Created: 02/28/2025

Updated: 03/04/2025

Legislative Glossary

Costs & Payment Terms

Term	Previous Definition	Updated Definition	Resource	Example in Pharmacy Practice
Insured (covered individual, or individual under a health plan)	The person covered under a health insurance policy/plan.	A person covered under a health insurance plan.	https://economictimes.indiatimes.com/tdmc/your-money/these-are-the-participants-in-your-insurance-contract/tomorrowmakersshow/60490992.cms?query=Insurance	A patient with employer-provided insurance pays a copay for their medications.
Uninsured (individual without health insurance)	A person who is not under a health insurance policy/plan	A person without health insurance coverage.	https://www.petersonhealth.com/sp_faq/what-does-uninsured-mean/	A patient pays full price for prescriptions due to lack of insurance.
Under-insured	A person whose out-of-pocket costs or deductible costs a significant amount of their household income	A person whose insurance does not adequately cover medical expenses.	https://www.goodrx.com/insurance/health-insurance/insured-vs-underinsured	A patient with a high deductible struggles to afford medications before meeting the deductible.
Insurer (health plan/health insurance plan)	Health insurance company that provides the coverage under a health insurance policy.	The company that provides health insurance.	https://economictimes.indiatimes.com/tdmc/your-money/these-are-the-participants-in-your-insurance-contract/tomorrowmakersshow/60490992.cms?query=Insurance	Aetna, Cigna, or Blue Cross Blue Shield providing prescription coverage.
Deductible	Amount the insured pays yearly before their health plan starts to pay their medical bills.	The amount a patient must pay before insurance covers costs.	https://www.bls.gov/ncs/ebs/sp/healthterms.pdf https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/uniform-glossary-final.pdf	A patient with a $500 deductible pays full price until reaching $500 in expenses.

Copay	Flat amount the insured pays for covered services (e.g., physician visits, at the pharmacy counter, specialists, etc.).	A fixed amount a patient pays for a prescription.	https://www.bls.gov/ncs/ebs/sp/healthterms.pdf https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/uniform-glossary-final.pdf	A patient pays $10 for generics and $50 for brand-name drugs.
Co-insurance	The insured's shared responsibility with insurance company after deductible is met.	A percentage of the cost a patient must pay after meeting their deductible.	https://www.bls.gov/ncs/ebs/sp/healthterms.pdf https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/uniform-glossary-final.pdf	If co-insurance is 20%, a patient pays $20 for a $100 medication.
Maximum Out-of-Pocket (MOOP)	Maximum amount the insured has to pay yearly for medical services. Once the insured meets the MOOP, their plan will begin to pay at 100%.	The most a patient has to pay in a year before insurance covers 100%.	https://www.bls.gov/ncs/ebs/sp/healthterms.pdf https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/uniform-glossary-final.pdf	After reaching $5,000, all medications and services are fully covered.
Premium	Amount the insured pays to obtain the insurance. This does not include the insured's deductible,	The amount paid for health insurance, usually monthly.	https://www.bls.gov/ncs/ebs/sp/healthterms.pdf	An employee pays $150 per month for health insurance.

	copay, MOOP, and other coverages.		https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/uniform-glossary-final.pdf	

