

Actuarially Equivalent Plan (AE)

- A monthly premium.
- A \$310 annual deductible (for 2010).
- A cost-sharing structure that may have flat copayments instead of a 25% coinsurance or uses a combination of copayments and coinsurance charges. Enrollees pay these costs for their covered drugs up to the initial coverage limit of \$2,830 (for 2010).
- A coverage gap ("doughnut hole") between \$2,830 and \$6,440 (in 2010) in costs for covered drugs.
- Catastrophic coverage where the beneficiary pays the greater of 5% coinsurance or a copayment of \$2.50 for a generic or preferred drug and \$6.30 for other drugs for the rest of 2010.

Adjudicate

The act of processing a pharmacy claim. The plan sponsor or insurer has contracted with the pharmacist and defined the basis or the terms and conditions of reimbursement for dispensing a drug.

Adjustment/Deletion Code

This field distinguishes original from adjusted or deleted PDE records so CMS can adjust claims and make accurate payment for revised PDE records.

AWP

Average Wholesale Price. Price of a prescription drug as identified by drug pricing services, or other sources nationally recognized in the retail prescription drug industry, selected by the Pharmacy Benefit Manager.

Basic Alternative Plan (BA)

- A monthly premium
- A reduced or eliminated annual deductible (ranging from \$0 to \$310 in 2010)
- A cost-sharing structure that may have flat copayments instead of a 25% coinsurance or uses a combination of copayments and coinsurance charges. Enrollees pay these costs for their covered drugs up to an initial coverage limit that is no less than \$2,830 (for 2010).
- A coverage gap ("doughnut hole") between \$2,830 and \$6,440 (in 2010) in

costs for covered drugs. If the initial coverage limit is raised, the coverage gap will be smaller in these plans

- Catastrophic coverage where the beneficiary pays the greater of 5% coinsurance or a copayment of \$2.50 for a generic or preferred drug and \$6.30 for other drugs for the rest of 2010

BOC

Basis of Cost. The foundation or source that identifies where the cost is determined. For example, if Usual and Customary (U&C) is the basis of cost, we can assume that the cost was established by the pharmacy. Similarly, a claim with Maximum Allowable Cost (MAC) as a basis of cost uses the respective PBM's MAC listing.

Brand Name Drug

A patented drug marketed by the original drug manufacturer following its FDA approval. The manufacturer receives a patent on the drug giving it the right to make that drug without any competition. When a patent expires on a brand name drug, other companies can start making the drug after receiving FDA approval. A brand name drug is usually known by its trade name, ("Motrin®") rather than by its chemical (or generic) name ("ibuprofen").

Catastrophic Coverage Code

Indicates that a beneficiary has reached the out-of-pocket threshold or attachment point. At this point, catastrophic coverage provisions begin, namely reinsurance and reduced beneficiary cost sharing.

CDUR

Concurrent Drug Utilization Review. Evaluation of drug therapy and intervention, if necessary, while the patient is undergoing therapy. Proactively warns the dispensing pharmacist of a broad range of safety considerations specific to particular prescriptions presented by the patient.

CHIP

Children's Health Insurance Program. provides low-cost health insurance coverage for children in families who earn too much income to qualify for regular Medicaid coverage but cannot afford to purchase private health insurance. Jointly financed by the Federal and State governments and is administered by the States.

Closed Formulary

There are two types of formulary plans used by health insurance companies. Most companies use a **closed formulary**, which means that only prescription drugs on the list will be covered by the plan. An **open formulary** may be offered, which means that the health plan may cover the costs of drugs that are not on the formulary list.

CMS

Centers for Medicare & Medicaid Services. A branch of the U.S. Department of Health and Human Services. CMS is the federal agency that administers the Medicare program and monitors the Medicaid programs offered by each state.

COB

Coordination of Benefits. Instances where a member has benefits from more than one insurance plan.

Coinsurance

The amount the patient may be required to pay as a means to share the cost of services. Coinsurance is a percentage.

