Medicare Prescription Drug Coverage:

An Overview for Oregonians

DHS

Oregon Department of Human Services

Table of Contents

The New Medicare Prescription Drug Coverage An Overview

The Medicare Modernization Act (MMA) is the biggest change in Medicare since it began in 1966. The most important change is the new prescription drug coverage program – Medicare Part D.

Who is Eligible?

Anyone with Medicare Part A and/or B can enroll in the new prescription drug program. This includes people over age 65 and younger people with disabilities.

Any eligible person who wants to have Medicare prescription drug coverage will need to enroll in a Medicare Prescription Drug Plan (PDP) or Medicare Advantage Prescription Drug Plan (MA-PD) that serves the area in which they live. People will need to contact the PDP or MA-PD to enroll. **People are not covered by Medicare Part D until they enroll in a plan.**

People who want Medicare prescription drug coverage will need to pay a monthly premium to their PDP or the MA-PD and will have other out-of-pocket expenses. There is a federal program to help people with limited incomes cover the out-of-pocket expenses.

If a person has good private health insurance that covers prescription drugs, they may not need to enroll in a PDP or MA-PD. Health insurance companies will notify their customers when they first become eligible for Medicare. The notice will say if the insurance is as good as or better than Medicare's prescription drug coverage.

Prescription Drug Plans and Medicare Advantage Plans

Unlike most of Medicare, private insurance plans offer prescription drug coverage. Plans choose drugs they will cover, their network pharmacies, and their monthly premiums. The plans must be approved by the Centers for Medicare and Medicaid Services (CMS) but each plan has flexibility in its design.

Each plan has a list of covered drugs called a formulary. The list must include both brand name and generic drugs. People should review the plan materials carefully to make sure their drugs are covered and that their pharmacy is in the plan's pharmacy network.

These private plans can provide different coverage:

- A stand-alone **Prescription Drug Plan** (PDP), which only covers the prescription drugs and not other medical costs. The plans only provide Medicare Part D coverage.
- A **Medicare Advantage Prescription Drug Plan** (MA-PD) that provides all Medicare benefits in one plan, including prescription drugs. MA-PDs cover Medicare Parts A, B, and D. Only people with Medicare Parts A *and* B may enroll in a Medicare Advantage Plan.
- A **Special Needs Plan** (SNP) that serves particular groups (such as people with specific diseases or conditions, people in nursing facilities, or people with Medicaid).

Prescription coverage can also be offered through an employer or union group. Employer and union plans will notify members whether their drug coverage is as good as Medicare's. People in these plans do not need to enroll in Medicare's prescription drug plan. They have "creditable coverage."

Medicare Supplement Insurance Plans (Medigap)

Because Medicare will be providing prescription drug coverage, Medicare Supplemental Insurance Plans (Medigap) cannot sell new plans with prescription benefits.

People who have these plans (labeled Medigap H, I, or J) have a choice to make about their prescription coverage.

- They can keep their current plan, but have the prescription coverage removed;
- They can cancel their current plan and enroll in a Medicare PDP and another Medigap Plan A, B, C, F, K, or L;
- They can enroll in a Medicare Advantage plan; or
- They can keep their current Medigap plan with prescription drug coverage and choose not to enroll in a Medicare PDP.

Caution: Medicare pays 75% of the cost of the Medicare Prescription drug coverage. Medicare does **not** cover Medigap costs. Medigap prescription coverage is not as good as Medicare's coverage. A person with Medicare will probably be charged a penalty if she or he waits to enroll in a PDP or MA-PD.

Enrolling in a Plan

CMS lists the names of the plans offering the prescription drug benefit in the annual *Medicare & You* handbook. One can also use Medicare's website www.medicare.gov, or call 1-800-633-4227, to learn the plans available in Oregon.

People with Medicare need to enroll directly with a PDP or MA-PD. Each plan has a different enrollment process. One may enroll by calling the plan directly or mailing an application form directly to the plan. However, most people use Medicare's toll free number or Medicare's website to enroll in a PDP or MA-PD. If one enrolls through Medicare rather than directly through the plan, there may be a delay in receiving an acknowledgement letter and a membership card.

There are different times when someone can enroll in a plan. They are:

- Initial Enrollment Period;
- Annual Enrollment Period; and
- Special Enrollment Period.

