

Medicare Part D Glossary

The introduction of MMA brings new vocabulary to learn. Below is a list of important acronyms and glossary terms you will need to be familiar with as you navigate through the implementation of Medicare Part D. For more information about MMA and Medicare Part D, contact your Omnicare pharmacy.

Actuarial Equivalence

In very general terms, actuarial equivalence means that the aggregate dollar value of Part D drug coverage for a set of Medicare beneficiaries under one Part D drug plan can be shown to equal the dollar value for those same beneficiaries under another plan.

Auto-Enrollment

The process by which CMS will automatically enroll a dual eligible individual in an eligible Part D drug plan if the individual fails to enroll in a Part D plan.

Beneficiary

A person 65 years of age and older, or a person with disabilities or end-stage renal disease, who is enrolled in the Medicare program.

Catastrophic Cap

A total annual out-of-pocket spending threshold, after which the enrollee is entitled to catastrophic coverage under a Part D plan. For 2006, the catastrophic cap is \$3,600, beyond which the enrollee's cost-sharing generally will equal the greater of: (1) five percent co-insurance; or (2) a co-payment of \$2 for a generic drug or a preferred multiple source drug and \$5 for any other drug.

Co-Insurance

A cost-sharing requirement where the insured person pays a portion of the costs of covered services. For example, under the standard Part D benefit, in 2006 beneficiaries will pay co-insurance equal to 25% of their total drug costs between \$250 and \$2,250.

Medicare Part D Acronyms

CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
FFS	Fee-for-Service
FPL	Federal Poverty Level
HMO	Health Maintenance Organization
MA	Medicare Advantage
MA-PD	Medicare Advantage Prescription Drug Plan
MCO	Managed Care Organization
MMA	Medicare Modernization Act
MTMP	Medication Therapy Management Program
NCPD	National Council for Prescription Drug Programs
OEPI	Open Enrollment Period for Institutionalized Individuals
PA	Prior Authorization
PACE	Program of All-Inclusive Care for the Elderly
P&T	Pharmacy and Therapeutics
PBM	Pharmacy Benefit Manager
PBP	Plan Benefit Package
PDP	Prescription Drug Plan
PDL	Preferred Drug List
PPO	Preferred Provider Organization
SEP	Special Enrollment Period
SPAP	State Pharmacy Assistance Program
TrOOP	True Out-Of-Pocket
USP	United States Pharmacopoeia



Cost Sharing

The total portion of the costs of covered services paid for by the beneficiary. Medicare Part D cost-sharing requirements include deductibles, co-insurance, and co-payments.

Coverage Gap

The portion of the Part D benefit structure in which beneficiaries pay 100% of their Part D medication expenditures. The coverage gap begins when total spending for drugs reaches \$2,250, exclusive of the beneficiary's monthly premium, and it ends when total spending for drugs reaches \$5,100 (generally equal to \$3,600 in total out-of-pocket spending for drugs). This is also called the "Doughnut Hole."

Coverage Year

A calendar year in which covered Part D drugs are dispensed. The claim for those drugs (and payment on the claim) must be made not later than three months after the end of the year.

Doughnut Hole

The portion of the Part D benefit structure in which beneficiaries pay 100% of their Part D medication expenditures. The doughnut hole begins when total spending for drugs reaches \$2,250, exclusive of the beneficiary's monthly premium, and it ends when total spending for drugs reaches \$5,100 (generally equal to \$3,600 in total out-of-pocket spending for drugs). This is also called the "Coverage Gap."

Dual Eligible

An individual who is eligible for both Medicare and Medicaid coverage.

Fee-For-Service

The traditional Medicare program, under which a fee generally is paid each time a service is used, with Medicare paying a share and the beneficiary paying the portion of the bill Medicare does not pay. Beneficiaries can choose any licensed/certified providers without referrals. This contrasts with managed care and other health plan options offered through Medicare Advantage.

Federal Poverty Level

The government's definition of poverty that is used to determine benefit levels for many low-income assistance programs, such as Medicaid, along with eligibility for certain Medicare Part D subsidies for low-income beneficiaries. The Census Bureau updates FPL each year. FPL in calendar year 2005 is \$9,570 for a single person and \$12,830 for a family of two in the contiguous United States.

