” They may be able to help obtain an *“exception”* to have the medicine covered, and have money spent counted towards *TrOOP*, or they may be able to prescribe another drug that is appropriate to meet the beneficiary’s medical needs.

**FPL** – Federal Poverty Level, (officially: the HHS Federal Poverty Guidelines.) The federal poverty statistics, including the FPL, are published annually by the Census Bureau for statistical purposes, usually in February of each year.

**Income** – Income includes earned wages, earnings from self-employment, royalties, annuity payments, pension payments, disability benefit payments, veterans compensation and pension, worker’s compensation payments, old age survivor and disability insurance benefit payments (including Social Security payments), unemployment insurance payments, prizes, support and alimony payments, inheritances, and earned rents or dividends. In determining whether a beneficiary is a *subsidy-eligible individual*, the income and that of the spouse (if married and live in the same household) will be added together.

**Initial coverage limit** – In **standard coverage**, the amount of drug costs where the 25% *coinsurance* ends, and the beneficiary is required to pay 100% of the cost of Medicare Prescription Drug Benefit covered drugs, up to the *TrOOP* limit. The *initial coverage limit* for 2006 is \$2,250 worth of prescriptions (including both what the beneficiary pays and what the plan pays, plus any subsidy).

**Late enrollment penalty** – A late penalty in the form of a 1%-per-month higher premium must be paid by an individual who has a continuous period of 63 days or longer without prescription drug coverage at any time after the end of their *enrollment period*. CMS may determine after 2006 whether an actuarially sound amount should be applied rather than the 1%.

**MA-EPD** – a Medicare Program that allows working people with disabilities to qualify for benefits at higher income and asset levels by paying a premium.

**Medicare Advantage** – a Medicare managed care program under which a non-government entity arranges for all Medicare covered services, including physicians, labs and hospitals. Some Medicare Advantage plans may offer the Medicare Prescription Drug Benefit to their enrollees.

**Medicare Supplement (Medigap)** – an insurance policy sold by private insurance companies to fill “gaps” in Original Medicare Plan coverage. In Minnesota, there are 3 types of Medicare supplements: Basic, Extended Basic and Medicare Select Plans.

**Minnesota Prescription Drug Program** – a state funded program to help QMB and SLMB enrollees pay for the cost of prescription drugs. Enrollees cannot be eligible for Medical Assistance without a spenddown. Enrollees currently pay a \$35 monthly deductible toward the cost of drugs.

**Negotiated discount prices** – prices for **covered drugs** that the **Medicare Prescription Drug Benefit Plan** must make available at participating pharmacies. For example, 25% *coinsurance* is 25% of the negotiated discount price. These prices take into account discounts, rebates, and other price concessions, given to the Plan by manufacturers and pharmacies. Even when the beneficiary is paying for prescriptions during the *deductible* or the “*doughnut hole*”, only the *negotiated discount prices* are paid by the beneficiary.

**Non-Preferred drug** – a drug that a plan discourages access to, typically by requiring a larger co-payment, which may be up to 100% of the *negotiated discount price* of the drug.

**Out-of-Pocket Payments** – Payments by the Medicare Prescription Drug Benefit enrollee toward the total cost of covered prescriptions, including the *deductible, coinsurance, co-payments*, and the cost of prescriptions during the “*doughnut hole*.”

**Part D** – is that part of the Medicare program providing prescription drug coverage. In general, Medicare Part A covers hospital services, Part B covers physician services, and Part C is Medicare Advantage, the comprehensive managed care program.

**Part D Eligible Individual** – means an individual who is entitled to Medicare Part A or enrolled in Medicare Part B.

**Part D Plan** – a Medicare Prescription Drug Benefit Plan may be either a *Prescription Drug Plan (PDP)* to add to traditional Medicare, or a *Medicare Advantage* plan that offers Medicare Prescription Drug Benefit coverage (*MA-PD*).

**Preferred drug** – a drug the Medicare Prescription Drug Benefit plan encourages physicians and patients to choose, typically by including it on a *formulary* or requiring a smaller *co-payment* or no *co-payment*.