Initial Enrollment Period

Individuals who first become eligible for Medicare have an Initial Enrollment Period during the three months before, the month of, and three months after they become eligible for Medicare (e.g., If someone becomes eligible for Medicare in August 2007, they will have an IEP during May through November 2007). People who have prescription coverage from the state Medicaid plan will be enrolled in a Medicare PDP effective the first month of Medicare eligibility. They will need to check if this plan meets their needs and switch to a better plan if it does not. If someone has the state Medicaid program help out with Part B premiums or cost-sharing, then CMS will enroll that person two months after Medicare eligibility if that person does not choose a plan.

Annual Enrollment Period

Each year people with Medicare will have a chance to enroll or change plans. This enrollment period will be from November 15 through December 31 each year (starting in 2006). If people missed previous opportunities to

join a PDP, they can join during this time period. If a person does not enroll when first eligible, she or he may have to pay a penalty.

Special Enrollment Period

A Special Enrollment Period may be given to a person who has prescription insurance coverage as good as Medicare's, or better, and didn't join a Medicare PDP during the initial enrollment period.

This allows a person to enroll in a plan without having to pay a penalty for late enrollment. The late enrollment penalty can be as much as 1% of the monthly premium for every month that enrollment was delayed without having coverage as good as Medicare's coverage.

It is possible to disenroll from a plan and join another plan when there has been a change in someone's situation. The events that would allow this are:

- If a person moves out of the plan's service area;
- If a plan has terminated its contract with Medicare;
- A person is admitted to a hospital or a skilled nursing facility for a long stay;
- If a person is deemed eligible for the Low-Income Subsidy by a state or the Social Security Administration because of their Medicaid status, Medicare Savings Program eligibility, or SSI status.
- If an agent of the plan misrepresents information regarding the plan; or
- If a person loses the Low-Income Subsidy from one year to the next.

The Standard Medicare Prescription Drug Benefit

CMS set deductible, and copayment limits as a "benchmark" for prescription drug plans. Under CMS's benchmark, plans can have different premiums, deductibles and copayment amounts. Some plans may have higher premiums or cost sharing but offer better benefits, such as a lower annual deductible or lower copayment on generic drugs.

People will be able to choose a variety of ways to pay their premium. These include having the premium taken from their Social Security check, sending the premium directly to the plan, or having the premium taken directly from a bank account.

For 2006, in addition to the average $32.00 monthly premium people can expect to pay:

- A $250 yearly deductible ($265 in 2007).
- 25% of the cost of drugs between $250 and $2,250 ($265 and $2,400 in 2007) (*Total out of pocket costs at this level are $750 and $798.25 in 2007*).
- 100% of drug costs between $2,251 and $5,100 ($2,400 and $5,451.25 in 2007) (*Total out-of-pocket costs at the end this stage is $2,850 and $3,850 in 2007*).
- 5% of all drug costs over $5,100 ($5,451.25 in 2007) (Catastrophic Coverage).

PDPs and MA-PDs will keep track of the amount the plan pays and the amount the person pays. Each month, a person receives a summary of benefits statement from his or her plan. The local pharmacy will know exactly how much a person needs to pay for each prescription. People with limited income and assets may be able to get help for the costs (see "Extra Help for Those with Limited Income" section).

Catastrophic Coverage and True Out-of-Pocket costs

Medicare helps those who have paid more than $3,600 for their drugs in any given year. Once a person reaches the $3,600 limit, Medicare pays 95% of the drug costs for the rest of the year.

This out-of-pocket cost can be paid for by family members, charitable organizations, and from Individual Health Savings Accounts. Payments from other insurance plans, tribal entities, and government entities (including most state programs) do not count toward the true out-of-pocket amount for Medicare's catastrophic coverage. Medigap plans cannot assist people with gaps in Part D coverage.

Alternative or Enhanced Benefit Packages

PDPs can also offer "alternative prescription" drug coverage that is equal or better than the standard benefit. Cost sharing will vary in these plans but the deductible cannot be more than the amount set by CMS and the out-of-pocket limit ($3600 in 2006) cannot be higher.

Plans can also offer "enhanced coverage" that might include changes to the deductible and the initial coverage limit. A PDP must offer a standard benefit package if it offers an enhanced or alternative coverage plan.

Extra Help for Those with Limited Income

People with Medicare who have limited income may qualify for extra help paying for their prescriptions. The Low-Income Subsidy (LIS) Program provides extra help with the cost of premiums, deductibles, and cost sharing for Medicare PDPs. Some people with Medicare will be automatically eligible for this help. Other Medicare beneficiaries must apply for this extra help through the Social Security Administration (SSA). SSA provides application forms for people with Medicare who have limited incomes but do not have Medicaid or other forms of help. If a person thinks

that she or he might qualify, she or he should fill out this form. Remember the adage: "When in doubt, fill it out."