Formulary

A list of specific drugs covered by a Part D drug plan. Formularies must include at least two drugs from each therapeutic category and class of covered outpatient drugs, but may exclude specific drugs within the categories or classes. If a Part D plan uses a formulary, it must establish a pharmacy and therapeutics (P&T) committee to develop and review that formulary.

Health Maintenance Organization

A type of managed care plan in which a group of doctors, hospitals, and other health care providers agree to deliver health care for a set reimbursement every month. The plan helps coordinate the health care with the individual and the providers that participate in the health plan. If an individual is enrolled in an HMO, he or she generally receives care from the providers in the HMO's network.

Long-Term Care Facility

For the purpose of Medicare Part D, CMS defines a long-term care facility as a skilled nursing facility, nursing facility, or medical institution where payment is made for an institutionalized individual under Medicaid. This also includes Intermediate Care Facilities for the Mentally Retarded and psychiatric hospitals. Not included in CMS' definition of a long-term care facility are assisted living facilities, boarding homes, or residential care homes.

Low-Income Subsidies

The amounts that CMS pays to cover certain cost-sharing obligations for enrollees with specified income levels. In general, assistance is provided on a sliding scale for beneficiaries with incomes between 100 percent and 135 percent of the federal poverty level.

Medicare+Choice (M+C) Program

The former name of the Medicare Part C program offering Medicare beneficiaries the option to receive their benefits through a health plan, such as a coordinated care plan (e.g., an HMO), a medical savings account plan, or a private fee-for-service plan. The MMA replaced the Medicare+Choice program with "Medicare Advantage," which offers additional plan options.

Medicare Advantage Program

The program that replaced the M+C program under Medicare Part C. Similar to M+C, Medicare Advantage offers Medicare beneficiaries the option of enrolling in a health plan to receive their Medicare benefits, although the Medicare Advantage program offers additional health plan options at the regional and local levels. Medicare Advantage plans must cover all Medicare benefits under Parts A and B, and may offer supplemental benefits.

Medicare Advantage Prescription Drug Plan

Medicare Advantage plans that include Part D prescription drug coverage.

Medicare HMO

An HMO that has contracted with the federal government under the Medicare Advantage program (formerly called Medicare+Choice) to provide health benefits to persons eligible for Medicare who choose to enroll in the HMO, instead of receiving their benefits through the traditional Medicare fee-for-service program.

Medicare Modernization Act

The Medicare Prescription Drug, Improvement and Modernization Act, which was signed into law by President Bush on December 8, 2003, and has come to be known as the Medicare Modernization Act or MMA. The MMA established the Medicare Part D prescription drug program.

Medicare Part A

Medicare's *hospital insurance* that helps pay for inpatient hospital stays, critical access hospital services, certain care in a skilled nursing facility, hospice care, and some home health care.

Medicare Part B

Medicare's *medical insurance* that helps pay for doctor's services, outpatient hospital care, durable medical equipment, and some medical services that aren't covered by Medicare Part A.

Medicare Part C

Created under the Balanced Budget Act of 1997, it includes the Medicare Advantage program (formerly called Medicare+Choice), through which beneficiaries can enroll in additional types of health plans, including managed care plans.

Medicare Part D

Created under the MMA, it features a voluntary outpatient prescription drug benefit beginning in 2006, along with an interim prescription drug discount card and transitional assistance programs.

Medication Therapy Management Program

Programs that focus on optimizing therapeutic outcomes for targeted beneficiaries through appropriate drug use. Part D drug plans are required to implement medication therapy management programs through which pharmacists or other qualified health professionals will target patients who have multiple chronic conditions, are taking multiple medications, and are likely to have high drug expenses.

Part D Drugs

In general, a Part D drug is available only by prescription, approved by the Food and Drug Administration (FDA), used and sold in the United States, and used for a medically-accepted indication. More specifically, Part D drugs include prescription drugs, biological products, insulin, certain vaccines, and certain medical supplies associated with the injection of insulin (syringes, needles, alcohol swabs, and gauze). Certain classes of drugs are excluded from the definition of a Part D drug, including drugs that may be excluded from coverage under Medicaid and drugs that are covered under Medicare Part A or Part B. A "covered Part D drug" is a Part D drug included on a drug plan's formulary.