Compound

A medication that has to be made by the pharmacist because it is not available from a manufacturer in the desired strength, or containing the ingredients prescribed by the doctor.

Compound Code

This field indicates whether or not the dispensed drug was compounded or mixed.

Concurrent DUR

Concurrent Drug Utilization Review. Online, real-time edits using the claims database to help identify potential drug-related problems.

Copayment

The amount a patient is required to pay as a means to share the cost of the medical service or supply. A copayment is normally a flat dollar amount, rather than a percentage.

Coverage Gap

This is also called the "doughnut hole." It is the part of the Medicare plan where the member pays for prescription drugs. The plan does not pay. The gap occurs **after** you reach your initial coverage limit. It lasts **until** the expenses you pay add up to a certain amount.

CPP

Covered D Plan Paid Amount. This field contains the net amount the plan paid for standard benefits (covered Part D drugs).

Datastore

Datastores are used to house each set of claims and experience data, as well as the results of any claim reprocessing that is done against that set of data.

DAW

Dispense as Written. This field indicates the prescriber's instruction regarding substitution of generic equivalents or order to dispense the specific product written.

Deductible

The amount a patient must pay before the prescription drug plan or other insurance begins to pay.

Defined Standard Plan (DS)

The Centers for Medicare and Medicaid Services (CMS) publish the Part D Defined Standard Benefit parameters each year. The parameters include such Part D plan variables as the initial deductible, as well as the Initial Coverage Limit and the Out-of-Pocket Threshold, which together form the boundaries of the Donut Hole or Coverage Gap. For 2010, these parameters were:

- A monthly premium.
- A \$310 annual deductible (for 2010).
- A 25 percent coinsurance for the cost of covered drugs up to an initial coverage limit of \$2,830 (2010).
- A coverage gap ("doughnut hole") between \$2,830 and \$6,440 (in 2010) in costs for covered drugs.
- Catastrophic coverage where the beneficiary pays the greater of 5 percent coinsurance or a copayment of \$2.50 for a generic or preferred drug and \$6.30 for other drugs for the rest of 2010.

Dispensing Fee Paid

This field contains amounts paid to the pharmacy for dispensing the medication. This field should only contain the activities related to the transfer of possession of the drug from the pharmacy to the beneficiary, including charges associated with mixing drugs, delivery, and overhead as delineated in the final rule and the preamble to the rule. No other costs shall be included in this field.

Dispensing Status

This field indicates how the pharmacy dispensed the complete quantity of the prescription. When the pharmacy partially fills a prescription, this field indicates a partial fill. When the full quantity is dispensed at one time, this field is blank.

Doughnut Hole

The part of the Medicare plan where the member pays for prescription drugs. The plan does not pay. The gap occurs after you reach your initial coverage limit. It lasts until the expenses you pay add up to a certain amount. Also referred to as the **Coverage Gap**.

Drug Coverage Status Code

This field indicates whether or not the drug is covered under the Medicare Part D benefit and/or a specific PBP.

DS

Days Supply. The number of days' supply of medication dispensed by the pharmacy and will consist of the amount the pharmacy enters for the prescription.

DU

Dosage Unit. The amount of a medication administered to a patient in a single dose.

DUR

Drug Utilization Review. The practice of drug utilization review ensures patient safety and manages medication therapy by examining a patient's physician orders and checking for drug-drug, drug-allergy, drug-food, and drug-condition interactions using patient factors such as gender, age, weight, medical history and current treatments.

EGWP

Employer Group Waiver Plan. A type of employer group plan where membership is restricted to employer or union sponsored group plan members. For example: Municipalities, School Districts, Unions. Insurance companies contract with the Centers For Medicare and Medicaid Services (CMS) to offer this benefit to the retirees' employer or union sponsor on CMS's behalf. The sponsored and certified insurance company receives direct subsidies, low income subsidies, and reinsurance payments for the employer or union's approved beneficiaries and passes the savings on to the employer or union and their members.

