Cornell University College of Human Ecology

CURxED Cornell University Resource Education for Medicare Part D

GLOSSARY OF TERMS

Term	Definition
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 ($265 for 2007).
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	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.
Assets	Assets are used to determine if a person is eligible for Low Income Subsidy. A primary residence and one car are not included. Assets of both spouses, if married and living in the same household, will be added together to determine eligibility for extra help. The same is true in determining the value of income.
Auto Enrollment	The Center 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 selected by your plan and is used as a benchmark for certain determinations.
Beneficiary	The person or entity designated to receive the benefits from the insurance company.
Benefit	Another name for coverage. For example, your benefits are the prescription drug costs paid for you by your prescription drug plan.
Benefit Percentage	The percentage of covered expenses that your plan pays after you meet your deductible.
Benchmark Plan	A Medicare Part D plan that meets just the minimum requirements laid out by the Center for Medicare and Medicaid Services.
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. 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 (CCE)	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://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.
Deductible	The amount you pay to purchase care or prescriptions before your benefit coverage begins.
Deemed Eligibles	People with Medicare and Medicaid and those receiving Supplemental Security Income are automatically eligible for the extra help and are "Deemed Eligible". These people do not need to apply for the extra help because they are automatically eligible.
Disenroll	When you disenroll, you end your coverage in a prescription drug or other health plan. Your plan can choose to disenroll you under specific circumstances.
Dose Restriction	The formulary may limit the number of doses available on a particular drug even if the prescription calls for more doses. 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 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.
Effective Date	The date your insurance is to actually begin. You are not covered until the policies effective date.

Elderly Pharmaceutical Insurance Coverage Program (EPIC)	A New York State sponsored prescription plan for senior citizens who need help paying for their prescriptions. www.health.state.ny.us/health_care/epic/
Eligible Drugs	A list of prescription drugs that are covered by a particular Part D plan. Drugs listed on the formulary are also called eligible drugs. A formulary can also be called a preferred-drug list (PDL), or a select drug list.
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 medically necessary for some other reason.
Exclusions	Items not covered by an insurance policy. Part D drug plans have two types of exclusions. The first type is the drugs that Medicare has excluded from coverage under Part D, no Part D plan will cover these. The second type is the drugs excluded from a particular plan's list of covered drugs, or formulary, this list varies by Part D plan.
Facilitated Enrollment	The Center 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 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.
Full-Subsidy	The full subsidy pays for the entire premium and deductible for recipients, and nearly all of the cost-sharing. The beneficiary pays a co-payment of $3 per brand and $1 per generic prescription until their total drug spending has reached $5,100. To qualify for a full subsidy low-income, beneficiaries need to be below 135% of the Federal Poverty Level.
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.
Generic Substitution	Dispensing of a generic drug in place of a brand name drug. Generic drugs must contain the same active ingredients as the brand name drugs.
Grievance	A grievance is a complaint about the way your prescription drug plan is providing services. For example, you may file a grievance if you have a problem calling the plan or if you're unhappy with the way a plan employee acted. You would not file a grievance to complain about a treatment decision or a service that is not covered; you would file an appeal.
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 life-time 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	A late penalty in the form of a 1% per-month higher premium must be paid by you 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.
Long Term Care Insurance Education Outreach Program (LTCIEOP)	This program informs and educates the general public about long term care insurance. Long term care is provided to people who are unable to perform the basic tasks of everyday living on their own for an extended period due to chronic medical, physical, or disabling injuries. http://www.nyspltc.org/
Mail Service Pharmacies	Mail-service 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 (MA-PD)	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 to their enrollees in addition to the above covered services.
Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA 2003)	The law signed into action for Medicare to provide the benefit of prescription drugs insurance utilizing tax breaks and subsidies so that private insurance companies may offer this coverage. This legislation is also known as Medicare Part D.
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 Savings Program	Medicaid programs that provide premium and cost-sharing assistance to Medicare beneficiaries with low-incomes and resources. These programs are for those who do not qualify for Medicaid. Individuals enrolled in these programs QMB, SLMB, QI - will be automatically deemed eligible for the low-income subsidy.
Medication Therapy Management (MTM)	Medication Therapy Management is a distinct service or group of services, 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 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-Network Pharmacy	A licensed pharmacy that is not under contract with a Part D sponsor to provide negotiated prices to Part D plan enrollees.
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 doughnut hole
Original Medicare Plan	A fee-for-service health plan that lets you go to any doctor, hospital, or other health care supplier who accepts Medicare and is accepting new Medicare patients. You must pay the deductible. Medicare 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).
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 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.
Patient Assistance Program (PAP)	Programs that provide indiviuals with limited resources increased access to prescription drugs.
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.
Pharmacy Network	This is the group of pharmacies who have contracted with the Prescription Drug 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.
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 is 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 that are taken into account to predict your expected spending to 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.
Sponsor	A non-governmental entity approved by Medicare to offer a Prescription Drug Plan.
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. http://www.shiptalk.org
State Pharmaceutical Assistance Program	SPAP programs exist in 22 states. They provide assistance to residents to purchase prescription drugs. Most programs are aimed at the elderly who lack other prescription drug coverage and many are limited to persons with low or moderate 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. If Drug A does not work for you, then the plan will cover Drug B.
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.
Therapeutic Substitution	Refers to a plan's request that the patient's physician prescribes an alternate, preferred drug in the same category or class.

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.
Transition Supply	A temporary, one-time amount of medication to be supplied by a pharmacy and covered by a prescription insurance plan to prevent interruptions in treatment when you have been stabilized on a treatment regimen and first enroll in a new plan.
True Out of Pocket Costs (TrOOP)	The amount that you actually pay, in addition to help from family members, Medicare’s new low-income subsidy, a state pharmacy assistance program, and charities that are not affiliated with a former employer. If a beneficiary pays out-of-pocket for a medication that is not considered a covered Part D drug, this cost does not count toward TrOOP.
Veterans Administration (VA)	This federal department serves America’s veterans and their families ensuring that they receive medical care, benefits, and social support. http://www.va.gov/

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