**Prescription Drug Plan** – also *PDP*. A plan that offers coverage for prescription drugs only to beneficiaries who choose to receive their other Medicare benefits in the traditional way. (This is not to be confused with the Minnesota Prescription Drug Program also known as PDP)

**Premium** – also monthly beneficiary premium. The amount a Medicare Prescription Drug Benefit enrollee pays monthly for Medicare Prescription Drug Benefit coverage. Each enrollee will pay a premium agreed to between Medicare and the *Sponsor*, plus any *late enrollment penalties* or charges for *supplemental coverage*.

**QI (Qualified Individual)** – a Medicaid program that pays for Medicare Part B premiums. People qualify for QI if they have income below 135% *FPL* and in Minnesota have assets no greater than \$10,000 for an individual or \$18,000 for a couple.

**QMB (Qualified Medicare Beneficiaries)** – a Medicaid program that pays for Medicare out-of-pocket costs, including the Part A or Part B premiums, deductibles, co-insurance and co-payments. People qualify for QMB if they have income at or below 100% *FPL* and in Minnesota have assets no greater than \$10,000 for an individual or \$18,000 for a couple.

**Rights of Enrollees** – Generally, enrollees have the right to have a *grievance* heard, the right to a timely *coverage determination* (expedited under certain circumstances), the right to an *appeal* – including coverage redetermination (expedited under certain conditions) and review by an independent review entity contracted by Medicare, and the right to notices of coverage determinations and certain plan changes.

**SLMB (Service-Limited Medicare Beneficiary)** – a Medicaid program that pays for Medicare Part B premiums. People qualify for SLMB if they have income below 120% *FPL* and in Minnesota have assets no greater than \$10,000 for an individual or \$18,000 for a couple.

**Sponsor** – A non-governmental entity approved by Medicare to offer a Medicare Prescription Drug Benefit Plan.

**State Pharmaceutical Assistance Program** – also SPAP A program (other than Medicaid) operated by a State (or under contract with a State) that provides financial assistance to Medicare beneficiaries to purchase prescription drugs. The Minnesota SPAP is known as the Minnesota Prescription Drug Program.

**Standard coverage** – also “standard prescription drug coverage” means the standard formula that apportions annual costs of Medicare Prescription Drug coverage among the Medicare enrollee, the Medicare Prescription Drug Benefit Plan and the federal Medicare program. Each Medicare Prescription Drug Benefit Plan must offer *standard coverage* to make it easier for potential enrollees to comparison shop between different *sponsors’* plans and their *supplemental benefits* options. In 2006, *standard coverage* has a \$250 *deductible*, 25% *coinsurance* on the next \$2000 worth of drugs, 100% payment of drug costs by the enrollee in the “*doughnut hole*”, and *catastrophic coverage* after the *TrOOP* limit.

**Step therapy** – Generally, a plan requirement that, with respect to a specific disease or condition, the patient must try one drug before having access to another, *nonpreferred* drug if the preferred drug does not work for the patient.

**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 receives SSI, Medicaid benefit, Medicare Saving Program benefits, or is enrolled in the Minnesota Prescription Drug Program.

**Supplemental benefits** – Individuals may pay an additional premium to purchase supplemental benefits to enhance *standard coverage* by reducing the *deductible*, the *coinsurance* percentage or *copayments*, filling the “*doughnut hole*”, or having a different *formulary*.

**Tiered cost-sharing** – also “tiered formulary” A *formulary* that has different levels of *coinsurance* or *copayments* for different drugs that could be used to treat the same disease or condition. Different tiers typically include generic drugs, *preferred* drugs, and non-preferred drugs.

**True Out-of-Pocket Spending** – also *TrOOP* limit. The amount a beneficiary must spend on *covered drugs* to reach *catastrophic coverage*. An individual’s payment of the *deductible*, *coinsurance*, *copayments*, and “*doughnut hole*” count toward *TrOOP*. For 2006, *TrOOP* is \$3,600. The Medicare Prescription Drug Benefit premium does not count toward *TrOOP*.

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