Enhanced Alternative Plan

- A monthly premium.
- A reduced or eliminated annual deductible (ranging from \$0 to \$310 in 2010).
- A cost-sharing structure that may have flat copayments instead of a 25% coinsurance or uses a combination of copayments and coinsurance charges. Enrollees pay these costs for their

covered drugs up to an initial coverage limit that is no less than \$2,830 (for 2010).

- If included, a coverage gap ("doughnut hole") between \$2,830 and \$6,440 (in 2010) in costs for covered drugs. If the initial coverage limit is raised, the coverage gap will be smaller in these plans. Some enhanced alternative plans will offer some coverage throughout the coverage gap.
- Catastrophic coverage where the beneficiary pays the greater of 5% coinsurance or a copayment of \$2.50 for a generic or preferred drug and \$6.30 for other drugs for the rest of 2010.
- Formularies may be broader, and may cover drugs that are generally excluded from Part D coverage.

Formulary

A list of drugs that are covered under a prescription drug plan. Also called a **preferred formulary**.

Formulary List

Many health insurance companies have created formulary lists to regulate what drugs they will cover or help pay for. If a member uses a drug not on their health insurance plan's formulary list, they will pay higher out-of-pocket costs. Also called a **preferred formulary**.

FRF

Formulary Reference File. A listing of drugs that Part D plan sponsors must utilize in the submission of Part D formularies.

FWA

Fraud, Waste, and Abuse. A comprehensive program from the Centers for Medicare & Medicaid Services designed to help for Part D drug benefit sponsors detect, correct, and prevent fraud, waste, and abuse.

Gap

The part of the Medicare plan where the member pays for prescription drugs. The plan does not pay. The gap occurs **after** you reach your initial coverage limit. It lasts **until** the expenses you pay add up to a certain amount. Also referred to as the **Doughnut Hole**.

GDCA

Gross Drug Cost Above Out-of-Pocket Threshold. This field represents the gross drug cost paid to the pharmacy above the Out-of-Pocket threshold for a given PDE for a covered drug.

GDCB

Gross Drug Cost Below Out-of-Pocket Threshold. This field represents the gross drug cost paid to the pharmacy below the Out-of-Pocket threshold for a given PDE for a covered drug.

Generic Drugs

A drug that is produced and distributed without patent protection. The generic drug may still have a patent on the formulation but not on the active ingredient.

Generic Equivalent

A generic drug whose active ingredients are identical in chemical composition to its brand-name counterpart.

Generic Product Indicator

An indicator that will distinguish a product either priced as a generic drug or priced as a brand.

GN/MS/SS

Generic/Multi-Source/Single-Source Brand

GPI

Generic Product Identifier. A Therapeutic Class maintained by Medi-Span® that defines pharmaceutically equivalent drug products. Products having the same 14-character GPI are identical with respect to active ingredients, dosage form, route, and strength.

GSN

Generic Sequence Number. Uniquely identifies a product specific to its agent, dosage form, and strength, and route of administration. It is not unique across manufacturers and/or package sizes. The digits which make up the GSN have no significance. Rather, the GSN is used to group generically equivalent

pharmaceutical products.

HICN

Health Insurance Claim Number. The health insurance claim number is a number assigned to each Medicare beneficiary. This claim number is used for identification purposes when processing Medicare claims.

HIPAA

Health Insurance Portability and Accountability Act of 1996. A federal law that outlines the requirements that employer-sponsored group insurance plans, insurance companies, and managed care organizations must satisfy in order to provide health insurance coverage in the individual and group healthcare markets.

HPMS

Health Plan Management System. A database of information on Medicare Part A and Part B recipients who are enrolled in coordinated care plans.

ICL

Initial Coverage Limit. This is the first part of a Medicare prescription drug plan. A member pays a set amount until the member and plan payments hit a certain total. Once this limit is reached, the terms change. Members may pay more as the plan moves to the coverage gap phase.