Pharmacy Benefit Management & Pricing Terms

Term	Previous Definition	Updated Definition	Resource	Example in Pharmacy Practice
Pharmacy Benefit Managers (PBMs)	Third-party administrators contracted by health insurance plans, unions, and government forces to manage prescription drug benefits programs. They are involved with evaluating claims (for medical treatment, injuries, etc.) for payment of benefits, manage pharmacy networks, determine what brand/generic drugs are covered by an insured's health plan, set co-pays, and set prior authorization criteria and the criteria for the insured's choice of pharmacy.	Companies that manage prescription drug benefits for insurers.	https://www.commonwealthfund.org/publications/explainer/2019/apr/pharmacy-benefit-managers-and-their-role-drug-spending	CVS Caremark negotiates drug prices and formulary placement.
Spread Pricing	A model of prescription drug pricing in which a pharmacy benefits manager (PBM) charges a health plan a contracted price for a prescription drug that is DIFFERENT from the amount the PBM pays (directly or indirectly) the pharmacist or pharmacy for the prescription drug. In this case, the PBM keeps a portion of the amount paid to them by the health plan for the prescription drugs, instead of paying pharmacies in	When PBMs charge insurers more for a drug than they reimburse pharmacies.	https://www.commonwealthfund.org/publications/explainer/2019/apr/pharmacy-benefit-managers-and-their-role-drug-spending#:~:text=A%20separate%20controversy%20involves%20a,pay%20pharmacies%20for%20these%20drugs.	A PBM charges insurance $100 for a medication but reimburses the pharmacy only $60.

	full; keeping the difference (or “spread”) as profit.			
Maximum Allowable Cost (MAC)	A standard measure used by pharmacy benefit managers (PBMs) when paying back retail pharmacies in their network. It is the upper limit/highest amount that the PBM will pay the pharmacy for a drug.	The highest amount a PBM will reimburse for a generic drug.	http://www.pbmwatch.com/mac-information-center.html#:~:text=Maximum%20Allowable%20Cost%20(%22MAC%22,(multi%2Dsource%20brands)	If the MAC for a generic statin is $5, pharmacies are reimbursed no more than $5 per pill.
Direct/Indirect Remuneration Fees (DIR)/Clawbacks	DIR fees are fees charged to pharmacies by pharmacy benefit managers (PBMs) and can include fees for being a part of the PBM’s network of pharmacies, compliance fees, fees for filling a prescription drug, fees based on pharmacy performance on meeting metrics, etc. These fees are sometimes charged weeks to months after a prescription drug is filled in a pharmacy. Ultimately, a clawback is the process of pharmacy benefit managers recovering from the dispensing pharmacy, and keeping as profit, the difference between a patient’s co-payment and the pharmacy drug cost when the co-payment exceeds the pharmacy drug cost. This leads to a higher drug cost than what the actual cost is and leads patients to pay higher copays for their medications.	Fees PBMs charge pharmacies after prescriptions are dispensed.	https://www.nacds.org/dir-fees/ http://www.nachc.org/wp-content/uploads/2019/02/White-paper-explaining-DIR-fees.pdf	A pharmacy is reimbursed $100 but later receives a $10 DIR fee, reducing net payment to $90.

Wholesale Acquisition Cost (WAC)	An estimate of the manufacturer's list price for a drug to wholesalers or direct purchasers. This does NOT include discounts or rebates.	The manufacturer's list price before any discounts.	https://www.uspharmacist.com/article/understanding-drug-pricing	A brand-name drug has a WAC of $500, but insurers negotiate lower prices.
National Average Drug Acquisition Cost (NADAC)	NADAC is based on the retail price surveys focused on the retail community pharmacy acquisition cost. It is used as a standard point of reference that reflects prices paid by community pharmacies to obtain (or acquire) prescription and over the counter drugs. Medicaid updates the NADAC data on a weekly basis with the goal of pharmacy providers are paid back adequately for their professional services.	The national benchmark for pharmacy acquisition costs of drugs.	https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/ful-nadac-downloads/nadacmethodology.pdf	Medicaid reimburses pharmacies based on NADAC instead of WAC.
Generic Effective Rates (GERs)	GERs and BERs are rates set by a pharmacy benefit manager (PBM) when they get into a contract with a pharmacy to manage the pharmacy's generic or brand drug spend. PBMs promise that they will provide a certain percentage discount off the average wholesale price of the generic or brand drug. For example, a GER/BER of 75% means the PBM will pay a pharmacy 75% less than the average wholesale price of that generic or brand drug. Although this may seem beneficial for pharmacies, the actual cost for the pharmacy of acquiring the generic/brand drug may be a lot higher than the reimbursements they	The overall reimbursement rate a PBM pays for all generic drugs.	https://www.pharmacyowners.com/generic-effective-rate-ger https://www.wearegnp.com/insights/what-pharmacies-should-know-about-dir-fees-and-ger-and-ber-recoupments	A pharmacy chain negotiates GERs to ensure consistent generic drug reimbursements.
Brand Effective Rates (BERs)		Similar to GERs but applied to brand-name drugs.		PBMs set BERs to control brand-name drug spending.