Automatic Eligibility (Deemed Eligible)

People with Medicare and Medicaid and those receiving Supplemental Security Income are automatically eligible for the extra help and are "Deemed Eligible". These people do not need to apply for the extra help.

Changes for those with Medicare and Medicaid

People who have Medicaid (the Oregon Health Plan) will not have

> Medicaid clients who also receive food stamps should ask to see if their food stamps can increase because of their drug copayments. Medicaid clients who pay for a portion of their care in a long-term care such as an adult foster home or assisted living facility should see if the amount they pay could be reduced.

prescription coverage from the state after they become Medicare eligible[1]. People with Medicare and Medicaid are automatically assigned to a PDP serving in their area to make sure they do not lose prescription drug coverage. It is very important to check the plan's list of covered drugs and its list of pharmacies to make sure the plan fits the needs of the person.

People who are changing from state prescription coverage to Medicare prescription coverage will have to pay copayments from $1.00 to $5.35 for each prescription, except for those in an "institution." CMS defines

---

[1] Medicaid will continue to pay for a very few drugs such as benzodiazepines, barbiturates and very limited over-the-counter medications.

institutions as nursing facilities, psychiatric hospitals, or the Eastern Oregon Training Center.

The amount a person pays depends on their income and whether they use generic or brand name drugs. (See page 12 for more detailed information on copayment levels.) People who have both Medicare and full Medicaid benefits fall into 3 categories for assistance. Full dual-eligible clients with incomes above 100% of FPL fall into LIS Category 1. Those individuals with incomes less than 100% of the federal poverty level ($817/ month for a single person in 2006) fall into LIS Category 2. Institutionalized full-dual clients fall into LIS Category 3.

Medicare Savings Program Clients who do not also have full Medicaid, will be in LIS Category 1.

If a person with Medicare loses his or her state medical assistance eligibility, he or she will no longer be automatically eligible for the extra help for the next calendar year. The individual must apply for the extra help with the Social Security Administration (SSA).

Others with Limited Income

Other Medicare beneficiaries with limited income apply for the extra help through the Social Security Administration (SSA). They complete the application form by providing their income, resources, and family size.

- Income includes all earned and unearned income (e.g., federal benefits, interest, pensions, wages, annuities, rental income, etc).
- Resources include cash and liquid assets that can be converted to cash within 20 days (e.g., real estate, bank accounts, stocks, bonds, etc.)

- Family size includes the individual, his or her spouse, and any relatives living with the individual, and who receive at least half of their financial support from the individual.
    - Relatives are people related to the individual by blood, marriage, or adoption.

Not all people with Medicare will qualify for extra help but they should apply anyway. If the Social Security Administration determines that an individual is qualified for the extra help, he or she will fall within one of the following groups:

LIS Category 1

Who: Individuals with Medicare and Medicaid whose income is above 100% of Federal Poverty Level; ***or,***

Individuals with Medicare whose income is below 135% of Federal Poverty Level and who have limited resources.

Benefit: No premium and no deductible
Copayments limited to $2.15 and $5.35 in 2007.

LIS Category 2

Who: Individuals with both Medicare and Medicaid coverage whose income is below 100% of the federal poverty level not living in an institution.

Benefit: No monthly premium and no deductible
Copayments limited to $1 and $3.10 in 2007.

LIS Category 3

Who: Individuals with both Medicare and Medicaid coverage who are expected to be institutionalized in a Nursing facility or other medical facility for a full calendar month.

Benefit: No monthly premium, no deductible, and no copayments on Medicare Part D covered drugs.

LIS Category 4

Who: People with Medicare whose income is between 135% of FPL and 150% of FPL and who have limited resources.

Benefit: A subsidy covering up to 75% of the monthly premium (Refer to the subsidy chart on page 21), and:

Out of pocket expenses in 2007 are limited to:

$53 annual deductible.
15% of the prescription costs up to $3,850 out-of pocket.
Copayments limited to $2.15 for each generic drug and $5.35 for each name brand drug after the annual prescription costs exceed $3,850 out-of-pocket spending.

SSA will review eligibility at the end of each calendar year. If an individual loses his or her eligibility during the calendar year, he or she will not lose the benefit until the end of the calendar year.