Ingredient Cost

Ingredient Cost. The cost of the drug product as stated on the drug claim, or as calculated by multiplying the quantity of drug dispensed times its unit cost. In simple terms, it is **AWP** less the contract pharmacy discount.

Ingredient Cost Paid

This field contains the amount paid to the pharmacy for the drug itself. Dispensing fees or other costs are not to be included in this amount except as allowed on non-standard format claims.

LIS (or LICS)

Low income subsidy. Financial assistance that is available for people enrolled in Medicare or Medicaid programs with low incomes (below 150% of the Federal Poverty Line) and limited assets.

LIS/HIS

A lab information system (LIS) is a class of software that receives, processes, and stores information generated by medical laboratory processes. These systems often must interface with instruments and other information systems such as hospital information systems (HIS).

MAC

Maximum Allowable Cost. The highest unit price at which a drug will be paid. It is specific, to a group of pharmaceutical equivalents.

MAC List

A list composed of specific prescription drugs that have a reimbursement rate based on the actual acquisition costs paid by pharmacies.

MAPD

Medicare Advantage Prescription Drug Contracting. Also known as Medicare Part C.

Maximum Allowable Benefit

The maximum allowable (dollar) benefit is an amount set by the health plan limiting the prescription benefits available to a member or family. Once the maximum is met, members are usually required to pay cash for future prescriptions.

Medicare Part A

Covers various forms of hospital stays. Its focus is inpatient care in hospitals, skilled nursing facilities, hospice and critical access hospitals. Home health care is also covered under this plan.

Medicare Part B

Covers medical services and supplies. Doctor's visits and other services are covered by the plan, as are occupational and physical therapists, outpatient care and additional home health care.

Medicare Part C

Also known as the Medicare Advantage Plan, Part C combines both Part A and Part B. Part C differs from the other plans because it is supplied through private insurance companies. These companies have been approved by Medicare and the often offer additional benefits and lower costs.

Medicare Part D

Medicare Part D is a federal program to subsidize the costs of prescription drugs for Medicare beneficiaries in the United States. It was enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and went into effect on January 1, 2006.

Medi-Span

Medi-Span® offers drug pricing information for drug pricing analysis and comparison, formulary management and drug utilization review through a drug pricing database.

MMR

Monthly Membership Report. Provides plans with detailed demographic and health status information CMS uses to calculate the risk score. Recently, CMS updated the MMR to include beneficiary Medicaid status and Original Reason for Entitlement (OREC).

MONY

Often referred to as the **Multisource Indicator**. A term used by Medi-Span to indicate the generic status of a drug. Valid values for a drug are:

- M=Single-Source, co-licensed product. Product is co-licensed and considered single-source product despite being available from multiple labelers.
- O=Multi-Source, originator product. Product available from multiple labelers

considered to be the industry standard.

- N=Single-Source product. Single-source product available from one labeler.
- Y=Multi-Source Product. Multi-source product available from multiple labelers.

MOOP

Maximum Out-of-Pocket. The limit on the total coinsurance and deductible you will pay in any calendar year.

Multi-Source

A prescription drug for which there are both brand and generic versions.

NABP

National Association of Boards of Pharmacy.

NCPDP

National Council for Prescription Drug Programs. An organization that promotes data interchange and processing standards to the pharmacy service sector of the healthcare industry.

NDC

National Drug Code. A system that is designed to provide drugs in the United States with a specific 11-digit number that identifies the labeler, product, and trade package size. Originally created under Medicare to help identify drugs for reimbursement. Digits 1-5 identify the manufacturer, digits 6-9 the strength/dosage, and digits 10-11 the package size.

Non-formulary

A drug not contained on a health plan's formulary list or preferred drug list.

Non-Formulary

Drugs not found on a health plan's formulary list. Also called **non-preferred**.

Non-Standard Format Code

This data element is used by CMS to identify PDE records that are compiled from non-standard sources. NCPDP is the standard format in which plans receive data from pharmacies.

