

Medicare Glossary of Key Terms

Tiered Cost Sharing

A process of grouping Part D drugs into different levels within a PDP sponsor's formulary.

True Out-of-Pocket Costs (TrOOPs)

The portion of cost sharing incurred by the individuals in a health plan. Under Medicare Part D, TrOOP will be counted to determine when a beneficiary reaches the coverage gap and when a beneficiary qualifies for catastrophic coverage.

Wraparound Benefits

When a state or other organization helps defray the out-of-pocket costs incurred by a Medicare beneficiary under Part D. The final Part D regulations clarify situations in which wraparound payments made on behalf of the individual will count toward the individual's TrOOP. It is unclear as to which secondary sources will choose to wraparound and to what extent they will do it. For example, some state SPAPs may choose to provide wraparound coverage for individuals who are eligible for that state's program.

The new Medicare prescription drug coverage, which begins January 1, 2006, comes with new terminology. This glossary will define many of the new words and phrases that are commonly used to explain this new benefit.

Auto-Enrollment

A process by which certain individuals may be automatically enrolled in Medicare Part D, regardless of whether they actively sought enrollment. Full-benefit dual eligibles (ie, those eligible for both Medicare and Medicaid) who do not actively choose a Part D plan will be auto-enrolled into a qualifying Medicare Part D plan to receive their prescription benefits.

Beneficiary

An elderly or disabled person who has health insurance through the Medicare program.

Centers for Medicare & Medicaid Services (CMS)

The federal agency responsible for administering Medicare and parts of Medicaid (formerly the Health Care Financing Administration).

Cost Sharing

Many insurance policies require the insured person to pay a portion of the costs of covered services. Medicare Part D cost-sharing requirements may include deductibles, copayments, and coinsurance, as well as gaps in coverage (sometimes referred to as the "Doughnut Hole").



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Deductible

Money or value of services that beneficiaries must cover before costs (or percentages of costs) are covered by their health plan. In 2006, the standard Part D deductible will be \$250.

Doughnut Hole

The standard benefit structure for Medicare Part D defined in the new Medicare law includes a "gap" in coverage (between \$2250 and \$5100 in total drug costs) during which a beneficiary may be responsible for paying 100% of their drug costs. Differences in benefit design and secondary payor assistance (eg, State Pharmaceutical Assistance Program, employer coverage) may be available, in some cases, to fill this gap.

Dual Eligible

An individual who is eligible for both Medicare and comprehensive Medicaid coverage. Drug coverage under Medicaid for these individuals will cease December 31, 2005.

Fail-First Program (Step Therapy)

A cost-containment mechanism that requires providers to try preferred/generic treatments and prove they are ineffective for a given patient before a nonpreferred treatment will be covered.

Federal Poverty Level (FPL)

The government's working definition of poverty that is used to determine benefit levels for many low-income assistance programs, such as Medicaid and Medicare Part D subsidies. The Census Bureau updates the FPL each year;

the FPL in 2005 is \$9570 for a single person and \$12,830 for a family of two in the contiguous United States.

Fee-for-Service (FFS) Medicare

Traditional Medicare. A defined benefit program that guarantees a defined range of services to all eligible persons.

Formulary

A list of drugs reimbursed by a drug plan. Part D plans are encouraged to use formularies. Many formularies contain three different "tiers" that dictate the patient cost-sharing amounts. Other formularies deny coverage of "off formulary" products.

Late Enrollment Penalty

Currently, individuals who do not enroll in Medicare Part B when they are first eligible to do so must pay a penalty for every month they have not participated. Under the new law, similar late enrollment penalties will be imposed for individuals who enroll in Part D after the initial enrollment period or who fail to maintain continuous coverage during the period of non-enrollment.

Medicaid

A joint federal and state program that helps with medical costs for certain people with low incomes and limited resources. Medicaid programs vary from state to state, but most healthcare costs are covered if a beneficiary qualifies.

Medicare Advantage (MA) Program

The program that offers Medicare beneficiaries the option of enrolling in a managed care plan to receive their Medicare benefits (both medical and drug coverage). The program replaces the Medicare + Choice (M+C) program under Part C in Medicare.