Remember that applying for extra help and enrolling in a Part D plan are two different steps. To have Part D coverage, you must either have insurance that equals Medicare coverage, or you must enroll in a plan. Finally, *all* people with Medicare can enroll in Medicare Part D, not just people with Medicare who have limited income and resources.

Medicare Prescription Drug Plan Coverage and Exclusions

PDPs and MA-PDs are required to cover certain drugs commonly called "Part D covered drugs." There are also certain drugs that are excluded. Plans are not subsidized by Medicare for the costs of excluded drugs.

Finding the right plan requires comparing plan formularies. People can use Medicare's formulary finder on www.medicare,gov: it will show plans that cover the person's drugs and it will show if covered drugs are limited by "Formulary Tools" described on page 16.

Medicare Part D Covered Drugs

Medicare will pay for the following:

- Prescription drugs;
- Biological products (e.g. Procrit, Raptiva);
- Vaccines (e.g. Hepatitis B vaccine for low risk individuals);
- Smoking cessation drugs;
- Insulin (insulin injection supplies), and
- Compounded drugs (two or more drugs added together by a pharmacy).

Medicare Part D Excluded Drugs

Medicare will not pay for the following:

- Drugs for weight gain or weight loss;
- Fertility drugs;
- Drugs for cosmetic purposes or hair loss;

- Prescription Vitamins (except for prenatal vitamins and fluoride preparations);
- Drugs for the relief of cough and cold symptoms;
- Over-the-counter (OTC) drugs;
- Barbiturates, and
- Benzodiazepines.

There are also many drugs that Medicare Part A and Part B cover. Medicare Part A drugs include many prescriptions given during a qualifying hospital stay (three or more days), during the first 100 days of a skilled nursing facility stay, and during hospice care. Part B covers drugs related to Part B-covered transplants and drugs administered by Part B-covered durable medical equipment (such as drugs administered by a nebulizer).

Medicaid Covered Drugs

For eligible Medicaid clients, who also have Medicare, the state will continue to provide coverage for three categories and classes of drugs. These are:

- Barbiturates (e.g. Barbital, Phenobarbital);
- Benzodiazepines (e.g. Valium, Xanax), and
- Limited over-the-counter medications (OTCs).

Formularies and Formulary Tools

A formulary is a list of drugs that a health plan will cover. Each PDP and MA-PD has a different formulary. Some drugs may be on one plan's formulary but not on another. Individuals need to compare each plan carefully and find the plan that best meets their needs.

Additionally, plans may use different strategies to control the use of expensive or unnecessary drugs. These are usually called Formulary Tools. They include:

Prior Authorizations (PA) - A process to determine if a specific drug is medically necessary for a specific individual.

- *Why* - Plans usually use a prior authorization process because a specific drug is expensive or has health risks.
- *How*:
    - Plans maintain a list of drugs that require a PA.
    - When the pharmacy receives a prescription that requires a PA, they submit information about the patient's condition.
    - The plan may contact the doctor to get more information.
    - If the plan approves the drug, the pharmacy will fill the prescription.
    - If a PA is not approved, then the drug will not be covered and the patient may need to get a different prescription or pay the entire costs of the prescription out of their own pocket.

Quantity Limits (QL) - A limit on the quantity of the drug that is covered.

- *Why* - Plans usually use quantity limits because the drugs are expensive or have health risks. They may also use QLs when someone is starting a new prescription.
- *How*:
    - Plans maintain a list of drugs with quantity limits.

- When the pharmacy receives a prescription that has a Quantity Limit, they submit a request to the plan.
- The plan reviews the information and either:
- Approves the request for the higher quantity; or
- Allows the prescription to be filled at the lower quantity.

Step Therapy - Trial of one or more less costly alternative drugs prior to allowing coverage of the more expensive drug. (*Example: A patient must try Prilosec before coverage of Nexium is allowed*.)

- *Why* - Drugs requiring step therapy are usually high cost and there are other drugs that are cheaper.
- *How*:
  - Plans require pharmacies to contact doctors to see if a less expensive drug can be substituted. Sometimes a PA can bypass step therapy if medical necessity is proven.
  - If step therapy is not completed, the more costly drug may not be covered.
    - Plans may cover the more expensive drug if the step therapy is unsuccessful. Step therapy is unsuccessful if:
      - Adverse side effects occur, or
      - Treatment is not effective.

Cost Sharing Tiers (The majority of plans use prescription drug formularies to determine the copayment amounts).

- Different levels of co-pay amounts depending on the type of drug.

