

Medicare Prescription Drug Teleconference Glossary of Acronyms & Terms

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Note: words in the table of contents are hyperlinks to definitions contained within the document.

Annual Election Period:	3
CMS: Centers for Medicare and Medicaid Services	3
Coinsurance:	3
Coordination of Benefits:	3
Creditable Coverage:	3
Deductible:	3
Disenroll:	3
Dual Eligibles:	3
EGHP: Employer Group Health Plan	3
Election Periods:	4
Formulary:	4
FPL: Federal Poverty Level	4
Generic Drug:	5
HCBS: Home and Community-Based Service Waiver Programs	5
HSA: Health Savings Account.....	5
LIS: Low Income Subsidy	5
M+C: Medicare Plus Choice	5
MA: Medicare Advantage Plan	5
MA-PDP: Medicare Advantage Prescription Drug Plan.....	6
MMA: Medicare Modernization Act.....	6
MSA: Medicare Medical Savings Account Plan	6
MSP: Medicare Savings Program	6
Out of Pocket Costs:	7
Part A: Medicare Hospital Insurance.....	7
Part B: Medicare Outpatient Insurance.....	7

Part D: Medicare Prescription Drug Benefit.....	7
PDP: Prescription Drug Plan.....	7
PPO: Preferred Provider Organization.....	7
QI: Qualifying Individuals.....	7
QMB: Qualified Medicare Beneficiary.....	7
SLMB: Specified Low-Income Medicare Beneficiaries.....	8
SPAP: State Pharmacy Assistance Program.....	8
SSA: Social Security Administration	8
SSI: Supplemental Security Income.....	8
TrOOP: True Out of Pocket Expenses	8
USP: United States Pharmacopeia.....	8

Annual Election Period:

The Annual Election Period for Medicare beneficiaries is the month of November each year. Enrollment will begin the following January. Starting in 2002, this is the only time in which all Medicare+Choice health plans will be open and accepting new members. (See Election Periods.)

CMS: Centers for Medicare and Medicaid Services

The federal agency that runs the Medicare program. In addition, CMS works with the States to run the Medicaid program. CMS works to make sure that the beneficiaries in these programs are able to get high quality health care.

Coinsurance:

The percentage of the charge for services that you may have to pay after you pay any plan deductibles. In a Private Fee-for-Service Plan, the coinsurance payment is a percentage of the cost of the service (like 20%).

Coordination of Benefits:

Process for determining the respective responsibilities of two or more health plans that have some financial responsibility for a medical claim. Also called cross-over.

Creditable Coverage:

Any previous health insurance coverage that can be used to shorten the pre-existing condition waiting period. (See Pre-existing Conditions.)

Deductible:

The amount you must pay for health care before Medicare begins to pay, either for each benefit period for Part A, or each year for Part B. These amounts can change every year. (See Benefit Period; Medicare Part A; Medicare Part B.)

Disenroll:

Ending your health care coverage with a health plan.

Dual Eligibles:

Persons who are entitled to Medicare (Part A and/or Part B) and who are also eligible for Medicaid.

EGHP: Employer Group Health Plan

An EGHP is a health plan that:

- Gives health coverage to employees, former employees, and their families, and
- Is from an employer or employee organization.

Election Periods:

Time when an eligible person may choose to join or leave the Original Medicare Plan or a Medicare+Choice plan. There are four types of election periods in which you may join and leave Medicare health plans: Annual Election Period, Initial Coverage Election Period, Special Election Period, and Open Enrollment Period.

Annual Election Period: The Annual Election Period is the month of November each year. Medicare health plans enroll eligible beneficiaries into available health plans during the month of November each year. Starting in 2002, this is the only time in which all Medicare+Choice health plans will be open and accepting new members.

Initial Coverage Election Period: The three months immediately before you are entitled to Medicare Part A and enrolled in Part B. If you choose to join a Medicare health plan during your Initial Coverage Election Period, the plan must accept you. The only time a plan can deny your enrollment during this period is when it has reached its member limit. This limit is approved by the Centers for Medicare & Medicaid Services. The Initial Coverage Election Period is different from the Initial Enrollment Period (IEP).