NPP

Non-covered Plan Paid amount. This field contains the net amount paid by the plan for benefits beyond the standard benefit.

OOP

Out-of-Pocket. An out-of-pocket expense is a nonreimbursable expense paid by a patient. Out-of-pocket expenses can also include covered expenses the patient is responsible for before his or her health-plan benefits kick in at 100% coverage.

Open Formulary

There are two types of formulary plans used by health insurance companies. Most companies use a **closed formulary**, which means that only prescription drugs on the list will be covered by the plan. An **open formulary** may be offered, which means that the health plan may cover the costs of drugs that are not on the formulary list.

OTC

Over-the-Counter. Any medication that may be legally purchased without a doctor's prescription, including, but not limited to, aspirin, antacids, vitamins, minerals, or herbal preparations.

Other TrOOP Amount

This field records all qualified third party payments that contribute to a beneficiary's TrOOP, except for LICs and Patient Pay Amount. Examples include payments made on behalf of a beneficiary by a qualified State Pharmacy Assistance Program, charities, or other TrOOP-eligible parties.

PA

Prior Authorization. The process of obtaining advanced approval of coverage for a health care service or medication.

Paid Date

The date the plan originally paid the pharmacy for the prescription drug. If the plan subsequently adjusts payment, the plan will report the original paid date in the adjustment PDE. This field is a mandatory field for fallback plans and optional for all other plan types.

Paid Price

The dollar amount that is reimbursed to the pharmacist for the prescription claim. It is the lower of the submitted amount or the maximum amount allowed by the benefit plan.

Patient Pay Amount

This field lists the dollar amount the beneficiary paid that is not reimbursed by a third party. For example, copayments, coinsurance, deductible or other patient pay amounts.

PBM

Pharmacy Benefit Manager. An organization that provides administrative services in processing and analyzing prescription claims for pharmacy benefit and coverage programs.

PBP Identifier

Plan Benefit Package Identifier. The unique number CMS assigns to identify a specific PBP within a contract.

PDE

Prescription Drug Event. Every time a beneficiary fills a prescription under Medicare Part D, a prescription drug plan sponsor must submit a summary record called the prescription drug event (PDE) data to CMS. The PDE data are not the same as individual drug claim transactions, but are summary extracts using CMS-defined standard fields.

PDP

Prescription Drug Plan. Prescription drug coverage that is offered under a policy, contract, or plan that has been approved as specified in 42 CFR Section 423.272 and that is offered by a PDP sponsor that has a contract with CMS that meets the contract requirements under subpart K.

Pharmacy Spread

The margin created when PBMs contract with pharmacies at a lower price than was negotiated with drug plan sponsors.

PLPRO

Patient Liability Reduction due to Other Payer Amount. This field takes into account coordination of benefits that results in reduced patient liability, excluding any TrOOP-eligible payers.

PMPM

Per member per month. Calculated by deriving the average of total healthcare costs for a single member in a month. PMPM is an indicator for healthcare expenditure and it is analyzed against different Health status category parameters.

Prescriber Identifier

This field contains the prescriber's unique identification number. CMS will transition to the use of the NPI when it is implemented. In the interim, CMS requires use of a DEA number whenever it uniquely identifies the prescriber and is allowed by State law.

Prescription/Service Ref. Number

This field contains the prescription reference number assigned by the pharmacy at the time the prescription is filled.

Pricing Exception Code

This field indicates that the PDE reports an out-of-network or Medicare as Secondary Payer (MSP) service that is subject to unique pricing rules.

Product/Service Identifier

This field identifies the dispensed drug using a National Drug Code (NDC). The NDC is reported in NDC11 format.

Quantity Dispensed

This field indicates how many dosage units of the medication were dispensed in the current drug event.

RDS

Retiree Drug Subsidy. A program offered by the Centers for Medicare & Medicaid Services (CMS) to reimburse municipalities, unions and private employers for a portion of their eligible expenses for retiree prescription drug benefits.