- Generic drugs have the lowest co-pay amount.
- Formulary drugs have the next lowest co-pay.
- Non-formulary drugs have the highest co-pay.

Drug Plan Guidelines

Medicare told the PDPs and MA-PDs that they must meet the needs of the Medicare population. This includes special instructions on working with long term care facilities and providing transition coverage for people who are new to their plans. Medicare also told the plans that they must cover the majority of drugs in six drug classes. These categories include:

- Anticonvulsants (seizure drugs);
- Antidepressants;
- Antineoplastics (cancer drugs);
- Antipsychotics;
- Antiretrovirals (HIV and AIDs drugs), and
- Immunosuppressants (transplant drugs). However, many immunosuppressants are covered under Medicare Part B.

This mandate was designed to protect seniors and people with disabilities who may be the most at risk if they are forced to change prescriptions. Plans must also cover at least two medications in all other drug categories and classes. The plans cannot discriminate against groups of people because of income, health status, or ethnicity. A plan must ensure its formulary does not discourage enrollment in its plan for any of these reasons.

Plans can change their formularies throughout the year by adding or removing drugs. However, if a person enrolls in a plan when the drug is on the formulary, it will remain covered for that person for the rest of the calendar year, *even if the plan removes the drug from its formulary*. Plans might cover some of the Medicare Part D exclusions as part of a step therapy program at no additional cost to the client.

Appeals and Exceptions

If a patient's drug is not one of the drugs on the plan's formulary, then the client can contact the plan to ask for an exception. If the exception is approved, the client can receive or continue to receive the drug, but may have to pay a higher copayment.

Individuals can also ask for a copayment exception. This means that if an exception is approved the person only has to pay the standard copayment rather than a higher amount.

Exception Timeframes

- Standard: 72-hour turnaround, and
- Expedited: 24-hour turnaround.

If an exception is granted, then it remains in place for the calendar year. If the exception is denied, the individual can appeal that decision. Appeals follow the normal Medicare appeals process.

- Re-determination by the plan;
- Reconsideration by an independent company contracted with CMS;
- Review by an administrative law judge;
- Review by Medicare Appeals Council;

- Review by Federal District Court.

The affected person, or the person's representative, must start the appeal at all stages. Appeals beyond the reconsideration stage may take a very long time.

Medicaid Client Information

People with Medicare and Medicaid (and those who receive state help for their Part B premiums and/or cost-sharing) can change plans as often as once a month. However, people should enroll in their new plan early in the month. The plan will take effect the first day of the following month.

In October 2006, CMS will announce the PDPs and MA-PDs available in Oregon for 2007. People with Medicare and any state help (Medicaid or a Medicare Savings Program) may switch plans. If a person is enrolled in a plan that does not have a full premium subsidy in 2007, that person will be enrolled by CMS into a plan that does have a full premium subsidy. If a person is enrolled in a plan that will not exist in 2007, CMS will enroll that person in a $0 premium plan. People who have Medicare and state help may have to find another plan if they are affected by these two changes. DHS will contact clients impacted by these changes and offer enrollment assistance.

Federal Poverty Levels		
Federal Poverty Level	**Family Size**	**Monthly Income (2006)**
100%	Individual	$817
	Couple	$1,100
135%	Individual	$1,103
	Couple	$1,485
150%	Individual	$1,225
	Couple	$1,650

LIS Resource Limits for SSA Applications		
LIS Category	**Family Size**	**Resource Limit (2007)[2]**
1	Individual	$7,620
	Couple	$12,190
2 & 3	Refer to state program eligibility	
4	Individual	$11,710
	Couple	$23,410

LIS Group 4 Premium Subsidy Amounts		
Income levels	**Premium Subsidy**	**Individual Pays**
135 – 140%	75%	25%
140 – 145%	50%	50%
145 – 150%	25%	75%

[2] Includes a total of $1,500 per person for burial costs.

Glossary: Acronyms and Definitions

AAA-Area Agency on Aging

ADAP-AIDs Drugs Assistance Program

APD-Aged and physically disabled

Auto-enrollment-In October 2005, CMS randomly assigns dual eligible individuals into Prescription Drug Plans (PDPs).

Beneficiaries – People who have Medicare.

Biological- Usually a drug or vaccine made from a live product and used medically to diagnose, prevent, or treat a medical condition (e.g. flu or pneumonia shot).

BOB-Benzodiazepines, OTC (over-the counter) drugs, Barbiturates.

