

Medicare Drug Benefit Glossary of Terms: Help for the Perplexed

Families USA • November 15, 2005

To navigate through the Medicare drug benefit and Medicare Prescription Drug Plan Finder on the Internet, it is helpful to be familiar with certain terms that relate to insurance, specifically drug coverage, prescription drugs, and some terms or concepts that are unique to the Medicare drug benefit. Here are 23 terms that a Medicare beneficiary is likely to encounter that he or she may not be familiar with.

Brand Drug – A prescription drug that is only available through one manufacturer. Brand drug names are typically capitalized and are often designated with a registered trademark sign.

Catastrophic Coverage – In 2006, catastrophic coverage begins once someone has paid \$3,600 of his or her own money for prescription drugs during the year. If a person has no other drug coverage, the \$3,600 threshold for catastrophic coverage will be reached when his or her total drug costs reach \$5,100. Catastrophic coverage lasts for the rest of year. In 2007, Medicare beneficiaries will probably have to pay more to qualify for catastrophic coverage. With catastrophic coverage, the patient pays up to 5 percent of the cost of each prescription; some people who qualify for extra-help will have all their drug costs covered (see Extra Help).

Coinsurance – Specific percent of the base price of each prescription that the patient must pay.

Copayment (copay) – Set dollar amount that the patient must pay for each prescription.

Cost-sharing – Broad term for the portion of drug costs that a patient pays for each prescription. It can be a set amount (copayment) or a percent of the drug's price (coinsurance).

Coverage Gap – Period during which beneficiaries pay 100 percent of their drug costs. In most plans in 2006, a beneficiary will reach the coverage gap when his or her total drug costs for the year (both the amount paid by the individual and the amount paid by the plan) reach \$2,250.

Deductible – This is the amount of drug costs that an individual has to pay up-front before the plan helps pay for anything.

Doughnut-Hole – (*slang*) See Initial Coverage Limit, below.

Enhanced Plans – These are drug plans that offer something beyond Medicare’s standard benefit. In most cases, they have higher monthly premiums.

Extra-Help (also known as the Low-Income Subsidy) – Additional financial help for people with limited incomes or resources that greatly reduces out-of-pocket costs. Individuals eligible for both Medicaid and Medicare automatically qualify for this assistance, as do those in Medicare buy-in programs (Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, and Qualifying Individual –1). Others must apply. Individuals should contact their local Social Security Office, Medicaid Office, or Medicare to get more information and see if they might qualify.

Formulary – The list of drugs that a plan will cover or help pay for. Plans do not have to help with the costs of drugs that are not on their formulary, and the costs of those non-formulary drugs do not count toward a person’s annual out-of-pocket expenses. Formularies vary by plan.

Gap in Coverage – See Initial Coverage Limit.

Generic – A drug available from multiple manufacturers. Generic drug names are not capitalized and are not noted with a trademark symbol.

Initial Coverage Limit – When a Medicare beneficiary’s drug costs reach this amount, the drug plan stops paying any prescription costs for the rest of the year unless that person spends enough to qualify for catastrophic coverage. In most plans, people reach the initial coverage limit once drug costs (what the individual has paid and what the plan has paid) reach \$2,250 in 2006. In 2007, the initial coverage limit will probably be higher.

Low-Income Subsidy – See Extra Help

Non-Preferred Drugs – Drugs on the plan formulary that have higher cost-sharing.

Non-Preferred Pharmacies – Pharmacies that are in a drug plan network (meaning they accept the drug plan card) but that generally charge more per prescription than preferred pharmacies.

Out-of-Pocket Expenses – The amount that the Medicare beneficiary pays toward prescription drug costs. This includes the deductible, co-insurance or copayments, and amounts paid after a person reaches the initial coverage limit. Any amounts paid by employer retiree plans or other health insurance are not counted as out-of-pocket expenses; amounts paid by charities may be, and amounts paid by state pharmacy assistance programs probably will be.

Pharmacy Network – Pharmacies that accept the drug plan card. Prescriptions filled at these pharmacies will be covered by the plan.

Preferred Drugs – Drugs on a plan formulary that have lower cost-sharing amount.

Preferred Pharmacies – Pharmacies in the plan network that generally charge less per prescription.

Premium – The amount that you have to pay every month to be enrolled in a specific drug plan. Premiums vary by plan and by area of the country in which a plan operates. Individuals who are eligible for extra help may not have to pay any premium.

Tier – Level of cost-sharing that applies to specific drugs on a plan's formulary. Plans generally have multiple cost-sharing tiers; tiers designated by smaller numbers (e.g. tiers 1 or 2) generally have lower cost-sharing than those designated by larger numbers (e.g. tiers 3 or 4).



1201 New York Avenue NW, Suite 1100 ■ Washington, DC 20005
202-628-3030 ■ Fax 202-347-2417 ■ E-mail: info@familiesusa.org
Web site: www.familiesusa.org