Special Election Period: You are given a Special Election Period to change Medicare+Choice plans or to return to Original Medicare in certain situations, which include: You make a permanent move outside the service area, the Medicare+Choice organization breaks its contract with you or does not renew its contract with CMS; or other exceptional conditions determined by CMS. The Special Election Period is different from the Special Enrollment Period (SEP).

Open Enrollment Period: If the Medicare health plan is open and accepting new members, you may join or enroll in it. If a health plan chooses to be open, it must allow all eligible beneficiaries to join or enroll.

Formulary:

A list of certain drugs and their proper dosages. In some Medicare health plans, doctors must order or use only drugs listed on the health plan's formulary.

FPL: Federal Poverty Level

Guidelines issued each year in the Federal Register by the Department of Health and Human Services (HHS). The guidelines are a simplification of the poverty thresholds for use for administrative purposes — for instance, determining financial eligibility for certain federal programs.

Generic Drug:

A prescription drug that has the same active-ingredient formula as a brand name drug. Generic drugs usually cost less than brand name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand name drugs.

HCBS: Home and Community-Based Service Waiver Programs

The HCBS programs offer different choices to some people with Medicaid. If you qualify, you will get care in your home and community so you can stay independent and close to your family and friends. HCBS programs help the elderly and disabled, mentally retarded, developmentally disabled, and certain other disabled adults. These programs give quality and low-cost services.

HSA: Health Savings Account

Health Savings Accounts, are found in a separate title of the MMA and are regulated by the Department of the Treasury. Current Medicare beneficiaries are not eligible to create HSAs. Briefly, however, HSAs are tax-advantaged savings accounts established exclusively for the purpose of paying qualified medical expenses of the account beneficiary who, for the months for which contributions are made to an HSA, is covered under a high-deductible health plan. The HSA account can be used to pay for medical expenses incurred by individuals, their spouse or their dependents. No permission or authorization from the Internal Revenue Service (IRS) is necessary to establish an HSA. An HSA is established for the benefit of an individual, is owned by that individual, and is portable. An individual who is an employee may establish an HSA with or without involvement of the employer, and if the individual later changes employers or leaves the workforce, the HSA does not stay behind with the former employer, but stays with the individual.

LIS: Low Income Subsidy

Low-income Medicare beneficiaries will receive full or partial subsidies of premiums and reductions in cost sharing for the Medicare prescription drug benefit. Certain groups of Medicare beneficiaries will automatically qualify for the low-income subsidy program.

M+C: Medicare Plus Choice

Former name for current Medicare Advantage plans. A Medicare program that gives you more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease. An alternative to the Original Medicare Plan.

MA: Medicare Advantage Plan

A Medicare program that gives you more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who

have End-Stage Renal Disease (unless certain exceptions apply). Medicare Advantage Plans used to be called Medicare + Choice Plans. Medicare Managed Care Plans is a type of Medicare Advantage Plan that is available in some areas of the country. In most managed care plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some managed care plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

MA-PDP: Medicare Advantage Prescription Drug Plan

Medicare prescription drug plans that are a part of Medicare Advantage Plans (like HMOs), in some areas.

MMA: Medicare Modernization Act

On December 8, 2003, President George W. Bush signed into law the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108-173). This landmark legislation provides seniors and individuals with disabilities with a prescription drug benefit, more choices, and better benefits under Medicare.

MSA: Medicare Medical Savings Account Plan

A Medicare health plan option made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help you pay your medical bills.

MSP: Medicare Savings Program

Medicaid programs that help pay some or all Medicare premiums and deductibles.

There are programs that help millions of people with Medicare save money each year. States have programs for people with limited incomes and resources that pay Medicare premiums. Some programs may also pay Medicare deductibles and coinsurance. You can apply for these programs if: You have Medicare Part A (Hospital Insurance). (If you are eligible for Medicare Part A but don't think you can afford it, there is a program that may pay the Medicare Part A premium for you.), you are an individual with resources of \$4,000 or less, or are a couple with resources of \$6,000 or less. Resources include money in a savings or checking account, stocks, or bonds and You are an individual with a monthly income of less than \$1,031, or a couple with a monthly income of less than \$1,384. Income limits will change in 2006. If you live in Hawaii or Alaska, income limits are slightly higher. Note: If your income is less than the amounts listed above, you may qualify for Medicaid.