	receive from PBMs through GERs/BERs. Also, PBMs may not be clear in the contract and use maximum allowable cost (MAC) pricing and if PBMs pay the pharmacy above the MAC, they charge the pharmacy to get their money back. GERs and BERs may lead to significant loss in profit for pharmacies.			

Pharmacy & Healthcare Models

Term	Previous Definition	Updated Definition	Resource	Example in Pharmacy Practice
Medicaid Managed Care Model (MMCM)	Plans that focus on preventive health care. These plans contract with various types of Managed Care Organizations (MCOs) to deliver Medicaid program health care services which can lead states to REDUCE Medicaid program costs and better manage the use of health services.	Private insurers manage Medicaid benefits.	https://www.medicaid.gov/medicaid/managed-care/index.html https://www.health.ny.gov/health_care/managed_care/#:~:text=Medicaid%20Managed%20Care%20offers%20many,managed%20care%20where%20you%20live.	A Medicaid patient's prescription coverage is handled by a private insurance company.
Medicaid Fee-for-Service (FFS) Model	A health care delivery system that allows the state to pay a covered individual's healthcare providers directly, instead of having individuals being enrolled in a managed care plan. This payment model rewards healthcare providers for the number of services provided, regardless of the outcome.	Medicaid directly reimburses providers for each service.	https://www.venturefothe.com/insurance-options/medicaid-ffs/#:~:text=Medicaid%20FFS%20(fee%2Dfor%2D,in%20a%20managed%20care%20plan.	The state pays pharmacies directly for prescriptions filled by Medicaid patients.
Value-Based Care Model	*** NCODA does not have this listed on the website	A healthcare approach that reimburses providers based on	https://www.ama-assn.org/practice-management/payment-delivery-models/what-	In a value-based care model, a primary care physician is rewarded for successfully managing a

		patient outcomes and quality of care rather than service volume.	value-based-care#:~:text=%E2%80%9CValue%2Dbased%20care%20is%20really,the%20AMA%20Update%20video%20series.	patient's chronic conditions, improving their overall health, and reducing hospital admissions.
Health Insurance Marketplace	A health insurance marketplace, also known as a health insurance exchange, is a place (both online and in-person) where consumers in the United States can purchase private health insurance plans They may also receive income-based subsidies to make coverage more affordable With the exception of people who are enrolled in Medicare coverage, almost all Americans are eligible to use the health insurance marketplace	A platform where individuals shop for insurance under the ACA.	https://www.healthinsurance.org/glossary/health-insurance-marketplace/	A patient selects a subsidized plan based on income level.
Affordable Care Act (ACA)	The Affordable Care Act is the comprehensive health care reform law passed in March 2010. It is also known as the Patient Protechtion and Affordable Care Act or “ACA”. The goal of this law is to make health insurace more affordable and more available for lower-income individual or families. This leads to lower healthcare costs in general.	A law that expanded healthcare access and reduced costs.	https://www.hhs.gov/healthcare/about-the-aca/index.html	ACA mandates coverage of essential medications.
Grandfathered Health Plan	A health insurance policy that was in place BEFORE the Affordable Care Act (ACA) was	A health plan that existed before the ACA and is exempt from some new rules.	https://www.insurance.wa.gov/what-grandfathered-plan	A patient remains on a plan that does not cover certain preventive services.

	signed on March 23, 2010			
Plan Sponsor	An employer or organization that offers a group health plan to its employees or members.	The entity responsible for administering a health plan.	https://www.bcbsm.com/agents/help/faqs/hipaa-faq/general/what-is-a-plan-sponsor.html#:~:text=A%20plan%20sponsor%20is%20an,to%20its%20employees%20or%20members.	An employer provides a health insurance plan for its employees.