RDUR

Retrospective Drug Utilization Review. Evaluating patterns of drug therapy either concurrent with therapy, or after a patient has completed therapy. The RDUR intervention program is aimed at patients who are at risk of drug-induced illness, potential drug overutilization and the monitoring of physicians' prescribing activities.

Reprocessing

The process AccuCAST uses to forecast claims costs.

Route of Administration

The path by which a drug is taken into the body. Routes of administration are usually classified by application location (or exposition).

RxCUI

RxNorm Concept Unique Identifier. RxNorm is organized around *concepts* which are assigned unique identifiers. A concept is a collection of names identical in meaning. For example, *Accuneb 0.042% inhalation solution* and *Albuterol 0.417 MG/ML Inhalant Solution [Accuneb]* name the same concept. In RxNorm, the second of these is designated as the preferred form of the name so it's assigned a *concept unique identifier* (CUI) of C1169664. This CUI always designates the same concept, no matter the form of the name and no matter in what table it is found. Drugs whose names map to the same CUI are taken to be the same drug, identical as to ingredients, strengths, and dose forms.

RxNorm

A standardized nomenclature for clinical drugs produced by the National Library of Medicine. RxNorm links these names to many of the drug vocabularies commonly used in pharmacy management and drug interaction software.

Service Provider Identifier

This field identifies the pharmacy where the prescription was filled. CMS will transition to the use of the National Provider Identifier (NPI) when it is implemented. In the interim, this field typically contains the NCPDP number which all NCPDP billers are assigned.

Service Provider Identifier Qualifier

This field indicates the type of provider identifier used in field 11 (Service Provider Identifier).

Single Source Brand

Single-source brand drugs are those drugs that do not have a generic equivalent and are manufactured by the company who originated the drug. Single source brand drugs are protected by patent laws.

Single Source Generic

When patent protection is exhausted for a brand drug, in most cases one manufacturer is awarded a six-month exclusive right to produce the generic form of that particular brand drug. Initially, the generic form of this drug is considered a single source generic since there is only one manufacturer.

SPAP

State Pharmaceutical Assistance Program. State-provided prescription drug subsidies to low-income elderly or disabled residents as supplemental or "wrap around" benefits to Part D.

Specialty Drugs

Prescription medications that require special handling, administration, or monitoring. These drugs are used to treat complex, chronic, and often costly conditions.

Table E

Table E is a table of base rate PMPM's by age band broken up by the plan drug coverage options.

Tiered Formulary

Formulary list of preferred prescription drugs in which different drugs have different co-pays. Each drug is assigned to a specific "tier" within the formulary. The most cost-effective drugs, often generic drugs, belong to the most preferred tier and typically have the lowest co-pay, whereas the least cost effective drugs belong to the least preferred tier and have the highest co-pay.

Total Amount Attributed to Sales Tax

This field contains the sum of all amounts paid to the pharmacy to cover sales tax.

TrOOP

True out-of-pocket (TrOOP) costs are the expenses that count toward a person's Medicare drug plan out-of-pocket threshold. TrOOP costs determine when a person's catastrophic coverage portion of their Medicare Part D prescription drug plan will begin.

TRR

Transaction Reply Report. The CMS communicates a comprehensive report of all eligibility changes through a weekly Transaction Reply Report. The weekly TRR covers the processing week and the monthly TRR covers the payment processing month.

U & C

Usual and Customary Price. Price that the pharmacy would have charged a cardholder for that particular prescription on that day for that member if they were not in a managed plan. This includes all applicable discounts including, but not limited to, Senior Citizen discounts, frequent shopper and special member discounts or other discounts intended to attract customers.

UMLS

Unified Medical Language System. A system from the US National Library of Medicine designed to facilitate the development of computer systems that behave as if they "understand" the meaning of the language of biomedicine and health.

WAC

Wholesale Acquisition Cost. The list price for wholesalers, distributors, and other direct accounts before any rebates, discounts, allowances or other price concessions that might be offered by the supplier of the product