Part D Eligible Individual

An individual who currently is entitled to receive Medicare benefits under Part A or who is enrolled in Part B. Eligible individuals can elect to enroll in a PDP or MA-PD plan in the service area where they live.

Part D Plan

A prescription drug plan, a Medicare Advantage prescription drug plan, or a Program of All-Inclusive Care for the Elderly ("PACE") plan or cost plan offering qualified Part D prescription drug coverage.

Pharmacy and Therapeutics Committee

An independent committee of healthcare practitioners whose purpose is to evaluate the relative safety, efficacy, and effectiveness of drugs within a class of prescription drugs and make formulary recommendations accordingly. Part D drug plans that use formularies must establish a P&T committee meeting certain standards.

Prescription Drug Plan

Part D prescription drug coverage that is offered to beneficiaries enrolled in Medicare fee-for-service by a plan sponsor under a contract with CMS. A PDP sponsor may offer more than one prescription drug plan.

Prescription Drug Plan Region

A geographic area in which a Part D drug plan provides access to covered Part D drugs. CMS has established 26 Medicare Advantage regions and 34 prescription drug plan regions.

PDP Sponsor

An entity that offers a prescription drug plan under Medicare Part D.

Preferred Provider Organization

A type of Medicare Advantage plan in which covered individuals use doctors, hospitals, and providers that belong to the plan network. The PPO may allow beneficiaries to use doctors, hospitals, and providers outside of the network for an additional cost.

Premium

The monthly payment for healthcare coverage made to an insurance or healthcare plan. Medicare Parts B and D are voluntary programs that require the payment of premiums.

Prior Authorization

A requirement that a beneficiary receive approval from a health insurer or drug plan in advance of receiving certain medical items or services. Part D drug plans may use prior authorization requirements as part of their drug utilization management programs.

Re-Insurance Subsidy

The supplemental payments CMS will make to Part D plans for enrollees whose annual out-of-pocket drug expenditures exceed the catastrophic cap threshold (\$3,600 in 2006).

Risk Adjusters

The CMS adjustments to the payments made to Part D plans based upon the health status of the plans' enrollees.

Special Enrollment Period

Special Enrollment Periods permit a Part D beneficiary to change plans without penalty in a number of circumstances, including, among others, if the beneficiary involuntarily loses certain other drug coverage, the individual is a full-benefit dual eligible individual, the individual moves outside of the region where the PDP is offered, or the beneficiary enters or leaves a long-term care facility.

State Pharmacy Assistance Program

A state-funded program that provides low-income and medically needy senior citizens and individuals with disabilities financial assistance for prescription drugs. Under the Part D drug program, SPAPs must meet a number of new requirements, including a requirement that the SPAP provide financial assistance for the provision of supplemental prescription drug coverage on behalf of Part D eligible individuals without discriminating based upon the Part D plan in which an individual enrolls.

Standard Prescription Drug Coverage

Standard prescription drug coverage consists of coverage of covered Part D drugs subject to an annual deductible; 25 percent co-insurance (or an actuarially equivalent structure) up to an initial coverage limit; and catastrophic coverage after an individual incurs out-of-pocket expenses above a certain threshold.

Step Therapy

A requirement that certain drugs be used only after preferred "first line" drugs have been tried and shown to be ineffective or inappropriate for safety reasons. Part D drug plans may use step therapy requirements as part of their drug utilization management programs.

Transition Process

The procedures Part D plans are required to establish to ensure clinically appropriate care for enrollees who are transitioning to Part D from other coverage, and whose current drug therapies may not be covered under the Part D plan's formulary.

True Out-Of-Pocket Costs

The portion of prescription drug expenses incurred by an individual in a Part D plan. Under Medicare Part D, TrOOP will be tracked to determine when a beneficiary reaches the coverage gap and when a beneficiary qualifies for catastrophic coverage.

United States Pharmacopoeia

An independent medication standard setting entity based in Bethesda, Maryland. For MMA, the USP developed a model set of guidelines listing drug categories and classes that may be used by Part D plan sponsors to develop formularies. The final USP guidelines list 146 unique therapeutic categories and pharmacologic classes. While conformance with the USP guidelines is voluntary, it would protect a plan from charges that its formulary classifications violate the MMA by substantially discouraging enrollment of certain individuals.



Omnicare

The prescription for positive outcomes®