Pharmacy Operations & Clinical Terms

Term	Previous Definition	Updated Definition	Resource	Example in Pharmacy Practice
Utilization Review Process	The process of making sure healthcare services are being used appropriately and efficiently. This review is done by a covered individual's health plan to evaluate the covered individual's care plan, including the need for certain medications and services. It is done to confirm whether or not the health plan will provide coverage for the medication, service, or treatment plan under review.	Evaluation of the necessity and cost-effectiveness of medications.	https://www.verywellhealth.com/utilization-review-what-it-is-how-it-works-1738788	A PBM reviews a request for an expensive cancer drug before approval.
Therapeutic Interchange Process	Practice of replacing, with the prescriber's approval, a prescription	Substituting a prescribed drug with another similar medication.	https://www.amcp.org/policy-advocacy/policy-	A pharmacist switches Nexium to omeprazole with prescriber approval.

	medication originally prescribed for a patient with an alternative prescription medication that produces equivalent therapeutic and clinical effectiveness based on available scientific evidence. Essentially, this process may allow a pharmacist to substitute the originally prescribed drug for a drug that is "therapeutically equivalent," which can save patients money for the care that they need.		advocacy-focus-areas/where-we-stand-position-statements/therapeutic-interchange-0	
Drug Formulary	A list of generic and brand name prescription drugs covered by an individual's health plan.	A list of covered medications in an insurance plan.	https://www.goodrx.com/insurance/health-insurance/medication-formulary	A medication not on formulary may require prior authorization.
Health Plan Formulary Tiers	Health plan's formulary are usually divided into 3 or 4 categories called "tiers" Drugs are placed in tiers based on the type of drug (such as generic, preferred brand, non-preferred brand, and specialty). Usually, the lower the tier, the lower the copay or out of pocket costs. Non-preferred medications will usually be placed in higher tiers and cost more whereas	Categories of drugs that determine cost-sharing levels.	https://www.goodrx.com/insurance/health-insurance/medication-formulary	A patient pays more for Tier 3 drugs than Tier 1 generics.

	generics will be placed in lower tiers.			
Prior Authorizations (PAs)	A process used by health plans to determine if a prescribed product will be covered in full or a portion. This process requires the doctor, or another provider prescribing the medication/other services, to get approval from the insured's health plan BEFORE the cost is covered by the health plan and the medication is given to the patient. This process can be long and DELAY patients from getting the care that they need.	Insurance approval required before a drug is covered.	https://www.cigna.com/individuals-families/understanding-insurance/what-is-prior-authorization	A prescriber submits a PA for a high-cost biologic drug.
Step Therapy Protocols	A process used by health plans/pharmacy benefit managers which require a patient to try and fail other medications (which are usually less expensive or generic) before they can use the medication/treatment originally prescribed to them by their doctor or provider (which may be more expensive or branded).	Requirement to try lower-cost drugs before expensive alternatives.	https://www.crohnscolitisfoundation.org/sites/default/files/2020-06/infographic2%20%281%29.pdf	A patient must use metformin before insurance covers a newer diabetes medication.
Extrapolation (in audits)	A process in which the auditor, chosen by the pharmacy benefit manager, reviews only a CERTAIN NUMBER of all claims submitted INSTEAD of all of the	Using a sample of claims to estimate overall billing accuracy.	https://www.pharmhealthlaw.com/single-post/2018/05/29/extrapolation-in-audits-when-pbms-use-it/	A pharmacy audit finds issues in 5% of claims and applies that rate to all claims.

	claims. From that number, the auditor counts the number of claims with errors or claims that do not comply with regulations, and extrapolates that across the TOTAL number of claims submitted. For example, if 500 claims are submitted by a pharmacy of which the auditor reviews 50 of them and finds that 5 contain errors, the auditor will EXTRAPOLATE and seek recoupment (or refund) for 10% of ALL 500 claims submitted. This is not an accurate representation of how many claims actually contained errors/non-compliance.			

