

**Medicare Part D Enrollment for Community Pharmacy  
GLOSSARY**

<b>Acronym or Term</b>	<b>Definition</b>
Actuarially equivalent	A prescription drug coverage plan is actuarially equivalent to the standard Part D benefit if it is considered to be at least as good as the standard benefit, from an insurance standpoint.
Annual coordinated election period	<p>The annual coordinated election period is the time when beneficiaries may change among MA-PDs and PDPs, or when they can enroll in these plans if they were not previously enrolled.</p> <p>This period will run from November 15 through December 31 every year starting in 2006.</p> <p>Note that this period is distinct from initial enrollment periods and special enrollment periods.</p>
Any willing provider	Any willing provider requirements in the Medicare law mean that PDP and MA-PD sponsors are required to permit any pharmacy willing to accept the plan's terms and conditions to participate in the plan's pharmacy network.
Benefit management tools	These are tools that MA-PDs and PDPs may use to control costs. They may include strategies such as prior authorization and step therapy.
Catastrophic coverage	Under the standard benefit, patients will receive catastrophic coverage after they reach \$3,600 in TrOOP costs in 2006. After they reach this amount, the beneficiary will pay the greater of 5% or \$2 for generics and \$5 for brands.
Centers for Medicare and Medicaid Services (CMS)	CMS is a federal agency that operates within the U.S. Department of HHS. It administers the Medicare program and works in partnership with the states to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards.
Coverage determination	A determination by the plan whether a medication is covered, and at what tier of the formulary.
Creditable coverage	Prescription drug coverage that is at least actuarially equivalent (equal to or greater in value from an insurance standpoint) to the standard benefit. Beneficiaries who have such coverage will not have to pay late enrollment penalties if they later enroll in an MA-PD or PDP.

Deductible	<p>The amount beneficiaries have to pay out-of-pocket for medications before receiving benefits. (This amount is separate from monthly premiums.)</p> <p>Under the standard Part D benefit, beneficiaries have a \$250 deductible in 2006.</p> <p>Beneficiaries who receive low-income benefits and have income greater than 135% and up to 150% of the federal poverty level pay a \$50 deductible. Those with incomes up to 135% pay no deductible.</p>
Deemed eligible	<p>A beneficiary is “deemed eligible” if CMS has determined that the beneficiary will receive the low-income benefits for 2006, and will not need to apply.</p> <p>Deemed eligible beneficiaries include those who receive Medicaid, Supplemental Security Income, or are enrolled in Medicare Saving Plans.</p>
Drug tier	<p>As part of their formularies, PDPs and MA-PDs can cover different medications at different tiers, or levels. This is true even though the standard benefit calls for a 25% coinsurance.</p> <p>For example, a plan could establish a formulary with 10% coinsurance for the first tier, 20% for the second tier, and 30% for the third tier.</p>
Dual eligible	<p>A dual eligible beneficiary is someone who receives both Medicare and Medicaid.</p>
Federal poverty level (FPL)	<p>In February of each year, the federal government releases an official income level for poverty called the Federal Poverty Guidelines, and often informally referred to as the “Federal Poverty Level.” For 2005, the FPL for a single person is \$9,570; for a family of four it is \$19,350. The benefit levels provided under many low-income and other social assistance programs, including Medicare, are based on these poverty figures.</p> <p>This measure is used to determine individuals who are eligible to receive low-income prescription drug benefits under Medicare Part D.</p>
Federally Qualified Health Center (FQHC)	<p>FQHCs are health care entities and organizations that receive grants under section 330 of the Public Health Service Act, certain tribal organizations such as Indian Health Centers (IHC), and FQHC Look-Alikes. These entities primarily serve low-income and special populations.</p>

