

Glossary

Appeal: the process by which a beneficiary may challenge an exception denial.

Assets: an item of financial value such as cash, deposit accounts, IRAs, stocks, bonds, mutual funds, or the cash-surrender-value of either "whole life" or "universal life" insurance policies.

Beneficiary: within the Medicare program, a beneficiary is an individual, normally 65 years old or older, receiving Medicare insurance benefits.

Benefit: benefit is sometimes used to refer to insurance coverage as a whole or a feature of the insurance coverage.

Brand Name: any drug or medication marketed under a proprietary trademark-protected name.

Catastrophic Coverage: a government program that protects beneficiaries in Medicare Part D and Part C from exceedingly large out-of-pocket expenses for medications. The minimum amount of out-of-pocket expenses to qualify for catastrophic coverage is set on an annual basis and applies only to on-formulary medication expenses incurred within a single calendar year.

Centers for Medicare & Medicaid Services: also known as CMS, the federal agency that administers Medicare and Medicaid Services and promotes awareness of the programs among beneficiaries, health care professionals, and the general public.

Co-Insurance: a fixed percentage of the price of a medication paid by the beneficiary for a medication that is included in the plan's formulary.

Co-Payment: a fixed dollar amount paid by the beneficiary for a medication that is covered in the beneficiary's insurance plan's formulary.

Cost Sharing: out-of-pocket medication expenses that are paid by a participant within an insurance plan. Examples of cost sharing include co-payments, co-insurance, and deductibles.

Cost Utilization Measures: special conditions that an insurance plan places on individual medications covered by the plan's formulary. These restrictions include any requirement to obtain the plan's permission to use a specific drug, limits on the quantity of a drug, or the requirement to have you try less expensive drugs before the plan will approve a more expensive drug.

Creditable Coverage: creditable coverage is a term used by Medicare to describe a non-Medicare health plan that is considered to be at least as good as the coverage offered by a standard Medicare prescription drug plan. Beneficiaries who have creditable coverage instead of the Medicare prescription drug plan will not face a penalty if they decide to enroll in the Medicare prescription drug plan at a later date.

Deductible: the dollar amount a beneficiary must pay for medication before an insurance plan will begin to make payments for medication or health care.

Donut Hole: a euphemism used for the discontinuation of medication cost sharing by a Part D plan after the initial coverage benefit is exhausted and before the medication costs reach the threshold where the Part D enrollee qualifies for the "catastrophic" program. Given the absence of cost sharing, the beneficiary will pay full price for a medication in the donut hole. The donut hole will be phased out between 2010 and 2020. Also referred to as the "gap."

Dosage: a specific quantity of a medication to be taken by a patient within a specified period or interval.

Dual Eligible: a person who participates both in the Medicare and the

Medicaid programs simultaneously.

Earned Income: money received in the form of wages, salary, self-employment, tips, commissions, and bonuses.

Election Periods: times when an individual is eligible to enroll in a Medicare Prescription Drug plan, Medicare Advantage plan, or Medicare Supplement Insurance plan.

Estimated Annual Cost: out-of-pocket expenses we expect you to pay in a calendar year given a specific insurance plan's monthly premium, annual deductible, and your co-payments (or co-insurance fees) for the medications entered within our Medicare plan comparison tool.

Exception: the process by which a beneficiary requests that his or her health plan provide coverage for a medication that is not on the plan's formulary. A beneficiary may also request an exception if the medication is a non-preferred drug on the formulary, but is medically necessary and, therefore, should be treated as a preferred drug. If the plan does not grant an exception, the beneficiary has the right to appeal the exception decision.

Extra Help: also known as the Low Income Subsidy or LIS), this program reduces the beneficiary expenses (e.g. premiums, deductibles, co-payments, and co-insurance) for a qualifying enrollee in a Medicare Part D plan. Extra Help is administered by Social Security.

Federal Employees Health Benefit: health insurance provided to federal employees. Also known as FEHB, this program qualifies as "creditable coverage" for someone eligible for a Medicare Part D plan. In many cases, switching from FEHB drug coverage to a Medicare Part D plan would not result in increased benefits to the enrollee.

Federal Poverty Level: Also known as the FPL, the Federal Poverty Level is

the income level set by the federal government to identify individuals who are impoverished and may qualify for various forms of assistance.

Fee-for-Service: The system where a payment is made to a health care provider for each service provided.

Formulary: a list of preferred medications, both generic and brand name, covered by a particular health plan. If a medication is listed within a plan's formulary, that plan will pay a portion of the medication's expense. Medications not included in a plan's formulary will typically not be eligible for payment by the plan.

Generic: a medication with the same active ingredients in the same amounts as the brand name medication for which it substitutes. The FDA requires a variety of tests and procedures to ensure that a generic may be substituted for a brand name medication. Generic medications typically cost less than their brand name counterparts.