Medication Distribution Models

Term	Previous Definition	Updated Definition	Resource	Example in Pharmacy Practice
White Bagging	White bagging practices occur when insurance companies require oncologists and health care facilities to administer medications that have been prepared from outside of the hospital. More specifically, the drug is purchased from an OUTSIDE PHARMACY (usually specialty pharmacy), that is under contract with the insurance company, and then SHIPPED to the hospital,	When insurance companies require physicians and healthcare facilities to have specialty (from an outside specialty pharmacy) meds shipped directly to a provider and administered to the patient. Concerns with white bagging	https://nabp.pharmacy/wp-content/uploads/2018/04/White-Bagging-and-Brown-Bagging-Report-2018_Final-1.pdf	A specialty pharmacy ships a cancer drug to a hospital.

	physician's office, or clinic to be administered to the patient	involve the uncertainty of whether or not the drugs have been properly stored, mixed, transported, and labeled. This leads to uncertainty with the safety and effectiveness of the drugs, increasing the risk of fragmentation of care and delays in treatment.		
Brown Bagging	Brown bagging practices occur when insurance companies require a medication to be dispensed from a pharmacy (usually specialty pharmacy) DIRECTLY to the PATIENT, who then TRANSPORTS the drug to the physician's office or clinic to have it administered	When insurance companies require patients to pick up and/or have directly delivered specialty meds and then take them to a provider/office to have administered. Concerns with brown bagging involves the uncertainty of whether or not the drugs have been properly stored by the patient and transported by mailing services or the patient. This leads to uncertainty with the safety and effectiveness of the drugs, increasing the risk for fragmentation of care and delays in treatment.	https://nabp.pharmacy/wp-content/uploads/2018/04/White-Bagging-and-Brown-Bagging-Report-2018_Final-1.pdf	A patient picks up Remicade from a pharmacy and brings it to an infusion clinic.
Clear Bagging	Clear bagging practices occur when a health system's OWN SPECIALTY PHARMACY delivers medication to the hospital, physician's office, or	A hospital's own specialty pharmacy supplies medications for administration.	Benefits of these practices include improved transparency among stakeholders involved with patient	A hospital pharmacy provides chemotherapy directly for treatment.

	clinic for administration to a patient.		care, reduced concern with stability/storage/effectiveness of drugs, reduced risk of treatment delays, and improved continuity of care. https://hospalliance.org/gold-bagging-is-the-newest-emerging-terminology-in-the-system-owned-specialty-pharmacy-arena/ https://nabp.pharmacy/wp-content/uploads/2018/04/White-Bagging-and-Brown-Bagging-Report-2018_Final-1.pdf	
Gold Bagging	Gold bagging is an emerging and more modern term that is very similar to clear bagging but with more of a gold-standard, comprehensive, and patient centered approach ensuring that quality care is delivered. It is more controlled and focuses on updated information regarding patients' physicians, patients' electronic medical records, and emphasizes the health system's own pharmacy processes (monitoring patients' labs, ensuring proper infusion preparations, etc.).	The insurer mandates the use of a specific specialty pharmacy.		A patient must get their specialty medication from the insurer's chosen pharmacy.