Food and Drug Administration (FDA)	FDA is a federal agency that operates within the U.S. Department of HHS. Among other responsibilities, it is responsible for ensuring that human and veterinary drugs, biological products, and medical devices are safe and effective.
Formulary	A prescription drug plan's list of drugs that are included in the plan (i.e., "covered"), and the level at which they are covered. Such lists used to help plans control prescription drug costs and are allowed as part of Medicare prescription drug plans.
Formulary exception	When a nonformulary drug is covered as though it were a formulary drug, or if a drug on a nonpreferred tier of a formulary is covered as though it were preferred.  Plans must have specific coverage determination and appeals processes in place to make formulary exceptions.
Gap in coverage	In 2006, under the standard benefit, beneficiaries will pay 100% of their prescription drug costs after they reach \$2,250 in total prescription drug spending, until they reach \$5,100 in total prescription drug spending (\$3,600 in TrOOP costs).
Grievance	A complaint about quality of care or other aspects of treatment that is distinct from formulary coverage determinations.
Health and Human Services (HHS)	This federal agency oversees many different health care-related agencies including the National Institutes of Health (NIH), CMS, FDA, and the Centers for Disease Control and Prevention (CDC) among others.
Initial enrollment period	For beneficiaries who are 65 years of age as of January 31, 2006, the initial Part D enrollment will run from November 15, 2005, through May 15, 2006. (Coverage will begin on January 1, 2006).  For beneficiaries who become eligible after this date, the initial enrollment period begins on the first day of the third month before eligibility begins, and lasts for 7 months. For example, if a beneficiary's birthday were in June 2006, the initial enrollment period would be March 1, 2006, through September 30, 2006.
Level playing field	A term that describes a provision of the Medicare law that allows community pharmacies to provide a 90-day supply of medication, similar to the service provided by mail-service pharmacies. Beneficiaries are not responsible for differences in negotiated prices, but are responsible for any higher cost sharing associated with providing the drug at a network community pharmacy rather than a network mail-service pharmacy.

Low-income benefit	A more comprehensive benefit that is provided on a sliding scale to beneficiaries with incomes up to 150% of the FPL. Patient materials provided by CMS refer to the low-income benefit as “extra help.”
Medically accepted indication	<p>An indication is the intended use of a medication. For example, an antihistamine could be used to treat allergies or to treat insomnia. Allergies and insomnia are two different indications.</p> <p>Medications covered for an MA-PD or PDP must be used for medically accepted indications. The final regulations define such indications as those that are approved by the FDA, or are in at least one of several authoritative compendia. Indications that are only supported by peer-reviewed research are not included in this definition.</p>
Medicare Advantage – Prescription Drug (MA-PD)	A Medicare prescription drug program that is provided through a Medicare Part C Medicare Advantage managed care program.
Medicare Modernization Act (MMA)	The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173) was signed into law on December 8, 2003. Since its enactment, it has been referred to as the Medicare Modernization Act. This legislation provides seniors and individuals with disabilities with a prescription drug benefit (Part D).
Medication therapy management (MTM)	A new type of program that all PDPs are required to provide to targeted beneficiaries. These programs must be designed to promote enhanced enrollee understanding and appropriate use of medication, improved adherence, and detection of adverse events.
Nonpreferred drug	A drug that is included on a plan’s formulary, but not at the best possible cost sharing.
Nonpreferred pharmacy	A pharmacy that is part of a plan’s network and can be counted toward meeting the plan’s access standards, but that does not provide prescription medications at the best possible cost sharing.
Part A	The part of Medicare that covers inpatient care in hospitals, skilled nursing facilities, hospice care, and some home health care. Many medications provided in these settings are covered through Part A.