Medicare Advantage Prescription Drug Plan (MA-PD)

Medicare Advantage plans approved by CMS to offer a prescription drug benefit under Part D.

Medicare Part A

Covers inpatient hospital care, inpatient drugs, some skilled nursing facility care, some home health agency services, and hospice care. Eligible Medicare beneficiaries are automatically enrolled in Part A.

Medicare Part B

Covers physician services, outpatient care, medical equipment and supplies, drugs administered in a doctor's office and immunosuppressants, and other medical services not covered under Part A (the drug coverage under Part B will not change with the advent of Part D). Enrollment in Part B is optional (but 94% of those eligible were enrolled in 2002), and beneficiaries pay monthly premiums and an annual deductible.

Medicare Part C

Medicare Part C refers to private managed care plans that offer Parts A and B services together. (See also Medicare Advantage Program.)

Medicare Part D

Created under the Medicare Modernization Act of 2003 (MMA), it is a voluntary outpatient prescription drug benefit for Medicare beneficiaries that begins in 2006.

Medigap

A Medicare supplemental insurance policy sold by private insurance companies to fill "gaps" in original Medicare coverage. Some Medigap plans currently offer limited drug coverage. Those plans can be "grandfathered" for current enrollees, but no new plans with drug coverage will be offered after January 1, 2006.

Negotiated Prices

Defined by law to mean prices for covered Part D drugs that take into account discounts, subsidies, rebates, and other price concessions from pharmaceutical companies and include any dispensing fees. Prescription drug plan sponsors and MA organizations are required to provide their enrollees with access to negotiated prices for covered Part D drugs included in the plans' formularies.

Patient Assistance Program (PAP)

A program administered by a pharmaceutical manufacturer that provides assistance with prescription drug costs. PAPs often offer free and discounted prescription drugs to those who qualify. It is unclear how these programs will or can interact with Medicare Part D.

Pharmacy Benefit Managers (PBMs)

Independent administrators who focus exclusively on providing pharmacy benefits and who are typically engaged by large employers, managed care plans, or the government.

Premium

The monthly payment for healthcare coverage to an insurance or healthcare plan. Medicare Parts B and D require payment of premiums.

Prescription Drug Plan (PDP)

PDPs, pursuant to a contract with CMS, will offer prescription drug coverage to beneficiaries enrolled in fee-for-service Medicare.

Preventive Care Services

The MMA expands preventive care services under Medicare Part B to include coverage of an initial preventive physical examination, cardiovascular screening blood tests, and diabetes screening tests. It also improves payment for certain mammography services.

Prior Authorization (PA)

A cost-containment tool sometimes used by health and drug plans that requires advance approval from the plan prior to providing coverage for particular services or procedures.

Regions (PDPs and MA-PDs)

CMS-defined areas in which a contracting PDP or MA-PD provides access to covered Part D drugs.

Standard Benefit

The standard Medicare Part D drug package in 2006 has an annual deductible of \$250 and beneficiary coinsurance of 25% for spending

above the deductible and up to the initial coverage limit of \$2250. The enrollee then pays 100% of the negotiated price between this initial coverage limit and the stop-loss threshold of \$5100 in total Rx spending (\$3600 in out-of-pocket drug spending). After reaching that threshold, an enrollee pays the greater of \$2 for generics, \$5 for brand drugs, or 5% coinsurance.

Plans may alter certain aspects of the benefit design (eg, lowering the annual deductible or reducing cost sharing above the initial coverage limit), as long as the design provides benefits at least "actuarially equivalent" to, or richer than, the standard Part D benefit.

State Pharmaceutical Assistance Program (SPAP)

Program operated by or under contract with a state to provide financial assistance for the purchase or provision of supplemental prescription drug coverage or for benefits on behalf of Part D eligible individuals. SPAP interaction with Part D plans will vary by state.

Subsidy-Eligible Individual

Part D eligible individual who is enrolled in a PDP or MA-PD plan, has an income below 150% of the FPL, and meets certain resource requirements. These individuals are eligible to receive extra help from CMS on the cost of their prescription drugs.

Therapeutic Classification System

System that lists categories and classes of drugs, which PDPs may use to design their formularies.