Health Care Provider: a professional (e.g. a doctor) or an organization (e.g. a hospital or clinic) that provides a health care service.

HMO: also known as Health Maintenance Organization, HMOs are a type of insurance plan. In HMOs, members pay a monthly premium for access to a specified group of health care professionals. Members are limited to these professionals for health care services. A member must also consult his or her primary physician within the HMO to obtain authorization for a specialized medical service.

In-Network: a doctor, pharmacy, or medical service provider that has entered into an agreement with a health plan and provides products and services according to that plan's policies.

Mail Order: medications that are obtained through mail as opposed to in-

person at a pharmacy.

Medicaid: a joint state/federal program that assists low-income individuals with medical costs.

Medical Supplies: non-medication health care items, such as bandages, that are covered by the Medicare program.

Medicare: a federal health insurance program for people 65 years old or older as well as individuals younger than 65 who have qualifying medical conditions such as ALS.

Medicare Advantage: a Medicare program that offers health plans through private insurance companies that contract with Medicare. These plans may be available with or without prescription drug plans.

Medicare Savings Programs: a collection of programs that help pay Medicare costs for those beneficiaries who have low incomes but do not qualify for Medicaid.

Medicare Supplemental Insurance: also known as Medi-gap, Medicare Supplemental Insurance covers various gaps within in the insurance coverage of Medicare Part A and Part B. 47 states have 10 standardized Medi-gap plans while Massachusetts, Minnesota, and Wisconsin have unique plans in their states.

Medigap: private insurance policies that cover gaps in Medicare's coverage of medical expenses.

Monthly Premium: the monthly cost you pay to be covered by an insurance plan.

More Expensive: this label is displayed on plans when the total annual cost spent on premiums and expenditures under the plan (at plan preferred

pharmacies) for medications entered by the user is projected to be a larger sum than would be the case for the user's existing drug coverage.

Network: a group of health care professionals (e.g. doctors) and facilities (e.g. hospitals and pharmacies) that are contracted to provide health care to a specific insurance plan's members.

Out-of-Network Provider: a health care professional or facility that is not contracted to provide health care services to members of a specific insurance plan.

Out-of-Pocket: medical expenses paid directly by the individual as opposed to a health insurance plan. Examples of out-of-pocket expenses include deductibles and co-payments.

Part A: the name for the Medicare program that provides hospitalization insurance.

Part B: the name for the Medicare program that provides medical insurance.

Part D: Part D is the name for the Medicare program that provides prescription drug coverage.

Plan Name and ID: the name of the insurance company's prescription drug plan as well as its identification code.

Premium: a payment, often monthly, to an insurance plan that enables the individual to receive insurance coverage.

Prescription Drug Plan: an alternative name for the Medicare Part D program that provides prescription drug coverage to Medicare participants.

Prior Authorization: a health plan restriction where an on-formulary medication must be approved by the plan before your prescription may be

filled.

Quantity Limit: a health plan restriction where the quantity of a prescription must remain within the maximum quantity allowed by the plan.

Savings: Savings are calculated given the user's input regarding prescription medications and the user's input regarding existing Medicare Part D or Part C plan. The baseline expenditure from which savings are calculated is based on the annual monthly premiums paid for the user's existing Part D/Part C coverage along with the associated annual cost-sharing for the medications entered by the user purchased at a preferred pharmacy associated with the user's existing Part D/Part C plan. This cost sharing included deductible, co-payment, and co-insurance within the coverage periods extrapolated from the monthly purchase of the entered medications in the same form, dosage, and quantity.

Prescription drugs not covered by an insurance plan's formulary were assigned an estimated retail drug price. If no medications were entered by the user, then only the annual cost of the existing Part D/Part C plan's monthly premium was used for the baseline expenditure. End users who did not enter existing prescription drug coverage were assumed to pay retail prices for the drug lists they entered based on estimated average retail prices for the drugs entered. An analogous calculation to the baseline expenditure is performed for the displayed plan containing the savings value. The savings amount was derived from subtracting the annual cost estimate for the displayed plan from the baseline expenditure described above. No savings were calculated when the user did not select an existing Part D/Part C plan and also did not enter any medications.

State Health Insurance Assistance Program: a program administered by the state that provides free health insurance counseling to Medicare beneficiaries.

Step Therapy: a health plan restriction where cheaper medicine must first be demonstrated as ineffective for a beneficiary before the beneficiary may use a more expensive medication.

TRICARE: a collection of Department of Defense health care programs serving active and retired military personnel as well as their family members.

Unearned Income: money you receive from sources other than employment such as social security checks, veteran's benefits, pensions, interest and dividends from investments, or income from rental property.

VA: abbreviation for the Veterans Administration.