Billing & Reimbursement Terms

Term	Previous Definition	Updated Definition	Resource	Example in Pharmacy Practice
Prescription/ Medication Synchronization	The process of a pharmacist coordinating a single day each month for patients to pick up their medication refills instead of having to come in to the pharmacy on different days to pick up their refills This is convenient for patients, allowing them fewer trips to the pharmacy to pick up their medications and	Aligning refill dates for multiple prescriptions.	https://www.aphafoundation.org/align-my-refills/about-medsync	A pharmacy coordinates refills so a patient picks up all medications at once.

	the chance to meet with their pharmacist monthly to discuss their medications			
Recoupment	For conducted audits, recoupments are requests for refunds from the auditor on claims that the health plan/PBM overpaid so that they are able to recover that extra money.	When an insurer takes back payments after an audit.	*** No resource on NCODA website	A PBM reclaims money from a pharmacy due to claim discrepancies.
Fiduciary Duty	A fiduciary duty exists in law when a person or entity (such as a health plan) places trust, confidence, and reliance on another (such as a pharmacy benefit manager) to exercise discretion or expertise in acting on behalf of the client. In this case, a pharmacy benefit manager must act in the best interest of the health plan it is contracted with.	A legal obligation to act in the best interest of patients.	https://www.investopedia.com/ask/answers/042915/what-are-some-examples-fiduciary-duty.asp	A pharmacist ensures ethical dispensing of medications.
Adverse Determination	A determination made by the health plan or health maintenance organization that the health care service has been reviewed and, based on the information provided, it is not medically necessary or appropriate	An insurer's decision to deny coverage for a service or medication.	https://www.ameritas.com/OCM/GetFile?doc=041605#:~:text=(adverse%20determinations).-,%22Adverse%20Determination%22%20means%20a%20determination%20made%20by%20us%20that%20a,not%20medically%20necessary%20or%20appropriate.	A claim for an expensive drug is denied, requiring an appeal.
Current Procedural Terminology (CPT) Codes	CPT stands for Current Prodcedural Terminology. CPT codes are used by doctors and health	Standardized codes used for billing medical services, including pharmacy interventions.	https://www.ama-assn.org/practice-management/cpt/cpt-overview-and-code-approval#:~:text=CPT%C2%AE%20code%3	A common CPT code used in pharmacy is CPT 99211, for a brief office visit with an established patient

	care professionals as a way of organizing medical services and prodecures in a uniform language. CPT codes are commonly used in the U.S to effectively and accurately report medical services under private and public health insurance programs.		F-,What%20is%20a%20CPT%C2%AE%20code%3F,reporting%2C%20increase%20accuracy%20and%20efficiency	

Cost Control Mechanisms

Term	Previous Definition	Updated Definition	Resource	Example in Pharmacy Practice
Copay Accumulator Programs	Started by insurers and pharmacy benefits managers to track an insured's accumulated, or total gathered, out of pocket expenses. These programs STOP manufacturer coupons from counting towards the insured's deductible & MOOP.	A program that prevents manufacturer copay assistance from counting toward deductibles.	https://www.ncoda.org/copay-accumulator-patient-resources/ https://infusioncenter.org/understanding-copay-accumulators-who-really-benefits/	A patient using copay cards still pays full deductible before insurance kicks in.
Copay Maximizer Programs	Started by insurers and pharmacy benefits managers to increases an insured's copay amount for a medication and evenly divide it to estimate the manufacturer coupon's monthly value. These programs also prevent manufacturer coupons from counting towards an insured's deductible & MOOP.	Uses manufacturer assistance to cover the highest copay without applying to deductibles.	https://infusioncenter.org/understanding-copay-accumulators-who-really-benefits/	A specialty pharmacy ensures the full copay is covered by assistance programs.

Reverse Auction Process	Occurs through an online platform in a clear and visible way. Pharmacy benefit managers compete with one another and counter offer LOWER prices in each auction round when selecting a health plan to contract with. The winning bid in this process is the LEAST expensive offer.	PBMs compete to offer the lowest drug costs for insurance plans.	https://www.nashp.org/states-save-on-rx-spending-by-using-reverse-auctions-for-pharmacy-benefit-manager-service-procurement/	A state Medicaid program lowers costs by making PBMs bid for contracts.