Out of Pocket Costs:

Health care costs that you must pay on your own because they are not covered by Medicare or other insurance.

Part A: Medicare Hospital Insurance

Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Part B: Medicare Outpatient Insurance

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

Part D: Medicare Prescription Drug Benefit

A very important new benefit available to Medicare beneficiaries beginning January 1, 2006. This new benefit will provide assistance to Medicare beneficiaries with the prescription drug coverage. The program is optional and requires beneficiaries to take action to enroll in the plan.

PDP: Prescription Drug Plan

Medicare prescription drug plans provide insurance coverage for prescription drugs. Insurance companies and other private companies will be working with Medicare to offer these drug plans and negotiate discounts on drug prices. These plans are different from the Medicare-approved drug discount cards that phase out by May 15, 2006, or when a beneficiary's enrollment in a Medicare prescription drug plan takes effect, if earlier.

PPO: Preferred Provider Organization

A type of Medicare Advantage Plan in which you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

QI: Qualifying Individuals

This is a Medicaid program for beneficiaries who need help in paying for Medicare Part B premiums. The beneficiary must have Medicare Part A and limited income and resources and not be otherwise eligible for Medicaid. For those who qualify, Medicaid pays a percentage or all of Medicare Part B premiums only.

QMB: Qualified Medicare Beneficiary

This is a Medicaid program for beneficiaries who need help in paying for Medicare services. The beneficiary must have Medicare Part A and limited income and resources. For those who qualify, the Medicaid program pays

Medicare Part A premiums, Part B premiums, and Medicare deductibles and coinsurance amounts for Medicare services.

SLMB: Specified Low-Income Medicare Beneficiaries

A Medicaid program that pays for Medicare Part B premiums for individuals who have Medicare Part A, a low monthly income, and limited resources

SPAP: State Pharmacy Assistance Program

A State Pharmaceutical Assistance Program is a program operated by or under contract with a State for purposes related to the Medicare Prescription Drug Benefit if it: (1) provides financial assistance for the purchase or provision of supplemental prescription drug coverage or benefits on behalf of Part D eligible individuals; (2) provides assistance to Part D eligible individuals in all Part D plans without discriminating based upon the Part D plan in which an individual enrolls; (3) meets the benefit coordination requirements specified in this part; and (4) does not change or affect the primary payor status of a Part D plan.

SSA: Social Security Administration

The Federal agency that, among other things, determines initial entitlement to and eligibility for Medicare benefits.

SSI: Supplemental Security Income

The Supplemental Security Income (SSI) program, administered by the Social Security Administration, pays benefits to individuals who are 65 and older, blind or disabled who are "needy". Persons are considered "needy" if they have limited income and resources. The limits on income vary from state to state.

TrOOP: True Out of Pocket Expenses

TrOOP stands for "true out-of-pocket" costs. The MMA and our regulations create a distinction between all beneficiary out-of-pocket expenditures and those that will be counted toward the annual Part D out-of-pocket threshold—the latter are known as "true" out-of-pocket (TrOOP) expenditures. These are costs actually paid by the beneficiary, another person on behalf of the beneficiary, or a qualified State Pharmaceutical Assistance Program (SPAP) and not reimbursed by a third-party (such as a supplemental insurance plan sponsored by a former employer) that will count toward the TrOOP threshold that determines the start of the catastrophic coverage. Most third-party assistance, such as that from employers and unions, does not count toward the TrOOP threshold.

USP: United States Pharmacopeia

USP was named in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). This legislation provides a prescription drug benefit for Medicare beneficiaries. USP has been asked to play a

critical role in creating Model Guidelines – a list of categories and classes that prescription drug plans may use as they design their formularies. To carry out this work, USP has entered into a Cooperative Agreement with the Centers for Medicare and Medicaid Services (CMS).