Catastrophic Coverage-The highest amount of money paid out-of-pocket before a health plan pays the majority or all co-payment amounts. Medicare Part D catastrophic coverage begins at $3,600 out-of-pocket and $5,100 in total drug costs (total drug costs include what the beneficiary and other payers have paid

Clawback-The amount that the state government pays the federal government to provide the Medicare Part D drug benefit for those individuals with both Medicare and Medicaid beginning January 1, 2006.

CMS-Centers for Medicare and Medicaid Services

COB-Coordination of benefits

Coinsurance-A fixed percentage paid per prescription per fill.

Compound Drugs-Two or more drugs added together by a pharmacy.

Co-payment (co-payment)-A fixed amount paid per prescription per fill.

Cost-sharing Tier-Different levels of co-payment amounts depending on the type of drug. The lowest co-payment is for generics, followed by formulary brands, and a non-formulary co-payment is in the highest tier.

Creditable Coverage-Creditable coverage means an insurance policy that is as good as or better than a Medicare Part D plan. (e.g. retiree drug coverage).

DD-Developmental disability

Deductible – The amount an individual must pay before an insurance plan pays.

Deemed-Any individual considered automatically eligible for extra help with the Medicare Part D drug benefit (this includes individuals with Medicaid, a Medicare Savings Program, or SSI).

DHS-Department of Human Services

Dual Eligible-A person who has Medicare and Medicaid

EOPC-Eastern Oregon Psychiatric Center

EOTC-Eastern Oregon Training Center

FCHP-Fully Capitated Health Plan (These are the Medicare Managed Care organizations that provide health coverage for OHP clients).

Federal Poverty Level – The income level set by the Federal government to determinate eligibility for many needs based programs.

Formulary-A formulary is a list of drugs that a health plan will cover. Formulary drugs usually have lower co-payments than non-formulary drugs. A formulary is also known as a Preferred Drug List.

FPL-Federal Poverty Level

ICF/MR-Intermediate care facility for the mentally retarded

LIS-Low Income Subsidy. The LIS program is operated by SSA and provides extra help with prescription drug costs for individuals who meet the income and asset requirements.

LTC-Long Term Care

MA-Medicare Advantage plans (currently known as Medicare Managed Care organizations, they replace Medicare +Choice plans).

MA-PD-Medicare Advantage Plan with prescription drug coverage

Medicaid - Sometimes called the Oregon Health Plan (OHP). If you have Medicaid you get a letter from DHS every month with your Medical “card.”

Medigap-A supplemental insurance policy provided by a private insurance company designed to provide coverage that fills the gaps for what Medicare does not cover. (some policies have a limited drug benefit).

MMA-Medicare Modernization Drug, Improvement, and Modernization Act

MSA-Medical Savings Accounts

MSP-Medicare Savings Program (these assist with paying for Medicare Part A and/or B costs).

OIM-Other incurred medical

OMAP-Office of Medical Assistance Programs

OMHAS-Office of Mental Health and Addiction Services

OTC-Over-the-Counter drugs

OSH-Oregon State Hospital

PA-Prior Authorization

PACE-Program for the All-inclusive Care of the Elderly (this is an acute LTC provider that is also fully capitated).

Partial Dual Eligible-Medicare beneficiaries (QMB, SLMB, QI 1) with Medicare premiums and/or deductibles paid for by Medicaid, however, there is no actual Medicaid coverage provided.

PBM-Pharmacy Benefits Manager

PDL-Preferred Drug List (also known as a formulary)

PDP-Prescription Drug Plan

PIF-Personal incidental fund

Premium – The amount paid to a plan for insurance coverage. Amounts are estimated. Plan premiums will vary depending on their contract with CMS and can be raised every year.

QI-1-Qualified Individual (Medicare Savings Program)

QMB-Qualified Medicare Beneficiary (Medicare Savings Program).

Quantity Limit-A limit placed on the quantity of a medication covered by an insurance company.

Self-Administer-Medicare considers a drug to be self-administered when patients are administering the drug more than 50% of the time.

SLMB-Specified Low-Income Medicare Beneficiary (Medicare Savings Program).

SNP-Special Needs Plan (an FCHP that serves primarily institutionalized clients and those with Medicaid).

SPA-State Plan Amendment

SPAP-State Pharmaceutical Assistance Program (Oregon does not have an SPAP).

SPD-Seniors and People with Disabilities

SSA-Social Security Administration

Step Therapy-Trial of an alternative drug before coverage is provided for the originally prescribed drug.

TrOOP-True Out-of-Pocket costs