Part B	<p>The part of Medicare that covers outpatient care, such as that provided by physicians, physical therapists, and occupational therapists, as well as some medical devices.</p> <p>Certain medications are covered by Part B, including drugs provided “incident to” a physician’s service, durable medical equipment supply drugs, immunosuppressive drugs for beneficiaries who receive Medicare-covered organ transplants, hemophilia clotting factors, oral anticancer drugs, oral antiemetic drugs used as part of an anticancer chemotherapeutic regimen, pneumococcal vaccine, and hepatitis B vaccine for high-risk individuals, influenza vaccine, antigens, erythropoietin, parenteral nutrition, and intravenous immune globulin provided in the home.</p>
Part C	The part of Medicare that refers to Medicare Advantage managed care plans. If prescription drug coverage is included as part of a Part C plan, it is referred to as an MA-PD.
Part D	The part of Medicare that refers to both stand-alone prescription drug plans, referred to as PDPs, and Medicare Advantage prescription drug plans, referred to as MA-PDs.
PDP	A Medicare prescription drug program that is provided through a stand-alone Medicare Part D plan.
Preferred drug	A drug that is included on a plan’s formulary at a favorable cost sharing.
Preferred pharmacy	A pharmacy that is part of a plan’s network and that has reduced cost sharing for beneficiaries.
Premium	A monthly fee that beneficiaries must pay to plans in order to maintain enrollment in the plan. (Estimated to average \$37 in 2006.)
Redetermination process	The process through which a beneficiary can appeal a plan’s coverage determination.
Special enrollment period	A period other than the initial enrollment period and annual coordinated election period during which a beneficiary can enroll in an MA-PD or PDP. A variety of conditions, such as loss of creditable coverage, make beneficiaries eligible for special enrollment periods.

Standard benefit	The prescription drug benefit defined by law that PDPs and MA-PDs offer to non-low-income beneficiaries. The benefit includes a monthly premium, an annual deductible, coinsurance, a gap in coverage, and catastrophic coverage for high drug costs. However, PDPs and MA-PDs can vary their actual benefits as long as they are actuarially equivalent to the standard benefit.
State Pharmaceutical Assistance Programs (SPAP)	<p>Programs that provide pharmaceutical coverage or assistance, primarily to low-income elderly or persons with disabilities who do not qualify for Medicaid. Most programs utilize state funds to subsidize a portion of the costs, usually for a defined population that meets enrollment criteria such as age and/or income limits.</p> <p>For the purposes of the Medicare law, an SPAP is defined as a state program that provides financial assistance for the purchase or provision of supplemental prescription drug coverage or benefits on behalf of a Part D-eligible individual. Each state that offers an SPAP will determine how its program will work with the Medicare benefits.</p>
Targeted beneficiary	An individual who is eligible for MTM services. These individuals must be Medicare Part D enrollees who have multiple chronic diseases, take multiple covered Part D drugs, and are expected to incur annual prescription drug costs of at least \$4,000 in 2006.
Transition supply	A temporary, one-time amount of medication to be covered by a PDP or MA-PD to prevent interruptions in treatment when beneficiaries who are stabilized on treatment regimens first enroll in a PDP or MA-PD.
TRICARE	A U.S. Department of Defense regionally managed health care program for active duty and retired members of the uniformed services and their families that combines military health care resources and networks of civilian health care professionals.
TRICARE pharmacy access standards	The minimum requirements for PDP and MA-PD pharmacy network access to community pharmacies.
True out-of-pocket costs (TrOOP)	<p>The amount that the beneficiary actually pays, in addition to help from family members, Medicare's new low-income subsidy, SPAPs, 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.</p> <p>(Wrap-around benefits provided by certain groups, such as former employers, do not count toward TrOOP.)</p>

<p>USP classification system</p>	<p>MMA directed the U.S. Pharmacopeia (USP) to develop a list of categories and classes that may be used by prescription drug plans to structure their formularies.</p> <p>USP's Medicare Model Guidelines consist of a listing of therapeutic categories and associated pharmacologic classes that create a framework that prescription drug plans may follow as they create a drug plan formulary. This classification system serves as a safe harbor for Part D plans that have at least two drugs available within each category and class.</p> <p>The USP classification system is available online at <a href="http://www.usp.org/healthcareInfo/mmg">www.usp.org/healthcareInfo/mmg</a>.</p>
<p>Wrap-around</p>	<p>Additional coverage from a third party that is designed to complement coverage available through MA-PDs and PDPs. For example, a former employer may choose to provide coverage that wraps around the standard benefit, and pays the beneficiary's annual deductible and coinsurance, and/or covers costs during the gap in coverage. Another example is Medicaid plans choosing to cover benzodiazepines, which are excluded from Part D coverage.</p>